AH&MRC Policy Submission

Select Committee on the Coronial Jurisdiction in NSW

Aboriginal Health & Medical Research Council of NSW

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Acknowledgement

The AH&MRC Acknowledges the Traditional Owners of the lands on which the AH&MRC stands, the lands of the Bidjigal and Gadigal people of the Eora Nation. The AH&MRC pays respect to Elders past, present and Emerging.

Background

The Coroners Court of NSW processes and investigates certain types of deaths, including deaths in custody. The coroner's role is to understand how death occurred through gathering evidence and undertaking formal investigations or inquests. Coroners may make recommendations based on the findings of these inquests to improve public health and safety. However, there is no requirement for governments agencies to adopt recommendations.

Aboriginal deaths in custody occur at unprecedented rates across the criminal justice system and overrepresented in almost every category of death presented to the NSW Coroners Court. Since the 1991 Royal Commission into Aboriginal deaths in custody (RCIADIC) report was released, 474 Aboriginal and Torres Strait Islander people have died in custody. In addition, 29% of the prison population comprises Aboriginal and Torres Strait Islander people despite making up only 3% of the general population.1 This is more than double the rate since the Royal Commission report was handed down. Despite numerous recommendations made to the public sector, there has been a lack of coordinated effort to address these issues.

The Select Committee on the Coronial Jurisdiction in NSW came days after the Parliamentary Inquiry into “the high level of First Nations people in custody and oversight and review of deaths in custody”, which recommended a complete review of coronial jurisdiction. The coroner's court plays a significant role in this space as it is the investigative body for deaths in custody and, as such, can have an enormous impact on providing justice to Aboriginal families who must engage with this system.2

The Coroners Court has not been enabled to act as an effective prevention mechanism for Aboriginal deaths in custody. This is due to several system and operational level issues relating to the scope of the coroner's court impacting the capacity for coroners to comment on the quality of care and safety of people before death, lack of appropriate resourcing causing delays and inadequate accountability measures for government agencies to implement recommendations.

Summary

Aboriginal and Torres Strait Islander people continue to be imprisoned at alarming levels in NSW. Of the 339 recommendations handed down through the RCIADIC, only 64% were fully implemented.3 The number of Indigenous people being incarcerated has been steadily increasing, with Aboriginal people more than 13 times more likely to be imprisoned than non- Indigenous people.4 Given the alarming rate of both incarceration and death in custody, there are questions about the level of treatment and healthcare provided to Aboriginal people in the custodial setting. Aboriginal people are currently at greater risk of dying in custody. As a result, the coronial jurisdiction plays a vital role in investigating Aboriginal deaths in custody and acting as a prevention mechanism for future loss of life.

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[1] National and state information about adult prisoners and community based corrections, media release, Australian Bureau of Statistics.

[2] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2602/Report%20No%201%20-%20First%20Nations%20People%20in%20Custody%20and%20Oversight%20and%20Review%20of%20Deaths%20in%20Custody.pdf

[3] https://apo.org.au/sites/default/files/resource-files/2018-10/apo-nid198656.pdf

[4] https://www.theguardian.com/australia-news/2021/apr/09/the-facts-about-australias-rising-toll-of-indigenous-deaths-in-custody

Coroners are to make death prevention recommendations upon the resolution of an inquest. However, significant system, structural and operational level issues impact the coroners from

performing optimally whilst investigating Aboriginal deaths in custody. Of these issues, the AH&MRC has identified the following areas of concern related to the NSW Coroners Court:

1. The limited scope of the NSW Coroners Court to adequately investigate systemic issues surrounding Aboriginal deaths in custody.
2. Institutional neglect and racism are leading to delay in healthcare and substandard level of care in custodial settings.
3. Poor resourcing and timeliness constraints is impacting the ability of the Coroners Court to adequately investigate Aboriginal deaths in custody.
4. Lack of culturally appropriate processes and Aboriginal representation in the coronial system to support bereaved families.

The modernisation of the coronial jurisdiction must be undertaken to ensure that the wellbeing of Aboriginal families is supported. Changes to the legislative framework and procedural settings that coroners work within must occur to enhance the NSW Coroners Court's effectiveness and reduce future loss of life in the Aboriginal community.

About the AH&MRC

The AH&MRC, formerly the Aboriginal Health Resource Co-op (AHRC), was established in 1985 following a recommendation of the Brereton Report by the NSW Aboriginal Task Force on Aboriginal Health in 1982-83.

The AH&MRC assists the ACCHO Sector across NSW to ensure they have access to an adequately resourced and skilled workforce to provide high-quality health care services for Aboriginal communities.

As the Peak Body for Aboriginal Health in NSW, the AH&MRC represents the rights and interests of 47 Member Services. The AH&MRC is committed to the delivery of four key priorities. These are:

- Aboriginal Community Control and Innovation
- Education and Workforce
- Research and Data
- Governance and Finance

The AH&MRC works collaboratively with the ACCHO Sector across NSW to ensure accessibility, sustainability and adequate resourcing of a skilled workforce providing comprehensive primary health care services for Aboriginal communities.

Opportunity to review

The AH&MRC would like to thank the Select Committee for the opportunity to provide a submission for this important review. The AH&MRC has consulted the AH&MRC Policy Advisory Group made up of Chief Executive Officers of our 47 Member Services and internal staff with expertise in this area to inform this review.

AH&MRC response

The coronial jurisdiction in NSW has a responsibility to respond to the needs of Aboriginal families and communities. Despite the important work done by NSW coroners, there are significant concerns related to the scope, limits and resourcing of the NSW coronial system that poorly impacts Aboriginal people and their families. There are broader structural issues that underpin the coronial system and its role in Aboriginal incarceration rates. The NSW Coroners Court forms part of the NSW Local Court, making up both the criminal court and the body for coronial investigations. As noted in the 'High Level of First Nation Peoples in Custody' report, this system was identified as a considerable design flaw given only a small number of magistrates work exclusively as coroners. Overall, it compounds an under-resourced system with competing priorities and principles that can impact the development of specialist skills required for coronial work across regional and metro areas. The AH&MRC acknowledges the high-quality work of state coroners in undertaking investigations; however, operational and design flaws significantly impact the capacity of the actors of the coronial system to adequately investigate Aboriginal deaths in custody.

Given that Aboriginal people are overrepresented in our prisons, it is important to understand broad system-level mechanisms that perpetuate this issue. As a result, achieving parity with the National Closing the Gap Agreement is a central pillar to reducing prison rates and preventing Aboriginal deaths in custody.

1 The limitations of the scope of the coronial jurisdiction in NSW creates inadequacies in investigating the full scale of systemic issues relating to Aboriginal deaths in custody.

The scope of coronial jurisdiction impacts the effectiveness of inquests in addressing the needs of Aboriginal people and communities. Limitations in the scope of the NSW Coroners Court has led to gaps in formalising conclusions relating to deaths in custody. The current legislative framework for coronial inquests has not enabled coroners to fully comment on prisoners' quality of health care and safety before their deaths.5 This is a significant oversight given that Aboriginal people in custody receive substandard health care compounded by institutional and interpersonal racism. The ongoing effects of colonisation has led to complex social and health issues that drive the disproportionate rate of Indigenous incarceration in our prisons. As such, the experiences of Aboriginal people within the criminal justice system is inherently underscored by a history of colonialism and dispossession.

The 2017 Pathways to Justice Inquiry developed by the Australian Law Reform Commission set out the key drivers of incarceration rates of Aboriginal and Torres Strait Islander people stemming from a history of colonisation. Socioeconomic factors such as housing, employment, education, and health status play a significant role in alcohol and drug use, leaving people vulnerable to incarceration.6 This sentiment was mirrored in the RCIADIC, which set out multiple recommendations to address underlying systemic issues that drive the over-representation of Aboriginal people in the criminal justice system.

Systemic issues relating to institutional racism, neglect and access to healthcare does not disappear once an Aboriginal person is incarcerated. Instead, these issues are further compounded in an environment structured as a place of punishment over rehabilitation. The NSW Coroners Court must have the scope to comment on how Aboriginal deaths in custody have occurred due to inadequate healthcare and self-harm, exacerbated by institutional neglect. Leading on from the AH&MRC's NSW Audit Office - Access to health services in custody submission, Aboriginal people are systemically failed whilst transitioning in and out of the custodial setting. Many Aboriginal people entering the criminal justice system are entering with complex health needs that go unaddressed. The AH&MRC has received reports that custodial officers are withholding medications and clinical management of health conditions. Further reporting by the Guardian has suggested that Indigenous prisoners are three times less likely to receive medical care in a custodial setting than others.7 Racism and neglect underscore the experiences of many Aboriginal people held within the custodial system. 30 years on since the RCIADIC was released, and little has changed from the racist attitudes and assumptions that drive this divide.

[5] https://humanrights.gov.au/our-work/indigenous-deaths-custody-part-c-profiles-analysis.
[6] https://www.alrc.gov.au/publication/pathways-to-justice-inquiry-into-the-incarceration-rate-of-aboriginal-and- torres-strait-islander-peoples-alrc-report-133/executive-summary-15/disproportionate-incarceration-rate/#_ftn4

Coronial reporting in NSW should be enabled to undertake a full investigation and comment around the systemic issues and drivers at play when a death in custody occurs. The Legislative Council's report on the High Level of First Nations people in custody and oversight and review of deaths in custody recommended that NSW Government should amend the Coroners Acts 2009 to ensure that coroners thoroughly examine the systemic issues related to a death in custody, an amendment that the AH&MRC supports.8

2 Resourcing and timeliness constraints during coronial investigations have significant impacts on the efficiencies of investigations and the wellbeing of Aboriginal families

The resourcing and timeliness of coronial inquests have been flagged as a significant barrier that disproportionately impacts, Aboriginal families. The NSW Coroners Court plays a vital role in investigating deaths in custody and can have a significant impact on bereaved Aboriginal families throughout the investigative process. It has been reported that under-resourcing of the coronial system has led to long delays and a growing backlog of mandatory inquests. This is hugely problematic given the negative flow-on effect for families forced to engage with a complex and, at times, culturally unsafe system. This is not only prolonging the trauma and grief for families but impacts the quality in which inquests are undertaken. In the instance of significant resource constraints, the coroner's court must compromise on the efficiencies of the system, including support offered to families. Information regarding the deceased family member has not been adequately provided to families. Aboriginal families are systemically left behind in a highly bureaucratic environment that compounds grief and suffering in addition to ongoing dispossession.

Further to this, delays and timeliness issues have led to inquests taking considerable time to conclude, particularly while investigating deaths in custody. The 'High Level of First Nation People in Custody' report outlined that coronial inquests can commonly take years to resolve from the point of commencement to resolution in NSW. Many inquests related to deaths in custody do not begin until two or three years after the person has died. It is important to note that this delay can compromise the quality of evidence and any recommendations to be beneficial. It was explicitly noted that resourcing contributes to poor compliance with practice notes as they are implemented. In 2018 a coronial practice note was introduced to address the timeliness of inquests to police operations deaths. The practice note recognised the impact of coronial proceedings on families and the need to promote efficiencies within coronial processes.9 However, without the provision of additional resourcing, it is unlikely that this can be meaningfully implemented.

Based on the latest report by the NSW State Coroner, there were 94 outstanding deaths in custody inquests at the end of 2019, with 91 of these cases a matter of death in prison custody.10 This is not just an issue of operation but has significant flow-on effects for Aboriginal families who are often left to make repeated requests for information that go unheard. The coronial jurisdiction must consider the needs of Aboriginal families and the growing dissonance against the NSW coronial system. The NSW State Coroner, Teresa O'Sullivan, released a statement urging a strong need for services within this setting that are culturally appropriate and safe.11 While it should be acknowledged that based on this statement, two Aboriginal-Identified positions were established to support families, more must be done to enhance the presence of Aboriginal people during coronial inquests. The coroner's court is situated to prevent future loss of life but is not adequately enabled to act as an effective prevention mechanism for Aboriginal families.

[7] https://www.bbc.com/news/world-australia-56728328

[8] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2602/Report%20No%201%20-%20First%20Nations%20People%20in%20Custody%20and%20Oversight%20and%20Review%20of%20Deaths%20i n%20Custody.pdf

[9] https://www.judcom.nsw.gov.au/publications/benchbks/local/practice_note_coroners_1.html

[10] https://www.legalaid.nsw.gov.au/_data/assets/pdf_file/0019/41509/200709-Legal-Aid-NSW-submission-First- Nations-people-in-custody.pdf

Recommendations

The AH&MRC proposes two recommendations:

1. The NSW Coroners Court must be better resourced to ensure thorough and timely inquests are undertaken. The Coroners scope must be reviewed to comment where questions are surrounding the healthcare received by people in custody.
2. The NSW Coroners Court must be reviewed for cultural competence, including but not limited to the inclusion of an Aboriginal advisory body, recognition of common practice cultural principles relating to dealing with the death of an Aboriginal person and the increased employment of Aboriginal people in senior roles within the NSW Coroners Court.

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[11] https://www.parliament.nsw.gov.au/lcdocs/other/15413/Letter%20-%20NSW%20State%20Coroner%20-%20received%2024%20March.pdf