public interest
ADVOCACY CENTRE

Submission to the NSW Legislative Council Select Committee on the Coronial Jurisdiction in NSW

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Level 5, 175 Liverpool Street, Sydney NSW 2000
Phone: 61 2 8898 6500 • Fax: 61 2 8898 6555 • www.piac.asn.au

About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is leading social justice law and policy centre. Established in 1982, we are an independent, non-profit organisation that works with people and communities who are marginalised and facing disadvantage.

PIAC builds a fairer, stronger society by helping to change laws, policies and practices that cause injustice and inequality. Our work combines:

- legal advice and representation, specialising in test cases and strategic casework;
- research, analysis and policy development; and
- advocacy for systems change and public interest outcomes.

Our priorities include:

- Reducing homelessness, through the Homeless Persons' Legal Service
- Access for people with disability to basic services like public transport, financial services, media and digital technologies
- Justice for First Nations people
- Access to sustainable and affordable energy and water (the Energy and Water Consumers' Advocacy Program)
- Fair use of police powers
- Rights of people in detention, including equal access to health care for asylum seekers (the Asylum Seeker Health Rights Project)
- Improving outcomes for people under the National Disability Insurance Scheme
- Truth-telling and government accountability
- Climate change and social justice.

Contact

Jonathon Hunyor
Chief Executive Officer
Public Interest Advocacy Centre
Level 5, 175 Liverpool St
Sydney NSW 2000

T: 8898 6500
E: jhunyor@piac.asn.au

Website: www.piac.asn.au

Public Interest Advocacy Centre

@PIACnews

The Public Interest Advocacy Centre office is located on the land of the Gadigal of the Eora Nation.

Contents

Summary of recommendations

Recommendation 1 – Strengthened mandate to make systemic recommendations

The Coroners Act 2009 should be amended to include provisions similar to those in s 28 of the Coroners Act 1995 (Tas), requiring preventive recommendations to be made whenever appropriate and for the coroner to report on the care, supervision or treatment of people who have died while in custody or care.

Recommendation 2 – Properly resource the Coroners Court to support its preventive function, including establishing a Coroners Prevention Unit

In addition to a general increase in resources for the NSW Coroners Court to address existing issues of delay, specific resources should be allocated to support the Court's preventive function, including resources for a Coroners Prevention Unit.

Recommendation 3 – Legislative requirement for responses to coroners' recommendations

The Coroners Act 2009 should be amended to require a response from government departments or agencies to coroners' recommendations, with such responses to be tabled in Parliament.

Recommendation 4 – Coroners Prevention Unit to have responsibility for monitoring

The Coroners Prevention Unit should be given specific responsibility for monitoring the implementation of coronial recommendations, with appropriate resources to support this function.

Recommendation 5 – Independent investigations into deaths in custody

An independent body should be established to investigate all deaths in custody. Should this function be given to a specialist unit within the Coroners Court, particular attention must be given to cultural awareness and competency, including the appointment of First Nations staff to senior roles.

Recommendation 6 – Comprehensive reform to meet the justice needs of First Nations people

The NSW coronial system should be comprehensively reformed to meet the needs of First Nations people. This aspect of the reform process should be led by First Nations people.

1. Introduction

The Public Interest Advocacy Centre welcomes this inquiry into the Coronial Jurisdiction in NSW.

PIAC has a long history of involvement in coronial inquests in NSW on behalf of the families of people who have died. Our work has focused on cases that raise systemic issues, particularly concerning deaths in custody and suicide. PIAC has also been actively involved in coronial law reform processes, including submissions to the 2014 review of the *Coroners Act 2009* (NSW).[1]

We make this brief submission to highlight the need for reform of the coronial system to:

- make good its potential to promote community health and safety;
- allow the court to play a therapeutic and restorative role;
- ensure robust, independent investigations of deaths in custody; and
- respond to the justice needs of First Nations people.

While limiting our submission to these issues, we recognise the strong case for more fundamental, structural reforms to strengthen and modernise our coronial system.[2]

We strongly support calls for comprehensive reform to deliver a modern coronial system that meets the needs of our community, including the establishment of a specialist, stand-alone coroners court.

2. Community safety and wellbeing

Coroners can play a significant role in identifying and examining systemic issues that may have contributed to a death and making recommendations to promote public health and safety. This is an important public interest function. Commenting in the context of deaths in custody, Boronia Halstead has observed:

> Coroners have much to contribute to the prevention of deaths in custody. The coronial process gives a direct insight into the causes of a particular death, and their unique role allows them to highlight preventive measures which logically form a part of coronial findings.[3]

It is also an important part of the therapeutic and restorative role of the coroner. Families and communities grieving the loss of a loved one may wish to see that steps are taken to ensure that a similar event does not happen again: the 'satisfaction of knowing that lessons learned… may save the lives of others'.[4] Such action is a mark of respect for the person who has died and demonstrates a commitment by the state to see that similar deaths do not occur in future.

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1 See https://piac.asn.au/2014/12/10/submission-to-the-nsw-attorney-general/. We note that this review appears never to have been completed.

2 See the report of the NSW Legislative Council Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (2020), [6.117]-[6.122].

3 Boronia Halstead, *Coroner's Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study*, Australian Deaths in Custody No 10, Australian Institute of Criminology (1995), 1.

4 *R (Amin) v Secretary of State for the Home Department* [2004] AC 653, [31]. See further Adjunct Professor Hugh Dillon, submission 104 to the NSW Legislative Council Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (2020), 5; Michael S King, *Non-*

In NSW, however, this role is significantly underutilised as a result of a weak legislative framework, a lack of resources and capacity to examine systemic issues. The potential for this role to effect real change is also undermined by the lack of mechanisms for accountability.

2.1 Legislative framework

While the *Coroners Act* provides that a coroner *may* make recommendations they think 'necessary or desirable… in relation to any matter connected with the death', including 'public health and safety',[5] this role is not considered to be part of the 'primary duty' of a coroner.[6] This reflects the historically narrow focus on the specific facts of the death (the 'who, what, when, where and why'). Halstead observes:

> This potentially preventive role has been marginalised in some coronial practice through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case by case basis, closing the file at the conclusion of each. A preventive focus requires additional steps: identifying patterns; identifying remedial responses; making recommendations to implement the response; ensuring that problematic situations are remedied.[7]

The legislative position in NSW can be contrasted with Tasmania, for example, where a coroner '*must*, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate'.[8] In the case of deaths in custody or care, 'the coroner *must* report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care'.[9]

The latter obligation is consistent with the recommendation of the Royal Commission into Aboriginal Deaths in Custody that broader powers be granted to coroners in order to prevent death. The Commission recommended that:

> A coroner inquiring into deaths in custody should be required by law to investigate not only the immediate cause and circumstances of death, but also the quality of the care, treatment and supervision of the deceased prior to death.[10]

The recent Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody recognised the need for a stronger legislative remit for coroners to make findings and recommendations on systemic issues.[11]

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adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model (2008) 16 JLM 442, 444.

5 Section 82 (1), (2)(a).

6 *X v Deputy State Coroner* [2001] NSWSC 46, [60].

7 Above n 3, 3.

8 Section 28(2) *Coroners Act 1995* (Tas), emphasis added.

9 Section 28(5) *Coroners Act 1995* (Tas), emphasis added.

10 Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) Vol 1, at [4.7.4].

11 Above n 2, 151, Recommendation 33.

PIAC accordingly recommends that the Coroners Act is amended to ensure a clear legislative mandate for coroners to make appropriate recommendations to address systemic issues that are connected with a death. Section 28 of the *Coroners Act 1995* (Tas) provides a strong model.

Such a change should ideally be made as part of a broader package of reform to the Coroners Act.

Recommendation 1 – Strengthened mandate to make systemic recommendations

The Coroners Act 2009 should be amended to include provisions similar to those in s 28 of the Coroners Act 1995 (Tas), requiring preventive recommendations to be made whenever appropriate and for the coroner to report on the care, supervision or treatment of people who have died while in custody or care.

2.2 Resources and capacity

The need for greater resources and capacity of the Coroners Court in NSW to explore systemic issues was also recognised by the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody.

The Select Committee recommended the NSW Government allocate additional resources to the NSW Coroners Court, especially to address concerns about delay.[12] In a system that is generally under-resourced, the capacity to properly undertake inquiry into systemic issues and make useful recommendations for change is particularly compromised.

In his submission to the inquiry, Adjunct Professor Hugh Dillon observed:

> Since the early 1990s, the death preventive function and potential of the NSW coronial system have never been fully explored by the NSW Government, its agencies and departments, or the Local Court. It has been assumed that granting power under the Act to coroners to make recommendations is sufficient to achieve that objective. Research conducted in Australia, Britain and New Zealand, however, has demonstrated that the power to make preventive recommendations, of itself, is insufficient to save lives and may, in fact, provide only a comforting illusion that 'something is being done'. The power must be exercised *effectively* and be responded to with genuine intent to mitigate risk of death and injury. We have some way to go in NSW before we can be confident our system is operating optimally.[13]

Witnesses to the inquiry gave evidence of a failure or reluctance by some coroners to examine systemic issues and confront systemic prejudice, as well as a lack of experience, training and professional development amongst part-time coroners to support thorough examination of systemic issues.[14]

PIAC supports calls by numerous expert witnesses to that inquiry for the establishment of a Coroners Prevention Unit,[15] as exists in Victoria, to 'strengthen coroners' prevention role and

12 Ibid 150, Recommendation 31.
13 Above n 4, 3-4, footnotes omitted.
14 Above n 2, 147 [6.106]-[6.10].
15 Ibid [6.111].

provide them with expert assistance in reviewing deaths, collecting and analysing data, and developing prevention-focused recommendations'.[16]

As noted above, this change would be most effective if it forms part of a more comprehensive overhaul of the coronial system in NSW to establish a specialist, stand-alone coroners court.

Recommendation 2 – Properly resource the Coroners Court to support its preventive function, including establishing a Coroners Prevention Unit

In addition to a general increase in resources for the NSW Coroners Court to address existing issues of delay, specific resources should be allocated to support the Court's preventive function, including resources for a Coroners Prevention Unit.

2.3 Lack of accountability

The potential for the coroners jurisdiction to deliver systemic change is also undermined by the lack of accountability mechanisms.

The failure of governments to respond effectively to coroners' recommendations is well-known and undermines the credibility and integrity of the coronial system.[17]

The need for greater accountability was highlighted by submissions to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody[18] and reflected in the Select Committee's recommendation for a statutory obligation for government departments to respond to recommendations, with such responses to be tabled in Parliament.[19]

South Australia, Australian Capital Territory, Victoria and the Northern Territory all have a legislative requirement that government agencies provide a response to coronial recommendations.[20] NSW lacks such a requirement. PIAC submits that a legislative requirement would provide a more effective, transparent and accountable mechanism to ensure government responds to recommendations.

PIAC also recommends that the Coroners Prevention Unit be given specific responsibility for monitoring the implementation of recommendations, with appropriate resources to support this function.

Recommendation 3 – Legislative requirement for responses to coroners' recommendations

The Coroners Act 2009 should be amended to require a response from government departments or agencies to coroners' recommendations, with such responses to be tabled in Parliament.

16 Ibid, citing the submission of the NSW Bar Association.
17 See, for example, Watterson, Brown and McKenzie, 'Coronial recommendations and the prevention of Indigenous death', (2008) 12(2) *Australian Indigenous Law Review* 4.
18 Above n 2, 142-144 [6.83]-[6.92].
19 Ibid 151, Recommendation 32.
20 Section 57(4) *Coroners Act 1997* (ACT); section 46B *Coroners Act 1993* (NT); section 25(4) *Coroners Act 2003* (SA); section 72 *Coroners Act 2008* (Vic).

Recommendation 4 – Coroners Prevention Unit to have responsibility for monitoring

The Coroners Prevention Unit should be given specific responsibility for monitoring the implementation of coronial recommendations, with appropriate resources to support this function.

3. Investigating deaths in custody

PIAC strongly supports calls for robust, transparent and independent processes for the investigation of deaths in custody.

PIAC shares the concerns expressed by witnesses to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody that the 'oversight arrangements for deaths in custody lack clarity and that investigating agencies lack independence'.[21]

These concerns include:

- Fragmentation of functions with a potential for a lack of depth of expertise;
- Ambiguity as to responsibilities of various oversight bodies;
- Lack of independence, given the involvement of the NSW Police Force and Corrective Services NSW in investigating deaths in custody.

Robust, transparent and independent Investigations are essential to the effective functioning of our coronial system and public confidence in the system. Avoiding the perception of bias is critical for justice to be served.

PIAC has previously called for the establishment of an independent body to investigate all deaths in custody.[22] Powerful evidence was given to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody about the need for an independent, First Nations-led investigative body with the resources and powers to fully investigate deaths of First Nations people in custody, including systemic issues.[23]

In the absence of such a body, PIAC notes the view of other experts before that Select Committee,[24] and the ultimate view of the Select Committee itself,[25] that a specialist unit within the Coroners Court be established to undertake investigations into deaths in custody. Should such an approach be taken, it is essential that there is a significant additional commitment to cultural awareness and competency across the Coroners Court, including the appointment of First Nations staff in senior roles. This issue is considered further below.

Recommendation 5 – Independent investigations into deaths in custody

An independent body should be established to investigate all deaths in custody. Should this function be given to a specialist unit within the Coroners Court, particular attention must be given to cultural awareness and competency, including the appointment of First Nations staff to senior roles.

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21 Above n 2, 153 [7.4] and generally at 153-155 [7.1]-[7.14].
22 Above n 1, 5-6.
23 Above n 2, 174-177 [7.103]-[7.117].
24 Ibid 165-167 [7.62]-[7.70].
25 Ibid 178 [7.120].

4. Responding to the needs of First Nations people

A number of submissions to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody identify the need for improvements and reform to the coronial system in NSW to meet the needs of, and deliver justice to, First Nations people.[26]

The submissions detail:

- A lack of cultural safety throughout the investigation and inquest processes;
- Problems for families in being able to participate in the coronial process, including a lack of information and opportunities for participation;
- Formality, complexity and delay contributing to the re-traumatisation of families;
- Imbalances of power and a lack of resources for representation of, and advocacy for, First Nations families;
- The need for greater support for families throughout the process, including counselling services and financial support to attend hearings.

PIAC urges this Select Committee to be guided by First Nations people and organisations in relation to the reforms required to ensure a coronial system that is culturally safe and effective, meeting the justice needs of First Nations people and providing a process that is therapeutic and restorative.

These reforms should go beyond deaths in custody and apply to all deaths involving First Nations people. This is especially important in the context of other deaths in which the state is involved, including deaths in institutional care or settings such as hospitals.

Specific reforms and recommendations may include:[27]

- Establishing a Koori Engagement Unit within the Coroners Court and/or creating identified First Nations roles within the Coroners Court[28]
- Establishing a separate specialised stream within the coronial system to respond to First Nations deaths
- Opportunities for restorative and therapeutic options such as family conferences with those involved in a death
- Developing protocols or practice directions to guide the conduct of inquests into deaths of First Nations people
- Resourcing 'wraparound' support for families throughout the coronial process
- Allowing coroners to conduct 'recognition' proceedings in court following investigations that do not result in an inquest
- Increasing funding for the Aboriginal Legal Service to advise and represent families and community members in connection with coronial investigations involving the deaths of First Nations people.

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26 Ibid 138-142 [6.65]-[6.81].

27 See submission 115 to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody by the Jumbunna Institute of Indigenous Education and Research, submission 120 by the Aboriginal Legal Service NSW/ACT, and submission 108 by Dr Fiona Allison, Professor Chris Cunneen and Melanie Schwartz.

28 We understand that this change is in the process of being implemented.

Recommendation 6 – Comprehensive reform to meet the justice needs of First Nations people

The NSW coronial system should be comprehensively reformed to meet the needs of First Nations people. This aspect of the reform process should be led by First Nations people.