Aboriginal and Torres Strait Islander Families in Australian Coroners Courts

A review of the research literature on improving court experiences

APRIL 2021

LAW AND JUSTICE FOUNDATION OF NEW SOUTH WALES

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Dr Kerryn Butler

Law and Justice Foundation of New South Wales

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The Law and Justice Foundation of New South Wales is an independent, not-for-profit organisation that seeks to advance the fairness and equity of the justice system, and to improve access to justice, especially for socially and economically disadvantaged people.

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Acknowledgements

This review has been conducted to understand the types of support available to Aboriginal and Torres Strait Islander families engaged with the coronial system.

This publication reports on the various services provided around Australia and acts as a starting point when reviewing culturally-sensitive practices. The scope of the report does not cover any consideration of future work or approaches to develop these services.

The Foundation acknowledges the Australian Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians of the lands in which we conduct our business. We pay our respects to ancestors and Elders, past and present.

This review was undertaken as part of the Legal Aid NSW Research Alliance and reflects the participation and commitment of many people. In particular, we acknowledge and thank David Evenden from the Coronial Inquest Unit for his time and expertise, Helen Cooper from the Coronial Inquest Unit for her valuable input; and Cherie Pittman and Naomi Cheetham from the Policy, Planning & Programs Division for their support. We would also like to thank the service providers and staff of coroners courts and legal assistance services who provided information.

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Glossary

A **coroner** is a judicial officer who investigates and makes findings about reportable deaths and suspected deaths. The coroner will be defined by the respective Coroners Act in each jurisdiction but usually must be a magistrate. The State Coroner and Deputy State Coroners are senior coroners and are usually appointed to their office by the Governor of the state.

Grey literature is research that is typically published outside of commercial or academic publishing. Examples of grey literature include statistics, government reports, conference proceedings, and policy statements. Grey literature can be an excellent source of information for a number of reasons; it can be more current than traditional academic literature, it can be a better source of information on policies and programs, it may minimise publication bias, such as reporting on negative as well as positive findings, and is often a good source of information. However, it should be noted that grey literature may not have been peer-reviewed to academic standards and should be evaluated accordingly.

An **Inquest** is a court hearing where the coroner considers evidence to determine their findings. Most coronial proceedings can be finalised by the coroner without the need of an inquest and this is often referred to as ‘on the papers’. In some cases, an inquest will be mandatory (e.g. death in custody).

Primary research is often described as firsthand accounts of a study written by a member of the study team. It typically follows the scientific method and includes data collected from surveys, interviews, focus groups, observations etc. Another way to describe primary research is ‘original research’.

(Senior) Next of Kin is the family member who is recognised as the main point of contact and the main decision maker for the family. Who the senior next of kin should be is defined in the Coroners Act of each state and territory. Broadly speaking the hierarchical relationship begins with the person’s spouse, adult children, parents, adult brothers or sisters, an executor of the will or legal personal representative. In some jurisdictions the Coroners Act also recognises traditional Aboriginal kinship relationships.

Post-Mortem / Autopsy examinations include non-invasive procedures such as medical record reviews, computed tomography (CT) scans, external examinations of the body and collection of blood or fluids for toxicology or other laboratory tests. More invasive procedures may include partial or full autopsies (internal) examinations.

Reportable deaths are defined by the Coroners Act in each jurisdiction. Broadly speaking (and subject to the Coroners Act) a person’s death may be a reportable death if the death is unexplained, unexpected, or suspicious. Definitions among the various states and territories are comparable.

Secondary research can be described as an analysis or interpretation of previously conducted primary research. The secondary research will draw together findings from studies the researcher did not conduct themselves.

Overview of the Australian Coronial System

A review of current coronial practices in Australia

Background

The Law and Justice Foundation of NSW (the Foundation) has undertaken a program of research for Legal Aid NSW which will support coroners courts and legal assistance services seeking to develop culturally appropriate services and practices. Legal Aid NSW sought to understand more about culturally sensitive practices or strategies that have been employed within various coronial jurisdictions. The starting point of the Foundation's investigation is a literature scan that is reported here. In this scan, the focus is on the experience of Aboriginal and Torres Strait Islander families' experience of the coronial process. Given the dearth of evidence in this space, the focus was then broadened to encompass the experiences of all families. This understanding can be used to identify where services could be developed or improved to better serve the families of Aboriginal and Torres Strait Islander people when engaged with the coronial system in Australia. This literature scan informs this work.

Coronial Investigation

The coronial system consists of both medical and legal processes. Broadly speaking, the medical processes are performed by state forensic medicine services who provide the coroner with expert advice concerning the medical cause of death. Forensic services utilise a number of procedures and tests including external examination, toxicology tests, microbiology tests and histopathology examinations. Where required, partial or full internal examination (autopsy) is performed. Some states will also utilise computed tomography (CT) scans which can inform the direction of autopsy, and in some instances can negate the need for internal examinations.

Legal processes are performed by the coroners court. It is the responsibility of the coroner to confirm or, if necessary, determine the identity of the person who died, the time, date, and location of the death, the cause and manner of the death. These findings are necessary for a death certificate to be issued.

Coroners court services

In Australia, the coronial system in each jurisdiction is governed by legislation. The Coroners Act in each jurisdiction provides for the appointment and functions of coroners and assistant/deputy coroners and or magistrates. Each Coroners Act details the types of deaths that must be reported to the coroner and establishes the authority of the office to investigate deaths or suspected deaths in order to determine the identities of deceased persons, the times and dates of their deaths and the manner and cause of their deaths. The coroners court is inquisitorial in nature and is concerned with finding out what happened. The coroners perform a unique and important role within the legal system.

Coroners are responsible for ensuring that deaths arising in suspicious, violent, unnatural and unknown circumstances are properly investigated.

For this research project we note coroners can assist grieving families by providing them with an understanding of the circumstances in which a loved one has died. Nevertheless, given that the deaths which fall under the jurisdiction of the coroner are often unexpected, sudden, and frequently traumatic in manner the coronial process can be very difficult for families. The very nature of these types of deaths and the uncertainty surrounding the details may cause a compounding of grief and a re-living or re-traumatising process for families involved with the coronial system. This requires sensitivity and consideration for families in order to not add to their distress.

Deaths investigated by coroners comprise only a small proportion of all deaths. Of all deaths investigated by a coroner, most deaths are dealt with 'on the papers', a largely administrative process. Some of these deaths may need an autopsy (post-mortem) to assist the coroner to determine cause of death. A small proportion of reportable deaths will require an inquest (court hearing) where the coroner considers evidence from witnesses. In some cases, such as where there is a death in custody or as a result of police operations, an inquest will be mandatory.

Although no current data is publicly available reporting the number and proportion of Aboriginal and Torres Strait Islander people whose cases have been considered in the coronial system, previous research has reported on this issue. Data collected for 2003–2004 in a Queensland study showed that 25% of the total number of Aboriginal and Torres Strait Islander deaths were reported to, and investigated by, the coroner. In comparison, only 9.4% of non-Indigenous deaths. Many deaths that come to the attention of the coroner, represent avoidable deaths, and even in natural cause deaths most come to the coroner because the death is unexpected. This apparent overrepresentation of Aboriginal and Torres Strait Islander people in these figures is strongly suggestive of the poorer health outcomes experienced. Nevertheless, this study showed there were disproportionately more Aboriginal and Torres Strait Islander deaths reported in nearly every category of reportable death and they are more likely to find themselves engaged with the coronial system than non-Indigenous people. Examples of categories include; natural cause deaths (for which a medical practitioner has not signed, and is not likely to sign, a death certificate), accidents, suicides, homicides, and medical/surgical complications.

The Coroners Acts and the Aboriginal and Torres Strait Islander community

The states and territories of Australia each have their own Coroners Act. There are slightly different aims and emphasis in each jurisdiction. In terms of engaging with Aboriginal and Torres Strait Islander people, the states and territories have implemented, to a lesser or greater degree, a number of recommendations that have been made through various coronial reform processes including the Royal Commission into Aboriginal Deaths in Custody.

The coroners courts of the states and territories operate under the following Acts:

- New South Wales – *Coroners Act 2009*.
- Australian Capital Territory – *Coroners Act 1997*.
- Victoria – *Coroners Act 2008*.
- Tasmania – *Coroners Act 1995*.
- South Australia – *Coroners Act 2003*.
- Western Australia – *Coroners Act 1996*.
- Northern Territory – *Coroners Act 1993*.
- Queensland – *Coroners Act 2003*.

Throughout the remainder of the report these are referred to collectively as the Coroners Acts. Table 1 below shows that across the various states and territories, particular mention of Aboriginal and Torres Strait Islander people (and families) in the Coroners Acts, is made in the following ways with clauses specific to the following issues.

Table 1: Comparison of clauses referring to Aboriginal and Torres Strait Islander peoples across Australian jurisdictions

	NSW 2009	ACT 1997	VIC 2008	TAS 1995	SA 2003	WA 1996	NT 1993	QLD 2003
Aboriginal ancestral remains[1]			Y	Y				Y
Senior next of kin / Family member[2]		Y		Y			Y	Y
Respect cultural diversity[3]			Y					Y
Consider RCIADIC recommendations[4]						Y		Y
Special notifications[5]		Y						

[1] Detection of any Aboriginal ancestral remains must notify and/or/refer to appropriate Aboriginal authority

[2] if the deceased is an Aboriginal person this can include, a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person.

[3] Encourage the Coronial system to engage with families in ways that respect cultural diversity.

[4] Have regard to recommendations of the Royal Commission into Aboriginal Deaths in Custody.

[5] Deaths in custody where the deceased is Aboriginal must notify appropriate Aboriginal Legal Service re: death, reports, decisions.

While NSW and SA have no specific references to Aboriginal and Torres Strait Islander peoples this does not mean that these states do not have procedures in place to respond to the cultural requirements of these families. Some jurisdictions have made administrative changes, and some have gone further and enshrined those changes in legislation. In NSW, many responses have been administrative in nature and based on the State Coroner's recommendations and findings. For example,

- The Aboriginal Strategy and Policy Unit (ASPU) was initially formed in 1993 as part of Corrective Services commitment to implementing the recommendations from the Royal Commission into Aboriginal Deaths in Custody. The ASPU acts as a strategic Aboriginal affairs advisory, planning, support, program and policy unit for Corrective Services. Recently released policy[6] sets out procedures that must be followed when there is a death of an Aboriginal inmate in Corrective Services NSW custody. Some examples of procedure that must be followed include;
    - Notify the Aboriginal Legal Services (ALS) and Aboriginal Affairs (NSW)
    - Assist the Governor or Officer in Charge with any family or cultural issues that may exist
    - Organise a meeting at the earliest opportunity with Aboriginal community members to allow them to raise any questions or issues they may have.

- The NSW Health Code of Practice and Performance Standards for Forensic Pathology in NSW[7] documents in its guidelines that where skeletal remains are discovered and clearly identified as being of historical Aboriginal origin all efforts should be made to avoid disturbance of the remains, the coroner should be notified, and the local land council consulted.

[6] Aboriginal deaths in custody (2020) Policy, Aboriginal Strategy & Policy Unit, Dept of Communities & Justice.

[7] NSW Health Code of Practice: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_049.pdf

Purpose and methodology

The purpose of this study is to describe practices aimed at improving processes and experiences for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system. This review consisted of a jurisdictional environmental scan and a literature scan.

Jurisdictional environmental scan

The Foundation conducted a jurisdictional environmental scan of current practices, policies, and/or strategies employed by Australian coroners courts. The jurisdictional environmental scan describes services provided by coroners' courts in each Australian jurisdiction. Publicly available information was confirmed with the court registrars or support services in each jurisdiction.

Literature scan

In addition to the environmental scan, a literature scan was undertaken to locate and summarise the targeted research evidence on the involvement in the coronial system of Indigenous people in Australia and abroad. A literature scan is not an exhaustive or systematic review but is a broad search of published and grey literature to identify relevant works to the research topic. It is hoped the results of this scan will provide insights into the current status of the coronial system as it affects Aboriginal and Torres Strait Islander people. These insights can provide a basis for planning improvements, particularly for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system.[8]

The Foundation developed a research protocol which defined the parameters of the scan and set out the inclusion criteria and the search strategy. A broad inclusive approach was employed as this was an exploratory scan of the available literature. The inclusion criteria comprised academic and grey literature **published between 1995 and 2020**, with a focus on the experience of Aboriginal and Torres Strait Islander families. The literature was sourced by:

- Searching academic databases
- Searching key websites, including Aboriginal justice organisations
- Google-searching
- Hand-searching reference lists quoted in the articles included in the scan.

Additionally, Legal Aid NSW alerted the Foundation to a number of recent reports on coronial assistance legal services and audits.

[8] This is a scan of the literature, not an exhaustive or systematic review and as such we cannot guarantee the completeness of the literature reviewed here. Likewise, the level of rigour of individual studies included has not been comprehensively assessed.

Overview of results

A total of 31 items of literature were identified as containing relevant information and were included in the literature scan. The literature was then categorised by type with priority given to peer-reviewed primary research, whether qualitative or quantitative. Secondary research and grey literature references were also reviewed.

Of the primary research reviewed, only six qualitative research papers were found that described the experiences of, or impact on, families involved in the coronial process. Being observational studies only, none explicitly interviewed Aboriginal and Torres Strait Islander families about their experiences.

Two quantitative research studies were reviewed that examined coronial data and reported on Aboriginal and Torres Strait Islander clients. The remainder of the reviewed literature are reports, commentaries, and case studies (peer-reviewed and non-peer-reviewed) that provide contextual analysis of the coronial system and services. Table 3 provides details and summaries of this literature in chronological order from 1996 to 2019.

Eight items of literature that were assessed as being of particular interest to the purpose of this scan have been summarised in further detail and appear in chronological order from 2008 to 2019 on pages 26–33.

A section found at the end of this report includes a compilation of detailed recommendations that have been extracted verbatim from the reviewed grey literature. Many of these recommendations are not necessarily applicable to the wider coronial discussion as they are specific to the time and jurisdiction for which they were written. The Foundation has not assessed those recommendations and, as such, do not carry our endorsement.

Jurisdictional environmental scan

Culturally specific services at the coroners court

It is important to recognise the diversity and uniqueness of Aboriginal peoples, as well as of individuals within communities. Aboriginal and Torres Strait Islander peoples have a diversity of language, culture, histories, and perspectives all of which need to be accounted for in the provision of any support services. It is not the intention of this review to imply that all Aboriginal people observe the same beliefs and traditions (and require the same services). As such, it is expected that service needs may vary considerably both between and within jurisdictions.

Perhaps in some ways reflecting this diversity, the jurisdictional environmental scan reveals a variety of models of services to families in the coroners court. These apply across Australia and various jurisdictional characteristics may have impacted the development of these service models. Smaller jurisdictions may opt for a holistic service model where service staff are trained in culturally competent approaches. In these cases, agreements with external specialist associations may provide additional support. Larger jurisdictions may opt to have specialist services in-house to ensure culturally appropriate support is always available. Jurisdictional characteristics such as the number of cases, the proportion of culturally and linguistically diverse people (including Aboriginal and Torres Strait Islander) who come under the purview of the coroners court, legislation, and available funding, will all impact the development of these services.

Culturally specific services range from very minimal or ad-hoc services in some states, to specialised in-house services in others. It is important to note the characteristics of each jurisdiction when considering the services provided. An example of an in-house specialised service is the service model employed in Victoria summarised below.

Koori Family Engagement Unit, Victoria

The Coroners Court of Victoria has partnered with the Aboriginal community through the Aboriginal Justice Caucus under a continuing Aboriginal Justice Agreement to address justice needs, support families and make communities safer. The Aboriginal Justice Caucus has identified the key benefit of this Agreement as the collaborative partnership that drives the strategic planning and facilitates culturally appropriate, and effective criminal justice responses. This has resulted in several culturally appropriate services now provided by the Coroners Court of Victoria, one of which is the Koori Family Engagement Unit. [9]

[9] https://www.aboriginaljustice.vic.gov.au/

Aboriginal Justice Agreements are formal agreements between state or territory governments and Aboriginal and Torres Strait Islander communities which aim to work together to improve justice outcomes.[10]

The Koori Family Engagement Unit is described as follows:

1. A designated Koori Family Engagement Unit provides guidance to the Coroners Court of Victoria to ensure its service provision is and remains culturally informed and appropriate. The three pillars of the Koori Engagement Unit are: family, coroners court staff development, and community engagement. The team is funded to support two roles to appropriately resource the team to support both Men's Business and Women's Business.
    a. The Koori coordinator is able to provide a cultural brief to the coroner on all cases which can detail specific culturally sensitive practices or approaches which include kinship and acknowledgement, naming and identifying preferences, country or countries of the deceased.
    b. The Koori coordinator can also support families on country where truth-telling can happen. The coordinator will also sit with the family throughout the inquest to provide support
2. "Sorry Business" is an important time of mourning for Aboriginal people following the death of a loved one. Each staff member is required to attend training in "Sorry Business". A sound knowledge of the requirements and traditions surrounding "Sorry Business" mean that staff are better placed to engage more effectively with Aboriginal families.
3. The court has introduced smoking ceremonies and Welcome to Country at the commencement of hearings where appropriate.

[10] http://classic.austlii.edu.au/au/journals/UNSWLRS/2014/14.pdf

Culturally specific service provision within Australian jurisdictions

The following information was sourced by a desktop investigation of services provided by coroners courts in each Australian jurisdiction.

Where feasible the Foundation verified and cross-referenced this information from other sources, but this falls short of an assurance of completeness as some references may have eluded our scan.

Aspects of coronial and related procedures that may impact Aboriginal and Torres Strait Islander families specifically have been identified in the literature and are included in the state summaries listed below. These include;

- how notification of the death is delivered,
- autopsy, and
- kinship.

Other aspects of service have been included to provide a clearer picture of how support is delivered in each state. These additional aspects of services are:

- counselling support,
- inquest support,
- regional area processes,
- culturally sensitive practices,
- training, and
- legal assistance.

All of these functional aspects of coroners courts are of importance to the objectives of this paper whether or not they make direct reference to Aboriginal and Torres Strait Islanders involved with the court's dealings. Aspects of functioning not specifically designed for First Nations people may well be capable of adaptation to particular cultural circumstances.

The following table presents the number of reportable deaths and inquests heard in the 2018–19 reporting year. It was not possible to provide further breakdown from the published data (e.g. rural/regional and metro deaths, Aboriginality, autopsy figures). The figures, for all but one jurisdiction, have been drawn from the relevant annual reports. [11]

[11] Figures for Northern Territory were requested by the author via email as the annual report did not provide coroners court figures.

Table 2: Reportable deaths and inquests heard by jurisdiction, 2018–19

	Reportable deaths	Inquests heard
New South Wales	6,673	117
Australian Capital Territory	315	8
Victoria	6,757	41
Tasmania	654	10
South Australia	2,687	37
Western Australia	2,452	61
Northern Territory	300	13
Queensland	5,797	29
TOTAL	**25,635**	**316**

New South Wales

NSW recorded 6,673 reportable deaths in 2018–19 and conducted 117 inquests.[12] The NSW Coroners Court is part of the Local Court of NSW. The State Coroner oversees and coordinates coronial services in NSW and is assisted by the Deputy State Coroners. Every local court magistrate is also a coroner and may be assisted by an Assistant Coroner.

Notification – Police generally notify next of kin in unexpected or sudden deaths and will advise the family that the coroner will be investigating the death. The senior next of kin will also receive a phone call from Forensic Medicine Social Work services within a day of the body arriving at the Forensic Mortuary or regional hospital. Social workers can explain the coronial process, support formal identifications and viewings, and facilitate information around the cause of death.

Autopsy – Religious and cultural needs of the family are considered by the coroner and the senior next of kin will be informed before any examination commences. The senior next of kin must inform the coroner in writing if they wish to object to an autopsy. The final decision rests with the coroner although the senior next of kin can apply to the Supreme Court for an order preventing post-mortem if the coroner determines a post-mortem must proceed.

Next of kin – NSW (at the time of writing) does not recognise Indigenous kinship relationships and follows the conventional hierarchy of kin.[13]

Counselling – Social workers from the Forensic Medicine Social Work services provides client-focused, short-term, early intervention support for families experiencing a sudden or unexpected death.

Inquest hearing – The Coronial Information and Support Program (CISP) employs social workers and psychologists who work exclusively with coronial mattes. They can provide

[12] Local Court of New South Wales, "Annual Review 2019," (2019).

[13] Section 6A *Coroners Act 2009*.

information and support to families including general information about the inquest process. This can include court familiarisation and practical information about attending court.

Regional areas – Coronial inquests in the Sydney metropolitan area are generally conducted by the State Coroner or one of the Deputy State Coroners in the coroners court at Lidcombe. Local court magistrates in their capacity as coroners also conduct a limited number of inquests in regional areas. In those cases where a senior coroner is required to preside over the inquest, the State Coroner or Deputy State Coroner will travel to regional courthouses to conduct the inquest.

Culturally sensitive practices – ad hoc practices are implemented where possible (including ways to honour the deceased in court). The Indigenous Services Unit (Department of Justice) (unofficial links) is consulted at times to facilitate Sorry Business activities. Additional links with Indigenous Social Justice Alliance and other external organisations are sometimes utilised.

Training – no publicly available information.

Coronial Legal Assistance – Coronial Inquest Unit, Legal Aid NSW, Aboriginal Legal Service (ALS).

Australian Capital Territory

The ACT recorded 315 reportable deaths in the year 2018–19 and conducted 8 inquest hearings.[14] All ACT Magistrates are also coroners and the Chief Magistrate is the Chief Coroner. The Registrar of the Magistrates Court is also the Registrar of the Coroners Court.

Notification – Australian Federal Police will notify families of the death and will collect information from the family regarding identification, property. Consideration is given to taking an Aboriginal liaison person for the notifications, particularly for a death in custody. A small group of police officers perform the role of the coroner's Liaison Officer and is the principal liaison and contact point for any dealings with the coroner.

Autopsy – Families are given the opportunity to raise concerns regarding autopsy, however the final decision rests with the coroner. The family may object to observers at autopsy (i.e. medical students) and these wishes will be followed. The coroner may decide no examination is needed in which case the body may be released to family immediately at the scene (for collection by an undertaker).

Next of kin – The ACT does not recognise Senior Next of Kin in the same way other jurisdictions do but takes a more inclusive approach which allows for all eligible people to be consulted and kept updated and specifically includes Indigenous kinship relationships. In a majority of cases the family may nominate someone to act as a senior next of kin.

Counselling – The Coronial Counsellors will do a welfare check by phone to the Senior Next of Kin within a week of the death and offer services. Referral to free counselling (provided by the ACT Coronial Counselling Service, Relationships Australia) is offered. This

[14]Chief Coroner ACT, "Act Coroner's Court Annual Report 2018/19," https://courts.act.gov.au/__data/assets/pdf_file/0005/1402493/Chief-Coroners-Annual-Report-2018-19.pdf..

counselling is available to anyone affected by a death being investigated by the ACT coroners court. It is available at no cost during the coronial process and for up to three months after the coronial process has been concluded.

Inquest hearing – In cases where an inquest hearing is required or directed, the coroner will forward the particulars of the time and place of the hearing to a member of the immediate family. Inquest hearings are held at the ACT Magistrates Court building.

Regional areas – In most cases, bodies of the deceased are brought to the ACT Forensic Medicine Centre for examination.

Culturally sensitive practices – The ACT Coroners Court aims to be sensitive to all backgrounds and cultures. The preferred way to refer to the deceased will be confirmed with the family. Where possible, cultural practices will be accommodated (smoking ceremonies at the death scene), face-to-face meetings may be more appropriate than telephone communication, and multiple visits for viewing the body are facilitated where operationally possible.

Training – Court-wide culturally specific training is available; however, this is not specific to coronial matters.

Coronial legal assistance – Legal Aid ACT and the ALS may be able to provide assistance or representation in certain circumstances. This is subject to eligibility criteria and may include facilitating access to reports/paperwork, inspecting documents, supporting requests for funeral assistance, making objections to autopsy, pre-inquest meetings and representation at inquests.

Victoria

Victoria recorded 6,757 reportable deaths in 2018–19 and conducted 41 inquests.[15] The Coroners Court of Victoria is a specialist court. Unlike other jurisdictions, magistrates in Victoria are not coroners by virtue of their appointment as a magistrate. All coroners are appointed to the position by the Governor in Council at the recommendation of the Attorney-General.

Notification – Victoria Police attend every death scene. The Coronial Admissions and Enquiries staff (CA&E) make the first of two calls to families. The first call informs the family that the death has been reported and that it is now a coronial matter, they establish who the next of kin is and ascertain if the family seek to object to an autopsy. The second call to the family will inform them of the preliminary cause of death *or* that an autopsy is required to establish this. Every family is asked about Aboriginality and specialised support is available. Support is then transferred to the Coroners Family Liaison Team.

Autopsy – The Coronial Admissions and Enquiries staff inform the family if an autopsy is required and explain the process, including how to object if so desired. The Victorian Institute of Forensic Medicine utilises a computed tomography (CT) scanner which can reduce the incidence of full autopsies in some cases.

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[15] Coroners Court of Victoria, "Annual Report 2018-19," https://www.coronerscourt.vic.gov.au/sites/default/files/2019-11/Coroners%20Court%202018_19_AnnualReport_0.pdf.

Next of Kin – Victoria follows the conventional view of next of kin and does not make special considerations for traditional Aboriginal kinship relationships.

Counselling – The Family Liaison service is staffed by social workers, welfare workers, and a psychologist. Brief intervention type counselling is available. Referral for ongoing therapeutic counselling can be made to external organisations.

Inquest hearing – Court Networks is a volunteer-based organisation that provides support to all court users. Families can request support from Court Networks through the Family Liaison Team.

Regional areas – Most inquests are held in Southbank Melbourne. Local magistrates courts can sometimes sit as a coroners court in cases where the majority of witnesses live in a regional area.

Culturally sensitive practices – See discussion of the Koori Engagement Unit above.

Coronial legal assistance – The Victorian Aboriginal Legal Service (VALS) represents clients in coronial matters. Also, a pro bono scheme has been launched between the court and the Victorian Bar to improve access to justice and support for those affected by the coronial process. Under the scheme pro bono counsel is available to families to provide legal advice about the appointment of senior next of kin, autopsies and the release of bodies.

Tasmania

Tasmania recorded 654 reportable deaths in 2018–19 and completed 10 inquests.[16] The Coronial Division of the Magistrates Court (or the 'Coroners Court') is a specialist court and in addition to the State Coroner, all magistrates are coroners.

Notification – Coroners' Associates (Tasmania Police) will inform families of the death and that it is a coronial matter. Coroners' Associates are specially appointed police officers who are assigned coronial duties only.

Autopsy – Objections to autopsy must be provided to the coroner in writing. If the coroner determines an autopsy is necessary, they will send out a notice to the senior next of kin who may then apply to the Supreme court. In rare circumstances, the coroner may proceed immediately to autopsy without the opportunity for the senior next of kin to object.

Next of kin – The Coroners Act in Tasmania observes a more inclusive and culturally sensitive definition of 'senior next of kin' and specifically includes Indigenous kinship relationships.

Counselling – No inhouse counselling available. Families are referred externally. Self-help information provided in the form of a Sudden Loss Support Kit distributed to all families.

Inquest hearing – No publicly available information.

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[16]Magistrates Court of Tasmania, "Annual Report 2018-2019," (2019).

Regional areas – No publicly available information.

Culturally sensitive practices – No publicly available information.

Coronial Legal assistance – No publicly available information.

South Australia

South Australia recorded 2,687 reportable deaths in 2018–19 and conducted inquests for 37 deaths. [17] In South Australia, all magistrates are Deputy State Coroners by virtue of their office.

Notification – Police who attend the scene of death will attempt to identify who the senior next of kin is and will inform family in person. If the death is interstate, patrols local to the family will inform the family. Within a day or two of the death being reported a social worker from the coroners court will contact the family to explain the process.

Autopsy – SA can use a computed tomography (CT) scanner with which to direct post-mortem investigations. Families may raise their concerns regarding autopsy; however, the final decision will rest with the coroner.

Next of Kin – The *Coroners Act (2003)* in SA observes the conventional definition of senior next of kin. Usually, only the senior next of kin will be the contact person, however in special circumstances, the court will endeavour to keep any other relevant person informed.

Counselling – Social workers are able to provide brief intervention-type counselling and will actively check with next of kin as to what supports they have available. Support and help is available in preparing for inquests, together with information about bereavement and support groups, as well as referral to longer-term counselling and other resources.

Inquests – The senior next of kin listed will be advised in writing by the coroners court of the time and place of any inquest hearing. During the inquest, an Inquest Support Officer acts as a point of contact for the family.

Regional areas – The majority of inquests are held in Adelaide. The coroner can attend regional courts to hold an inquest – for example, where the majority of witnesses reside in a regional area or it is deemed to be beneficial to hold the inquest in the local community.

Culturally sensitive practices – The coroners court seeks to be culturally sensitive in all matters and with all families. Coronial staff will speak with families concerning cultural aspects (i.e. how to refer to the deceased person). Aboriginal Justice Officers work across a range of locations and courts and may be available to provide advice regarding Aboriginal culture and communities.

Training – No publicly available information.

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[17] Coroners Court of South Australia, "2018-19 Annual Report," (2019).

Coronial legal assistance – Family members/interested parties can apply to the Aboriginal Legal Rights Movement (ALRM).

Western Australia

Western Australia recorded 2,452 reportable deaths in 2018–19 and completed 61 inquests. [18] In WA, in addition to a State Coroner and Deputy State Coroner, every magistrate is also a coroner.

Notification – Where family were not present at the death, police from the Police Coronial Investigation Squad will notify family of the death and discuss the next steps. If it is a coronial matter, identity procedures will occur at this time, facilitated by the Coronial Investigation Squad and/or the Coronial Counselling Service. Depending on the circumstances of the matter and the request of the family, the Coronial Counselling Service would then contact the family. The counselling service is staffed by qualified psychologists and may provide updated information on request as to the status of the inquiry and answer any questions.

Autopsy – The Coronial Counselling Service explain the rights of the family and discuss the implications of making an objection. Where concerns are raised, they will brief the coroner. Less invasive forms (i.e. CT imaging) will be used where possible. Autopsies conducted are performed at the State Mortuary in Perth. There is also a bereavement service available to families at the State Mortuary.

Next of kin – These are usually identified by the police. WA observes the conventional definition of 'senior next of kin'. More than one person can be kept informed of progress but generally the senior next of kin will be the contact person.

Counselling – Coroners Counselling services can provide brief interventions and will refer out to external services for ongoing counselling if requested.

Inquest hearing – In cases where a hearing is mandatory or determined as desirable by the State Coroner, the Principal Registrar will be informed. When an inquest is to occur, the file will be assigned to Counsel Assisting the coroner, who will then manage the file in preparation for the inquest and appear at the inquest. They will also communicate with families, or their legal representative. A Courtroom Companion Service may be available to sit at court with families if desired.

Regional areas – Perth uses specialised coroners who are able to travel to regional locations to conduct inquest hearings. Administrative findings or determinations made 'on the papers', are generally performed by the local magistrate (who completes the role as a local coroner).

Culturally sensitive practices – The Aboriginal Legal Service of Western Australia (ALSWA) is contacted when the deceased is Aboriginal. The Coronial Counselling Service has contacts in regional areas to provide on-the-ground support to families. On occasion there have been smoking ceremonies outside the courts, but it is done separately, and not

[18] Coroners Court of Western Australia, "Annual Report 2018-2019," https://www.coronerscourt.wa.gov.au/_files/Annual_Report_2018_2019.pdf.

as part of the inquest. In matters involving Aboriginal deceased persons, family are asked, before the inquest, how they wish the deceased to be referred to. In all inquests, regard is given to how the family wish the deceased to be referred to.

Training – Cultural awareness training is provided court-wide. Trauma-informed training is available specifically for coroners court staff.

Coronial legal assistance – ALSWA represents families and persons of interest where eligibility criteria is met. Eligibility criteria is Aboriginality. Support is available in remote and regional courts where civil lawyers with expertise and specialist coronial knowledge are available to travel. Services include (but are not limited to): facilitating access to reports/paperwork, inspecting documents, ongoing investigation, requests for inquest, and inquest representation.

Northern Territory

The Northern Territory recorded approximately 300 reportable deaths in 2018–19 and completed 13 inquests.[19] In the NT, a person who is a local court judge is also a coroner, however, the Territory coroner conducts all inquests.

Notification – Families are usually notified by police. Every family is contacted by the grief counsellor within a week of each reported death, usually after the preliminary cause of death is determined. The grief counsellor will inform the family that the death is a coronial matter and outline the process. This contact will also seek to identify any need for additional support, offers self-care tips and provides information (including printed material) regarding sudden death. A letter is sent detailing the preliminary cause of death along with contact details for the grief counsellor.

Autopsy – Families are given the opportunity to object to autopsy when the police speak with family. The coroners constables will then liaise with the coroner's office/deputy coroner to discuss. Where appropriate, the coroner will take the family's request into consideration.

Next of kin – The Coroners Act in NT observes a more inclusive and culturally sensitive definition of 'senior next of kin' and specifically includes Indigenous kinship relationships.

Counselling – The grief counsellor is able to offer a limited number of short-term counselling sessions and can refer to external services for longer-term counselling needs.

Inquest – In cases where an inquest is required, the grief counsellor will contact the family and invite them for a pre-inquest meeting which is also attended by the deputy coroner. This is an opportunity for the family to ask questions and they may be invited to prepare a statement about the deceased. The family will also be accompanied to the court room to familiarise themselves with the setting and the court process will be explained. The grief counsellor also attends all inquests to offer support.

Regional areas – Support is provided via phone and local referrals can also be made. Inquests are routinely held in Katherine, Alice Springs, Darwin, and occasionally to remote communities. The State Coroner conducts all inquests and can travel, if necessary.

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[19] No further data was publicly available

Culturally sensitive practices – The coroners court will confirm with the family on the preferred way to refer to the deceased. In many cases, the coroner can respect the wishes of the family regarding the level of invasiveness of autopsy (where appropriate).

Training – While no formal training is routinely offered, staff in the NT coroner's office collaborate with community on cultural issues and can shape services to accommodate many cultural issues.

Coronial legal assistance – The North Australian Aboriginal Justice Agency (NAAJA) is informed of Aboriginal coronial deaths and can provide services and support for coronial matters.

Queensland

Queensland recorded 5,797 reportable deaths in 2018–19 and completed 29 inquests.[20] In Queensland, in addition to a State Coroner and Deputy State Coroner, every magistrate is contemporaneously a coroner.

Notification – Police will notify family of the death. Police Referrals can refer families to external service providers.

Autopsy – Police will canvas autopsy concerns with the family at the time of notification. Any concerns will be clarified by Coronial Family Services. The coroner will take concerns into account when determining whether autopsy is required and at what level. Queensland uses computed tomography (CT) scanners routinely. Recent amendments allow preliminary examinations (CT scans, blood tests) to be undertaken immediately. The number of partial or full autopsy has reduced in recent years.

Next of Kin – Police will normally identify the senior next of kin. Coronial counsellors will confirm. In the case of any contention between family members on who should be the senior next of kin, the final determination is made by the coroner. Queensland recognises Aboriginal kinship relationships in the Act.

Counselling – Coronial counsellors based at Queensland Health Forensic and Scientific Services (QHFSS) provide information and crisis counselling services to relatives of the deceased. This support is available only at the very beginning of the process (first 48 hours). External referrals may be provided.

Inquest hearing – Coroners court staff will inform the family if an inquest is to be held and when.

Regional area – State or Deputy State Coroners will travel to regional and remote areas to conduct mandated inquests. Regional magistrates may perform the role of a coroner in other matters.

Culturally sensitive practices – All Aboriginal deaths are reported to Aboriginal and Torres Strait Islander Legal Service (ATSILS) in Queensland.

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[20]Coroners Court of Queensland, "Annual Report 2018-19," (2019).

Training – Cultural Competency Guidelines have been developed for Queensland Health and sit within the Cultural Capability Framework. In addition, formalised vicarious trauma resources and training are available to all Department of Justice employees.

Coronial legal assistance – Caxton Legal Service, Townsville Community Law, ATSILS.

Literature scan

It must first be acknowledged that there is a dearth of literature available in Aboriginal and Torres Strait Islander voices. Particular care and attention was therefore taken to identify Indigenous voices among the literature. For instance, unpublished or self-published (non peer-reviewed) sources have been pursued and included in the scan. It is important to uncover research done by and with Aboriginal people if we are to understand Aboriginal experiences. It is a widely acknowledged research principle that in conducting research or developing policy that targets a specific population, the participation and inclusion of that population is desirable. This is especially true for Aboriginal and Torres Strait Islander Peoples [21]

A range of literature was reviewed including peer-reviewed primary research (one non-peer reviewed paper was included due to its obvious relevance), peer-reviewed secondary research, and a number of 'grey papers' (government reports, policy statements, etc).

Our search did not reveal any primary research investigating the experiences of Aboriginal families engaged with the coroners court where Aboriginal families were active participants. While we prioritised the Aboriginal experience, learnings from all family experiences with the coronial process were examined to supplement our understanding. Three broad themes emerged through the scan of literature on the impact on families involved with the coronial system. They were coronial communication and information-seeking, respect of culture, and voice and jurisprudence. These themes are outlined below. They provide a useful framework for understanding the challenges that Aboriginal and Torres Strait Islander families face in navigating the coronial system and the supports from which they may benefit.

Coronial communication and court information-seeking

- Communication between the coroner's court and grieving families has come under criticism with the coronial system being accused of being difficult to navigate, and fraught with unfamiliar processes and procedures that seem 'uncaring'.[22] It is these difficulties that families of people who have unexpectedly and sometimes violently died may face. It has been argued that the system should centre on the rights of bereaved families and should aim to put families at the centre of coronial processes .
- Improving access to legal representation for coronial proceedings remains an important goal. The coronial system can be difficult to navigate, difficult to understand, and if the court is not culturally competent in its processes, Aboriginal people and other culturally diverse families may face distinct disadvantage in obtaining answers and being involved

[21] National Health & Medical Research Council, *Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Researchers and Stakeholders* (National Health and Medical Research Council, 2018).

"National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)," *Canberra: National Health and Medical Research Council* (2018).

[22] Caxton Legal Centre, "Coronial Investigation in Queensland: (Counter)-Therapeutic Effects," ed. Coronial Assistance Legal Service (2019).

in the coronial process. While families do not stand to gain anything materially from participating in a coronial inquest, there can be great benefits from participating in a process where their interests and concerns are acknowledged, and they have an opportunity to have input into the direction of the inquiry.

- The potential limitations of police conducting the investigation on behalf of the coroner have also been noted. With the historical conflict between the Indigenous community and police,[23] the use of the police as investigators for the coroner may fail to provide the dynamic required for information-gathering and cooperation and may undermine Aboriginal and Torres Strait Islander families' trust in the process.

Respect of culture

- Some traditional Aboriginal and Torres Strait Islander peoples believe that if the body is not whole, the deceased is prevented from being able to enter the spiritual country and be with their ancestral family. In some circumstances, ascertaining the precise cause of death may be less important to the family than having their spiritual and cultural beliefs upheld and respected. There are a number of judgements cited [24] where the Supreme court has found for the families in their objections to autopsy in cases where an invasive autopsy is "unlikely to contribute in any meaningful way to a better understanding of the death". The opportunity to object to an autopsy, or request a less-invasive autopsy, is important to families, as is the acknowledgement of the distress an autopsy order may cause.[25] Other forms of medical investigation (scans, medical history, and other forms that are non-invasive) may be preferred as an alternative when appropriate.[26]
- The ability to mourn and grieve for family and community in a culturally appropriate way is vital. Decisions regarding the viewing of the deceased, speaking for the deceased in court, and the naming of the deceased should all consider the cultural aspects of traditional Aboriginal people and involve the families in ascertaining if/how these beliefs may be accommodated within the coronial proceedings.[27]

Voice and jurisprudence

- Much has been written about therapeutic jurisprudence and the opportunities for coronial inquests to be therapeutic through their conduct.[28] One aspect of this is the opportunity for coroners to make recommendations in the best interests of the public in an effort to prevent future deaths.[29] This ambition may be worthy of pursuit and features

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[23] Chris Cunneen and Juan Marcellus Tauri, "Indigenous Peoples, Criminology, and Criminal Justice," *Annual Review of Criminology* 2 (2019).

[24] Evans v Northern Territory Coroner, Wuridjal v The Northern Territory Coroner, Raymond-Hewitt v Northern Territory Coroner.

[25] Belinda Carpenter, Gordon Tait, and Carol Quadrelli, "The Body in Grief: Death Investigations, Objections to Autopsy, and the Religious and Cultural 'Other'," *Religions* 5, no. 1 (2014).

[26] Bruce Baer Arnold and Wendy Bonython, "Autopsies, Scans and Cultural Exceptionalism," *Alternative Law Journal* 41, no. 1 (2016).

[27] Ian Freckelton, "Minimising the Counter-Therapeutic Effects of Coronial Investigations: In Search of Balance," *QUT L. Rev.* 16 (2016).

[28] Ibid.

[29] Olivia McFarlane and Prue Vines, "Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody," *Indigenous Law Bulletin* 4, no. 27 (2000).

prominently in the literature. Indeed, if mechanisms to ensure the application of, or at least the consideration of, recommendations made by a coroner existed the prevention of future deaths may be possible.

- If family members are given the opportunity at inquest to tell their story, or speak for the deceased, the opportunity for therapeutic jurisprudence is amplified. Much research has been conducted on the counter-therapeutic effects of the coronial process on grieving families.[30]
- Where institutions or large organisations participate in inquests, they often have legal representation to protect their interests. Where families have no such representation, they report feeling left out of the process.[31].

Implications for practice

Findings from the peer-reviewed literature support a number of 'implications for practice' outlined below. It should be noted that numerous reports and research studies argue that any services developed to support Aboriginal and Torres Strait Islander peoples should include appropriate consultation and collaboration with their communities. Creating a coronial process in which Aboriginal and Torres Strait Islander people feel culturally safe, recognised and acknowledged is an important goal. Effective collaboration that provides genuine opportunities for Aboriginal and Torres Strait Islander peoples to participate in the design of services is widely recognised as good practice and has been acknowledged as achieving the best outcomes.

Notwithstanding the above, the following implications for practice provide a sound starting point for consideration if improving the experiences of Aboriginal and Torres Strait Islander families in the coroners court is to be achieved:

1. Training for investigating police officers specifically regarding cultural proscriptions against autopsy, Indigenous communication, and a deeper understanding of the broader context of social, political and historical factors impacting Aboriginal people should be considered to enhance the necessary empathy, knowledge and skills required to sensitively support Aboriginal families during a death investigation and the coronial process.

2. Training and widespread adoption of adequate numbers of Aboriginal Community Liaison Officers (Police) should be considered, and their early engagement in all coronial matters involving an Aboriginal deceased or Aboriginal relatives of a deceased person.

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[30] Stephanie Dartnall, Jane Goodman-Delahunty, and Judith Gullifer, "An Opportunity to Be Heard: Family Experiences of Coronial Investigations into Missing People and Views on Best Practice," *Frontiers in Psychology* 10, no. 2322 (2019).

Belinda Carpenter et al., "Communicating with the Coroner: How Religion, Culture, and Family Concerns May Influence Autopsy Decision Making," *Death studies* 35, no. 4 (2011).

[31] Caxton Legal Centre, "Coronial Investigation in Queensland: (Counter)-Therapeutic Effects."

3. A culturally specific unit should be established within the coroners court in each jurisdiction. This unit would employ Aboriginal or Torres Strait Islander staff who would act as a point of contact for First Nation families.[32]

4. Direct and comprehensive pre- and post- inquest briefings should be given to Indigenous families where feasible. This service could: explain opportunities for families to express their views, check family understanding of written notifications and court decisions, and identify the professionals responsible for relaying information to families.

5. Procedural reform to improve communication with bereaved families is needed to better support and inform them during the coronial process.

Discussion

The three themes emerging from the literature, together with the implications for practice noted above, should not be viewed in isolation but must be considered within the broader context.

Contextual factors not reviewed in this literature scan but that will have profound impact on experiences of Aboriginal and Torres Strait Islander families include access to legal assistance and an understanding of the impact of systemic disadvantage and discrimination.

Legal practice in the coronial jurisdiction is distinct from other types of legal practice and experience and expertise should not be undervalued. Given that coronial practice is a small practice area, access to legal assistance may be impacted by the meagre availability of a limited number of lawyers with this specialisation.

Trying to make sense of what has happened following a reportable death is a difficult process at the best of times. It may well be especially complex for Aboriginal and Torres Strait Islander families whose grief is often compounded within intergenerational trauma, social disadvantage, and a history of dispossession and marginalisation. Given the context within which the loss of a loved one is experienced, the potential for distrust of the 'system' can be high. The Royal Commission into Aboriginal Deaths in Custody found that some families of people who had died in custody or in care had been denied information about the manner of the death of their loved one. In cases like these, families were left to rely on the sometimes-dispassionate findings of the coroner. Nevertheless, the coronial process provides opportunities for trust to be built while also delivering on the responsibility of jurisprudence.

Creating a coronial process in which Aboriginal and Torres Strait Islander people feel culturally safe, recognised, and acknowledged is an important goal.

[32] Similar to the Koori Family Engagement Unit

Detailed summary of selected literature

A selection of literature has been provided below in date order (from current and most recent to oldest). Due to the lack of research into Indigenous-specific family experiences of the coronial system, a broader approach was adopted, reporting also on studies concerning experiences of the coronial system by non-Indigenous families.

An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice. S Dartnall, J Goodman-Delahunty, J Gullifer (2019) *Frontiers in Psychology* 10: 2322.

This paper examines the experiences of family members and friends of missing people who have been involved in coronial investigations into the suspected death of a missing person. It uses in-depth qualitative interviews to explore participant perceptions of the impact of the coronial proceedings on well-being, and views on best practice approaches to families in the coroners court.

Key findings

- Families benefited from opportunities to have input and feel heard, compassionate treatment and appropriate education about the process.
- Distress and trauma were reported in response to significant delays (particularly where this delay led to a loss of evidence).
- Intrusive media and the presence of unknown persons in court also led to reports of distress and concern.
- A finding of death was profoundly distressing for some participants and highlighted the need for post-inquest debriefing and support.

Implications

Findings from this study support measures implemented by some courts to assist families. These include family statements, opportunities to read the brief, and court-based counselling services. While this study did not examine any Indigenous-specific experiences, the family experiences presented here provide insights into broad aspects of the coronial process.

'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. L. McCabe (2019) Submitted for Honours Degree, University of New South Wales (unpublished)

This paper presents findings from eight qualitative interviews conducted with legal professionals and advocates who represent Indigenous families in the coronial system in NSW.

Key findings

- The impact of delays during the process was considered the biggest challenge faced by families. These delays were sometimes described as 'retraumatising', 'compounding grief', and 'extremely distressing'.
- Participants identified better training and opportunities for professional development to be crucial for improving ways of engaging with families and better understanding the coronial system and its processes. Every participant identified 'communication' between the coroners courts, and the family and legal representatives, to be a major barrier.
- Access to information, both for families of the deceased, and for those who represent and advocate for them is poor and often who should be contacted is not clear.
- Despite making recommendations (including recommendations relating to public health) being a clear object of the Coroners Act, recommendations are seen as impotent without any mechanisms for accountability.

Implications

The findings of this study confirm areas for reform and its investigator has drafted several recommendations. These are especially relevant to this paper and are included in the final section of this report.

Minimising the counter-therapeutic effects of coronial investigations: in search of balance. I Freckelton (2016) *QUT Law Review* 16: 4

This paper addresses and describes the opportunity for both therapeutic jurisprudence and restorative justice to contribute to the minimisation of counter-therapeutic effects. The author chronicles the development of awareness for these issues and reviews the evidence of impact on families (and non-family people) involved in the coronial process.

Key findings

- Despite the inquisitorial nature of coronial inquests, several research projects have reported families and non-family witnesses have felt that the processes are adversarial in nature. It is claimed this has counterproductive implications for witnesses giving an account or evidence during an inquest.
- In instances where government agencies or large organisations are involved in a person's death, lawyers are often employed due to individuals' concerns of being found liable in subsequent proceedings. This causes a power imbalance between grieving families who are unable to afford representation and their quest for answers and organisations whose interests are to avoid any inference of wrong-doing.
- Where the media takes an interest in an inquest, families have sometimes reported what is perceived as an invasion of the deceased person's privacy, and their loss of opportunity for their own private grieving.
- Delays in the process have been reported as interfering with the grieving process.
- Inadequate communication from a court, excessive inhibition on providing information to a court, lack of legal representation, delays, and unclear findings have been reported as 'toxic' by family members and can result in re-traumatising of those involved.

Implications

Many of the recent calls for coronial reform[33] centre on the premise that coronial proceedings can provide opportunities for these proceedings to be therapeutic. This requires a balance between achieving justice and reducing the potential for harm caused by the legal process. This paper argues that to accomplish such outcomes requires the "creation of a culture of sensitivity to the hurtful sequelae of sudden, unexpected and unnatural fatalities, recognising the distress and potential damage that can be done by coroners' investigations to many persons who are affected by such deaths".

[33] See Law Reform Committee, "Parliament of Victoria, Inquiry into the Review of the Coroners Act," (1985).; Law Reform Commission of Western Australia, "Review of Coronial Practice in Western Australia," (2012). Federation of Community Legal Centres Victoria, "Saving Lives by Joining up Justice," (Federation of Community Legal Centres Melbourne, Australia, 2013).

Autopsies, Scans and Cultural Exceptionalism. B.B. Arnold, and W. Bonython (2016) *Alternative Law Journal*. 41(1): 27-29

This article highlights several judgements that emphasise use of digital scanning rather than invasive interference with a deceased person. These judgements embody recognition that non-invasive autopsies (in the form of imaging and blood tests rather than dissection and organ removal) may be appropriate.

Key findings

- Treatment of deceased, physical integrity and timely burial is a significant facet of cultural identity.
- Freedom from arbitrary and disproportionate interference are important Australian values, evidenced in Australian law by the right of individuals to refuse medical treatment (including diagnostic procedures). These values are often not prioritised in death despite cultural/religious objections.
- Cultural exceptionalism recognises that in some circumstances the values of particular communities should override the practice 'norm'.
- Digital imaging systems and other technologies, such as advanced blood tests, offer opportunities for forensic post-mortem examinations that are less invasive and potentially quicker than traditional investigations based on dissection and organ removal. While these options may not always provide comprehensive results, where possible they may provide a mechanism that balances the state's desire for information and a community's desire to prevent desecration of the deceased and timely burial.

Implications

This article highlights successful legal challenges to invasive autopsies and supports non-invasive technologies as an alternative to the default invasive approach for identification of the cause of death where no compelling reason for a more visceral interference with a deceased person exists. Non-invasive approaches may provide a balance between community, institutional, and private needs. It should be noted that some jurisdictions now have computed tomography (CT) scanning routinely available.

Investigating death: the emotional and cultural challenges for police. B. Carpenter, G, Tait, C. Quadrelli and I. Thompson (2016) *Policing and Society*, 26:6, 698-712

This study explores the specific ways in which coronial personnel (coroners, pathologists, counsellors, nurses, and police) engage with families during a death investigation, particularly those that present as culturally or religiously different and includes Indigenous Australian populations. Findings are based on interviews conducted with 34 coronial professionals in one Australian jurisdiction. Exploration of understanding of the role of families in a death investigation, impediments to a family's involvement, the appropriateness of familial involvement in coronial decision-making and views on colleagues interactions were addressed through semi-structured interviews. Particular focus on the role and capacity of police officers to investigate deaths for the coroner identified specific criticisms especially where Indigenous families are involved.

Key findings

- Police culture and allocation of non-criminal death investigation tasks to inexperienced or junior officers impact the quality and reliability of information provided to the coroner and the ways in which police engage with families.
- Specific criticisms focus on the incapacity of police to engage sensitively with grieving families and the impact that has on collecting accurate information from families.
- For Indigenous families, the role of police investigating a sudden death is made more complicated within the context of "a long and well-documented history of poor relations between police and Indigenous people, where volatile conflict and accusation of police abuse and harassment, excessive force and institutional racism are common features".
- Despite widespread support for community police liaison officers, they seem to be underutilised, particularly in death investigations where they could provide considerable support.

Implications

"Death investigations rarely include a suspect of an offender and so require a different model of communication in a context where police may emotionally identify with the grieving family." Non-criminal death investigations may be a low priority for police and as a consequence less experienced, or junior officers are likely to attend the death scene. While coronial professionals agree that police are not the most appropriate to attend to a death scene and gather the information required, they are the only profession that is logistically available to perform these tasks. "The challenge is to make sure that police have the capacities to perform this non-criminal investigation in a manner that protects police and does not re-traumatise the families."

Communicating with the coroner: How religion, culture, and family concerns may influence autopsy decision making. B Carpenter, G Tait, G Adkins, M Barnes, C Naylor, N Begum (2011) *Death Studies* 35(4):316-337

This paper examines the coronial data collected in Queensland in 2004. While the paper "Health, Death and Indigenous Australians in the coronial system" (presented below) also reports on the same data, this paper provides additional analysis for religious, family concerns as well as cultural concerns. Furthermore, analysis of the level of invasiveness of autopsy is presented.

Key findings

- Only in the categories of accidental death and death in a medical setting were autopsy decisions significantly different when a specific religious status was identified.
- In accidental deaths external-only autopsies occurred more often when the deceased was identified as having a religious status with a proscription against autopsy as were deaths in a medical setting. These findings were based on very small numbers.
- Significantly fewer external-only autopsies were ordered when a religion with a known prescription against autopsy was noted when compared to those cases where no such religion was identified.
- Family concerns were significantly related to orders for less invasive autopsies (except in cases of suspected homicide).
- Findings suggest that two circumstances may lead to less invasive autopsy orders. These are: a) the deceased was a member of a religious group with a prohibition against autopsy, and b) the expression of a genuine family concern.
- The authors report that while Indigenous status should lead to a consideration of a less invasive autopsy, this was not the case.

Implications

This paper highlights the need for thoughtful and informed coronial autopsy decision-making, particularly where Indigenous people are involved. The data presented shows that Indigenous people are unlikely to raise family concerns, which the authors attribute to the fact that in Queensland, local police are the investigators for the coroners (and, as such, it is with the police that concerns and objections need to be raised). Two central reasons as to why prohibitions against Indigenous autopsy are proffered by the paper's authors. First, they suggest a lack of widespread knowledge on the part of coroners of these aspects of traditional Indigenous culture, and secondly, it may also be that Indigenous deaths appear less clear and/or more suspicious to coroners.

Health, death and Indigenous Australians in the coronial system. B Carpenter and G Tait (2009) *Australian Aboriginal Studies* (1):29

This paper presents findings from research conducted in Queensland during the first year following the introduction of the new *Coroners Act 2003*. Data included coronial findings from all completed investigations for 12 months from December 2003 and included all five categories of reportable deaths: accidental, suicide, natural, medical and homicide.

Key findings

- Twenty-five percent of all registered Indigenous deaths during the reporting period were reportable deaths compared to just nine percent of non-Indigenous deaths.
- Indigenous people were over-represented in each category of reportable death, with the exception of deaths in a medical setting, where they were wholly absent.
- Indigenous people were more likely to have died violently than non-Indigenous.
- Indigenous people are also over-represented in figures for full internal autopsy.
- The identification of Indigenous status by police during the initial stages of a coronial investigation did not influence orders for a full internal autopsy any more than the communication of no Indigenous status.

Implications

The research findings and discussion of this paper makes suggestions to how the over-representation of Indigenous people (specifically in full internal autopsies) may be addressed. Changes in legislation (specifically in Queensland where this research is positioned) allows for Indigenous status to be reported to the coroner, along with family concerns against autopsy is an important first step. Further improvements could include training for police officers and coroners about traditional cultural proscriptions against autopsy. For this to be successful, training in Indigenous communication or an increase in the number of Aboriginal community liaison officers is required.

Why This Law? Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention. R.S. Bray (2008) *Australian Indigenous Law Review* 12:27-44

This paper discusses the potential of coronial findings to contribute to the prevention of future deaths in the community. It emphasises the capacity of the coronial jurisdiction to provide a wider social and historical context to the death investigation.

Key findings

- Inquests provide the opportunity to understand individual death in the wider context of community life.
- Coronial decisions have the potential to inform social understanding about, and responses to, death and injury. This potential is embedded within the authority of all Australian coroners, who have the power to make comments and recommendations to avoid preventable deaths in the future. Yet, no accountability to act on recommendations exists.
- Coronial recommendations, in their focus on public health and their capacity to prevent future deaths, have the potential to improve in some way the disadvantage experienced in many Indigenous communities.
- As coronial investigations continue to uncover the 'how' of 'how death occurred' in reportable Indigenous deaths, broader issues of lower life expectancy and higher mortality rates than non-Indigenous are relevant. These issues and resulting recommendations may lead to a closer examination of social policy not strictly within the jurisdiction of the coroner.

Implications

The potential of the coroner to make recommendations in an effort to reduce future preventable deaths may lead to an expectation of 'social justice' that may not be reasonable.

The literature

Table 3: Literature summary

P – Peer-reviewed

Primary research	
An opportunity to be heard: Family experiences of coronial investigations into missing people and views on best practice. Dartnall, S., Goodman-Delahunty, J and Gullifer, J. (2019). *Frontiers in psychology* 10: 2322. *This paper is included in the detailed summary section.*	Experiences of family members and friends of missing people of a coronial investigation into the suspected death of missing people in NSW. Fifteen qualitative interviews were conducted exploring participant perceptions of the impact of the coronial proceedings on well-being, and views on best practice approaches to families in the coroners court. Overall, families benefited from opportunities to have input and feel heard, compassionate treatment, and appropriate education about the process. Negative experiences reported include distress and trauma in response to significant delays, intrusive media, and unwelcoming, formal court environments. **P**
'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. McCabe, L. Submitted for Honours Degree, University of New South Wales (unpublished) (2019) *This paper is included in the detailed summary section.*	This paper presents findings from eight qualitative interviews conducted with legal professionals and advocates who represent Indigenous families in the coronial system in NSW. Key themes identified include the impact of delays to the process, a lack of training for staff involved in providing coronial services/support, access to information, and the opportunity for making recommendations.
Coronial practice, indigeneity and suicide. Tait, G., Carpenter, B., & Jowett, S. (2018). *International Journal of Environmental Research and Public Health* 15(4): 765.	Indigenous Australians and Indigenous people around the world have a higher rate of suicide that may be linked to their experiences of persecution and disenfranchisement. The study conducted in-depth interviews with 32 Australian coroners and identified that Indigenous families do not engage with the coronial process to the same degree as non-Indigenous. As a consequence, coroners are not placed under the same degree of pressure by families resistant to a finding of suicide. The study concludes that Indigenous Australians are treated differently within the coronial system. **P**

Primary research	
The coronial investigation of suspected deaths: Prevalence and outcomes in New South Wales. Dartnall, S. and Goodman-Delahunty, J. (2016). *Journal of Law and Medicine* 23(3): 609-627.	Where a missing individual remains unlocated, this may be referred to the coroner for investigation as a suspected death. Of the 322 suspected deaths between 2000 and 2013, 96% resulted in an inquest and 94% of these inquests resulted in a finding that the missing person was deceased with the cause (81%) and manner (73%) of the death unknown. For one-third of suspected death cases there was over 20 years between the date of disappearance and the closure of the coronial investigation. Arguments supporting mandated inquests in suspected deaths cite positive functions, such as attracting public awareness and media attention which could assist an investigation, to provide a 'therapeutic benefit' for families of missing people. **P**
Decision-making in a death investigation: Emotions, families and the coroner. Carpenter, B., Tait, G., Adkins, G., Barnes, M., Naylor, C., & Begum, N. (2016). *Journal of Law and Medicine* 23(3): 571-581.	This paper uses qualitative methods to describe the experiences of qualified coroners and how they engage with grieving families. The interviews focus on how coroners negotiate the grief and trauma evident in death investigations. This paper acknowledges that while emotional distance may be an understandable response by coroners to the grief and trauma experienced by families, it concludes that coroners may be better served by offering emotions such as sympathy, consideration and compassion directly to the family in situations where families are struggling to accept, or are resistant to, coroners' decisions. **P**
The body in grief: Death investigations, objections to autopsy, and the religious and cultural 'other'. Carpenter, B., Tait, G., Quadrelli, C. (2014). *Religions* 5(1): 165-178.	Legislative reform in a number of jurisdictions has given families the ability to raise concerns about autopsies on the basis on religious and cultural grounds. However, the continuing ability for coroners to reject said concerns and continue to autopsy can exaggerate a family's grief. This study explores the disjuncture between medico-legal discourses and more 'therapeutic' discourses through interviews with staff involved in the coronial process. Interviews suggested that Indigenous objections to autopsy were all but invisible in the Queensland Coronial system and reasons for this are hypothesised to include Indigenous people not wanting to have their cultural identity known to police, and that Indigenous people may feel powerless to have their objections heard. **P**

Primary research

Health, death and Indigenous Australians in the coronial system. Carpenter, B. and Tait, G. (2009). *Australian Aboriginal Studies* (1): 29. *This paper is included in the detailed summary section.*	Research was conducted in Queensland during the first operative year of the *Coroners Act 2003* (QLD), with investigations completed between December 2003 and December 2004. The research investigated five categories of death: suicidal, accidental, natural, medicinal and homicide. In all categories Indigenous people were over-represented except medicinal. 25% of Indigenous deaths were reported on by the coroner as opposed to 9.4% of the non-Indigenous population. Despite Indigenous people being against dissection of their deceased community members, they are still over-represented in coronial investigations and reporting. The changes contained in the *Coroners Act*, allows for someone to be identified as Indigenous by family or community members to the coroner and allows for them to discuss their cultural concerns regarding an autopsy. **P**
Investigating death: The emotional and cultural challenges for police. Carpenter, B., Tait, G., Quadrelli, C., & Thompson, I. (2016). *Policing and Society* 26(6): 698-712. *This paper is included in the detailed summary section.*	This study explores the specific ways in which coronial personnel (coroners, pathologists, counsellors, nurses, and police) engage with families during a death investigation, particularly those who present as culturally or religiously different and included Indigenous Australian populations. Findings are based on interviews conducted with 34 coronial professionals in one Australian jurisdiction. Exploration of understanding of the role of families in a death investigation, impediments to a family's involvement, the appropriateness of familial involvement in coronial decision-making and views on colleagues' interactions were addressed through semi-structured interviews. Particular focus on the role and capacity of police officers to investigate deaths for the coroner identified specific criticisms especially where Indigenous families are involved. Widespread support for community police liaison officers identified the functions of informing families, dispelling agitation and allowing grieving and other important practices to be an underutilised asset. **P**

Secondary Research	
Autopsies, scans and cultural exceptionalism. Arnold, B. B. and Bonython, W. (2016). *Alternative Law Journal* 41(1): 27-29. *This paper is included in the detailed summary section.*	The decision in *Rotsztein v HM Senior Coroner for Inner London* [2015] EWHC (Admin) (28 July) [unreported] analysed the appropriateness of using non-invasive, technological methods for autopsies. Whilst no Australian High Court or state or territory Supreme Court has ordered that an autopsy cannot proceed on the basis of religious or cultural beliefs, the decision in *Rotsztein* should influence the practices of coroners in Australia. Where non-invasive methods such as scans or blood tests are available to coroners these could be favoured over more invasive examinations that may involve the removal of organs; the preference for these methods could be heightened where non-invasive methods would respect cultural or religious beliefs. **P**
Minimising the counter-therapeutic effects of coronial investigations: in search of balance. Freckelton, I. (2016). *QUT L. Rev*. 16: 4. *This paper is included in the detailed summary section.*	Coronial processes seek to balance therapeutic jurisprudence and principles of restorative justice; law reform proposals have sought to increase the role of families in the process to bolster the balance between the two. This paper seeks to describe and address the opportunity for both therapeutic jurisprudence and restorative justice and the minimisation of counter-therapeutic effects. The author chronicles the development of awareness for these issues and reviews the evidence of impact on families (and non-family people) involved in the coronial process. **P**
Scrutinising the Other: Incapacity, Suspicion and Manipulation in a Death Investigation. Carpenter, B, Tait, G., Quadrelli, C., & Drayton, J (2015). *Journal of Intercultural Studies*, 36:2, 113-128	Research has demonstrated the importance of training and education for staff in the context of criminal investigations – with its over-representation of vulnerable and marginalised populations – this is less likely to occur in the context of death investigations, despite such investigations also involving the over-representation of vulnerable populations. This paper explores the ways in which cultural and religious minority groups are positioned as 'other'. Three issues of concern are raised. First, positioning as 'the other' is dependent on professional training. Second, specific historical and contemporary events affect the Othering of religious and cultural difference. Third, the grieving practices associated with religious and cultural difference can be collectively Othered. **P**

Secondary Research	
Normalising post-mortems–whose cultural imperative? An indigenous view on New Zealand post-mortem policy. Selket, K., Glover, M., & Palmer, S. (2015). *Kotuitui: New Zealand Journal of Social Sciences Online* 10(1): 1-9.	It is still held that traditional post-mortem practices outweigh all other alternatives despite the implications that this has for the Indigenous people of New Zealand. For Indigenous Māori New Zealanders, however, post-mortems remain a foreign and desecrating act that impacts on their cultural bereavement. Thus, there is a challenge for medical and coronial services to balance the cultural aspects and medical and legal requirements. **P**
'Why This Law?' Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention. Bray, R. S. (2008). *Australian Indigenous Law Review* 12: 27-44. *This paper is included in the detailed summary section.*	Inquests into Indigenous deaths and Indigenous deaths in custody continue to expel the message that greater socio-political aspects contribute to 'how the death occurred'; that Indigenous deaths are not isolated occurrences but rather spur from governmental and social treatment of the Indigenous population and their experience in the community. The results of these inquests are often quite political or at least speak to social issues that remain unanswered without mandating a response to the recommendations put forward by the coroner. There is a need for mandatory responses to change services, policies and practices which will subsequently assist in preventing future deaths. **P**
Respecting the Dead, Protecting the Living. Brazil, R. (2008) *Australian Indigenous Law Review* 12: 45-54.	The Royal Commission's proposals for reforming the coronial system hold value for coronial practice beyond the issue of deaths in practice. This paper provides an assessment of how a more fully realised preventative role in the coroners court may serve a broader public health interest by advocating for an enhanced focus on prevention. Additionally, this paper presents two case studies that illustrate how culturally appropriate representation at coronial investigations ensures that the voices of the families of the dead are heard. Investigations carried out in a respectful manner remains fundamentally vital to the public interest. **P**

Secondary Research	
Telling and retelling your story in court: Questions, assumptions and intercultural implications. Eades, D. (2008). *Current Issues in Criminal Justice* 20(2): 209-230.	The telling of one's story in everyday differs extremely from the retelling of this story in court, this difference is influenced by police interviews, lawyer interviews and examination in a court room. Where storytelling is influenced by culture, there are complex implications for the retelling of this story in court, especially for Indigenous peoples who are still 20 times more likely to come in to contact with the criminal justice system. **P**
Clusters of Suicide...: The Need for a Comprehensive Postvention Response to Sorrow in Indigenous Communities in the Northern Territory. Hanssens, L. (2008). *Aboriginal and Islander Health Worker Journal* 32(2): 25.	There are significant gaps in training and support provided by coronial support services for Indigenous families amidst the coronial process. Improving these services may lead to deepened respect for Indigenous bereavement and the cultural, physical, emotional and spiritual needs of Indigenous people regarding grieving the loss of someone to suicide. **P**
Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model. King, M. S. (2008) *Journal of Law and Medicine* 16: 442.	A mixture of therapeutic jurisprudence, restorative justice, mediation and problem-solving could resolve comprehensive issues experienced by families in the bereavement process and increase the findings of coronial investigations including cause of death determination and public health and safety recommendations. Non-adversarial practices can create a collaborative, sensitive and empowering model of coronial investigation and inquests. This can be assisted by increasing the support services available for those taking part in the coronial process. **P**
Coronial recommendations and the prevention of indigenous death. Watterson, R., Brown, P., & McKenzie, J. (2008). *Australian Indigenous Law Review* 12: 4.	Coroners have the ability to contribute to preventing future deaths of Indigenous people by speaking to public health and policy considerations in their recommendations. However, these recommendations continue to prove ineffective in creating positive change as there is no obligation on legislatures to implement them. There is no consistency in Australian jurisdictions as to the process of implementing recommendations despite their vitality in preventing future deaths. **P**

Secondary Research	
Coronial Reform in Western Australia. Allingham, K and Collins, P. (2008) *Australian Indigenous Law Review Special Edition* 12(2): 90	This paper, written in 2008, reviews the reforms made to the *Coroners Act 1996* (WA) in line with the Royal Commission into Aboriginal Deaths in Custody. Key issues identified include the need for independent investigators to be responsible for investigating deaths in custody, and the need for a statutory provision in the *Coroners Act* that requires government agencies to respond to coronial recommendations. Additionally, it is suggested that all coronial recommendations should be tabled in the Western Australian Parliament. **P**
Australian findings on Aboriginal cultural practices associated with clothing, hair, possessions and use of name of deceased persons. McGrath, P and Phillips, E. (2008) *International Journal of Nursing Practice* 14:57	Recognition of the cultural gap between westernised Australian and Aboriginal cultures, especially in regard to care of the dying, is significant. Aboriginal peoples in Australia embrace traditional practices, customs and rituals associated with the deceased person's clothing, hair, possessions and name. **P**
Death investigation, the coroner and therapeutic jurisprudence. Freckelton, I. (2007). *Journal of Law and Medicine* 15(2): 242.	Coronial investigations are unique in that they incorporate both adversarial and inquisitorial elements, resulting in a function quite distinct from any other judicial officer. This allows coroners to have a further reaching impact than other judicial officers, particularly to influence public health and safety and community impacts. However, many aspects of the coronial process inadequately respond to the needs of families and sectors of the community, especially regarding their need to be informed about the process and outcome of investigations. These needs can be addressed by imposing an obligation on the entities subject of the coroners recommendations to state whether they will implement said recommendations and within what timeframe. **P**

Secondary Research	
The Sacred and the Profane: The Role of Property Concepts in Disputes About Post-Mortem Examination. Vines, P. (2007) *Sydney Law Review*, 29, 235	Traditional Aboriginal communities believe that an autopsy is desecration of the body of the deceased. Feelings of grief and advertence to autopsies may be exacerbated where the death has occurred in custody. It is recommended that a framework established to include not only consultation with Aboriginal Legal and Medical Services, but that greater weight be given to a family's preference to not conduct an autopsy on cultural grounds. **P**
The 2004–05 South Australian Inquests into Deaths on the Anangu Pitjantjatjara Yankunytjatjara Lands: An Opportunity for Forthright Government Action. Charles, C. (2005). *Australian Indigenous Law Reporter* 9(4): 77-79.	This report exemplifies a disconnect between the function of the coroner to make recommendations to prevent future deaths and how the lack of accountability can undermine this aim. It recounts the 2002 inquests investigating the causes and circumstances of the deaths of three people who died on the Anangu Pitjantjatjara Yankunytjatjara Lands as a result of sniffing petrol. Detailed findings and a comprehensive set of recommendations to Government were published by former State Coroner of South Australia, Wayne Chivell. Despite this, no action on behalf of the government was taken in response to these recommendations and, in 2004–05, four more similar deaths are investigated. **P**

Secondary Research	
The interaction of death, sorcery and coronial/forensic practices within traditional indigenous communities. Byard, R. W. and Chivell, W.C. (2005). *Journal of Clinical Forensic Medicine* 12(5): 242-244.	This paper describes how western coronial systems may cause considerable distress to traditional Indigenous communities and provides examples of how standard medical/forensic and coronial practices can work together with Indigenous communities. In traditional tribal practices, mainly 'men of high degree' within 'sorry camps' carry out traditional rituals and procedures to determine whether the death of a member of their community involved sorcery and, if sorcery is determined, who the perpetrator is. The standard method of autopsy and coronial reporting not only adds delay to the Indigenous community performing these rituals but can cause significant distress. It is argued that a simplified preliminary report should be issued to traditional Indigenous communities at the conclusion of an autopsy including a statement that 'no sticks, stones, bones or other foreign objects were found within the body that would implicate another person in the death'. These measures may assist in the practices carried out in the 'sorry camps', initiate discussion between traditional Indigenous communities and authorities about death and create respect for both systems. **P**
The rights of the dead: autopsies and corpses mismanagement in multicultural societies. Benteln, A. D. (2001). *The South Atlantic Quarterly* 100(4): 1005-1027.	Traditional Anglo-American law holds that a deceased person is not property of their relative, rather is property of no-one and the next of kin retains purely quasi-property rights on the basis that they may decide how the deceased person is buried. In the United States, the legal next of kin has the ability to grant authority or deny the ability of a coroner to carry out an autopsy on a deceased person, however an individual's refusal may not always be respected. The ability of a coroner to carry out an autopsy despite a refusal has led to numerous lawsuits initiated by family members who have refused on the basis of religious beliefs that denounce the mutilation of the dead in any form. **P**

Secondary Research	
Investigating to save lives: Coroners and Aboriginal deaths in custody. McFarlane, O. and Vines, P. (2000). *Indigenous Law Bulletin* 4(27): 8.	Coroners and coronial inquests play a vital role in preventing future deaths where social, economic, racial and other factors contributed to how and why the death occurred. Legislatures have exhibited low levels of legislative reform in compliance with the recommendations made by the Royal Commission into Aboriginal Deaths in Custody. Of particular interest, recommendations regarding notification and involvement of the family in coronial proceedings remain unimplemented in legislation in most Australian jurisdictions. While many of the recommendations have resulted in administrative changes, further calls for a legislative response to "establish rights rather than expectations, rules rather than discretions". In response to the number of deaths continuing to rise, systems must be put in place which are mandatory and not discretionary. **P**
Legal Recognition of Cultural Differences in Communication: The Case of Robyn Kina" Eades, D. (1996). *Language and Communication* 16(3): 215.	The Royal Commission into Aboriginal Deaths in Custody revealed that Indigenous people are 20 times more likely to be taken into custody and 15 times more likely to be incarcerated. Factors contributing to these rates include racism, social, economic and educational factors, as well as the history of dispossession. Inextricably linked to empowerment and self-determination lies language and communication issues. This paper describes how Aboriginal ways of communicating must be taken into account if Aboriginal people are to be treated fairly in the justice system. **P**

Grey literature (government reports, policy statements, etc)	
Coronial Investigation in Queensland: (Counter)-Therapeutic Effects. Coronial Assistance Legal Service. Caxton Legal Centre (2019).	Coronial procedures are characterised by legal and scientific principles, which can often be counter-therapeutic for a grieving family. Services, including counselling and assistance for the families to access and provide further information during an investigation or inquest, can assist both the coronial process and the family. The response of a government to recommendations put forth after an inquest, which has positive impacts of reducing future deaths or community benefit, may also have therapeutic benefits for families who have lost a loved one.
Delivering Coronial Services. Report 6: 2018-2019. Queensland Audit Office. (2018).	In this audit, the Queensland Audit Office assessed whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. The audit specifically examined whether agencies: provide adequate support to bereaved families, have efficient and effective processes and systems for delivering coronial services, and plan effectively to deliver sustainable coronial services. The report finds that the Queensland's Coronial System is under stress and is not effectively and efficiently supporting coroners or families.
Fourth reference report: Rights to appeal coronial findings and re-open investigations. Coronial Council of Victoria (2017). Victoria, Australia, Coronial Council of Victoria.	It is not uncommon for the coronial process to leave families with unanswered questions and no sense of closure. This effectively prompted a review of the rights to re-open or appeal coronial investigations and findings. Appeals must be on a question of law and re-opening of an investigation is available where there is new information. The old system of appeal had a number of grounds on which families could appeal or request the investigation be re-opened. It is not recommended that the coroners court return to the earlier system, however, much can be done in the initial stages of a coronial proceeding to assist families and reduce the need to seek redress by appeal. The report contains 11 recommendations which include the ability for the coroner to exercise greater discretion in whether an investigation is re-opened, and the courts should introduce a framework to better understand the systematic issues that arise for families and attempt to remove these.

Grey literature (government reports, policy statements, etc)	
Review of Coronial Practice in Western Australia. Aboriginal Legal Service of Western Australia (Inc.) (2010). Submission to the Law Reform Commission of Western Australia.	At the time of publication (2010) Western Australia had not received legislative reform for coronial proceedings since 1996, making it the second oldest Coroners Act in Australia. The Law Reform Commission was asked to conduct a review of the coronial proceedings in Western Australia and an in-depth review of the *Coroners Act*. The Aboriginal Legal Service has provided its own recommendations in its submission. The recommendations focus on the community's demand for greater accountability, transparency, knowledge of proceedings and contribution to preventing future deaths. Of particular interest is the recommendation that additional funding for Aboriginal Legal Services (WA) (ALSWA) to appear in coronial inquests. ALSWA provides cultural sensitivity and understanding, strong community ties, law reform expertise, and knowledge and experience about history, policy, social and cultural matters that impact on the lives of Aboriginal peoples across WA.

Specialist coronial legal assistance

A desktop review of specialist coronial legal assistance services revealed only a few services, namely:

- Coronial Inquest Unit – Legal Aid NSW
- Coronial Assistance Legal Service – Caxton Legal Centre (QLD)
- Coronial Assistance Legal Service – Townsville Community Legal Service (QLD)
- Coronial and Public Sector Monitoring – Aboriginal & Torres Strait Islander Legal Service (QLD)

Legal Aid NSW established the Coronial Inquest Unit in 2006, and for many years (until the Queensland Services commenced in 2017) this was the only specialist unit providing legal representation to families at inquests. Coronial Inquest Unit lawyers have appeared as advocates in numerous inquests throughout NSW involving public interest issues, including deaths in custody, police shootings, and health care matters. Lawyers from the service also provide legal advice and assistance to family members of a deceased, together with persons of interest at inquest. Provision is also made for legal aid funding within NSW of private lawyers and counsel to appear for families and interested parties at inquest.

At Legal Aid NSW a means-test and public interest test normally applies where a grant of aid is sought for representation at inquest. For families of an Aboriginal Torres Strait Islander who has died in custody these tests do not apply.

The most common minor/discrete assistance tasks include explanations of the coronial process, requests for documents and information and requests for inquests or a review of a coroners' decision. Full support and representation at inquests under a grant of aid will often involve preparing statements, attending pre-inquest conferences and directions hearings, requesting further investigation or documentation on behalf of a client, requesting particular witnesses be called, together with appearing in court to examine witnesses and make submissions, or alternatively briefing barristers to do so.

Process or effectiveness evaluations of these services could provide valuable learnings about what works or doesn't work for these matters. It was not within the scope of this review to explore barriers or facilitators; however, the following issues are of interest;

- Referral pathways and access to services for clients
- Expectation of what the coronial system can deliver may be significantly different to the reality. This is especially important where death occurs in care or in custody.
- Access (funding) for briefing barristers (where required)
- Social worker support for families.

While there are few specialist coronial legal assistance services, Aboriginal and Torres Strait Islander Legal Services around Australia may be available to assist their clients with coronial matters if they have the capacity. In particular, the Aboriginal Legal Service (NSW/ACT) provides representation to families in coronial inquests for deaths in custody and are the main service provider now for First Nations people.

Concluding remarks

The purpose of this study is to describe practices aimed at improving processes and experiences for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system. More specifically it aims to discover how Aboriginal and Torres Strait Islanders experience the delivery of coroner court services. It is hoped this will lead to improving service encounters in this group of the population which has distinctive and strong cultural values, but which is also generally disadvantaged.

This has been achieved by conducting a jurisdictional environmental scan to describe services, and a literature scan to summarise the research evidence on the involvement in the coronial system of Aboriginal and Torres Strait Islander people.

It was not within the scope of this study to examine the effectiveness, or otherwise, of service delivery models, although we believe this would be a useful exercise particularly if developing appropriate culturally sensitive services is the intention.

Our findings suggest that little has been done to study service encounters in these courts from the perspective of Aboriginal and Torres Strait Islander people and it is hoped that the literature presented in this paper might shed light on broader understandings about service encounters that would be relevant to those desiring to understand the service needs of Aboriginal and Torres Strait Islander people.

Recommendations from the literature (not endorsed)

The literature reviewed contains a number of recommendations. The Foundation has not assessed these recommendations and as such they are not endorsed. For ease of access, these are listed, along with reference to the publication in the table below. They may provide a useful starting point for further consideration and are found on the following pages.

Author	Study/Report	Their recommendations
'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. McCabe, L. Submitted for Honours Degree, University of New South Wales (unpublished) (2019)	These recommendations are not evidence-based but have been put forth by the author (McCabe). These recommendations are specific to NSW and similar services may already be available in other jurisdictions.	1. Establish a culturally specific unit within the coroners court. This identified position would act as a point of contact for Indigenous families, would assist in the navigation of the system and provide support in a culturally appropriate manner.[34] Additional services could include: (a) Provision of training for regional Aboriginal Legal Service field officers to work with, and support, families involved in the coronial system in regional areas, (b) Provision of training to Aboriginal Community Liaison Officers who work with NSW police on the specifics of the coronial process. 2. Increase contact and communication with families (at least every 3 months). Suggested technologies to assist this recommendation include opt-in text messaging services. 3. Establish community transport for families to attend inquests at Lidcombe court. A suggested model proposes local community funding for this service. 4. Develop online training module for legal professionals regarding the coronial system in NSW. It is posited that many legal professionals have minimal experience or knowledge about the coronial system. 5. Family members should be offered the opportunity to make a statement (speak to the memory) to the court reading the deceased during an inquest or inquiry 6. Making the coroners court a more welcoming environment (tea, coffee, etc).

[34] A similar service is available in Victoria

Author	Study/Report	Their recommendations
Delivering Coronial Services. Report 6: 2018-2019. Queensland Audit Office. (2018).	The Queensland Audit Office prepared an audit report assessing whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. Recommendations set forth in *Delivering Coronial Service*s are largely specific to the Queensland setting and are detailed in the next column.	[We] recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners: 1. establish effective governance arrangements across the coronial system by: • creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist • more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services • establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established. 2. evaluate the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems. [We] recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners: 3. improve the systems and legislation supporting coronial service delivery by: • identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports • reviewing the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process • reviewing the *Burials Assistance Act 1965* and the Burials Assistance Scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.

Author	Study/Report	Their recommendations
		4. improve processes and practices across the coronial system by: • ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators • ensuring there is a coordinated, state-wide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy • establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process • ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses. 5. assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased. [We] recommend the Department of Justice and Attorney-General: 6. implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners 7. improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.
Fourth reference report: Rights to appeal coronial findings and re-open investigations. Coronial Council of Victoria (2017). Victoria, Australia, Coronial Council of Victoria.	The Fourth reference report examines the rights to re-open a coronial investigation or appeal coronial findings. While this scope is narrow, recommendations may be relevant for broader purposes. Recommendations are detailed the next column.	**Recommendation 1**: The Coronial Council considers that the operation of s 77 of the *Coroners Act* is appropriate. However, the Victorian Government should seek to amend the *Coroners Act* to clarify that the findings of inquests made under the 1985 *Coroners Act* may be reviewed by the State Coroner as provided for by that Act. **Recommendation 2:** The Victorian Government should seek to amend the *Coroners Act* to allow the coroners court to separately consider an application to: (a) set aside a finding if the coroners court considers it appropriate, and it is not necessary to re-open the

Author	Study/Report	Their recommendations
		investigation to do so; or (b) revise the wording in any part of a decision if the coroners court considers it appropriate, and it is not necessary to re-open the investigation to do so. Consistent with s 77(4) of the *Coroners Act*, the coroners court should be constituted by the coroner who conducted the original investigation unless they no longer hold the office of coroner, or there are special circumstances. An application for review on the proposed grounds should be subject to a three-month time limit from the day on which the finding of the coroner is made. In order to achieve greater clarity of review opportunities within the coroners court, consideration should be given to linking ss 76 and 77 more closely in the *Coroners Act*. **Recommendation 3**: The coroners court should adopt appropriate measures to facilitate greater engagement and understanding of court processes by families with the advice of the Client Advocacy Office (see Recommendation 4). In particular, the coroners court should work together with the Victorian Institute of Forensic Medicine to: (a) develop standardised court processes to provide regular and accessible information to families on the role and work of the coroners court; (b) better manage expectations of the timeline and scope for the coronial investigation, and advise families of significant milestones in the process; (c) provide regular updates on the progress of the coronial investigation, including when significant milestones have been reached, and the reasons for any delays; and (d) advise families on opportunities to make a submission on issues they consider relevant to the investigation. **Recommendation 4**: The Victorian Government should fund the establishment of a Client Advocacy Office within the coroners court. The Client Advocacy Office should have a high level of expertise in grief counselling, so they can provide sophisticated guidance and advice to the coroners court and the Victorian Institute of Forensic Medicine on best practice in assisting families and other interested parties engaging in the coronial system. **Recommendation 5**: The coroners court should develop appropriate guidelines and templates to ensure that, to the extent that it is consistent with the judicial independence of coroners, coronial findings: (a) follow a clear and consistent style; (b) clearly identify 'findings', 'commentary' and 'recommendations'; (c) that are made in respect of the circumstances in which the death occurred, must confine those circumstances to matters which are proximate and causally relevant to the death; and/or underpin matters which relate to the preventative role of the

Author	Study/Report	Their recommendations
		coroners court; (d) advise how submissions from families and other interested parties have been considered; and explain the rationale for making certain findings or recommendations (and not others) in sensitive or contentious cases. **Recommendation 6**: The Victorian Government should fund a centralised Coronial Legal Advice Service, through Victoria Legal Aid, to provide legal advice to interested parties relating to the coronial process. **Recommendation 7**: The coroners court should work with Victoria Legal Aid, the Victorian Bar and the Law Institute of Victoria to develop appropriate arrangements to assist families to access legal representation to enable them to effectively participate in the coronial process, particularly in circumstances where there is a significant power imbalance between parties, or there is a significant public interest issue at stake. **Recommendation 8:** The Victorian Government should seek to amend the *Coroners Act* to make it clear that an appeal against a coronial finding in s 83 is available on a question of law; and where the finding is 'against the evidence or the weight of the evidence'. **Recommendation 9:** The Victorian Government should seek to amend the time limit for commencing an appeal against a refusal by the coroners court to re-open an investigation in s 84 of the *Coroners Act* from 28 days to three months. **Recommendation 10:** The Victorian Government should fund a restorative justice program to enable families to resolve outstanding issues and questions following the conclusion of a coronial investigation. The referral of cases considered suitable for a restorative justice process should be managed by the Client Advocacy Office within the coroners court. **Recommendation 11**: The coroners court should take steps to better understand and respond to systemic issues that may arise during coronial processes. In particular, the coroners court should: (a) establish mechanisms to collect and analyse systemic data on court performance; (b) undertake periodic client feedback surveys; and (c) become a party to the International Framework for Court Excellence.
Review of Coronial Practice in Western Australia. Aboriginal Legal Service of Western Australia (Inc.) (2010).	The Aboriginal Legal Service of Western Australia (Inc.) (ALSWA) reviewed coronial practice in Western Australia and made a	**1.** ALSWA recommends that findings and recommendations from the coroners court be publicly available following appropriate amendment to maintain confidentiality and sensitivity.

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Submission to the Law Reform Commission of Western Australia.	submission to the Law Reform Commission of Western Australia in 2010. It is possible that some of these recommendations have already been acted upon, and some may be specific to Western Australia. We have included them for reference.	**2.** That the *Coroners Act 1996* (WA) be amended to require: government departments and agencies and private organisations to respond to coronial recommendations within three months of the publication of the coronial recommendations; the coroner to publish the government or company response, along with his/her report, within 30 days of receipt of the response; and government departments and agencies and private companies to provide a progress report on the practical implementation of the coronial recommendations twelve months after their initial response. **3.** That administrative practices and procedures within the coroners court be improved to enhance communication between the court and legal counsel, particularly through early delivery of the brief. **4**. That the coroners court be allocated a dedicated courtroom and adjoining private rooms for witness preparation and family privacy. **5.** That independent investigators be appointed to investigate coronial matters, particularly matters involving a death in custody and / or police presence. **6.** That the WA government provide funding to ALSWA to appear for family or community when so instructed and better monitor the implementation of coronial recommendations. **7.** That the coronial counselling service be better resourced, particularly to meet the needs of affected people in regional and remote areas. **8**. That an Aboriginal Liaison Officer be appointed to the coroners court to bridge the gap between the court and Aboriginal families, communities and organisations. 9. That the WA State Government allocate funds to the coroners court to assist families attend and participate in coronial inquests. 10. That the WA Government develop and adequately fund a state-wide interpreter service for Aboriginal languages. **11.** That support be provided to family members to assist them manage any media interest generated by the coronial inquest. **12.** That persons other than police officers engage with family to provide information about the coronial investigation process as required under s 20 of the *Coroners Act 1996* (WA). **13.** That processes be established to ensure that families are provided with more information about the coronial process from the outset including expected timeframes, the powers and purpose of coronial inquests and the right of family to be legally represented at an inquest.

Author	Study/Report	Their recommendations
		14. That all counsel assisting the coroner be required to undertake cultural awareness training to improve their understanding and appreciation of cultural sensitivities surrounding Aboriginal grieving.

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