ABORIGINAL LEGAL SERVICE OF WESTERN AUSTRALIA (INC.)

Submission to the Law Reform Commission of Western Australia

Review of Coronial Practice in Western Australia
Project No. 100

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Contents

1. Introduction and Scope of the Submission

The Aboriginal Legal Service of Western Australia (Inc.) (ALSWA) represents Aboriginal families, and occasionally the Aboriginal community, in Coronial Inquests. ALSWA is also a member of the Australian Inquest Alliance[1] and is involved in advocating for improvements to Coronial practices and procedures in Western Australia (WA).

ALSWA was consulted by the Law Reform Commission of Western Australia (LRCWA) in its preparation of the Background Paper into Project No 100, Review of Coronial Practice in WA. During the consultation, ALSWA raised several issues that have been included in the LRCWA's Background Paper.

ALSWA endorses the Background Paper and the issues it identifies for consideration in the development of the LRCWA's Discussion Paper on Project No 100. In this submission, ALSWA seeks to identify the areas included in the Background Paper that are considered by ALSWA to be most in need of reform. Additionally, ALSWA identifies further elements of Coronial practice in WA that may require consideration by the LRCWA and reform.

2. About ALSWA

ALSWA is a community based organisation that was established in 1973. ALSWA aims to empower Aboriginal peoples and advance their interests and aspirations through a comprehensive range of legal and support services throughout WA.

ALSWA aims to:

- deliver a comprehensive range of culturally-matched and quality legal services to Aboriginal peoples throughout WA;
- provide leadership which contributes to participation, empowerment and recognition of Aboriginal peoples as the Indigenous people of Australia;
- ensure that Government and Aboriginal peoples address the underlying issues that contribute to disadvantage on all social indicators, and implement the relevant recommendations arising from the Royal Commission into Aboriginal Deaths in Custody;[2] and
- create a positive and culturally-matched work environment by implementing efficient and effective practices and administration throughout ALSWA.

ALSWA uses the law and legal system to bring about social justice for Aboriginal peoples as a whole. ALSWA develops and uses strategies in areas of legal advice, legal representation, legal education, legal research, policy development and law reform.

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[1] The Australian Inquest Alliance consists of a growing number of organisation and individuals across State and Territory borders, including community legal centres, Aboriginal and Torres Strait Islander legal services, advocates for imprisoned men and women and academic researchers. The Alliance offers a significant depth of advocacy, research and social policy experience and expertise over many years. This knowledge encompasses coronial investigations, inquests and broader coronial frameworks across jurisdictional boundaries. The Alliance seels systemic change in order to eliminate and reduce preventable deaths. We believe that this requires each State and Territory to effectively address the structural issues underpinning preventable deaths.

[2] Royal Commission into Aboriginal Deaths in Custody (1991), available from http://www.austlii.edu.au/au/other/IndigLRes/rciadic/, 13 July 2010.

ALSWA is a representative body with 16 Executive Officers[3] elected by Aboriginal peoples from their local regions to speak for them on law and justice issues. ALSWA provides legal advice and representation to Aboriginal peoples in a wide range of practice areas including criminal law, civil law, family law, and human rights law. ALSWA also provides support services to prisoners and incarcerated juveniles. Our services are available throughout WA via 17 regional and remote offices and one head office in Perth.

3. Important issues identified in the Background Paper

ALSWA highlights the following issues identified in the LRCWA Background Paper as being most pressing and in need of reform:

- publication of coronial findings and recommendations, in a suitably confidential manner, to improve accountability while also respecting families' rights to privacy;
- creation of a mandatory reporting requirement for government and private organisations in response to coronial recommendations;
- improvements to administrative practices and procedures within the Coroner's Court to better engage with legal representatives to ensure that they are kept informed of developments in matters, receive briefs with adequate time to prepare cases and are consulted about listing dates to ensure availability;
- appointment of independent coronial investigators with impartiality and specialised skills, particularly to investigate deaths involving police and / or prisons or complicated medical issues;
- increased funding for organisations such as ALSWA to appear in coronial inquests to represent families or communities in matters of significant public interest; and
- improved resourcing of the coronial counselling service to make it more accessible to people in regional and remote parts of WA and enable coronial counsellors to develop better relationships with service providers in regional and remote areas to facilitate appropriate referrals for grief counselling and other support.

Some of these issues are discussed in greater detail below.

3.1 Publication of Coronial Findings

The Coroner's Court has a specific role in the judicial system: to investigate a particular death to identify contributing systemic problems or failures and provide recommendations to address them and avoid future deaths in similar circumstances. A significant quantity of time and resources are invested in coronial processes to achieve this aim. However, often after recommendations are provided by the Coroner, there is little ongoing advocacy to ensure that recommendations are considered and implemented. Where coronial recommendations are disregarded, it will often be to the detriment of the community.

[3] There are two Executive Officers for each of the former eight ATSIC regions (Metropolitan, Central Desert Region, Murchison/Gascoyne Region, Southern Region, Pilbara Region, Goldfields Region, West Kimberley Region and East Kimberley Region). They are elected by Aboriginal peoples every three years.

The role and function of the Coroner's Court does not currently extend to monitor consideration and implementation of its recommendations. The publication of Coroner's findings and recommendations will however enable other bodies, including government and non-government organisations (NGOs), to better perform an advocacy role to promote and monitor the implementation of coronial recommendations. Public availability of the Coroner's findings and recommendations will also enable analysis to be conducted of the historic failings of government departments or policy makers, which will be particularly valuable to counsel preparing for future inquests arising from similar circumstances as previous inquests.

It is noted however that coronial findings will by nature be very sensitive given their connection with deaths or suspected deaths. Therefore, it is imperative that public availability of coronial findings be carefully managed to minimise the suffering of families. Ultimately, ALSWA is of the view that the benefit gained from making coronial findings and recommendations publicly available is considerable and concerns could be adequately addressed by appropriate amendment to publically available coronial findings to protect families and their confidentiality.

Recommendation 1: ALSWA recommends that findings and recommendations from the Coroner's Court be publicly available following appropriate amendment to maintain confidentiality and sensitivity.

3.2 Mandatory Reporting Requirement

ALSWA supports the introduction of a system of mandatory reporting in response to coronial recommendations, for government and private bodies, to enhance the effectiveness of the preventative role of the Coroner's Court.

ALSWA has previously provided lengthy comment and recommendations in relation to amendments to the *Coroner's Act* 1996 (WA) to introduce a mandatory reporting requirement. ALSWA's position can be found at "Part 7. Amendments to the Coroner's Act 1996 (WA)" of its submission to the WA Legislative Council Standing Committee on Environmental and Public Affairs in relation to the Inquiry into the transportation of detained persons. This submission is available online at:

http://www.als.org.au/images/stories/publications/Submissions/Prisoner_Transport_May_2010_WA_.pdf

Recommendation 2: That the *Coroner's Act* 1996 (WA) be amended to require:

- **government departments and agencies and private organisations to respond to coronial recommendations within three months of the publication of the coronial recommendations;**
- **the Coroner to publish the government or company response, along with his / her report, within 30 days of receipt of the response; and**
- **government departments and agencies and private companies to provide a progress report on the practical implementation of the coronial recommendations twelve months after their initial response.**

3.3 Improved administration and facilities for the Coroner's Court

As a legal organisation, ALSWA's ability to effectively act in coronial matters would be aided by an improvement in practices and procedures within the Coroner's Court. Despite efforts to notify the Coroner's Court of ALSWA's instructions to act in a matter at the earliest opportunity, there are occasions where the Coroner's Court does not notify ALSWA of relevant developments. Particularly crucial is early supply of the coronial brief. In ALSWA's experience, regular contact needs to be initiated by ALSWA with the Coroner's Court to determine whether a brief is available in a matter. ALSWA submits that an improved system for the Coroner's Court, within which details of acting counsel may be recorded and alerts could be sent, would reduce delays and improve the timeliness of communication between the Coroner's Court and legal representatives. This would enable better preparation of Coronial matters and ultimately, enhanced outcomes from the coronial process.

Recommendation 3: That administrative practices and procedures within the Coroner's Court be improved to enhance communication between the court and legal counsel, particularly through early delivery of the brief.

It is acknowledged that many delays in the coronial process are beyond the control of the Coroner's Court. Delays in obtaining medical and post mortem analysis and reports, for example, are difficult to overcome. As discussed at 3.4 below, delays often arise due to police officers having responsibility for coronial investigations which are not prioritised amongst other police work. This may be overcome by the Coroner appointing independent coronial investigators under section 14 of the *Coroner's Act* 1996 (WA).

Delays are also caused however by a lack of access to court facilities to enable inquests to be held. This is particularly the case in regional and remote areas. ALSWA notes that the Coroner's Court currently uses the same court facilities as the District Court and that generally, District Court matters are prioritised above coronial matters. ALSWA recommends that the Coroner's Court be allocated a dedicated courtroom to enable coronial matters to be listed more frequently and with greater ease. Ideally, ALSWA recommends that the dedicated court room be purpose built and that consultations are undertaken with key stakeholders as to the location, layout and facilities of the purpose built court. Additionally, the court should include rooms for family to utilise to afford them greater privacy during sensitive proceedings. However, it is acknowledged that given resource constraints and the recent construction of a new District Court building, it may be more realistic for an existing courtroom to be assigned to the Coroner's Court.

Recommendation 4: That the Coroner's Court be allocated a dedicated courtroom and adjoining private rooms for witness preparation and family privacy.

3.4 Independent coronial investigators

ALSWA has long raised concerns about the practice of police investigating deaths in police custody or deaths in which police conduct may be relevant. ALSWA considers that the appointment of independent coronial investigators would address three critical concerns arising from police conducting coronial investigations. The first concern is the obvious potential lack of objectivity and independence afforded by an investigation of police by police. The second concern relates to the inadequate prioritisation by police of coronial investigations which contributes to delays in the coronial process. Finally, the third concern is the often poor quality and narrow scope of police investigations of coronial matters which impacts upon the evidence provided to the Coroner and at inquests. Each of these concerns is discussed below.

Key cultural and systemic issues within the police force may impact upon internal investigations into potential police misconduct related to a death in custody or police presence. It is possible that police investigations may not be conducted in as thorough, objective and independent manner as is required when a death in police presence and / or custody occurs.[4] In addition to police officers being unwilling to be critical of individual police colleagues, investigating police officers may also be unwilling or unable to identify and criticise broad systemic issues within the police force that may have contributed to the death. This limitation is understandable given that police officers would not be sufficiently removed from the police force to maintain objectivity and offer criticisms of policies and guidelines created by their management and to which they are subject. Therefore, ALSWA supports the appointment of independent investigators to avoid police having responsibility for investigating deaths to which their colleagues or police systems may have contributed.

ALSWA has recently been involved in two coronial investigations where it was evident that police investigations were inadequate for the purposes of the coronial inquest. Traditional police investigations are narrowly focussed on compliance with the law and criminality. By contrast, coronial investigations require a broader ambit that involves the identification of important thematic issues and consideration of all the circumstances surrounding the death. The consistent failure of police to fulfil this type of investigatory role significantly impedes the quality of the evidence before the Coroner as statements are often not obtained from relevant witnesses until many months after the incident, if at all, and evidence is generally less robust than required.

Police officers assigned coronial investigations are often senior officers who retain responsibility for other investigations within their units. Consequently, coronial investigations are only one of many current investigations in which the officer may be involved. In ALSWA's experience, police officers generally assign coronial investigations lower priority than their other cases. This results in significant delays during the investigatory stages of coronial preparation and unnecessarily lengthy lapses between the death of a person and the Coroner's Court receiving the police brief in relation to the matter. ALSWA submits that these delays would be substantially reduced if the Coroner

[4] Allingham K and Collins P, 2008, "Coronial Reform in Western Australia", *Australian Indigenous Law Review,* 12 (SE2), p91.

appointed independent investigators, who would focus on and prioritise coronial investigations.

Recommendation 5: That independent investigators be appointed to investigate coronial matters, particularly matters involving a death in custody and / or police presence.

3.5 Additional funding for ALSWA to appear in coronial inquests

Currently, ALSWA is not specifically funded to appear in coronial inquests either on behalf of family members or the Aboriginal community. ALSWA's involvement in coronial Inquests is funded by monies assigned to ALSWA by the Commonwealth for its core legal work or through special expensive case funding, which is occasionally obtained through a grant application processes. This means that ALSWA's involvement in coronial matters often requires a redirection of some resources from its core work to enable ALSWA to appear in the coronial matter. Given the heavy caseload of ALSWA lawyers, ALSWA is unable to always act for family or community in coronial matters when approached, simply due to resource constraints.

ALSWA is well placed to appear for Aboriginal family and community members in coronial matters. In addition to being a specialised legal service, ALSWA provides cultural sensitivity and understanding, strong community ties, law reform expertise and knowledge and experience about history, policy, social and cultural matters that impact on the lives of Aboriginal peoples across WA. With additional funding, ALSWA would also be better able to monitor the implementation of coronial recommendations pertaining particularly to Aboriginal issues.

ALSWA strongly recommends that the WA government provide ALSWA with funding to engage more frequently and meaningfully with the Coroner's Court and inquest process to ensure that the Coroner's role in preventing future, similar deaths is effective.

Recommendation 6: That the WA government provide funding to ALSWA to appear for family or community when so instructed and better monitor the implementation of coronial recommendations.

3.6 Coronial counselling service

As stated in the Background Paper, it is recognised that the coronial counselling service is severely under-resourced which impacts upon the extent of work it is able to undertake. Given the expanse of WA and considering that in the past five years between 22 and 43% of all inquests have been in regional areas, it is unsurprising that three coronial counsellors are insufficient to service the state-wide demand for counselling associated with coronial matters. ALSWA is particularly concerned that many Aboriginal peoples, particularly in regional and remote areas, experience significant and enduring trauma that often predates the coronial-related death and is exacerbated by it. The need for multi-faceted and ongoing counselling for these peoples cannot be adequately met through the existing coronial counselling service.

ALSWA notes the need for the coronial counselling service to maintain well established connections with other, preferably Aboriginal, counselling services in communities or servicing communities in order to make appropriate referrals. ALSWA also submits however that there is currently a dearth of mental health and counselling services available to people in regional and remote parts of WA which amplifies the need for a strong and well resourced coronial counselling service.

Recommendation 7: That the coronial counselling service be better resourced, particularly to meet the needs of affected people in regional and remote areas.

The Background Paper comments that the coronial counselling service is infrequently accessed by Aboriginal peoples, often due to the reluctance Aboriginal people have to access the service when referred by court clerks, police or others due to the mental health associations of the term "counselling". ALSWA supports the coronial counselling service being renamed to avoid associations with mental health. ALSWA submits however that the absence of an Aboriginal Liaison Officer also contributes to the low levels of Aboriginal utilisation of the coronial counselling service. An Aboriginal Liaison Officer within the Coroner's Court would be well suited to provide support and information to families as well as make more culturally appropriate referrals to the counselling service.

Recommendation 8: That an Aboriginal Liaison Officer be appointed to the Coroner's Court to bridge the gap between the court and Aboriginal families, communities and organisations.

4. Additional issues for consideration

In addition to the matters discussed above, which were raised in the LRCWA's Background Paper, ALSWA has identified additional issues which require reform within the WA coronial system:

- additional support for families including interpreting, financial and media support to assist them to follow and participate in coronial inquests;
- better education and explanation to families about the coronial process; and
- established coronial procedures that indicate how and when families are advised about particularly sensitive material.

4.1 Support to families of deceased persons during Inquests

In representing families and the Aboriginal community in coronial inquests, ALSWA has noted a scarcity of resources available to families to assist them engage with and keep abreast of coronial proceedings. Family members, as those most closely affected by the death of a loved one, are intimately concerned with the content of the proceedings and its conclusion. Naturally, these persons often want to attend the inquest and have a right to fully understand and contribute to the findings and recommendations of the Coroner. However, as inquests can occur over several days or weeks, in communities other than those in which family reside and under heavy media scrutiny, attendance can be challenging, and at times unachievable, due to financial and other constraints.

During its involvement with the Ward Inquest, ALSWA became aware of family members of Mr Ward being unable to attend the inquest due to their inability to leave paid employment for a lengthy period without financial assistance, or to arrange and afford transportation to the inquest, accommodation and childcare for their children. These practical limitations are common and burdensome.

ALSWA submits that an Aboriginal Liaison Officer may provide limited relief to families if able to assist family members to make practical arrangements such as childcare and transport to enable their attendance at inquests. However, ALSWA also recommends that funds be allocated in the State budget to the Coroner's Court to assist family members attend and participate in coronial inquests.

Recommendation 9: That the WA State Government allocate funds to the Coroner's Court to assist families attend and participate in coronial inquests.

ALSWA further notes that cultural and linguistic barriers impede the capacity of some families to properly understand inquests, particularly when they include technical or specialised evidence. This may be the case for Aboriginal family members who have English as a second or third language and low English literacy levels. Given the importance of inquest proceedings to family members of the deceased, ALSWA considers it imperative that interpreter services be provided to ensure their comprehension of the proceedings.

While ALSWA believes that the Coroner's Court would be supportive of providing interpreter services for family where required, ALSWA notes that this is often not possible due to the absence of a state-wide interpreter service for Aboriginal languages in WA. The absence of this service makes it difficult to reliably contact and secure interpreters for Aboriginal languages and constrains the effectiveness of service delivery to Aboriginal peoples throughout WA in a number of key areas, including access to justice. ALSWA recommends the development and adequate funding of a state-wide interpreter service for Aboriginal languages that could be utilised by the Coroner's Court to ensure better communication with and understanding by Aboriginal families of the coronial process and inquests.

Recommendation 10: That the WA Government develop and adequately fund a state-wide interpreter service for Aboriginal languages.

The purpose of an inquest is to investigate a death where it is in the public interest to do so. Consequently, inquests often generate media attention and this can be focussed on family members of the deceased. Depending on the circumstances of the death and community perceptions, media attention may be significant and overwhelming. Generally, relatives of the deceased will be unaccustomed to the sudden media interest and may require support to manage it at a time when they are already under enormous strain following a death.

ALSWA recommends that some support be provided to family members to assist them with the media. This may involve emotional support from a combination of the Coroner's counselling service and Aboriginal Liaison Officer and a briefing from a media officer or a pamphlet with media tips and information about managing the media for the family.

Recommendation 11: That support be provided to family members to assist them manage any media interest generated by the coronial inquest.

4.2 Education and explanation to families

Section 20 of the *Coroner's Act* 1996 (WA) stipulates information which is to be provided to the next of kin if a death falls within the jurisdiction of, and is to be investigated by, the Coroner. Amongst the information that is to be provided are details of the post mortem procedure, who has control of the remains, possibility of tissue samples being taken and the fact that a counselling service is available. The Act states that where practicable the information should be provided in writing and in a language that the next of kin will understand.

The Coroner's Court verbally confirmed ALSWA's anecdotal experience that this information is most frequently provided to family members of a deceased person by police officers. ALSWA submits that in many cases this is inappropriate, particularly, in an instance of a death in custody or arising out of police contact.

ALSWA recommends that a person other than a police officer contact the family and provide the relevant information to them about the post mortem and coronial investigation process. If the Coroner's Court were to appoint independent investigators, these investigators would be well placed to provide this information to family. This is another area in which the Aboriginal Liaison Officer could play a valuable role.

Recommendation 12: That persons other than police officers engage with family to provide information about the coronial investigation process as required under section 20 of the *Coroner's Act* 1996 (WA).

ALSWA also notes with concern the limited information provided to families about the coronial process. Family members who have contacted ALSWA regularly had not been advised about expected time frames. Frequently, family members are further distressed by the delays in the coronial process because the delays were not expected. Similarly, families approaching ALSWA have often had little or no understanding about the powers and purpose of coronial inquests. Families are disappointed to learn during the inquest that no verdict or sentence will be apportioned. Commonly, families are uncertain whether they can engage their own legal representation for the inquest to ensure their questions are answered. At no stage does correspondence from the Coroner's Court advise family members that they may seek assistance from a lawyer or suggest they speak to ALSWA or Legal Aid if they have queries.

ALSWA recommends that more education and explanation be provided to families and next of kin during the coronial process. Information about the purpose and practicalities of an inquest must be offered in a language that is understood. ALSWA suggests that processes and more informative proforma letters be established to ensure that important information is relayed to every family, rather than requiring family to proactively seek information from the Coroner's Court or coronial counselling service during this stressful time.

Recommendation 13: That processes be established to ensure that families are provided with more information about the coronial process from the outset including expected time frames, the powers and purpose of coronial inquests and the right of family to be legally represented at an inquest.

4.3 Coronial procedures to protect families from sensitive material

Coronial inquests necessarily relate to particularly sensitive material and occur at a time when family members are vulnerable. Often, coronial inquests will include detailed and graphic evidence depicting the deceased person which may impact significantly on family members. ALSWA appreciates the efforts of the Coroner's Court to minimise trauma experienced by family members who attend inquest proceedings. However, in ALSWA's experience, greater precautions are required to ensure families are forewarned about any graphic or upsetting evidence and provided the opportunity to leave the courtroom to avoid exposure.

This may be assisted through greater cultural awareness amongst staff within the Coroner's Court. ALSWA recommends that all counsel assisting the Coroner be required to undertake cultural awareness programs to improve their understanding of cultural sensitivities around Aboriginal grieving processes and traditions.

Recommendation 14: That all counsel assisting the Coroner be required to undertake cultural awareness training to improve their understanding and appreciation of cultural sensitivities surrounding Aboriginal grieving.

5. Conclusion

ALSWA endorses the Background Paper prepared by the Law Reform Commission of Western Australia in its review of coronial practice in WA. In particular, ALSWA highlights the importance of:

- publication of coronial findings and recommendations;
- a mandatory reporting requirement in response to coronial recommendations;
- improvements to administrative practices within the Coroner's Court;
- the appointment of coronial investigators independent of police;
- increased funding for ALSWA and others to represent families and communities in coronial inquests; and
- improved resourcing of the coronial counselling service.

Additionally, ALSWA recommends that greater support be provided to families involved in the coronial process through financial aid, media assistance, improved education about the coronial process, purpose and their rights within it and access to interpreters. ALSWA further recommends that the Coroner's Court develop clear procedures to ensure that all sensitive matters within an inquest are appropriately managed to minimise the grief experienced by family members.

6. List of ALSWA Recommendations

1. ALSWA recommends that findings and recommendations from the Coroner's Court be publicly available following appropriate amendment to maintain confidentiality and sensitivity.
2. That the *Coroner's Act* 1996 (WA) be amended to require:
   - government departments and agencies and private organisations to respond to coronial recommendations within three months of the publication of the coronial recommendations;
   - the Coroner to publish the government or company response, along with his / her report, within 30 days of receipt of the response; and
   - government departments and agencies and private companies to provide a progress report on the practical implementation of the coronial recommendations twelve months after their initial response.
3. That administrative practices and procedures within the Coroner's Court be improved to enhance communication between the court and legal counsel, particularly through early delivery of the brief.
4. That the Coroner's Court be allocated a dedicated courtroom and adjoining private rooms for witness preparation and family privacy.
5. That independent investigators be appointed to investigate coronial matters, particularly matters involving a death in custody and / or police presence.
6. That the WA government provide funding to ALSWA to appear for family or community when so instructed and better monitor the implementation of coronial recommendations.
7. That the coronial counselling service be better resourced, particularly to meet the needs of affected people in regional and remote areas.
8. That an Aboriginal Liaison Officer be appointed to the Coroner's Court to bridge the gap between the court and Aboriginal families, communities and organisations.
9. That the WA State Government allocate funds to the Coroner's Court to assist families attend and participate in coronial inquests.
10. That the WA Government develop and adequately fund a state-wide interpreter service for Aboriginal languages.
11. That support be provided to family members to assist them manage any media interest generated by the coronial inquest.
12. That persons other than police officers engage with family to provide information about the coronial investigation process as required under section 20 of the *Coroner's Act* 1996 (WA).
13. That processes be established to ensure that families are provided with more information about the coronial process from the outset including expected time frames, the powers and purpose of coronial inquests and the right of family to be legally represented at an inquest.
14. That all counsel assisting the Coroner be required to undertake cultural awareness training to improve their understanding and appreciation of cultural sensitivities surrounding Aboriginal grieving.