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Précis Paper

Civil Law Policy relating to Coronial Inquests

A discussion on NSW policy in relation to deaths in custody and in particular, on recent changes to legal aid policy in relation to representation for indigenous families in cases of indigenous deaths that result in coronial inquests.

Discussion Includes

- **Deaths in custody**
- **Recommendations of the Royal Commission**
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- **Legal aid and indigenous deaths**
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Civil Law Policy relating to Coronial Inquests

1. **In this edition of BenchTV, David Evenden (Solicitor Advocate – Legal Aid NSW, Sydney) and Jake Harris (Barrister – Maurice Byers Chambers, Sydney) discuss the policy in NSW in relation to deaths in custody and in particular, on recent changes to legal aid policy in relation to representation for indigenous families in cases of indigenous deaths that result in coronial inquests.**

Deaths in custody

2. **In NSW each year, the state coroner must provide a report to the government about deaths in custody and deaths in police operations. This is required by the *Coroners Act* 2009 (NSW).**
3. **These reports specifically list the number of aboriginal deaths that have occurred and show that there are about 20 deaths in custody each year in NSW. Of those, in the last 10 years about 11% have been aboriginal deaths in custody.**
4. **At the time of the Royal Commission into Aboriginal Deaths in Custody, which began in 1987 and concluded in 1991, there was an agreement between governments following the recommendations of the Royal Commission as to what would constitute a death in custody.**
5. **This meant that a death in custody included a death in prison custody, a death in police custody, any juvenile in detention and any people who may be in custody in relation to the *Migration Act* 1958 (Cth).**
6. **Imposing a concrete definition of a death in custody under section 23 of the *Coroners Act* 2009 (NSW), was one of the changes that took place after the Royal Commission.**
7. **The definition now covers deaths of people in custody of a police officer or other lawful custody, anyone who dies escaping or attempting to escape, anyone who dies in transit to a jail or other facility and anyone who is temporarily absent from jail, such as in a hospital.**
8. **Any death that occurs in those circumstances can end up in an inquest, including a death from natural causes that simply happens to occur in custody.**
9. **Since 2008, the most common cause of death in custody (around two thirds) are due to natural causes, mostly cardiac related death.**
10. **Another quarter of the deaths are suicide related death.**

Recommendations of the Royal Commission

11. **When the Royal Commission took place between 1987 and 1991, the *Coroners Act* 1980 (NSW) did not require any mandatory inquest for a death in custody .**

12. **One of the recommendations of the Royal Commission was that there would be mandatory inquests for deaths in custody conducted by either the state coroner or a deputy state coroner.**
13. **Powers were given to coroners to compel production of documents and obtain things relevant to their investigation**
14. **There were also changes to the *Coroners Act* 1980 (NSW) with it endorsing the common law practice of attaching recommendations to findings.**
15. **Another major change in response to the Royal Commission was to legal aid policy regarding the representation of indigenous families in cases of indigenous deaths that result in inquest.**
16. **Deaths that are reported to the coroner are investigated and it is part of the coroner's function to answer a number of questions in relation to the death and ultimately reaching findings about the death.**
17. **In relation to deaths in custody, those inquests are mandatory.**

A mandatory inquest for deaths in custody

18. **Whenever there is a death in custody there is generally a question, particularly for families as to what took place.**
19. **An inquest allows a focus on what happened and what these institutions might have done to prevent these deaths.**
20. **When someone's liberty is taken away, there is an expectation upon the institution housing them that they have a responsibility to ensure that they are subjected to proper treatment and adequate services.**
21. **An inquest provides an incentive for these institutions to treat people properly and ensure that they are taking steps to prevent any preventable deaths.**
22. **There is also public interest in examining deaths that take place in situations where a person has had their liberty taken away.**
23. **Generally, legal aid is available in cases where there is a public interest in providing support for families to be represented in inquest.**

Legal aid and indigenous deaths

24. **The most recent change in relation to indigenous deaths in custody is to a legal aid test which has always required the applicant to satisfy a public interest test.**
25. **For legal aid to be granted for someone to appear at an inquest on behalf of a family or another interested party, there must be some public interest that is advanced.**
26. **This is often an easy test to satisfy in cases of larger inquests which are addressing systemic issues.**

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27. **The Coroner has the power to make recommendations about public health and safety and there is often a public interest element to these inquests**
28. **For indigenous families, regardless of whether or not there is some public interest in the case, there is a real need for assistance and representation in order to assist families in dealing with the inquest process.**
29. **Justification for legal aid for indigenous families at coronial inquests can be found back in the recommendations that were made by the Royal Commission in 1991.**
30. **In particular, recommendation 23 which concerned post death investigations noted that the family of the deceased be entitled to legal representation.**
31. **The purpose of the recent amendment is to fall in line with the recommendation from the Royal Commission that legal aid should be available for any family.**
32. **Legal aid is now to be provided to all indigenous families when there has been a death of their family member in custody.**
33. **There is a special position for families at inquests in relation to their capacity to seek leave and appear under section 57 of the *Coroners Act* 2009 (NSW).**
34. **The rationale being that families should be in a position to advocate and obtain answers about what has happened where someone has died in situations where there is going to be an inquest.**
35. **The inquest process involves a coroner making formal findings and potentially recommendations.**
36. **The inquest process also allows families to seek the answers which they may be looking for and to have an objective determination of the facts and a ventilation of the issues that surround the death.**
37. **It is significant to note that NSW is the only State in Australia that has a dedicated coronial inquest unit at Legal Aid.**
38. **Aboriginal Legal Service (ALS) is part of a system that exists involving deaths in police custody and deaths in prison custody whereby they will be notified if there is an aboriginal death in custody.**

<u>Access to Legal Aid</u>

39. **Legal Aid referrals come from a variety of different sources including the Crown Solicitor's office, the court and Law Access.**
40. **Legal Aid not only provides a representation service at inquests but an advice service for anyone involved with the coroner's court.**
41. **Section 6 of the *Coroners Act* 2009 (NSW) requires that certain deaths to be reported to the coroner, these are called reportable deaths and include violent or unnatural deaths including all suicides, deaths that occurred in suspicious or unusual circumstances.**

42. There are about 50,000 deaths per year in NSW and about 6,000 of those get reported to the coroner.
43. Of those reportable deaths, the coroner has the discretion to dispense with inquests and in 99% of cases inquests are dispensed with because there is sufficient evidence to determine the formal findings the coroner has to make; the identity of the person, date and place of death and the manner and cause of death.
44. There are less than 100 inquests being run per year and a large number of those are the mandatory inquests as a result of deaths in custody or deaths in police operations.
45. Section 27 of the *Coroners Act* 2009 (NSW) dictates that not only can mandatory inquests not be dispensed with, but any inquest into a death that might be a homicide cannot be dispensed with as well as any inquest where the coroner does not have sufficient information to make a conclusion about the formal matters such as manner or cause of death.
46. The input of the family is considered an important element by the coroners in utilising their discretion under section 27, however the difficulty is when the family's concerns do not fall within the scope of the inquest.
47. It is important for the coroner to determine a causal link between the circumstances that are to be examined and the death of the deceased.
48. Most of the work of the inquest is looking at the manner and cause of death and there is some guidance in case law about what that means.
49. In *Conway v Jerram, Magistrate and NSW State Coroner and Another* (2010) 78 NSWLR 689, the court held that the phrase, 'manner or cause' should be given broad construction.
50. In *Harmsworth v State Coroner* (1989) VR 989 which was a case which involved a prison death where there was an argument run that had the prisoners not ended up in prison, then the death would not have occurred. This question was said to be outside the scope of the inquiry.

<u>Healthcare</u>

51. There is a real issue in regard to healthcare that is given to prisoners and some of the conditions under which they serve their sentence which is a recurring theme throughout many death in custody matters.
52. For example, about a quarter of deaths in custody are suicides, the vast majority by hanging. Questions of hanging points and the means to commit suicide is one that has been in the public arena for a great length of time and there are still recommendations being made in regard to it.
53. In regard to healthcare in custody, the jails are overcrowded, there has been a significant increase in NSW in jail population, there is a shortage of beds for mental

health patients and the level of care is often found in many inquest matters to be inadequate.

54. **The numbers might not suggest that there is a crisis in regard to deaths in custody, there is little doubt that there is significant room for improvement in terms of resourcing the system and an eradication of the major issues that exist for patients with psychological issues at risk of self harm**
55. **Prevention is a key role of the coroner and the coroner has the recommendation function which is now found in section 82 of the *Coroners Act 2009* (NSW). This section specifically refers to recommendations relating to public health and safety.**
56. **Nevertheless, there is an issue in regard to how enforceable those recommendations are and what is actually required once they are made.**
57. **Under section 82 of the *Coroners Act* 2009 (NSW), the coroner has the power to make recommendations in situations where it is necessary or desirable in any matter connected with a death .**

<u>After an inquest</u>

58. **The recommendations are provided to the interested parties and generally, they are only made to parties who are represented at the inquest.**
59. **There is a requirement that if recommendations are made in relation to a government body, then they are required to report back within 6 months, however this is not legislated.**
60. **In comparison, In Victoria, there is a legislated requirement to report back in 3 months time.**
61. **In NSW, a Premier's memorandum notes that government bodies are required to consider the recommendation and subsequently report back to about what is going to be done about the recommendation. This information eventually then becomes publicly available.**
62. **There is no doubt that the system and the law could go further in NSW to make legislative imperative to do something about the recommendations.**
63. **An inquest can often be a therapeutic process for families.**
64. **However, in terms of having a system for preventing preventable deaths, the amount of time that it takes to complete an inquiry and produce recommendations hinders the success of the system.**
65. **In relation to section 82 of the *Coroners Act* 2009 (NSW), the question of whether the recommendations are necessary and desirable arises. Inquests can often take years and as a result at the time of inquest, many institutions may have recognised and addressed the problems that they had so there is no need for recommendations to remedy what happened.**

66. **From the family's perspective, the delay is very difficult to deal with as it is not unusual for matters to be finalised 3-4 years after there has been a death even when an investigation starts straight away**

BIOGRAPHY

David Evenden

Solicitor Advocate – Legal Aid NSW, Sydney

David was admitted as a lawyer in 1997. Prior to joining Legal Aid NSW, David spent several years working in the Northern Territory as a solicitor for Aboriginal Legal Aid. He has extensive experience in preparing and appearing as an advocate in criminal trials and sentence matters in the NSW District Court, in committals and Local Court hearings as well as Children's Court matters and coronial inquests.

Jake Harris

Barrister – Maurice Byers Chambers, Sydney

Jake was admitted as a solicitor in NSW in 2010 and called to the NSW Bar in 2018. As a solicitor, he held roles with the Crown Solicitor's Office and Legal Aid NSW's Coronial Inquest Unit. Prior to qualifying in NSW, he practised as a barrister in London for 8 years. His areas of expertise include coronial inquests and inquiries, criminal law, employment and industrial law, family law, personal injury and professional negligence and discipline.

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- **Conway v Jerram, Magistrate and NSW State Coroner and Another (2010) 78 NSWLR 689**
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- **Coroners Act 2009 (NSW)**
- **Migration Act 1958 (Cth)**