Report into Restorative Justice & Coronial Hearings

Report prepared on behalf of Victims Support ACT

As part of the Coronial Restorative Reform Process

Lindsay McCabe

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Acknowledgements

I would first like to acknowledge every person across the ACT who, through the death of a loved one, has had contact with the coronial system, and in particular the advocates who fight so hard to ensure that the system inflicts the least trauma possible on bereaved families and communities.

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Acronyms

AIHW	Australian Institute of Health and Welfare
ACAG	ACT Coronial Advocates Group
ACT	Australian Capital Territory
AFP	Australian Federal Police
ALS	Aboriginal Legal Service
AMS	Aboriginal Medical Service
JaCS	Justice and Community Safety Directorate
FLO/s	Family Liaison Officer/s
NSW	New South Wales
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RJ	Restorative Justice
TJ	Therapeutic Jurisprudence
UK	United Kingdom
VSACT	Victim Support ACT

Figures

Executive summary

In 2015, the Australian Capital Territory (ACT) Government committed to transforming Canberra into a 'Restorative City,' emphasising the principles of restorative practice. This approach prioritises relationships, respect, and inclusivity in governance and problem-solving. By November 2021, this commitment led to the introduction of a pilot initiative aimed at reforming the coronial system to enhance its restorative practices. The goal was to make the Coroner's Court process safer, more sensitive, and meaningful for families and the public. The initiative, endorsed by ACT Attorney-General Shane Rattenbury, was overseen by an Independent Facilitator to ensure impartial management. The Victims of Crime Commissioner was appointed as an Independent Honest Broker. The restorative reform process began in September 2022, culminating in a report presented in June 2024, the aims of which included improving transparency, consistency, and family and community confidence in the coronial system.

Restorative justice, emerging in the late 1970s, focuses on repairing harm caused by crime and death through inclusive, empathetic processes that involve all stakeholders. This approach is particularly relevant to coronial processes, where it can enhance transparency, community engagement, and support for bereaved families. By understanding deaths within their social context and aiming to prevent future harm, restorative justice principles can guide improvements in the coronial system.

This report examines the experiences of Aboriginal Peoples with the coronial system in Canberra, acknowledging the historical and systemic factors affecting these interactions. The report aims to identify ways the coronial system can better address the needs of bereaved Aboriginal families, promote cultural safety, and address systemic inequalities.

The coronial system in the ACT faces significant challenges, including the lack of a dedicated coroner, inadequate training, and delays in case processing. Recent efforts to reform the system include the appointment of a family liaison position and funding for a dedicated coroner. However, the process has faced setbacks, including limited stakeholder engagement and persistent delays.

The report underscores the need for a more robust, culturally sensitive approach to coronial processes that aligns with restorative justice principles. It highlights the importance of

including bereaved families, particularly bereaved Aboriginal families and communities, in reform efforts to ensure that the system meets their needs effectively. For Canberra's vision of becoming a restorative city to be realised, it is crucial to address these systemic issues and foster genuine collaboration among all stakeholders.

The recommendations of the report include:

1. Independent Review: An independent review should be established as a matter of priority to assess whether the dual roles of Chief Magistrate and Chief Coroner are delivering optimal outcomes for the ACT. This review should evaluate the effectiveness of the current model in ensuring a timely and effective coronial process.
2. Economic Modelling: If the review recommends separating these roles, the Attorney-General should consider conducting independent economic modelling to weigh the costs and benefits of this approach.
3. Trauma-Informed Commitments: The Chief Magistrate/Chief Coroner should be held accountable for commitments such as conducting a trauma-informed audit, providing training to court staff. Police should also undergo trauma-informed training.
4. Trauma-Informed Workshop: Organise a workshop (or series of workshops) to introduce trauma-informed principles to court and police staff, ensuring a shared understanding for forthcoming work.
5. Family Experience Survey: Commission an independent survey of families who have experienced coronial processes in the ACT to gather insights on their experiences across all stages, ensuring that the survey is developed with input from relevant stakeholders.
6. Reporting and Improvements: Post-survey, the Court and support services should report on the findings, identifying gaps in service delivery and how they align with trauma-informed practices.
7. Stakeholder Engagement: Establish an independent facilitator to promote consistent engagement between institutional stakeholders and families, fostering collaboration aligned with the ACT Government's commitments, including the Restorative City Initiative.
8. Joint Committee Formation: As an interim measure, create a jointly facilitated working group with the Dedicated Coroner, ACT Policing, and advocates to advise on key priorities for coronial reform.

9. Empower Aboriginal Community Liaison Officers: Aboriginal Community Liaison Officers should receive information and training about coronial processes and should accompany police when an Aboriginal Person or family is to receive a notification that someone has died. They should also be able to access trauma-informed training opportunities.
10. Expand Victim Support Services: Address service gaps by extending eligibility for Victim Support ACT services to all families involved in the coronial process, not just those linked to criminal matters.
11. The ACT Coroner's Court should discuss with other coronial jurisdictions the role of family liaison officers, including whether their FLOs are able to support all families involved in coronial matters, including those with legal representation. As a matter of urgent priority, information about the role of the Coroners Court FLOs should be displayed on the Coroners Court Web page, including that at this point in time the FLOs will not provide support to families who have their own legal representation.

By implementing these recommendations, the ACT can advance its goal of becoming a truly restorative city, delivering justice and support in a manner that respects and includes all its residents.

Introduction

In 2015, the Australian Capital Territory (ACT) Government embarked on an ambitious journey to transform Canberra into a 'Restorative City.' This initiative was grounded in the principles of restorative practice, which emphasise the centrality of relationships, equality, respect, and inclusion in fostering community well-being and effective governance. These principles aim to reshape how societal challenges and conflicts are addressed, promoting a more empathetic and collaborative approach to problem-solving.

A significant step in this transformation was the endorsement of a pilot initiative in restorative reform within the coronial system by ACT Attorney-General Shane Rattenbury in November 2021. This initiative sought to enhance the restorative practices employed by the Coroner's Court, with the overarching goal of making the process safer, more sensitive, and meaningful for families and the public. The reform was to be overseen by an Independent Facilitator, ensuring impartial management and transparent engagement of all stakeholders, including the Justice and Community Safety Directorate (JaCS) as a non-directive participant. Additionally, the Victims of Crime Commissioner was appointed as an Independent Honest Broker to uphold the integrity of the reform process.

Commencing in September 2022, the restorative reform process has been a critical component of Canberra's broader effort to embody the principles of a restorative city. By June 2024, the reform process was documented in a comprehensive report, which included a significant coronial case study aimed at enhancing transparency, consistency, and the confidence of bereaved families in the coronial system.

This report provides a case study by which we might begin to understand the experiences of Aboriginal Peoples with the coronial system in Canberra, recognising the complex interplay of historical, contemporary, and systemic factors that influence their interactions with this judicial mechanism. It acknowledges the unique social and cultural contexts of Aboriginal communities and the enduring impacts of colonialism and racism on their experiences of death and bereavement, especially in cases involving state intervention or contentious circumstances.

The report aims to critically examine the relationship between Aboriginal families and the coronial system, highlighting the specific challenges and barriers they face. It seeks to

identify opportunities for improving the system's responsiveness to the needs and preferences of bereaved Aboriginal families, promoting cultural safety, and addressing systemic inequalities and injustices. By informing policy development, service delivery, and advocacy efforts, this report aspires to enhance the effectiveness of the coronial system for Aboriginal communities and, by extension, for all residents of Canberra.

The principles of restorative justice, which emerged in the late 1970s as a response to the limitations of traditional justice practices, offer a framework for understanding and addressing these challenges. By focusing on repairing harm, fostering inclusive dialogue, and preventing future injustices, restorative justice principles can guide meaningful reform in the coronial system, aligning with Canberra's vision of becoming a restorative city.

As Canberra continues its transition towards this vision, the insights and recommendations presented in this report are crucial for ensuring that the coronial system not only meets the needs of bereaved families but also contributes to a broader culture of healing and justice within the community.

Background and Purpose

In 2015, the Australian Capital Territory (ACT) Government first committed to the idea of Canberra as a 'Restorative City 'based on the principles of 'restorative practice'. These principles recognise that relationships are central to our wellbeing, community and society and can be used to develop a shared approach to governance and problem solving based on equality of respect and inclusion, accountability and support.

In November 2021, the ACT Attorney-General, Shane Rattenbury, unveiled endorsement for a pilot initiative in restorative reform, specifically targeting enhancements within the coronial system. An aim of these enhancements was to strengthen restorative practices in the Coroner's Court to ensure safer, more sensitive and meaningful processes for families and for the public interest.

This initiative, as articulated by the Attorney-General, was to be overseen by an Independent Facilitator. The primary objective was to ensure that the restorative reform process was perceived as impartially managed by all stakeholders. Notably, the government, represented by the Justice and Community Safety Directorate (JaCS), assumed the role of a stakeholder within the process rather than assuming a directive role.

Further to this, in line with international best practice, the Victims of Crime Commissioner was asked by the ACT Attorney-General to act as an Independent Honest Broker for the overall process. The restorative reform process commenced in September 2022 and a final document detailing the reform process, key outcomes achieved and recommendations for next steps was presented to ACT Attorney General in June 2024. A key outcome from the process was the engagement of this researcher to undertake a coronial case study. It was hoped that:

> *Having a public case study may help to improve transparency and consistency and may assist in improving families' confidence in the operation of the coronial court and the Courts more broadly.*

This report then explores the experiences of Aboriginal Peoples with the coronial system in Canberra, ACT, acknowledging the historical, contemporary and systemic factors that shape interactions with the system. It recognises the unique and multifaceted social and cultural contexts of Aboriginal communities in the ACT, and the impacts of colonialism and racism on their experiences of death and bereavement, particularly when those deaths occur at the hands of the State, or where the circumstances of the death are contentious. In addition, this report aims to examine the relationship between Aboriginal families and the coronial system in the ACT, with a focus on understanding the challenges and barriers, and opportunities for improvement. It seeks to identify areas where the coronial system can better meet the needs and preferences of bereaved Aboriginal families, promote cultural safety and sensitivity, and address systemic inequalities and injustices.

The report also aims to inform policy development, service delivery, and advocacy efforts to enhance the responsiveness and effectiveness of the coronial system for Aboriginal communities in Canberra. As will be discussed, there are many challenges and barriers experienced by *all* bereaved families who have contact with the coronial system - these are magnified and exacerbated via the specificities of existing as an Aboriginal Person in the colony known as Australia. However, if we can get it right for bereaved Aboriginal families, we are much more likely to get it right for all who have contact with this system.

Defining restorative justice as it relates to coronial hearings

Before a discussion of the particular policy context that led Canberra to become a 'restorative city', it is prudent to first outline what restorative justice *is*. In the late 1970's, restorative justice emerged from a 'disparate and diverse set of critiques of, and alternatives to, traditional justice practices' (Suzuki & Wood 2017: 393). Throughout the 1970s there was a focus on civil rights, the rise of feminism, and the rights of the victim. Restorative justice proponents recognised that crime, and indeed death, is a 'harm caused not only to the victim, but also to the wider community and offender' (O'Mahony & Doak 2017: 30). The harm caused by crimes produced a number of obligations and liabilities – for instance, the person who caused the harm has a social, if not moral, obligation to repair said harm (O'Mahony & Doak 2017: 30). By repairing this harm, the relationship between offender and victim and offender and community can be 'restored'. Thus, in the context of the criminal legal system, restorative justice provides a framework for recognising the obligations of offenders to their victims and communities in a holistic, and ideally therapeutic, manner (O'Mahony & Doak 2017: 197), restoring relationships to achieve a 'just' outcome.

What is a 'just' outcome depends very much on the stakeholders involved in the restorative process – as will be discussed in more detail below, a 'just' outcome in a coronial matter depends very much on what the families – key stakeholders in coronial processes – hope to achieve. However, the guiding principles of restorative justice practices have broader applications than in criminal justice; for example, there is great scope to use these principles in coronial processes and decision-making. Restorative justice asks that we make room for the involvement of all parties concerned, not only in the sense of offender/victim, but also where families and communities are key stakeholders in processes, procedures, and potential outcomes that affect them. Restorative justice also requires that we understand a problem within its social context (Marshall 1999).

In the context of coronial inquests, hearings, and decision-making processes, we must understand the relationship between Aboriginal families and the coroner as occurring within a context of colonisation and, too often, state violence. There must also be a preventative element to restorative justice processes; once the harm and its causes are recognised, how might we

prevent similar future harms from occurring? Last, restorative justice is flexible, encouraging creativity in its practice, and asking how we might 'think outside the box' to create better, and less harmful, ways of living, working, and decision-making that involve all stakeholders in their design. When considering these key principles we can see that restorative justice 'is not a single theory of justice, rather we can be guided by its principles and values' (Marshall 1999: 6), and thus its application is far greater than in the criminal legal system only.

Canberra as a Restorative City

In 2016, the ACT Legislative Assembly called on all Canberrans to work toward redefining Canberra as a restorative city. With a strong focus on the prevention of harm and a communal approach to dispute resolution, restorative justice ideals informed this call to action (ACT LRAC 2018: 8). In striving to become a restorative city, the goal is to foster connections, promote well-being and create a safer, more flourishing environment for all residents.

The ACT Law Reform Advisory Council was then commissioned to determine how this call may become a reality. Handing down its final report in 2018 (ACT LRAC 2018), the ACT Law Reform Advisory Council made several recommendations to the ACT Government, including options to embed restorative values and principles into regulatory and policy frameworks (ACT LRAC 2018: 9). Dubbed the 'Restorative Practices Inquiry', the ACT Law Reform Advisory Council sought to determine what it would mean, in practice, for Canberra to be a restorative city, particularly in the legal and judicial sense.

The Inquiry also established areas of priority, as well as uncovering the ways in which the Canberra community more broadly could be involved in reshaping Canberra via the *Canberra Restorative Practices Network* (ACT LRAC 2018: 11). Two key areas determined to have significant impacts from restorative approaches were the areas of child protection and public housing, both systems affecting some of the most marginalised members of the Canberra community.

The Inquiry was informed by a number of submissions from interested community members. In addition, the Inquiry also sought advice from Aboriginal community members and organisations. Yarning Circles with the United Ngunnawal Elders Council were held, facilitated by the University of Canberra. Meetings were also held with staff from Winnunga Nimmityjah Aboriginal Health Services, and the Chair of the Aboriginal and Torres Strait Islander Elected Body, Ms Katrina Fanning (ACT LRAC 2018: 12). The Canberra Restorative Community Network, the Australian National University, Canberra University, and other key supporters such as Relationships Australia, also held their own events to learn more about how the shift to a restorative city might be achieved. Importantly, this included yarns between the Ngunnawal Elders Council and Māori from the Whanganui Health Service, as well as a

conference attended by experts from Hull and Leeds in the United Kingdom; public lectures; and workshops (ACT LRAC 2018: 12-13).

Restorative justice, coronial reform, and coronership in the ACT

There exists considerable potential for coronership to both inform and respond to the concept of Canberra as a 'restorative city'. The coroner may contribute to this vision in several ways. For instance, the conducting of inquests or hearings into deaths can certainly be approached in a restorative manner – a transparent and inclusive approach that respects the various needs and perspectives of those bereaved, and the community more broadly, is one that could be understood as aligned with restorative processes. In addition, coroners should engage with the community and stakeholders to foster dialogue and understanding around issues related to death, bereavement, and public safety. This can include outreach initiatives, public forums, and partnerships with community organisations to raise awareness and promote restorative approaches to dealing with death and its aftermath.

Coroners also play a role in supporting bereaved families. When done well, and in a restorative manner, this can involve providing the bereaved with information, guidance, and support throughout the coronial process. This should include ensuring that families are kept informed about the progress of investigations, inquests, and hearings, facilitating access to support services, and treating the bereaved with empathy and respect. Further, in line with restorative principles, coroners may make recommendations aimed at preventing similar deaths in the future and promoting healing within the community. These recommendations can, and indeed should, include suggestions for systemic changes, improvements to services, and where applicable, initiatives to address any underlying or systemic issues that have contributed to the death occurring.

Coroners might also collaborate with other agencies and organisations involved in restorative justice initiatives in Canberra, such as victim support services; community mediation programs; and restorative justice forums. By working together, stakeholders can make use of their respective expertise and resources to promote restorative approaches to justice and healing in the community. A key part of this is prioritising the inclusion of those with lived experience of the system – those bereaved by the death of loved one, who through no choice of their own have been subjected to coronial processes. While the role of the coroner in the ACT primarily focuses on investigating deaths and making findings about their cause

and circumstances, coroners can contribute to the vision of Canberra as a restorative city by embracing restorative principles in their work and collaborating with the bereaved, the community more broadly, and other stakeholders, to promote healing and community well-being, and in the prevention of death and injury.

In the ACT, the role of 'coroner' is not a legislated stand-alone position. Rather, each magistrate working in the ACT legal system can be called on by the Chief Magistrate at any time to take on a coronial caseload – nine magistrates rotate in and out of coronial work; when the regular caseload of the courts is high, coronial work stops, extending the delays already so keenly felt by bereaved families *(Canberra Times* 2021). The Chief Magistrate also acts as Chief Coroner in the ACT, and the Court receives no allocated resourcing for coronial functions (Vue 2022). The ACT is the only jurisdiction in the nation without a legislatively appointed dedicated coroner (Burdon 2018).

Coroners in the ACT then are not adequately trained to undertake coronership, and their constant rotation in and out of coronial work means that they also lack the experience and institutional knowledge to perform this work in a way that is consistent with best practice. The mandatory coronial investigation and subsequent hearing into the death of a man whilst in the custody of corrective services was described as involving 'failure, unacceptable ignorance, incompetence...[and] delay' (Waterford 2018), highlighting some of the key issues that can occur when magistrates alternate their regular work with coronial work.

Of course, this is not to discount the important work that these magistrates do in coronial matters, rather it serves to argue that they should be better supported to do this work in the first instance, and that that support is best directed toward the role of dedicated coroner. This is not a new idea, and there have been calls for a dedicated coroner since at least 2009, with the then-head of ACT Policing, the then-Director of Public Prosecutions, Legal Aid ACT, and other urging the government to appoint a dedicated Chief Coroner in their submissions to a review of the coronial legislation (Burdon 2018b).

This apparent lack of political will to better resource the coronial system in the ACT has meant that many bereaved families have been left traumatised by the very system that should have provided them with answers into the deaths of their loved ones. Families have in some instances been forced to wait more than five years for the coronial hearing into their loved

one's death to begin, stifling any natural processes of grieving, freezing them in time. Further delays are experienced when the services of a forensic pathologist are required, as the ACT has no dedicated forensic pathologist for the coroner's court, with an average wait of a month before forensic reports can be finalised (Crowe 2021). A full-time family liaison position was appointed in 2020, and in 2021, the allocation of 3.2 million dollars (AU) was announced, intending to fund a dedicated coroner and support staff for four years (Foden 2020; Lindell 2021). The appointment of the family liaison position is significant; indeed, it has been described by former NSW Deputy State Coroner Hugh Dillon as 'the single best and most effective reform that the ACT Government could institute' (Foden 2019). However, it must be noted that the ACT Coroners Court does not permit FLOs to support all families, most particularly those who have legal representation. The appointment of a dedicated coroner is also significant, however this has yet to be legislatively enshrined, and so is subject to the whims of the ACT Government, the Chief Magistrate, and budget.

Importantly, all of this occurred within the context of Canberra redeveloping itself as a 'restorative city', with Attorney General Ramsay highlighting that a goal of the government is to 'embed restorative practices' within coronial processes and investigations (Foden 2019). Despite this, advocates for coronial reform, many of whom have themselves had traumatic experiences with the coronial system in the ACT, were excluded from contributing to discussions about what these 'restorative practices' might entail (Foden 2020). This is the opposite of what a restorative process could and should engender, and seems to be symptomatic of the broader systemic issues present in the coronial space in the ACT.

In 2021, the ACT Government, as part of the move toward being a 'restorative city' announced funding to engage an Independent Facilitator to focus specifically on coronial processes. The Independent Facilitator would 'identify ways of enhancing the accessibility, timeliness, and transparency of the coronial system'; to achieve this, the Independent Facilitator was to place bereaved families 'at the heart of the reform process' (Legge 2024: 5). The intention of this process was, according to the Attorney-General, to 'ensure that the restorative reform process was independently managed', with the ACT Government to be involved as a stakeholder only (Legge 2024: 5).

This marked an important step in Canberra's move to become a 'restorative city', demonstrating the ACT Government's 'willingness to embark on a different way forward to

achieve systemic change' (Legge 2024: 5). This process, dubbed the *Coronial Restorative Reform Process*, sought to bring all relevant stakeholders together to determine which reforms were necessary and how they might be implemented, evaluated, and monitored. Stakeholders included advocates,[1] ACT Courts, the ACT Policing Coronial Team, JaCS, and Relationships Australia Coronial Counselling Service (Legge 2024: 3). Only one meeting was able to occur, with the advocates, police representatives, court staff, and the dedicated Coroner in attendance (Legge 2024: 6).

This was a disappointing outcome, particularly for the advocates who expressed 'repeated and strong desire for such joint meetings to occur', and who maintained a willingness to participate in such meetings throughout the reform process (Legge 2024: 6). For the advocates, the failures on the part of key stakeholders mirrored the failures they had already experienced in their coronial matters. The 'unwillingness to engage, the lack of communication' and 'excessive delays' were all features of their experiences with the coronial system in the ACT (Legge 2024: 6). These were, unfortunately, some of the very issues that they had been advocating about, reinforcing the immense difficulties they had experienced with the system since the death of their loved ones. As highlighted by Independent Facilitator Legge, the suffering and distress that these failings have caused for the advocates cannot be understated, both during the original coronial processes they experienced, and the subsequent actions of stakeholders engaged in the coronial reform processes project (Legge 2024: 6). This result is a direct contradiction of the goals of Canberra to become a restorative city.

[1] As per Legge (2024), 'advocates' is used here to refer to members of the Canberra community who have been advocating for coronial reforms for several years, all of whom have lived experience of coronial processes.

Restorative justice and coronial hearings

The role of the coroner

Across jurisdictions coroners are tasked with determining how and why a person has died, or is suspected to have died, and can seek to prevent similar deaths from occurring in similar circumstances. The coroner has legislated authority to conduct inquiries into deaths that are sudden, unexpected, suspicious, or unnatural, as well as deaths in certain other circumstances specified by law, such as deaths resulting from accidents, suicides, homicides, and those that occur in custody or State care. The coroner must determine the identity of the person or persons who has died; where they died; the manner of the death; and the cause of the death. It is a role with enormous potential to prevent injury and death by way of the coronial recommendations they are often expected to make following their investigations. Coroners across Australia are appointed from within the legal profession, and act as independent judicial officers.

In each Australian State and Territory there exists legislation outlining the functions of the coroner; in the ACT, the coroner operates according to the *Coroners Act 1997* (ACT). This Act outlines the powers and duties of coroners in the ACT and provides the legal framework for conducting inquiries into deaths. The *Coroners Act 1997* (ACT) covers various aspects related to coronial investigations, including the jurisdiction and powers of the coroner and their deputies; the conduct of investigations and hearings; the determination of identity, cause and manner of death; coronial recommendations; reporting; and matters of legal compliance. The *Coroners Act 1997* (ACT) is supplemented by regulations and rules that provide further detail on specific aspects of coronial investigations and procedures. These regulations and rules may cover matters such as the conduct of hearings, the format of reports, and other administrative aspects of the coronial process. Overall, the role of the coroner is to provide an independent and transparent investigation into specific kinds of deaths that occur within the ACT, with the aim of establishing the truth about how and why a person died and, where appropriate, making recommendations to prevent similar deaths in the future.

The Coronial Context

There is a growing body of literature concerning coronial decision-making, procedures, and potential reforms. This literature points to an urgent need for coronial reform in a number of jurisdictions globally, with many experiencing the same failings despite differences in coronial legislation and approaches across countries and states. This section will outline some of the most common concerns pertaining to the operation of coronial processes, and examples of reforms already achieved, before moving to a focus on the experiences of those in the ACT. Some of the studies included here have emerged from the United Kingdom, however the similarities in both the nature of coronial processes and the experiences of families are profound, and so are relevant to this report. All other studies included here are from across Australian jurisdictions.

Coronial processes: common concerns

Across jurisdictions we see the same pertinent issues affecting the ways in which bereaved families and friends experience coronial processes following the death of a loved one. Overwhelmingly, these relate to the delays between the time of death and the culmination of the inquest; the provision of information, and how and when this is communicated; and the opportunities, or lack thereof, for families to be involved in decision-making processes.

The effects of delays on the bereaved cannot be underestimated. A study in the UK by Biddle (2003: 1039) found that more than three quarters of respondents had experienced significant delays between the time of death and the inquest, with almost all respondents describing this as distressing. This lead many to 'fearful speculation' as to why the delay was occurring, with one participant reporting that they felt as though the coroner was 'keeping things' from them, further complicating the grieving process (Biddle 2003: 1041). In addition, when the inquest did eventuate, many of the participants signalled that they felt unprepared for the inquest resulting from a lack of information from the coroner's office (Biddle 2003: 1038; 1041), which in turn was the cause of 'fear and anxiety' for many participants (Biddle 2003: 1042). Where the delays are prolonged, the emotions and anxieties of the bereaved are likely to be exacerbated – in Biddle's (2003) study, most participants waited up to two years for the

inquest to begin – in the ACT, as evidenced by the following case study, this can be as long as five years.

In New South Wales too, delays are often lengthy – three to four years between the time of the persons death and the culmination of the inquest is a common period to wait. Some participants in a study by McCabe and George (2021: 215) however waited five years or more. This took an enormous toll on these bereaved families, with some describing these delays as 'retraumatising' and 'extremely distressing' (McCabe & George 2021: 215). As the delays between when a death occurs and the culmination of the inquest continues to grow, families will continue to feel distressed, and too often, disrespected. Indeed, as noted by a participant in McCabe and George's (2021: 215) study, 'If you've got to wait five years for an inquest, how much respect do you think you're getting?'.

The impacts of delays on the bereaved were also cited as a major concern in a study by Dartnall, Goodman-Delahunty, and Gullifer (2019). Participants described the delays as 'traumatic' and 'tormenting', particularly where the reasons for the delays were not communicated to the families. Coronial professionals themselves are keenly aware of the impacts these delays have on bereaved families. Participants in a study by Dartnall, Goodman-Delahunty and Gullifer (2022: 10) identified delays as one of the 'main counter-therapeutic' aspects of coronial process, significantly exacerbating families' distress. These delays, often the result of protracted investigations, kept families in a 'suspended state of distress', as identified by the coronial professionals interviewed for the study (Dartnall, Goodman-Delahunty & Gullifer 2022: 11). Conversely, coronial professionals in this study highlighted instances where families sought to delay the inquest, and it was accepted by some participants that allowing an appropriate delay was therapeutic for families who needed time to 'accept a coronial investigation' was to take place (Dartnall, Goodman-Delahunty & Gullifer 2022: 11).

The most important factors in alleviating some of this distress are timely, regular communication from the coroner's office, and the provision of information to the bereaved. Participants have explicitly articulated that 'frequent communication about the reasons for delays' would have improved their experience of the coronial process (Dartnall, Goodman-Delahunty & Gullifer 2019: 10). Accordingly, most participants stressed the importance of timely communication, suggesting that they 'should not endure lengthy periods between updates' (Dartnall, Goodman-Delahunty & Gullifer 2019: 8). The importance of timely and

proactive communication was also stressed by McCabe and George (2021: 215), wherein every participant found the lack of communication from the court to be a significant barrier for families engaged in the coronial system, describing the communication as 'atrocious', a 'failure' that 'happens all the time'. In Biddle's (2003: 1014-2) study, the inadequate information and preparation provided to the bereaved both prior to and during the inquest resulted in 'differing agendas' between them and the coroner, and a 'mismatch' between what they hoped the inquest would achieve and its 'actual legal scope'. For many, particularly those who thought the inquest would result in accountability for the services that had failed the deceased, the inquest resulted only in 'a strong sense of pointlessness' (Biddle 2003: 1041).

A study by Spillane et al. (2019: 4) found that many participants felt a sense of 'foreboding' and 'apprehension' about the inquest, driven in large part by the lack of information about the inquest and related coronial processes (Spillane et al 2019: 4). This lack of information not only caused considerable distress in the lead up to the inquest for many participants, but also meant that many felt unprepared. Therefore, unexpected aspects such as the formal and judicial nature of the inquest resulted in many participants feeling as though they were on trial – this in turn serving to exacerbate feelings of guilt and grief (Spillane et al 2019: 4). Indeed, a key finding by Spillane et al (2019: 7) indicates the heightened possibility of a traumatic inquest process where 'family members are not adequately informed' of the coronial process. Delays between the time of death and the inquest taking place were also a key source of distress for families in this study (Spillane et al 2019). Although a UK-based study, the findings by Spillane et al (2019) support the notion that timely, comprehensive and accurate information may prevent families from having 'unrealistic expectations' about how soon the inquest could occur, and indeed more generally, what the coronial process may achieve, thereby hopefully minimising their distress (Dartnall, Goodman-Delahunty & Gullifer 2022: 6).

Access to information about all aspects of the coronial process is paramount in ensuring that families are empowered to participate. In their study, Dartnall, Goodman-Delahunty and Gullifer (2019: 7) found that bereaved family members who had pre-inquest opportunities to receive and clarify information, as well as opportunities to ask questions about the inquest process, valued these opportunities. In some cases, family members were invited to attend directions hearings, giving them a space to share their views and suggest avenues for further investigation (Dartnall, Goodman-Delahunty & Gullifer 2019: 6). Active involvement in the

coronial process was identified by participants and understood by the researchers as having an 'opportunity to be heard' (Dartnall, Goodman-Delahunty & Gullifer 2019: 1). Having meaningful into the inquest process was described as 'cathartic' and 'therapeutic' and was highlighted as a 'crucial factor impacting wellbeing' (Dartnall, Goodman-Delahunty & Gullifer 2019: 5), however the ability to actively engage with the process was predicated on a number of things. Where these family members had access to information and points of contact with the coroner's court, they were 'better prepared for' and 'less anxious' about the inquest process (Dartnall, Goodman-Delahunty & Gullifer 2019: 12). Conversely, the inquest was experienced as 'distressing' for those who did not have these opportunities for information and engagement, particularly concerning coronial processes and systems (Dartnall, Goodman-Delahunty & Gullifer 2019: 5). Significantly, there were some reported incidences where families were excluded from the coronial process altogether, having not been notified of the inquest until after it had taken place (Dartnall, Goodman-Delahunty & Gullifer 2019: 6). Not surprisingly, lack of information and indeed proactive contact from the coroner's court caused 'distress', 'pain' and 'anger' (Dartnall, Goodman-Delahunty & Gullifer 2019: 7).

Participants who valued the coronial process tend to be those who have frequent communication with the court and its actors; who receive timely information; and those who can access legal representation. Ngo et al. (2021: 457) found that the families who felt empowered were able to utilise their legal representatives to 'actively participate' during the inquest, including the interrogation of witnesses. These participants were more likely to 'trust and accept the final inquest findings' (Ngo et al 2021: 457).

Contrastingly, families that did not have access to legal representation during the inquest felt 'excluded from proceedings', and that they were 'unable to have their voice heard' (Ngo et al 2021: 457). These families 'often became vulnerable' during the inquest process, particularly as they felt unable to challenge witness statements, thereby limiting their satisfaction with the inquest process overall (Ngo et al 2021: 460). This in turn lead these families to feel as though justice had not been achieved (Ngo et al 2021: 457). This highlights the need for accessible and affordable legal representation for bereaved families and other interested persons to ensure that the bereaved are empowered to participate, thereby inviting a more restorative process.

The inquest or coronial hearing itself can be a source of distress for families. In Biddle's (2003: 1036) study, many participants felt 'confronted' and 'disturbed' by the 'judicial atmosphere' and 'highly formal' setting, stemming directly from the lack of information about what to expect on the first day of the inquest proceedings, again highlighting the need for timely and proactive communication and information. Similarly, Dartnall, Goodman-Delahunty and Gullifer (2019: 11) found that some participants felt intimated by the formality of the court, and where their previous knowledge of formal courtrooms was likened to a criminal court this may have raised unrealistic expectations about the determination of 'guilt' or blame, which is outside the legislative scope of the coronial investigation.

On the other hand, they supported the idea that the court's formality lent 'gravitas' and 'respect' to the proceedings, reflecting on the 'cathartic' effect it can have for families to come and honour their loved one in a 'formal setting' (Dartnall, Goodman-Delahunty & Gullifer 2022: 14). Unfortunately, however, this 'cathartic' effect is too often overshadowed by the routine nature of coronial processes - many of the bereaved feel anger at coronial processes, that 'no attempt had been made to disguise the reality that their enormous personal tragedy was no more than routine administration', a 'conveyor belt of inquiries', highlighting the 'system's failure to acknowledge their personal tragedy' (Biddle 2003: 1038' 1039).

The above sample of the literature has highlighted that across jurisdictions we are seeing the same pertinent issues affecting the ways in which bereaved families and friends experience coronial processes following the death of a loved one. Overwhelmingly, these relate to the delays between the time of death and the culmination of the inquest; the provision of information, and how and when this is communicated; and the opportunities, or lack thereof, for families to be involved in decision-making processes. From the agonising wait to be heard, to the importance of legal representation in empowering families, each systemic issue noted here can be addressed via restorative justice principles and practices. Families must be involved at each step of coronial process, from determining the scope of the inquest, to having opportunities to ask their own questions. As seen above, in doing so the bereaved are much more likely to find value in the coronial inquest or hearing, the very least we can do, and a responsibility within the context of a restorative city.

Coronial reforms and the importance of accountability

In 2006, the Law Reform Committee of the Victorian Parliament released their report into the *Coroners Act 1985* (Vic). The Report sought to recognise the distinctiveness of the coronial jurisdiction, particularly the specific functions of the inquest and 'their potential to alleviate community concerns' and 'respond to family members' needs' (Freckelton 2006: 151). The Report made a total of 138 recommendations, heralding a 'new generation of coronial reform' (Freckelton 2006: 152). The Report 'embraced the public health model of the coroner', especially in the avoidance of preventable deaths (Freckelton 2006: 154). It further recommended that coroners be empowered to refer 'findings and/or recommendations to any individual or agency' and require from that individual or agency a written response within six calendar months (Freckelton 2006: 154). It was recommended that these agencies include, as a bare minimum, government departments or agencies, as well as incorporated companies (Freckelton 2006: 154). Additionally, it was recommended that the State Coroners be able to request further information or explanation in regard to the implementation of coronial recommendations (Freckelton 2006: 154). This allowed for a new degree of accountability, built into the legislative framework, an accountability still regrettably missing from other jurisdictions.

The Report is a 'high quality', 'carefully reasoned', 'product of considerable consultation' (Freckelton 2006: 155). Not only has the public health capacity of the coroner in Victoria been expanded, but the State Coroner now has the capacity to mandate responses from those who are the subject of coronial recommendations (Freckelton 2006: 155). This is an enormous step forward, not only for the families of the deceased and the wider community, but for coronial jurisprudence more broadly, and perhaps signals the introduction of a therapeutic jurisprudential lens.

In the case of the ACT, a shift toward restorative justice practices can only be encouraged by the actions of Victoria. It is important to note however that state-based reforms are suggestive of an 'increasing disuniformity' of the coronial legislation in Australia (Freckelton 2010: 471). Despite a number of reforms, there remains growing calls for a 'nationally consistent approach' to any future coronial reform in Australia (Freckelton 2010: 471). A nationally consistent approach to coronial legislation in Australia would facilitate a

national, ‘modern, integrated and prevention-focused coronial system’, bringing it into the 21st century (Freckelton 2010: 479-80).

A modern and prevention-focused coronial system is one that encourages the use of coronial recommendations to prevent death, and that requires accountability from those to whom the recommendations have been made. Indeed, the death prevention function of the court is one way in which the coronial system can ‘justify its existence and its investigation in the face of expressed concerns and criticisms’ (Dillon 2019: 10). Coronial recommendations speak to the prevention-inspired coronial climate (Scott Bray 2010: 232), yet the issue of mandatory responses to those recommendations has raised, and continues to raise, several issues. The ‘focus on the importance of recommendations highlights the social value of the coroner who has a unique and capacious socio-legal role in improving health, safety and the administration of justice, and contributing to the avoidance of preventable deaths’ (Scott Bray 2010: 233), yet recommendations achieve nothing when they go ignored.

Coroners have a vital role in the sphere of public health, particularly via recommendations for the prevention of death. If we consider their public health and death prevention role in terms of human rights, then this role may be strengthened using a human rights framework, either nationally or locally (Freckelton 2008). Certainly, this works in conjunction with, rather than in opposition to, the recreation of the ACT as a restorative city. However, in practice, this opportunity to prevent death is stifled by the apparent unwillingness of ACT coroners to make recommendations.

Coronial recommendations, and accountability to those recommendations, is a concern not only across Australian jurisdictions but internationally. In a 2014 study, 124 coronial findings in Aotearoa/New Zealand were examined to ascertain the frequency of which coroners make recommendations, and the extent to which recommendations are implemented (Mok 2014). Due to the absence of official, standardised, nationalised reporting systems, prior to the study information was extremely limited (Mok 2014: 325). Having a greater understanding of the frequency at which recommendations are made and implemented is vital in assessing the injury- and death-prevention function of the coroner, as well as providing greater transparency and accountability to the loved ones of the deceased, and the community more broadly (Mok 2014: 321).

The scope and nature of the 154 recommendations examined in Mok's (2014) study varied greatly, however several findings were made. For instance, specific recommendations such as those directing signage alterations tended to be implemented swiftly following the recommendation being made, whereas recommendations that were wide-ranging, or required legal reform, had little to no prospect of implementation (Mok 2014: 328). Significantly, even where recommendations were supported in principle, there were many occasions where the implementation of some recommendations was described as 'not feasible' (Mok 2014: 328).

The infeasibility of some recommendations coupled with impractical and/or costly recommendations has the potential to diminish public confidence in the coronial system, as well detracting from sound recommendations (Mok 2014: 328). The quality of recommendations then is paramount, and providing coroners with guidance and training concerning the making of recommendations is essential for ensuring the feasibility and practicality of future recommendations (Mok 2014: 342). Further, Mok (2014: 342) suggests that opportunities for collaboration between parties affected by proposed recommendations be increased – this is supported by the shift toward Canberra as a restorative city, whereby the collaboration of community members in problem-solving is paramount.

However, for a robust death-prevention system, there must be accountability on those to whom the recommendations are made. It must be noted that even where 'strong recommendations' are made, across most Australian jurisdictions there is no requirement that those to whom the recommendations are directed respond (Newhouse, Ghezelbash & Whittaker 2020: 85). Establishing a nation-wide official reporting system for coronial recommendations and their implementation status would likely improve the consistency and transparency not only of recommendations, but in the way governments and other agencies respond to those recommendations (Mok 2014: 352).

This has been echoed in the findings of the *Legislative Council Select Committee on the Coronial Jurisdiction in NSW* (2022; hereafter the Select Committee). The Select Committee was established following concerns raised during the *Select Committee on the high level of First Nations people in custody and oversight and review of deaths in custody during 2019 and 2020* (2021). Thirty-five recommendations were made by the Select Committee regarding the coronial jurisdiction in NSW, including recommendations to improve the accountability to and oversight of coronial recommendations. Importantly, the Select

Committee noted that while the *Coroners Act 2009* (NSW) does indeed enable coroners to make recommendations, the purpose, and thus potential importance, of this ability is not effectively communicated to coroners. The Select Committee also noted that a Premier's Memorandum is in effect in NSW. This memorandum outlines the process by which ministers and government agencies in NSW are to respond to coronial recommendations.

The memorandum states that:

> *ministers and government agencies to whom coroners' recommendations are directed should write to the Attorney General within 21 days acknowledging receipt of the recommendation. Within six months, they must write to the Attorney General outlining any action being taken to implement the coronial recommendation and, in the circumstances, where it is proposed that a recommendation will not be implemented, the reasons why.*[2]

Key agencies in NSW also have particular processes for responding to coronial recommendations. For example, the NSW Police Force Executive is required to acknowledge receipt of coronial recommendations, and to create action items for implementation. They are also required to approve an organisation response to those recommendations. Similarly, NSW Health has a System Management Branch which is responsible for coordinating responses to coronial recommendations and provides reports to the Secretary of NSW Health regarding any coronial recommendations directed at NSW Health (see *Legislative Council Select Committee on the Coronial Jurisdiction in NSW* 2021: 83). In the ACT, the legislation requires that responses to coronial recommendations be made to the Attorney-General within three months of receipt, however this only applies to deaths that occur in State custody or 'care'. While an important feature of the legislation, this does little to prevent future deaths from occurring outside of State institutions.

Across the ACT, the coronial reforms that have occurred have done so in large part because of the tireless and tenacious work of coronial advocates. Membership of the ACT Coronial Advocates Group (ACAG) consists of bereaved people who have lived experience of

[2] NSW Government, M2009-12 Responding to Coronial Recommendations, Premier and Cabinet (31 December 2014), https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/).

the coronial system in the ACT. Many members have been a part of the ACAG for several years, fighting through their own grief to ensure other families do not have the same horrific experiences with the coronial system that theirs did. Through their advocacy and activism, members of the ACAG have successfully secured a number of reforms. It was their advocacy that led to the eventual appointment of a dedicated coroner in the ACT, and the creation of the Family Liaison Officer roles.

These successes alone have dramatically altered the coronial landscape in the ACT. The dedicated coroner is able to now focus solely on coronial matters, building a wealth of institutional and role-based knowledge that will only serve to improve their coronership, and thus the experiences of families with whom they have contact. The appointment of Family Liaison Officers means that families will now have a point of contact at the coroner's court, and access to practical supports (such as parking vouchers) where appropriate. The ACAG has also been able to contribute to legislative reforms concerning those who die while subject to a mental health order.

Prior to the ACAG's advocacy, a person who died while subject to a mental health order was referred to as a *death in custody*, rather than *death in care*, imbuing a sense of marginalisation and stigmatisation in all coronial process, including in the narrative about who the person was and might have been. Most recently, the ACAG has legislatively changed the way in which errors in coronial findings could be addressed (for example, erroneous spelling of a person name) - previously, a family had to appeal to the Supreme Court to request corrections to the findings; this is now done by liaison directly with the coroner's court. These are significant reforms that will positively impact those who will have contact with the coronial system following the death of their loved one, and brings the ACT coronial jurisdiction a step closer to being truly restorative.

Coronial Processes & Aboriginal Communities in Canberra

Despite a number of significant reforms taking place across jurisdictions, as discussed in the previous section, the coronial landscape is one fraught with tensions concerning the futility of coronial recommendations, and the need for accountability to those recommendations, and indeed more generally. So too is it a fraught and potentially traumatising process for the bereaved. Across jurisdictions we see the same barriers to restorative, or even effective, engagement between coronial actors and the families subjected to these processes following the death of a loved one: the crushing delays; the lack of timely communication and the poor provision of information; and the disempowerment of the bereaved that limits meaningful involvement in the coronial inquest or hearing. These failings are compounded for bereaved Aboriginal families for whom these issues are inextricably bound with the realities of existing within the colony of Australia. The following section attempts to bring to light some of the failures of coronial processes, inquests and hearings, as experienced by Aboriginal families. This section draws on the recent use of the Galambany circle sentencing court as the venue for the coronial hearing into the death of an Aboriginal man to illustrate these failings, as well as to highlight the benefits of this restorative approach.

There has been a lack of academic attention[3] given to the experiences of Aboriginal families within the various Australian coronial systems, despite this being a core focus of the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC; Johnston 1991). The RCIADIC was established following an alarming number of deaths of Aboriginal and Torres Strait Islander men and women in police cells, watchhouses, and prisons across Australia. At the heart of the calls for a royal commission into these deaths was a 'suspicion of the internal police investigations', 'infrequent coronial inquests' into those deaths, the apparent collusion between police and police witnesses, and the resultant masking of police violence toward Aboriginal and Torres Strait Islander Peoples (Newhouse, Ghezelbash & Whittaker 2020: 80). The RCIADIC made thirty-four recommendations pertaining to the coronial system in

[3] This is of course does not discount the incredibly important work being done by scholars such as Alison Whittaker and Latoya Rule, and with acknowledgement to all coronial scholars across Australia who are creating knowledge in this space.

Australia, highlighting the urgent need for reform. [4] Unfortunately, very few of these recommendations have been implemented, and thus any legislative changes made 'do not reflect the systemic reviews that were envisaged' (Newhouse, Ghezelbash & Whittaker 2020: 79).

Importantly though, inquests or hearings into deaths that occur in the custody of police or prisons are now mandatory across Australian coronial jurisdictions (Walter et al. 2012), highlighting the preventative, and potentially restorative, role of the coroner in avoiding the occurrence of these kinds of deaths. Of course, these inquests and hearings though are not without their issues – no inquest or hearing is held in 'isolation from the general legal system', and thus 'must be understood in terms of the institutional baggage they carry for Aboriginal and Torres Strait Islander Peoples' (Newhouse, Ghezelbash & Whittaker 2020: 77). The coronial systems across Australia 'must be viewed in the context of a colonial legal system', one that is 'imposed on the lives and bodies of Aboriginal and Torres Strait Islander Peoples' (Newhouse, Ghezelbash & Whittaker 2020: 77). It is perhaps not surprising then that in addition to the challenges and failings experienced by all bereaved Australians caught in coronial processes, Aboriginal families bear additional and compounding stressors that can, and indeed must, be alleviated. This should surely be a core focus of Canberra as it establishes itself as a restorative city.

A number of failings that have led to the increased burden carried by bereaved Aboriginal and Torres Strait Islander families have been identified in recent years (Newhouse, Ghezelbash & Whittaker 2020). Paramount is the failures of coronial processes themselves, and the legislative limitations of coronership. The exclusion of families from participating in the explication of the ambit of the coronial investigation is experienced by almost all who encounter the coronial system, however for Aboriginal and Torres Strait Islander Peoples this exclusion can be understood as a ploy to limit the questioning of broader systemic issues (Newhouse, Ghezelbash & Whittaker 2020: 84).[5] Time and again, coronial investigations adopt a narrow approach to the scope of the inquiry, including the potential scope of

[4] The full list of recommendations relating to Australian coronial recommendations can be found in this report's appendix.
[5] The Victorian inquest into the death of Yorta Yorta woman Tanya Day (2019 – 2020) was the first to consider the influence of systemic racism following a death in custody (Whittaker 2019).

recommendations, excluding the broader systemic issues, thereby failing to address the 'systemic failings that contribute to deaths' of Aboriginal and Torres Strait Islander Peoples (Newhouse, Ghezelbash & Whittaker 2020: 84).

Not only is this narrow approach in contravention of Recommendation 13[6] of the RCIADIC (Johnston 1991) but fails to acknowledge and thus address the very existence of systemic racism as highlighted by the RCIADIC in 1991 (Cubillo 2021). This failure means that we continue to see disproportionate rates of incarceration and the deaths in custody of Aboriginal men, women, and children (Cubillo 2021), as well as the deaths that occur in the context of other institutions such as healthcare settings.

There are of course exceptions to this: the inquest into the death of Yorta Yorta woman Tanya Day was the first to consider the role of systemic racism in a death in custody (Whittaker 2019), and the inquest into the deaths of three Aboriginal women in Doomadgee found that institutional racism, and a lack of cultural competency from health services, contributed to their deaths (Smith 2023). The ability of coroners to recognise systemic issues including racism allows them to address these issues by way of coronial recommendation, thus acting within their legislated purview to prevent future similar deaths from occurring.

It is then vital that the bereaved families of Aboriginal and Torres Strait Islander Peoples who have died are empowered to actively participate in determining, with the coroner, what the scope of the investigation might be, including but not limited to the systemic issues that impact every facet of Aboriginal and Torres Strait Islander Peoples' lives.

Of course, as seen above, the ability for families to be involved in coronial processes is too often hampered by a lack of access to legal representation and resources. Many families of all cultural backgrounds are forced to attend inquests or hearings without legal representation (Gilbert + Tobin, Submission 39 to *Legislative Council Select Committee on the Coronial*

[6] Recommendation 13 provided that coroners be empowered to make recommendations as deemed appropriate and should be enabled to make recommendations on any other matters as he or she deemed appropriate (RCIADIC 1991).

Jurisdiction in NSW (2022), and again this is magnified for Aboriginal families. In 2021, Aboriginal and Torres Strait Islander households had a median gross income of $830.00 per week, approximately $250.00 less than non-Indigenous households (AIHW 2023), thus affecting people's ability to access legal advice or representation.

Aboriginal Peoples are overrepresented in custody across jurisdictions, and so it is very likely that they are overrepresented in the number of mandatory inquests, thus having disproportionate contact with the coronial system (McCabe, forthcoming; McCabe & George 2021), necessitating a greater frequency of legal advice and/or representation. There is an 'ever-increasing demand' for legal representation for coronial matters (ALS NSW/ACT, Submission 36 to *Legislative Council Select Committee on the Coronial Jurisdiction in NSW* (2022: 118) and yet neither Legal Aid nor the Aboriginal Legal Service have the resources they need to 'adequately provide proper representation and assistance to all families who require it' (Evenden, Evidence to *Legislative Council Select Committee on the Coronial Jurisdiction in NSW* (2022: 118).[7]

Thus, there is a glaring disparity between the resources the State is able to employ and that of the families: many families find themselves 'outgunned not only by the quality of counsel but by their quantity' (Newhouse, Ghezelbash & Whittaker 2020: 83). Families then are 'so locked out of the process', so disempowered, that the coronial inquest or hearing cannot possibly be a restorative process for them (Newhouse, Ghezelbash & Whittaker 2020: 83). Any resultant findings from such an investigation will 'look biased, even insurmountably weighted against them' [the bereaved] (Newhouse, Ghezelbash & Whittaker 2020: 83).

It must be acknowledged that there has been a move toward encouraging participation from family members in coronial processes, however, 'their interventions are generally restricted to narratives about their loved one's life, rather than the cause or circumstances of their death' (Newhouse, Ghezelbash & Whittaker 2020: 81). This almost performative

[7] As of late 2023, the ALS has been funded to establish a coronial unit, as well as a number of coronial and community advocate positions.

inclusion of the bereaved only serves to further marginalise them, adding to the 'perception that they are not being heard' (Newhouse, Ghezelbash & Whittaker 2020: 81). This

> *...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.'* (Newhouse, Ghezelbash & Whittaker 2020: 81).

Taking a different approach – a case study

As highlighted throughout this report, there exists enormous potential for coronial processes to further traumatise already grieving families. The poor communication, lack of information provision, and lengthy delays are only exacerbated when the same families are then subjected to impersonal, disempowering, and oft confronting coronial hearings or inquests.

The following is a case study that follows the experiences of an Aboriginal family in Canberra from the time they were notified of their loved one's death, to the culmination of the coronial hearing. Much of the earlier accounts were self-reported by the family for the purposes of this case study, whereas observation was used throughout the coronial hearing. While every effort has been made to protect the identity of the family, the author acknowledges that Canberra is a relatively small place, and there was considerable media attention given to this matter. The family will be referred to throughout this case study as the Z family, and each family member referred to in this report shall be given an alias/acronym.

The Initial Investigation

AZ was reported missing at Tuggeranong Police station by their mother, BZ, on the 2nd of September 2019, having last been seen on the 22nd of June 2019. AZ was quickly designated to a 'high risk' category, and inquiries to locate them were initiated. From the front desk of the police station, next to be notified of AZ's disappearance was the Criminal Investigations Reception Office, who triage matters, before being sent across to Criminal Investigations proper, finally landing on the desks of the Homicide team. From this point, a 'Be on the Lookout', or 'BOLO', was issued to all serving police officers in the ACT; family, friends and acquaintances were interviewed; media releases were issued; and the Australian Federal Police (AFP) Aboriginal and Torres Strait Islander Liaison Team was notified. Every reasonable effort was made to locate AB and to return them home.

This is, of course, the official story. For the family, it was an entirely different experience, one founded in experiences of racism, of dismissal, and of distrust. The family members who reported AZ missing spoke of the way they felt dismissed by the police; that they did not take them seriously, and asked why it had taken so long to report AZ missing. Not only is AZ's mother a survivor of the Stolen Generations, fostering a long-held distrust of police, but AZ was known to police, and the family was reluctant to cause any trouble for them (AZ). It is also important to note that AZ lived with their partner when they went missing, and the partner failed to report them missing at all.

In addition, there is increasing evidence to support the experiences of Aboriginal Peoples who have been dismissed by police; who have experienced inadequate investigations into the disappearance of their loved one; and who have themselves been arrested when attending a police station to report a loved one missing. None of this is conducive to an Aboriginal Person approaching police to report a loved one missing. An Australian Parliamentary Senate inquiry into Missing and Murdered First Nations Women and Children is currently underway[8], which has already heard harrowing stories of the systemic failures of police across this continent to take seriously reports concerning missing Aboriginal and Torres Strait Islander Peoples. In some instances, there is a failure to fully investigate; a lack of urgency (it took ten days for police to attend the last known location of AZ following the missing person report being made); and the criminalisation of those who there to make the report (Collard 2023). Even those who are missing are criminalised in their own disappearance – they 'are still painted as criminals' (McQuire 2022).

Not only did the Z family feel as though police were unconcerned by the disappearance of AZ, but they also felt as though police could not look past their prior knowledge of AZ, painting them still as a criminal and a substance user, colouring the entire investigation. Calls for information and updates went unanswered, with AZ's sister, CZ, told to stop calling the police station. At one point, BZ was asked by police officers to tell her daughter, CZ, to stop calling the station. This is demonstrative of a profound lack of compassion on the part of the ACT Police. The family did not recall ever having contact with the AFP Aboriginal and Torres

[8] The Inquiry is expected to finish in December 2024.

Strait Islander Liaison team, nor were they actively approached with updates or with new information from anyone at the AFP/ACT Police.

At 11:42am on the 1st of December 2019, two boys called emergency services to notify that they had come across a deceased person in the local riverbed. It took local police until 1pm to arrive on the scene, a task made more difficult by the relative remoteness of the location. From that point they were joined by Search and Rescue officers, crime scene investigators, the Coroner's Office, the AFP forensics team, ACT Maritime members, and approximately forty SES volunteers. The discovery pf the deceased person immediately became a coronial investigation, with then-Coroner Glenn Theakston appointed to the matter. On the 28th of December 2019, the deceased person was identified as AZ.

Coroner #1

Coroner Glenn Theakston was the Magistrate initially appointed in September 2019 to the coronial investigation concerning the death of AZ. The investigation was closed, and the matter finalised on the 18th of February 2020, with Constable Turner of the AFP making a statement to the effect that there was 'no resources allocated and other cases taking priority'. Coroner Theakston had determined that Z died as a result of 'own misadventure', yet the family vehemently disagreed, and in the absence of a coronial hearing (/inquest) had many questions yet to be answered. In communication to the Z family, Coroner Theakston said:

> *It appears to me that over a period of about 12 months, the police conducted a careful investigation, exhausting all credible clues about what may have happened. I am leaning towards accepting that the manner and cause of [Z's] death is sufficiently disclosed by that investigation and that a hearing is unnecessary.*

This communication was sent to the Z family in October 2021, almost two years after the body of AZ had been recovered. Coroner Theakston invited the Z family to explain why they felt that a hearing into AZ's death was required, and while involving the Z family in this way is a welcome action, the family had no legal expertise to formulate such a response, and certainly

not within the twenty-one-day timeline to respond; thus, it was perhaps merely a performative attempt at restorative practice.

Coroner Theakston also forwarded a response to the family that had been prepared by the AFP, wherein Detective Leading Senior Constable Daniel Shaw responded to several concerns raised by the Z family about AZ's disappearance, and the location and condition of their body once found. The report is impersonal, without any semblance of compassion, and without even an introductory or conclusionary paragraph to recognise the anguish of the Z family at the loss of AZ. While any increase in communication with families is to be encouraged, this an example of the kind of poor communication that is too often the norm, and left the Z family feeling both anger and anguish at the coroner, the police, and the system more broadly.

The Fight to be Heard

The apparent impetuosity of Coroner Theakston and the AFP to label the death of AZ as due to misadventure, and the perceived lack of care afforded to the family, further stoked their desire to know exactly what happened to their loved one, and why. This would herald the start of a long journey toward having their voices heard, and for justice to be seen to be done, despite knowing that this would not bring AZ back. Their sister, CZ, would become the spokesperson for the Z family, initiating a fight to be heard that would span five long years, and is still not over.

Initially, the focus for the Z family was on the AFP and the ways in which ACT Police conducted their inquiries. In their view, the initial investigation was done without 'vigor and tenacity' (Whaler 2024); CZ has reported that much of the information given to ACT Police by them was lost – or never properly recorded in the first place. Too often, CZ would call police 'trying to give information and they wouldn't take our info' (Whaler 2023). Perhaps not surprisingly, this was reflected in the initial brief of evidence presented to Coroner Theakston, which totaled fourteen pages in length.

The inadequacy of investigations conducted by police on behalf of a coroner is a growing area of research, and no doubt concern. In recognising the specificity of coronial investigations, whereby the majority occur in non-criminal circumstances, Carpenter et al. (2014) sought to better understand how police themselves approach coronial investigations. They found that non-criminal death investigations are often allocated to junior officers, which has significant implications for the ways in which information is gathered and shared (Carpenter et al. 2014: 7). Having interviewed a number of coroners for their study, Carpenter et al. (2014: 7) were able to identify a disturbing trend whereby information gathered at the scene of deaths for the coroner is 'sloppily' or 'inadequately' completed.

While perhaps seemingly innocuous, 'poorly completed paperwork undermines confidence in the capacity of police to conduct non-criminal investigations such as these', raising concerns about the capacity of police more generally to gather accurate information from both the scene of the death and the bereaved families and friends (Carpenter et al. 2014: 7). One coronial counsellor in their study raised 'incredible concerns' about the information gathered by police and reported to the coroner, noting that 'sometimes information is inaccurate, sometimes police say that they've asked the questions and they haven't...' (Carpenter et al. 2014: 8; *Coronial Counsellor 2*).

These concerns are magnified when we consider the already-fraught relationships that are brought to interactions between police and Aboriginal Peoples. Police continue to demonstrate adherence to negative stereotypes of Aboriginal Peoples, with one police officer stating, 'a lot of them are alcohol dependent'; 'it's hard to get someone that's actually...sober enough to deal with' (Carpenter et al. 2014: 12; *Police Officer 4*). These are the kinds of attitudes and beliefs that far too many police hold when they attend a scene where an Aboriginal Person has died; when they speak with the grieving family; and when they decide what evidence to gather and what to pass on to the coroner. For the Z family, every step of the initial investigation, right from when AZ was reported missing, has been infected by the systemic racism inherent in ACT Policing and the AFP.

Coroner #2

In March 2022 the role of dedicated coroner had been established on a trial basis, and Coroner Ken Archer was appointed. Magistrate/Coroner Theakston's matters were given over to Coroner Archer. By August 2022, Coroner Archer had met with the Z family regarding the possibility of a hearing into the death of AZ, noting that 'there is a lot to be gained from listening to those present...about next steps' (meeting minutes as provided by CZ). A large part of the process for Coroner Archer was ensuring that 'family and community' have trust in the process. These early conversations were welcomed by the Z family, and an opportunity for them to raise a number of issues. For example, concerns about the information, or lack thereof, being collected by the police, and ways that information might be gathered by the family to share with police.

The family was also explicitly able to highlight that they did not believe a proper investigation into AZ's death had occurred, with Coroner Archer informing them that the initial investigation was conducted by the Crime Team within the AFP. From here on in, the investigation would be managed by the AFP's Coronial Team, who would undertake their investigation on the coroner's behalf and at their (the coroner's) instruction.

In May 2023, Senior Constable Cunningham was appointed as the new Case Officer for the coronial investigation into the death of AZ. More than 930 hours was spent over six months to prepare a more comprehensive brief for Coroner Archer, including new statements being taken. It is important to note though that while Senior Constable Cunningham did a thorough job in putting together this brief, the quality of a statement taken more than three years after an event can be questioned. Indeed, there are a number of studies that speak to the unreliability of witness statements after a period of time has passed – the original memory is eroded over time, influenced by new information (Davies 1995; *see also* Loftus 1979).

Galambany

The first Directions Hearing was held at the Galambany Court on 27th June 2023. For the first time, the court was made available to an Aboriginal family for the purposes of a coronial hearing. It was not, however, the first time the court was made available for a coronial matter. In 2021 Galambany was used for the coronial hearing into the death of a non-Aboriginal person, demonstrating a shift toward recognising processes that are more restorative in nature. This section will first discuss the nature of courts such as Galambany, before moving specifically to a discussion of how the Z family experienced this space, as known from the author's own observations, and a survey conducted with members of the Z family.

The formalisation of Aboriginal Peoples' involvement in court processes began in South Australia in 1999, leading to the establishment of culturally informed justice practices across Australian jurisdictions (Marchetti & Daly 2004). Dubbed the Nunga Court, similar courts have emerged in Queensland, Victoria, and New South Wales, where the philosophy of the court is also influenced by First Nations Canadian circle sentencing (Marchetti & Daly 2004) and restorative justice principles more broadly. While differences exist across jurisdictions, there are some similarities – for example, the offender accessing the court must be an Indigenous Person and must have entered a guilty plea. In the ACT, Galambany was established in 2004 and initially named the Ngambra Circle Sentencing Court (Marchetti 2017: 382).

The Galambany Circle Sentencing Court is a powerful example of the ACT Magistrates Court's commitment to working in partnership with ACT Aboriginal and Torres Strait Islander communities to improve the experiences of Aboriginal and Torres Strait Islander Peoples with the justice system. Through listening to, and engaging with, the wisdom and knowledges of Aboriginal Peoples and communities, the Galambany Circle Sentencing Court is making a significant and positive difference, including reducing the over-representation issues that have plagued Aboriginal and Torres Strait Islander communities since the time of colonisation. It provides a powerful example of how listening to the voice of lived experience can transform the experience of the justice system for the better. As one parent of a person appearing at Galambany noted:

In mainstream they tell their solicitor stuff and there is no response. In Galambany they own it. In the mainstream there is all this legal jargon and one-off interactions. In Galambany they are heard, it isn't time limited, there is space for feelings, people are asked why, the language used means they know what they are being charged with and family could speak. This creates a sense of obligation and respect for the country you are on.

Independent economic modelling of the work of the Galambany Circle Sentencing Court has also shown over $3.00 in benefits is delivered for every dollar of cost (Daly, Barrett & Williams 2020: 19). This is an outstanding result, noting that the World Bank holds that any benefit-cost ratio over 2:1 is an excellent return on investment.

Circle sentencing, including courts such as Galambany, is understood to be a restorative legal practice, although not without its criticisms. For instance, Suzuki and Wood (2017) note that restorative justice practices might actually re-colonise First Nations Peoples, highlighting that the benefits for Aboriginal Peoples are still uncertain. Further, Tauri (2022) asserts that the globalisation of Indigenous restorative practices has removed the self-governance and –determination from First Nations Peoples, transforming Indigenous restorative practices into a mechanism of the crime control industry. Indigenous-centred and –led restorative processes however are markedly different, in that they are culturally and locally relevant (as opposed to a one-size-fits-all approach) and promote the participation of community members to facilitate ownership over the ways in which these processes are undertaken (Tauri 2022).

Whether state-centred or Indigenous-centred, the aims of these courts include 'providing better sentencing outcomes, empowering Indigenous communities...and achieving restorative justice outcomes' (Cunneen & Tauri 2016: 120). Of particular relevance here are the aims to empower First Nations Peoples and to achieve restorative outcomes. The point of using Galambany was to ensure that the Z family were empowered to participate, and to aim to achieve a restorative outcome following the death of AZ. What follows then has been

informed using participant observation – the author attended each day of the coronial hearing into the death of AZ, and recorded observations made.

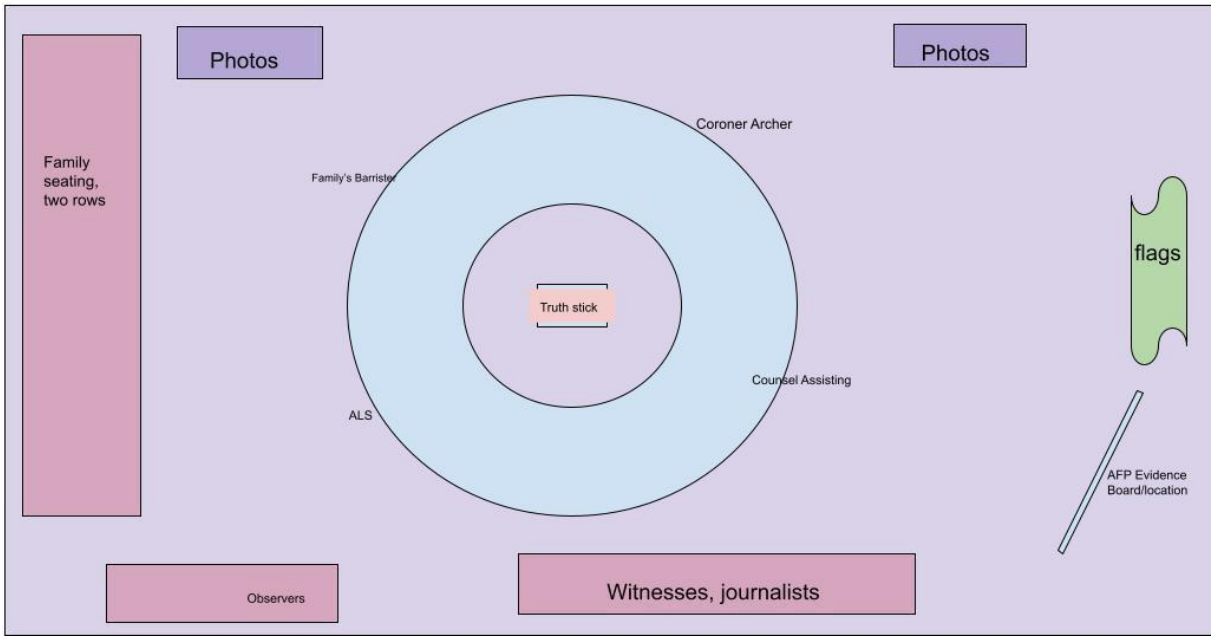

Figure 1 – image based on author's own sketch of the inside of Galambany

The days leading up to AZ's coronial hearing were marred by confusion. The dates were moved forward by almost a month, with the Z family told that they were no longer having AZ's hearing at Galambany, but rather in one of the other courtrooms at the ACT Magistrates Court. The Friday before the hearing commenced the Z family were notified that the order of evidence had changed, and that the police evidence would now be first. The change of date, change of location, and change in what to expect on Day One of the hearing only served to confuse and distress the family at what was already an extremely emotional period. On the morning of the first day of the hearing, the family was notified that it would take place in Galambany after all, and while a relief, this was only a small comfort after the preceding confusion. Added to this was the absence of the Family Liaison Officers (FLO's), who were needed to open the family room at the court and to assist with parking vouchers for the family.

In a break from tradition, the hearing was formally started close to where AZ's body had been found, with the coroner, counsel assisting, legal representatives for the family, and immediate family members attending. The formal proceedings began at the Galambany court shortly after midday, with more than twenty-five members of AZ's family in attendance. In a departure from more typical matters, no one was asked to stand when the coroner entered or left the room, and this informal air was maintained throughout the hearing, despite the formal nature of the proceedings themselves.

Counsel Assisting read an opening statement to the court, one imbued with the principles of restorative justice. They acknowledged the impacts of the delays in hearing this matter on the family, and the efforts of the Z family to get this to court and in uncovering new evidence. In speaking to the current climate of coronial reform in the ACT, Counsel Assisting verbally recognised the 'right' of AZ's family and friends to 'have their reasonable questions answered'. They also stressed throughout their opening statement that the purpose of the hearing is 'not to attribute blame', and 'not a criminal investigation'. While coronial investigations are not criminal investigations, they have a purposeful role in identifying practices and people who might have contributed to a death occurring, and to, where feasible, make recommendations to prevent those practices from occurring in the future.

This also raises questions about what it means to seek accountability – accountability does not necessarily have to emerge in a criminal sense; that is, a person is identified in having contributed to the death and is punished; rather, accountability can mean a person taking ownership of their actions and recognising the harm caused. In a matter from British Columbia, Turtle Island/Canada, accountability was recognised not as an opportunity to apportion blame, which is not within the purview of a coronial hearing, but rather an opportunity for people to take responsibility and acknowledge the harms caused (Kooijman 2021). Accountability might also look like, in this case, the police recognising the callousness experienced by the family after AZ was reported missing, and by amending internal processes to prevent this from happening to another family.

Following Counsel Assisting's opening statement, the court heard a recording of BZ, AZ's mother, speaking earlier that day. It was an incredibly emotional and heartfelt reflection, an acknowledgement of her child and her profound loss. In effect, this reminded the court that they have a particular accountability to this grieving mother and the rest of the Z family, and an accountability to AZ to find out how (cause) and perhaps why (manner) they died. The coroner thanked BZ for sharing their reflection with the court, and paused the hearing to ensure that the family members in the family room (external to Galambany) were able to see the documents being shared in the court by way of the video link that had been arranged.

The coroner appeared at all times to be being considerate of the Z family, simplifying legal jargon throughout. The coroner also checked in on BZ several times, asking 'are you okay to sit another twenty-five minutes, is that okay?'. At the end of the first day of the hearing, the coroner asked the family if they would share their photos and stories of AZ with him on the final day of the hearing, and he thanked them all for being there, a compassionate approach that was well-received.

The second day started with almost as much confusion as the first. The family did not have contact with the FLO's, and the family room was locked. Further, the family was only given one parking pass to use – this was sorely inadequate, given the number of family members in attendance each day, including Elders and small babies, and the prohibitive cost of the parking closest to the court. Once the hearing commenced, the coroner thanked the Z family for being there again. The coroner took time to explain to the family that there would be 'confronting material' discussed by the experts throughout the day, noting that these materials would not be shared on the screen, and hopefully not visible to the family or observers. The coroner also made arrangements for hearing loops to be provided to some members of the Z family, to ensure that they could hear everything that was happening.

Following the first part of the experts' evidence, the coroner paused to ensure that family was able to put to their legal representatives any questions they wanted asked of the experts, facilitating an empowered and inclusive moment for the family's participation in the hearing. The Z family's legal representatives did ask the questions put to them, demonstrating

how a family might be empowered to participate, and in stark contrast to the experiences of so many others.

The coroner and counsel assisting continued their efforts to refer to AZ by name, gently guiding others back; for example, the legal representative from the Aboriginal Legal Service more than once referred to AZ as 'the body', only to be guided back to using AZ's name by the counsel assisting. This too is demonstrative of inclusion, and the restorative practices that are easy to achieve but significant in their application. Before finalising the proceedings for the day and excusing the expert witnesses, the coroner again encouraged the family to ask any questions they might have of the experts - 'it's happened before and appropriately so'; 'now is the time'. Before closing the session, the coroner asked BZ, CZ, and their 'trusted advisor', if they had had all their questions answered. The unanimous answer was 'yes'.

Day three of the hearing into the death of AZ started much like the first two – fifteen minutes before the hearing, the family room was still locked, and a security guard had to be found to come and open it. The Z family had also had to bring their own food all week. The first thing said to this author in the morning was that the family was not happy about the day before – BZ said "my sister walked out she was so angry". It eventuated that there had been some frustration at the interpretation of the evidence by the AFP Search & Rescue Officer, who had intimated that AZ had behaved in a manner contrary to what the family knew and expected of AZ, reinforcing the Z family's frustration at not being able to fully contribute to, or have a modicum of control over, the narrative being created about AZ's life. The coroner did however ask for the family's permission to allow the local media to use images of AZ in their articles; again, this showed a willingness to enable the Z family to have some kind of control over appropriate parts of the process.

Throughout the final day of the hearing, the coroner continued to ensure that the Z family were involved and able to participate in the proceedings. When witnesses referred to AZ as 'it' (for example, the witness from the AFP Search & Rescue team kept referring to AZ's body as "it"; "*it* was wedged", "removed *it*") the coroner gently guided them back to using AZ's name, instead. Some frustrations were brought to light, frustrations that did not need to

occur. In the break, one of AZ's family members lamented the lack of communication and information provision in the years leading up to hearing - "if they knew he died quickly and didn't really suffer why didn't they tell us years ago, save all this heartache". Certainly, to have known this earlier may have alleviated much of the anguish of not knowing – five years is a long time to have had to wonder how long your loved one suffered before passing.

At the end of this last day, the coroner invited the family to speak to the photos they had arranged in the Galambany courtroom, and all present heard stories about not only AZ and their role in the family, but also of the family more generally – their closeness and the strength found in each other. CZ said later that this was incredibly important to the Z family: not only to regain some control over the narrative of who AZ was, but also to show that they were so many things to so many people, part of a family, all of whom have been affected by the loss of AZ and the subsequent administrative/judicial trauma.

In all, the hearing into the death of AZ lasted three days. There remains so many questions, some that perhaps will never be answered. The coroner advised that the family will receive a letter of summation, at which point they will be invited to comment on whether there are outstanding questions, questions with a high likelihood of being answered by calling further witnesses. If not the case, the coroner will move to finalise the hearing, to determine the cause and manner of death, and to present their findings. This is a crucial part of the hearing. The Z family have fought tenaciously against the original finding of 'misadventure', a cause of death too often applied to Aboriginal Peoples, and for this hearing to result in the same finding would be a devastating blow. The hope of the Z family is that the death of AZ is recorded as an Open Finding, allowing the possibility to reopen the matter should new evidence come to light.

Following the culmination of the hearing, members of the Z family were invited to complete a survey for the purposes of this report, of which five family members participated. This has allowed for key insights into the different ways in which the family experienced the hearing. For instance, in the below figure (Figure Y), there is a clear divide between those who have had their questions answered and those who have not.

Figure 2

Similarly, key insights into the role of the FLO's were also gained – the lack of support from the FLO's is a significant finding, and one that must be addresses for coronial processes to move toward being any kind of restorative process (Figure Z). If 60% of family members do not meet or receive assistance from the FLO's, then one might question why the roles exist. It should also be noted that the respondent who answered the 'They helped a lot' was referring to the coordinator of Galambany itself, not the coronial FLO's.

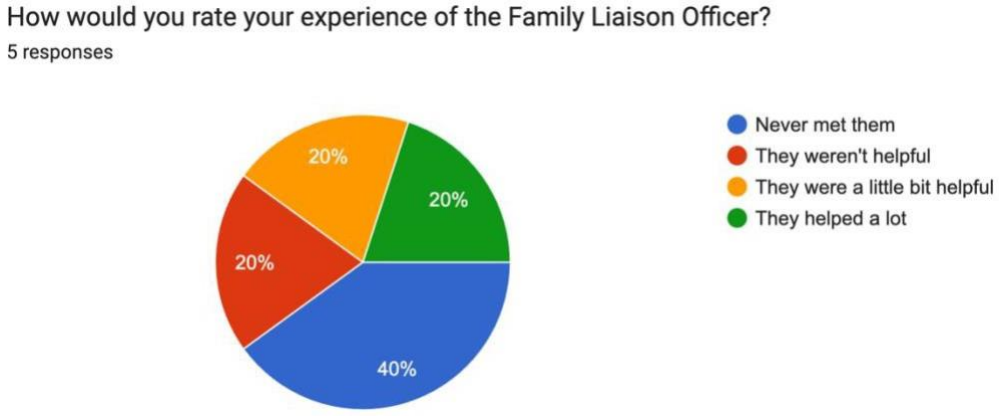

Figure 3

Access to the family room at the court was a positive element of the coronial proceedings, allowing those with small children and babies to still watch the hearing take place, as well as providing a haven for the Z family during breaks (Figure A). This then is an important and yet simple way to support families who are attending coronial hearings.

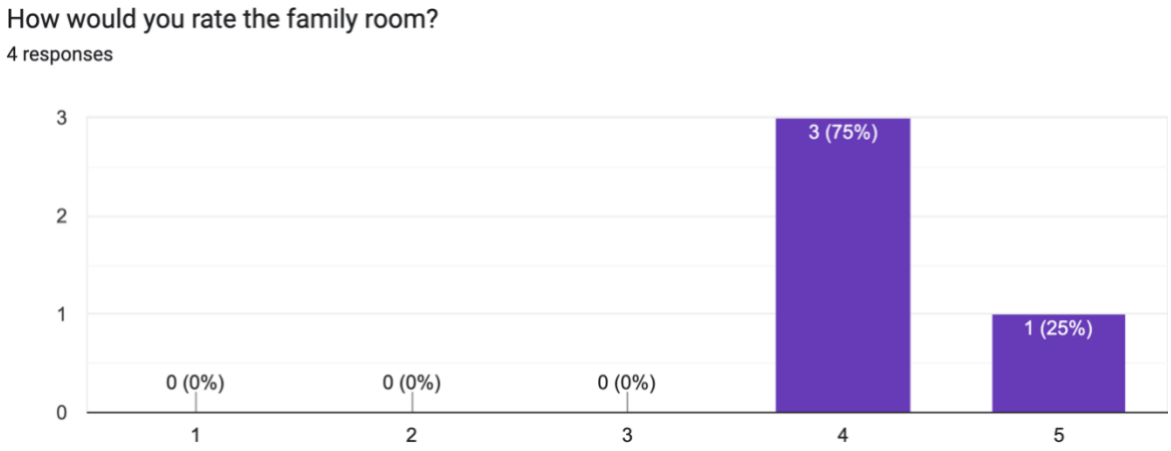

Figure 4

Of course, the entire coronial process is not complete until the coroner's findings have been handed down. This has the potential to alleviate some of the concerns the family has held for so long, or, conversely, to undo the restorative shift that has taken place throughout this process.

The Findings

At the time of this report,[9] the findings into the death of AZ have still not been handed down. This report will be amended once the findings have been delivered.

[9] September 2024.

Challenges

The following section will attempt to bring together some of the challenges experienced by the Z family right from the notification that AZ was missing, to the culmination of the coronial inquest, or hearing. The Police are typically the first point of contact when a person goes missing, or when their loved one has died. Thus, police have enormous potential to initiate a restorative process, and conversely, the potential to infect all that follows with a deep sense of distrust and retraumatisation. The police then play a key role in all coronial investigations, and so it is vital to identify the challenges they present to achieving restorative coronial processes and outcomes.

The role of the coroner itself also presents a challenge: as discussed previously, in the ACT the Chief Magistrate is the Chief Coroner, with a dedicated coroner only a temporary trial. Magistrates are not trained to be coroners – they are trained to undertake adversarial legal practice, not the inquisitory role performed by coroners. Nor are magistrates specially trained to respond to the needs and behaviours of grieving families, many of whom have lost their loved ones through non-criminal circumstances. The making of coronial findings is also different from the making of a legal judgement. All of these points are only some of the challenges brought to bear when there is no legislatively protected, independent, dedicated coroner.

The Family Liaison Officer roles also present a number of challenges. While they are a welcome and necessary addition, families must be able to come to know them, and be meaningfully supported by them, throughout the entire coronial journey, one that begins long before the coronial hearing, and continues for months and even years afterward. While some criticisms have been made of the FLO's, this is a representation of the experience of the Z family. The FLO's undertake incredibly important, yet often undervalued, work, and this must be acknowledged. There is however a great deal of potential for the roles to be improved for the families that need them, and questions to be asked regarding the requirements to hold a role such as this, and the training, support, and resourcing afforded to them. This section suggests

ways in which these challenges might be addressed, before moving to consider what future challenges that need to be addressed.

Police

Police officers are involved in coronial investigations from the time they attend they locate a deceased person, to the culmination of the coronial hearing (where one is required). It is almost always police who notify the next-of-kin that their person has died. This means that there is great scope for police to create a respectful engagement with that family and/or next-of-kin, or conversely, to infect the entire coronial investigation. Despite the important and sensitive nature of this task, little to no training is provided to police regarding death notification (Hofmann et al. 2023: 346). Often assigned to more junior officers, this task can have significant impacts on the bereaved. In one study, bereaved family members described the police officer who delivered the notification as 'being overwhelmed by the situation, distant, and insecure', affecting the mental health of those family members (Hofmann et al. 2023: 354). On the other hand, where police had spent time with the family members until other supports arrived, and where police had information sheets about what to expect next and available supports, family members felt 'less alone' in what is for many 'an exceptional situation' (Hofmann et al. 2023: 355).

These issues are magnified when the deceased person is an Aboriginal Person. Carpenter and Tait (2014b: 12) found that police officers used similar strategies for communicating with bereaved family members that are used for victims and offenders, which is not always appropriate. Families may interpret this as being seen as 'suspicious and possibly guilty of a crime' (Carpenter & Tait 2014b: 13), particularly within the context of hundreds of years of fraught and often violent relationships between police and Aboriginal Peoples (Cunneen 2001). Where a family might choose not to identify as Aboriginal People to avoid this tension, cultural obligations may not be able to be fulfilled - 'if they don't identify themselves, their grieving practices will be severely interrupted at a time when they are suffering the trauma and shock of a sudden death' (Carpenter & Tait 2014b: 13). The police must be better trained to work sensitively with grieving families, and particularly with Aboriginal families in the ACT.

Given the significant role that police officers play, from the notification of the death to the culmination of the coronial hearing, this must be considered using a restorative lens. The current practice, with little to no training, fails to equip police officers with the necessary skills to communicate with bereaved families in a sensitive way, or at the least, in such a way that is not counter-therapeutic.

Regular training and competency measures regarding death notifications should be considered as a core restorative action for all police across the ACT, and indeed Australia more broadly. Given the fraught historical and contemporary relationships between Aboriginal Peoples and police, it is a great wonder that there is no sustained training given to police for how best to respond in these situations.

In addition to regular training and competency measures, it is further recommended that Aboriginal Community Liaison Officers accompany police wherever they are required to perform a death notification duty. This may have a significant flow-on effect for the rest of the coronial investigation, ensuring that families feel respected and supported from the very start.

A Dedicated Coroner

The Chief Magistrate is, in the ACT, also the Chief Coroner. The Chief Magistrate then is responsible for the oversight of both the magistrate's courts and the coroner's court, ensuring all are working through caseloads efficiently. They are also responsible for developing best-practice guidelines for the operation of coronial matters, and the role of coroner itself. This is a specialised kind of legal practice, inquisitorial not adversarial as in criminal, civil, and family court matters. It follows then that the Chief Coroner should have specialised knowledge of the coronial system and coronership in order to develop best-practice.

The appointment of a dedicated coroner is an excellent start to developing the kind of specialised institutional knowledge required, yet without a dedicated Chief Coroner, there may be a lack of support for or understanding of what the dedicated coroner requires to deliver best-practice coronership to bereaved families in the ACT. It is therefore recommended that the role of Chief Magistrate/Chief Coroner be separated, with the dedicated coroner or another appointed judicial officer becoming Chief Coroner. This will allow the dedicated coroner/Chief Coroner to develop and hone the specialised institutional knowledge required to fully reform the ACT's coronial system into a restorative one.

This will also facilitate the meaningful involvement of bereaved families in their loved one's coronial investigations. Coroners who have been engaged in coronial work for longer periods of time are far more likely to be responsive to the needs of bereaved families (Dillon 2019b), enhancing their experiences and embedding restorative practices in the coronial investigation and any subsequent hearing. Bereaved families can be meaningfully involved in setting the scope of the hearing by being consulted during the initial stages of the investigation.

A dedicated and experienced coroner may be more receptive to speaking with families, facilitating discussions about the issues they feel are important to address. Empowering bereaved families to be involved in coronial decision-making would be a significant shift toward restorative coronial practice. Families are best situated to provide valuable information and insights into their loved one's life, health, and the circumstances leading up to their death. This in turn can help inform the findings and ensure a more comprehensive understanding of the events.

Whether the role of the dedicated coroner is enshrined in legislation or not, it is imperative that magistrates in the ACT are provided with training before undertaking coronial matters. Coronial law and procedure can be complex and specific. Magistrates, and whomever is in the role of dedicated coroner, require training to understand the relevant legislation, rules of evidence, and legal precedents, with a particular focus on the inquisitorial nature of coronial proceedings. Training in investigative techniques may also help magistrates properly assess evidence and make informed decisions, and better inform future recommendations made to

prevent similar deaths from occurring. Given the death-focused nature of the coronial system, coroner's (and the magistrate pool from which they are drawn) must be trained in trauma-informed practice to better understand and respond to bereaved families. Engaging with bereaved families requires sensitivity and effective communication skills and must be communicated with in a compassionate and respectful manner. This is not something taught across law schools, and yet is an important part of restorative coronial practice.

Family Liaison Officers

Improving the support and training of the Family Liaison Officers (FLO's) in the coronial system can significantly enhance support for families dealing with the loss of a loved one. FLO's should receive thorough training on trauma-informed practice, communicating with the bereaved, and the specifics of the coronial process. Understanding of coronial law and procedures is crucial for FLOs to effectively guide families through the process and explain what to expect. Further, they must receive cultural competency training to ensure that they are empowered to work with Aboriginal families in a culturally safe and responsive way. Ideally, at least one of the FLO's should be an Aboriginal Person.

It has become apparent that when a family has legal representation the FLOs are not able to provide them with support. This is not clear for the families, nor is it outlined on the Coroners Court web page. This lack of a clear explanation as to why support is not provided along with the 'lack of support' itself, adds to the trauma and distress of families, when those families reach out to the FLOs who then do not respond. Furthermore, the range of supports provided by FLOs are not ones that can necessarily be provided by the lawyers for a family. In other jurisdictions it is not the case that legal representation precludes support from the FLOs. It is unclear why this decision has been made in the ACT and it would be helpful for the ACT to explore how any potential 'conflicts of interest' that may arise in the role are managed in other jurisdiction. If it is to remain the case that FLOs in the ACT will not provide support to families in the coronial system then this should be clearly and simply detailed on the Coroners Court web page. It also further highlights the need for coronial families to have access to support from the VSACT. Lastly should any Aboriginal FLOs be employed it would be culturally inappropriate if they were not able to support all Aboriginal and Torres Strait Islander families, including those who may have legal representation.

While creating a dedicated identified position solely for coronial matters might not be feasible due to low coronial case numbers Canberra, a shared role model could work well. For instance, someone with experience in Aboriginal Liaison roles, such as a social worker or ALS member who is familiar with the community, could be appointed. This individual could serve as a liaison specifically for Aboriginal families, offering cultural understanding and support. This would drastically improve the experiences of bereaved Aboriginal families, as has been evidenced in the NSW and Victorian jurisdictions. It should also be noted here that an identified position for an Aboriginal Liaison might not necessarily only work with Aboriginal families – there are many communities across the ACT who may benefit from the support of an Aboriginal Liaison Officer.

FLO's should also be empowered to collaborate closely with other agencies in and around the ACT, in particular with VSACT, the ALS, Legal Aid, and hospital liaisons and social workers, to ensure that families receive holistic support. Further, they must have access to resources to provide practical supports to families. This can be as simple as parking vouchers when people are required to attend court, and the ability to provide tea, coffee, and other refreshments for families. These minor supports go a long way in supporting families throughout coronial investigations and hearings. As noted in the case study above, the FLO's were not readily available to the Z family, and they felt unsupported in both a practical and emotional way.

Establishing a robust feedback mechanism from families about their experiences with the FLO's can help identify areas for improvement, as well as affirm what the FLO's are doing well. This feedback can be used to inform ongoing training and development initiatives, ensuring that the FLO's contribute to the shift toward a restorative coronial system in the ACT.

Future challenges

Embedding Restorative Practices in Coronership

The principles of Galambany, which emphasise restorative justice and community involvement, can be applied to the coronial system and coronial practice in the ACT. There is an opportunity here as Canberra moves toward becoming a restorative city to extrapolate and implement these principles in the coronial system, aiming to adopt restorative practices in coronership. It is argued here that introducing restorative circles or conferences where affected parties (such as families, witnesses, and community members) can come together to discuss the impact of the death, share their perspectives, and seek understanding and healing, will be a significant shift toward a restorative coronial system. This might also involve using mediation or facilitation techniques to resolve disputes or conflicts that may arise during the coronial process, promoting dialogue and mutual understanding.

In line with restorative city principles, establishing community forums or panels similar where community members can participate in discussions about coronial matters would help to achieve an informed and responsive coronial system, one that is transparent and inclusive of community perspectives. Further, recognising and respecting the cultural practices and beliefs of all involved parties, especially bereaved Aboriginal families and community members, will improve the experiences of all families who experience this jurisdiction.

Another way to embed restorative practices within coronership in the ACT is to introduce restorative conferences/circles. A similar pilot will soon be taking place in the NSW coronial jurisdiction, providing an opportunity for bereaved family members and other affected parties (such as ACT Health or JaCS) to come together to discuss the impacts of the death, share perspectives, and to seek understanding. Mediation might also be used to resolve disputes that arise during coronial investigations and/or hearings, promoting dialogue and contributing to a restorative process.

This is of course only part of the picture. For a truly restorative coronial system in the ACT, families must be meaningfully empowered to participate. This means ensuring that

families have access to legal representation, especially where the death has occurred as a result of the actions, or inactions, of State agencies or actors. Legal representation is vital in helping bereaved families navigate the complexities of the coronial system and advocate for their interests. This will also facilitate a more transparent coronial process for families, with legal representatives and advocates able to provide clear information about coronial findings and decision-making. There is an important role here too for the dedicated coroner – families may be much more willing to accept decisions made by the coroner if they understand the reasoning behind them.

Applying Galambany's underlying restorative practices and principles to coronial matters involves fostering community engagement, cultural sensitivity, restorative practices, accountability, and ensuring equitable access and participation for all involved parties. These steps can contribute to a more supportive and inclusive coronial system in the ACT or any jurisdiction seeking to enhance its approach to handling deaths and supporting families.

Training

Across all Australian jurisdictions there exists a paucity of coronial legal information and training. Magistrates, solicitors, and other legal advocates often have little to no knowledge of how the coronial system functions until they become involved in a coronial matter. Research conducted in 2019 found that too often legal representatives are trying to stay one step ahead of the coronial process, learning as they go (McCabe 2019). This can result in families not receiving the best possible advice and support during this critical time. Law students are trained to be adversarial, not inquisitorial, and it is from these law students that the future pools of magistrates, and therefore coroners, will be drawn. It is then imperative that law students are provided with a robust coronial education, including but not limited to a comprehensive understanding of the relevant legislation, as well as coronial procedures and decision-making.

Ideally, this would also include a focus on legal writing. Training in how to draft clear and legally sound decisions, particularly in the context of coronial findings, is important. This includes the ability to articulate findings and recommendations effectively and in a language

that will be accessible for the bereaved family, friends and community of the person who has died. The findings delivered at the end of a coronial matter hold great weight, not only in their capacity to confirm the circumstances of a death and to prevent similar deaths from occurring but are perhaps the final 'official' record of that bereaved family's loved one. Thus, it is crucial that they are constructed in a manner that is both legally sound and compassionate.

Speaking for the Dead to Protect the Living – taking the coronial system seriously

The function of the coroner holds enormous potential to prevent serious injury or death from occurring. This preventative potential must be taken seriously, not only to preserve life but to honour the lives of those who have died. The best way to do this is to establish a legislatively enshrined dedicated coroner in the ACT. This naturally has funding implications; however, it is argued that there are also potential cost savings in doing so. This section will look first to expected expenditures, before a discussion of the cost-saving measures that a dedicated coroner, and thus specialist coroners court, may engender.

The initial set-up costs associated with establishing the office of the dedicated coroner are perhaps negated by way of the 2022 appointment of the dedicated coroner, and the existence of the Chief Coroner/Chief Magistrate. There is a system in place that is already constituted by the required administrative infrastructure and necessary facilities. The operational costs, such as salaries, rents, utilities, legal and administrative support, and forensic services, already exist. These would however be expected to increase should a standalone court building itself be established. Another additional expense would be the development of specialised training packages for magistrates, solicitors, and other legal advocates who are interested in taking coronial matters. The benefits of this in the improved representation of families and others is arguably worth this additional expense, and is one that might be shared with university law schools and other accredited training bodies.

The purposeful allocation of funding and resources in this way will truly enable the coroner to 'speak for the dead to protect the living', asserting the ACT government's faith in

the coronial system and signalling the vital role it plays in the prevention of death. A dedicated coroner, and indeed coroner's office, may streamline processes and improve efficiency compared to a system where coronial functions are integrated with other judicial roles - in other words, the dedicated coroner and their legal and administrative supports will have a better and more holistic understanding of coronial processes and procedures, enabling them to work more effectively and confidently. This in turn could reduce the backlog of coronial matters and result in quicker resolution of matters, potentially leading to indirect savings in judicial and administrative resources. Perhaps most importantly, a distinct dedicated coroner's office in the ACT could result in higher quality investigations with a focus on restorative practices and principles, potentially reducing the need for prolonged legal proceedings and trauma associated with these.

The current coronial system in the ACT is fragmented and largely inexperienced, too often leading to inefficiencies and inconsistencies in the way matters are handled, resulting in the traumatisation of too many bereaved families and communities. Without a legislatively enshrined dedicated coroner and the recognition of the coronial jurisdiction as the specialised court that it is, there will continue to be delays in conducting investigations and in the issuing of findings, disrupting the grieving processes of bereaved families and impacting the societal outcomes from coronial recommendations.

While a distinct coronial system in the ACT will attract some costs and resourcing considerations, the cost of doing nothing may be far worse. Indeed, as former Deputy State Coroner Hugh Dillon has surmised, fully utilising the death-prevention function of the coronial system is 'worth its own cost many times over' (Dillon 2019b: 12). Coroners and the coronial system give us an incredible opportunity to learn from the tragedies of death in such a way as to prevent similar deaths from occurring again.

The case study of the Galambany circle sentencing court for coronial hearings into the death of an Aboriginal man exemplifies both the failings and potential benefits of restorative approaches. This initiative highlights systemic issues within the coronial system, particularly those affecting Aboriginal families. The lack of academic and practical attention to Aboriginal

experiences within this system, despite the RCIADIC (1991) recommendations, underscores a critical gap in addressing systemic racism and ensuring equitable processes. Many of the RCIADIC's recommendations, aimed at reforming the coronial system, remain largely unimplemented, reflecting a broader failure to address systemic issues identified decades ago.

To confront and indeed address these ongoing challenges, several steps are crucial:

1. Independent Review: An independent review should be established as a matter of priority to assess whether the dual roles of Chief Magistrate and Chief Coroner are delivering optimal outcomes for the ACT. This review should evaluate the effectiveness of the current model in ensuring a timely and effective coronial process.
2. Economic Modelling: If the review recommends separating these roles, the Attorney-General should consider conducting independent economic modelling to weigh the costs and benefits of this approach.
3. Trauma-Informed Commitments: The Chief Magistrate/Chief Coroner should be held accountable for commitments such as conducting a trauma-informed audit, providing training to court staff. Police should also undergo trauma-informed training.
4. Trauma-Informed Workshop: Organise a workshop (or series of workshops) to introduce trauma-informed principles to court and police staff, ensuring a shared understanding for forthcoming work.
5. Family Experience Survey: Commission an independent survey of families who have experienced coronial processes in the ACT to gather insights on their experiences across all stages, ensuring that the survey is developed with input from relevant stakeholders.
6. Reporting and Improvements: Post-survey, the Court and support services should report on the findings, identifying gaps in service delivery and how they align with trauma-informed practices.
7. Stakeholder Engagement: Establish an independent facilitator to promote consistent engagement between institutional stakeholders and families, fostering collaboration

aligned with the ACT Government's commitments, including the Restorative City Initiative.

8. Joint Committee Formation: As an interim measure, create a jointly facilitated working group with the Dedicated Coroner, ACT Policing, and advocates to advise on key priorities for coronial reform.
9. Empower Aboriginal Community Liaison Officers: Aboriginal Community Liaison Officers should receive information and training about coronial processes and should accompany police when an Aboriginal Person or family is to receive a notification that someone has died. They should also be able to access trauma-informed training opportunities.
10. Expand Victim Support Services: Address service gaps by extending eligibility for Victim Support ACT services to all families involved in the coronial process, not just those linked to criminal matters.
11. The ACT Coroners Court should discuss with other coronial jurisdictions the role of family liaison officers, including whether their FLOs are able to support all families involved in coronial matters, including those with legal representation. As a matter of urgent priority, information about the role of the Coroners Court Family Liaison Officers should be displayed on the Coroners Court Web page, including that at this point in time the FLOs will not provide support to families who have their own legal representation

By prioritising these reforms, the ACT can empower bereaved families, particularly Aboriginal families, to actively participate in coronial investigations and processes. Implementing a dedicated coroner with specialised training in trauma-informed and restorative practices, alongside culturally safe collaboration with Aboriginal-led organisations and the involvement of Aboriginal Liaison Officers, could significantly enhance coronial processes, and the coronial jurisdiction more broadly.

Conclusion

Coronial jurisdictions in Australia, despite numerous reforms, remain a landscape fraught with challenges and tensions. The inefficacy of coronial recommendations and the systemic issues of accountability and engagement are prevalent concerns. These challenges are magnified for bereaved families, particularly for Aboriginal families, who face compounded barriers in accessing justice and support. For the bereaved, particularly Aboriginal families, the coronial process can be fraught with delays, poor communication, and a lack of meaningful engagement, exacerbating their trauma and sense of disempowerment.

The case study outlined here regarding the Galambany circle sentencing court for coronial hearings into the death of an Aboriginal man exemplifies both the failings and potential benefits of restorative approaches. This initiative highlights the broader systemic issues within the coronial system, particularly those that affect Aboriginal families. The lack of academic and practical attention to Aboriginal experiences within the coronial system, despite the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991) recommendations, underscores a critical gap in addressing systemic racism and ensuring equitable processes. The RCIADIC's recommendations, many aimed at reforming the coronial system, remain largely unimplemented, reflecting a broader failure to address the multitude of systemic issues identified decades ago. The persistent narrow approach of coronial investigations, often excluding broader systemic issues, continues to perpetuate injustices. The coronial system's failure to adequately address systemic racism and other broader issues continues to result in disproportionate rates of incarceration and deaths in custody among Aboriginal Peoples, as well as in other institutional contexts such as healthcare.

To address these issues, it is crucial to empower bereaved families, particularly Aboriginal families, to actively participate in coronial investigations. This involves recognising and addressing systemic racism and ensuring that families have access to adequate legal representation and resources. The current disparities in legal support and the inadequate training of police and coronial officers further exacerbate the difficulties faced by bereaved families. A restorative approach would also necessitate meaningful family involvement in setting the scope of investigations and addressing systemic issues. Currently, families are often

excluded from key aspects of the coronial process, which limits their ability to contribute to the investigation and its outcomes. Ensuring that families have access to legal representation and support is crucial in this regard. Legal representation would help families navigate the complexities of the coronial system and advocate for their interests, contributing to a more transparent and responsive process.

A dedicated coroner with specialised knowledge and training in trauma-informed and restorative practices could significantly improve the coronial process. This would involve separating the roles of Chief Magistrate and Chief Coroner, ensuring that the latter has the expertise required to handle complex coronial matters effectively. Additionally, enhancing the role of Family Liaison Officers (FLOs) through better training and support, including cultural competency and trauma-informed practices, would provide critical assistance to bereaved families. The establishment of culturally safe practices and collaboration with Aboriginal community organisations could further enhance support and engagement.

In light of these ongoing challenges, there is a significant opportunity for the ACT to reimagine the coronial system through restorative practices. The principles of the Galambany circle sentencing court, which emphasise restorative justice and community involvement, offer a compelling model for reform. Implementing restorative circles or conferences within the coronial system could allow affected parties—families, witnesses, and community members—to come together to discuss the impacts of a death, share perspectives, and seek understanding and healing. This approach aligns with restorative city principles and could lead to a more inclusive and transparent coronial process.

Ultimately, the transition towards a restorative coronial system in Canberra and beyond requires a fundamental shift in how the system addresses and engages with bereaved families. By prioritising meaningful participation, cultural sensitivity, and systemic reform, the coronial system can better align with the principles of restorative justice and support the needs of *all* families, particularly those from marginalised communities. This approach not only addresses immediate concerns but also contributes to a broader culture of justice and healing within the community.

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Appendix

The *Royal Commission into Aboriginal Deaths in Custody – Recommendations regarding Australian coronial systems*

6. That for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:

a. The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

b. The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention;

c. The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and

d. The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention. (1: 170)

7. That the State Coroner or, in any State or Territory where a similar office does not exist, a Coroner specially designated for the purpose, be generally responsible for inquiry into all deaths in custody. (In all recommendations in this report the words 'State Coroner' should be taken to mean and include the Coroner so specially designated.) (1:171)

8. That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests. (1:171)

9. That a Coroner inquiring into a death in custody be a Stipendiary Magistrate or a more senior judicial officer. (1:171)

10. That custodial authorities be required by law to immediately notify the Coroners Office of all deaths in custody, in addition to any other appropriate notification. (1:171)

11. That all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death. Unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings. A full record of the evidence should be taken at the inquest and retained. (1:172)

12. That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death. (1:172)

13. That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate. (1:172)

14. That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate. (1:172)

15. That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person. (1:172)

16. That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendation s. (1:173)

17. That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above. (1:173)

18. That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody. (1:173)

19. That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known. (1:174)

20. That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody. (1:174)

21. That the deceased's family or other nominated person and the Aboriginal Legal Service be advised as soon as possible and, in any event, in adequate time, as to the date and time of the coronial inquest. (1:174)

22. That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family' s intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family. (1: 174)

23. That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise. (1:175)

24. That unless the State Coroner or the Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroners Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death. (1: 175)

25. That unless the State Coroner, or the Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service. (1:175)

26. That as soon as practicable, and not later than forty-eight hours after receiving advice of a death in custody the State Coroner should appoint a solicitor or barrister to assist the Coroner who will conduct the inquiry into the death. (1:176)

27. That the person appointed to assist the Coroner in the conduct of the inquiry may be a salaried officer of the Crown Law Office or the equivalent office in each State and Territory, provided that the officer so appointed is independent of relevant custodial authorities and officers. Where, in the opinion of the State Coroner, the complexity of the inquiry or other

factors, necessitates the engaging of counsel then the responsible government office should ensure that counsel is so engaged. (1:176)

28. That the duties of the lawyer assisting the Coroner be, subject to direction of the Coroner, to take responsibility, in the first instance, for ensuring that full and adequate inquiry is conducted into the cause and circumstances of the death and into such other matters as the Coroner is bound to investigate. Upon the heating of the inquest the duties of the lawyer assisting at the inquest, whether solicitor or barrister, should be to ensure that all relevant evidence is brought to the attention of the Coroner and appropriately tested, so as to enable the Coroner to make such findings and recommendations as are appropriate to be made. (1:176)

29. That the Coroner in charge of a coronial inquiry into a death in custody have legal power to require the officer in charge of the police investigation to report to the Coroner. The Coroner should have power to give directions as to any additional steps he or she desires to be taken in the investigation. (1:176)

30. That subject to direction, generally or specifically given, by the Coroner, the lawyer assisting the Coroner should have responsibility for reviewing the conduct of the investigation and advising the Coroner as to the progress of the investigation. (1:177)

31. That in performing the duties as lawyer assisting the Coroner in the inquiry into a death the lawyer assisting the Coroner be kept informed at all times by the officer in charge of the police investigation into the death as to the conduct of the investigation and the lawyer assisting the Coroner should be entitled to require the officer in charge of the police investigation to conduct such further investigation as may be deemed appropriate. Where dispute arises between the officer in charge of the police investigation and the lawyer assisting the Coroner as to the appropriateness of such further investigation the matter should be resolved by the Coroner. (1:177)

32. That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank. (1:177)

33. That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death. (1: 177)

34. That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer. (1:178)

35. That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, *inter alia,* that:

a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;

b. All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;

c. The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;

d. In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and

e. The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography. (1:178)

36. Investigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner on inquest into the cause and circumstances of the death and the quality of the care, treatment and supervision of the deceased prior to death. (1: 179)

37. That all post-mortem examinations of the deceased be conducted by a specialist forensic pathologist wherever possible or, if a specialist forensic pathologist is not available, by a specialist pathologist qualified by experience or training to conduct such post-mortems. (1:179)

38. The Commission notes that whilst the conduct of a thorough autopsy is generally a prerequisite for an adequate coronial inquiry some Aboriginal people object, on cultural grounds, to the conduct of an autopsy. The Commission recognises that there are occasions where as a matter of urgency and in the public interest the Coroner may feel obligated to order that an autopsy be conducted notwithstanding the fact that there may be objections to that course from members of the family or community of the deceased. The Commission recommends that in order to minimise and to resolve difficulties in this area the State Coroner or the representative of the State Coroner should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the

removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rites and that relatives of a deceased Aboriginal person be spared further grief. The Commission further recommends that the Coroner conducting an inquiry into a death in custody should be guided by such protocol and should make all reasonable efforts to obtain advice from the family and community of the deceased in consultation with relevant Aboriginal organisations. (1:179)

39. That in developing a protocol with Aboriginal Legal Services and Aboriginal Health Services as proposed in Recommendation 38, the State Coroner might consider whether it is appropriate to extend the terms of the protocol to deal with any and all cases of Aboriginal deaths notified to the Coroner and not just to those deaths which occur in custody. (1:180)

40. That Coroners Offices in all States and Territories establish and maintain a uniform data base to record details of Aboriginal and non-Aboriginal deaths in custody and liaise with the Australian Institute of Criminology and such other bodies as may be authorised to compile and maintain records of Aboriginal deaths in custody in Australia. (1:180)