REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

CORONIAL JURISDICTION IN NEW SOUTH WALES

CORRECTED

At Virtual hearing, Video conference, Sydney on Wednesday, 29 September 2021

The Committee met at 9:30 am

PRESENT

The Hon. Adam Searle (Chair)

The Hon. Catherine Cusack
The Hon. Trevor Khan
The Hon. Rod Roberts
The Hon. Penny Sharpe
Mr David Shoebridge (Deputy Chair)

The CHAIR: Welcome to this virtual hearing for the inquiry into the coronial jurisdiction in New South Wales. Before I commence I would like to acknowledge the Gadigal people of the Eora nation, who are the traditional custodians of the land on which Parliament sits and where I am today. I would also like to pay my respects to the Elders past, present and emerging of the Eora nation and extend that respect to all Aboriginal persons present.

Today's hearing is the Committee's first public hearing and is being conducted virtually. This enables the work of the Committee to continue during the COVID-19 pandemic without compromising the health and safety of members, witnesses and staff. As we break new ground with the technology, I ask for everyone's patience through any technical difficulties we may experience or encounter today. If participants lose their internet connection or are disconnected from the virtual hearing, they are asked to rejoin the hearing by using the same link provided by the committee secretariat. Today we will hear from a number of stakeholders and witnesses, including previous State Coroners and a Deputy State Coroner, and legal experts and researchers in the field of the coronial jurisdiction.

Before we commence I would like to make some brief comments about the procedures for today's hearing. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the virtual hearing. I therefore urge witnesses to be careful about comments they may make to the media or to others after they complete their evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. There may be some questions that witnesses could answer only if they had more time or with certain documents to hand. In these circumstances, witnesses are advised that they can take a question on notice and provide an answer within 21 days of receipt of the transcript. Today's proceedings are being streamed live and a transcript will be placed on the Committee's website once it becomes available.

Finally, I will make a few notes on virtual hearing etiquette to minimise disruptions and assist our Hansard reporters. I ask Committee members to clearly identify to whom questions are directed and I ask that everyone please state their name when they begin speaking. I ask that everyone please mute their microphones when they are not speaking. Please remember to turn your microphones back on when you are getting ready to speak. If you start speaking whilst muted, please start your question or answer again so it can be recorded in the Hansard transcript. Members and witnesses should avoid speaking over each other so we can all be heard clearly. I remind members and witnesses to speak directly into the microphone and avoid making comments when your head is turned away.

MARY JERRAM, NSW State Coroner from 2007 to 2013, affirmed and examined

HUGH DILLON, Deputy NSW State Coroner from 2008 to 2016, and researcher in relation to coronial systems at the Law Faculty, University of New South Wales, sworn and examined

MICHAEL BARNES, Queensland State Coroner from 2003 to 2013, and NSW State Coroner from 2014 to 2017, affirmed and examined

The CHAIR: I now welcome our first panel of witnesses. Would any of you like to make a short opening statement, given I know you have all provided very useful and comprehensive written submissions? Adjunct Professor Dillon, yours is very comprehensive. Nevertheless, each of you is welcome to make an opening statement should you wish, or we could just proceed to questioning. Ms Jerram, did you wish to give an opening statement?

Ms JERRAM: Yes. It will be very short, I assure you.

The CHAIR: Please proceed.

Ms JERRAM: Honourable Mr Chair and other honourable members, thank you for inviting me to this hearing. I will speak briefly, as it is now six years since I last sat in the coronial jurisdiction and I am not up to date with changes which may have been made in that time. My two learned colleagues provide you with further details on some areas. However, I believe nothing has altered to redress the major discrepancies with other States that I witnessed during my years as State Coroner. I realised then how important the coronial jurisdiction is, not only for the bereaved but also for victims of natural disasters and for all those concerned with justice. I realised how much more could be achieved with full resources and independence, and being answerable only to the Attorney General as the specialist area which it is, rather than being a subsidiary of the Local Court.

I observed with envy the Victorian system, with its independence and 14 coroners, and New Zealand's 21 coroners compared to the then five—recently become six—full-time coroners in New South Wales with its considerably larger population. Then and now, Victoria has a Coronial Prevention Unit of 21 researchers who coordinate, disseminate recommendations and publicise; New South Wales has effectively none. The Victorian attorney appoints coroners in consultation with the State Coroner. In New South Wales the State Coroner has virtually no input into appointments, which are always from the ranks of the Local Court, and coroners as a matter of practice are liable to be moved back to the general magistracy every three years, thus both failing to achieve the standard of the most skilled and suitable personnel and often wasting experience learned, which takes a year or two to develop.

Coronial work is significantly different from that of a general magistrate. In New South Wales, country magistrates with heavy daily workloads are expected to undertake some coronial work while having neither the opportunity properly to gain full experience and training in that field nor the benefits of the collegiate system pertaining in Sydney's head Coroners Court amongst the full-time coroners. With more full-time coroners, regional matters should be handled from Sydney either by bringing cases in or by a coroner travelling to the locale, as occurs now only with major matters. Finally, to provide the authority and dignity to the jurisdiction that it requires, in my view the State Coroner should be a judge, as in Victoria and New Zealand. The public deserves such a reflection of the importance of this specialist area, which should be seen to be acknowledged by government. Thank you.

Adjunct Professor DILLON: I also have some remarks. I have timed myself; this will take about 3½ minutes, so forgive me if I run over the three minutes. I thank the Select Committee for the invitation to give evidence at this important inquiry. I am speaking to you from Drummoyne, which is traditional Wangal country. I respectfully acknowledge the Elders and traditional custodians of the lands on which this inquiry is taking place. This inquiry and the Government's response to it will probably shape the coronial system for generations. In the past 30 years fundamental changes in the philosophy and practice of coronership have been prompted by inquiries around Australia and internationally. In New South Wales, however, serious reform has been resisted within the Local Court. The result is a suboptimal death investigation system which particularly disadvantages people living in country and regional New South Wales.

Why does this matter? Because it implies a lack of proper respect for the dead and their bereaved relatives and a failure to recognise the common humanity of ourselves and those who are mourning and the dead; because it inflicts additional unnecessary suffering on people who have the misfortune to be drawn into the coronial system; because we do not learn all the lessons we should from preventable deaths; because government agencies and agents involved in deaths are not always held fully to account; and because opportunities for healing and restorative justice are missed.

What is to be done? The great management thinker, Peter Drucker, argued:

> To make service institutions and service staffs perform does not require genius. It requires, first, clear objectives and goals. Next, it demands priorities on which resources can be concentrated. It requires, further, clear measurements of accomplishment. And, finally, it demands organised abandonment of the obsolete.

The coronial jurisdiction falls short on all four Drucker criteria. Its statutory goals and priorities lack clarity. It lacks a strategic plan to meet its objectives. Its KPIs and measurements of performance are inadequate and in some respects misleading, such as the over-emphasis on high clearance rates. Finally the Coroners Act 2009, with its obsolete arrangements of the Chief Magistrate having control and direction of the jurisdiction and of country magistrates acting as coroners, reflects an anachronistic concept of coronership that has been abandoned in every other jurisdiction in Australia—and, I may say, practically everywhere else in the Commonwealth.

The coronial system has a number of real strengths, especially the people who work within it and its culture of compassion. The Committee has read some heartbreaking stories in submissions, but there are also stories of healing and catharsis. Nevertheless, the system and its structure make it harder than it should be to produce healing outcomes and to prevent future deaths. To build on its strengths, we need a new Act and a new specialist court. We need coordination of the whole multidisciplinary system. We need resources to meet the system's objectives in a timely and humane way. We need a much more serious commitment to prevention of death. The coroners and the system as a whole need proper KPIs and reporting mechanisms. And those who are suffering need more therapeutic and restorative processes. Thank you.

Mr BARNES: I would like to just make a few remarks about what I say is one of the essential characteristics of a reformed coronial system: the need for all coronial work to be undertaken by specialist full-time coroners. In my submission, support for the proposition that all coronial work should be done by specialist full-timers can be found in three characteristics of coronial work: one, the need for esoteric expertise; two, the profound difference between an adjudicator and an inquisitor; and three, the logistical challenges that invariably confront part-time magistrate coroners.

If we turn to expertise first, an effective coroner must be able to recognise and balance competing priorities: the investigation, death prevention and the assuaging of bereavement. What circumstances justify giving precedence to one over the others and to what extent? Should the body be brought to the government mortuary for autopsy or tests? What level of autopsy should be ordered? Should tissue or organs be retained? Which family member's views should be preferred? When should those views be overruled? To whom should the body be released? When should an operating theatre or other death scene remain unchanged and when can the body be moved and cleaned for family viewing? When should family be given access to the death scene? What material can be released to family members and when? Should an inquest be held to generate recommendations? What recommendations can be made?

Many slight variations in circumstances can mandate a different answer to each of these questions. Those answers cannot be found in legal texts or judicial authorities; they depend upon the Coroner having sufficient tradecraft, which can only be developed with considerable experience that unfortunately is unlikely to be available to part-time regional magistrate coroners. The other experts involved in coronial cases—the detectives, the pathologists, the various specialist investigators—will offer conflicting advice based on the perspective of their respective disciplines. The Coroner has to be sufficiently experienced and confident to know which to follow in any given case.

I turn now to the question of an inquisitor. With no parties to determine the course of the investigation or the inquest, the Coroner must be comfortable to take the lead and must have sufficient understanding of the contributing disciplines to know what steps are warranted—to do everything that is necessary, but only what is necessary. It is not a homicide investigation, except when it is. Anticipating at an early stage what is needed to be done to answer the likely questions of interested parties and to enable the Coroner to make the required statutory findings is a very different task from adjudicating on whether the evidence the parties to a criminal or civil action have chosen to put before the court has discharged their onus.

Expertise in one type of proceeding does not necessarily equip one to adequately preside over and manage the other. There is a huge range of possible investigative responses to most reportable deaths. Do too much, order too many tests or require too many witness statements and the whole matter will be unnecessarily prolonged—and the whole system can get clogged up and bogged down, with terrible results. Conversely, the failure to order a particular test may result in the permanent loss of the opportunity to do so, resulting in key questions being unable to be answered. Regional magistrate coroners who only handle a few cases each year may never develop sufficient experience to make these calls. While they wrestle with these issues, the family is waiting to get the body of their loved one back so that they can proceed with the grieving, the death ceremonies, and the waiting for answers about why their loved one has died and whether it could have been avoided.

The third and last aspect I want to address is logistics. In the hours and days following a reportable death key decisions must be made in a timely manner based on ready access to vital information. In order to make properly informed decisions in relation to the various matters I have already referred to, a coroner may need access to medical histories, death-scene photographs, the views of family members and the opinions of pathologists and detectives. Often this information cannot simply be requisitioned all at once. The answer to one question needs to be considered and frequently leads to another, and so on.

At the beginning or at the end of a court day regional magistrate coroners frequently have to drive from one centre to another. Even if they are presiding in the centre in which they reside, a regional magistrate usually has a lengthy list to manage or a contested trial to hear. It can be difficult for a magistrate in that situation to process the information as it comes in and to consider what more might need to be discovered. Making decisions "on the corner of the desk" as they move between matters or move between court centres is far from ideal. In some regions it is not unusual for the body to be in one town, the coroner's clerk to be in another and the Coroner to be in a third area. Information and communication technology is frequently unreliable. While all these issues are juggled the family, in its most vulnerable time, is asking for answers that, unfortunately, they frequently do not get. That is all I would like to say at this stage. Thank you, Chair.

The CHAIR: I thank all three of you for your opening statements and for your submissions in writing. Adjunct Professor Dillon, I think yours is very comprehensive. With the indulgence of Committee members, I might commence the questioning. My first questions are to the two former Coroners, Mr Barnes and Ms Jerram. In the legislation as it currently stands, the Coroner and the deputy State coroners must be magistrates. All magistrates are automatically coroners, but there is a provision in the Act for people to be appointed coroners who are not otherwise magistrates. Has the Government ever availed itself, in your experience, and appointed people as coroners who are not also magistrates?

Ms JERRAM: No, as far as I am aware. Apart from the last few years—and Mr Barnes may know this a bit more recently. But no, never appointed directly from outside.

Mr BARNES: The only time I am aware of it happening is when it has been necessary to bring a coroner from another State to deal with a matter that local coroners could not deal with because of a potential conflict. But in each case that I am aware of that happening, the person who has been brought from another State has been a coroner in the State in which they usually reside.

Adjunct Professor DILLON: Sorry, could I just add something to that? When the 2009 Act was drafted there were a small number of registrars who were coroners and the Act, I think, was drafted so as to enable them to continue on as coroners. For example, at the Glebe Coroners Court I think the registrar was a coroner and also the executive officer was a coroner, and there were one or two people in the country. I think that was the reason. The Act as you read it literally seems to suggest that people who are not magistrates could be appointed for particular inquests or something like that, but I think it was more to protect public service positions than for any other reason that the Act was drafted that way.

Ms JERRAM: But Mr Dillon, I do not think that anybody, after the 2009 Act, who was a registrar continued to carry out coronial duties—not in my experience, anyway. Whereas when I was magistrate at Goulburn well before that Act the clerk of the court, as he then was called, did almost all the coronial matters and he was not legally trained. He did them quite well, I think, but he was not legally trained at all. Yes, I do not [disorder]—

Adjunct Professor DILLON: Ms Jerram, I can tell you that Don McLennan, for example, at Glebe was a coroner. He worked, he was—

Ms JERRAM: [Disorder].

Adjunct Professor DILLON: —commissioned as a coroner and he only did natural-cause deaths. That is why he kept that commission, I suppose. He was allowed to do that. There was a man at Gosford, also. It was an anomaly.

The CHAIR: Okay. I would just like to turn now to the issue of resourcing. Mr Barnes, in your submission at paragraph (26) you make the point that the resourcing of the coroners' jurisdiction here in New South Wales on a per capita basis is about half that of Victoria and Queensland. I think, Mr Dillon, you attach one of Mr Barnes' analyses of the review of government spending at page 80, I think, of your submission. The funding of the New South Wales coronial jurisdiction compared to other States is anywhere between 45 per cent and 60 per cent. What impact is that significantly lower level of resourcing having on the outputs and the ability of the coronial jurisdiction to meet its existing statutory charter, apart from any greater aspiration that people might have for the jurisdiction?

Mr BARNES: In my experience it means that matters which should go to inquest or should be further investigated do not receive that level of attention, simply because the coroners do not have the capacity to do it. You simply have to finalise about as many matters that are coming in or you will get buried in a backlog. That is only achieved by dispensing with inquests expeditiously, even though there might be legitimate questions that you would otherwise choose to investigate.

Adjunct Professor DILLON: It is one of the most frustrating aspects of working as a coroner. If you think about it, 40 per cent of deaths reported in New South Wales—around about that number—are unnatural deaths. That is of the order of 2½ thousand deaths per annum, maybe more—even up to 3,000—of which only around about 100 go to inquest. Given the Act only allows you to make recommendations if you hold an inquest, there is an enormous pond or reservoir of preventable deaths that we are not addressing at all. Of course, you could tackle that in different ways if the Act allowed you to do that, but at the moment five full-time coroner positions simply cannot cope with that enormous number of preventable deaths, much less the country coroners. The country coroners do hardly any inquests at all. Of the inquests they do, very few result in recommendations to prevent future deaths. The system is just not tackling that problem as it should be doing.

The CHAIR: Mr Dillon, in your submission at page 3 you raise the prospect that maybe, like in Ontario, the New South Wales legislation should be expanded to allow coroners to make recommendations arising out of investigations, not only out of the actual inquests. Would that be a significant reform measure that could be recommended here?

Adjunct Professor DILLON: I think it is, but not if unqualified, amateur coroners were doing it. I remember talking about this with Michael Barnes some years ago. We both concluded that it was a good idea in theory, but you would not want to let a lot of the country magistrates start making recommendations because they simply did not have the expertise to do so. The expertise problem that Mr Barnes talked about earlier is an impediment to adopting that kind of system, I think.

The CHAIR: Mr Dillon, I note in your submission—and I think it arises elsewhere—you make the point that there is no specific training given to people to be coroners. I am of the understanding that when people become magistrates or judges the Judicial Commission of New South Wales does provide a certain level of basic training for new appointees. But would I be right in assuming—and maybe the witnesses who were the Coroner can confirm or elaborate on this—that people who are made coroners do not get specific coronial training before they commence duties? Is my understanding correct?

Adjunct Professor DILLON: There is a little bit of training. It did improve when Ms Jerram was appointed. Newly appointed magistrates who were about to go and do their country service would come and spend a little bit of time at the Coroners Court. The problem is that it takes time to develop expertise. I would say it took me probably a couple of years before I felt I was competent. We were all doing 600 or 700 cases a year. If you are doing 20 cases a year or 10 cases a year, even with some training in Sydney before you go off to the regions you are just not going to develop expertise.

The training really that I would say I got was basically from on the job, hanging out with more experienced coroners. I would go around to talk to Ms Jerram or Mr Barnes—"I've got a problem," blah, blah, blah, "how do we solve this?"—or talk to counsel assisting, or talk to the pathologists, or talk to the police investigators or whatever. It is an entirely different sort of training. It is kind of like an apprenticeship rather than theoretical training that you might get. Do not forget that most people who are appointed as magistrates have come from the criminal law. They are Director of Public Prosecutions [DPP] lawyers, Legal Aid lawyers or Aboriginal Legal Service lawyers. The Local Court is basically a specialist criminal court, so you are already a specialist in your field when you are appointed to a specialist court. As Ms Jerram and Mr Barnes said, coronial work is completely different. Training has to be done in the Coroners Court.

The CHAIR: Ms Jerram, does that accord with your experience?

Ms JERRAM: Yes, it does. As Mr Dillon says, it was just towards the end of my term that people began to be given, if they came in as a coroner, slightly more training. The only other training they had, though, was that twice a year the regions have a three-day conference and there was usually a coronial component in that. But these are people who are away from home for three days. They would get an hour lecture and question-and-answer from me or Mr Dillon or subsequently Mr Barnes—whoever was presenting—and that was really the extent of their training once they were in a country area.

The CHAIR: Mr Barnes?

Ms JERRAM: Can I just say one more thing?

The CHAIR: Sure.

Ms JERRAM: I think it was Mr Barnes talking about preventable—or was it Mr Dillon?—and the number of inquests. At the moment, for example, I understand the State Coroner is hearing an inquiry into bushfires. There were 25 deaths that had to be investigated. It is not finished yet so I will not comment on anything about it in particular, but that sort of factor is growing daily with natural disasters like floods, bushfires and climate change and they are not being catered for. How can they be, with only six full-time positions in New South Wales?

The CHAIR: I think the Government in its submission makes the point there are 5.3 full-time equivalent judicial officers given to the coronial function here in New South Wales.

Ms JERRAM: Yes.

The CHAIR: Mr Barnes, did you have any views on training?

Mr BARNES: I agree with—

The CHAIR: And then I will open it up to other members for questions.

Mr BARNES: I agree with what both my former colleagues have said. I will just draw attention to one other extra aspect that makes it even more important that proper training be arranged. If I am a criminal barrister and I am appearing in criminal courts on a daily basis I fairly well understand the role of the person on the bench because they do it mostly in front of me, apart from going to their chambers to write decisions; whereas if I am an experienced coronial advocate I participate in inquests but, as we know, that is only 10 per cent of the work of a coroner. I have no exposure to the other 90 per cent of the work that coroners do on a daily basis. There is no exposure to that sort of work for people in private practice, so I come to the court even less well equipped to discharge the role than were I going as a criminal barrister to a general court list.

Ms JERRAM: Good point.

The CHAIR: I have many other questions but I might throw to other Committee members, starting with Mr Shoebridge, to ask their questions.

Mr DAVID SHOEBRIDGE: Thanks, Chair, and thanks to all of you for being here. We really do not have enough time with you so I will try to be quick. Can I ask first about resourcing? The *Report on Government Services* data seems to be questionable at best. [Audio malfunction] I think Mr Dillon—sorry, that was a cat launching itself through my house. The *Report on Government Services* seems to be questionable at best, suggesting that the New South Wales spend is $990 per finalised case as against the national average of $2,195. That seems to be because it is very hard to work out what the Coroners Court does in New South Wales—costing the regional work, costing the registry work, costing the forensics work. Can any of you shed some light on the actual funding?

Ms JERRAM: I defer to my more learned colleagues about that. I have not done any research recently into that.

Mr BARNES: I agree. Mr Dillon has done more work, but I think Ms Jerram's crude measure is still the most valuable: Some 5½ or six magistrates in a State as big as New South Wales compared to the rest of the country is ludicrous.

Mr DAVID SHOEBRIDGE: Yes. That is a good reality check. Mr Dillon?

Adjunct Professor DILLON: Yes, well it is; it is the reality check, really. I was thinking about this last night, to be honest. I think New South Wales is doing it on the cheap. Some $990 per case is the spend on the Lidcombe effort divided into 6½ thousand cases; I think that gives you a case cost of around about $1,800. This is very, very rough—and the Government should be doing it itself, of course. But my feeling is that Queensland probably—because it is the most comparable of jurisdictions—spends around $2,200 per case. I think if we take that number, that is probably what it costs per case in New South Wales. What the real number is I have no idea, and the Government and Local Court make no effort to try to work out what the real cost is. But Queensland has seven or eight—I think eight—coroners now. We have five and there is going to be a new one appointed, so coming up to six. It is still a woeful effort, really, when you compare—I think New Zealand, for example, now has 26, up from 21.

Ms JERRAM: And its population is 4½ million.

Mr DAVID SHOEBRIDGE: The Government then responds with other data, trying to suggest that there are no problems in New South Wales. One is the clearance rate. They say—

Adjunct Professor DILLON: That is rubbish.

Mr DAVID SHOEBRIDGE: —the clearance rate for cases in New South Wales is comparable to what it is in Victoria so there is nothing to see here. Do any of you have any comments on that?

Adjunct Professor DILLON: Yes, I do. Look, this is a classic case of picking a statistic that supports a particular view, but it is so misleading. It is really outrageous, frankly. I do not blame the Government for this, really, because this over-emphasis on clearance rates as though it explains everything comes from the Local Court. That is what the Local Court would like to tell everybody is going on—well, I excuse the new Chief Magistrate. Why it is misleading is this: All a clearance rate tells you is how fast files are opened and closed. It does not tell you anything about the quality of the investigation that is done on them.

As we were talking earlier about the number of cases which should go to inquest but are not, they all contribute to a higher clearance rate. But what we can say about those cases is that the adequacy of the investigation is not being investigated itself. In other words, a clearance rate seems to suggest that nothing is wrong and that we have got a very efficient system, whereas it is actually hiding a lack of investigation. If you look at another jurisdiction, say Victoria, where they have a 93 per cent clearance rate, that might suggest actually that they are putting a greater effort into investigating the true causes and circumstances of deaths. A clearance rate can be utterly misleading in itself. Of course you should have high clearance rates if you can, but you should be doing good investigation simultaneously. Quality should not be dismissed at the expense of quantity.

Mr BARNES: Clearance rates are the mechanism by which overworked coroners cope with too much work. Unlike any other jurisdictions—if you get a traffic ticket you can demand a hearing. In the coronial jurisdiction that is not the case. You can ask for an inquest but the Coroner has to choose to give you one, or you go to the Supreme Court, if you can afford that, to get an order that an inquest be held. Coroners manage their workload simply by dispensing with matters. You could say that it is an easy way out for people who do not want to do more work than they need to; I do not think that is the case. I think it is overworked magistrates coping with too much work by simply dispensing—and that is reflected positively for them. They have got a great clearance rate.

Mr DAVID SHOEBRIDGE: Sorry Ms Jerram, did you have something to contribute?

Ms JERRAM: Mr Shoebridge, I do not want to sound just like an echo but I completely agree with what both Mr Dillon and Mr Barnes have just said. The clearance rate really does not reflect anything other than pressure on the coroners and nothing about quality. When you take into account what I mentioned earlier about the increase in major incidents like bushfires having to be investigated it throws any figures out anyway. Who would have imagined the Lindt cafe matter, which took up Mr Barnes' time almost totally for over a year, or now the bushfires?

Mr DAVID SHOEBRIDGE: We see some of that in the ongoing downward trend in the number of actual hearings held. That is also reflected in that overwork, is it not?

Ms JERRAM: Yes.

Mr DAVID SHOEBRIDGE: And it is a good quality check if you are testing whether or not the system is doing what you want it to do, which is interrogate the reasons and rationale for deaths and look for recommendations, if they are not having hearings.

Ms JERRAM: Yes. You obviously have a fairly clear insight, Mr Shoebridge, may I say.

Mr DAVID SHOEBRIDGE: Oh, Ms Jerram, you can keep answering questions!

The CHAIR: Mr Shoebridge, we might move to Mr Roberts and then to Ms Sharpe and then circle back.

The Hon. ROD ROBERTS: Thank you, Chair. Thank you for your attendance today and for your detailed submissions as well. I just want to take you to the practicality side, if I may. It is open to any one of the three of you to answer. Section 23, mandatory inquests, obviously adds to the workloads of coroners. I understand the logic and the reasoning behind mandatory inquests, but do you think that that section or that particular part of our legislation could be looked at? Whereas the death while being in custody—let us just use a Corrective Services facility—the death is clearly of a natural cause. Do you think there is a way we could work the system so that that does not become a mandatory inquest?

Ms JERRAM: I would agree that that is probably not necessary when it is pretty clear that it is a natural cause, but only if it is clear that it is a natural cause could it be dispensed with, in my view. Otherwise, the mandatories are often to do with concerns about the prison officer's treatment of prisoners or the police treatment of possible perpetrators. For those, I can see why they are mandatory. I would think Mr Barnes and Mr Dillon agree with me about that.

Mr BARNES: I think there are opportunities to make savings. You know that it is a mandatory inquest if the Coroner cannot be sufficiently certain about the manner and cause of death. Unfortunately, that has been interpreted to mean, "If you haven't got a body then you've got to have an inquest." Someone falls off the tenth floor of a cruise liner, their body is recovered and they are found to be terribly injured and have ingested a tonne of water. They get a death certificate that says they have died from a fall from a height causing drowning or injury: no inquest. If you do not find their body and you cannot say which was the cause of death you have got to have an inquest. All missing persons have to go to inquest. Another example is homicides. A suicide-homicide where someone shoots a person and then shoots themselves: mandatory inquest because there is a homicide involved. There is room where you could do away with or try to tune those.

I would not be inclined to take deaths in custody out. I think historically there has been such concern about the quality of healthcare given to people in custody—the Royal Commission into Aboriginal Deaths in Custody, for example. You know the heat is still quite understandably around that issue. I think to wind back deaths in custody inquests is unnecessary. I think there are other areas you could make savings.

Ms JERRAM: But Mr Barnes, I certainly can recall several matters where someone very old had been known to be very ill with something terminal for some time while in prison and there was still a requirement for an inquest. Mind you, we dealt with those pretty quickly—

Mr BARNES: I was going to say. It is a half-day inquest at maximum.

Ms JERRAM: Yes, but still, it would be one way of cutting back a little bit.

Mr BARNES: Sure.

Ms JERRAM: I just do not know how many of those there are, Mr Roberts. I cannot tell you a figure on those.

The Hon. ROD ROBERTS: That is fine. [Disorder]

Adjunct Professor DILLON: If I could just add a little bit to that, there are questions sometimes about the quality of care given to dying prisoners. There are concerns of course, particularly from Aboriginal families, about the quality of care and treatment given in detention. I think those are important concerns that need to be addressed. But I also think that there are possibly different ways of running inquests in less adversarial ways than currently is the case. I have been talking recently with the State Coroner about a more therapeutic or restorative process which may be less traumatising for families but also, I may say, for prison staff and Justice Health staff. There are concerns there about the traumatising effect of inquests on those people as well. But I think we need to think about the process as well as just numbers of inquests that we conduct.

The Hon. ROD ROBERTS: Just one other question if I may, Chair, on a different avenue. Clearly from your submissions—and not only yours but others we have received—the Coroners Court and the Coroners Act needs a complete overhaul. Mr Barnes, I think you drew the conclusion—and correct me if I am wrong; I do not want to put words in your mouth—that you prefer a hybrid model similar to the Children's Court. Mr Dillon, you prefer a standalone, completely autonomous model. There is probably merit to both of those. Could you add anything further, Mr Barnes? I must admit that your model enthuses me when I research it further, as distinct from a standalone model. But could you expand on that a bit more for us?

Mr BARNES: Sure. The standalone model is what Victoria has. They have a State Coroner and then appointed coroners. They are appointed for a period of five years; they can be reappointed. I do not support that. I cannot understand why those judicial officers, unlike any others, would not have permanent tenure. As you know, coroners are frequently required to investigate the performance of State instrumentalities—public hospitals, police forces, corrections. To have your reappointment depending upon you making findings that find favour with government I think is hugely dangerous.

The CHAIR: That undermines judicial independence, for a start.

Mr BARNES: Completely. It is inconsistent with judicial independence. The difficulty, though, is that if your only role is to be a coroner and you have got nowhere else to go, if the chief Coroner—or indeed the Coroner himself or herself—comes to the view that "this is not what I thought it was going to be"—and as I said before, there is a great risk of that being the case as no-one really knows what a coroner does until they get in there, going to mortuaries and watching autopsies be performed and the like—you have got nowhere else to go. The chief Coroner has got to either sack you by not getting you reappointed or you have got to choose to abandon your career and try to restart your practice that you have been out of for five years.

Whereas the hybrid model, similar to the Children's Court in New South Wales, means we have got full-time coroners doing all the work but we have the potential for Local Court magistrates to rotate through the

court if they consider that might suit them—and if the chief Coroner and the Chief Magistrate are agreeable. It also means that people can take a break. It is very distressing, confronting work. Doing it for your whole career is not going to suit everybody. Doing it for five years and going back to the Local Court is a legitimate alternative. It also means that the Coroners Court has a more widely distributed workforce. It has coroners in all of the regional towns if there is need for a coronial function to be discharged in a local area. It gives it that surge capacity and that flexibility of workforce. That is why I prefer that model.

Ms JERRAM: On the other hand, there is no reason perhaps why someone who wants to be a coroner cannot be appointed but as a magistrate, and then straight to coroners. I agree that it is too dangerous to have people just on a contract. Conflict of interest is the obvious worst problem about that. I am not quite sure how they deal with that in Victoria. I did try to speak to my ex-colleague, and still friend, Jennifer Coate, who was State Coroner there at the same time I was and who has gone on to greater things since then, as you all know. She seemed to think it worked but I was not quite satisfied as to how it did if someone is on a five-year contract. She said, "Oh well, they might go back to the bar or to the public service," but they would have to have some guarantee of that. What if they did not want to go? I think they often are renewed, the outsiders who have been appointed. But no, I think the hybrid option is probably preferable. But it would have to be strong conferring between the State Coroner and the attorney, as well as with the Chief Magistrate. Of course, then you often have differences of view. I do not know how you legislate for that.

Adjunct Professor DILLON: I have a slightly different view—in fact, quite a big difference of view—to Michael on this subject. I prefer the stand-alone court. I must confess I have flirted with the idea of a limited term for coroners but I have changed my mind completely on that. You need tenured coroners because they do investigate governments and so forth. We have seen in other jurisdictions all sorts of political appointments and that is a very unsatisfactory thing—where people feel they are bound, subconsciously or consciously, to find for governments. Nevertheless I think the real strength of the Victorian model, leaving aside the question of limited term appointments, is that you can recruit from a much wider and deeper pool.

We talked about specialists needed in the jurisdiction. Well if you come from, for example, a background of workers compensation where you are used to industrial accidents, if you come from the public health sector where you are used to dealing with hospitals and root cause analysis and those sorts of things, those are good backgrounds for coroners I think and, in fact, much more suitable backgrounds than the criminal law is. I would not die in a ditch over this argument, I have to say, but I can see the attractions of, I would not call it a Children's Court model, I would call it a Queensland model—where the State Coroner and the Queensland Coroner's Court is linked to but independent from the Queensland Magistrate's Court. I think that works, but I think the problem is that you are drawing your personnel from this pool of Queensland magistrates rather than from the wider legal profession. That troubles me.

Mr DAVID SHOEBRIDGE: You could have separate courts and individual appointments, could you not? You could be appointed to both the Coroners Court and the Local Court and that would resolve the problem that if there wasn't work for the Coroners Court you could move but still have independence?

Adjunct Professor DILLON: Yes.

The CHAIR: The reverse of section 16: if you are appointed a coroner you are also a magistrate, but you are primarily a coroner.

Adjunct Professor DILLON: In Victoria there are people who are magistrates and there are people who are coroners. The magistrate coroners, I assume, have an appointment to the Magistrates Court of Victoria and can go back, as Michael has suggested. It gives you more career flexibility. Personally I would have stayed on as a coroner if I hadn't been told that I was going to be rotated out. I decided I did not want to go back to the Local Court; I opted for re-entering academia. I think the Coroners Court is the most interesting work that a judicial officer can do in New South Wales, and I was told that on my first day as a coroner by a barrister. I do not know why you would want to leave it if you did not have to.

Mr BARNES: You are unusual man to please Mr Dillon.

Adjunct Professor DILLON: Oh well, yes, that is true.

Ms JERRAM: What was your comment, Mr Chair? Sorry, I did not hear you.

The CHAIR: We will go now to Ms Sharpe to ask some questions. I forgot to unmute.

The Hon. PENNY SHARPE: Mr Barnes, I want to ask about the comments in your submission around how coroners deal with bereaved families. You would be aware that most of the members of this Committee have previously done the First Nations deaths in custody inquiry and the extreme issues of concern around that—not all of it actually the court's fault; a lot of it systemic as raised by all three of you today. But I was very interested

in your general comments about that intersection between care for the bereaved versus procedural fairness. I was concerned by your comment about whether suicides are necessarily being declared suicides because of some of that conflict. Do you want to take us through your thinking about that?

Mr BARNES: I think it is an ongoing problem. Are we going to have a legalistic approach to deaths, a restorative approach or a preventative approach? That is what I meant in my opening comments about coroners having to balance competing priorities. If you just want to focus on finding out what happened and making correct decisions about what exactly occurred you, for example, are happy to leave a body in a death scene all day until all examinations can be made of it, even though that means the body will blow up so it is unrecognisable and that is what you give back to the family. That is giving pre-eminence to the investigation. Equally, on other occasions you might say "We are not going to have any autopsy, even though we are not quite sure why the person died. We are reasonable comfortably satisfied it is natural causes, so we will not have an autopsy because the family has a very heart-felt objection to what they would see as mutilation of the body. We are going to release the body to them and make a finding of undetermined natural cause of death." That is giving prominence to the restorative bereavement process.

So on each occasion you have to make a decision about what part of the role is most important. A good example is deaths that occur in a medical setting. The investigation would leave everything where it is. Come in take photographs, leave everything connected, zip up the body bag and send it off to the mortuary. So the family cannot have any contact with the dead person until it gets to wherever that is. Horrible situations of police demanding that a new borne be given to them so they can take it off to the mortuary while the parents are still wanting some contact with their dead child. It is always a question of which do you prefer? Which outcome are you going to give prominence to? That is the sort of difficulty that people who have only practised in the criminal law, I think, might have difficulty achieving that balance.

The Hon. PENNY SHARPE: I am assuming from what you have all said this morning that the guidance given to coroners, whether they have been there for 10 years or five minutes, on these types of issues is basically zero?

Mr BARNES: It is hard to give guidance—sorry, Mary.

Ms JERRAM: Except in the collegiate system, meaning that if you are altogether in one good place, like Lidcombe now is, there is a lot of discussion goes on. I am sure that was true when I worked with Mr Dillon. Unfortunately Mr Barnes, although I knew him from Queensland, came along after me so I did not have that opportunity. But there was a lot of discussion. You could always find somebody else to talk things through but that was as far as it went.

Adjunct Professor DILLON: Yes, there is a lot of collegiate talking and so forth. One of the problems in the system though is that coronial discretion, as Michael said right at the start, is terribly wide. You can do all sorts of things without anybody looking over your shoulder and telling you not to do that or to do something else. I used to think of the whole system as being a bit like a cottage industry—you know, everybody is working away furiously at their own little tasks and a collection of cases and so forth. There was interaction of course, but we were more or less left to do our own thing. I have often thought that this is not the most efficient way to use the limited resources of the system.

Another way of thinking about it is like a chamber of barristers. Everybody has got their own caseload and so forth. You talk, for sure, but you make your own decisions and you do your own stuff. I used to think that a better model might be a firm of solicitors where, as a group, you took on certain types of work and you concentrated on various objectives and that sort of thing. So you tried to tackle various kinds of problems and the whole body of coroners was focussed on similar objectives. We do not have that in New South Wales. I think they do in Victoria. I think they have a much more focussed system in Victoria. But that is another problem too that we have to work out here.

The CHAIR: Mr Khan, do you have any questions?

The Hon. TREVOR KHAN: I do not want to cut across Ms Sharpe.

The CHAIR: She has finished.

The Hon. TREVOR KHAN: My question arises from those last responses. Asking my questions from Tamworth today, I suppose I am interested in this concept of collegiality arising in Lidcombe when the punters can be quite disbursed geographically in New South Wales. If we go to a system of, in a sense, more permanent coroners, as opposed to the local magistrates doing the coronial work, how are you going to provide timely and effective access to the court to those people who are so dispersed?

Mr BARNES: Can I answer that first because I have tried both models. In Queensland we had regional coroners. So there was a coroner in Cairns, a coroner in Townsville, a coroner in McKay, a coroner on the Gold Coast and then a cluster of coroners in Brisbane. That was underpinned by the sorts of issues that you are raising Mr Khan: that a coroner should be a member of the community he or she is serving. They are a social function rather than a government function.

The Hon. TREVOR KHAN: Yes.

Mr BARNES: There is an advantage in having a relationship with the local hospital superintendent, the local chief of police, the local forensic pathologist and that is why we set up that system. The problem with it is, its single point failure: you have got one corner, one coroner's clerk, one counsel assisting and a couple of administration people. If any of them go rogue or go off then your system crumbles. So, it has been stressful. It had advantages in that they had much better key decision-makers in their communities but they lost the ability to be efficient, So, bit by bit they have drawn people back to Brisbane.

The Hon. TREVOR KHAN: Sorry, I do not want to interrupt before the others speak but I think we have seen that in the family law jurisdiction. Some of the problems arising with judicial officials, sort of, not having the support of their colleagues in outlying areas—Queensland indeed, I think.

Adjunct Professor DILLON: I have obviously given a great deal of thought to this as well. My feeling is that the Victorian system works as well as any coronial system can work because you have the centralisation of most functions. Nowadays we have these kinds of systems. We have communication systems which can reach families anywhere in the State. The system as it is currently designed was set up in the early twentieth century when magistrates and coroners still travelled around in steam trains or on horses and buggies. We can do a lot better than that and provide a much better service than that.

In terms of being a local coroner, if the coroners did inquests or if they tried to make recommendations which prevented local deaths, I think there might be an argument for keeping coroners in the locality, but they actually don't. Very rarely do you see this being done. In fact, I did a study—over a 10 year period I think there were 30 cases in which regional coroners made recommendations to prevent future deaths. So that is three a year out of 6,000 cases or 3,000 cases being reported in country areas. It is not just a system that works very well, and who just drops into a Local Court to see their local magistrate? Well only people who are going to court. Nobody has a personal relationship with a coroner or a magistrate unless they have a real problem. I do not see the coroners as, sort of, social workers or local grandees helping out in the local community very much.

The CHAIR: Time is running short. Mr Shoebridge, you had a question and then I might finish with a couple.

Mr DAVID SHOEBRIDGE: Sorry to throw this to you at the end. One if the big issues that is raised in a great many of the submissions, but particularly your submissions, is that there is very little guidance in the Act about what the Coroner should be focusing on. We have a lot of ad hoc practices done by individual magistrates and one of the big issues is whether the focus should be on the immediate cause of death. There may be cases where that is what families and everybody wants if there is a potential homicide—immediate cause of death may be the very core focus. But there are other cases where you actually want to have a systems analysis—maybe it is medical, maybe the hospital system failed or maybe there was a failure within the jails. Do we need different practices for those two different forms of inquiry? Does the Act need to specify this?

Adjunct Professor DILLON: Can I have a crack at that? Sorry, Mary.

Ms JERRAM: It still comes back to the individual judicial officer, like everything else. Like saying: should the criminal Act tell District Court judges and magistrates just exactly what they should be focussing on? I mean over time it becomes fairly clear, but I would have thought you cannot expect the Act to do more. It is not a good Act, and I do not suggest otherwise. It is all over the place. It doesn't, and I don't think it should be, split into different categories. I think that has got to be up to good coroners. Sorry, just a moment and then I will shoosh, but to Mr Khan's question involving Tamworth as an example, it is probably for the same reason that country magistrates are not appointed for more than a few years because—and I was Goulburn magistrate for some years, and I loved it—you can become too involved in local matters. You go to the bank or something and they say "Oh, what happened with Mr So-and-so's matter today?" I would think that could be a problem too if you had a purely regional coroner based in towns like Tamworth. On the other hand, full-time coroners go out to the regions and I think that should be chosen on an as-needs basis which ones are brought to Sydney and which ones the Coroner should go out with the team. Then it is best to be a bit remote, I think. Anyway, sorry, that is my say.

Adjunct Professor DILLON: Can I very briefly respond to the question asked by Mr Shoebridge? The starting point always in any death investigation is: Who died? When and where did they die? What was the physiological cause and what brought about the death? That will happen in every case but the question of "How

did this death come about?", as you say, may raise systems issues. And that is where, going back to Michael's opening remarks, you need people who can spot those systems issues when they arise and who can distinguish between a case that has a simple answer and a case that has a much more complex answer, and that isn't people who have no experience, no training and no resources—namely, country magistrates.

Mr BARNES: Mr Shoebridge, your interest about objectives and what we are seeking to achieve, if you are interested in looking at that further, the Victorian Act has a lengthy list of guiding principles which I think is essential and we would definitely recommend importing that into our legislation. Ms Sharpe, your question about hesitancy in making suicide findings, I know that is a bigger problem for country magistrate coroners who know the family, who could not possibly bring that shame upon the family, so-called, because of the terrible artificial stigma surrounding suicide.

The CHAIR: We are running short of time but I might conclude with a couple of propositions that I want to put to the panel. If you can just indicate yes or not. If you need to elaborate, maybe you could answer on notice. The Civil and Administrative Tribunal is headed up by a Supreme Court judge. The Drug Court is populated by District Court judges. The work of the coronial jurisdiction in New South Wales is no less important than either of those two bodies. Do you agree with that?

Ms JERRAM: Absolutely.

Mr BARNES: Agree. Western Australia has a Supreme Court judge as a State Coroner. He is not called a judge but the same level and conditions.

The Hon. ADAM SEARLE: Okay. I note that Victoria has the crime prevention unit which uses coronial data to identify trends and patterns of preventable deaths, identify vulnerable populations. It deals with systems information and also tries to provide a robust evidentiary base to assist coroners in writing more meaningful recommendations. I take it you would advocate—and I think Professor Dillon says in his submission—that we should have such a body underpinning the coronial jurisdiction here?

Ms JERRAM: I certainly did, Mr Searle, and I think its enormously important but it also raised the standard, for example, of recommendations made. The prevention unit would ensure that the recommendations made were collated—and they are not really very well in New South Wales—and then, if there was another similar type death which showed that those recommendations had not been taken up, one of the jobs of that prevention unit in Victoria was to make sure that that was made public. I think that was a very strong weapon actually that meant that recommendations were listened to.

The CHAIR: Normal coronial findings are made public in New South Wales. They are not all published. Should not all coroners' decisions be published in New South Wales?

Mr BARNES: There is a step before that. There should be a finding in all cases. In New South Wales there are only findings if you have an inquest. For the rest of the country you do chambers' findings in all cases. All you get here is a letter saying you are not getting an inquest and you are not getting anything else other than date, time and cause of death.

The CHAIR: So we should have findings in every matter and they should all be published?

Mr BARNES: Yes, or publishable.

The CHAIR: Coroners can make their recommendations but they do not have the power to follow up. I think Professor Dillon recommended some kind of follow-up power, maybe resulting in reports to Parliament if there is continued non-compliance? Is that right?

Adjunct Professor DILLON: Yes, that is correct. You have that in other jurisdictions. Interestingly, the NSW Ombudsman has that kind of power in that if recommendations are not responded to, or if there is an unsatisfactory response, under the Ombudsman's Act the Ombudsman can make a report to Parliament and it has to be tabled. We now have a deaths in custody and a deaths in police operations report that is tabled every year by the State Coroner. I think that should be done every year in relation to all recommendations and there should be a power to follow up. The State Coroner should have a power to follow up and see what is happening with recommendations, certainly.

The CHAIR: We could go on for some time but I am being chastised by my colleagues for letting the hearing run over time. I thank the three of you for your submissions and your evidence today. Committee members may have supplementary questions that they will place on notice. If that happens, you will have 21 days to respond. As Mr Shoebridge has reminded me, the one hour was never going to be long enough given the detail of material. I, for one, will certainly have some questions to put on notice for you. We will now take a short break before we begin our next session.

(The witnesses withdrew.)

(Short adjournment)

DAVID EVENDEN, Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW, affirmed and examined

The CHAIR: Mr Evenden, I thank you for your submission on behalf of Legal Aid NSW, which is No. 46, and you have emailed some documents to the secretariat this morning, which we will take to be tabled documents. Would you like to make a short opening statement of no more than a couple of minutes?

Mr EVENDEN: Thank you for the invitation to give evidence today. Legal Aid NSW operates the only specialist coronial advice and legal representation service within New South Wales. Until several years ago it was the only service of its kind in Australia. Since 2006 our coronial inquest unit and other lawyers from within Legal Aid have provided representation of families in many inquests, and legal advice and assistance to countless others. Something like 40 per cent of all families represented before the Coroners Court have their representation provided by Legal Aid. At the moment in New South Wales we operate within a coronial system that is in many respects archaic, grossly under-funded and lacking effectiveness. It has been like this for a number of years and the situation is now chronic. It is demonstrated most obviously through the lengthy delays in inquests being heard and finalised.

About 6,000 families every year experience the loss of a loved one in New South Wales that is reported to the Coroner. It is important to note that just a handful of these matters become inquests and, of those that do, a large proportion are deaths in custody and deaths as a result of police operations—section 23 deaths: inquests that the law says must be conducted. Families wait, usually for years before inquest proceedings get heard. Other families, wanting information about the death of a loved one or for an inquest to take place, are routinely denied that information in our experience or refused an inquest. This is the more opaque side of the coronial system. Over 5,900 reportable deaths each year never proceed to inquest—that is, more than 98 per cent of the total.

As you already heard today, most explicitly and clearly from past State Coroner Barnes, matters that should be going to inquest are not because of resourcing issues—because there are not enough coroners. The families of people who die from reportable deaths, and often avoidable deaths, deserve better. The community at large also deserves better. Sudden and unexpected deaths can happen to anyone. Not only should the coronial system serve families of the deceased and provide them with answers, but it also should have a preventative function so that the fruits of the system—the findings and recommendations made by coroners—bring about systemic change. Real changes to our hospitals, mental health care, our jails or the operation of our police force.

In New South Wales we have an ineffective system for the implementation of coronial recommendations. No legislative imperative for agencies to act nor even report and often a complete disjuncture between the good work of the Coroner and the hope that it might embraced by the government of the day. There is an over-riding need for better resourcing within the coronial system not only of coroners and those who support and assist them, but also the legal services that are available for families. For a family, having a lawyer means they have a voice. They can get answers in this foreign and often bewildering system. Legal representation of families brings integrity and vigour to the process and serves an important therapeutic role.

Put quite simply, Legal Aid and the Aboriginal Legal Service do not have the resources they need to adequately provide proper representation and assistance to all families who require it. It is highly likely that Aboriginal people through New South Wales are over-represented in deaths reported to the Coroner. Much more can be done to cater for those from culturally and linguistically diverse communities and, in particular, the many Aboriginal people who come into contact with the coronial system. The Coroners Court, forensic medicine and the NSW Police Force all have a role to play. It is a sign of a civilised society that it is willing and able to review certain deaths, especially avoidable deaths, and learn from its mistakes; more so, that it is willing to support the families of those who die in avoidable or unusual circumstances, giving them hope that some change may come about with the death of their loved one. Our written submission contains 25 recommendations which, if implemented, Legal Aid NSW considers would dramatically improve the coronial system in New South Wales and, in particular, the situation for families.

The CHAIR: Thank you for that opening statement. We will commence with questions from Mr David Shoebridge.

Mr DAVID SHOEBRIDGE: Thank you very much for the very detailed submission that you have given with a series of recommendations. Given Legal Aid has the broadest practice, the broadest experience across the State about how the system works, we have had a number of submissions concerned about a two-tiered system with part-time coroners and magistrates in the regions, and specialist coroners in the city with all the support services around Lidcombe. What is the experience of Legal Aid? Is there a two-tiered system for the Coroners Court? If so, what is its impact?

Mr EVENDEN: When we look at coronial expertise, the greatest coronial expertise is clearly concentrated in the Lidcombe Coroner's Court where we have specialist coroners who are doing that work the entire time. Then there are many, many reportable deaths that are dealt with on a regional basis by Local Court magistrates and there is a real inconsistency in what happens in the regions. The system is so broken that there is a lot of things happening that we probably do not even know about, but certainly from the experience of our service we have many people from regional locations, a large proportion of them or at least some proportion being Aboriginal, who are getting in touch because they are getting no information from the local Coroner's Court. They might have been refused an inquest or refused access to information. No real guidance is provided to these regional coroners.

I think the comments that have already been made in today's earlier session about the ability of a full-time regional criminal law magistrate to do coronial on top of their work are very well made comments, but certainly it is our service that is interacting on a regular basis with people from all throughout the State who are having these difficulties with local coroners. At the other end of the spectrum, we have some very good coronial inquiries that take place under the direction of the State and Deputy State coroners at Lidcombe and throughout other parts of the State—for example, Newcastle in particular. Those inquiries, with the assistance of services such as the Crown Solicitor's Office, are really high-class inquiries. Of course, they take a long time before they are reached but we have good analysis of systems that are taking place and then, as I have indicated in my opening statement, a complete failure when it comes to implementation or any sort of accountability in relation to the recommendations.

Mr DAVID SHOEBRIDGE: Is it too simplistic to say that under the current system there are basically two classes of deaths, two classes of grieving families: those in the regions who get part-time coroners and a sub- standard service; and those in the cities who get full-time coroners with a full suite of services? Is it too simplistic to look at it as two separate classes?

Mr EVENDEN: In fact, I think it is because there are also many people or families where deaths are reported to the State Coroner's Court who also are not getting the information that they need. They are not getting the updates. Matters are getting dispensed with by those same coroners—you heard ex-coroner Barnes talking about the need to simply dispense with matters because of the volume of work. That is happening at Lidcombe as it is happening throughout the State.

Mr DAVID SHOEBRIDGE: Those resource constraints you find is a practical daily reality for the work you have with families wanting to have inquests. Is that right?

Mr EVENDEN: They are resource constraints but as we have also raised in our submission, there is a real problem with the practice in the jurisdiction, particularly the provision of the information to families. There is no onus on coroners at the moment by way of any sort of legislative provision or practice direction to provide information to families. We just had a practice note No. 3, which applies to section 23 deaths, which does deal with the need to inform families but, again, there is no provision that mandates that investigation materials—so I am talking about witness statements, closed-circuit television—be provided at an early stage to families. Chapter 9 of our submission covers that and we have, in fact, made two recommendations which we say would change that system. Reversing the onus completely so that families are required to be given information by the Coroner and that direction should be clear to Deputy State coroners, to regional coroners, because what is actually happening is often families—whether it is in the regions or at Lidcombe—are being denied information or not getting it for a long, long time. It is a source of great frustration and, in fact, increased distress for them.

The CHAIR: Both the New Zealand and Victorian legislation provides that kind of onus, does it not?

Mr EVENDEN: The Victorian legislation—it is covered in our submission to an extent. The Victorian legislation—in the same way that the New South Wales legislation does—has a provision that deals with the provision of information to families. But they also have a practice note which says that a brief of evidence will be given to families. There is nothing similar in New South Wales. The material that I provided this morning to the Committee contains a document from Queensland which I would ask the Committee to have a look at when it considers the rights of families, and particularly this issue of provision of information to families. It is a an extensive document all about the way in which coroners ought to be operating in terms of dealing with families and providing them with information at an early stage. What we have put forward in our submission is that families should be given information as soon as it is available, unless there are compelling reasons to not do so. It is recommendations 13 and 14 in our submission. In my submission there is no reason why that sort of requirement should not either be in the law, or at the least in a practice note, and there should be a similar document in New South Wales to what there is in Queensland setting out quite clearly for both coroners and for families what their rights are throughout the process.

Mr DAVID SHOEBRIDGE: The Government submission states that the Chief Magistrate and the State Coroner are in the final stages of drafting a revised practice note for guidelines for senior coroners for case management of deaths in custody. Apparently there is also a draft State Coroner's protocol for the case management of inquests under section 23 involving First Nations People. But then it says this:

> The Local Court plans to conduct targeted consultations with key legal and First Nations stakeholders once the draft Practice Note and Protocol are finalised …

That seems to me to be odd way of consulting: you consult once you finalise documents. What, if anything, has been the involvement of Legal Aid with this?

Mr EVENDEN: We have been consulted in relation to both the draft protocol and the practice note. Just to go back some time, since about 2018 we have been agitating for there to be a practice note in relation to, particularly, First Nations or Aboriginal and Torres Strait Islander deaths. The State Coroner has been very supportive of that. When we were sitting here last year, in relation to the First Nations inquiry, there was talk about a draft protocol then. The State Coroner issued what was a draft protocol earlier this year. When I say "issued" it was distributed to some practitioners dealing with some of these cases, and in individual cases we have been working to comply with that protocol. So who has been working? The legal representatives, importantly the Crown Solicitor's Office, which is now being briefed in relation to all First Nations deaths—that is a very major development that has occurred. It means that there is now a process where there is an early directions hearing and a lot more is going on at the very start of the coronial process for First Nations' section 23 deaths.

In the last six months there have been consultations in relation to that draft protocol and also in relation to practice note No. 3 of 2021. That practice note has now commence—it commenced about a week ago, 24 September—and it applies to all deaths in custody and all deaths in police operations. There we are talking about 40 to 60 deaths per year that are coming into the coronial system. About anywhere between four and seven of them are First Nations or Aboriginal and Torres Strait Islander deaths. Those First Nations' deaths will be the subject of the Coroner's protocol, which is issued under an earlier provision of the Act—I think it is section 10 or 11 which allows the Coroner to issue guidelines to other coroners. There is a consultation that is going on, I am aware of that, where the State Coroner, in conjunction with the Department of Communities and Justice [DCJ], is seeking to identify relevant Aboriginal community members and organisations that might provide input into that draft protocol.

The CHAIR: Mr Shoebridge, do you have other questions?

Mr DAVID SHOEBRIDGE: There a number of other Committee members. I do, but I will hold off.

The CHAIR: Does any other Committee member have questions? The Hon. Penny Sharpe, no. The Hon. Rod Roberts, no. The Hon. Trevor Khan, no. If not, I might ask a few questions**.** At page 10 of your submission you strongly urge the Department of Communities and Justice to share a copy of the draft 2017 statutory review with the Committee. We have not yet requested that but we will do so. What in particular is in that draft that you think we should turn our minds to in this review?

Mr EVENDEN: If I could take that question more globally?

The CHAIR: Of course.

Mr EVENDEN: Obviously the Committee is looking at whether or not there should be a new Act. There is a lot of strong evidence being given to the proposition that there should be a new Act and a stand-alone court. What the Government might do to remedy the system is a different question. What the draft statutory review did is looked at all of the issues that exist with the current Act and the way in which they might be amended in order to rectify some of those issues. There was a consultation that took place and many stakeholders were involved. Legal Aid was involved. We were provided with a draft report in 2017, which contains a number of recommendations. They are all recommendations about amending the current Act.

It would not be guesswork to work out that they include some of the similar sorts of recommendations that we made about having, for example, a preventative object or function in the Act at the very start; about having a replica effectively of section 8 of the Victorian Act, which gives guidance to people making coronial decisions about the impacts on families of delays, of trauma and the need for information and those sorts of things. There is no reason why the Committee ought to be doing the hard work again. It has already been done by DCJ in that statutory review to identify all of the problems that we have with the existing Act.

The CHAIR: Your recommendation 6 suggests that the legislation should mandate that the quality of care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest. Do I take it that should also include persons who die not just in prison or police custody but also in mental

institutions and the like? For any person who is, sort of like, in care, as it were, in a government institution there should definitely be an inquest into those situations?

Mr EVENDEN: Under our submission in relation to the jurisdiction of the court we made some recommendations—I think it is recommendation 5—in relation to the scope of jurisdiction that exists. One of those recommendations relates to section 23: that there should be some clarity that deaths where someone is in involuntary detention in a mental health facility should be under section 23. The short answer is, if that change was made then it would be the case that that person's care and treatment would also be looked at.

The CHAIR: In your submission at page 52 you also discuss the Victorian innovation of a Koori family engagement unit. There have been some steps towards this taken in the New South Wales jurisdiction. What is your understanding of what has happened in New South Wales to date on the Aboriginal engagement front and whether it reaches the level of what has been done in the equivalent jurisdiction in Victoria or whether there is room to improve further?

Mr EVENDEN: I think there is vast room for further improvement in New South Wales. We have got Aboriginal people interacting with the system all the time and the level of Aboriginal people employed by the system is virtually negligible and that creates or exacerbates this cultural divide. My understanding is—we are talking about two major parts of the system: the courts and the forensic medicine service—when someone dies the first interaction that the family might have is with a forensic medicine social worker. My understanding is there has never been an Aboriginal person employed in that role. That is of concern because obviously that is the first contact, and often one of the only contacts, that family have with the system at all. Then when matters get to the court and the family might be contacting the court, it could be a regional Local Court and how many Aboriginal people are employed in that court? It could be the Lidcombe Coroner's Court, and my understanding is there are no registry staff that are Aboriginal working there.

So the changes that have happened—having identified last year the potential for there to be some Aboriginal employment—are that two positions have been funded and they are funded to employ two Aboriginal people, a male and a female, within the Coronial Information and Support Program [CISP]. That service at the moment has been staffed by several non-Aboriginal counsellors who provide assistance when matters come to court. They do not provide any ongoing counselling or anything of the like. I understand what is envisaged with the new Aboriginal staff in CISP is that they will have an involvement from a very early stage, at the very least in all First Nations section 23 deaths. It is likely that that will be written into this First Nations protocol which the State Coroner is going to issue.

That, in my opinion, is really only the start. I have included at page 51 of our submission some information about the employment of Aboriginal people by Legal Aid. I do not know why we have a system like both Forensic Medicine and the Coroners Court where there are no Aboriginal people employed and yet we can have over 100 of our staff who identify as Aboriginal and almost 7 per cent of our workforce is Aboriginal. I have also had some engagement with Forensic Medicine about this. It is part of our submission that there ought to be protocols that are established about post-mortem issues. The documents that I provided earlier today—if I can take you to those—are, in fact, examples from Queensland of the sort of thing that we should have in New South Wales.

In Queensland there is already a document produced by the court—which is the second document that I have provided to the Committee—which is a guide to cultural competency and engagement between the Coroners Court and Aboriginal and Torres Strait Islander people. It goes into a lot of detail about who is the next of kin, about autopsy, about investigating deaths et cetera. There is nothing like that in New South Wales. There is nothing that has been produced by Forensic Medicine nor by the State Coroners Court. The third document I have provided is prepared by Queensland Health. Again, there is nothing from our Forensic Medicine service that goes into these sorts of cultural issues. So we are a long way behind in terms of taking those steps.

I also believe that, in terms of getting access to legal services, there is a big vacuum throughout regional New South Wales. How does the family in Moree when their son or daughter suicides get access to legal assistance? Sure, some of them might contact us, but even getting the information out there that that sort of assistance is available is, at the moment, something that we struggle with due to resources.

The CHAIR: Does any other member have further questions? I will keep going then. In relation to your submission, at page 61 you talk about the need for a Coroners Prevention Unit [CPU] of the kind that exists in Victoria. Can you outline to the Committee what you understand the Victorian unit does that is useful and beneficial in terms of the coronial jurisdiction?

Mr EVENDEN: The context in which I have suggested the coronial prevention unit in the submission is in relation to recommendations. My understanding is that in Victoria there is support provided to coroners

provided by the Coroners Prevention Unit where they might be considering particular recommendations. They have research support. Those people will engage, as I understand it, with agencies to try and determine whether recommendations are appropriate. And if there is a need for follow-up then the Coroners Prevention Unit can be involved in that. Effectively, what we have in New South Wales is regional magistrates virtually running no inquests at all and overworked deputy State coroners and the State Coroner with very little or no research support—in fact, no research support that I am aware of—who are required to run these large inquest matters.

The point about the CPU is if we want proper death prevention then we need to resource that function so that it is done in an intelligent and researched way. You can go to the Coroners Court website in Victoria and look at the array of publications that have been prepared by the Coroners Prevention Unit on overdose deaths, on suicides—on all manner of types of death that have recommendations. Because the findings of a single inquest really do not go anywhere, but once we start to compile that information—which is what the Coroners Prevention Unit does—then you start to have force behind the recommendations that can be made.

The CHAIR: Your submission also talks about the need for the coronial jurisdiction in New South Wales to better develop greater cultural competency, both generally and specifically, in relation to First Nations persons. In evidence we have received from Adjunct Professor Hugh Dillon, he outlined how some other jurisdictions in Australia do have specific focus in their legislation on First Nations people and, in particular, looks at the New Zealand legislation, which specifically recognises Maori burial and other death customs. What should we do in New South Wales to better reflect the needs of First Nations people?

Mr EVENDEN: The changes can be various. They can include amendments to the Act to provide recognition. They can include practical measures on the ground—so, as I have said, employment of Aboriginal people within the court system, within Forensic Medicine and better training for New South Wales police. They play a huge role in the coronial system. They investigate every one of those 6,000 reportable deaths. They are the ones often that are primarily responsible for providing information to families. When those families are Aboriginal there is an issue, particularly in regional areas, because there is such a level, in some places, of distrust or a history of being treated badly by the police that families are incredibly sceptical. Often that might lead to there not being the levels of contact that should exist.

The New South Wales police can and do do an excellent job, in some cases, of staying in contact with family members, of keeping them updated, but I have also seen the situation where it does not happen at all. My concern is that with Aboriginal people, there is a lot of improvement that could take place. Again, when we look at what publications or guidance the police have about cultural considerations and about the investigations of deaths, we are not seeing the same sort of material that I have just shown you from Queensland, which really recognises the things that are culturally important to Aboriginal people and sets them out for everyone to be able to see.

The CHAIR: I have one last question and then I will pass to Mr Shoebridge, who does have some other questions. In relation to the often unhappy history of First Nations people in New South Wales and Australia, and their interactions with the police force, given that the police are the investigators for the Coroner, should some consideration be given to a separate coronial investigations team who are not police but maybe have the same powers and immunities as police in terms of doing that coronial investigation? Or is this simply something that the Police Force of New South Wales needs to work through with First Nations communities?

Mr EVENDEN: My view is that there is a lot that could be done to improve police procedures but that because of the breadth of their service throughout New South Wales, they are, in fact—and ought to be—the primary investigators for coronial matters. What needs to change is there needs to be better engagement, there need to be better processes. Last year when Inspector Crandell gave evidence before the First Nations select committee, he talked about perhaps the utility of there being a protocol for engagement with families. That does not exist, as far as I am aware, and in my view a lot of improvement could take place. There are Aboriginal community liaison officers. I am not aware at any point in time of them being utilised, at least routinely, in coronial investigations. My view is the police are the people that ought to be investigating.

The second thing to note about more complex inquests is that they will almost always be referred to the Crown Solicitor's Office for them to assist. The investigation does not stop after the initial police investigation. The Crown Solicitor's Office will obtain expert reports, obtain other statements. Some of that is done through the police, other times it is done directly. A lot of investigation happens there. If there is no family legal representative then they are the ones that are talking to the family and contacting them and providing them with information and sometimes advice about the process.

Mr DAVID SHOEBRIDGE: Obviously the Aboriginal Legal Service [ALS] will bring some specific focus as well, which we should hear from in the inquiry. Given First Nations people's family history and historic interactions with the criminal justice system and the police, what is your experience of representing First Nations

families and bringing them into the court environment having the police there, having a magistrate there? What are the particular cultural issues that are apparent for First Nations peoples, given their personal and family history with the criminal justice system?

Mr EVENDEN: I have had varying experiences. I have represented some families who have been through terrible experiences who somehow are incredibly respectful of the process and are able to deal with the massive delays and the sort of inadequacies that exist. But, in other cases, even before we step into court, there are families that are outraged by what has happened. As I think I said in previous evidence to the select committee last year, often that will come about because of that intergenerational trauma. Despite the efforts of us lawyers representing families to sit down, to explain things, sometimes that level of distress just does not go away. The solution that I see is that we need to get early engagement of lawyers with families, ideally lawyers that are culturally competent. Ideally the ALS should be staffed to deal with more than just a section 23 deaths and should be able to provide other coronial services or representation in other coronial matters.

Legal Aid, whilst we are not an Aboriginal-controlled organisation, we have a large number of Aboriginal clients—both the Coronial Inquest Unit and Legal Aid generally. Sometimes Aboriginal people will come to us and say, "We prefer Legal Aid." So we work in partnership with the ALS and we are in regular contact with the ALS. The solution is legal representation and good representation from an early stage, information to families as soon as they can get it so that the potential for theories about what might have happened is minimised, less delays in the process, and then things that the court might do to recognise the cultural background—so, welcome to country. We have given a couple of examples in our cultural competency section of cases where the court has done things. There is an example of a haka that took place. I was not appearing in that matter but I have spoken to those that were and I have spoken to those that saw that, and the significance of that for that family was huge.

Mr DAVID SHOEBRIDGE: Surely all of this points to taking the Coroners Court out of the Local Court, getting it as far away from the criminal justice system and providing a more culturally appropriate space for First Nations peoples. That would be one of the benefits, wouldn't it, for a standalone Coroners Court—moving away from the criminal justice system?

Mr EVENDEN: There is huge benefit in that happening. Into the future that has to happen. What we do need are changes to this system immediately, but obviously the long-term goal would be to have a standalone court and a new Act incorporating those factors—Mr Barnes mentioned them—the six factors that are in the Coroners Act in Victoria that recognise different cultures, different beliefs, different practices, the impact of coronial proceedings on families. It needs to become a more therapeutic jurisdiction where the needs of the family really are put at the forefront of the jurisdiction as well as the other very important component, which is reducing deaths—preventing deaths—by using the work of the Coroners Court to change existing systems.

The CHAIR: Does any other member have any other questions? Mr Shoebridge, you have the last question.

Mr DAVID SHOEBRIDGE: I think time has beaten us, Chair. But I do have questions I will put on notice as supplementary, if that is acceptable?

The CHAIR: Of course. Time for this round of questioning has elapsed. We will take a short break and recommence at 11.40 a.m. I remind all members to mute themselves and switch off their cameras during the break. Mr Evenden, thank you for your evidence. I do not think you took any questions on notice. If I am wrong and you have, the secretariat will be in touch. Members may have supplementary questions that they will place on notice for you and you will have up to 21 days to respond.

(The witness withdrew.)

(Short adjournment)

KRISTINA STERN, Chair, New South Wales Bar Association Inquests and Inquiries Committee, affirmed and examined

KIRSTEN EDWARDS, Member, New South Wales Bar Association Inquests and Inquiries Committee, affirmed and examined

LOUIS SCHETZER, Policy and Advocacy Manager and National Manager, Australian Lawyers Alliance, affirmed and examined

CATHERINE HENRY, Principal, Catherine Henry Lawyers, affirmed and examined

Ms HENRY: I am a solicitor practising in Newcastle. I am also giving evidence today on behalf of the Australian Lawyers Alliance [ALA].

The CHAIR: Thank you, Ms Henry. Would each of the organisations like to commence by making a short opening statement of no more than a couple of minutes? Ms Stern? Dr Schetzer?

Dr STERN: Yes, I would seek to make a statement on behalf of myself and Ms Edwards and on behalf of the New South Wales Bar Association. I begin today by respectfully acknowledging the traditional custodians of the land on which this inquiry is taking place and pay my respect to their Elders past and present. On behalf of the New South Wales Bar Association, we welcome the opportunity to speak today, and we wish to reiterate our strong support for reform and additional resourcing of the coronial jurisdiction in New South Wales and of the establishment of a statutory specialist court. In this short opening statement we wanted to highlight four matters from the particular perspective of the New South Wales Bar Association.

First, we wanted to emphasise what we regard as a key element of the value of the coronial jurisdiction in New South Wales from a public policy perspective. We raise this as a means of emphasising our overarching submission that there is a weighty public interest not just in favour of modernising the court structure and Act, but also in ensuring that the system is adequately resourced to effectively meet the many public interests it serves. In the experience of the New South Wales bar, the Coroners Court fulfils an invaluable role as a means of ensuring scrutiny and accountability of State agencies when their actions, submissions or processes are such that they either lead to serious risk of harm to members of the community or fail to operate to prevent such harm. The scrutiny is particularly effective because it enables the actual functioning of the agency to be investigated and explained in a way that is efficient and can have far-reaching consequences in terms of introducing often much-needed changes and promoting reflective and safe practices.

The jurisdictional focus on death prevention, in part through public scrutiny of the safety and efficacy of systems, sets the coronial jurisdiction apart in our legal system. Civil litigation cases involving serious failure or wrongdoing are often settled out of court, precluding any effective public scrutiny of failures and sometimes without any real accountability of those involved. It is also rare to see the conduct of public entities proceed through the criminal justice system in part because of the high threshold for proof and also due to the focus on the individual in criminal law. It is thus almost uniquely through the coronial jurisdiction that there is an opportunity for public scrutiny of the actions and decisions of those who hold great responsibility and power in our society.

An often overlooked element of this is that, in our collective experience, the knowledge that coronial scrutiny is imminent frequently leads organisations themselves to scrutinise their conduct and introduce significant reforms. It is often unlikely that such necessary changes would have been introduced or internal critiques would have occurred absent the imminence of public scrutiny by the Coroners Court. The second matter—is that, in our view, one issue which should be addressed as part of the consideration of this Committee and, in particular, of the form of the standalone specialist court that is established—is the importance of judicial independence. Given the frequency with which coroners are required to engage in scrutiny of the actions of emanations of the State, in our view the maintenance of judicial independence and the undesirability of concern about renewal of tenure seems to us to be of critical importance.

Thirdly, we consider there is a need to sharpen and reshape how responses to recommendations made by the Coroners Court are dealt with. We recommend that consideration be given to establishing a standing parliamentary committee on the compliance and adequacy of responses to recommendations by government entities. We also consider there should be a requirement that recommendations, and governmental responses thereto, should be published on the Coroners Court website for greater transparency and public scrutiny. We also recommend the State Coroner be afforded power to require any government agency to provide a response to recommendations within a fixed period of time and for the State Coroner to report to Parliament if no adequate response is received.

Fourthly, we want to highlight the need to facilitate flexible but effective procedures that enable, where appropriate, the court to offer options to meet the needs of families and communities of the deceased whilst also ensuring that there can be effective investigation and meaningful scrutiny of involved agencies and individuals. There is a need to front-load more of the coronial process so that restorative and investigative steps are taken promptly after a death even if a hearing will not take place for some time. We raise this because we well understand the devastating impact of delay on all participants in the system, but we also consider that inquests conducted too soon after a death may undermine the thoroughness of investigation and scrutiny, the ability to provide procedural fairness, and to invoke the restorative and healing functions of the jurisdiction.

However, we recognise that the passage of time can also prejudice the ability of the process to serve its other functions. Memories dim, agencies can be less able to provide accurate exposition of the offence that led to the death, and families and communities may feel unrepresented and excluded from the process.

The CHAIR: Dr Schetzer, would you or Ms Henry like to give an opening statement on behalf of the Australian Lawyers Alliance?

Dr SCHETZER: The Australian Lawyers Alliance also welcomes the opportunity to appear before the select committee today. I also acknowledge that we are all on traditional lands of First Nations peoples. I am coming to you today from the land of the Bidjigal people and I pay my respects to Elders past, present and emerging. The ALA is a national association of lawyers and academics. We estimate that our 1,500 members nationally represent up to 200,000 people each year in Australia. The ALA is represented in every State and Territory in Australia, including New South Wales, and also has a national criminal law special interest group with representation from each State and Territory.

In our submission to this inquiry we canvass various issues, including the structure of the New South Wales Coroners Court, the lack of funding and resourcing to the Coroners Court of New South Wales and the consequent delays in commencing and completing coronial inquests, the capacity of the New South Wales Coroners Court to examine systemic issues, and the need for greater accountability for implementing recommendations by New South Wales coroners. I will briefly touch on each of those issues. In terms of the structure of the New South Wales Coroners Court, the ALA strongly submits that the Coroners Court New South Wales should be a standalone specialist coroners court similar to what exists in Victoria, Queensland, South Australia and Western Australia.

The ALA submits that funding and resourcing of the New South Wales Coroners Court needs to be improved in order to address delays in the coronial system. In our submission we refer to the data from the Productivity Commission's finding in 2019 that New South Wales recurrent expenditure on coronial services was $6.9 million, compared with $21.5 million in Victoria and $12.4 million in Queensland. We express concerns regarding the significant delays in terms of progress and completion of inquests. ALA members have encountered matters in which coronial inquests commence two or three years after the death and can take several years to resolve. My colleague Ms Henry will be able to provide further details to the Committee as to her experiences with such delays, particularly in regional areas and in the region in which she provides her legal representation and services. The ALA is concerned that these delays cause significant distress and trauma to grieving families, and can detract from the quality of the evidence and damage the utility of any of the recommendations that are made.

In terms of the capacity to examine systemic issues, the ALA submits that it is essential that this capacity is further enhanced and resourced. We agree with the New South Wales Bar Association that the court should establish a coroners prevention unit similar to what exists in Victoria. We also support the establishment of a specialist death review team with a statutory basis to monitor and inform policy and systemic change for all deaths in custody, particularly for Aboriginal and Torres Strait Islander deaths in custody. In terms of accountability for recommendations, the ALA express support for a number of recommendations from the select committee into the high level of First Nations people in custody and oversight review of deaths in custody. We submit that there is a necessity to improve the accountability through recommendations made by the Coroner, including amending the Act to ensure that relevant government departments and correctional centres respond in writing within six months of receiving a coroner's report, detailing the action being taken to implement the recommendations, or if no action is taken the reasons why, and that this response be tabled in the New South Wales Parliament.

We submit that it is particularly First Nations people who are in custody that are often at greatest vulnerability and that there is need for an active oversight by the Coroners Court in terms of accountability for recommendations made to address deaths in custody.

The Hon. TREVOR KHAN: What I am interested in are your views on section 63 of the Act—essentially, the interaction between the capacity for refusal to give evidence on the grounds of self-incrimination

and the benefits of a proper ventilation of the facts in the coronial proceedings. I am thinking of this in the context particularly of deaths in custody or interactions between First Nations people and the police.

Ms EDWARDS: If I could start off with that. Section 61 and section 63 of the Coroners Act is an area where the Bar Association considers there needs to be urgent reform. It is the section which is probably singled out by most participants as the most dysfunctional system because it is not fit for purpose within the coronial jurisdiction. It is mirrored on section 128 of the Evidence Act but it plays an entirely different role in the coronial system than it does to the criminal system. With respect to what is colloquially known as "taking the fifth"—declining to answer on the basis of self-incrimination—there are two issues within that. The first is that significant delay is being caused in inquests because there is no facility within the Act to allow people to give evidence in written form by way of statement with protection of a certificate. That means that coroners can wait months and years to get an account from critical people involved in a matter because they are seeking protection when they give evidence under oath.

That can lead fairly to a lot of speculation and unhappiness as to why it is that person is not giving that account, and sometimes that is based on cautious legal advice and does not necessarily disclose the true issue. That is a matter we identify as needing significant reform, and it arises frequently in police matters and also in health matters. Secondly, there is the compulsion to compel an account after somebody has taken that objection but there are certain consequences which flow from that in terms of not being able to use it later in criminal proceedings and not being able to use it in some other civil penalty proceedings. That can place coroners in an invidious position in terms of, as you say, are we going to let the family hear what really happened and let the public have that aspect of transparency and accountability? Secondly, is the consequence of that that there will be no accountability for the particular people involved? That is a matter which arises in many of those inquests and it is not susceptible to easy resolution.

The practice at the Coroners Court at the moment is that if there is any prospect of a criminal proceeding, like a trial or a referral, a person will not be compelled to give evidence because that could eventually prejudice any steps that were taken to prosecute that particular person. The coroners are required to make an assessment of how likely a referral is. It is really, really important that families have access to legal representation or people that can explain to them, if that is going to be the case, why that is not going to happen. At the moment, that can be very difficult because there is inadequate access to legal representation. They may not understand that that step is being taken to preserve the ability to hold someone accountable in a different forum, and it can feel like a whitewash or a cover-up. With respect, it is an important area of reform.

The CHAIR: Mr Khan, do you have follow-up questions?

The Hon. TREVOR KHAN: No, that is what I wanted to hear.

Mr DAVID SHOEBRIDGE: Thank you to all four of you for your detailed submissions. If we could go to the starting point, could I ask you about what the purposes of a modern coronial system should be and whether or not we are best to look at perhaps the way the Victorian Act is structured to gain the purposes for a reform to the New South Wales Act, or maybe Ontario or maybe New Zealand? Also, if you could deal with any inadequacies in the current Act in that response? I will go to the Bar Association first.

Dr STERN: The first aspect of the question looks to what the purposes of the system are. I think that there are obviously a variety of different purposes, and we have spoken to that in our submission in more detail. There is the fact-finding purpose, there is the restorative and therapeutic justice purpose. There is also the purpose of trying to mitigate the risk of future deaths and learn from what has happened so far. There is also a broader purpose, which we have emphasised not so much in the headline aspect but more in the body of our submission, and that is the overarching human rights purpose, which one sees as reflecting the mainstay of the jurisdiction elsewhere—for example, in the UK, where you see a recognised human right underscoring the importance of investigating deaths.

When one looks at those purposes, there are obviously a number of problems with the current system. One of the overarching difficulties with the current Act is that there is no articulation of the purposes underscoring the steps that are taken within the coronial jurisdiction. It also means that in all sorts of decisions, even in relation to matters like section 61 and privilege and who should be compelled to give evidence with the benefit of a certificate—a whole range of issues—one does not have guiding principles which can be articulated and understood by all of those working within the system. In terms of whether that suggests that a particular model of Coroners Court is better, we certainly have in our submission identified a preference for the Victorian model with some tweaks and balances.

Some of the significant advantages of that model are that it is an overarching, freestanding system; secondly, it has a clearer articulation of the purposes; but, thirdly, the preventative function is more expressly

articulated and reflected. From the perspective of the NSW Bar Association, all of those advantages are things that should be given very careful consideration, we would say, by this Committee in any reformed system in New South Wales.

Mr DAVID SHOEBRIDGE: Does the ALA have a position on this?

Dr SCHETZER: I might briefly mention from my perspective, having practised in the coronial jurisdiction in Victoria, and then I might hand over to my colleague Ms Henry, who has practised in New South Wales. My experience as a former Victorian practitioner who had some experience in the coronial jurisdiction was that the importance of the Victorian restructuring and model was very much emphasising, in the context in which it took place, the need for a standalone court that was also capable and adequately resourced to address systemic issues. I am always one to go back into the history lessons as well. The restructuring of the Victorian Coroners Court followed a period during the 1980s and 1990s in Victoria where there was a significant number of fatal police shootings, particularly as occurred in a particular locality in inner Melbourne in which I was practising—at the Flemington and Kensington Community Legal Centre.

There were concerns that were raised throughout the coronial inquest into a number of those shootings about the method of policing and the policing reliance on the use of deadly force. That set the context in which it was considered that an appropriately resourced coronial jurisdiction was necessary to address some of the broader public interest and systemic issues that were at play there—to look at broader issues such as alternative policing models that would have been relevant in those particular inquests. In that regard, the need for capacity to address those systemic issues was a strong driving factor with the Victorian reforms.

Mr DAVID SHOEBRIDGE: Ms Henry?

Ms HENRY: I support all that has been said in regard to recommendations. I wanted to speak specifically on the issue of resourcing. I have seen firsthand over the course of the last three decades a general diminution of hearing time and a contraction of the work done by the Coroners Court. If you look at the comparative funding of the various States and the coronial system in each State, you can see that that is so. I also had the opportunity as a regional practitioner to see firsthand how coronial matters are dealt with in regional areas. It is a major negative of the current system in New South Wales that we have a mere five specialist coroners, with the bulk of the other matters heard in regional New South Wales. You would be aware of what is being played out in the media regarding the revelations of the upper House inquiry into health care and health resourcing in regional, rural and remote New South Wales.

As a regional practitioner with a practice that covers the top two-thirds of New South Wales, I do see some very parlous and awfully tragic cases. One in particular, the most recent example of the inadequacies from a resourcing perspective, is the matter referred to at paragraph 11 of the submission of the Australian Lawyers Alliance—an inquest concerning the death of an 18-year-old boy. It was only just over 12 months ago that the parents received the results of the inquest. This is a boy who died in 2015. The magistrate who was allocated the hearing of the inquest only had available to him one day each year during which he could hear evidence in this matter. So from 2015 to 2020 the family's lives were put on hold while this inquest was played out. I was also concerned—it goes to the independence factors that Ms Stern has mentioned in any new system—that we had the magistrate acting as the Coroner sitting in Gloucester and Forster hearing evidence from local ambulance service officers who he may well have had existing relationships with. The family did not see that there was any degree of independence, according to him—according to that [disorder].

Mr DAVID SHOEBRIDGE: Ms Henry, can you speak to the experience of a family in a case like that who have had the death of their boy—their 18-year-old boy—and the grief and the trauma associated with that and wanting to know why, but then being brought back once a year for a day in court?

Ms HENRY: Yes.

Mr DAVID SHOEBRIDGE: That, on the face of it, sounds very re-traumatising.

Ms HENRY: It was re-traumatising. Spending a lot of time with the members of the family, the mother, who has had the most awful time—without going into her reaction, she has had a very shocking response to her son's untimely and avoidable death. But, yes, to have the circumstances of his death brought to bear one day each year, as you say, did re-traumatise. Much has been said about the—

The Hon. TREVOR KHAN: Sorry, could I ask a question? If I go to paragraph 11 of the submission, Ms Henry, it does not explain the gap in between. But it seems to me that what is being suggested is there were two-day hearings in 2018. The matter was then adjourned and there is a further two-day hearing in the following year. I am concerned that there is a 12-month delay—I hear what you say—but it seems that there was a block of time of more than one day in those two years.

Ms HENRY: Yes, we had to really push for that. There was—and this has been my experience, that the—

The Hon. TREVOR KHAN: Ms Henry, I have practised in local courts in country areas so I have got some idea of the difficulty of getting time allocated. But your evidence is one day a year. The submission talks in both of those years as being two days.

Ms HENRY: Yes.

The Hon. TREVOR KHAN: It is not an explanation as to the gap, but your evidence is different from the submission. That is the only question I [disorder].

Ms HENRY: All the way through the inquest there was a pressure to truncate the proceedings. Yes, it did spill into the second day but the magistrate—I should say a factor was that counsel assisting initially allocated to the matter died and a new counsel assisting had to be appointed. The point is that it was a five-year period. Whether it was one day, two days—really, there was a lot more that could have been said at the inquest than was.

The CHAIR: Sorry to interrupt. Just on that, Ms Henry, leaving aside the details of any particular case, is it generally your experience that there are systemic delays, often in a number of years, in having findings in coronial inquiries made by coroners?

Ms HENRY: Yes, that is my experience. Not always but often. In this particular case, members of the upper House inquiry will no doubt remember the case of Magistrate Dominique Burns and the evidence given before that inquiry—sorry, it did not actually reach an inquiry, but there was much made in the media about the crushing workload of local court magistrate Dominique Burns, and the point has been made elsewhere that magistrates do have an inordinately high workload and that is a separate issue. But it does come into and have relevance on this particular inquiry because it is the magistrates who have to try to find a day, two days, anytime in the midst of this crushing workload, in the midst of hearing a great pile—I have been a local court solicitor too; I have also been a local court prosecutor. You have a massive list of matters: apprehended violence orders, drink driving offences, hearings. Magistrate Burns, it appears, had an inordinately high—she was an inexperienced magistrate. She was sitting up there on her own. To imagine how a magistrate like her would have the capacity to manage an inquest in the middle of her list is just fanciful.

Mr DAVID SHOEBRIDGE: Ms Henry, I might just ask—and I think it is useful to ask the Bar Association—have you noticed the same concerns and is there more delay? Is it more difficult in regional New South Wales than in the city? Have you noticed the same concerns?

The CHAIR: Just in answering that, Ms Edwards and Dr Stern, I think at page 36 of the Bar Association's submission you provide some very compelling statistics about the level of delays in coronial findings, even where there are inquests. So could you focus on that as well, please. You are muted.

Ms EDWARDS: I will start with that. The case is that there are delays in both aspects of the system. There is delay in inquests that occur out of Lidcombe, and there is delay in regional inquests. The New South Wales Bar Association strongly supports a centralised system so that all deaths are being reported to a centralised system so that they can be assessed and triaged and themes can be identified as emerging. The difficulty with a two-tier system is that a great number of important deaths in the regions may go unnoticed, for example, in a particular hospital with a particular area because they are not coming to the attention of the State Coroner unless someone is bringing it to her attention. So there is that aspect as well.

It is undoubtedly the case that the workloads of all magistrates in New South Wales make it impossible for them to manage a coronial workload in any way similar to what is being done through senior coroners. Having said that, we think it is important to make clear that senior coroners regularly travel to regions and do inquests emanating from the regions, and the bar strongly supports that continuing. So a centralised system does not mean that inquests are being taken away from the regions. We consider that there should be an overt preference that any death which occurs in the regions should be held in that locality, and that is something which greatly benefits the therapeutic aspect because it is something that the families almost always strongly support.

In terms of the causes of delay both in the regions and centrally, we wanted to highlight that it is a multifaceted thing. It is easy to say it is inadequate resourcing, but it operates at a number of levels. We also wanted to make clear it is certainly not because of a lack of diligence or work ethic in any of the coroners, including any of the regional coroners, some of whom I have worked with, or the solicitors at the Department of Communities and Justice [DCJ] or the Crown Solicitor's Office [CSO]. There is a lot of weekend work and then there is a lot of night work with those organisations. We have police putting together briefs with a great variety of experience, and that can take a very long time. There are significant delays in the Department of Forensic Medicine with releasing autopsy reports, and that causes delay. A brief, when it arrives, needs to be assessed by

somebody and then, depending on the quality of the brief—some homicide briefs, for example, are exceptionally well prepared; some briefs are put together by a constable in their first six months of practice and they cannot possibly be expected to have the skill—and they have no specific training in these matters—to do it well. So it might be that the first brief has to be almost reinvented again with a series of requisitions, and that will again potentially add six months, one year to the process.

We then have the resources of the DCJ and the CSO declining, which means those solicitors, if they are involved in those matters, have to be reviewed for their appropriateness. But then they also have to be taken on and people with carriage, and we focus more on those complex matters because that is where we tend to be briefed. So there are delays in that process as well. Then government departments are being faced with a large amount of what we call requisitions—requests for information, requests for statements. They do not necessarily have specific resources allocated to responding to requests from the coroners. We find that almost inevitably deadlines that are set by the coroners go begging without any real recourse. Another aspect of the Act is that coroners do not have the power to really compel people to produce. They can ask by a certain date, but there is no costs or any other mechanism for them to enforce that.

There is also an aspect of medical statements and how medical statements are collected by lawyers or whether they should be done by medical organisations, which causes delay. Then there is an aspect of review by way of non-publication order and public interest immunity claims, which in our experience are increasing and are causing significant delays in that regard. Finally, when we get to the hearing, there is a shortage of coroners both in Lidcombe and in the regions that have any court time. As Ms Henry said, in the Local Court a Local Court magistrate might have at best one day out of a six-month period and the particular inquest may be one that no possible justice can be given to that inquest within that period of time. So we wanted to draw attention to that multifaceted aspect of delay because it is from so many different areas and it is not just resourcing one area but multiple areas.

The CHAIR: Thank you for that. I have got some questions for the Bar Association based on its submissions. At page 20 you talk about the need to have First Nations persons involved to a greater degree in the coronial jurisdiction, not just in operational levels but in positions of power, and you have two instances. You talk about the need for First Nations coroners to be appointed as a matter of urgency and also to have, perhaps, First Nations commissioners perhaps assisting coroners on relevant death inquiries. In relation to the first proposition about First Nations coroners, I should not have to ask this but, given your knowledge of the state of the bar, are there a number of sufficiently experienced practitioners who could be appointed as First Nations coroners should the Government decide to make this a priority?

Ms EDWARDS: I can certainly say that there are some, and the first person that comes to mind is Senior Counsel Tony McAvoy, who is the chair of our First Nations committee, and he could assume the role almost instantly because of his skill and experience. There are other senior First Nations lawyers at the New South Wales bar. Whether they are interested and have the requisite experience, I would have to take that question on notice.

The CHAIR: Sure.

Ms EDWARDS: We put forward that submission in consultation with our First Nations committee and we are certainly happy to enhance it with their input, but it is not necessarily the case that we anticipated that all of those First Nations representatives would necessarily be barristers or magistrates. We see a role for First Nations people sitting in court where they may not be conventionally legally trained. Particularly, there may be a role for somebody, a First Nations person, to sit aside a senior coroner, for example, in a death in custody matter. The senior coroner would have that legal training and experience, but they would be sitting alongside and providing what we consider to be a really essential perspective and also having genuine input into how that hearing progresses. So there are multiple ways in which we see that that could be achieved.

The CHAIR: At page 42 you talk about in 2020 coroners made recommendations to a number of non-government bodies in terms of recommendations being made. Are there legislative impediments to magistrates actually requiring non-government persons and bodies to respond to coronial recommendations? If there are, should some enhancement be given to compel non-government actors to have to respond to coronial recommendations?

Ms EDWARDS: Well, right now the coroners do not have any power to compel anybody to respond to coronial recommendations, either State agencies or private entities. So, yes, there does need to be legislative attention to how that is done. I should say that that has to go hand in hand with some sort of policy support for the coroners to have the ability to identify that these things are not happening or have some sort of longitudinal perspective as to how many [disorder].

The CHAIR: Like inspecting mechanism.

Ms EDWARDS: Yes, we support that. Private entities are much less likely to be recurrent players within the system, so while that is important it is not necessarily as urgent as government agencies. Having said that, there are some notable exceptions, private prisons being the most obvious notable exception or any private care facility that deals with either children or elderly people or things of that nature. They, to some extent, can be considered to be as important in terms of State agencies, but we consider that that needs to be done hand in hand with a policy framework for the Coroners Court where the coroners have support to understand death prevention and themes and what has happened over a period of time and then having the legislative power to follow up and to ask people and hold people to account as to what has been done and what has not been done. We also, as Dr Stern indicated, see a role for Parliament in that area as well. Just knowing that that oversight is occurring we consider could be of great assistance in facilitating better compliance and faster compliance.

The CHAIR: To do that, something like the Victorian Coroners Prevention Unit providing research and analysis of coronial data to better assist coroners to make well-thought-through recommendations would also be of assistance; I take that would be your view?

Dr STERN: Can I cut in? I think that is another key aspect of what we see is one of the problems with recommendations, and that is that they are not publicly available, readily collated and easy to research. So it does seem to us that that sort of death prevention unit or something of that nature would be so helpful because when you are working within the jurisdiction, you come up against problems all the time where you are trying to work out what recommendations have been made on this particular subject in the past and whether they have been acted on. There is also a sense of a lack of accountability when no-one has been really publicly made to say what has happened, when and within what time frame it was acted upon. It seems to us that that aspect is so important for every aspect of the jurisdiction.

The CHAIR: We have had evidence that not all coroners' findings are actually published. Presumably, your view would be they should all be published and they should all be easily locatable?

Dr STERN: Yes, but there is a particular issue with recommendations because they will be at the end of findings and so often we have to rely upon sort of asking people who work in the jurisdiction to just say, "Look, have you done a case in this area?" Then you find the name of the case, then you find the findings, and then you find the recommendations. That is just a ridiculous system when you are looking at a death-preventative function. So it is not just that they are not all published; it is that even if they are published, it is not always easy to find the recommendations. It just should not be that time consuming and opaque.

The CHAIR: My last question is this: At page 46 you set out I think the many desirable aspects of the Victorian model. One of the aspects of the Victorian model is, though, that their coroners are only appointed for five years. They are renewable, but they do not have judicial independence. I take it the bar's traditional view would be in favour of judicial independence?

Dr STERN: Yes. Our view is very much in favour of judicial independence, and we appreciate that there is a tension between judicial independence and having forms of fixed-period appointments. The other tension is that if you are a judicial officer, questions of misconduct et cetera have to go through very high thresholds and the Judicial Commission procedure. That is another aspect of reform that we think needs to be given express consideration. But we are very concerned about judicial independence in the context where coroners are scrutinising the actions of governmental agencies day in, day out.

The CHAIR: At page 48 you outline what a reform model in New South Wales might look like, but one of the things that is not teased out is if we were to have, for example, a separate Coroners Court as in Victoria, should there remain a nexus with another court—i.e. should every coroner appointed also be a magistrate so they have got somewhere maybe to go back to when their term comes up if they are only going to have limited-term appointments, or should it just be like other specialist jurisdictions and you should just be appointed to that body and have a general term of appointment until retirement?

Dr STERN: Certainly for the Bar Association we quite carefully did not take a fixed position as to which model of specialist court. We see the advantages of an entirely independent court as being much greater control and flexibility. You do not have to appoint people from the Local Court, which can have advantages if you are trying to appoint people from different backgrounds, and it is more amenable to an integrated system, which would cover all aspects of the jurisdiction. As against that, we think there are advantages of what we often call the Children's Court model, which I think will probably be familiar to the Committee, and that is that there remains the system of judicial independence and the protection of the Judicial Commission and the high thresholds. It also enables an interaction in terms of resourcing between the Local Court and the specialist court, and it enables the court to have access to the longer term expertise of judicial officers. Certainly the Bar Association's position is that there are pros and cons both ways. I just want to add in terms of the regional inquests,

when you conduct them the advantage of cooperation and the accesses of the Local Court are very real, although that is not to say that that could not be arranged even in an entirely independent standalone court.

Dr SCHETZER: I would just add one comment to the question as well.

The CHAIR: Of course, Dr Schetzer.

Dr SCHETZER: One would have to be very cautious that in resourcing the coroners' jurisdiction with the appointment of judicial figures and enabling them to be part of the judiciary that you are not then draining resources from the local court as well and then basically shifting the resource problem down to the Local Court as well. It needs to be an additional injection of resourcing for coroners that does not come at the cost of magistrates in the Local Court as well.

Ms HENRY: Can I just make a further point that goes to brick-and-mortar accommodation-type concerns. In Newcastle, for example, we had a purpose-built new court complex built about five or seven years ago. If you walk into that court any day of the week, you will see a lot of—there might be two out of eight courts being utilised. I would not want members of the Committee to think that judicial resourcing equates to establishment of new brick complexes to accommodate a specialist court because I do not think that is right. I do not think that is the case.

The CHAIR: I think time for this session has technically elapsed, unless Committee members have any last questions. I thank the witnesses for their evidence. It has been very useful. If any questions have been taken on notice—I do not think they have but if they have, the secretariat will contact you in relation to those questions. Committee members may have additional questions which they will put on notice to you and you will have 21 days to respond. That is the usual process. I thank Dr Stern, Ms Edwards, Ms Henry and Dr Schetzer for their time this morning. It has been very illuminating and useful—at least for my own part.

(The witnesses withdrew.)

(Luncheon adjournment)

CRAIG D. LONGMAN, Head, Legal Strategies and Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit, sworn and examined

ALISON WHITTAKER, Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit, affirmed and examined

REBECCA SCOTT BRAY, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney, affirmed and examined

MEGAN WILLIAMS, Head of Girra Maa Indigenous Health Discipline, School of Public Health, Faculty of Health, University of Technology Sydney, affirmed and examined

The CHAIR: I welcome our final panel of witnesses. Would any of the witnesses like to give a brief opening statement. We traditionally take an opening statement from each body or group, so Jumbunna could give one opening statement and the two academics could give their own, I guess, because they are appearing in different capacities. Would someone like to give an opening statement on behalf of Jumbunna of just a couple of minutes?

Ms WHITTAKER: I am giving the opening statement on behalf of Jumbunna.

The CHAIR: Thank you, Ms Whittaker.

Ms WHITTAKER: I am on Gadigal and Wangal country today, and I want to take the chance to acknowledge their Elders and ancestors and their continuing sovereignty. In speaking to you today, Craig Longman and I represent the work of the Jumbunna Institute, an Indigenous-led research unit at the University of Technology Sydney. On behalf of our colleagues, thank you for the opportunity to submit on a long overdue review of the Coroners Court. We hope this is an opportunity for an institutional-level reform on a court that causes great harm to Indigenous families but that also has the potential, recognised by the Royal Commission into Aboriginal Deaths in Custody, to offer them justice.

We walk beside families through the Coroners Court after their loved ones have died in custody. We see these courts diminish their hopes for justice for their loved ones, sideline them from critical procedures in which they should be central stakeholders and alienate them in the day-to-day of an inquest, at times degrading them and the memory of their loved one, and leaving them drained of resources, wellbeing and a path forward for justice. They come to the Coroners Court to address the wound that a carceral system has given them and then they leave with a new wound, one made by the inquest itself.

The way the coroners courts encounter surviving First Nations families is not only a cultural competency issue, although we agree with Professor Williams that this is also a matter requiring urgent redress. These are fundamental design problems in the Coroners Court that presently make the court inadequate for addressing First Nations deaths in custody, and that inadequacy has had grave consequences for our community. Families approach these courts seeking justice and find themselves managed, instead of brought in as full and involved participants in a judicial process. They seek to point out to coroners the racism, the colonialism and the discriminatory systems that came to bear on their loved one and are met by procedures that see their role as sentimental or ceremonial rather than substantive.

These inquests instead prioritise the substantive rights of other interested parties of which there are many, most funded by the State itself, in a context of growing adversarialism. Those parties routinely work side by side and appear before the Coroner over years, developing a shared language, assumptions and trust that a family who only appears once in an inquest in their lives could never hope to influence. The inquest itself is informed by the investigations of police rather than independent investigators. Its scope is conceived narrowly, focusing so intently on the person who has died and a biomedical model for their death, but it fails to see the actors and systems that took them. Families are asked to wait years—in recent cases up to five—for answers that, because of memories being lost to time, now will never come.

The inquest is often naive to race and colonisation, except to accommodate small cultural practices in its procedures and to sometimes cast First Nations communities as deficient and implicate them in deaths in custody. These inquests are not transparent. There is no central repository of non-publication orders and no findings were systematically digitised until 2012. Referrals made to prosecutors are not done on the record, unlike in other States and Territories, and, like the provision of section 61 certificates offering protection from liability for witnesses, they come with strict publication restrictions. Families seeking to publicly share materials revealed to the court, like CCTV footage or the names of officers involved in proceedings, face nearly insurmountable barriers in doing so. There is no systematic body of funding to support them in doing this work. Except for the efforts of our community, community-controlled organisations and supporters, families would be nearly alone in this

experience. These are questions of substantive justice fundamental to the design of the court itself, not the procedural cultural accommodations that, while crucial, are only a small part of the picture.

The Coroners Court, it is our submission, must open up to the First Nations community and the surviving families to hear from them on independent specialist practices and procedures for First Nations deaths and deaths in custody. These must be enshrined in statute as a distinct part of the Coroners Act, based on what this consultation process has been told, and there must be significant resources made available to make good on these commitments to the community. That is what is required if inquests are able to be just for First Nations.

The CHAIR: Thank you, Ms Whittaker. Dr Scott Bray and Professor Williams, do each of you want to give a brief opening statement? We will start with Dr Scott Bray.

Dr SCOTT BRAY: Thank you. I would like to identify myself to the Committee, the panel and others watching. I am a settler on the unceded lands of the Wangal people. I live and work on Wangal and Gadigal land, and I acknowledge the Wangal and Gadigal people of the Eora nation and their traditional custodianship and continuing care of country. I pay my respects to their Elders past and present and acknowledge their sovereign connection to this land. This was, is and always will be Aboriginal land. Thank you for the opportunity to appear before the select committee. I firstly want to refer to the questions of cost that repeatedly come up when we talk about either questions of resourcing the jurisdiction or reforms to the jurisdiction. Coronial death investigation, including but not restricted to the holding of inquests, is a considerable and necessary justice investment. New South Wales, as it has been revealed in the earlier sessions today and in many submissions, spends less on coronial death investigation than other comparable jurisdictions. However, any outlining of cost must take account of the other primary costs to the community.

The cost is acutely felt in other areas: missed work due to illness and bereavement, delays which compound trauma and pain and echo for years in the lives of families. People who have lost loved ones often report that they do not wish other families to suffer the loss and the cost of losing a loved one in similar circumstances. Really, it is important to note that it is the bereaved, ultimately, who are left to embrace the benefits or bear the failings of the coronial system. Negative experiences in the coronial jurisdiction compound community trauma and pain, and this means that there is a lot at stake, including in this inquiry. Facets of death investigation seemingly so endemic in Australia, such as inquest delays, disrupt the capacity of coroners to exercise a therapeutic jurisdiction. The ethos of therapeutic jurisprudence cannot operate in an under-resourced system. Compassion is not embodied solely in the demeanour of coroners or their careful attention to the truth and to the bereaved who come before their court for answers. It is also brought to bear in the daily work of death investigation, from forensic medical processes through to months of communication, disclosures, timing and conduct of inquests, finalisation of investigation. One issue—one—such as delays in inquest can disappear the other good work that coroners can do.

It is important to note that coroners do not work alone. The "system" involves many people—forensic medical staff, registrars, lawyers, advocates, witnesses, support people and, of course, families and their communities. This is reflected in courtrooms which bring people together before the Coroner, who presides over often adversarial proceedings. The operation and logistics of the Act and the law are one thing, but the practice of coronership and interrelated professionals is another. This is to say nothing about the conduct outside of courtrooms in bathrooms, cafes or corridors. The issues requiring attention by this inquiry are manifold: questions of overarching principles, processes and practices from notification of death through to post-finding conduct whereby the bereaved's desire for truth, their demands for accountability and their need for acknowledgement are recognised and respected; the status and recognition of the bereaved, such as via a charter for the bereaved, for example, which clearly outlines expectations and rights; and increased attention to the place and status of family and community engagement at inquests, such as via statements, or about appropriate counselling and support.

There is the question of supporting the work of coroners via research that is not just epidemiological in nature. There are significant questions about the place of open justice, including how the Office of the Coroner interfaces with broader publics such as researchers and journalists, its internet presence and the availability of resources, findings and recommendations. The challenge for many coronial jurisdictions, including New South Wales, lies in realising the preventative potential of coronial practice via the issuing of recommendations. There has been limited research into the effect and impact of coronial recommendations, but what the research does highlight is the complexity and diversity of issues involved in the formulation, expression and implementation of coronial recommendations and responses to them, including oversight mechanisms.

Examining the characteristics of coronial findings and recommendations and organisational responses is an important step to understanding the coronial role and its contribution to prevention, which is supposed to be a guiding attribute of the modern jurisdiction. 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. Research is imperative to examining the intersection of coronial work and reform to document death prevention. Without this information, the effectiveness or suitability of the Coroner as an agent of death prevention cannot be fully ascertained.

Families' and communities' pain does not end at the completion of an investigation or an inquest. As the written evidence of families to this inquiry and written and oral evidence to other inquiries demonstrates, the death of a loved one, someone loved and missed, irrevocably changes the lives of those left to grieve them. The work of grief and mourning goes on. It never ends. The end of the coronial process is not "it" for families. Many families express that they have had to do the labour to follow up whether recommendations have been acted upon. As a society, we owe it to them to ensure that a core part of the coronial process—recommendations, those very things that are intended to represent the preventative potential of the modern jurisdiction—are received, acted upon, followed up, monitored and that all of that is recorded. Respectfully, I submit that as its priority, the select committee listens closely to the experiences and views of those directly affected by coronial process and practice. Families and their communities possess authoritative knowledge about the numerous issues the inquiry is concerned with and speak to what is at stake in its outcomes.

The CHAIR: Thank you. Professor Williams.

Professor WILLIAMS: Greetings, all. I acknowledge that I come from the land of the Gadigal today and I pay my respects to their ancestors and spirits of this land and their Elders of the past and present. I acknowledge all Aboriginal and Torres Strait Islander people participating in this inquiry. As well as speaking from a Wiradjuri family perspective of the coronial perspective, I speak from 25 years' experience as a public health professional, having focused on better evidence about the health of Aboriginal and Torres Strait Islander people in the criminal justice system. I am a chief investigator of a national palliative care in prisons project, and I tend to focus on questions about increasing Aboriginal and Torres Strait Islander workforces and also the use of our evidence in system design.

Some of the discussion earlier today risks problematising Aboriginal and Torres Strait Islander people as hard to engage, distrusting, having complex problems and needing unique fixes that are somehow "other" to Australian systems. But there is an alternative and a leadership view, and I urge you to take it, and that view is that Aboriginal and Torres Strait Islander people have highly developed expertise in health and social care policy development, research, system design. We know the way forward, and it is our cultural responsibility to be leaders and of leaders of this country, and we are skilled in being able to do that. From the evaluative data evidence perspective too, Aboriginal people do much better at looking after the needs of Aboriginal and Torres Strait Islander people, and we have got evidence of that in the legal and health systems. We have a large workforce that is able to do that that currently exists.

There is that simple phrase that if you get it right for Aboriginal and Torres Strait Islander people, you will get it right for everyone. But in my role, say, at the National Centre for Cultural Competence and in collaborative research, I am constantly told by non-Indigenous people, "I'm scared of saying or doing the wrong thing," and that includes my experience in the coronial process. Even if non-Indigenous staff are confident, Aboriginal and Torres Strait Islander people have the right to and need to be leading decisions, including about how material in the coronial process is interpreted, from causes of deaths to the gathering of evidence, and processes for family care. In terms of the non-Indigenous workforce, there are guidelines in the professions associated with issues relevant to the coronial process, such as health, and any employee of New South Wales Government that mean that conduct should already be informed, culturally safe, culturally responsive—whatever the phrase people choose to use—as well as informed by leadership of Aboriginal and Torres Strait Islander people and Aboriginal people's perspectives, as well as in partnership with Aboriginal and Torres Strait Islander community controlled organisations. So we already have that written in current documents.

My submission to this inquiry outlines some of those expectations, including through the Aboriginal Health Plan, for example, but non-Indigenous colleagues I am among say that they do not meet the visions of this plan. They do not have funds for cultural safety frameworks, plans or actions and so cannot operate in accordance with New South Wales Government's own existing directives for its staff. This also erodes the right of Indigenous people to self-determine. In my experience, if non-Indigenous staff are fearful and under-developed in their capacity to engage with Aboriginal and Torres Strait Islander people or cultural processes, they retain power and norms in a way that excludes us. So plans and questions have to be asked about the way forward that includes Aboriginal and Torres Strait Islander leadership. Partly, that needs to happen because we are over-represented in New South Wales, with poorest health and wellbeing, some of the highest mortality rates as well as numbers in prisons and numbers of deaths in prisons that need to be responded to.

I can hear you thinking, and we have heard today, that we do not have enough Aboriginal and Torres Strait Islander workforce like lawyers. But it is about looking to where we do have the existing Aboriginal and Torres Strait Islander workforce such as our community controlled health services. In my view, it is a real shortcoming that the coronial process and criminal justice system do not use these services. They are underfunded and, yes, we must not burden these services with more work, thinking that we are making progress by inviting them to be part of the process. We must find new funding mechanisms that overcome the Commonwealth-State jurisdictional divide that drives the exclusion of our Aboriginal and Torres Strait Island community controlled health organisations from State business such as coronial processes. If we find new mechanisms, we will tap into a large existing Aboriginal and Torres Strait Islander workforce that we can plan to become a skilled workforce for coronial processes into the future.

The other part of this issue that is important for me to raise is that universities do have aims to improve curriculum that includes Aboriginal and Torres Strait Islander people's knowledges so that all lawyers, for example, of the future will be able to be more attuned, but universities do not generally meet Aboriginal and Torres Strait Islander staff numbers. So progress on this is slow. It will be some time before we are able to have a mainstream workforce or an Aboriginal and Torres Strait Islander health workforce to meet the needs of the coronial process. That is why partnerships with Aboriginal and Torres Strait Islander community controlled health organisations could be one solution important to consider, and they will have some independence as well. For example, there are social and emotional wellbeing workers within these organisations. We have heard many times that families need more support, and this could be one potential way, but an actual plan for an Aboriginal and Torres Strait Islander workforce for the coronial process is essential, as is a plan for the non-Indigenous workforce and their current capacity to engage respectfully and in accordance with our rights to self-determine as Indigenous peoples. Thank you for the opportunity to make those statements.

The CHAIR: Thank you, Professor, and thank you all for your opening statements. We will commence with questions from Mr Shoebridge.

Mr DAVID SHOEBRIDGE: Thank you all for your submissions and not just your submissions and your time today but also your ongoing work in this space. Professor Williams, it is hard to know where to start with your raft of really carefully crafted recommendations, but could I start with Aboriginal Controlled Community Health Organisations. How do you see them being integrated into the coronial system? Do you see them as being a conduit between the coronial system and the Aboriginal community by reason of them being trusted and on the ground and knowledgeable, or do you see them also as having an institutional role within the court? If so, what would that be?

Professor WILLIAMS: I think an institutional role is possible. We do have long experience working in partnership and making shared agreements and those agreements can be made, as have been made culturally for tens of thousands of generations, between the institutions that participate in the coronial process—for example, Justice Health, a community-controlled health organisation and the Coroner. So it is a matter of making clear terms of reference but also funding those, too.

Mr DAVID SHOEBRIDGE: We have seen this State-Federal divide exposed in funding in the current pandemic crisis with Aboriginal community-controlled health organisations excluded from most of the State responses and being seen as an exclusive Federal resource. Do you think we have lessons to learn from this?

Professor WILLIAMS: I do, absolutely. That is just a decision that is made by humans to fund and arrange Indigenous health affairs in that way and there is no reason it cannot be changed. We need to boost New South Wales' own capacities for engaging respectfully with Aboriginal and Torres Strait Islander communities. Our ACCHOs, the acronym is our Aboriginal Community Controlled Health Organisations, have evidence of doing it well. The New South Wales State Government has many challenges they have identified. Partnerships between NSW Health and ACCHOs are to occur on paper because of the National Aboriginal and Torres Strait Islander Health Plan but they are not resourced. There is no implementation plan. So, yes, we need more funding at the Commonwealth level for ACCHOs and, say, the use of Medicare for in-reach for people, say in my field, who have a life-limiting illness, are in prison, and are expected to die. Why can Medicare not be used to support the family and the individual that way, as well as a different funding mechanism by the State to ensure ACCHOs can support and have an institutional role in the coronial process in New South Wales. It is not an either/or; it is a both/and funding mechanism change required.

Mr DAVID SHOEBRIDGE: But some of the institutional resistance from a State Government perspective to having ACCHOs at the table seems to come from a fear that they will be responsible for a proportion of funding and this historical concept of, you know, that that is all Federal business. Would statutory reform in this regard be helpful giving ACCHOs a statutory role in the coronial court to, if you like, force the hand?

Professor WILLIAMS: A statutory role would be helpful and should be seriously considered, but we also need the New South Wales Government to take responsibility for the fact that it currently does not meet the burden of health and illness and does not currently meet its own requirements that it has set out on paper to support Aboriginal and Torres Strait Islander peoples in a way that we have the right to do. We need attention to both of those at the State level.

Mr DAVID SHOEBRIDGE: Can I ask all the witnesses: According to the Government's submission, the Local Court and the Coroners Court have been going through the process of a revised practice note for senior coroners for case management of deaths in custody, together with a State Coroners protocol for the case management of section 23 inquests involving First Nation deaths. What has been their outreach to you? Do you have any views about the process that has been used to develop those protocols and practice notes? I might start with you, Miss Whittaker.

Ms WHITTAKER: I actually think my colleague Mr Longman might be better placed to talk about this.

Mr LONGMAN: Yes, thank you. There has not been, as far as I am aware—or certainly I have not seen—a coronial protocol in relation to First Nation deaths in custody. I am aware of it because of the work that we do with allied organisations. My understanding is that the consultation has been with certain stakeholders that have not included, for example, many of the families that gave evidence to the inquiry last year. It has not included consultation with some of the Indigenous support workers who regularly work with those families. It has not included consultation with at least some of the lawyers who have represented families whose matters have highlighted particularly concerning systemic problems in the coronial jurisdiction. I do not say that to be critical.

Not being in the tent, so to speak, I do not know what the plan is. But I do think it is important to make this observation: I read in the New South Wales Government's submission that those steps have been taken and I heard the evidence given by Mr Evenden earlier today. It is concerning to me that the manner in which this was done appears to be, effectively, that the lawyers in the court drafted a document that they then shared with other lawyers who work in the court with some feedback from families—through the lawyers, clients of those lawyers—that they then intend to consolidate and share with stakeholders. I understand, of course, that is how traditionally courts often seek to reform or improve their roles. It is a common institutional process, that idea of a practice note, but I think it speaks to a central problem and it goes to highlight something that Professor Williams said earlier, which is that what we have heard time and again from families I think makes clear to this Committee that business as usual will not work. It will not fix the fundamental problem with the coronial system.

I think the first question that needs to be asked, and it is raised in Professor Dillon's submissions, is: Really, what is the purpose of this system? A lot of the tinkering—and I do not intend that to be derogatory because I understand even small changes can require a lot of political effort and will and I also want to single out the efforts that have been made by our current State Coroner to improve this system and there have been some improvements—but what is the purpose? A purpose, from our view at least, needs to start with proper consultation with First Nations communities about what is truth seeking and what is justice in the context of First Nations deaths in custody because, until you know that answer, you are attempting to reform a system without truly understanding what the goal is.

The CHAIR: Just on that point, I draw your attention—and I am happy for you to take this on notice—to appendix C to the Bar Association's submission 17 to this inquiry, which is a copy of the "State Coroner's Draft Protocol" for case management of mandatory inquests involving deaths of First Nations people. It is dated March this year and it has the name of the current State Coroner. I will get the secretariat to send that to you. Perhaps on notice you could give us your views on that draft protocol just so we have your insight into a step that the Coroners Court has taken or is apparently taking in this important direction, but its adequacy or your insight into that would be useful for us.

Mr LONGMAN: I am very happy to take that on notice. I can say one thing that I think arises from the submissions from families that have been made to the previous inquiry and this inquiry and that I think would be agreed by many of the practitioners that represent them is that often there are common issues between inquests that are either in custody or not in custody. For example, one of the things many families say to us—and the family of Aunty Tanya Day said this and it is extracted in our first submission from last year—is, "I need you to understand the same system that killed my uncle killed my mum. I need you to understand this." It is that issue of systemic issues. I do not think I can add anything more to what I have previously said and I do not want to take other people's time.

Mr DAVID SHOEBRIDGE: Dr Scott Bray or Professor Williams, do you have a response to that question I have about the development of these protocols and case practice notes?

Dr SCOTT BRAY: Thank you. Well, yeah, I have not been consulted. I am a coronial researcher but I do not necessarily think that that is important in this circumstance. But, yeah, I would have thought that especially given the issues raised in terms of the select committee last year and what we have seen emerge in Victoria, for instance, that that engagement is not actually just a question of what is contained in the practice note; it is a question of process that, I will say, is incredibly important as well.

The CHAIR: Mr Khan, I think you had a question. Can you un-mute?

The Hon. TREVOR KHAN: I am sorry. It beats me every time. This is directed at Jumbunna and I think it is probably to Mr Longman as I suspect this is probably his area, but no doubt I will be shown to have been completely wrong in that regard. Page 19 of the submission and more particularly recommendation 4, why do you propose that that is the section for amendment? I suppose, if you saw some of the earlier hearings, my interest is in what I think is—and I will have to just go here—section 58 and section 61. Those are the sections dealing with, essentially, self-incrimination. It seems to me in the deaths in custody space the ability to have the story told, or some part of the story, is often frustrated by the self-incrimination provisions. I am wondering if you have given that consideration as to whether it is appropriate for those sections to be the subject of reform?

Mr LONGMAN: We have. I think that there is a need for reform for those sections and I think it speaks to this broader question of purpose: What is the intention? One can understand those sections but I think their insertion in the Coroners Act is almost a throwaway attempt to protect against possible consequences in criminal proceedings. But the point that was made earlier—and I apologise I think it was one of the speakers from the Australian Lawyers Alliance who made this point that there is no ability to consider those certificates prior to hearing—is deeply problematic because, by the time the witness gets the certificate and is willing to give their evidence, very often their evidence is unreliable due to time. Also I think it does not necessarily work as intended, in any event in some cases. For instance, some individuals like police officers are often required to give interviews anyway as a result of departmental orders so I do think there is a need for reform.

But I also think there can be a danger in reforming that provision without again considering the centrality of the family. For instance, I would advocate for a coroner, who is considering giving that protection and trading that immunity for information, to speak to a family about it beforehand; identify from the family what their intentions are. Some families we speak to are very stringently about accountability. Some families are very stringently about finding out what happened. My suspicion is that with some deaths, if the Coroner was engaging with the family earlier and had the capacity to make decisions about investigations and whether inquests should flow, some families would say, "Well, this is what we're particularly concerned about and you've answered that so we may or we may not want an inquest and we may or may not want the inquest to consider this."

I think that the danger of that provision is that it comes up sort of while you are on your feet under fire in a court and we cannot help but treat it like we are in a trial when those provisions come up. That is what we are trained for. And you can feel the energy in a courtroom when you are starting to stray into areas of evidence that the family is particularly interested in and all of a sudden there is a sudden interjection and there might be an hour-long debate about whether the certificate should be given. That is a very longwinded way of saying yes. I apologise.

The Hon. TREVOR KHAN: No, that is all right.

The CHAIR: Mr Khan, do you have further questions?

The Hon. TREVOR KHAN: No. I think that covers my area of concern.

The CHAIR: Ms Sharpe or Mr Roberts, do you have questions? Mr Shoebridge, do you have additional questions? I have some questions as well so I might start while you are getting yourself off mute. This question is directed to Jumbunna. At page 19 recommendation 2, you recommend the return of directly initiated coronial prosecutions in First Nations deaths in custody matters. I think that is referable to paragraphs 11 and 12 of your submission. Have I understood correctly that you want the coroners to be able, as it were, to commit people for trial, or are we simply talking about the issue of referral of a matter to the Director of Public Prosecutions [DPP]?

Mr LONGMAN: I should say this is partially a product of the short turnaround time for the submissions.

The CHAIR: Of course.

Mr LONGMAN: If possible, I would like to take that on notice.

The CHAIR: I am happy for you to do so and give a longer response. That is fine.

Mr LONGMAN: Yes.

The CHAIR: All right.

Mr LONGMAN: I might just say this—and I apologise, Mr Searle—the reason I would like to take it on notice is because of some of the submissions and evidence that has flowed previously today and from other submissions. It seems that everybody is attempting to find a way to fix this issue.

The CHAIR: Yes.

Mr LONGMAN: Some suggestions are hybrid models and some suggestions are a specialist court. This was one suggestion that we made but I think that my preference—or I should not should say "my preference"—

The CHAIR: You can take it on notice. You have a right to take a matter on notice and you do not need to explain. That is perfectly fine. My final question to Jumbunna is in relation to your recommendation 3. Do I understand your evidence is that when the issue of a referral to the prosecuting authorities is being considered by the Coroner, families do not have standing at the moment to make submissions to the Coroner on that matter? Is that what you are suggesting needs to be remedied here, or is it a different perspective; that you want the families to be able to require a matter to be referred to the prosecuting authorities? I just want to get a better understanding of what it is you are suggesting here.

Mr LONGMAN: The interpretation given to those provisions by Coroner Lee in the David Dungay matter was that the family has no right to be heard. The reasoning process was that no parties have a right to be heard at an inquest except for the Coroner. Families are regularly conferred a right to appear and be heard but Coroner Lee characterised that right by reference to the traditional idea of a party having a right to be heard because there may be some negative comment made about their behaviour or some suggestion of accountability. Therefore, Coroner Lee's view was, because there is no possibility that a family's right to be heard in that way could be damaged by a failure to refer, there is no right to be heard on a referral.

In that matter, out of fairness, Coroner Lee received submissions from the family and then in his findings held that he was not going to consider submissions and he did not need to hear from Counsel Assisting so you can imagine how that felt to the family being told you do not actually have a right to be heard on the question of whether there should be a referral.

The CHAIR: Okay. I think I understand your concern.

The Hon. TREVOR KHAN: Can I ask a follow-up question?

The CHAIR: Of course.

The Hon. TREVOR KHAN: Mr Longman, do I understand that to be in a sense the Coroner observing that under the Coroners Act no party has a right of appearance; that is, in the inquisitorial model everything is done by leave.

Mr LONGMAN: That is right. That is exactly right. The Coroner's view was that in those circumstances really understanding that provision is about understanding—and the referral provision is really about understanding—that it is a handbrake, effectively. When the Coroner forms a view that there may be a serious indictable criminal offence that has occurred on the admissible evidence or one is charged, that is designed as a handbrake to stop anything happening; to protect the interests of the accused. It is not designed as a lens through which to consider accountability. But often families, when they come to coronial inquests, are looking for accountability and they understand that the Coroner has the power to refer. I should say it does raise another issue about the Coroners Act—and the previous Coroner spoke about this today—which is that the discretion is extremely broad. There is very little supervision of it in the Supreme Court so the decision of Coroner Lee potentially would be judicially reviewable in the Supreme Court but—

The CHAIR: If you had the resources to go there.

Mr LONGMAN: If you have the resources, and most practitioners are going to say, "To what end?"

The CHAIR: Yes. Thank you. Dr Scott Bray, I wish to ask you a question. I think in your submission to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody you touched on the coronial jurisdiction. As one of your concerns you raised the lack of accountability around coroners' recommendations, about whether they were binding or not binding, and you discussed, I believe I can recollect, the obligation on at least State actors to meaningfully respond to coroners' recommendations. I think your view was that those provisions certainly needed to be strengthened. Are you able to speak to those matters in a bit more detail here and, in doing so, should coroners be able to require responses of State agencies and non-State actors as well who might be the subject of their recommendations?

Dr SCOTT BRAY: Thank you. Yes, I think they should. I mean, it is important to note that in all jurisdictions where recommendations are issued—for example, in Victoria where there is a mandatory statutory response regime—recommendations are still not binding in that sense. It is really: Where does the issue begin and

where does it end? In my opening comments I made a statement about the significance of recommendations and the attention to the issues which seem to get stuck on the issue of whether there should be a mandatory response regime—whether it should be enshrined statutorily and these sorts of issues—compared to what I would call, frankly, the mess that currently exists in New South Wales in relation to the policy memorandum issued in 2009 right through to the recording and the storage online of responses to recommendations, which is just a swamp of information. It is not even located. You have to do a Google search. It is on the department of justice website. It is on this sort of completely clunky Word document you open up and you have to kind of trawl through. Then it has got sort of a separate section where you can look at specific recommendations categorised under particular, you know, deaths related to mental ill health or deaths in custody, for instance, which still is inadequate to the task, you know.

I think when we talk about the coronial jurisdictions, including internationally as well, we get hung up on these quite obvious points. But, really, there is a lot of much more subtle and nuanced and complex work that has to go on around recommendations beyond the issue of whether there is a mandatory response regime or not. I think this has been highlighted by the experience of Victoria, which has had a mandatory response regime for a number of years. That was essentially since the Victorian Parliament Law Reform Commission [VPLRC] review of 2006 and then the new Act in 2008 where we have a very sort of slick online posting of findings and responses to them, which is a requirement, so that they can be accessed, remembering that it is not only advocates who seek to interrogate databases which contain coronial information. It is researchers. It is journalists but it is also, really importantly, families who engage with the coronial system and who look for—I do not mean to use the term lightly—like cases. I have spoken to many families in Victoria—I am currently doing a project with some colleagues—who have used that facility to try to gain traction in understanding the coronial appreciation of the circumstances of death which might be similar to their loved one.

We have over a decade of experience with a mandatory response regime but the very limited research that has been done into that regime is that there are all sorts of issues that undergird it, you know: the formulation of recommendations; the issue of supplanted recommendations where you have Sutherland et al, who did a study into supplanted recommendations, where, essentially, you have such a long period of delay between the death and the inquest and coronial findings and recommendations that you have organisations that have subsequently sort of tidied up and fixed some issues, not necessarily all, so there are those issues; and there is also the formulation of appropriate recommendations, but then there is the nature of the responses to them.

So, yes, I think that we should have a mandatory response regime. I think it is the right thing to do in a system which hinges on the espousal of death prevention at its modern heart. I think that is very important. But I also think that the Victorian experience illustrates that there is a whole range of other issues that we really need to wrestle with when we are looking at this issue of coronial recommendations and the effect that they have. It also relates to how many inquests we hold, the discretion of coroners to hold inquests, the capacity of coroners to make preventative forward-looking discretionary decision-making around the kinds of inquests and the scope of inquests. Former State Coroner Jerram this morning raised what I consider to be a very important issue in relation to issues around climate change. There is heat mortality. There is a whole range of issues specific to the modern society in which we live that coroners can have quite productive interventions in under the label of death prevention. There is a lot of work to be done that is not just legislative. It is a question of policy and it is also a question of practice and it is threaded right through the system.

The CHAIR: Yes. One of the innovations in the Victorian system, I guess, is the Victorian Coroners Prevention Unit which seems to have as its charter the analysis and interrogation of data produced through coronial inquiries and assisting coroners to provide, if you like, an evidence base so that they can make improved recommendations. This is a question to all of you: Is that an innovation New South Wales should also embrace? Dr Scott Bray?

Dr SCOTT BRAY: Thank you. I think so. I think there are a number of issues with research informing coronial processes and the nature of the kind of research which is privileged. That was not a legislated initiative. That was a policy initiative. Eventually, it was a trial initiative, essentially, by the Victorian Government which has since been solidified and consolidated. It does not just inform recommendation practice. It informs inquests. In the case of Vekiaris, an important case around excited delirium, here we had the CPU engaging in research which sought to enliven the Coroner about particular research and debates around the issue of excited delirium as a potential diagnosed cause of death. Then what we see through that is the kind of importation of that to the New South Wales coronial jurisdiction in some matters recently held here into the deaths of people, including First Nations people, where the State Coroner made an explicit statement in her findings about the value of the CPU informing not only this question of recommendations, which people talk about the CPU in relation to quite often, but really around these other issues that inform inquests, whether it is scope or whether it is forensic medical issues, and important matters like that.

The value of having a research unit concentrated in one jurisdiction where we have kind of a country with a federated system of coronial practice is really important because, of course, the National Coronial Information System was set up as a kind of federated initiative to bring a uniform perspective to something that had been missing hitherto from the coronial system. Arguably, the CPU is infusing this expertise through other jurisdictions. Of course, you have then a question of coroners being able to draw on insights from the Victorian-based system but related to issues which are actually being raised across the country—and really important issues. It is not just about recommendations; it is also about informing the scope and the perspective of coroners within investigation and inquest. One of the issues is in relation to the emphasis on the kind of research. People may say, "You will say that because you're a social scientist so, you now, of course you sort of value the practice of social science research." But I do think that an emphasis on public health, an emphasis on trends and patterns—and Ms Whitaker's work speaks really importantly to this as well—you cannot just restrict coronial scope to those sorts of issues.

There are social justice issues involved in the investigation of death that really come to the fore, obviously, in very specific deaths. There is a wealth of expertise amongst advocates, community-based organisations, disability advocates and First Nations communities that have expertise and resources that can inform questions of research in the coronial jurisdiction. I think we do a great disservice to the issues that coroners are tasked with investigating—and the deaths that coroners are tasked with investigating—by closing off the scope of what we would consider to be productive research capacity. I believe that it is important to expand what we would consider verifiable or useful research in the context of coronial death investigations.

The CHAIR: Okay. Does Jumbunna have a response to my query? Then I think we might go to Mr Shoebridge. No? Okay. Mr Shoebridge?

Mr DAVID SHOEBRIDGE: Can I ask about some very practical details about the engagement of First Nations families with the coronial system? I probably direct it to you first, Ms Whittaker, and then to you, Professor Williams. If you live in Moree, you have a modest income and you need to get eight family members down to Lidcombe to spend a week to hear a coronial inquiry, what support is there?

Ms WHITTAKER: There is virtually none except that which the families manage to organise themselves. Often what happens is that the community-controlled sector or the community itself organises to fundraise to cover as many of these expenses as they can, but this is often done at the last minute when it becomes apparent, usually through the family's counsel, that it is necessary. A lot of these inquests for the more complex and serious matters, especially the First Nations deaths in custody, go for up to two weeks—the period that is extraordinarily difficult in which to get a large group of people who might comprise that about that person's kin and loved ones. It is very difficult to find that kind of accommodation at late notice, extraordinarily expensive, and very difficult to organise that transport. There is nothing systematic about that support and it relies a lot on community goodwill that is already is so, so stretched.

Mr DAVID SHOEBRIDGE: Professor Williams?

Professor WILLIAMS: I concur with Ms Whittaker. Also we must note that this comes at a cost. Those costs are not borne or considered—that is, financial costs if people take time off work, child care, costs to health and wellbeing, as well as to participation in other elements of community life that others then have to take on, or that there are gaps when that occurs. We need to not only pay but to cover those broader costs and urgently think through practical strategies to do that.

Mr DAVID SHOEBRIDGE: And the additional stress that that places on families who are already grieving—stress about the coronial system, to not even know if they have got somewhere to stay—it seems to be a mark of disrespect to the families from the system. It is like they are an add-on. How is it felt by families?

Professor WILLIAMS: That is right. What if I could read some words of a Wiradjuri Elder who has been through the coronial process, it has stayed with her for several years what they did to the body, the atrocities that occurred to the body, the pictures, the language used, and the medicalising of social issues. The need for debriefing about these atrocities has persisted for years and there are costs across generations for the children of the Elders and also the sheer interruption to the passing-on of critical cultural knowledges that cannot occur when families are experiencing atrocities perpetuated by the State's processes.

Mr DAVID SHOEBRIDGE: Thanks, Professor. Could I just ask you this: Is there a fundamental problem with the current structure for First Nations families, particularly for deaths in custody? They have seen a family member caught up in the criminal justice system, taken into a State institution, dying in the State institution and then their access for justice is to go right back into the court system with a bunch of lawyers around them. Is that a kind of irremediable problem? How do we address that? I might go to you, Professor Williams.

Professor WILLIAMS: I think that is an example of multiple and compounding trauma to not only have traumas from incarceration and the drivers of incarceration that are often outside an individual's control to not be addressed but then also these experiences as you have outlined. I think, too, from a public health perspective, we do use a socio-ecological model or a holistic model of care and I think about why say in palliative care—for example, when people are expected to die in prison and, if they have not been released from prison, to die in the community or die on country, which is our cultural protocol and responsibility, I need to add—that our model of care, say, it is case management, according to Indigenous knowledges, it should be continuous case management from within prison throughout the period of the person passing on and then throughout the coronial process that includes support for the family.

There is no reason why systems like that cannot be designed so that then there can be referral and funding of therapeutic care that does address the deeper distress that people have when they see atrocities that are not spoken of, as well as the sheer burden of carrying these issues over such a long period of time, often to then experience an injustice at the end of it that lingers then for decades or across generations. That is the reality of our families. That is destructive in the face of us actually having solutions that we think the State could use in making a better way forward.

Mr DAVID SHOEBRIDGE: Ms Whittaker?

Ms WHITTAKER: On your observation, Mr Shoebridge, I recall experiencing with families who are trying to develop a family statement, that this kind of protocol is reasonably informal that tends to happen at First Nations deaths in custody inquests where the final day, effectively, will be given to the family about who the deceased person was, what they meant to them and what they were looking for out of the inquest. That is a tremendous moment for families to have but it often in a sense procedurally isolates them to having this memorial role rather than the substantial role that they often want to play in the fact-finding mission of the Coroner. In the course of developing that, families often find it difficult to have the resources and the space to do that. I bring it up because you note the, I suppose, pathway of trauma from criminalisation and incarceration into this quite reasonably strict judicial setting, which, despite its informalities, has a lot of protocols that mimic policing, like the really heavy security on days when there is going to be lots of attendants or especially sensitive inquests, to also the policing that families experience when they are doing something as simple as taking a photo of their loved ones in a family conference room which, while prohibited under the Court Security Act, from memory, is actually not affecting the sensitive protocols of the court. Their experience of policing in that moment can be quite traumatic because they are participating in an act of memorialisation, an act of gathering their families, that is then brought home again to this idea of penalty.

I also want to bring up something that Mr Longman and I saw in Professor Williams's submission that we would really love to make sure is brought to this Committee's attention. It is the idea of a complaints mechanism that families can access in relation to the matters kind of surrounding the proceedings. In our time supporting families through these proceedings in various capacities, Mr Longman and I observed what I can only describe as grossly insensitive bordering on cruel misconduct done by anybody who is sitting at the bar table. Often, as I think was mentioned in an earlier submission, in the corridors and the cafes of the court one especially egregious example of this is a party and their advocate were gathered after just having given evidence about restraint technique in the cafe engaging in horseplay, mimicking that restraint technique and saying very, very insensitive things about the deceased person, which was then overheard by the family. They had, in effect, no formal mechanism by which they could access redress for the wound that had caused them, for the sense of indignity and contempt they felt that they were being treated by the court within that time, even though it was not coming from the Coroners Court itself.

It is also common to see these practices especially from people at the bar table before the court is formally sitting engaging in the discussion of the routine of the day, how much they are charging, et cetera, et cetera, in a way that families find incredibly degrading in their experience as well. So a formal complaints mechanism, not only to address these insensitivities, but also some of the more egregious violations that families experience during the course of the inquest would be incredibly, incredibly valuable. Although it would not go any way in redressing the full suite of violences that First Nations people experience in the Coroners Court, it would be one small step forward to at least having them ventilated.

The CHAIR: Dr Scott Bray, I think you want to respond but I just want to draw everyone's attention to the fact that formally time for this session has expired. We will take Dr Scott Bray's response and we will conclude the proceedings at that point.

Dr SCOTT BRAY: Thank you. I am sorry. I will be really brief.

The CHAIR: That is okay.

Dr SCOTT BRAY: I just wanted to really echo and support that recommendation. I think it is really important. I think that jurisdictions the world over are wrestling with how they place those who are most affected by the death of someone at the centre or to be given appropriate status within Crown investigation process, practice and procedure, whether we legislatively enshrine this and recognise it in the objectives or principles to an Act or whether we engage in guidance, practice notes and things like this. But if we take a sort of parallel example of victims in the criminal justice system, we have a charter of victims' rights, we have a complaints process that is available to victims. The status of victims can be a very problematic one but I think that if we are wrestling so much with how we actually appropriately acknowledge and recognise families in the process, I think a charter for the bereaved, as Professor Phil Scraton and I suggested to the select committee last year, would be a good place to start in terms of formalising it.

I think this also goes to the issue that Ms Whittaker also raised about questions of memorialisation and the status that families have; so, the role of statements. Statements are something that have slowly developed and evolved. Families typically give family and community statements at the close of the inquest and it is such a tumultuous time for families, the close of the inquest, and I sort of wonder. I am not a person to presuppose that any model is the right model because you have to talk to the families about it and communities, but do we need to have some formalisation of recognition of the role of family statements and the purposes for which they are given, when they are given in terms of proceedings; whether it is, for example, empowering and a suitable form of recognition to have at the beginning of proceedings, which it sometimes is and it is more frequently in terms of the England and Wales jurisdiction.

Obviously, I do not want to go on to chew up time but I think it is very important when we are talking about questions of rights and roles that we start to think about how we can sort of really structure these things into the jurisdiction so that they are not sort of informal ad hoc processes.

The CHAIR: I thank all the witnesses for attending this hearing. Your evidence has been very insightful and I am sure it will be very useful in our deliberations. For those who have taken questions on notice, the secretariat will contact you in relation to those questions. Committee members may have supplementary questions that they will put on notice to you and the secretariat also will be in touch with you about those matters. This concludes the first public hearing of the inquiry. I conclude by thanking you all for coming along and sharing with us your insights today.

(The witnesses withdrew.)

The Committee adjourned at 2.18 p.m.