The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line

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Abstract

This article explains the way that Australian coroners' courts often fail Aboriginal and Torres Strait Islander peoples. We discuss the gap between the expectations of families of the deceased and the realities of the process of the coroner's court. The discussion is illustrated with reference to real-life examples, drawn from the authors' experiences representing the families of the deceased.

Keywords

Coronial; inquest; death; Australia; Indigenous; Aboriginal.

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Introduction

Well-functioning coroners' courts not only serve as important tools to hold our governments and their officials accountable, but they also have the power to drive reform and play a therapeutic role for the families of the deceased and their communities. Sadly, the traditional approach taken by most Australian coroners' courts, which focuses on the narrow cause and manner of death, is failing Aboriginal and Torres Strait Islander peoples on both counts. By and large, the families of the deceased want justice through the identification of wrongdoers and by holding them accountable and they demand systemic change and/or law reform to prevent similar deaths in the future. Despite recommendations made almost 30 years ago by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) for coronial inquests to take on this broader scope, most coroners have not embraced the recommendations in practice.

Not only are the families and kin networks of deceased Aboriginal and Torres Strait Islander people being let down by the coronial system, it often inflicts its own special form of harm on them. Families seeking redress against acts of state violence—such as the death in custody of a loved one—can find themselves re-traumatised by a coronial system, which they feel does not listen to them, does not respect their culture and fails to address their demands for accountability and systemic reform. Those failures can be viewed as further perpetuating a form of state violence.

The authors are practitioners and advocates who work with families who have lost relatives in health care, inside prisons and at the hands of police. There has been relatively little academic attention paid to the functioning of coroners' courts in Australia, and the experience of First Nations peoples in those processes remains under-studied.[1] We share these insights from the field and our research to foster critical scholarship and law reform projects aligned to the interests of Aboriginal and Torres Strait Islander peoples who routinely encounter these systems of death review.

The article begins by situating Australia's coronial system in the context of a colonial legal system that was imposed on Aboriginal and Torres Strait Islander peoples. We then provide some background on the history of the coronial system and how it operates today in Australia. Next, we outline three areas in which the current system is failing Aboriginal and Torres Strait Islander families. First, we examine the structural and practical impediments to the effective participation of family and community members in inquests. Second, we critique the overly adversarial nature of the process. Third, we explore the ramifications of the reluctance to apportion blame or make recommendations for systemic change. We conclude with recommendations on how the system can be reformed. The purpose is not to examine the law in detail[2] but to identify the shortcomings of the lived experience of the law and how this can be improved.

Australia's Settler Legal System

Australia's coronial inquest system must be viewed in the context of a colonial legal system that is imposed on the lives and bodies of Aboriginal and Torres Strait Islander peoples. It not only governs them, but it also governs how they are described and understood. Inquests are not held in isolation from the general legal system and must be understood in terms of the institutional baggage they carry for Aboriginal and Torres Strait Islander peoples. Coronial inquests are an alien concept to Indigenous peoples:

> Indigenous programs [and systems] start with the collective Indigenous experience. Inevitably that involves an understanding of the collective harms and outcomes of colonisation, the loss of lands, the disruptions to culture, the changing of traditional roles of men and women, and the collective loss and sorrow of the forced removals of children. (Cunneen 2011: 322)

Inquests do not meet that aspirations or the basic needs of Aboriginal and Torres Strait Islander peoples. Instead, we argue that they are part of a broader claim of legalistic impunity for Aboriginal and Torres Strait Islander death. Eualeyai and Kamilaroi woman, Professor Larissa Behrendt articulates this as she writes about the colonial justice system in the following terms:

> The law concludes with a seemingly frustrated shrug that what is morally wrong is not always legally wrong. There are, as these cases bear out, lawyers' tricks to stop justice—definitions, intent, proof, evidence. Narrow formulations of questions facilitate the avoidance of the context and effects of legislation.
>
> This […] façade of neutrality, has also meant that expressions from an Indigenous point of view are sidelined. […] What seems to be more important from the Indigenous perspectives are the effects of the actions of the government—these actions have amounted to damage to Indigenous people, families and communities and they choose to use the word 'genocide' to describe it. This moves the discussion outside of the words of the statute to the side-effects and legacies of those sanctioned actions. (Behrendt 2001: 142)

This impunity relies on the kind of legal neutrality that retells the stories of Indigenous realities in its own terms, incentivising particular forms of participation from Aboriginal and Torres Strait Islander parties, writes Tanganekald and Meintangk woman Irene Watson:

> Australia like other colonising states has been successful in building a white nation, one based on our exclusion and inclusion. Inclusion occurs when our level of whiteness blends with their own. In saying this I am not speaking of a desire for inclusion, but of the failed acknowledgment of our existence and our laws. The power of the state to exclude or to make invisible is a universal phenomenon experienced by other colonised peoples. (Watson 2002: 263)

Watson's observations echo what Aboriginal and Torres Strait Islander activists have observed in the inquest system—that the system is complicit in their loved one's suffering and it tends to refuse a critical narrative of deaths in custody. Families and communities who have lost family members 'inside' often share these insights into how the death review system operates, but they are not always taken seriously by coronial research:

> It's traumatising yes, but it still needs to be put out there … They can't hurt us anymore, but they can traumatise us more by still holding back the truth … There will never be any justice unless there is truth and accountability. (Shaun Harris, quoted in Deathscapes 2017)
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> I'd feel a lot more confident if there wasn't a police officer investigating my mum's death and if that police officer had actually obtained all the footage, which hasn't happened. There are pieces of the truth that we will never know. (Apryl Watson, quoted in Wahlquist 2019: para. 33)
>
> I would love us to be the last family to have to deal with this. But let's be honest. The system hasn't changed in 30-odd years. It's not going to change overnight, but we want to do our best. (Belinda Stevens, quoted in Wahlquist 2019: para. 35)
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> 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. (Uncle Sam Watson, Sydney Morning Herald 2007: para. 12)

Background to the Coronial Inquest System in Australia

The office of the Coroner traces its origins to 1194. In the English legal system, it is only predated by the Sheriff's office. Initially, the Coroner's duties related to keeping the King's records and collecting his revenue. Modern coroners have quite a different role. They investigate deaths, and each Australian state

and territory has its own laws governing the powers and the role of the Coroner's Court. This article does not focus on the differences in the laws,[3] but rather the general experiences of Aboriginal and Torres Strait Islander peoples who interact with Australian coroners' courts.

Broadly speaking, coroners' courts are magistrate-level specialist courts, which are often physically attached to institutes of forensic medicine (as is the case in Melbourne and Sydney). Coroners, the judges who oversee the jurisdiction, are arranged by seniority from the State/Territory Coroner, to the Deputy State/Territory Coroner, to generalist coroners and to generalist magistrates who can attend to some local matters by referral. As a rule, deaths in custody and more complex cases are overseen by either the State or the Deputy State Coroner.

Coroners' courts are inquisitorial and they are not supposed to operate in an adversarial manner. This is a character they share with other commissions of inquiry, such as Royal Commissions and the Independent Commission against Corruption. The primary purpose of a coroner's court is to answer questions about how a death occurred and how it might be prevented. It does not determine criminal or civil liability. In fact, coroners are barred from making any direct findings or remarks about criminal or civil liability. However, they can (and in some states, must) refer individuals to prosecutors or disciplinary bodies if there is sufficient evidence that an offence has been committed or that professional standards have been breached. As we discuss below, this is very uncommon in practice.

When is an Inquest Required?

The RCIADIC noted the importance of post-death inquiries and made 34 recommendations for reforming the coronial system (RCIADIC 1991). While many recommendations have not been acted on, most jurisdictions have implemented the key recommendation that inquests should be mandatory where individuals die in police custody, prison and youth detention (Amnesty International and Clayton Utz 2015). Whilst changes have been made in law to allow coroners to investigate deaths in custody, the legislative changes do not reflect the systemic reviews that were envisaged in the RCIADIC recommendations. Coroners have close to absolute discretion to hold inquests referred to them where a death is not in custody or otherwise reportable.

The Role of Counsel Assisting, Procedures and Scope

Once an inquest is underway, coroners are guided in their inquiry by a Counsel Assisting. The ordinary rules of evidence are dispensed with at an inquest (most significantly, the rule of hearsay). However, procedural fairness rules apply, and protections are afforded for the compulsion of evidence that may incriminate a witness. The inquisitorial nature of the Coroner's Court means that coroners can ask questions themselves and can ask for evidence to be made available. Interested parties, such as the next of kin, have standing at the inquest, with human rights and community groups sometimes seeking leave to appear and interrogate witnesses, but they do not control what evidence is called. It is not uncommon for inquests to have close to a dozen interested parties representing individuals, organisations, families and government institutions.

Once an inquest has been called, coroners usually define the limits or scope of the subject matter of the inquest through a series of early interlocutory court hearings. Questions and evidence that stray from the scope of the inquest, and accordingly, from the relevant inquiry are disallowed. The scope of the inquest is principally confined to the cause and manner of death. Recently, some coroners have permitted the issue of systemic racism in the treatment of Aboriginal and Torres Strait Islander peoples, notably women, to be canvassed (e.g., *Inquest into the Death of Naomi Williams* 2019; *Inquest into the Death of Tanya Day* 2020). These cases represent a cultural shift in the Coroner's Court, mostly among those in the eastern states, to expand the scope to invite a race-critical analysis of morbidity and mortality. However, most coroners still tend to confine their inquiry to the cause of death, rather than to the manner, and they tend to avoid systemic issues such as systemic racism and neglect (*Inquest into the Death of Jayden Stafford Bennell* 2017).

Suppression Orders

During the inquest, coroners are commonly asked to issue suppression or non-publication orders for sensitive material, including the identities of interested persons and suicide methods. While the rules vary among states, coroners' courts are not courts of record and are subject to their own internal procedures on suppression and non-publication orders—fusing the open justice principles governing most suppression orders with the theoretically therapeutic mandate of the Coroner. Media and families can, and sometimes do, apply to release brief evidence or footage pertaining to the death (notably in the inquests into the deaths of Ms Dhu, David Dungay Jr and Aunty Tanya Day). These applications are often unsuccessful because of a high degree of Coronial discretion and a perception that families must be protected and the deceased are best dignified through privacy. A view that state actors are vulnerable if identifiable and conflicts within represented parties (like families) about what footage should be made public also contribute to this.

Findings, Recommendations and their Implementation

Coroners issue their findings and recommendations at the conclusion of the inquest. Depending on the state or territory, they may also issue other formal particulars about the death, such as the deceased's Indigenous status. Recommendations are limited to the scope of the inquest and are poised to answer preventative questions in the death that is the subject of the inquiry. In most states and territories, there is no obligation on the agencies to which the recommendation is made to heed or even respond to the recommendation.

Aboriginal Deaths in Custody and the Role of the RCIADIC's Recommendations

First Nations activists and advocates have coordinated an enduring movement against police and carceral violence against Indigenous peoples. Most recently, thousands took to the streets across Australia as part of the Black Lives Matter protests, rallying against First Nations deaths in custody. Other impactful recent campaigns emerged in response to prominent deaths like those of John Pat, TJ Hickey, Mulrunji Doomagee and Ms Dhu, and inquests into the circumstances of their deaths. What united each campaign, and the early movement that precipitated the early Aboriginal Deaths in Custody Watch Committee and the Committee to Defend Black Rights (Luckhurst 2006), was a cogent theory of change through culpability and accountability of state institutions or individuals. What was necessary, the campaigns put it, was at least an independent investigating body. This came from suspicion of the internal police investigations and infrequent coronial inquests, which appeared to permit collusion between police witnesses, exclude communities from participation and mask police violence.

Matters came to a head after the inquest into the death of Lloyd James Boney in 1987 concluded that his death was by suicide caused by ligature compression of the neck (he had been violently arrested 90 minutes prior while intoxicated). A public outcry prompted the Australian Government to establish the RCIADIC. The RCIADIC examined 99 Indigenous deaths in custody from the previous decade and issued 339 recommendations—from custodial health and safety to imprisonment as a last resort, and Indigenous self-determination, including a suite of 35 recommendations on post-death investigations.

The implementation of the recommendations has been patchy at best. Amnesty International Australia and Clayton Utz published a review in 2015 that concluded that most RCIADIC recommendations remained unimplemented, in what they referred to as a 'categoric fail[ure]' of state, territory and federal governments (Amnesty International and Clayton Utz 2015). In 2018, the Federal Government funded Deloitte Access Economics to monitor the RCIADIC's recommendations and their implementation. That review concluded that all but six per cent of the recommendations had been implemented or partially implemented (Deloitte Access Economics 2018). However, this assessment has been vigorously disputed by independent observers and researchers. They have argued that the implementation rate is substantially lower than what the Deloitte Access Economics report claimed and that the recommendations are qualitative and not easily quantified. A group of 33 academic and professional experts directly responded

to the report, stating their concern with the 'scope … methodology … and the substantive findings of the review' (Jordan et al. 2018: 1). They went on to say:

> At the time of writing this response … there are 14 Aboriginal deaths in custody awaiting a coronial hearing or findings in Victoria, South Australia, New South Wales, Western Australia, Queensland and the Northern Territory. These include deaths that occurred where Aboriginal women were incarcerated due to intoxication, Aboriginal men were denied adequate health care, and Aboriginal young people were on remand. All these circumstances are contrary to the recommendations of RCIADIC.

Since the RCIADIC, it is estimated that over 430 Indigenous people have died in custody (Allam, Wahlquist and Evershed 2020)—this represents a higher rate per the Aboriginal and Torres Strait Islander population than before the commission handed down its reports in 1991.

Key Failings of the Current System in Practice

In this section, we draw on our firsthand experience representing family members of deceased Aboriginal and Torres Strait Islander women and men who had died in custody to identify and explore three areas in which the current coronial inquest system is letting them down. First, we examine the barriers to family participation. We then critique the overly adversarial nature of proceedings, and finally, we examine the reluctance of coroners to apportion blame or make recommendations for systemic change.

Family Participation

Coroners' courts appear to encourage a façade of family participation—lamenting in findings when families have declined to participate (Whittaker 2018). While family members are encouraged to participate in the coronial system, their interventions are generally restricted to narratives about their loved one's life, rather than the cause or circumstances of their death. Given that the focus of the family members is usually on getting answers and their desire for accountability, stifling their meaningful intervention on those issues marginalises them. It adds to the perception that they are not being heard. It shuts out Indigenous participation in the storytelling of Indigenous death by making families authorities only on sentiment rather than substance, where they most urgently wish to be heard. Families who do attempt to intervene on narratives and findings surrounding the death of their loved ones find themselves subject to coronial scorn.

For example, in the inquest into the death of Robert Bropho, 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' (*Inquest into the Death of Robert Bropho* 2013: 12). Coroner King suggested, 'if there was any substance to the deceased's complaints … they would have been investigated and the results of the investigations attached to the Department's offender management file' (*Inquest into the Death of Robert Bropho* 2013: 13). These observations confirm the preference of the courts for state documentation over the testimony of family members of the deceased when considering state culpability. Moreover, Coroner King made the demeaning finding that the 'difficult and demanding' Bropho 'cried wolf' to 'elicit … attention' from his family (*Inquest into the Death of Robert Bropho* 2013: 15).

Existing approaches to including families in the process appear to be more about providing a veneer of moral endorsement to the inquest than addressing the more fundamental question posed by Aboriginal and Torres Strait Islander communities about state impunity (Whittaker 2018). Far from engaging families in their quest for justice, existing coronial practices often create new sites of trauma.

A lack of resources and support services also hamper family and kin network engagement in the coronial system. Free and low-cost legal resources for inquests are few and strained. Legal Aid NSW, for instance, has only two solicitor advocates in their inquest unit. Most Aboriginal Legal Services do not have a

dedicated inquest practice. However, they do offer their services to Aboriginal and Torres Strait Islander clients or families of an Indigenous person who has died in custody. There are no clear procedures on how to obtain or even refer under-resourced families to coronial legal services or whom to approach. A lack of specialised practitioners operating in community legal centres, Legal Aid or Aboriginal Legal Services means that these services lack vital institutional knowledge for a unique jurisdiction or a shared strategic model for how to engage it. Organisations, such as the National Justice Project, do offer such specialised knowledge in selected cases. However, their service offering remains ad hoc, focused on strategic cases, and their limited capacity cannot meet the volume of cases that even overwhelms the coroners' courts.

Many Aboriginal and Torres Strait Islander families feel marginalised and excluded from the coronial process because of a lack of cultural sensitivity, a lack of institutional transparency and dissonance between the families' demands for justice and the statutory limits of the courts. Inquests ask a lot of family and community members, without offering much in return for their significant work under deep bereavement. This is particularly pronounced whenever there is a failure of a court or a coroner to accommodate cultural and religious concerns about the treatment of bodies of the deceased. Bodies are often subjected to an autopsy before the family can see the deceased or make decisions about them. Body parts, such as brains, sometimes need to be separated from bodies for forensic testing, and this can be traumatising for those families who seek to exert a religious or cultural authority to refuse an autopsy or require a more timely burial.

Coroners' courts in eastern states have recently made some concessions to Aboriginal and Torres Strait Islander families, kin networks and community groups who have worked for a more culturally secure treatment of their loved ones — such as allow them to participate in smoking ceremonies, conducting ceremonies and dances (Davidson 2019), demanding respectful treatment of evidence and exhibits in the process, changing hearing dates to accommodate Sorry Business (e.g., *Inquest into the Death of Naomi Williams* 2019). Some coroners have also accommodated the inclusion of objects of cultural, familial and personal significance in the court architecture—such as leaving sand from Dhungalla in front of the bench at the inquest into the death of Aunty Tanya Day to 'carry her footsteps' (McKinnon et al. 2019). Although these are welcome and necessary steps, coroners consider them supplementary to their jurisdiction and therefore outside of their substantive investigation. These practices do not amend a coroner's statutory, procedural or collegiate obligations to which Indigenous communities and families have so cogently objected for decades.

Coroners' courts often struggle with the plurality of personal and kinship interests that Aboriginal and Torres Strait Islander families hold, with a tendency to treat them as an essentialist and united unit. This has most publicly surfaced in the challenging of non-publication orders concerning the release of evidence on the deceased's final moments, as occurred in the inquests into the deaths of Yamatji woman Ms Dhu (Wahlquist 2016) and Dhungutti man David Dungay Jr (Mitchell 2018). In both inquests, families were split on this question and sought to arbitrate or advance distinct social and cultural concerns with how their loved ones will be exhibited in a public testament to their death. While these have been negotiated with sensitivity by those family members, the structure of the Coroner's Court leaves little room for what may be a necessary and private tension in bereavement.

Adversarial Nature

While coronial proceedings are ostensibly inquisitorial, they are increasingly run in an adversarial manner. The result is that families feel like they are on trial and that the process is more about suppressing their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice. The coroners' courts in every state and territory are formally inquisitorial forums. They are, as a general principle, not concerned with adjudicating disputes, causes of action or prosecutions, but to determine the cause and manner of a death and offer recommendations—an end to which those involved in a coronial inquiry are expected to contribute. But the parties engage with the process in line with their interests and strategies under the guidance of practitioners who are not commonly trained in the coronial jurisdiction, and this often gives rise to an adversarial mindset.

Moreover, when inquest findings might expose individuals or organisations to a civil or criminal penalty, coroners apply the Briginshaw standard when considering the evidence. This standard requires a higher degree of persuasion than otherwise applies in the coronial setting and makes controversial findings difficult when there are significant matters in dispute. Hence, while inquests are free from the ordinary rules of evidence (apart from procedural fairness), in deaths in custody matters where individual and institutional consequences in regulation, crime and insurance are at stake, the net and degree of formality tighten (Whittaker 2018).

The disparity between state and family resources for inquests is also significant. In a recent case, the family of Gomeroi man Tane Chatfield, were forced to fundraise for inquest attendance (Justice for Tane Chatfield, 2019).[4] When families are from remote, rural and regional communities, these expenses include accommodation and transport for often-lengthy inquests and often-large groups.

Families also find themselves outgunned not only by the quality of counsel but also by their quantity. State parties, both as institutions (police, corrections, hospitals) and individuals (police officers, corrections officers, doctors), are numerous and well-heeled. For example, consider the inquest into the death of Ms Dhu. After being arrested for outstanding fines, Ms Dhu died over three days in a police lock-up. She died in agony due to an untreated infection in her broken ribs after police were called to a family violence incident in which she was injured. Ms Dhu was repeatedly taken to a hospital, where after only perfunctory examinations, it was concluded that she was not suffering from a physical ailment. As a consequence she was discharged back into custody. At the inquest, Ms Dhu's family was represented by one Senior Counsel and two juniors (one acting separately for Ms Dhu's father). The family faced 11 lawyers acting for 29 interested persons and organisations, two of which were state parties. The polycentrism of proceedings, wherein up to a dozen actors each shift blame and liability somewhere else and enjoy heightened evidentiary standards, often means that the only valve for blame, even informal storytelling blame, lands on the deceased.

Worse than adversarial—to families so locked out of the process—the proceedings look biased, even insurmountably weighted against them. As Caroline Andersen, mother of Wiradjuri Kookatha and Wirangu man Wayne Fella Morrison (whose death in custody is currently pending findings) expressed to NITV News: 'I feel like I'm on trial. I'm his mum, you know what I mean? I feel pressure. My parenting skills. How I raised him. It's like I'm on trial for their lack of care' (Kurmelovs 2018). That one is 'on trial' is a common refrain among families who experience the inquest process and who sometimes become witnesses themselves—like the mother of Ms Dhu, who was cross-examined about whether her daughter was injured by an act of domestic violence (*Inquest into the Death of Ms Dhu* 2016).

Apportioning Blame and Failure to Address Wider Issues

Some coroners are reluctant to directly apportion blame for a death to a particular individual or to address issues of systemic racism. This is often disappointing for family members, who rightly view such findings as central to the purpose of coronial proceedings. In terms of individual culpability, as discussed, coroners have the power (and in some states a duty) to refer individuals to prosecutors on disciplinary bodies if there is sufficient evidence that an offence has been committed concerning a death. However, this rarely happens, and even when made, these findings are sometimes subsequently overturned. The inquest into the death of Mulrunji Doomagee is a telling example. Coroner Clements concluded that the death was the result of the deliberate actions of Queensland police officer, Senior Constable Chris Hurley (*Inquest into the Death of Mulrunji [No 1]* 2006). This was based on evidence uncovered during the investigation, including other documented instances where Senior Constable Hurley had been violent towards Aboriginal and Torres Strait Islander persons. Following Hurley's acquittal for the manslaughter of Mr Doomagee, the coronial findings were overturned by the Queensland Supreme Court. A new coroner oversaw new findings into the death. The strong findings of wrongdoing by Coroner Clements were replaced by new findings that there was not enough evidence to conclude that Officer Hurley intended to assault Mr Doomagee (*Inquest into the Death of Mulrunji [No 2]* 2010).

As discussed above, coroners frequently limit the scope and ambit of inquests to identifying the immediate cause and nature of the death, which frustrates the next of kin, families and community members who want the coroner to examine the wider and related circumstances that contributed to the death (Whittaker 2018). The need for a more expansive inquiry into Aboriginal deaths was highlighted in the RCIADIC's Recommendation 12, which advised that any coronial investigation of deaths in custody should include, as a matter of law, an investigation into the 'quality of the care, treatment and supervision of the deceased prior to death' (RCIADIC 1991). This recommendation has not been followed with adequate stringency. In South Australia, the legislation provides only that the 'causes and circumstances' of a death are to be examined (Coroners Act 2003 (SA): s 25(1)). Amnesty International observed that this means that there is no clear obligation to examine the quality of care, treatment and supervision where these are not directly related to the death (Amnesty International and Clayton Utz 2015: 40). In Victoria, New South Wales and Queensland, the power is discretionary (Coroners Act 2008 (Vic), s 67(3); Coroners Act 2009 (NSW), s 82; Coroners Act 2003 (Qld), s 46(1)).

Coroners often explicitly limit the ambit of the investigation and the questioning of witnesses to avoid broader systemic issues. For example, during the inquest into the death of Jayden Stafford Bennell in Western Australia, Coroner Linton ruled that the:

> questioning of witnesses, other than the lead police investigators, was generally to be limited to other relevant issues … [and] questioning directed towards any potential systemic issues and preventative comments/recommendations must relate to the particular circumstances of Jayden's death rather than extending into a broad-reaching inquiry into prison systems as a whole. (*Inquest into the Death of Jayden Stafford Bennell* 2017)

Coronial inquests often adopt a similarly 'narrow' approach to the potential scope of recommendations that can be made—and thus fail to address systemic failings that contribute to deaths. Recommendation 13 of the RCIADIC not only provided that coroners should be empowered to make 'recommendations as are deemed appropriate with a view to preventing further custodial deaths' but also that they should be enabled 'to make such recommendations on other matters as he or she deems appropriate' (RCIADIC 1991). The schemes in both the Northern Territory and Tasmania incorporate this recommendation, making such findings a mandatory requirement.[5] However, the power is discretionary in Western Australia (Coroners Act 1996 (WA) ss 22, 25(2)), New South Wales (Coroners Act 2009 (NSW) s 82), South Australia (Coroners Act 2003 (SA), ss 21(1)(a), 25), Victoria (Coroners Act 2008 (Vic) ss 67(3), 72(2)) and Queensland (Coroners Act 2003 (Qld) s 46(1)).

The former Western Australian State Coroner, Alistair Hope, took an expansive view of the Coroner's powers in the inquest into the death of Mr (Ian) Ward, endorsing the following quotation from Watterson, Brown and McKenzie (2008: 6):

> [The RCIADIC] provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous

> disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.

Unfortunately, Coroner Hope's approach of making findings on broader systemic issues is not being followed by his successors.

The findings of the recent inquest into the death of Ms Dhu illustrate the tendency towards narrow recommendations that avoid broader issues, even in the rare circumstances where systemic failings are identified. In her findings, Coroner Fogliani made multiple references to the RCIADIC. She highlighted persistent systemic failings in the criminal justice system that remain unremedied, particularly regarding jailing fine-defaulters—a causal factor in many of the death in custody cases in Western Australia (*Inquest into the Death of Ms Dhu* 2016: 785, 791–792). The Coroner endorsed the concept of 'institutional racism', defined in expert evidence by Professor Thompson as:

> societal patterns that have the net effect of imposing oppressive or otherwise negative conditions against identifiable groups on the basis of race or ethnicity. Institutional racism is manifested in our political and social institutions and can result in the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. (*Inquest into the Death of Ms Dhu* 2016: 857)

Despite findings that such institutional racism explained the racially biased conduct of police and medical staff without them necessarily being 'motivated by conscious deliberations of racism', and that this was a 'community-wide issue' requiring a 'seismic shift' in the collective cultural consciousness, no core recommendations were made to address such factors at an institutional level (*Inquest into the Death of Ms Dhu* 2016: 859–860). Instead, the Coroner limited her recommendations to improvements in the conditions and oversight of detention of Aboriginal and Torres Strait Islander peoples, including improving notification services, monitoring, cultural sensitivity training and higher staff levels at police lock-ups and in hospital emergency departments.

We see a similar approach in the inquest into the death of Jayden Stafford Bennell, with Coroner Linton explicitly refusing to make recommendations about the implementation of the RCIADIC or 'in relation to those broader issues relating to deaths in custody and the treatment, care and supervision of Aboriginal prisoners, that do not relate to the specific circumstances of Jayden's death' (*Inquest into the Death of Jayden Stafford Bennell* 2017: 59).

Even where strong recommendations are made, in most Australian jurisdictions there is no requirement that responsible agencies (like state health departments, corrective services, state police forces or local area commands) read and respond to them. Even in Victoria, where there is a duty to read recommendations and report on a response to them, this does not translate into the implementation of reforms proposed by the coroner. A 2014 study found that only one-third of recommendations received by Victorian agencies were accepted and implemented (Sutherland et al. 2014).

Recommendations and Conclusion

The coronial inquest system is failing Aboriginal and Torres Strait Islander families and communities. At times, it appears to Aboriginal and Torres Strait Islander peoples as indistinguishable from a review and policy arm of the systems these families and communities accuse of violence. Many of the solutions for 'fixing' the system are already known—in particular, the unimplemented recommendations of the RCIADIC and the calls for reform from families and communities who disproportionately experience inquests into deaths in custody.

The proposed solutions are designed to make the coronial process culturally safe for Aboriginal and Torres Strait Islander families and communities. We do not believe they are all-encompassing, but they reflect the

recommendations of the RCIADIC and the more recent demands for voice treaty and truth telling (The Uluru Statement from the Heart 2017).

The first and most crucial issue is to hear the voice of Aboriginal and Torres Strait Islander communities. One way would be to act on Recommendation 2 of the RCIADIC and establish independent Aboriginal Advisory Committees in each state and territory to advise on Aboriginal peoples' perceptions of criminal justice matters and the implementation of reforms.

The following additional reforms cannot address the broader colonial context of death review in a settler legal system. However, these reforms offer more transparency to families and communities and would mitigate some of the secondary and institutional trauma of the inquest for First Nations peoples. Specifically, we propose the following:

- Employing Aboriginal liaison officers in each jurisdiction who are trained in coronial practice to guide the coroner on Indigenous cultural practices and to guide Aboriginal and Torres Strait Islanders on coronial processes;
- Appointing Aboriginal and Torres Strait Islander coroners, counsel assisting and investigators with lived experience to undertake inquests into Aboriginal deaths in custody;
- Training forensic pathologists on Aboriginal and Torres Strait Islander peoples' cultural practices to do with bodies and how to respect those practices;
- Adequately funding Aboriginal and Torres Strait Islander legal services to represent the next of kin at inquests into the deaths of Aboriginal and Torres Strait Islander peoples or providing an experienced and well-resourced legal aid service;
- Amending the Coroners' Acts to require
    a) Coroners to make findings on whether the implementation of any, some or all RCIADIC recommendations could have reduced the risk of death in all cases where an Aboriginal or Torres Strait Islander person has died in custody, in or around a police action, or within 48 hours of attending or leaving a health facility or coming into contact with the police and
    b) Coroners to make recommendations to address any systemic problems that may be relevant to a death or the care and/or the treatment of an individual in the lead up to that death.

Moreover, the faith of family members in the coronial process and its ability to contribute to systemic change would be enhanced by implementing the following RCIADIC recommendations:

- Transferring investigative resources and authority over deaths in custody to an independent investigative body, away from police and corrections;
- Permitting Aboriginal and Torres Strait Islander peoples to view the body of the deceased if possible before tests are undertaken;
- Requiring annual reports to be laid before Parliament on all Aboriginal and Torres Strait Islander deaths in custody with all states and territories to report in a consistent manner to the Federal Parliament, so that outcomes can be compared and progress or lack thereof monitored.

Beyond the RCIADIC recommendations, further legal as well as simple practical changes to the way inquests are run could greatly enhance the engagement and participation of family members. This could be achieved by:

- Amending the Coroners' Acts to respect traditional Aboriginal and Torres Strait Islander kinship structures when granting leave for individuals to appear at coronial inquests to represent the interests of the deceased's family;

- Providing the next of kin of any Aboriginal or Torres Strait Islander person whose death is being investigated by the Coroner at an inquest with travel money and if required accommodation to attend the inquest hearing;
- Amending the Coroners' Acts to require that Aboriginal and Torres Strait Islander post-death practices are respected;
- Permitting activities such as a smoking ceremony or other ceremonies or cultural dances as part of an inquest process where an Aboriginal or Torres Strait Islander person has died;
- Allowing the family of a deceased Aboriginal or Torres Strait Islander person to perform an acknowledgement of country or a welcome to country as appropriate in the circumstances;
- Providing a private room of a suitable size for large families and supporters attending inquests into the death of an Aboriginal or Torres Strait Islander person;
- Amending the Coroners' Acts to mandate inquests where Aboriginal or Torres Strait Islander people die from acts of gender-based violence or unexpectedly in health care and to mandate *recommendations that seek to prevent future deaths and to address the impact of conscious or unconscious prejudice in similar circumstances.*

The changes we propose have the potential to transform the perception of coronial inquests among Aboriginal and Torres Strait Islander communities from a place that perpetuates state violence against participants to a forum that holds to account the perpetrators of state violence.

The RCIADIC recommended that the Coroner's role should expand to become a formal means to ensure proper public accountability and to provide a system of review that draws from the general experience gained from all inquests held into Aboriginal and Torres Strait Islander deaths. State and territory governments have been reluctant to grant coroners such broad powers or the budget to effectively conduct such a function. Consequently, Aboriginal and Torres Strait Islander families are often disappointed when they ask coroners to broaden the scope of their inquiries, to hold state actors accountable and to make recommendations for systemic reform.

It may be that the coroners' courts are not the appropriate jurisdiction to provide justice for Aboriginal and Torres Strait Islander peoples and to implement the RCIADIC recommendations regarding independent investigation. Perhaps an Indigenous-run investigative organisation might better meet the RCIADIC objectives? In reality, governments are reluctant to subject themselves to independent scrutiny given the cost and embarrassment that would flow from the far-reaching findings and recommendations of an unconstrained well-funded investigatory body that respected the cultural safety of the families of the subjects of its inquisitorial powers.

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[1] For notable exceptions to this, see among others Bray 2008; Watterson, Brown and McKenzie 2008; Whittaker 2018.
[2] For detailed coverage of the law in New South Wales, see Abernethy et al. 2010.
[3] For such a comparison, see Vines and McFarlane 2000.
[4] Justice for Tane Chatfield, 18 November 2019: https://au.gofundme.com/f/justice-for-tane-chatfield
[5] NT legislation provides that the Coroner must, as they consider relevant, make recommendations to prevent similar deaths and can make comment on 'public health or safety or the administration of justice' (Coroners Act 1993 (NT) ss 26(2), 34(2), 124). In Tasmania, the Coroner must make appropriate recommendations to enable future prevention of deaths, comment on matters relating to the care, supervision or treatment of a person while in custody and comment on further connected matters (Coroners Act 1995 (Tas) s 28).

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