Submission No 115

INQUIRY INTO HIGH LEVEL OF FIRST NATIONS PEOPLE IN CUSTODY AND OVERSIGHT AND REVIEW OF DEATHS IN CUSTODY

Organisation: Jumbunna Institute of Indigenous Education and Research, Research Unit

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Submission to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

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To the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody —

The Jumbunna Institute's submission to this inquiry is enclosed.

While we appreciate the chance to be heard about these critical issues, we want to note that this inquiry will receive countless submissions like ours that lay out what First Nations communities have been saying for a long time. It is important that this inquiry does not become another repository for good ideas. This inquiry must lead to concrete action.

This submission is from the Research Unit the Jumbunna Institute at the University of Technology Sydney. Our members are committed interdisciplinary scholars and practitioners. We work from one key guiding principle, that our work should be driven by Aboriginal and Torres Strait Islander people, and contribute to their strength, self-determination, sustainability and wellbeing. In the course of this work, we have close contact with systems that review deaths in custody and walk with families and communities who have lost loved ones through this process.

This submission was prepared by the Jumbunna Institute Legal Strategies Hub, headed up by Craig Longman and assisted by Katie Lowe. The following Jumbunna Institute staff have also assisted with the preparation of this submission — Alison Whittaker (Senior Researcher, Indigenous Policy), Associate Professor Paul Gray, (Head of Indigenous Child Protection), Professor Christopher Cunneen (Professor of Criminology); Paddy Gibson (Senior Researcher, Indigenous Child Protection) and Dr Fiona Allison (Research Fellow, Indigenous Law and Justice Hub).

We are happy to provide further information on any of the matters raised within this submission.

Regards,

Distinguished Professor Larissa Behrendt

Professor Lindon Coombes

Craig Longman

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Introduction

> As a mother, I deserve to know the truth and will not rest until I know why my son died.
>
> — Leetona Dungay

1. This Select Committee will be presented with statistics. Underneath these statistics are Indigenous people, families and communities profoundly affected by their contact with the criminal justice system. They are at the heart of our concern around the high rates of incarceration of First Nations and the continuing number of First Nations deaths in custody. That concern is intensified with the consistent finding in investigations into First Nations deaths in custody that many of those deaths were preventable. Each is a life lost, and the impact of this loss on First Nations communities is immeasurable.

2. The systemic discrimination faced by First Nation peoples within the Australian police and prison systems started with colonisation and has remained a consistent feature for over 200 years. Any attempt to effect real change in that discrimination must recognise this fact.

3. The path to address First Nation incarceration and deaths in custody is already well-known. It is the political, regulatory and judicial will to act that has kept us in endless reviews and impunity that suggest otherwise.

4. As recently as June 2020, tens of thousands marched through the streets of Australia under the banner of *Black Lives Matter. Black Lives Matter* is an international movement raising awareness of the violence of police and prisons against Black and Indigenous peoples in the United States and across the world. The call of the movement, being the last words of both David Dungay Jnr and Eric Garner — 'I can't breathe!' — encapsulates the sense of frustration and despair amongst First Nations communities who continue to be punitively discriminated against by police, prisons, and other public agencies.

5. We welcome this inquiry and the opportunity to provide this submission. In relation to the Terms of Reference, we note that their breadth is apt given the multiplicity of levels at which First Nations people experience discrimination. We also note that, like the multitude of reviews into First Nations people, they seek answers that have already been given, time and time again — by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC),[1] by the ALRC's recent *Pathways to Justice* report,[2] by dedicated research scholarship,[3] and by dozens of inquests into individual First Nations deaths in custody undertaken in just the last decade.

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[1] See generally, *Royal Commission into Aboriginal Deaths in Custody* (National and Regional Reports, 1991).

[2] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017).

[3] See, e.g., J Ransley & E Marchetti, 'Justice Talk: Legal Processes and Conflicting Perceptions of Justice about a Palm Island Death in Custody', *Australian Indigenous Law Review,* vol. 12, no. 2, 2008, pp. 103–114; Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 *Austl. Indigenous L. Rev.* 4. . Laura Beacroft, Mathew Lyneham and Matthew Willis, 'Twenty Years of Monitoring since the Royal Commission into Aboriginal Deaths in Custody: An Overview by the Australian Institute of Criminology' (2011) 15(1) *Australian Indigenous Law Review* 64; Australian Institute of Criminology, 'Deaths in Custody in Australia: Monitoring and Reports', *Australian Institute of Criminology: Criminal Justice System* (2013) <http://www.aic.gov.au/criminal_justice_system/deaths%20in%20custody.html>; Victorian

6. To us, it appears that the terms of reference relate to two central questions. Firstly, the circumstances under which First Nation people enter, live under and leave the criminal legal system and secondly, whether the legal system lives up to its self-professed duty to protect those lives and to deliver justice when it fails to meet that duty.

7. That duty has been characterised by former State Coroner Kevin Waller (speaking to the need to make deaths in custody the subject of mandatory inquests):

> The answer must be that society, having effected the arrest and incarceration of persons...owes a duty to those persons, of ensuring that their punishment is ...not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated.[4]

8. Notwithstanding that such mandatory inquests were instituted in response to the RCIADIC recommendations reported in 1991, as is set out below, the obligation has not had the desired effect. For example, in the case of Aunty Tanya Day, her family's submission to the Coroner said —

> 'I need you to see, and to acknowledge, that my death was caused by the same system that killed my uncle, Harrison Day, the same system that dispossessed and killed so many of my ancestors and so many other Aboriginal people; that fractured our communities and culture, and caused deep intergenerational trauma. I need you to see that this is not past history, this is the ongoing story of our country.
> …
> 'It is not enough to change the law on public drunkenness. I need you to tell the truth about why the law was applied to me differently from the way it would have been applied to a white Australian grandmother, drunk and asleep on a train, on her way to Melbourne to visit her daughter; about why the police took me into a cell, rather than to hospital or home; about why the police treated me like a criminal and completely failed to care for me, even though they said they were imprisoning me for my own safety'.[5]

Aboriginal Legal Services Cooperative Ltd, 'The Centrality of the Royal Commission into Aboriginal Deaths in Custody When Discussing Potential Reform to the Victorian Coronial System' (2008) 12(2) *Australian Indigenous Law Review* 55; Rebecca Scott Bray, '"Why This Law?": Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(2) *Australian Indigenous Law Review* 27; R. Scott-Bray, *Death Scene Jurisprudence*, Griffith Law Review, 2010, vol. 19, no. 3, pp567-592; Christopher J Charles, 'The Coroners Act 2003 (SA) and the Partial Implementation of RCIADIC: Consequences for Prison Reform' (2008) 12 *Austl. Indigenous L. Rev.* 75 ('The Coroners Act 2003 (SA) and the Partial Implementation of RCIADIC'); Watterson, Brown and McKenzie; Raymond Brazil, 'The Coroner's Recommendation: Fulfilling Its Potential? A Perspective from the Aboriginal Legal Service' (2011) 15(1) 94 ('The Coroner's Recommendation'); Lauren Day, 'Grieving Families Lament Lack of Deaths in Custody Reform', *ABC News* (Sydney, online, 14 April 2016) <http://www.abc.net.au/news/2016-04-14/grieving-families-lament-lack-of-deaths-in-custody-reform/7327630>.; Editors, 'Editors' Introduction: Coronial Reform and Preventing Indigenous Death' (2008) 12(1) *Australian Indigenous Law Review* viii; A Whittaker, 'Dragged 'l ke a dead kangaroo': Can Australian justice systems do justice for Indigenous deaths in custody?' 2018 LLM thesis (Harvard Law School, enclosed); C Longman, *Scales of justice still tipped towards police who harm people in their custody*, 15 April 2016, The Conversation, viewed 7 November 2017, <https://theconversation.com/scales-of-justice-still-tipped-towards-police-who-harm-people-in-their-custody-57125>.

[4] Abernathy & Ors, *Waller's Coronial Law & Practice in New South* Wales, (LexisNexis Butterworths, 4th ed, 2010) p106 at [23.6].

[5] The Children of Tanya Day, 'Submissions by Belinda Day/ Stevens, Warren Stevens, Apryl Watson and Kimberly Watson, The Children of Tanya Day', Submissions in *Inquest into the Death of Tanya Day,* COR 2017/6424, 15 October 2019, [25], [29].

9. In our experience, and consistent in the experience of the First Nations families with whom we work, regularly across Australia (including in New South Wales) deaths occur because of a failure to implement recommendations of the RCIADIC. Had New South Wales, and its counterparts, been sincerely committed to addressing First Nations deaths in custody, it would have implemented those recommendations twenty-eight years ago and continued to evolve and reform its child protection, policing, judicial and prison cultures and practices. The cost for its failure to do so has been paid by First Nations' lives.

10. It has also been our experience that the current processes established to investigate deaths of First Nations people in custody both compound the trauma experienced by families and fail to deliver justice. A system where the investigation of deaths at the hands of state actors is led by police or collegiate investigators does not have the trust of First Nations communities. It has never properly held either the people or systems responsible for these deaths to account. Mandatory coronial inquests have been a meagre and defective substitute for the thorough independent investigation assuming homicide (recommended in RCIADIC)[6] and prosecution that we believe has been warranted in a number of cases.

[6] *Royal Commission into Aboriginal Deaths in Custody* (National Report, 1991) vol 5, recommendation 35(a).

1 (A) — The unacceptably high level of First Nations people in custody in NSW

Overview

11. The unacceptable overrepresentation of First Nations people in custody has been acknowledged as a national policy issue, dating back to the 1991 RCIADIC.[7] Addressing the disproportionate incarceration rates of First Nation people has been identified as a key target in the COAG Closing the Gap initiative which contains a targeted reduction of at least 15% in the incarceration rate of First Nation adults by 2031.[8] The 2017 ALRC report demonstrated that, although First Nation adults account for around 2% of the national population, they are grossly overrepresented in the prison population.[9]

12. The problem has worsened with First Nations' peoples accounting for 28% of the total Australian prisoner population, and 23% of the NSW adult prison population.[10] First Nations women constitute 34% of the female prison population, a figure which has significantly increased in recent years, with the overall rate of imprisonment of First Nations peoples at 28%.[11] Despite this, there has been poor implementation of the RCIADIC recommendations and an ongoing failure to develop serious policy attempts to address overrepresentation, with the notable exception of the campaigns devised and led by First Nations communities.

Historical context of incarceration and interactions of First Nations peoples with the criminal legal system

13. We believe that the current rate with which First Nations peoples are overrepresented in custody is connected to Australia's colonial history, the demise of previous systems of penalty and control,[12] and continuing attitudes of racism and indifference towards First Nations peoples.[13] It is by the transformation of these colonial systems of oppression into the modern day criminal legal systems that the entrenched marginalisation and discrimination of First Nations peoples is embedded.

14. The incarceration of First Nations peoples in Australia is a result of a continuing colonialism that seeks to govern First Nations peoples, as well as the ongoing experiences of trauma from that colonialist project. From 1788, the colonisation of Australia imported English common law, a 'law that was created by White people, for White people'.[14] For First Nations peoples, with their own systems of law, governance and ways of being, from time immemorial, they were unwillingly and immediately

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7 See generally, *Royal Commission into Aboriginal Deaths in Custody* (National and Regional Reports, 1991).
8 Closing The Gap (In Partnership), *National Agreement on Closing the Gap* (July 2020), Outcome 10.
9 Australian Bureau of Statistics, *Prisoners in Australia, December 2016* (Catalogue No 4517.0, 8 December 2016).
10 Ibid.
11 Australian Bureau of Statistics, *Prisoners in Australia, December 2019* (Catalogue No 4517.0, 5 December 2019).
12 See, for example, the move from the formal exclusion of Indigenous people from townships, to highly-discretionary arrest and charge patterns using public order offences. Penelope Edmonds (2012) Unofficial apartheid, convention and country towns: reflections on Australian history and the New South Wales Freedom Rides of 1965, Postcolonial Studies, 15:2, 167-190, DOI: 10.1080/13688790.2012.693043
13 Chris Cunneen et al, Penal Culture and Hyperincarceration: The Revival of the Prison (Routledge, 2016) 32.
14 Mabo v Queensland [No 2] (1992) 175 CLR 1, 80 per Deane and Gaudron JJ.

subject to foreign rule from this point in time. This is important to understand as context as it speaks to a structural power imbalance between the Australian legal systems and First Nations peoples. It also explains an historic lack of faith of First Nations in the institutions of the State.

15. RCIADIC made 339 recommendations for change.[15] These recommendations acknowledged the continuing effects of colonialism on the interactions between First Nations peoples and non-Indigenous peoples and institutions. According to the RCIADIC and as echoed by scholars, 'the most significant contributing factor [contributing to overrepresentation] is the disadvantage and unequal position in which Aboriginal people find themselves in society – socially, economically and culturally'.[16]

16. Its recommendations have largely not been followed. For a decade after its final report, human rights lawyers and advocates issued RCIADIC recommendation-monitoring reports before the resourcing for such projects eventually succumbed to diminished Commonwealth and State policy interest. Alongside these are criticisms that, on the whole, bodies of public inquiry about the criminal justice system perpetuate Indigenous suffering without providing redress or reform for it.[17] Recent reporting commissioned by the Commonwealth and carried out by Deloitte Access Economics claimed that RCIADIC's work is 78% completed, and 16% of its recommendations are 'partially implemented', a claim met with dismay by experts because it relied on a desktop review of government policy and government self-assessment.[18] In contrast, an independent 2015 report by Amnesty International, Change the Record and Clayton Utz suggested governments had 'categorically failed'.[19]

17. These are not administrative errors or poor system design — the endemic criminalisation and death in custody of First Nations peoples comes from the foundation of Australia itself. From First Nations leaders fighting for change at the grass-roots, to leading scholars within the field of criminology, there is a compelling case made that the question of racial and minority overrepresentations, such as that of First Nations peoples within custody in Australia, is rarely an issue of simply crime and punishment, but rather stems from dispossession and oppression.[20]

18. Nevertheless, there have been attempts through inquiries such as this to reduce or mitigate the impact of these systems on First Nations peoples. It is important to note that, while these changes to process may make a difference for First Nations peoples, on their own they only minimise harm. An undue focus on reform over more fundamental change can also run the risk of expanding the scope of policing and imprisonment, and therefore the potential for deaths in custody.

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[15] Royal Commission Into Aboriginal Deaths in Custody, vol 5 Recommendations.
[16] Royal Commission Into Aboriginal Deaths in Custody, vol 1 at [1.7.1].
[17] Martin Flynn, 'The Coroners Act 1993 (NT): Is It an Adequate Response to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody?' (1993) 3(63) *Aboriginal Law Bulletin* 13; Brazil, above n 3; Charles above n 3.
[18] K Jordan, T Anthony, T Walsh and F Markham, 'Joint Response to the Deloitte Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody', *Centre for Aboriginal Economic Policy Research Topical Issues*, no. 4, 2018, pp. 3-10.
[19] Change the Record, Amnesty International Australia, and Clayton Utz 2015, Review of the Implementation of RCIADIC, Change the Record, May, viewed 10 January 2019, https://changetherecord.org.au/review-of-the-implementation-of-rciadic-may-2015
[20] Chris Cunneen, 'Postcolonial perspectives for criminology' in Mary Bosworth and Carolyn Hoyle (eds) *What is criminology?* (Oxford University Press, 2011) 249, 254.

19. The 2017 ALRC Pathways to Justice report identified an array of social determinants relating to the hyper-incarceration of First Nations peoples, and the significance of such determinants as external drivers of the overrepresentation of First Nations peoples in custody.[21] Along with education, employment and health, First Nations people have cited the ongoing impacts of colonialism, dispossession, displacement from traditional land, weakening of culture and separation from family as contributing to the contemporary high levels of incarceration.[22] Rather than repeat these factors here, we have attached as Appendix A, a list of the findings and recommendations identified in that Report that accord with our experience.

[21] See generally Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017).
[22] Aboriginal Peak Organisations Northern Territory, Submission 117 to Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 62.

1 (B) — The suitability of the oversight bodies tasked with inquiries into deaths in custody in NSW

20. To understand what happens after a death in custody from the perspective of a family who is experiencing the review process, we have ordered our submission in the sequence by which someone in their position would experience it. There is, given the regulatory overlap, some blurring between these stages that occur simultaneously, or that feed information and referrals in to one another.

The Investigation Stage

21. All deaths in police or corrective services custody must be reported to the Coroner, and inquests must be held by a senior Coroner (a State or Deputy Coroner).[23] The mandate of this referral power is broad and covers a variety of circumstances in which someone is under close control of states. In NSW, it includes deaths that occur —

    - while in the custody of a police officer or in other lawful custody,
    - while escaping, or attempting to escape, from the custody of a police officer or other lawful custody,
    - as a result of police operations,
    - while proceeding to, in, or temporarily absent from, any of a number of identified institutions or places of which the person was an inmate.[24]

22. New South Wales Police then conduct an investigation on behalf of the State Coroner and Counsel Assisting in accordance with the obligations set out in the NSW Police Force Critical Incident Guiding Principles.[25] Depending on the institutional setting of the death, there may also be investigations from Corrective Services NSW, NSW Justice Health or a hospital, or other healthcare institution, that may contribute to the police brief, though such investigations are often privileged and do not form part of the coronial brief. The investigations of these bodies may also appear at inquest when these institutions are represented.

23. In our view, it is not suitable that NSW Police — nor any other state body with an interest in the investigation — investigate deaths in custody. This is particularly true when the death occurs in police custody or a police operation, but even when it does not, the historic and contemporary relationship between the police force and First Nations communities makes police unsuitable for this role.

24. It is not only the relationship between NSW Police and the First Nations community in this State that is cause for concern. NSW Police commonly appear before the Coroner on a range of matters other than deaths in custody, as do (albeit less commonly) other state bodies like Corrective Services NSW and hospitals or healthcare institutions. They appear together over long periods of time, in a niche judicial setting.

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[23] *Coroners Act 2009* (NSW), s 35(1)(a) and *Crimes (Administration of Sentences) Act 1999* (NSW), s 74.
[24] *Coroners Act 2009* (NSW), s 23(1).
[25] Craig Longman, 'Police investigators too in-house to probe deaths in custody', *The Conversation* (online, 15 April 2011) https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838.

25. This creates something called ‘regulatory capture’. Regulatory capture is where an otherwise independent institution of review is (inadvertently or otherwise) influenced by the bodies it is meant to keep in check, regulate, or keep transparent.[26] When an institution experiences ‘capture’, it means a variety of things — we argue here that many regulatory bodies are so deeply reliant on NSW Police (whether for training, research, forensic capacity, investigation, briefs, the running of an inquest) that they cannot effectively be said to be working independently of them.

26. The Coroner or their Counsel Assisting, for instance, could be a former police officer or prosecutor because of the unique combination of biomedical, forensic and legal expertise required to be a specialist in this space. They may have institutional relationships with those organisations appearing before them, but more importantly, they may think similarly or make similar assumptions and decisions.

27. The transmission of knowledge and institutional power also goes the other way, the party acting for NSW Police could, for instance, become so familiar with the operations of the Coroners Court over time that they can (without any grand plan to) shape unwritten discretionary rules by establishing institutional precedent for their use. Everyone who routinely appears at an inquest could develop the same way of understanding an issue, which, over time, becomes institutionally authoritative in the Coroners Court.

28. It is not just a phenomenon confined to the Coroners Court. Investigators within NSW Police, while theoretically independent from those they are investigating on behalf of the Coroner, have been trained by the same trainers as other police, may come to think or concede in the same was as other police, and may be governed by the same policies and share underlying assumptions. This convoluted process within a court system, writes US scholar Anna Lvovsky, has shaped niche courts to accept police evidence they may not otherwise, assuming expertise (through a process called ‘structural spillover’), where these assumptions spread into the rest of the law and other accountability institutions —

> spillover effects facilitate the multiplication and aggregation of errors in judicial reasoning about the police, compounding biases in any one sphere by replicating them in others. Most basically, spillover results in the proliferation of unsupported presumptions, as beliefs produced in one sphere of the judicial system invade and multiply in others. […] At the same time, spillover facilitates the aggregation of error in judicial reasoning, corroborating structural biases born in separate arenas. […] Like substantive doctrine, structural biases are calibrated to particular legal contexts, with their own limiting presumptions and procedural checks. Transferring those biases beyond their initial contexts removes such mitigating influences, making their effects all the more dangerous.[27]

29. ‘Capture’ and ‘structural spillover’ are highly concerning structural issues that can restrict or frustrate families attempts to engage with the Coroner's office in relation to investigations or inquests. Families do not have the same relationships with the Coroners Court as state parties who regularly appear there do. Most families are before these courts only once or twice in their lives. They do not have the same

[26] For a background, and analysis on multiple kinds of capture, see Ian Ayres and John Braithwaite, ‘Tripartism: Regulatory Capture and Empowerment’ (1991) 16(3) *Law & Social Inquiry* 435.
[27] Anna Lvovsky, ‘The Judicial Presumption of Police Expertise’ (2017) 130(8) *Harvard Law Review* 195, 2076-2077.

chance to learn from or influence the unwritten convention of Coroners Courts. They are only one party compared with the multiple experienced state parties who appear before the Coroner. They do not share the same institutional way of thinking about deaths in custody demonstrated in the approach by NSW Police and other state agencies. These institutions treat deaths in custody as aberrative health problems, arising by chance or circumstance, that well-meaning and professional staff are required to respond to. Hence their focus is often on minimising individual responsibility and focusing on training and procedures of institutions. In contrast families rightly recognise the problem as one of state violence and the way in which state institutions legitimise that violence through the creation of a mistake or aberration.

30. These institutional views have developed over the course of decades, and allegiance to conventions and procedures (both in the Court and in their institutions) reinforces that view in the guise of objectivity and professionalism. Expressions of anger or frustration at the continuing experience of First Nation deaths in custody without individual accountability, and demands for Inquests to consider how systemic power has been utilised against their loved ones, can often be dismissed as emotional or a naïve misunderstanding of 'jurisdiction'. Sometimes, this means that Coroners fail to adequately hear what families bring to the inquest, because they are not allowed to provide input on or even sometimes be regularly updated on the investigation.

31. To give an example from Western Australia (where practices are substantially similar), in the *Inquest into the death of Mr Bropho*,[28] Coroner King rejected Bropho's daughter's evidence that her father complained of abuse in prison, including being denied medical care and food, as 'hearsay' and made 'with little notice to the court.' This is a strange assessment because Coroners are not bound by the rules of evidence[29] and commonly embrace hearsay evidence. In dismissing Mr Bropho's daughter's evidence, Coroner King suggested 'if there was any substance to the deceased's complaints…they would have been investigated [by WA Police and WA Corrective Services] and the results of the investigations attached to the Department's offender management file', indicating a preference for state documentation and police investigation. Moreover, he purported that the 'difficult and demanding' Bropho 'cried wolf' to 'elicit…attention' from his family. Presumably, this was a painful thing for his family to be told as they tried to participate in the inquest with their evidence, and impacted their ability to be heard.

Community relationships, distrust, and the perception of bias

32. We have previously raised the issue of the complex relationships between NSW Police and First Nations in submissions to the Bowraville Inquiry and the *Bowraville Report* contained observations by this Parliament on the relationship between police and the First Nations community in Bowraville.[30] The relationship between First Nations and police has been addressed in many previous reports. The RCIADIC report noted that police forces across Australia often exhibit "active and passive ideas of racial superiority in relation to Aboriginal people",[31] and addresses the

[28] *Inquest into the Death of Robert Charles Bropho* (Unreported, Western Australia Coroners Court, Coroner King, 28 June 2013).
[29] *Coroners Act 2009* (NSW) s58.
[30] Standing Committee on Law and Justice, Legislative Council of New South Wales, *The family response to the murders in Bowraville* (2014) [3.21]-[3.30].
[31] *Royal Commission into Aboriginal Deaths in Custody* (National Report, 1991) vol 1 at [1.4.12].

relations between First Nations people and police historically:

> The relations between Aboriginal and non-Aboriginal people were historically influenced by racism, often of the overt, outspoken and sanctimonious kind; but more often, particularly in later times, of the quiet assumption that scarcely recognises itself. What Aboriginal people have largely experienced is policies nakedly racially-based and in their everyday lives the constant irritation of racist attitudes. Aboriginal people were never treated as equals and certainly relations between the two groups were conducted on the basis of inequality and control.
> …
> Police officers naturally shared all the characteristics of the society from which they were recruited, including the idea of racial superiority in relation to Aboriginal people and the idea of white superiority in general; and being members of a highly disciplined centralist organisation their ideas may have been more fixed than most; but above and beyond that was the fact that police executed on the ground the policies of government and this brought them into continuous and hostile conflict with Aboriginal people. The policeman was the right hand man of the authorities, the enforcer of the policies of control and supervision, often the taker of the children, the rounder up of those accused of violating the rights of the settlers. Much police work was done on the fringes of non-Aboriginal settlement where the traditions of violence and rough practices were strongest.

33. In its report in 2017, the Australian Law Reform Commission noted poor perceptions of police (informed by 'strong historical antecedents') continue to this day:

> the ALRC heard that many Aboriginal and Torres Strait Islander people continue to have negative attitudes towards police, with the view that the law is applied unfairly and that complaints about police practices are not taken seriously. It is clear that those perceptions have strong historical antecedents (see Chapter 2) and that there is evidence that the law is applied unequally—for example Aboriginal and Torres Strait Islander young people are less likely to be cautioned and more likely to be charged than non-Indigenous young people. [32]

34. These perceptions have a basis in fact. Consistently, studies have demonstrated that Indigenous communities are more heavily policed than non-Indigenous communities, and that police discretion is more likely to be exercised against Indigenous peoples in relation to the exercise of stop and search powers, charging discretions and charge strategies, diversionary options and police and judicial bail determinations.

35. This is not an isolated distrust — nor is the problem community trust itself. Measures that are about changing that relationship will not change whether these investigations are defensible. Without significant and fundamental change, these investigations will continue to not only demonstrate institutional bias in support of police but will continue to frame the way that First Nations deaths in custody are talked about and understood so as to confirm that bias. They will also continue to devalue First Nations lives and underestimate the extent to which state and non-state violence against First Nation peoples is dismissed by the Australian legal system. Such an approach was evident in the flawed police investigations into the disappearance of three First Nation children from Bowraville in late 1990 and

[32] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 447.

early 1991, a matter this Parliament has previously considered. In its Report, the Parliament noted that racist assumptions about Aboriginal people crippled the efficacy of the initial investigation. Had the police investigated the first disappearance properly, and interviewed the suspect at the time, it is probable the lives of two children would have been saved. This is one example of how the cost of racist policing is borne by the lives of First Nation people.[33]

Death of Mulrunji Doomadgee in Palm Island

36. The death of Mulrunji Doomadgee remains the highest profile death in custody due to the refusal of the Palm Island community to accede to a biased Police Investigation that absolved the officer involved, Snr Sgt Christopher Hurley ('Hurley'), of any responsibility for the death. Mulrunji was arrested by Hurley on 19 November 2004 for loudly singing 'who let the dogs out' as the police car in which Hurley was travelling with Aboriginal Police Liaison Lloyd Bengaroo passed by him. He was arrested for alleging causing a public nuisance. The autopsy report stated that Mulrunji had suffered four broken ribs, and a ruptured spleen and liver. In the aftermath of the death, the community were told the injuries where caused when Mulrunji tripped up a small step going into the police station. In the face of that (clearly absurd) explanation there was substantial civil disobedience on the Island, with two police buildings being burned down but no officers being seriously injured (though clearly that could have happened had that been the intention of the community).

37. A review by the Queensland Crime and Misconduct Commission ('CMC') conducted in June 2010 of both the investigation into the killing (the Police Investigation) and the internal Police review of the Police Investigation ('the Review') found that both were deeply and critically flawed. Amongst the issues raised in regard to the Police Investigation were —

    a. possible collusion between police investigators and the suspect police officer;

    b. a failure to remove the suspect police officer from the area where witnesses were subsequently interviewed;

    c. the failure of investigating officers to include allegations of assault by the suspect police officer against the victim in the information provided to the medical examiner conducting the autopsy; and

    d. the appointment of an investigator who was friends with the suspect police officer and whom had previously failed to properly investigate an allegation that the suspect officer had driven over the foot of another community member and then sort to influence the evidence of a doctor at the hospital; and

[33] See generally Standing Committee on Law and Justice, Legislative Council of New South Wales, *The family response to the murders in Bowraville* (2014) p19 -28 & p37-61.

Moreover, the CMC investigation found that The Review had failed to properly investigate these concerns.

38. Notwithstanding the CMC report, we are aware of no police officers having ever been charged with or investigated for criminal offences arising from a possible cover-up relating to a death in police custody. In such cases accountability simply does not exist. Despite the subsequent criticisms, it remains that in this case a deeply flawed investigation tainted or failed to collect evidence properly, and that this almost certainly contributed to a DPP refusal to prosecute the suspect police officer.

39. Even when later, a special prosecutor was appointed to prosecute an ex-officio indictment brought by the Attorney General, the evidence available was limited and/or potentially tainted. It is impossible to know what evidence was never collected, and what impact it might have had at the trial (at which the suspect officer was acquitted).

The Death of Mr Ward in Western Australia

40. This case involved the brutal killing of a respected Ngaanyatjarra elder, Mr Ward, who died from extreme heat whilst being transported by Western Australian corrective services in a prison van without air conditioning that reached temperatures of over fifty degrees. Despite damning coronial recommendations, the Western Australian DPP again refused to prosecute, citing a lack of evidence. The company and individuals responsible were later charged under occupational health and safety legislation and fined for their role in the death. A failure to separate witnesses during the investigation was again an issue in this case.[34]

41. These cases represent particularly heinous examples of the lack of accountability and public confidence that occurs in First Nation cases and demonstrate the importance of rigorous, effective, efficient and independent investigations into Police conduct, if the public are to believe that accountability in fact exists. Consequently, we believe they contain important lessons for consideration in a police oversight model.

42. These findings are reflected in our experience working with First Nation families in either suspected but unsolved homicides and death in custody work. In engaging with the voices of First Nations peoples and their experiences with the NSW Coroner, we have experienced many First Nations families who are dissatisfied with the way in which police conducted their investigations. They reported being kept out of the loop, being omitted from critical background conversations, sometimes even being treated as contributors to the death in custody for the role they played in the persons' life outside of custody. First Nations families, and experts working with the families, believed police investigations were hindered by racial prejudice and lacked the rigour that would be expected in an investigation into the death of a white victim.

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[34] *The WA Coroner's Findings in the Relation to the Death of Mr. Ward,* Coroner's Court of Western Australia, 12 June 2009, 72.

43. Put simply, absent the presence of extraordinary individual officers willing to repair particular relationships, First Nation families do not believe that police officers value their lives in the same way as non-Indigenous people, or that police are working as hard for them. Nor do First Nation communities believe that police will prioritise their entitlement to justice over their fraternity and loyalty to the police as an institution. It is our submission that they are justified in thinking this. Because post-death in custody oversight processes almost entirely rely on this investigation, setting near-unilateral responsibility for it onto the police undermines the entire foundation of defensibility and accountability that these review processes rely on.

44. For these reasons, in our view the only suitable investigative organisation is a genuinely and thoroughly independent one, the characteristics of which are set out below in response 1(d) of the terms of reference.

Coronial investigation and inquest

45. The suitability of the NSW Coroner in inquiring into deaths in custody can be understood in reference to the experiences of First Nations victims and families when engaging with this jurisdiction. In our experience, the view of many First Nation families — a view that we and other practitioners share with them — is that the current office of the NSW Coroner and its practice and procedure has limited capacity to provide appropriate access to justice to First Nations families.

46. The lived experiences of First Nation families within the coronial jurisdiction has often been very negative. Extracted below is a statement from Jumbunna Institute Snr Researcher Padraic Gibson of his observations in relation to two cases in which he has worked:

> **Background to my work**
>
> Over the course of more than a decade working as a Senior Researcher at Jumbunna, I have provided support to numerous Aboriginal families who have suffered the death in custody of a loved one, across a number of jurisdictions. This support has ranged from providing referrals to lawyers and medical professionals, arranging media interviews, helping to organise protest demonstrations and petitions calling for justice, fundraising and arranging travel for families. In some cases, I have been in a position to provide intensive assistance to families both in their preparation for and throughout the hearing of a Coronial Inquest.
>
> The most intensive work I have done around Coronial Inquests has been in NSW with the families of David Dungay Jnr, who died in Long Bay gaol in December 2015 and Tane Chatfield, who died in the Tamworth goal in September 2017. In both cases, I worked closely with the families from shortly after the death of their loved one and the support is ongoing. I helped both families prepare for their inquests and was an active participant in the respective inquest processes. I have acted as a liaison for the family with their own legal representatives and Counsel Assisting, helped provide background research to their legal representatives and helped prepare family statements for use both in the media and the Inquest hearing. In the Dungay case, my work took place in the context of a formal partnership between Jumbunna and the National Justice Project (NJP), who were representing the family, while other colleagues at Jumbunna were also providing research support to the NJP. In the Chatfield case there was a more informal co-operative relationship between myself as a representative of Jumbunna and the Chatfield's legal counsel.

The need for an independent body to investigate deaths in custody

There are enormous problems with the current system, where police carry out the initial investigation of an Aboriginal death in custody, make early decisions about whether to treat a death as suspicious and also prepare the brief of evidence for the Coroner.

The close institutional relationship between NSW Police and NSW Corrective Services and the historic adversarial relationship between the Police and Aboriginal communities in NSW, means that the integrity of these investigations is very commonly called into question by Aboriginal families who have lost a loved one in custody. It is my view that the integrity of these investigations is compromised by an institutional racism against Aboriginal people and a reflex within police culture which is adverse to pursuing criminal prosecutions of police or Corrective Services officers.

David Dungay Jnr

The case of David Dungay Jnr is a clear example of where family grievances at the inadequacy of the police investigation are very warranted. David was killed by prison guards involved in violent raid of his cell in the Long Bay prison hospital. The investigation lacked the rigour the family would expect from what should have been investigated as a homicide case. Evidence that may have been important for a potential criminal prosecution was destroyed without consequence. For example, David's blood was cleaned from the floor by staff in the prison hospital and CCTV tapes of David's movements prior to his final entry into his cell were wiped. I do not suggest here that these actions and the lack of consequence is evidence of a conscious conspiracy to frustrate criminal prosecution. There is indeed sufficient evidence on the record to warrant such a prosecution. But these actions are illustrative of the lack of seriousness and care with which investigations of Aboriginal deaths in custody take place.

Through the Coronial Inquest into David's death, it became clear that on the very important question of who authorised the use of (ultimately lethal) force on David by the Immediate Action Team (IAT), the key witnesses had contradictory stories. Neither Corrective Services officers or Justice Health staff were willing to take responsibility for actually authorising the raid on David's cell. "Officer F", the senior Corrective Services Officer who instructed his colleagues in the IAT to raid the cell, testified that he was acting on a request from Nurse Xu, who was on duty at the Long Bay hospital at the time and concerned about David's welfare. However, Nurse Xu denied ever requesting the raid on the cell or even knowing that it was going to take place.

Clearly, one story is not correct. If a homicide occurred outside of a custodial setting and key witnesses disagreed about fundamental facts surrounding responsibility for the death, this would surely be taken far more seriously and treated as suspicious. However, from the evidence presented at the Coronial Inquest it seems neither witness was subject to questioning by investigating police in a manner fit for a suspect in a homicide case. No serious effort was made to interrogate this discrepancy. There is no evidence to suggest that the prospect of criminal prosecution of the guards responsible was ever seriously contemplated by police.

Through the inquest into David's death, the ostensibly non-adversarial nature of the Coronial Inquest process worked to frustrate proper examination of the potential criminal culpability of the those responsible for David's death. For example, David's family were under a lot of pressure not to explicitly raise their demand for criminal prosecution of those responsible in their closing statements. Advice communicated

from Counsel Assisting was that a family statement in the inquest was not the appropriate forum to raise these issues and doing so might somehow compromise the inquest.

Ultimately, the IAT raid on David's cell was carried out without proper authorisation. In the opinion of Philip Boulton QC (see annexure x?) this cell raid was an unlawful use of force. A coronial inquest is not the appropriate forum to for these issues to be explored – there should have been, and still should be, a criminal prosecution of the guards who killed David Dungay Jnr.

Tane Chatfield

Tane Chatfield died in Tamworth prison in September 2017. His death has been ruled to be a suicide by hanging by the Coroner, in findings delivered on August 26, 2020 and I accept this finding. Despite this, the case is still illustrative of the importance of establishing an investigation process run by an authority completely independent from the police, guided by significant First Nations involvement and committed to involving the family of the deceased all the way through the process.

Tane's family have a long a bitter history with the police and prison systems, having suffered consistent harassment and brutality. There was no trust from the family that the police would carry out an investigation seriously committed to exploring the possibility of foul play in Tane's case. They held a deep suspicion Tane had been killed by prison guards and this was the subject of public debate and reporting. Yet detectives involved in the investigation did not communicate with Tane's family, update them on progress, or seek any insights from them about the circumstances surrounding Tane's death. Similarly, there was very little communication from Corrective Services about the investigation or the circumstances around Tane's death.

In the Coronial Inquest, held in July 2020, it was evident that there had been a very sloppy approach taken by investigating police to important forensic evidence. For example, on the second last day of the inquest it became apparent that there were in fact two nooses found in Tane's cell. No one had an explanation available for this, or could explain how the two nooses were actually used by Tane during his suicide. Tane's family have also raised consistent grievances that the whereabouts of some of the clothes Tane was wearing when he died remain unknown to them.

Tane's family felt "kept in the dark" about crucial information in the long period between his death in September 2017 and the time they were provided with the brief of evidence for the inquest by their legal counsel, in the week before the inquest was set to start almost three years later.

I believe that in the case of Tane Chatfield, having an independent investigation team, dedicated to both involving the family of the deceased and pursuing evidence with due rigour, would have saved the considerable extra trauma suffered by the family, who spent many years without basic facts, suspecting foul play.

47. There are deep injustices evident in the death of Tane in prison, including the fact that he was held on remand for two years, the inadequate standard of care he received in the critical hours before his death and the fact that he was very likely innocent of the crime for which he was incarcerated. Tane's parents maintain that "the prison system killed our son" and are seeking fundamental reforms to this system as part of their ongoing campaign for justice. In the Chatfield case, the Coronial Inquest process did allow some time for the family to put forward their perspective on these issues during the final day, which was dedicated to family

statements. One key demand from the family is for the creation of an independent body to investigate deaths in custody instead of police, so no other family has to experience the callous, indifferent treatment they received for almost three years after Tane's death, before finally receiving crucial information and an opportunity to have their perspective heard in an inquest.

48. There is a view amongst First Nations communities that the coronial system does not work to prevent similar deaths in custody. It has been almost thirty years since the RCIADIC and its recommendations and large swathes of those recommendations remain unfulfilled,[35] even though Coroners repeatedly iterate them in their own recommendations.

49. There is also a risk that where the focus of the inquest is too narrowly upon the medico-legal questions, the deceased's humanity — and the responsibility of the systems and/or individuals that killed them — disappears into an inquisitorial legal process devoid of speaking actively about these matters. Both the use of language to describe the deceased and the way that actions or omissions of individuals involved are characterised, serves to minimise the accountability of individuals and the state. Where actors are blamed through anecdotes by Coroners 'it was for their failure to intervene in tragedies that apparently spiralled out from nowhere. They were not blamed for deliberately depriving people of care nor for weaponising indifference in circumstances of total control'.[36]

Notifications of deaths in custody

50. We have commonly heard complaints about the manner in which notification of a death in custody was made to the families, including often notifications that pay no regard to who is the appropriate member of the family to notify or in what manner a notification should be made.

51. The act of notifying a family as to a death in custody is made by NSW Police who are often culturally insensitive and in whom there is often little trust, sometimes to families who have pertinent reasons to fear a visit from police. An alternative proposal would be to give this role Aboriginal Liaison Officers working independently of both NSW Police and Corrective Services NSW, and working within a crisis team in a proposed independent investigations body.

52. Similar positions exist in Victoria where they help families to navigate the Coroners' Court, including delivering 'sensitive information on behalf of the coroners, helping families understand information contained within coronial brief and providing support during court proceedings'.[37] It is not clear whether they are responsible for informing

[35] We are aware of a report by Deloitte Access Economics for the Department of Prime Minister and Cabinet in August 2018 that only 6% of the RCIADIC recommendations had not been implemented. We share the concerns raised about the scope and methodology of that Report that means it misrepresents governments' responses to RCIADIC, and has the potential to misinform policy and practice responses to Aboriginal deaths in custody: K Jordan et ors, '*Joint response to the Deloitte Review of the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody*', (2018) Centre for Aboriginal Economic Policy Research ANU College of Arts & Social Sciences, CAEPR TOPICAL ISSUE NO. 4/2018.

[36] Alison Whittaker, 'Dragged like a dead kangaroo', *The Guardian (Australian Edition)* (online, 8 September 2018),<https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody>.

[37] Victorian Aboriginal Justice Agreement, 'Goal 3.1: The needs of Aboriginal people are met through a more culturally informed and safe system: Koori Registrar in Coroners Court' (Web Page, 10 August 2020) <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-7>.

next of kin in that jurisdiction, it is appropriate that this form part of their role in our view.[38]

53. Inappropriate notification of First Nations families has a large cumulative impact on the transparency and accountability of the review system. Families who are not appropriately informed — as occurs commonly — miss critical opportunities to know and exercise their legal rights over the custody of their body, how the early investigation is conducted, to receive legal advice in critical early stages, and to access support services. There is no standardised follow-up protocol with families after notification, no standardised referral to legal assistance (while ALS NSW/ACT are notified, they are not provided with contact details for families), or wellbeing and throughcare (except where communities stand in to provide it through their own organising).

54. We note that changes have been made with the implementation of a CSNSW policy and procedure[39] this year. They require notifying legal services and notifying families in a culturally-appropriate way, subject to First Nations oversight. The new policies require notifying Next of Kin of possible financial assistance, organising meetings between CSNSW and family members, providing contact details for the investigating police officers, and organising meetings between CSNSW with Aboriginal community members. It also provides for smoking ceremonies in the cell of the person who has died in custody, if the family wishes, organised by a Regional Aboriginal Program Officer.

55. However welcome this clarity of procedure is, we still do not see these guidelines as changing much of the sense of lost control, fear and secrecy that families experience in the act of notification and subsequent state intervention. Notification systems still lack independence, community control and resourcing. So long as CSNSW thinks of its responsibility as hearing out concerns about investigation partiality or post-death control of a loved one's body, it will continue to understand objections after a death in custody as 'family or cultural issues'[40] and these systems will replicate the same power imbalances.

56. In the Coronial jurisdiction, it is only recently that Coroner's have begun to explicitly address the impact of discrimination, including through implicit bias and stereotyping, in their role of determining the manner and cause of deaths. For deaths in custody, the first inquest to consider systemic racism was in Victoria — the *Inquest into the death of Tanya Day*[41] — with findings from that inquest confirming systemic racism delivered in April this year.

57. With this development, it is possible that these cases will reflect to some degree the evolution in the law generally in their thinking about how racism appears. This was demonstrated in *Wotton v Queensland (No. 5)*[42] a decision that moved from requiring

[38] Ibid; see also https://www.abc.net.au/radio/programs/am/calls-for-aboriginal-liaison-to-be-appointed-to-coroners-courts/11644942

[39] NSW Department of Justice Aboriginal Strategy & Policy Unit, 'Aboriginal Death in Custody' https://www.correctiveservices.justice.nsw.gov.au/Documents/aboriginal/ASPU%20-%20Aboriginal%20deaths%20in%20custody%20-%20v1.1%20-%2020052020.pdf

[40] Ibid, p 4.

[41] *Inquest into the Death of Tanya Day* (Unreported, Coroners Court of Victoria, Coroner Caitlin English, 9 April 2020). Findings available here: coronerscourt.vic.gov.au/sites/default/files/2020-04/Finding%20-%20Tanya%20Day-%20COR%202017%206424%20-%20AMENDED%2017042020.pdf

[42] *Wotton v Queensland (No 5)* [2016] FCA 1457.

first-hand evidence of discrimination in the form of words or actions, to considering evidence of the indicia of systemic discrimination in the form of implicit bias and stereotyping as a matrix against which to evaluate direct evidence of the circumstances in which a particular death has occurred.

58. In the *Inquest into the death of Naomi Williams* (a death of a pregnant Aboriginal woman at Tumut hospital), NSW Deputy State Coroner Harriet Graham found it was necessary, given the evidence in the matter, to:

> examine whether Naomi's care was affected or compromised by unconscious, implicit bias or racism. It was necessary to place Naomi's care within the context of the well-known disparity between the health outcomes of Aboriginal people and those from the non-Aboriginal population, but also to place it in the context of the specific community and family dissatisfaction which was reported.[43]

59. Although the signs are promising, whether we can expect ongoing recognition by judicial systems of systemic racism is uncertain. As detailed below, these systems of review after a death in custody, or in other cases of systemic failure like Ms William's case, have their own systemic racism. Outcomes like the recognition of systemic racism and the recognition of systemic or individual responsibility for a death in custody depend largely on factors outside of surviving families' control. They include the awareness of legal representatives; reliance on the contingency that Coroners Courts are increasingly willing to consider such issues; the cooperation of investigators or access to independent investigation; and, on the wide range of discretion the Coroner is willing to exercise. It will rarely be the case that official investigators will focus on these issues.

60. In *Williams*, it was the solicitors of the National Justice Project, instructed by Ms William's family, who, in speaking with the broader First Nations community, obtained evidence of the view amongst First Nations people in the catchment area that the Hospital was well known for treating Aboriginal patients discriminatorily, and often, indifferently. It was that evidence that provided a basis for arguing that the issue of systemic discrimination legitimately fell within the scope of the inquiry into the 'manner and cause' of death (s81(1)(c) of the Act).[44] Such investigations are often unlikely to be undertaken by Police investigators who are trained to identify individual suspects.).[45] Another example of in which a NSW Coroner acknowledged systemic issues forming the context of a specific inquest is in the findings in the *Inquest into the death of Jonathon Hogan* at paragraphs [8] to [17] where the death of Mr Hogan is contextualised more broadly against the context of disproportionate incarceration of First Nation people.

61. Given the lack of First Nation consultation in the creation and operation of the Coroner's Office to date in NSW, it lacks cultural authority and compatibility amongst First Nation communities and is not embedded within First Nation knowledges surrounding death and truth-finding, the primary aim of the Inquisitorial function. The location of the coronial inquest process within the Australian legal system, and its

[43] *Inquest into the Death of Naomi Williams* (Unreported, New South Wales, Coroner Grahame, 29 July 2019) At [224].
[44] *Coroners Act 2009* (NSW) s81(1)(c).
[45] *Coroners Act 2009* (NSW) s81(1)(c).

consequent focus has been addressed by both Dist. Prof. Behrendt and Snr. Researcher Alison Whittaker.[46]

62. In addition to making findings about the cause and manner of a death, a Coroner also makes recommendations 'as [they consider] necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned'.[47]

63. Coroners routinely make recommendations about the procedure of police and prisons, often around information deficits or training deficits in police, nurses, custodial officers, and doctors. However, they have been historically resistant to making recommendations addressing why First Nations people are either detained or in custody, which RCIADIC identified as the most significant contributor to deaths in custody.[48] For instance, *Lord* died of a heart attack while incarcerated for driving while disqualified,[49] a common carceral entrapment for First Nations people. When his family raised this phenomenon at the inquest and suggested recommendations that limited the criminalisation of First Nations peoples for minor driving offences, Coroner Barnes regarded it as out of scope and a political decision beyond the jurisdiction of the inquest, noting—

> These competing policy imperatives pose a challenging balancing exercise. However, for a number of reasons, this inquest is not an appropriate forum to attempt to resolve that dilemma. First, I do not consider Bud's death was sufficiently connected with the habitual offender provisions to bring a critique of that regime within the jurisdiction of this inquest – he didn't die because he was disqualified from driving; indeed, he didn't die because he was in custody.[50]

64. The failure to implement recommendations also undermines the Coroner's preventative function. Unlike Victoria or other jurisdictions that have recently made moves to implement this, NSW has no statutory requirement that a Coroners' recommendations be read and responded to by state agencies or private organisations.

65. Currently, NSW government agencies are only bound by *Premier's Memorandum M2009-12* to respond to coronial recommendations. The memorandum was due for review in 2014, but is yet to be amended or reviewed. It requires that 'Within six months of receiving a coronial recommendation, a Minister or NSW government

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[46] George Newhouse, Daniel Ghezelbash & Alison Whittaker, '*The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line*' (pending publication) attached as **Attachment B**.

[47] *Coroners Act 2009* (NSW) s82.

[48] For example, in *Harmsworth v State Coroner* [1989] VR 989 Nathan J held (at 996), in relation to an inquest into deaths in prisoners, 'the sociological factors which related to the causes of their imprisonment could not be remotely relevant'. In contrast, in the *Inquest into the death of Perry Jabanangka Landgon* [2015] NTMC 016 Coroner Cavanagh SC criticised the paperless arrest scheme in the NT which saw the arrest of people drinking in public parks, 'almost all of whom' were indigenous (at [64). His Honour found the scheme 'disproportionately impacts on Aboriginal Territorians', was irreconcilable with the recommendations of the RCIADIC, would cause the death of 'more and more disadvantaged Aboriginal people' (at [90] and recommended the laws be 'struck from the statute book' at [90]. The NT Government refused that call (https://www.abc.net.au/news/2015-08-14/paperless-arrest-system-manifestly-unfair-langdon-inquest-told/6697818) and the High Court upheld the laws (https://www.abc.net.au/news/2015-11-11/high-court-upholds-northern-territory-paperless-arrests-law/6930340).

[49] *Inquest into the Death of Stanley Lord* (Unreported, Coroners Court of New South Wales, Coroner Barnes, 11 September 2014).

[50] *Inquest into the Death of Stanley Lord* (Unreported, Coroners Court of New South Wales, Coroner Barnes, 11 September 2014), at 4.

agency should write to the Attorney General outlining any action being taken to implement the recommendation.'[51]

66. This is not a publicly-performed function — although the Attorney General does compile a report twice a year (under the memorandum, in practice this occurs more often) containing excerpts of government agency responses. From a brief scoping of those available on the NSW Communities and Justice Website in August 2020, responses from health organisations tended to be extensive. Responses from NSW Police and Corrective Services tended to be brief, describing prospective changes (rather than changes made), or marked as 'awaiting response'.

67. New South Wales also has no independent, easily accessible systematic monitoring of Coroners' recommendations. It is difficult to know, then, which are being followed, which are even being considered, or whether the recommendation function has the desired impact of preventing future deaths in custody.

68. It is common in our experience for inquests to grapple with circumstances in deaths in custody that have been the subject of prior recommendations, often in other jurisdictions. For example, in the David Dungay Jnr inquest evidence was received that corrective services officers had not undergone training on the dangers of restraint asphyxia, a well-known risk and the subject of training for some time for NSW Police.

69. The similarity between deaths considered by RCIADIC and deaths considered contemporaneously at inquest confirms the perspectives of First Nations people in NSW that little has changed.

70. The death in police detention of Wiradjuri woman Rebecca Maher is a case in point. Across Australia, First Nations peoples have consistently been detained and held in Police custody because of intoxication, and died in circumstances where, had they not been in police custody, they — their family or community — could have taken steps to protect everyone involved.

The referral power

71. There is a view amongst some First Nations families who experience this system that coronial inquests fail to provide any form of accountability for those whose actions or omissions contribute to the death of their family members in custody. This perception arises from a number of factors.

72. Firstly, it arises from the fact that referral of deaths in custody from the Coroner to prosecutors is extremely rare and has only occurred a handful of times in NSW.[52] The appropriate state response to a death that could involve unlawful action is an independent investigation, report, referral and prosecution, as seemingly occurs quite reliably when the perpetrator is anyone but police or corrective services.

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[51] Premiers Memorandum, Responding to Coronial Recommendations 2009 (NSW) available at arp.nsw.gov.au/m2009-12-responding-coronial-recommendations

[52] When it does occur, it is rarely on the record as with other jurisdictions. See, for instance, Coroner Cavanagh's remarks at the Inquest into the Death of Reba Lakuwanga [2003] NTMC 007, at 31. 'I expressly reject…that any report pursuant to Section 35(3) "must necessarily be a private function of the Coroner and not a determination that is recorded in his official findings." This submission does not accord with the public nature of my function at Inquest, and *would have me sending private missives behind people's back to police and prosecutorial authority*.' (emphasis added)

73. Coroners in NSW have the power to refer cases to the ODPP for consideration in the following circumstances[53] —

> the coroner forms the opinion (having regard to all of the evidence given up to that time) that--
>
> i. the evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and
> ii. there is a reasonable prospect that a jury would convict the known person of the indictable offence, and
> iii. the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

74. Distinct in NSW from other jurisdictions, a referral requires the Coroner suspend the inquest (except for identifying the deceased, date and place of death, not often contested in deaths in custody). The referral is not often made at the conclusion of the inquest as part of the findings. This makes a systematic review of deaths in custody prosecutions in NSW difficult, and is a concerning opacity of an already institutionally-closed investigation process. Where a prosecutor declines to prosecute, or there is an acquittal in relation to the death, the inquest may resume but does not have to, a discretion that falls on the State Coroner.[54] In jurisdictions where the referral is more clearly made on the record, communities, media and families can more clearly see how these systems work and account for how deaths in custody cases progress. Otherwise, the process appears secretive and contrary to RCIADIC recommendations that they be conducted in such a way as to ensure public trust.

75. Recently, in the *Inquest into the Death of David Dungay*, Coroner Lee ruled that even in the event of a referral to prosecutors, families would not have standing to make either an application for a referral or submissions on the substance of the referral:

> The solicitor for the Dungay Family submitted that a referral ought to be made to the NSW Director of Public Prosecutions pursuant to section 78(4) of the Act with respect to the conduct of Officer A and Officer F. On this basis it was submitted that the evidence in the inquest enlivened section 78(1)(b) of the Act. That section does not provide the basis for a sufficiently interested party to make an application for a referral pursuant to 78(4) of the Act. Rather, section 78(1)(b) provides the basis for certain procedural steps to be taken in relation to the conduct of an inquest if a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with. Its purpose in doing so is to preserve the rights of any such person of interest and the integrity of any consequent criminal proceedings, and to separate the role and functions of the coronial and criminal jurisdictions.
>
> If an issue had arisen during the course of the inquest as to the possible enlivenment of section 78(1)(b) then, as a matter of procedural fairness, the opportunity to make submissions regarding this issue would only have been extended to any interested party in potential jeopardy, and to Counsel Assisting. The opportunity would not have been extended for submissions to be made on behalf of the Dungay Family, or any

[53] *Coroners Act 2009* (NSW), s 78(1)(b).
[54] *Coroners Act 2009* (NSW), s 79(5A).

other party with sufficient interest in the inquest but that was not in jeopardy. This is on the basis that any party's right to be afforded procedural fairness could in no way be effected by whether section 78(1)(b) was enlivened or not.[55]

76. Both the refusal, and the manner in which it was done, caused substantial anxiety for the family and impacted on their perception of access to justice in that matter. Firstly, Coroner Lee interpreted section 78 as not providing a basis for an interested party to apply for a referral to the Office of the Director of Public Prosecutions (ODPP). If that interpretation is correct this means that in New South Wales the family of a person killed in police or corrective services custody has no standing to ask the Coroner to make a referral to the ODPP, nor therefore, a right to be heard on the merits of such an application. The consequence of that is to further alienate First Nations families from being heard in relation to whether a criminal offence has been committed. His Honour went further, holding that a right to be heard on such an issue would be extended only to parties in jeopardy (being the Police or Corrective Services Officers involved in the death) and Counsel Assisting. Given the absence of any First Nations Coroners and the rarity of First Nation Counsel Assisting in NSW this excludes First Nations voices from the discussion of whether a referral is appropriate in circumstances where it is a central mechanism for accountability in a death in custody.[56]

The Office of the Director of Public Prosecutions

77. There have been multiple instances across Australia and in New South Wales in which the ODPP has exercised its discretion not to prosecute matters in which there is substantial evidence. Given the rate at which NSW Police and the NSW ODPP bring First Nations people before the courts in New South Wales, there is a legitimate sense amongst First Nations communities that those responsible for the identification and prosecution of offenders do not exercise those powers equally on behalf of First Nations victims.

78. The following is an example of the frequent underestimation by the ODPP of the prospect of conviction in cases with First Nations homicide victims. Lynette Daley was an Aboriginal woman. She was killed by two non-Indigenous men on 26 January 2011 during a camping trip. Coronial findings delivered in 2014 publicly referred the matter to prosecutors and strongly recommended charges be laid. Despite this, the ODPP did not prosecute.

79. An ABC Four Corners Program in 2016 raised the awareness of the matter, following which current DPP Lloyd Babb SC brought in independent counsel who prosecuted the matter. The two men were convicted by a jury that deliberated for only 32 minutes.[57]

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[55] *Inquest into the Death of David Dungay* (Unreported, Coroners Court of New South Wales, Coroner Lee, 22 November 2019) at 16.20-21,

[56] An example where such a referral was made is the matter of Tanya Day where a referral was made and the Coroner characterised the question as to whether the evidence discloses that an indictable offence 'may' have been committed. Importantly, in that case, the evidence disclosed that Aunty Tanya Day had a 20% chance of survival, a beit with substantial impairment, had medical assistance been forthcoming. The possibility, albeit relatively low, that Aunty Tanya Day could have survived was thought sufficient to refer the matter to the ODPP for consideration of a manslaughter charge. That approach is in stark contrast to the one taken by Coroner Lee in the Dungay matter; *Inquest into the Death of Tanya Da*y (Unreported, Coroners Court of Victoria, Coroner Caitlin English, 9 April 2020) at 624-625.

[57] 'Callous Disregard', Four Corners (Australian Broadcasting Corporation, 2016) <https://www.abc.net.au/4corners/callous-disregard-promo/7388056>; Mazoe Ford, 'Lynette Daley trial: NSW Attorney-General wants explanation over DPP handling of

80. Similarly, recently the NSW ODPP advised solicitors for David Dungay Jr that they would not review the evidence that arose in the Coronial Inquest into his death in custody in Long Bay Prison Hospital on 29 December 2015. One of the preeminent criminal barristers in New South Wales, and former head of the NSW Bar Association Philip Boulten SC, provided the family with advice to the effect that there is, in his view, sufficient evidence to find reasonable prospects of a conviction of manslaughter. Notwithstanding this advice, we understand the position of the DPP is that it cannot act.

81. There is no statutory nor guideline requirement that the ODPP consult with families about the decision to prosecute. There is no requirement that they provide public reasons for not proceedings with the prosecution of a death in custody, or sometimes even to surviving families. The prosecution guidelines (as of August 2020)[58] provide —

> Reasons for decisions made in the course of prosecutions or of giving advice, in appropriate circumstances, may be disclosed by the Director to persons outside the ODPP. Reasons will not be given in any case, however, where to do so may cause serious undue harm to a victim, a witness or an accused person, or could significantly prejudice the administration of justice.
> …
> Reasons will only be given to an inquirer with a legitimate interest in the matter and where it is otherwise appropriate to do so. A legitimate interest includes the interest of the media in reporting the open dispensing of justice where previous proceedings have been public.
> …
> Where there have been no prior public proceedings and a decision is made not to commence or continue a prosecution, reasons may also be given by the Director. However, where it would mean publishing material assessed as not having sufficient evidentiary value to justify prosecution, only a brief explanation may be given.

Delays

82. In our experience, it is common for coronial inquests in NSW to take years to both commence and resolve. For example:

- David Dungay Jnr died on 29 December 2015. The Inquest did not start for another 2 and a half years, (July 2018), the evidence did not close until March 2019 and the findings in relation to his death were not handed down until almost 4 years after his death in November 2019;

- Rebecca Maher died on 19 July 2016 whilst being detained by NSW Police. Her Inquest took over two years before the Inquest (March 2019) with Findings handed down comparatively quickly in July 2019 (3 years after her death);

case' *ABC News* (online, 7 September 2017) <https://www.abc.net.au/news/2017-09-07/lynette-daley-dpp-given-please-explain-over-32-minute-jury-case/8882894>

[58] The Office of the Director of Public Prosecutions, *Prosecution Guidelines of the Office of the Director of Public Prosecutions* (2007). Guidelines at: https://www.odpp.nsw.gov.au/prosecution-guidelines-0.

- Tane Chatfield died in September 2017 on remand and his Inquest was heard recently, almost three years after his death;

- Nathan Reynolds died on 1 September 2018. His inquest is set down for October 2019 and one would expect the findings to be handed down in 2021.

83. In an article in *the Guardian*, Taleah Reynolds said:

> Something needs to change…I've read that many coronial reports and findings. No one's ever held accountable. Why aren't they prioritising deaths in custody? Why does it take so long? We're coming up to a year since he died and we still don't know anything more.
>
> I feel like they don't have any remorse; they hide behind the system. No one's held accountable, that's the most frustrating part. The care factor is zilch. They don't care about the inmates…It's almost a year since he died, but the brief of evidence on his death is not likely to be ready until early next year. Some time after that, the coroner will hear the case.
>
> There's no timeline for anything…It just goes on and on. I went to a funeral last week and I sat there and thought, once you have a funeral, that's your closure. But because of what's happened, there's no closure. We've never had the time to mourn Nathan.[59]

84. Whilst we imagine these delays apply to all Coronial matters in New South Wales,[60] they have, in our experience, particular and damaging impacts on First Nations families who are more likely to have a distrust of both the institutions in which the deaths occur and those tasked currently to investigate the deaths. This can lead to an even greater sense that a) the NSW State is indifferent to these deaths and the families who suffer as a result, and/or b) that there is an intention to 'cover up' what happened.

85. A striking comparison between the delays in NSW compared with the inquests of other jurisdictions is that Aunty Tanya Day (whose inquest findings were delivered in April 2020) was, before her death fundraising and advocating for the family of Tane Chatfield after he died in custody in 2017. The findings into his death in custody were delivered well after hers, on 26 August 2020. Hearings into the death of Tane Chatfield's death commenced in July 2020, three months after Aunty Tanya Day's findings were delivered.

86. This sense is compounded by the length of time it takes for a coroner's brief to be compiled and provided to family. The practical reality for many families is that they can wait for over a year before they receive any evidence or update as to what happened to their loved ones in custody. Even when a brief of evidence becomes available, presentation of this evidence in a timely and accessible manner to the family also relies on having a committed and culturally competent legal counsel.

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[59] Lorena Allam, "Why does it take so long?' The desperate wait for answers after a death in custody', *The Guardian (Australia Edition),* 25 August 2019 https://www.theguardian.com/australia-news/2019/aug/25/why-does-it-take-so-long-the-desperate-wait-for-answers-after-a-death-in-custody.

[60] For example, Naomi Williams died at Tumut Hospital on 1 January 2016 and findings in her matter were delivered three and a half years later on 29 July 2019.

87. David Dungay Jr's mother, Leetona Dungay, spoke about the impact of these delays;

> We have waited so long for an inquest date to be set. Why must I live in pain not knowing?... we want to know the truth. As a mother, I deserve to know the truth and will not rest until I know why my son died.
>
> I'm incredibly upset and stressed, with my family here with me, about the lengthy delay that's taken to get us here today. I hoped and prayed for closure from this inquest, but now we have to wait another year in our fight for justice, to again hear from all those responsible that they don't 'recall' what happened to my son.[61]

88. In our view, given the importance of the circumstances of a death in custody being properly investigated, and the importance of ensuring that justice in this sense is not just done but seen to be done, the appropriate course of action is to develop a culturally informed coronial practice of delivering updates and expediting the review process, developed in consultation with First Nations communities.

89. In our view, the following elements of the Coronial jurisdiction operate to provide some protection for First Nations peoples and families involved in Inquests and should be preserved through the reform process:

    a. It is appropriate that deaths in custody or police operations be subject of a mandatory inquest (s.23 of the Act).

    b. The fact that Coroners are not bound to observe the rules of procedure and evidence that are applicable to a court of law[62] has benefits for First Nations families of Deceased.

       Firstly, this means that, where a Coroner is alive to the potential impact of cultural differences in Court, such as language and communication issues, the versatility of the process can be utilised to address those issues. One example in the Coronial process for example is the making of family statements to the Court.

       Secondly, the versatility in procedure has been used on occasion to cultural expressions as part of the proceedings. One example in the Naomi Williams inquest was a dance performed by a family member that formed part of the family statements. Other examples we are aware of include smoking ceremonies and welcomes to Country / acknowledgments of Country. One area where this flexibility should be encouraged in our view is the taking of evidence and/or the delivery of findings, on country such as takes place in Native Title proceedings and in the Bowraville Inquiry.

    c. One area in which the NSW Coroner's office is suitable and should be retained is the capacity of the NSW Coroner to compel testimony from parties in an inquest pursuant to part 6.3 of the *Coroners Act 2009* (NSW). In other states where no such legislative scheme exists, witnesses can refuse to give

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[61] Joseph Pugliese 'Dispatch Sydney: A series of daily dispatches from the coronial inquest currently underway in Sydney for Mr David Dungay, Dunghutti Warrior', *Deathscapes* (Web Page, 16 July 2018-14 August 2018) <https://www.deathscapes.org/engagements/dispatch-sydney/>.

[62] *Coroners Act* 2009 (NSW) s53.

evidence where to do so might expose them to a civil penalty, frustrating the fact-finding purpose of the Coroner.[63]

d. The fact that proceedings are governed and directed by the Coroner in conjunction with Counsel Assisting means that there is some practical protection of families who would not have the means to bring civil proceedings.

90. We have addressed below in relation to Terms of Reference 1(d) submissions how the current system might be reformed to provide an improved access to justice for First Nations families, and a 'best practice' approach to the creation of a separate, culturally appropriate version of the Coroner's office for First Nation deaths in custody.

[63] See for instance *Bell v Deputy Coroner of South Australia* [2020] SASC 59.

1 (C) — The oversight functions, overlaps and funding of various state bodies reviewing deaths in custody

The Office of the Director of Public Prosecutions

91. One of the chief oversight institutions into deaths in custody is the criminal legal system. The decision to investigate and prosecute individuals involved in deaths in custody represents the pinnacle of State-actioned accountability mechanisms by engaging the criminal law. The criminal law is very rarely ever deployed by the State to determine the accountability of those involved in First Nations deaths in custody and has very rarely been deployed in NSW.[64]

92. Currently under New South Wales law, criminal prosecutions for serious offences are dealt with on indictment. Generally, indictments for manslaughter are in the name of, and brought by the DPP who has a statutory power to bring such indictments, though the Attorney General retains the power to do so.[65] For the purpose of deciding whether to lay an indictment, the DPP can direct the NSW Police to provide information and or investigate or further investigate matters.[66]

93. As noted above, there have been high-profile refusals by various DPPs throughout Australia to prosecute deaths in custody that appeared to involve, at the least, manslaughter by gross negligence and/or by unlawful and dangerous act.[67]

94. Across Australia, we have seen case after case of First Nations deaths in custody in which Coroners have failed to refer cases for consideration by prosecutorial bodies. The failure to refer matters to the DPP, and inaction by the DPP, are at the core of why First Nation communities view the inquest system and the broader legal system as incapable of holding individuals involved in deaths in custody accountable.[68]

95. As noted by Alison Whittaker, of 134 cases researched by her, referral to prosecutors was only considered by Coroners 11 times, occurred only five times and in only two cases were cases actually pursued by prosecutors (being the deaths of Mulrunji and Mr Jongmin).

96. It is notable that the Queensland DPP refused to prosecute the Mulrunji matter leading to the Attorney General prosecuting it on an ex-officio indictment only after an independent review by Sir Laurence Street and consequent public pressure.[69] Prosecutions were laid in the Mr Ward death by the Workplace Occupational Health and Safety regulator which resulted in fines.

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[64] There is no systematic record keeping on prosecutions of deaths in custody. We know of only one such matter, a manslaughter prosecution for the killing of a young Aboriginal man walking across a park, resulted in an acquittal. See, Bellinda Kontominas, 'Officers Cleared of Deadly Crash-Tackle', *Sydney Morning Herald* (Sydney, online, 15 October 2008) <https://www.smh.com.au/news/national/officers-cleared-of-deadly-crashtackle/2008/10/14/1223750036925.html>; Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12 *Austl. Indigenous L. Rev.* 45, 49–50.

[65] *Criminal Procedure Act 1986* (NSW), s 5, 8, 9; s

[66] *Director of Public Prosecutions Act 1986* (NSW), ss16 and 18.

[67] *Crimes Act 1900* (NSW), S18.

[68] Craig Longman, 'Where is the accountability for Aboriginal deaths in custody?' (2016) 25 (3) *Human Rights Defender* 5.

[69] The Sydney Morning Herald, 'Officer to be charged over Palm Island death', *The Sydney Morning Herald* (online, 27 January 2007) <https://www.smh.com.au/national/officer-to-be-charged-over-palm-island-death-20070127-gdpc0t.html>

97. More recently, the Coroner in the matter of Aunty Tanya Day has referred that matter to the Victorian DPP to consider the laying of criminal charges — a referral that was rejected without providing public reasons or reasons directly to the family in late August.[70]

98. Police have laid charges in relation to the shooting death of 19-year-old Kumanjayi Walker in Yuendemu in November 2019 and the shooting death of 29-year-old Joyce Clarke in September 2019. Both have resulted in officers pleading not guilty.

99. It is worth noting that where prosecutions have been initiated, it is commonly because of immense public pressure and public advocacy on the part of the surviving families and communities. As Alison Whittaker noted in *The Conversation* —

> Prosecution or referral seems to come only from cases where First Nations families have strong public advocacy and community groundswells behind them and strategic litigation resources (not just inquest legal aid).
>
> As the late Wangerriburra and Birri Gubba leader Uncle Sam Watson said of the campaign for justice for the death of Mulrunji Doomagee on Palm Island:
>
> > Unfortunately, the government had to be dragged to this point screaming and kicking every inch of the way. Every time there's been a breakdown in the procedure, the family and community on Palm Island are being subjected to more trauma, drama and unnecessary grandstanding by politicians.
>
> Right now, three deaths are either before prosecutors or in their early stages of prosecution. All have been part of growing, public campaigns driven by their families and communities — although many others, like Dungay's family, have done the same and still been faced with institutional complicity.[71]

100. There is a systematic problem with the assessment of viability of prosecutions for First Nations deaths in the ODPP, not just for deaths in custody. As noted above, the viability of evidence in prosecuting the death of Ms Lynette Daley, was a key barrier to a trial that took just thirty-two minutes for a jury to return guilty verdicts on.

101. There exists, on a case by case basis, contrary legal opinion on the assessments made by ODPPs across the continent to prosecute. As noted above, Coroner Lee refused to refer David Dungay Jr's death to the ODPP. An independent review of the matter by Philip Boulten SC — one of New South Wales most experienced criminal law barristers and the former President of the New South Wales Bar Association — provided an advice to the Dungay family stating there was 'sufficient force in evidence' to pursue prosecution of the guards involved on grounds of manslaughter or assault. Notwithstanding, the ODPP has taken no action towards consideration of the evidence or prosecution. Nor has the NSW AG taken any steps to evaluate the viability of a prosecution in his name.

102. The current system cannot be said to be suitable in circumstances where the status quo appears to be that the chief law officers of the NSW State appear disinterested in

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[70] Human Rights Law Centre, 'Police officers involved in Tanya Day's death avoid prosecution' *Human Rights Law Centre* (Web Page, News, 26 August 2020) <https://www.hrlc.org.au/news/2020/8/26/police-officers-involved-in-tanya-days-death-avoid-prosecution>

[71] Alison Whittaker, 'Despite 432 Indigenous deaths in custody since 1991, no one has ever been convicted. Racist silence and complicity are to blame', *The Conversation* (online 3 June 2020) <https://theconversation.com/despite-432-indigenous-deaths-in-custody-since-1991-no-one-has-ever-been-convicted-racist-silence-and-complicity-are-to-blame-139873>.

taking a pro-active role in evaluating whether First Nations people have been unlawfully killed whilst in the custody of the state. As a number of advocacy strategies continue to work through the Coroners Court to access its referral power to the Director of Public Prosecutions, it becomes more important that the ODPP's decision to prosecute or otherwise be transparent.

Law Enforcement Conduct Commission

This section on LECC has been drafted with the assistance of the Redfern Legal Centre.

103. In NSW the statutory oversight mechanism in place is a limited form of statutory oversight contained in the *Law Enforcement Conduct Commission Act* 2016 (NSW) ('LECCA').[72] The LECC was introduced by the NSW Government, in response to the recommendations made by the 2016 Review of Police Oversight Report, compiling the oversight functions previously undertaken by the Police Integrity Commission and Police Division of the Office of the Ombudsman.[73] The Commission only investigates cases of serious misconduct or serious maladministration's of employees of the NSWPF and NSW Crime Commission.[74] The Commission's functions extend to that of making publicly available findings and making recommendations pertaining to findings of misconduct, including recommendations of disciplinary actions against persons engaging in officer misconduct, serious misconduct, and maladministration.[75] Whilst the Commission has the power to make such recommendation, the role of the Commission is limited in their ability to enforce such disciplinary actions[76] and any recommendation is not a finding or opinion of guilt.[77]

104. Whilst the LECC is independent of Police, there remains some limitations as to the extent to which the LECC is an appropriate and adequate body in investigating matters pertaining to interactions of First Nations peoples with police. Because it only has jurisdiction to investigate complaints of 'serious misconduct', it is unable to investigate generalised systemic discrimination. If the LECC determines that a complaint does not meet the legal threshold of 'serious misconduct' it may be referred to NSW Police or NSW Crime Commission for investigation.[78]

105. Where a LECC investigation does identify misconduct or maladministration, it is limited to making findings to that effect (along with recommendations) to the NSW Police Commissioner. The Commissioner is not bound by the LECC's findings or recommendations and it is solely within the Commissioner's power to decide whether to take action against officers under s.173 of the *Police Act 1990* (NSW). This means that there is no true effective oversight of police misconduct. In our experience, it is common for senior Police to defend Police behaviour before any investigation is conducted (for example, Commissioner Fuller's recent characterisation of a young

[72] *Law Enforcement Conduct Commission Act 2016* (NSW).
[73] NSW Department of Justice, 'The Tink Review into Police Oversight and the NSW Government's Response' 2015.
[74] LECCA s26.
[75] LECCA (NSW) s29.
[76] LECCA s30.
[77] LECCA s29 (4).
[78] LECCA s45, s47.

Aboriginal man being thrown to the ground by an officer as the officer 'having a bad day').[79]

106. We endorse the submission of Redfern Legal Centre to the ALRC that section 45 of LECCA should be interpreted so as to include the capacity of LECC to investigate a single complaint where that complaint is in relation to an issue that disproportionately impacts First Nation people, even where there may be only a single instance of impugned behaviour in relation to a single person.

107. In relation to First Nations Death in Custody, the oversight function of that body is even more limited, as it only has jurisdiction to oversee the mandatory NSW Police Force investigation into its own officer's involvement in a First Nations Deaths in Custody (i.e. it does not conduct the investigation itself). Whilst any police officer in a First Nations Death in Custody will inevitably be subject to scrutiny in a mandatory inquest, such inquests are often delayed by up to 3 years, and there is no power on the Coroner to compel evidence from witnesses prior to the conduct of the Inquest (though a refusal to provide evidence in contravention of a directive from a senior officer can found a disciplinary charge (see generally *Inquest into the death of Rebecca Maher - Decision on inclusion of directed interviews in brief* 4 March 2019*).* As has been previously noted, a flawed Police investigation, identified as such many years in the future, still results in tainted or missing evidence that can critically undermine any legal proceedings that may result in accountability.[80]

108. Whilst LECC makes its reports public, it is not clear to what extent the Police Commissioner makes public his determinations to act, or not to act, in relation to a particular complaint of misconduct. A Commissioner's decision is reviewable as an administrative decision by the Supreme Court[81] and those decisions that are deemed 'reviewable' by the structure of the Act are reviewable by the Industrial Relations Commission.[82] Complaint findings (and other documents generated as a result of a complaint) are not admissible in criminal or civil proceedings.[83] What these provisions mean in practice is that, even where there has been criticism of individual Police Officers in a Coroner's findings, there is no way to determine whether the Commissioner has taken action under s173 (other than where the officer acted against takes legal proceedings), nor (given the breadth of the terms of section 173) any likely judicial remedy to force such action.

109. An example of the limitations of the current model was seen in 2020, when LECC produced its findings in relation to NSW Police compliance with strip searches, following several high-profile strip searches of juveniles between 2015 and 2019. One of the cases reviewed in this report, which is of particular interest to this submission, was Operation Mainz, in which a 16-year-old Aboriginal boy was strip searched by officers in 2018.[84] During the search, the Aboriginal teen was subject to officers removing his shorts, forcing him to squat, with one officer in particularly

[79] Sally Rawsthorne, 'Family want the constable to be charged over Aboriginal boy's arrest', *The Sydney Morning Herald* (online, 3 June 2020) https://www smh com au/national/police-commissioner-concerned-by-video-of-aboriginal-teen-s-arrest-20200603-p54z0d html.
[80] Craig Longman, 'Police investigators too in-house to probe deaths in custody', *The Conversation*, (online, 15 April 2011) https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838.
[81] *Police Act 1990* s173 (10).
[82] *Police Act 1990* s173 and Div 1.
[83] *Police Act 1990*, s.170.
[84] Law Enforcement Conduct Commission, Operation Mainz, (Report to Parliament Pursuant to Section 132 Law Enforcement Conduct Commission Act 2016, May 2020).

forcefully pressing down on his shoulders. Of concern in the findings of this particular case (and the wider report into six other strip searches) was the preference of the LECC to make recommendations pertaining to the training and direction given to Police surrounding strip searchers, rather than disciplinary action to individual officers. That is, whilst the LECC in Operation Mainz identified the performance of officers as 'unsatisfactory', it did not amount to serious misconduct.[85] The head of the ALS NSW/ACT Criminal Law Practice Sarah Crellin criticised the report for 'not going far enough' in its findings, and was 'deeply disappointed there have been no recommendations for disciplinary action' against individual officers.[86] We concur with Ms Crellin's characterisation. In our submission it is demonstrative of a confrontational, quasi-militaristic, Policing culture that officers require training not to strip search children.

110. Similarly, Operation Trieste is one investigation conducted by the LECC which gained widespread media attention, for the misconduct of two police officers, in racially abusing two female motorists.[87] In their findings, the LECC was satisfied that the two officers had engaged in serious misconduct, intimidating the female drivers, using abusing language and bullying and frightening the women. The LECC too found the conduct to be partially motivated by and exhibited racial prejudice, in breach s7 of Police Act 1990, the NSWPF Code of Conduct and provisions of LEPRA. Whilst the LECC recommended these officers for disciplinary action, as mentioned above, it is unclear whether they ever faced any.

111. Finally, we note that as part of its function, LECC produced a report in 2019 in relation to NSW Police compliance with its own *Critical Incident Guidelines*. Of substantial concern is the finding in that report of systemic failures in uploading relevant documentation to the NSW Police computer program 'e@glei', including conflict of interest disclosures.[88]

NSW Coroner

112. The role of the NSW Coroner in oversight of First Nation Deaths in Custody and Police Operations is addressed above.

113. There is limited oversight of the Coroner's function. The Supreme Court has a statutory jurisdiction to review some Coronial decisions (*Abernethy v Deitz* (1996) 39 NSWLR 701), to exercise powers in its own name under the Coroner's Act and to determine judicial review of the Coroner's decisions, though in such proceedings the Supreme Court will give 'considerable deference' to coronial decisions which are otherwise made within jurisdiction.[89]

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[85] Law Enforcement Conduct Commission, Operation Mainz, (Report to Parliament Pursuant to Section 132 Law Enforcement Conduct Commission Act 2016, May 2020).

[86] Michael McGowan, 'NSW police watchdog says strip searches illegal but critics say findings 'did not go far enough', *The Guardian (Australian Edition)* (online, 8 May 2020) <https://www.theguardian.com/australia-news/2020/may/08/nsw-police-watchdog-says-strip-searches-illegal-but-critics-say-findings-did-not-go-far-enough>

[87] Law Enforcement Conduct Commission, Operation Trieste, (Report to Parliament Pursuant to Section 132 Law Enforcement Conduct Commission Act 2016, October 2019); Sarah Gerathy, 'NSW Police engaged in misconduct by racially abusing Afghan women, commission finds', *ABC News* (online, 31 October 2019) https://www.abc.net.au/news/2019-10-31/nsw-police-misconduct-over-racial-abuse-of-afghan-women/11659402

[88] Law Enforcement Conduct Commission, Review of 29 NSW Police Force critical incident investigations, (Report, June 2019)

[89] See *Musumeci v Attorney General of NSW* [2003] NSWCA 77.

114. Other states and territories have made either operational or statutory moves to constrain the scope of deaths in custody inquests — with families in Western Australia having to pursue what should be mandatory investigations for police-involved death.[90] Measures in Victoria that allow summary findings made if the 'medical investigator provides a report to the Coroner that includes an opinion that the death was due to natural causes'[91] have resulted in First Nations deaths in custody being summarily examined, contrary to RCIADIC recommendations. We urge this Committee to advise strongly against NSW moving into this troubling practice, either operationally or as a matter of law.

Oversight by the NSW Parliament

115. The NSW Parliament broadly can be recognised as a body which exercises a level of oversight over deaths in custody. The Premiers Memorandum M2009-12 specifically pertains to the role of the NSW Ministers and Parliament, in reviewing deaths in custody, complementary to any sections of The Act.[92] According to the Memorandum, the role of the NSW government or specific Ministers is to acknowledge and respond to any relevant coronial recommendations. Within six months of receiving any recommendations from the coroner, such ministers and agencies are encouraged to write to the attorney general, detailing their efforts of implementing recommendations. We identify one of the main limitations of this Memorandum to be the limited enforceability it has in obligated agencies to respond.[93] Government responses to coronial recommendations are made public biannually, available by Justice NSW website.[94]

116. Weeks after the death of Nathan Reynolds in custody (which is scheduled for inquest in October 2020), there was limited early information available to the public and his loved ones. In the same month, at a Legal Affairs Portfolio Committee on Parklea Correctional Centre and Other Operational Issues, David Shoebridge was able to seek answers from the CEO of Justice Health Gary Forrest and Commissioner Peter Severin of CSNSW on delays in Nathan's treatment. These are now active questions before the Coroner, and this was a vital source of transparency for the family and for the broader community. However, it is important to note that the answers had to be actively sought out through Hansard and this was not a particularly accessible or well-distributed form of transparency.[95]

117. Whilst this mechanism is suitable in our view, it must be said that it is clearly not sufficient. Had the Parliament been invested in properly addressing the causes of First Nations deaths in custody, there would be no need for the current inquiry. There is no value in requiring government departments to respond to Coronial recommendations if the Parliament more broadly does not hold it to account.

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[90] See, for instance, the death of Cherdeena Wynne who was handcuffed and detained in Perth by WA Police, subsequently lost consciousness and later died. Calla Wahlquist, '"It's time for this to stop": Aboriginal woman dies in custody 20 years after her father', *The Guardian (Australian Edition)* (online, 15 April 2019)< https://www.theguardian.com/australia-news/2019/apr/15/its-time-for-this-to-stop-aboriginal-woman-dies-in-custody-20-years-after-her-father>

[91] *Coroners Act 2008* (Vic), s17(1)(b).

[92] Premiers Memorandum, Responding to Coronial Recommendations 2009 (NSW).

[93] Ibid.

[94] NSW Communities & Justice, 'Government Responses to Coronial Recommendations' (Web Page) <https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx>.

[95] Report on proceedings before Portfolio Committee No. 4 – Legal Affairs: Parklea Correctional Centre and other operational issues. 28 September 2018.

118. For example, Rebecca Maher died in NSW Police Custody whilst being detained without charge in 2016. At the time, there was substantial commentary about the need to extend the obligation on NSW Police to contact the ALS Custody Notification Service in the case of persons detained, but not charged. Evidence was taken on that issue during the Inquest, and recommendations for the amending of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) were made. More than 4 years after Ms Maher's death that Act remains unamended.

Attorney General

119. The oversight function of the Attorney General specifically, is tied to that of the aforementioned role of the NSW parliament broadly in providing broad overview of deaths in custody. Specifically, for the Attorney General, such oversight functions pursuant of the Memorandum, extends to receiving information from the appropriate state agencies regarding the actions and implementation of coronial recommendations from government agencies. [96]

120. Whilst M2009-12 encourages Ministers and State agencies to respond accordingly to coronial recommendations, the memorandum is limited in the extent that it only uses language to suggest agencies *should* respond, rather than an obligation to do so.[97] Similarly, it is unclear what responsibility there is of the Attorney General to continue to follow up progress and implementation of recommendations. To the benefit of NSW State agencies and the Attorney General, an examination of recent Coroners Recommendations and Government Responses documents shows an adherence to responding to such recommendations. However, a more explicit codification of such obligations would ensure greater compliance and accountability for agencies involved in First Nations deaths in custody.

Corrective Services NSW

121. Corrective Services NSW as a body under the NSW government is limited in its oversight features in reviewing deaths in custody. They have no formal oversight role, though we understand that institutionally they conduct an internal review in relation to a death in custody. On the basis of that review they will often make changes to their policy and procedures prior to the conduct of an Inquest. That review may also inform the recommendations proposed by their legal representatives at an Inquest.

122. CSNSW also has a Management of Deaths in Custody Committee that is responsible for managing and reporting on inmate deaths in custody for Corrective Services, as well as reviewing and reporting on implementations of recommendations arising from internal investigations, reports and coronial inquiries. It is not explicitly clear of the level of oversight this body exercises, other than ensuring a 'proactive approach to duty of care responsibilities' and 'proactively managing contributions to inquiries by the Coroner and responses to Coroners recommendations'.[98]

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[96] Premiers Memorandum, Responding to Coronial Recommendations 2009 (NSW).
[97] Ibid.
[98] NSW Corrective Services, '*Management of Deaths in Custody Committee'* (Web Page) <'https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/management-of-deaths-in-custody/management-of-deaths-in-custody.aspx#ManagementofDeathsinCustody%C2%A0Committee>.

123. In the experience of Jumbunna, any internal response of Corrective Services to a death in custody tends to lack any transparency or public accountability and could not properly be characterised as an oversight role. Moreover, due to the redacted nature of CSNSW Custodial Operations Policy and Procedure documents, a true understanding of the procedures and level of internal review and oversight of deaths in custody by CSNSW is unknown. Finally, it has been our experience in the Inquests in which we have worked, that Corrective Services NSW has an institutional tendency towards defensiveness and the suppression of material, rather than towards transparency.

SafeWork NSW

124. Codified under *Work Health and Safety Act 2011* (NSW),[99] SafeWork NSW could act as an oversight body in investigating workplace incidents, but we are unaware of any occasion that it has actually done so. We are aware that in the recent death in custody of David Dungay Jnr, it has refused to even consider the matter. In investigating such incidents, SafeWork may receive recommendations from the coroner, in reference to systemic unacceptable conduct of employees within agencies where death has occurred. Supplementary to acting on the recommendations of the coroner, SafeWork has the function of instigating criminal prosecution under the WHSA, with enforceability of such findings. Given the broad functions of SafeWork NSW, there is potential to investigate deaths in custody (with an overlap and liaison with the Coroner). Despite this potential existing, we are not aware of this body ever investigating any individual in connection with a First Nation death in custody.

125. In the *Inquest into the Death of Rebecca Maher*, Maher's family and legal team raised concern of the systemic conduct of NSWPF, and encouraged a referral to SafeWork NSW to pursue a criminal investigation into widespread systemic behavioural issues of NSWPF. Coroner O'Sullivan was not inclined to refer the matter of individual officers to SafeWork, rather noted the steps taken by NSWPF in implementing wider measures of change.[100] As noted above, 4 years after the death of Maher, there remains little change in accordance with the coronial recommendations.

126. Moreover, in the *Inquest into the Death of David Dungay Jr*, Coroner Lee did not refer any IAT members or JHFMHN staff to SafeWork for criminal investigation. Since this inquest, in August 2020, the Dungay family and their supporters delivered a petition with over 95,000 signatures to Parliament, calling the NSW Attorney General to refer the matter to NSW DPP and SafeWork NSW. [101]

Family: legal assistance and media

127. While not a NSW Government body, families who have lost First Nations loved ones in custody play a critical role in oversight and investigations. Indeed, in our

[99] *Work Health and Safety Act 2011* (NSW).
[100] *Inquest into The Death of Rebecca Maher* (Unreported, Coroners Court of New South Wales, Acting State Coroner, Magistrate Teresa O'Sullivan, 5 July 2019).
[101] M. Deserio, 'Justice for David Dungay Jr', National Justice Project (Web Page) <https://justice.org.au/justice-for-david-dungay-jr/>.

experience it is the families who have been the main driving force in ensuring any meaningful oversight in First Nation deaths in custody (and unsolved homicide) cases. Their roles have relevance to the oversight of all the NSW agencies outlined above — with Coroners especially relying on families for an insight into the person who was lost but also to de facto stand in for their interests.

128. While they are not state actors, there are significant steps the NSW Government could take to reflect this important role in oversight and accountability. These are resources in the form of adequately-funded legal assistance and clarifying media restrictions.

129. It is highly relevant that First Nations families do not have a systematic access to legal assistance for inquests into deaths in custody. While Legal Aid do have a coronial unit which specialises in inquests and offers assistance to those otherwise unable to access it, its capacity is limited by just how few lawyers and advocates work on staff. The Aboriginal Legal Service NSW/ACT also provides advocacy for First Nations families who lose a loved one in custody, but lacks a systematic funding stream to do so and is also limited by a relatively small team compared with need.

130. It is not just at inquests that families require legal advocacy. From the moment of death in custody, families navigate a highly complex system of overlapping state oversight. Families can be lost in knowing where the body of their loved one is, how they are going to be examined after death, how do they get custody of the body, how to contribute to investigations, and how to ensure they are kept in the loop as investigations unfold. The timing of legal support is also crucial in ensuring that families are prepared and can strategise around inquests, a preparatory process which takes a significant amount of time and expertise beyond what can happen if lawyers are engaged with just a few months to prepare for inquest. Without robust and early legal support, these are new sites of trauma for families.

131. Another concerning barrier for families is a complicated web of restrictions on what they can say after the death of their loved one. Recently, we have observed a rise in the use of suppression and non-publication orders over the identity of state agents and employees who may have played a role in the death of a loved one. These orders are introduced before inquest and often continue after the inquest has closed. This is distressing and inappropriate for families who need to campaign around the death of their loved one as part of an informal transparency mechanisms — especially in cases where the death is more directly connected to the actions of state actors. This could be aided by a review of the non-publication powers under ss 73—77 of the *Coroners Act 2009* (NSW), in the context especially of the principles guiding the *Suppression and Non-Publication Orders Act 2010*.

132. Similarly, there is uncertainty for families, advocates and media organisations alike around the *sub judice* contempt rule and how it applies to inquests. As noted earlier this year —

> Outside of coroners courts, there is the threat of subjudice contempt, when media coverage may pose a prejudicial threat to a potential trial.
>
> This carries a risk for families who speak out about their loved one's deaths in a way that even implies something happened or someone did something. Subjudice contempt poses liability to them personally when they speak out, but also could jeopardise their push for justice.

This puts First Nations peoples at the mercy of what can be raised before a jury, judge or coroner. With lengthy procedural delays, this can also mean a case is hard to talk about publicly for years.

This is problematic given that timely publicity about deaths in custody is what drives attention. [102]

133. Greater clarity is desirable so that First Nations families and communities are supported, or at least not restrained inappropriately and unfairly, in their role as crucial participants in oversight bodies and as advocates in their own right after a death in custody.

[102] Alison Whittaker, 'Despite 432 Indigenous deaths in custody since 1991, no one has ever been convicted. Racist silence and complicity are to blame', *The Conversation* (online 3 June 2020) https://theconversation.com/despite-432-indigenous-deaths-in-custody-since-1991-no-one-has-ever-been-convicted-racist-silence-and-complicity-are-to-blame-139873.

1 (D) — How those functions should be undertaken and what structures are appropriate

Truly independent investigations of deaths in custody and police operations

134. We note that the definition of oversight contemplated by the Inquiry includes not just corruption and misconduct, but providing accountability for the exercise of police powers. Police oversight issues are seen by the broader community in the light of the historical experience of Aboriginal people outlined above. Moreover, research shows that this relationship remains plagued with contemporary issues regarding the policing of Aboriginal people.

135. In adherence with international law, acts of police or state brutality, violence, excessive force or severe misconduct should be investigated in a manner than is prompt, effective and impartially independent, with no connection to the alleged perpetrators.

136. Tamar Hopkins, founding lawyer of the Police Accountability Project in Melbourne, has written comprehensively of the characteristics required for an independent investigation function. In summary, such an investigative body must be independent, adequate, enable public scrutiny and ensure the involvement of the victim.[103]

True independence

137. In our view it is essential for accountability that any investigations of alleged misconduct, discriminatory exercises of power, human rights breaches, or criminal behaviour (including a death or injury in custody) are conducted by organisations that are institutionally, practically culturally and politically independent of the Police Force.[104] This requirement is in keeping with International Law obligations.[105]

138. The importance of such independence effects both the public perception of the extent to which Police officers are accountable to the law, but also the effectiveness of any investigation. Where officers feel a collegial obligation and duty to other officers, there is the risk of a conflict of interest leading to bias that in turns effects the adequacy of the investigation. There is also a risk of regulatory capture as noted above.

139. In this regard, investigations of misconduct must take priority over any associated Police-instigated criminal investigation. This ensures that investigations into misconduct are not hampered by the role of Police in pursuing criminal investigations of the complainant, during which Police exercise a large power over the complainant in the form of the various discretions as to charge, bail etc.

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[103] Tamar Hopkins, 'An Effective System for Investigating Complaints Against Police', Victoria Law Foundation Grants Publication Education, (2008-2009), **Attachment C**.
[104] Tamar Hopkins, *An Effective System for Investigation Complaints Against Police* (Victoria Law Foundation), August 2009, Recommendation 1, 6.
[105] See for instance *Brecknell v United Kingdom* (2008) 46 EHRR 957.

Moreover, it also reduces the temptation to pre-emptively charge a complainant with a criminal offence in an attempt to impugn their character and create a fictitious motive for the complaint, putting its veracity in issue before any investigation has commenced.

140. Given the need for a genuinely independent organisation, we submit that a mere oversight body that is tasked with overseeing an internal investigation is insufficient to prevent conflicts of interest or the influence of a strong police culture of collegiality and loyalty, and address the opportunities that arise for collusion and the tainting of evidence at the time of an event. Consequently, such a body must have the following mechanisms conferred on an independent statutory basis:

    a. powers and training to investigate complaints in a rigorous, timely and effective matter, including the powers to conduct the investigation as a standard criminal investigation and interview Police officers. Police officers should be required to co-operate with such a body in such investigations, subject to standard common law rules against self-incrimination;
    b. the ability to institute and conduct criminal prosecutions; and
    c. A statutory basis as an independent statutory body, being properly funded and resourced.

Adequacy of investigation

141. The failings demonstrated above in reference to a series of high-profile First Nation Deaths in Custody demonstrate the critical importance of adequate investigations that are timely, rigorous and effective. We endorse the concept of 'the golden hour' in this context, which identifies the importance in collecting evidence as soon as possible on the occurrence of an event. Importantly, this requires that witnesses be separated immediately, and be prevented from discussing the matter, so as to ensure that evidence is not tainted.

142. In addition to the characteristics outlined above, in our submission that investigative body should be informed, through consultation with First Nation communities, by First Nation cultural values.

143. An independent investigative body that operates with a ‘healthy scepticism’ of the evidence of involved Police, health service or corrective Service (and indeed any state actor) should be established to investigation First Nation deaths in custody. Whilst such a body would, in best practice, investigate all such deaths in custody, the unique role that state actors have (and continue) to play in implementing legal and policy frameworks that discriminate against First Nation people (as outlined above at 1(a)) necessitates that justice be both done, and be seen to be done, by First Nations.

144. The use of NSW Police officers as investigators on behalf of the NSW Coroner should be ceased in First Nation deaths and a First Nations-led investigative body should be established to inquire into the circumstances of First Nation deaths in Custody (that

body should also have a role in overseeing Police investigations into suspected homicides of First Nation peoples).

Addressing a failure to prosecute

145. Currently the NSW ODPP's guidelines provide (as of August 2020) that 'Reasons for not proceeding with a prosecution where committal proceedings or an inquest has taken place may be given by the Director' (Guideline 12),[106] but contain no obligation to provide such reasons. This position should be amended.

146. The need for a mechanism for transparency and review arises because, notwithstanding that decisions of ODPP are administrative decisions, there is traditionally no avenue in Australian law for review of those decisions.[107] A decision to prosecute a person is explicitly excluded from review under the ADJR scheme[108] and at least two justices of the High Court have previously indicated that a decision 'whether or not to prosecute' is 'insusceptible of judicial review'.[109] In a later case the High Court has found that 'sanctions available to enforce well established standards of prosecutorial fairness…are not directly enforceable at the suit of the accused or anyone else by prerogative writ, judicial order or an action for damages'.[110] Nor does the Coroner's Act provide a mechanism for review of a decision not to refer a matter. Review of such exercise of power is only available by way of s69 of the Supreme Court. Such review is limited to an 'error of law on the face of the record'[111] and jurisdictional error.[112]

147. Given the limited available means for oversight, it is submitted the progression of a matter between the Coroner's Court and the ODPP process must be adequately transparent. This is in the interests of families, communities, and of ensuring independent scrutiny of these processes from a DPP that has an operational working relationship with state agencies that are often implicated in deaths in custody.

148. One possible mechanism that we believe warrants further investigation is the enactment of a scheme similar to the Victims' Right to Review Scheme discussed in Anna Talbot's paper cited above. That scheme provides for independent review of such decisions by specialist lawyers. Such schemes would provide families of those killed in custody with an independent review, and would alleviate any cultural pressure that ODPP officers may experience in the prosecution of police officers with whom they have a close working relationship.

The inquest

149. The institutions responsible for truth-seeking in First Nation Deaths in Custody must be based upon a commitment to meeting the expectations of First Nation families in both truth-finding and treatments of death.

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106 The Office of the Director of Public Prosecutions, *Prosecution Guidelines of the Office of the Director of Public Prosecutions* (2007). Guidelines at: https://www.odpp.nsw.gov.au/prosecution-guidelines-0

107 Anna Talbot, *'Criminal Justice: DPP complaints and oversight mechanisms'* [2016] PrecedentAULA 66: http://classic.austlii.edu.au/au/journals/PrecedentAULA/2016/66.html.

108 *Administrative Decisions (Judicial Review) Act 1977* (Cth), paragraph (xa) of Schedule 1.

109 *Maxwell v The Queen* (1996) 184 CLR 501, 534.

110 *Likiardopoulos and The Queen* (2012) 247 CLR 265, but see the dissent of French on the question of unreviewability of prosecutorial decisions at 269, [2]-[4].

111 *Supreme Court Act* S69(3).

112 *Kirk v Industrial Court of NSW* (2010) 239 CLR 531; [2010] HCA 1 at [100]

First Nations staffing

150. We recommend the appointment of a First Nations Elder to assist in the conduct of all inquests into First Nation deaths in custody. The role of that Elder could include working with the Nation of the deceased to incorporate relevant spiritual and cultural practices of their community associated with death and healing.[113] Currently within the Coroner's Court in NSW, there are no court personnel that have an explicit, culturally informed role in representing the culture and traditions of First Nations peoples, surrounding death and traditional law. As well as engaging with First Nations methods of death investigation through the appointment of a First Nations elder, such a role would also be similar to the functioning of an Elder present in Koori Court proceedings.[114] That is, in our view, Elders operating within the Coroners Court could be of use in contributing to recommendations in a meaningful way, as well as directing proceedings within the court and promoting an inclusive, less formal arena as well as directing ceremonial grief practices.

151. Further, we recommend the introduction of an Aboriginal Liaison Officer to the Coroner's Court. As discussed above, in NSW the Police act as the first point of contact with First Nations families, following a death in custody. In recognising the gross historical context and distrust between police and First Nation's communities, such a role is unsuitable. Rather, we would recommend adopting from the Victorian Coronial jurisdiction, in their introduction of an Aboriginal Liaison Officer.[115] At present, such a role in Victoria see's greater communication between First Nations families and the court, with Koori Family Engagement Officers and Coordinators (Aboriginal Liaison Officers) keeping First Nations families informed of particular progress of an inquest, as well as aiding in the liaison with other services, including funeral assistance and immediate care and service after learning of a death. Similarly, such a role would enhance in the organisation and facilitation of culturally led and appropriate grieving practices such as Smoking Ceremonies during the period of Sorry Business. Previously such ceremonial practices have often been organised by family and supporters. We encourage the incorporation of such practices into the formal functioning of the inquest, coordinated with the liaison of appropriate First Nations court personnel, so as to recognise First Nation knowledge of death and healing.

Engagement with therapeutic jurisprudence

152. As noted by Alison Whittaker et al,[116] ultimately, it can be said that the existing coronial jurisdiction and proceedings can exacerbate trauma for First Nations families, already grieving and mourning a loss of a loved one. First Nations families that we have worked with, alongside experiences outlined within the existing

[113] Roger W. Byard and Wayne C. Chivell, 'The interaction of death, sorcery and coronial/forensic practices within traditional indigenous communities' (2005) 12(5) *Journal of Clinical Forensic Medicine* 242; Pam McGrath and Emma Phillips, 'Aboriginal Spiritual Perspectives: Research Findings Relevant to End-Of-Life Care' (2008) 16(2) *Illness, Crisis & Loss* 153.
[114] See generally Michael S King and Kate Auty, 'Therapeutic Jurisprudence: An emerging trend in courts of summary jurisdiction'(2005) 30(2) *Alternative law journal* 69.
[115] Victorian Aboriginal Justice Agreement, 'Goal 3.1: The needs of Aboriginal people are met through a more culturally informed and safe system: Koori Registrar in Coroners Court' (Web Page, 10 August 2020) <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-7>
[116] Newhouse et ors, '

literature, have equally expressed feelings of trauma and victimisation by the existing coronial proceedings.[117]

153. In our experience, reforms that focus on therapeutic jurisprudence in the coronial jurisdiction have the capacity to improve the experience of First Nation communities within the Inquest process. In the coronial jurisdiction, and for the purpose of this submission, we are most interested in the way in which a therapeutic jurisprudential model would empower First Nations families within the coronial inquest process, providing a greater space to listen to First Nations voices and the perspectives of families.

154. Former WA Coroner Michael King and QC Ian Freckelton have both written of the potential for the coronial jurisdiction to engage in greater therapeutic practices, so as to minimise the presence of further harm during these inquests.[118] As an approach, therapeutic jurisprudence seeks to encourage self-determination of participants within the court, whilst promoting positive behavioural change and considering the psychological and emotional wellbeing of those involved.[119] It attempts to do so whilst ensuring procedural fairness and the functions of the coroner in investigating First Nation deaths in custody.[120]

155. The exercise of therapeutic jurisprudence in practice for coronial inquests into First Nations deaths in custody would also commend the suggestion noted above of the appointment of Indigenous Coroners, Counsel Assisting and investigators with lived experience to undertake inquests into Aboriginal deaths in custody.[121]

156. Engaging with First Nations psychologists and counselling personnel would also enhance the therapeutic nature of the proceedings, through understanding the unique social and emotional wellbeing of First Nations peoples.[122]

157. Additionally, there should be a greater platform for First Nations family members, as direct interested parties in the investigation, to assist the coroner (if they wish to do so), to voice their experiences, expressing their feelings and the impact of the death on their family. Imperative to the therapeutic jurisprudential model is the communication and interaction between the judge (or coroner) and the parties involved in the inquest. As such, we encourage coroners to actively listen to concerns and interests of First Nations families, as well as considering their lived experience in the context of a First Nation deaths in custody. This can also be done so by providing an experienced and well-resourced legal aid service to the next of kin at inquests into First Nation deaths in custody.

158. Adequate and approprate spaces should be provided for First Nations families and supporters during the coronial inquest. In recognising the extent to which a First Nation Death in Custody impacts the community, we would recommend that to

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[117] Ethan Blue, 'Seeing Ms. Dhu: Inquest, conquest and (in)vis bility in black women's death in custody' (2017) 7(3) *Settler Colonial Studies* 299.; Pauline Klippmark and Karen Crawley, 'Justice for Ms Dhu: Accounting for Indigenous deaths in custody in Australia' (2018) 27(6) *Social & Legal Studies* 695.

[118] Ian Freckelton QC, 'Minimising the counter-therapeutic effects of coronial investigations in search of balance' (2016) 16(3) *QUT Law Review* 4*; Michael King, 'Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model' (2009) 16(3) Journal of Law and Medicine 442.*

[119] Ibid.

[120] Ibid.

[121] For more on social and emotional wel being for First Nations peoples see generally Pat Dudgeon, Abigail Bray, Belinda D'Costa and Roz Walker 'Decolonising Psychology: Validating Social and Emotional Wel being' (2017) 52(4) *Australian Psychologist* 316.

[122] Ibid.

minimise the counter-therapeutic nature of the coronial inquest process, private rooms of a suitable size should be made available for large families and supporters attending inquests into the death of a First Nations person.

159. Further, drawing on the principles of circle sentencing, in which those involved are able to gather in an informal setting, we recommend engaging with family and community, either during or after a coronial inquest, at an appropriate location of their choosing on country, in which the family can share their story about the deceased, the impact of the death, their grief and other healing storytelling.

160. In recognising the travel associated with attending a coronial inquest, we recommend financial support be offered to the family to cover travel, accommodation and living costs through the inquest. These arrangements need to take account of the extended family groups very often affected by a First Nation death in custody and wanting to be involved in the coronial process.

Amendments to the Coroners Act 2009 (NSW)

161. We recommend an amendment to the *Coroner's Act 2009 (NSW)* to impose a statutory obligation on the Government to report on what steps it has taken to ensure private organisations it contracts with have implemented any recommendations directed at them. Such powers exist in other jurisdictions (see for example Coroners Act 2008 (VIC) s72 which *mandate* a response to recommendations).

162. The Act should also be amended to clearly mandate Coroners to make findings on whether implementation of any, some or all RCIADIC recommendation could have reduced the risk of death in all cases where an Aboriginal or Torres Strait Islander has died in custody, in or around a police action, or within forty-eight hours of attending or leaving a health facility or coming into contact with police

163. Given the experiences of the families in the cases mentioned above, we recommend that the Act broaden the Coroners scope to empower them to make recommendations to address any systemic problems that may be relevant to a death.

164. We further recommend that the definition of 'relative' within the Act be broadened to recognise the and encompass First Nations kinship and familial units.

Improving accountability

165. Require the Office of the Director of Public Prosecutions to publicly provide reasons for not proceeding with a prosecution where an inquest into a death in custody has taken place.

166. Parliament should give adequate consideration to the implementation of an independent merit review scheme accessible for First Nation peoples to review Prosecutorial decisions not to prosecute individuals involved in the death of First Nation people in custody.

167. The lengthy delays of coronial inquests often result in state agencies or oversight bodies making procedural and policies changes prior to receiving formal recommendations from the coroner. The consequence of this, combined with the Coroner's strict statutory constraint to making relevant recommendations, is that the Coroner's recommendation power can be mooted out or pre-empted by state bodies. This prevents multiple parties from contributing to Coronial recommendations that are relevant to the death in custody. This is especially pertinent nationally on deaths in police custody, where lock-up procedure is changed prior to inquest and the Coroner is thereby unable to make recommendations regarding lock-up procedures. It is a serious limiting factor of advocacy and the transparent oversight funding of the Coroners Court in issuing or taking submissions on pertinent potential recommendations.

1 (E) — Other matters

168. In addition to the above issues, we raise the following other matters:

Appropriate funding

169. There is a need to secure funding for the above reforms, in relation to both addressing incarceration rates and addressing the divide between First Nation and non-First Nation experiences in death investigation. In particular, the Federal and State Governments should work with First Nation communities, the NSW State Coroner and academics such as Jumbunna to develop a best-practice and culturally informed model of First Nation Death Investigation. Such a model would be a first in Australia and provide inspiration for other states and territories.

170. There is also a need to ensure adequate funding to Aboriginal Legal Services and (where preferred by families) private legal practitioners to guarantee proper representation in Inquest matters. That funding should also extent to assistance to the family to engage with media. That funding should be commensurate to funding levels for the Crown in a homicide/manslaughter investigation and prosecution. Aboriginal Legal Services continually fight to receive adequate government funding and support, to ensure they can provide legal services to First Nations peoples. In 2019 alone, the Aboriginal Legal Services raised concern for funding cuts, due to federal budget changes:

> "Funds should not just be 'quarantined' for servicing Aboriginal clients, but they should go directly to Aboriginal Community Controlled Organisations, such as the ALS, which deliver culturally-appropriate services. The Federal Government must surely realise that this is a serious issue which impacts all ATSILS around the country."[123]

Appropriate counselling and support services.

171. The funding and implementation of counselling services and advocacy bodies supporting First Nations peoples in their interactions with the criminal legal system and death investigation process is recommended. This requirement was identified by the NSW Parliament in the Bowraville Report and remains relevant today.

Private institutions involved in deaths in custody

172. As with Corrective Services and state agencies, we recommend the inquiry investigate private prisons and their obligations to report on deaths in custody. Where the culture or policies or procedures of a private organisations have contributed to the death of a human being, they should be under both a legal and moral obligation to report on the implementation of those recommendations. Further research is required to determine the extent to which such organisations currently implement

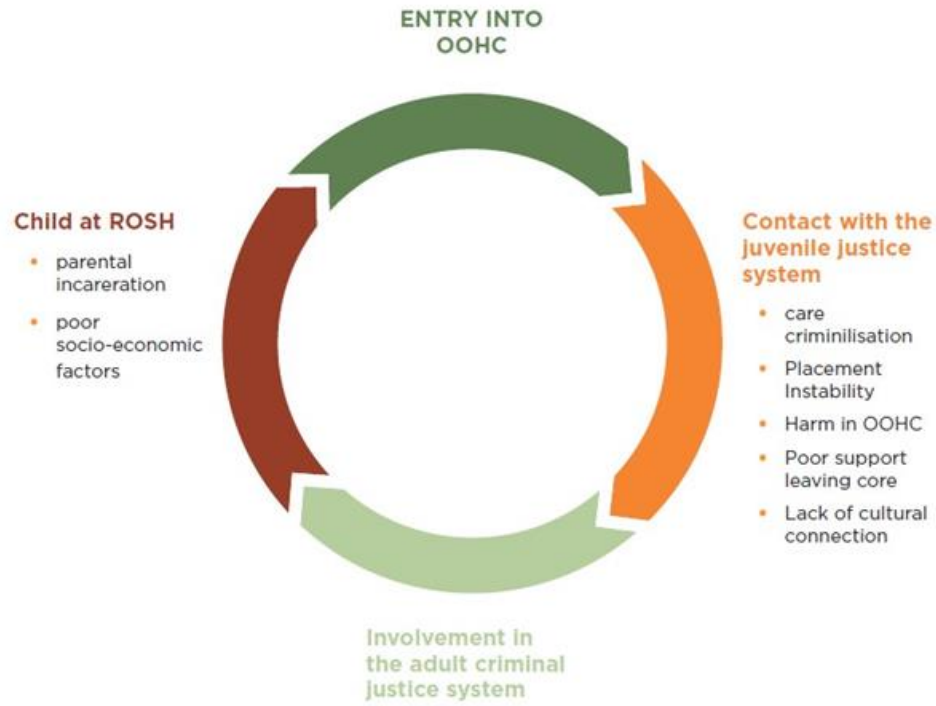
[123] Aboriginal Legal Service (NSWACT), 'Budget Changes Put Aboriginal Legal Services at Risk' (Media Release, 4 April 2019).

relevant recommendations. It is our view that private prisons must be held to the same account as state prisons and services, in the case of reviewing a death in custody, and publicly responding to any coronial recommendations or changes to policies and procedures following a death in custody.

Children and care criminalisation

173. One of the areas in which we see the intersection of access to justice and criminal legal issues is in the disproportionate rate of First Nation child removal in Australia.

174. The ongoing over-representation of First Nation children in out-of-home care also contributes to the over-representation of First Nations people in the criminal legal system through care-criminalisation.[124] Drawing on the existing literature as well as submissions and consultations, the recent independent review of Aboriginal children and young people in out-of-home care, *Family is Culture,* included a focus on care-criminalisation as "one of the broader harms of removal experienced by Aboriginal children in OOHC".[125] The *Family is Culture Review* identified a cycle of care criminalisation through which entry into out-of-home care contributed to increased contact with the juvenile justice system, contributing to increased adult incarceration, and in turn increased likelihood of children at Risk of Significant Harm (ROSH) due to parental incarceration or poor socio-economic factors, creating an intergenerational cycle of risk.[126]



[124] Megan Davis, F*amily is Culture Final Report: Independent Review into Aboriginal Out-of-Home Care in NSW* (Family is Culture, Final Report 2019); Kath McFarlane, 'Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system' (2017) 51(3) *Australian and New Zealand Journal of Criminology*, 412-433..
[125] Megan Davis, F*amily is Culture Final Report: Independent Review into Aboriginal Out-of-Home Care in NSW* (Family is Culture, Final Report 2019) pp.XXXV. See Chapter 15 for the Review's discussion of Care-Criminalisation. (**OOHC** in this section refers to 'out of home care').
[126] bid.

Figure 1: Family is Culture Representation of Care Criminalisation process. See Davis, M. (2019) Family Is Culture Final Report: Independent Review into Aboriginal Out-of-Home Care in NSW, pp. 242

175. The *Family is Culture Review* noted multiple possible contributors to this relationship between out-of-home care and involvement in the criminal legal system, including the pre-care experiences of abuse and neglect giving rise to psycho-social risk factors associated with offending, as well as the legacy of the impacts of colonisation, past policies of forced removal, intergenerational trauma and disconnection, as outlined above.

176. However, it also noted that the care context uniquely contributes to involvement in the criminal legal system, including inadequate supports for children and families, placement instability, and disconnection from key relationships to siblings, family, community and culture, as well as an increased likelihood of a criminal legal response to emotional and behavioural difficulties that might otherwise be dealt with in the home – key features that may contribute to the risk of offending and involvement in the criminal legal system.

177. This analysis is informed by research that examined a representative sample of children before the NSW Children's Court for criminal matters, which found that almost half had spent time in out-of-home care, with Aboriginal children significantly over-represented.[127] Those in out-of-home care had a different and more negative experience of the criminal legal system – entering at a significantly younger age and were more likely to experience custodial remand, were less likely to have access to key supports at the police station or in court, and were at times excluded from diversionary options or bail accommodation services. On some occasions, the research noted that child protection caseworkers argued for children to remain in custody "for their own protection". The research concluded:

> "Factors specific to the care experience, such as accumulated trauma, placement instability, separation from siblings and significant others, police interactions and the removal process itself, shaped children's trajectory through the justice system. Criminalising practices operating within the OOHC system escalated children's exposure to the [criminal legal system] for offences that would not have led to police involvement if these offences had occurred at home. The two factors – being in OOHC and offending – then exacerbated each other."[128]

178. The *Family is Culture Review* also identified other factors such as increased likelihood of school suspensions and disengagement from education that represented disconnection of Aboriginal children in out-of-home care from key protective factors associated with reduced risk of offending.[129]

179. A recent similar review in South Australia examined children involved in both the child protection and criminal legal systems.[130] The report highlighted a number of key

[127] Kath McFarlane, 'Care-criminalisation: The involvement of children in out-of-home care in the New South Wales criminal justice system' (2017) 51(3) *Australian and New Zealand Journal of Criminology*, 412-433.
[128] Ibid 424.
[129] Megan Davis, F*amily is Culture Final Report: Independent Review into Aboriginal Out-of-Home Care in NSW* (Family is Culture, Final Report 2019).
[130] Guardian for Children and Young People, A Perfect Storm? Dual status children and young people in South Australia's child protection and youth justice systems – Report 1 (Report 1, November 2019), available http://www.gcyp.sa.gov.au/wp-content/uploads/2019/12/Dual-Status-CYP-in-SA-A-Perfect-Storm.pdf

issues, including systems-centric decision making, disjointed rather than holistic approaches to meeting the needs of this cohort of children, and the lack of properly resourced therapeutic care models. Aboriginal children, and those with disabilities were disproportionately affected, with those from rural, regional and remote areas experiencing compounding disadvantages. Additional research that emphasised the need for improved prevention through family support, greater use of diversionary pathways, and a broader differentiated youth justice response for children involved in the child protection system.[131]

180. Addressing the over-representation of First Nations people in incarceration includes taking urgent action to address the care-criminalisation processes that disproportionately affect Aboriginal children and families. The *Family is Culture Review* provided a comprehensive blueprint for reform of the child protection system to reduce the over-representation of Aboriginal children and young people in out-of-home care, focused on self-determination, increased independent public accountability and oversight across the child welfare system, and increased family supports and other community-led services to meet the needs of Aboriginal children and families. This included specific recommendations to improve coordination between child welfare and criminal legal systems, prioritising supports and other diversionary approaches as well as improving data collection and research to address the pathway from out-of-home care to the criminal legal system.

181. The government's response to these recommendations has failed to commit to the significant reforms to systems and practice, and is unlikely to be successful in addressing the over-representation of Aboriginal children in out-of-home care or the issue of care-criminalisation. Further urgent action is needed, including an immediate commitment to the implementation of the *Family is Culture* recommendations, in partnership with Aboriginal communities and their representative organisations. This must include structural change consistent with the principle of Aboriginal self-determination, enabling Aboriginal community-led design and administration of key local services to address the over-representation of Aboriginal children in out-of-home care and the care-criminalisation pathway, and the appointment of an independent and empowered Aboriginal Commissioner focused on Aboriginal children and young people to provide oversight and accountability.

182. These reforms should further reflect a clear commitment to keeping First Nations children with their families and communities by strengthening family preservation and restoration practice and protecting Aboriginal children from inappropriate permanency orders including adoption and proportionate investment in antenatal supports, early childhood education and care and family supports, directed towards Aboriginal community controlled organisations and approaches.

183. It is acknowledged that the Minister has committed to further engagement with Aboriginal communities, regarding the recommended reforms. This must be progressed as a matter of urgency. The recent *National Agreement on Closing the Gap* provides further impetus for a genuine partnership approach towards systemic change. These recommendations are outlined in our recent call on the NSW Government to take eight actions to help stop Aboriginal Deaths in Custody (attached as Appendix B).

131 bid.

Recommendations

1. The NSW Government should commit to the **immediate and comprehensive implementation of the recommendations of the RCIADIC**. This includes the recommendations that seek to address the need for broader community education on Aboriginal history and culture, dealing with the underlying issues that cause Aboriginal people to have disproportionate contact with the criminal justice system, the importance of alternatives to incarceration, the need for training in the medical services, police and custodial services and judicial officers, and the importance of the principle of self-determination as a framework principle.

2. The NSW Government should fund and establish, in consultation with First Nations, a **First Nation's counselling and therapy service** available to surviving families of both deaths in custody and homicides. That service should be informed by the culture and traditions of First Nations surrounding death.

3. The establishment of a **First Nations-led investigative body** to inquire and determine the circumstances of First Nations deaths in custody. That body should accord with best-practice guidelines of independence, adequacy, public scrutiny and involvement with the victim and be developed and directed by First Nation communities and their culture and traditions surrounding death. The body should have the power to refer to prosecutors in the event that they find sufficient evidence that an indictable offence may have been committed in connection with the death.

4. The appointment of a **First Nation elder** to sit with and assist the Coroner similar to the function that Elders currently play in Koori Court proceedings.

5. **First Nation Liaison Officers** should be employed within the Coroner's office. Their role should include acting as a first point of contact with First Nations families from the point of notifying the family of a death as well as a liaison throughout the investigation process.

6. The NSW Government should prioritise the **appointment of First Nation Coroners and Counsel Assisting** when conducting investigations and inquests into the death of First Nations people, and, in particular, First Nation deaths in custody.

7. The NSW Coroner's Court should incorporate and prioritise the principles of **therapeutic jurisprudence**, subject to the guidance of First Nation communities, Liaison Officers and Elders.

8. The NSW Coroner's Court should **prioritise** the investigation of, and inquest into, First Nation deaths in custody and/or care. The Coroners Court should

also adopt a scheme of early and continuing disclosure of evidence to Families.

9. **Appropriate spaces** should be provided for the First Nation surviving families and their supports at the Coroners Court Complex. In addition, the Coroners Court should adopt the principles of circle sentencing and embed within their procedures the opportunity to meet with Families in an informal sitting at a location of their choosing to facilitate the family sharing their story of the deceased, the impact of the death, their grief and other healing storytelling.

10. The ***Coroners Act* should be amended**;

    10.1 to explicitly broaden the scope of the Coroner to consider systemic issues of discrimination where those issues relate to the circumstances of the death (including explicitly considering the impact of RCIADIC);

    10.2 to provide standing to, and require the Coroner to consider the views of, the families of deceased persons in determining whether to exercise the power of referral to prosecutorial authorities under s78 of the Act;

    10.3 to provide a right of appeal to Families of the deceased where the Coroner refuses to refer a matter to the Director of Public Prosecutions;

    10.4 to embed a mandatory requirement for Government departments and private institutions to respond to, and report on the implementation of, recommendations made; and

    10.5 to broaden the definition of 'relative' to encompass First Nations kinship and familial units.

11. The **Office of Director of Public Prosecutions Guidelines should be amended** to:

    11.1 require Prosecutors to consult with families about decisions not to prosecute individuals involved in First Nation deaths where there has been a referral by a NSW Coroner; and

    11.2 require Prosecutors to give written reasons to families where it refuses to consider prosecution of, or makes a determination not to prosecute, individuals involved in a First Nation death in custody.

12. The NSW Government should establish an **independent merits review process** to review decisions of Prosecutors not to investigate and/or prosecute deaths of First Nations people.

13. The NSW Government should commit to **properly funding the Aboriginal Legal Aid Service** and a new service within it specialising on representation for families in First Nation Deaths in Custody and/or Care.

14. The NSW Government should **review ss 73 - 77 of the *Coroners Act*** to ensure those provisions strike the appropriate balance between the protection of the rights of individuals and the interest in open justice, and do so by consultation with First Nation surviving families.

15. The NSW Government should commit to the **implementation of the *Family is Culture Review***.

16. The NSW Government should commit to the **implementation of the recommendations from the *Australian Law Reform Commission, Pathways to Justice*** *— An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples Report*.

Enclosed

Appendix A — Findings and recommendations contained in the ALRC 2017 Pathways to Justice Report.

Appendix B — Black Lives Matter: Our call on the NSW Government (June 2020).

Appendix C — Statement from Paul Silva

Attachment A - Whittaker, Alison, *'CARRIED 'LIKE A DEAD KANGAROO': Culpability & accountability in Australian justice system responses to Indigenous deaths in custody'*, LL.M. Long Paper submitted April 2018, Harvard Law School - **PRIVLEGED.**

Attachment B - George Newhouse, Daniel Ghezelbash & Alison Whittaker, '*The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line'* (pending publication) - **PRIVILEGED**.

Attachment C - Tamar Hopkins, 'An Effective System for Investigating Complaints Against Police: A study of human rights compliance in police complaint models in the US, Canada, UK, Northern Ireland and Australia', Victoria Law Foundation.

Appendix A — Findings and recommendations contained in the ALRC 2017 Pathways to Justice Report

Charges before the courts

1. First Nation peoples are seven times more likely to be charged with a criminal offence and appear in court than non-Indigenous people.[132]

2. The number of First Nation defendants increased during 2018-19 in NSW by 6%.

Short sentences and recidivism

3. First Nation offenders are more likely to receive a short-term sentences for low-level offending rather than sentences of non-imprisonment. Short-term custodial sentences not only fail to deter offenders, they also exclude First Nations offenders from accessing alternative programs or training that are focused on addressing offending and promoting rehabilitation, they too have significant impacts on the health of First Nations offenders.[133] Short sentences of imprisonment significantly influence the experience of 'cycling' through the system, in which the stigmatisation, negative impacts on families, accommodation and employment associated with serving a period of imprisonment may lead to further arrest and incarceration.

4. First Nation offenders are more frequently sentenced to a term of imprisonment. Three quarters (76%) of First Nations prisoners have a prior record of imprisonment, in which they have served a custodial sentence on one or more occasions across the life-course. This is compared to half (49%) of non-Indigenous prisoners.[134]

Bail and remand

5. Both the bail determinations and bail conditions significantly act as drivers for the overrepresentation of First Nations peoples on remand. One third (34%) of all First Nations prisoners in 2019 were on remand,[135] with First Nations women overrepresented in the remand population at an alarming rate.[136] Increasingly, First Nations women who have difficulty finding suitable accommodation, are being placed in custody on remand for 'therapeutic reasons'.[137] In 2015, the NSW Supreme Court recognised the detrimental impacts of prolonged periods of remand and separating from family, suggesting such conditions are likely to exacerbate the cycle of disadvantage for First Nations peoples.[138]

6. One option for reform is the introduction of a provision akin to s3A introduced in Victoria which requires a court to 'take into account (in addition to any other requirements of this Act) any issues that arise due to the person's Aboriginality,

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132 Australian Bureau of Statistics, *Criminal Courts, Australia Annual Report, 2015–16* (Catalogue No 4513.0, 2 March 2017)
133 Just Reinvest NSW, Policy Paper: Key Proposals #1–Smarter Sentencing and Parole Law Reform (2017) prop 2.
134 Australian Bureau of Statistics, *Prisoners in Australia, December 2016* (Catalogue No 4517.0, 8 December 2016).
135 Australian Bureau of Statistics, *Prisoners in Australia, December 2019* (Catalogue No 4517.0, 5 December 2019).
136 Ibid.
137 Emma Russell and Cara Gledhill, 'A Prison Is Not a Home: Troubling "Therapeutic Remand" for Criminalised Women' (2014) 27(9) Parity 27.
138 R v Alchin (Unreported, NSWSC, 16 February 2015) [3]. See also: R v Wright (Unreported, NSWSC, 7 April 2015) [7]–[9].

including (a) the persons cultural background (including the persons ties to extended family or place) and (b) any other relevant cultural issue or obligation. [139]

7. In exploring Bail Reforms the State must acknowledge First Nation sovereignty and expertise as recognised in recommendations 5-1 and 5-2 of the Report.[140]

Sentencing

8. At present, pre-sentencing reports and submissions fail to adequately encompass the background information relevant to First Nations offenders.[141]

9. Currently, the rate of conviction does not substantially vary for First Nations peoples and non-Indigenous peoples, however, there remains significant variance in the proportion of prison sentences imposed. Almost one third (31%) of all First Nations defendants are sentenced to a period of incarceration, compared to 18% of non-Indigenous defendants.[142] In 2018-19 in NSW, 24% of First Nations defendants who were found guilty were sentenced to a custodial sentence.[143] Moreover, the type of offences that First Nations people are more frequently charged with result in the imprisonment of First Nations peoples at a rate 16.8 times higher compared to non-Indigenous offenders.[144]

10. We support the ALRC recommendations for greater provisions in sentencing to account for the unique systemic and background factors affecting First Nations peoples, as well as greater options for presenting such information to the court, such as through the use of Elders. [145]

Community-based sentencing options and alternatives to imprisonment

11. First Nations peoples continue to be less likely to receive a community-based sentence compared to a non-Indigenous offender.[146] One of the key issues identified in hindering the reduction of First Nations peoples represented within custody, is the availability and flexibility of community-based sentencing options. Due to the significant proportion of First Nations peoples living in regional and remote communities (44%), remoteness has commonly been tied to the higher rates of imprisonment of First Nations peoples.[147] In NSW in 2015, intensive correction orders were ordered much less frequently in remote regions, compared to major cities, with

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139 Ibid

140 Aboriginal Legal Service (NSW/ACT), Submission 63.; Aboriginal Legal Service of Western Australia, Submission 74; to Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017); Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017) 13.

141 Change the Record Coalition, Submission 84 to to Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017); Thalia Anthony, Lorana Bartels and Anthony Hopkins, 'Lessons Lost in Sentencing: Welding Individualised Justice to Indigenous Justice' (2015) 39(47) Melbourne University Law Review 68.; Thalia Anthony et al, 'Individualised Justice through Indigenous

142 Australian Bureau of Statistics, *Criminal Courts, Australia Annual Report, 2015–16* (Catalogue No 4513.0, 2 March 2017)

143 Australian Bureau of Statistics, *Criminal Courts, Australia Annual Report 2018-19* (Catalogue No 4513.0, 27 February 2020)

144 Australian Bureau of Statistics, *Prisoners in Australia, December 2016* (Catalogue No 4517.0, 8 December 2016).

145 Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017) 14.

146 Australian Bureau of Statistics, Corrective Services, Australia, June Quarter 2017 (Catalogue No 4512.0, 29 November 2017).

147 Productivity Commission, Overcoming Indigenous Disadvantage: Key Indicators 2016—Report (2016) figure 3.4.1

74%, 19% and 0.6% of offenders respectively in major cities, inner regional areas and remote to very remote areas subjected to intensive correction orders.[148]

12. We strongly support First Nations communities in self-governing, designing and implementing community-based, non-custodial sentences. Such an approach would also ensure the appropriateness of any conditions imposed by reference to the lived experience of the offender. Moreover, in reference to community-based sentences as an alternative to full-time imprisonment sentences, we endorse the recommendations put forward by the ALRC.[149]

Access to Justice

13. Both the harmful effects of the aforementioned structural injustice, a history of dispossession and genocide (and a failure in legal academies to create culturally proficient practitioners (for example by a failure to recognise the role that lawyers have historically played in that history)) have led many First Nations peoples to distrust mainstream legal services, pushing them to underfunded Indigenous legal organisations.[150] The National Aboriginal and Torres Strait Islander Legal Services (NATSILS) is the peak body for First Nations legal representation.[151] NATSILS assists in over 200,000 cases per year and are Indigenous led, providing culturally competent legal representation to First Nations peoples.[152] In the years 2017 and 2018 NATSILS saw a six million dollar decrease in funding.[153] The important of continuous, ongoing and reliable funding to these Indigenous led services is essential for Indigenous people to secure legal representation and therefore access justice cannot be stressed enough.[154]

14. We endorse the recommendations put forward by the ALRC in reference to enhancing the access of First Nations peoples to justice. [155]

Women

15. First Nations women account for one of the fastest growing prison population groups in Australia, overrepresented, as both victims and offenders, in the criminal legal system and the prison population. The drivers of incarceration of First Nations women are representative of the structural oppression they face, manifesting in social, cultural and economic disadvantage and increased contact with the justice system. [156]

16. For First Nations women, the drivers of incarceration are multifaceted. As well as overrepresentation in the prison population, national prison surveys have revealed high rates of victimisation from family violence and sexual assault amongst First Nations women. In NSW specifically, a 2014 study found 70% of First Nations women

148 NSW Sentencing Council, Intensive Correction Orders: Statutory Review (2016) figure 2.4.
149 Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017) 14.
150 Ibid 326.
151 Cheryl Axleby 'Access to justice for our most vulnerable citizens is a right not a privilege' (2017) 39(4) *Bulletin (Law Society of South Australia)* 22, 24.
152 Ibid.
153 Ibid.
154 Ibid.
155 Australian Law Reform Commission Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (Report No. 133, December 2017) 16.
156 Human Rights Law Centre and Change the Record Coalition, Over-Represented and Overlooked: The Crisis of Aboriginal and Torres Strait Islander Women's Growing Over-Imprisonment (2017) 16.

in prison had been survivors of child sexual abuse, 78% experienced violence as adults, and 44% were subject to ongoing sexual abuse as adults.[157] As such, we believe that in order to address the overrepresentation of First Nations women within custody, the wider issue of victimisation and experiences of family and sexual violence needs to be addressed, from a First Nations led, culturally appropriate, trauma-informed model.

[157] Ibid, 17.

Appendix B — Black Lives Matter: Our call on the NSW Government (June 2020)

In the spirit of self-determination for Aboriginal and Torres Strait Islander people, we, the undersigned call on the NSW Government to adopt the following reforms to address First Nation deaths in custody and provide accountability for such deaths where they do occur:

Justice Now

1. **Ensure independent oversight of all deaths in police and corrective services custody. Such investigations should:**
    a) accord with best practice and be institutionally, culturally and politically independent from both the NSW Police and NSW Corrective Services, including by not sourcing investigators connected with NSW Police and NSW Corrective Services;
    b) embed mechanisms for victims' families to be involved in the investigatory function;
    c) embed principles of First - Nations self-determination, be overseen by a First Nations Commissioner, and be staffed where possible with First Nations investigators;
    d) have equal investigatory powers and equivalent funding as NSW Police and NSW Corrective Services in matters related to deaths in custody;
    e) be empowered to issue public reports, recommendations and referrals with statutory immunities.
    f) be empowered to re-open investigations into historical cases of deaths in custody where justice has not been served.

2. **Refer the *Law Enforcement Conduct Commission Amendment Bill 2020* currently before the NSW Parliament to the joint select committee of the NSW Parliament to investigate whether the amendment of the LECC can implement the above reforms.**

3. **Justice for the Dungay Family**

David Dungay was killed by prison guards in Long Bay jail on December 29, 2015. We back his families call for prosecution of those responsible. We call on the NSW Attorney-General to refer this matter to both the NSW DPP and Safework NSW for prosecution.

4. **Support for First Nations families and victims of violence**

Establish a First Nations community-controlled victim's support service that will provide assistance (irrespective of case outcome) to First Nations families who have been victims of violence and/or have lost relatives in custody, to provide counselling, legal support and advice, working in partnership with Victims Services.

Defund the Police – Free the Prisoners

5. **Reinvest in community support and engagement by redirecting funding away from the police including:**

   a) Cease the continued increase in budget and staff numbers and divert this funding to First Nations-led initiatives that address the underlying causes of discrimination against First Nation people in the criminal justice system.

   b) Redirect police resources to non-violent support services, principally First Nations led services, to respond to people in crisis situations including mental health, domestic violence and homelessness with priority given to the First Nations community-controlled agencies

   c) End the use of sniffer dogs by NSW Police at public events and music festivals, stop random and illegal strip searches and the use of NSW Police as private security contractors

   d) Remove police from public transport and traffic enforcement roles

   e) Reverse militarisation of the police force including removing assault weapons, sound weapons and water cannons;

   f) Reduce prison numbers through implementation of the recommendations of the ALRC report Pathways to Justice (2017), and redirect funding to community-based programs for people coming into contact with the criminal justice system

6. **Drug law reform to stop the over-incarceration of First Nations people, including:**

   a) Legalise cannabis and MDMA for personal use;

   b) Decriminalise and regulate personal use of all drugs;

   c) Implement the recommendations of the ICE Inquiry, including the immediate establishment of the Walama Court;

   d) Expand the drug court to all of NSW noting its role will be reduced by decriminalisation.

7. **A Decarceration Agenda**

   a) Establish a Decarceration Commission chaired by a First Nations judge. The commission would review individual cases of incarcerated prisoners with a view to their release to the community where release does not pose an unacceptable risk to the community or to any individual.

   b) Decarceration will be accompanied by case management plans and ongoing resources including drug and alcohol counselling to support those released into the community.

   c) Law Reform to repeal summary offences that impact disproportionately upon First Nation peoples including;

      - Offensive Language
      - Resist Arrest
      - Assault Police.

   d) Reform the legal obligations regarding Police discretion to address the disproportionate impact upon First Nation peoples of the following police powers:

      - Move on Powers

- Consorting Law
- Strip Searches.

Bring the Children Home

8. Return First Nations control over their families and deliver real self-determination

a) Implement and fully fund the recommendations from Family is Culture report in genuine partnership with First Nations peoples;

b) Keep First Nations children with their families and communities by reversing the two-year permanency reforms for First Nations people, strengthening restoration practice and ensuring First Nations children are not adopted from OOHC;

c) Commit to proportionate investment to First Nations children and families across the service system, through community-controlled organisations and approaches with a focus on antenatal supports, early childhood education and care and family supports;

d) Close youth prisons and raise the age of criminal responsibility;

e) Reinstate funding to AbSec;

f) Appoint a First Nations Children's Commissioner to promote transparency and accountability;

g) Deliver on previous commitments including establishing a state-wide network of First Nations Organisations delivering holistic family and community supports, full implementation of the Aboriginal Case Management Policy, and the transition of First Nations children in OOHC to accredited First Nations agencies

Appendix C — Statement from Paul Silva

Published on Facebook September 1, 2020 — facebook.com/permalink.php?story_fbid=189141715943369&id=100045426244879

Enclosed with permission.

My name is Paul Silva I'm a proud Dunghutti man from Kempsey NSW and I am the nephew of David Dungay Jnr.

On the 29th of December 2015, a group of Immediate Action Team Officers (IAT) stormed the cell at Long Bay Hospital ward where David Dungay Junior was being held as he was a diabetic and refused to stop eating some biscuits.

The officers then dragged the 26-year-old Dunghutti man into another cell, where five IAT officers held him face down in a potentially lethal prone position on a bed.

David called out that he could not breathe on numerous occasions but the guards didn't let up and refused to listen to David.

After David was being held down a nurse then inject him with a strong sedative as a result David became lifeless.

I've been fighting for justice for David Dungay Junior and systematic change within our police stations and prisons since December 2015, when David's life was tragically taken by New South Wales Corrective Offices and Justice Health staff that didn't adequately provide CPR to save his life. We need to unite and fight together against this corrupt system and to also stop future deaths in custody.

From the day that the Kempsey police came to my grandmothers house to tell us of the devastating news that David Dungay Junior has been killed.

Days later I brought to my family's attention that we would not receive any justice, as I have never seen a prison guard be criminally charged, found guilty and put in jail in regards to an aboriginal death in custody since the royal commission in 1991.

Upon the dressing and viewing of David's body 3 weeks after this tragic incident had taken place, I was exposed to lacerations to his face, a size 10 boot mark in-printed on his lower back and not to mentioned that his nose was basically flat to his face.

He didn't look like my uncle!! He look like someone badly brutalised due to the unnecessary use of force applied by the Corrective Services IAT team.

For the past five years I have March the streets of Sydney and Kempsey in a fight for justice for my uncle.

Many have seen the traumatic video released to the public although there is so much more footage that has not been released due to a non-publication order, issued by the courts.

We have sat through the coronial inquiry and listen to the numerous amount of evidence final findings was:

Manner of death

- David died whilst being restrained in the prone position by Corrective Services New South Wales officers.
- David's long- standing poorly controlled type I diabetes
- Hyperglycaemia
- Prescription of antipsychotic medication with a propensity to prolong the QT interval
- Elevated body mass index
- Likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint were all contributory factors to David's death.

There was no recommendation out of the coronal inquiry to the Department of Public Prosecutions for criminal charges against Corrective Service New South Wales officers and/or Justice Health staff involved.

Due to the fact there was no recommendations for criminal accountability out of the Coronial inquiry, our family's legal team had engaged a criminal barrister Philip Boulten SC and he believes that there is a bases to charge prison guards responsible for David Dungay Jnr's death with manslaughter and/or assault.

We are calling the attorney general to request the department of public prosecutions to investigate the incident on the 29th of December 2015 at Long Bay correctional facility at 2:42pm, Use of force was a contributing factor to the death of David Dungay Junior. We demand work safe NSW to also take back there second rejection and undertake an investigation as David's death occurred in a workplace.

We had our wonderful legal team request WorkSafe New South Wales to do an open investigation into the death of David Dungay not once but twice and they were both rejected. It states in their policies that they will investigate a finger being cut off in a workplace but they're not willing to undertake an investigation for a human being that was held down and killed in a work place despite his cry's for help.

Over the past year at protests attendees have signed a petition that we submitted with More than 100,000 signatures to the NSW Parliament demanding that the Department of public prosecution and WorkSafe New South Wales conduct an investigation into the death of David Dungay junior.

I will continue to demand justice for a deceased man that can't tell his side of the story, after all the evidence that has been provided, I believe there can and will be accountability for all involved and it will only be a matter of time before David Dungay gets the justice he deserves.

It's an over whelming experience to meet so many great people in my determination for justice and change in the Australian system and together if we unite to fight for the justice and the accountability will eventually arise.

Almost 5 years on I haven't taken a step back nor taken a step down from fighting for what's right, when you see something that is so traumatic and you know that there can be accountability against individuals involved the determination becomes so real. My fight along side other families that have become and are victims of an Aboriginal death in custody will

not stop until all families receive accountability and answers, if there is no Justice there will never be any peace.