Submission to the NSW Law Reform Commission — Open justice review

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“When they started hiding things in court, that’s when the injustice started. We wanted Australia and the world to see how the corrections officers acted, and how the medics were unable to adequately respond and provide the proper care to David. They claimed that they wouldn’t release the guard’s identity for their protection but it was just a cover-up. We wanted them to face us in the court and hear them explain themselves. That had a huge impact on our right to justice and healing.” **Paul Silva, Nephew of David Dungay Junior**.

Below is a still image extracted from a video of Dhungutti man David Dungay Jr’s final moments as he died in custody. That video opens with an officer from Corrective Services NSW’s Immediate Action Team at the door. He says —

‘Hello David my name is [redacted].’

His face is blurred. Throughout the inquest, he is only known and referred to as Officer A. Officers A, B, M, O and E inject David with a sedative that slows his breathing. They hold him down in a prone position, some with the full weight of their bodies through their knees and arms. These are the circumstances in which David is killed — in an extraordinary exercise of state power over his body. He was eating biscuits.

Even though inquests are a crucial open justice mechanism into the otherwise opaque exercise of power by police and prisons, as recommended by the Royal Commission into Aboriginal Deaths in Custody, we cannot tell you these officers’ names. Suppression and non-publication orders prevent us from doing so. Such orders, along with other restrictions in the Coroners Court, are an escalating concern for Aboriginal and Torres Strait Islander families and communities after someone they love has died in custody.
The enclosed submission has been jointly authored by the Jumbunna Institute, the Aboriginal Legal Service (NSW/ACT) and the National Justice Project.[1] Between them, these

[1] An overview of Jumbunna, ALS and NJP is contained in Annexure A.

organisations have a long history of advocating for, and representing, Aboriginal and Torres Strait Islander clients in Coronial matters.

In many of those matters, and increasingly in current times, state parties and state employees involved in deaths in custody have sought and been granted orders from the NSW Coroner's Court that impair or abrogate the principle of open justice, including suppression or NPO orders (together 'Orders'). We can't validate our sense that the frequency of these Orders is increasing because the Coroner's Court keeps no central record of the number of these orders made, or the circumstances of their making.

In our experience, the impact of those Orders upon families of the deceased is unique and often traumatic and should be considered in the scope of the current review, as should the unique circumstances of a coronial investigation and inquest into an Aboriginal or Torres Strait Islander death in custody. It is our view that transparency within the Coroner's Court, from the initial stages of evidence gathering through to inquest, should be a paramount consideration (and certainly so when balanced against any concerns of embarrassment or damage to reputation raised by those involved in those deaths).

We have previously written on the importance of transparency in the coronial jurisdiction in relation to the experience of Aboriginal and Torres Strait Islander people when engaging in this domain.[2] The importance of transparency in the Coroner's Court, in comparison to that of the criminal and civil jurisdictions, is a reflection of the responsibility of the state (agents and employees) to answer to the public, Indigenous and otherwise, for a fatal exercise of its power.

Should you have any queries related to this submission, please contact Craig Longman or Alison Whittaker at Jumbunna on [redacted].

Yours faithfully,

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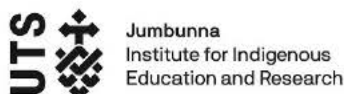

[2] George Newhouse, Daniel Ghezelbash & Alison Whittaker, '*The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line*'. (2020) 9(4) International Journal for Crime, Justice and Social Democracy 76.

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1. Why care about open justice in the Coroners Court?

1. The Coroners Court (the **Court**) commonly escapes scrutiny in discussions about open justice principles, yet given its role in ensuring transparency of, and accountability for, state action leading to the death of Aboriginal and Torres Strait Islander people, its processes and decisions can have a disproportionate impact on the lives of Aboriginal and Torres Strait Islander people who have lost loved ones in state settings.

2. There are multiple provisions in the *Coroners Act 2009* (the **Act**) that recognise the importance of both the Coroner's inquisitional function and exercising that function transparently in accordance with the dictates of open justice. For example; proceedings in the Court must generally be open to the public[3] and, the Court is recognised (at least in NSW) as a Court of record.[4] The Court is also required to record in writing a Coroner's findings in a matter.[5]

3. The principle of open justice is conditional however. We do not intend to set out in great detail the relevant statutory or implied powers that allow the Coroner's the right to close courtrooms or prevent publication of information in a coronial inquest, all of which are considered in the consultation paper.

4. Our submission focuses on the unique impact these provisions have on Aboriginal and Torres Strait Islander families represented at inquests into the death in custody or care[6] of an Aboriginal or Torres Strait Islander person.

5. The Coronial jurisdiction is a hybrid of adversarial and inquisitional elements,[7] tasked with a range of functions aimed, at its core, at placing on record all relevant evidence as to the facts and circumstances of the death and to serve a preventative function by identifying recommendations that might prevent similar future deaths.

6. In the present context, there are aspects of that jurisdiction that deserve emphasis.

7. It has been recognised that part of the purposes of an inquest include 'the satisfaction of the legitimate concerns of relatives; the concern of the public in the proper administration of institutions, goals and the care of persons in custody and the like…'[8] The inquiry of the Coroner's Court has been said to be 'inquir[ing] so that the public may know'.[9]

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[3] s47 of the Act.
[4] Abernathy (2010), *Waller's Coronial Law & Practice in New South Wales,* 10, [I.46] (**Wallers**) citing, inter alia, *Decker v State Coroner* [1999] 46 NSWLR 415.
[5] s81 of the Act.
[6] We adopt here a broad definition that includes any Aboriginal or Torres Strait Islander death that occurs in institutions of the state (or privately-run institutions providing state services, i.e. private prisons), where those institutions have historically been the source or agent of government policies of assimilation and colonisation, notably, Police, Prisons, Health Services and Child Protection bodies.
[7] *Musumeci v Attorney General* (2003) 57 NSWLR 193.
[8] *Bilbao v Farquhar* [1974] 1 NSWLR 377 at 388.
[9] Wallers, p17.

8. In this way, the work of the Coroner's Court differs to that of civil and criminal courts. Those Courts are engaged in resolving a dispute or allegation — the Coroner's function is inimically tied to a public inquiry, after all, it is only by a public inquiry that the public can 'know'. That role has been said to be 'particularly important' in deaths in custody.[10]

9. That role takes on particular importance in relation to Aboriginal and Torres Strait Islander Deaths in Custody, given that the Court is a crucial institution for many Aboriginal and Torres Strait Islander families. Following the RCIADIC recommendations in 1991, the Act was amended to mandate Coronial inquests into all deaths in custody. Given the notorious failure of police and prosecutorial bodies to properly investigate and prosecute deaths in custody,[11] for many families, the Coroner is the only institution tasked with an impartial and transparent investigation into the cause of their loved one's death in State custody and care.[12] That inquisitional role fulfils not only obligations towards the families who have died, but an essential part of the process of public accountability of state actors;

   'society, having effected the arrest and incarceration of persons...owes a duty to those persons, of ensuring that their punishment is ...not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and **public inquiry** into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated'.[13] (emphasis added).

   It is difficult to see what 'positive incentive' exists for custodians if they know that they are able to remain effectively anonymous at a subsequent inquest.

10. The RCIADIC noted the importance of proper investigation of deaths in custody to ensure that such deaths occur in the '*common course of nature*' and not;

    'by some unlawful violence or unreasonable hardship put on him by those under whose power he was while confined. There should not be given an opportunity for asserting that matters with regards to deaths in public institutions are 'hushed up''.[14]

11. Put another way;

    'Police and Prison officers are amongst those who represent the physical manifestation of the State's lawful and coercive force. Officers should be required to

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[10] Wallers p17 at [I.70].
[11] For commentary on this failure see Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to NSW Parliament *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*, [77] – [81] and Longman C, *Police investigators too in-house to probe deaths in custody*, the Conversation - https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838
[12] The traditional mechanism of an independent police investigation and prosecution by public prosecutorial bodies has never been an effective mechanism for accountability in Australia as demonstrated by the many DICs in Australia without a single successful prosecution for manslaughter of any individual involved in such deaths.
[13] Wallers, p106 at [23.6].
[14] (Report on the death of John Pilot by Commissioner Wyvill and cited at [4.7.2] of RCIADIC; National Report Vol 1, 4.7 Conclusion).

answer questions about how they exercise such force, particularly when someone has died in their custody'.[15]

12. It is essential to recognise that this oversight role is fundamentally different in nature for Aboriginal and Torres Strait Islander people, who have been subject since colonisation to violence legitimised by the legal structures of the Australian settler colonial legal system. Aboriginal and Torres Strait Islander people have little reason to trust judicial institutions in Australia, however they have even less reason to trust those institutions that, even in contemporary times, assert punitive control over their lives. Such institutions: police, prisons, care and protection authorities and health services, have been central to the colonisation of Aboriginal and Torres Strait Islander people (both historically and contemporaneously) and are almost always implicated in deaths in custody. It was recognised during the RCIADIC that —

    'The adequacy [including transparency] of coronial investigations is critical if the tragic aftermath of such deaths is not to perpetuate the feeling of anxiety and suspicion in the minds of the deceased's family and the Aboriginal community, which to a substantial degree gave rise to the need for this Commission's work. The inadequacies of post-death investigations throughout Australia must be addressed as a matter of urgency.'[16]

13. Because of this, the Coroners Court is a significant institution in the oversight of State power against Aboriginal and Torres Strait Islander peoples in NSW. For families and communities, it is usually the only opportunity to have a matter heard and investigated on the public record.

14. In addition to that purpose, it has been recognised that the Coroner's jurisdiction also fulfils a preventative role, as noted by RCIADIC —

    'In human terms, thoroughly conducted coronial inquiries hold the potential to identify systemic failures in custody practices and procedures which may, if acted upon, prevent future deaths…adequate post death investigations have the potential to save lives.'[17]

15. We have addressed below specific areas regarding the use of suppression, non-publication and closed court orders, and other actions taken by the Court that compromise the principles of open justice.

[15] Craig Longman, 'Indigenous Issues/Evidence/Coronial Law: Police silence and Aboriginal deaths in custody' (2020) 68 *LSJ: Law Society of NSW Journal* 66.
[16] See RCIADIC [4.7.1] and generally recommendations 6 – 40 regarding post-death investigations.
[17] RCIADIC, National Report, Vol 1, AGPS, Canberra 1991, at para 4.7.4.

2. Recent experiences in the Coroner's Court

16. There are clear provisions in the Act that confer powers on the Coroner to prevent the disclosure of information,[18] and it has been suggested that the Court retains at least

> 'those common law powers necessary to fulfil coronial functions (in much the same way as a Local Court Magistrate has 'implied power' to do that which is "required for the effective exercise of a jurisdiction which is expressly conferred..."[19]

17. Certainly, in our experience the Court has rarely sought to critically analyse the extent of any of its 'implied powers' but has assumed its capacity to do such things as;

- Anonymise the names of witnesses during the hearing;
- Obscure the identify of witnesses in CCTV played into the Courtroom (even to the other parties involved);[20]
- Allow for witnesses to enter and exit Courtrooms otherwise than through the public entrance; or
- Prevent the publication of evidence, submissions and findings of an inquest.

18. We note also the effect of s75 of the Act which confers discretion on a Coroner to approve a non-publication order over reports or proceedings concerning self-inflicted deaths.

19. In our submission, the importance of the principles of open justice, the importance of transparency and the impact of suppression and non-publications should operate differently within the coronial jurisdiction, in comparison to that of the civil and criminal jurisdictions.

2.1. Suppression and non-publication orders in Aboriginal and Torres Strait Islander deaths in custody

20. At the outset, it must be noted that there remains value in the use of various Orders in the protection of personal details of the deceased in the Coroners Court. We strongly support the use of various Orders in such circumstances, in which material from the offender's criminal, disciplinary or medical records and other personal details of the deceased or related family members are protected by an Order. These Orders are important for families, so as to minimise further trauma, harm and public scrutiny towards bereaving Aboriginal and Torres Strait Islander families. Moreover, it is in our experience, surpassingly rare for such details to be relevant to the Coronial function of

[18] Part 6.4 of the Act.
[19] Wallers p13 at [I.55]. Certainly such implied powers have been recognised in South Australia: *Kuskoff* (2018) 130 SASR and 321 and it has been suggested in that jurisdiction the Court has similar inherent powers to a superior court 'where necessary'…'to be able to manage its activities appropriately' (see *Commissioner of Police & Ors v Coroners Court of South Australia* [2020] SASC 86 in which such powers were held to be available to forbid publication of names, close the court, anonymise names with initials in the proceedings and in witness statements and forbid publication of evidence contained in witness statements).
[20] This occurred at the inquest into the death of David Dungay Jr.

determining cause of death or its related preventative function. One obvious example is the case of a prisoner who dies in custody, in which it will rarely be relevant why that prisoner is in custody.

21. However, during recent years, a number of trends appear to be arising in Coroner Courts across the country as well as in NSW. We have noticed a growth in the use of various Orders as well as other discretionary powers exercised by Coroners that limit public accessibility both to coronial processes and findings. The Coroners Court is unique in deserving some focus in the NSWLRC's review. Its specialisation and position mean it is often overlooked by similar reviews, and it exercises a range of discretionary powers, the oversight of which is relatively limited (being limited largely to limited review by the Superior Court).[21]

22. We note that the provisions of Part 6.4 of the Act contain fewer mandatory considerations for the exercise of those powers than their counterparts in the *Court Suppression and Non-Publication Orders Act 2010* (NSW) ('CSNPO' Act). For example, under that Act, grounds for suppression and non-publication orders include but are not limited to provisions such as 'the order is necessary to protect the safety of any person'.[22] The absence of equivalent grounds and considerations in the Coroners Court can be interpreted to indicate a parliamentary intention that such Orders should be used more sparingly in a coronial setting. We believe that is appropriate as it allows for a higher level of public scrutiny and accountability of state agents and parties involved in deaths of citizens of the state.

23. The exercise of these powers in the Coroners Court however (unlike those under the CSNPO Act), are infrequently appealed or reviewed. We could find no record of an appeal or review of the use of these powers in the course of an inquest into an Aboriginal or Torres Strait Islander death in custody in NSW.

24. Coroners are regularly asked by legal representatives of institutional parties to prevent the publication of identifying details of interested persons or footage in connection with the death. In our experience, that is more likely to occur when inquests are subject of substantial media interest. This is concerning, suggesting that often these applications are brought to protect the reputation, or suppress the publication of criticism or embarrassment, of institutions or institutional actors rather than a concern about the integrity of the judicial process.

25. Equally, we are concerned about the impact of these Orders when they are made, specifically those which in effect protect public identification and scrutiny of state agents. This is of particular concern because many of those agents remain employed in positions (or indeed promoted into new positions) in which they remain responsible for the lives of Aboriginal and Torres Strait Islander people. Limiting the identification of such actors (particularly actors such as corrective services officers for whom there is no separate investigatory and disciplinary body) can appear to families as having the effect of

[21] The NSW Act contains certain provisions that imbue statutory oversight functions to the NSW Supreme Court, including the ability to order a new Inquest (s 85 *Coroners Act 2009* (NSW)).
[22] *Court Suppression and Non-Publication Orders Act 2010* (NSW), s8(1)(c).

enabling state actors who have mistreated someone, or otherwise contributed to their death, to do so again in the future. That so many state actors involved in deaths appear at coronial inquests two or three years after the deaths having been through little, if any, training or disciplinary investigations, confirms a perception that the lives of those who have died are not valued by state institutions. The use of Orders perceived by family as prioritising those persons' privacy over public accountability contributes to that perception.

26. In addition, we are also aware of some applications that have been brought by some institutional actors on what are, in our view, plainly racist grounds based on stereotypes of Aboriginal and Torres Strait Islander people as intrinsically 'violent' or 'unsafe'. Some of these applications follow a logic in asking the Coroner to protect witnesses and interested persons from identification because they face an inherent risk of violence from all Aboriginal and Torres Strait Islander people by virtue of being named in connection with an Aboriginal or Torres Strait Islander death in custody. Others draw from generalist media commentary or protests against Aboriginal and Torres Strait Islander deaths in custody to suggest that they face imminent danger if their identity is publicised. We do not see these submissions made in comparable non-Indigenous deaths. We are unable to identify those cases because of existing non-publication orders.

27. We have also observed applications for Orders over certificates protecting witnesses from prosecution or civil liability, granted by the Coroner per s 61 of Act. The granting of Orders of this nature pose difficulties for families, with such restrictions limiting the practice of truth-telling and seemingly protecting and absolving institutional actors from future legal action. This is only reinforced by Section 76(c) that provides that objections on the basis of potential incrimination of a witness (objections which often cumulate in the issuing of a certificate) are not allowed to be published without the express permission of the Coroner. Given that objections can be taken to any evidence that may tend to prove a witness is liable to a civil penalty[23] (meaning a penalty arising under an Australian law), these provisions go far beyond ensuring the rights of criminal accused. Again, we are unable to provide information on particular cases because of the operation of such Orders that remain on foot.

28. Standing publication prohibitions in the Act are also a source for concern. Section 76(d) prohibits, without the consent of the Coroner, the publication of 'any submissions made […] concerning whether an inquest or inquiry should be suspended' and referred to prosecutors in relation to a possible indictable offence. This has prevented considerable publicity and public accountability over notable discontinued inquests in NSW that have resulted in the prosecution (and, historically, subsequent acquittal) of police and corrections officers in relation to an Aboriginal or Torres Strait Islander death in custody. This is a blanket ban that covers even descriptive publicity that would otherwise comply with the sub judice rule and pose no risk to the future administration of justice. At a time of renewed attention to Aboriginal and Torres Strait Islander deaths in custody, the recent suspension of an inquest and charge of a Corrective Services officer in relation to an Aboriginal death in custody in NSW has had comparatively little impact on public discourse when considered against comparable interstate cases that are also ongoing.

[23] s61 of the Act

29. NSW Police and Corrective Services NSW also consistently make of claims of privilege on the basis of operational security in seeking to suppress CCTV footage from public view or publication. It is hard to identify what the risk of showing CCTV footage is, and how it would present security concerns. Similar concerns arise with internal policies, and on occasion we have seen the Court act essentially on the assertion by the state actor that the disclosure of information would jeopardise their functions without interrogation of that claim.

30. In a similar vein, applications for suppression of particular restraint or policing strategies, designs, or operational protocols have been suppressed from findings where they have a material bearing on the death.

31. The use of these various Orders makes it increasingly difficult for families to identify state actors, and their actions, that have resulted in the death of their loved ones. This not only exacerbates trauma and frustration in their pursuit for justice and truth-telling around the circumstances of death, it also undermines their capacity to campaign or participate in media in relation to the public awareness for which inquests themselves are run.

2.2. Case studies

Inquest into the death of David Dungay Jr

32. David Dungay Jr was a proud Dunghutti warrior. On the day he died, David was a patient in Long Bay Prison hospital. He was 26 years of age and a diabetic. Before he died, he was alone in his cell, eating some rice crackers he had purchased at the prison shop. Some of the nurses were concerned about David's high blood sugar. Prison guards got involved. What happened next led to the tragic and unnecessary death of this young man.

33. When the Deputy State Coroner released his findings into David's death. His findings were deeply distressing to David's family as the Coroner focused on a rubric of the care and wellbeing of Indigenous peoples, a focus that appeared to the family to excuse the systemic and relentless use of violence by prison guards on Indigenous men by characterising it as a misunderstanding. In our experience, David's family will never accept that his death can be attributed to a misunderstanding, nor the moral legitmacy of the suppression orders placed on them that continue to restrict them from naming the prison guards involved in David's last moments or releasing the unedited video footage of David's death.

34. David Dungay died in a hospital within a prison at the hands of prison guards who had no business interfering in his medical care. Few people are aware that NSW is the only State in Australia that holds mental health patients in prison hospitals. In all other States, mental health patients are held in dedicated mental health facilities without the supervision of corrective service officers.

35. Hospitals and clinicians are supposed to focus on patient health but the prison regime, with its militaristic command structure, focuses on the "good order" of the institution and not the individual. The two organisations do not sit well together. Their objectives are

contradictory, as are their cultures and values, so they are primed for conflict. The risks inherent in the policy decision that led to, and maintain, this unique structure, as well as the role it played in the death of a young man are, in our submission, precisely the kind of thing that the public have a vested interest in knowing. Those risks were demonstrated throughout the evidence that fell during the inquest process.

36. The evidence was that Prison guards intervened after David refused to obey an order to hand over the rice crackers he was eating. They responded to that refusal with an explosive use of force when one guard decided to call in the Immediate Action Team (**IAT**) to force David to give up his biscuits and to forcefully move him into another cell so that he could be monitored with a CCTV camera. In a key finding, Coroner Lee said that:

    "***it was neither necessary nor appropriate for David to be moved [at all]. Officer F acknowledged that David was already safely contained within his cell, and therefore did not pose a security risk. Similarly, Officer E held no security concerns regarding David's circumstances at the time. From a medical point of view there was no evidence of any acute condition which would have warranted a cell transfer and the need for David to be observed in a camera cell. Indeed, the evidence points to the contrary in the sense that whilst David's blood sugar level was elevated, and he was consuming biscuits, he had been observed to be asymptomatic.***"[24]

37. The Coroner ultimately decided that the error was the result of a communication breakdown between nurses and guards. David's family respectfully disagreed, however, the Coroner did go on to say that, given the risk of injury, the IAT should not have been called in without conducting a proper enquiry as to whether there was a basis to do so[25] or without calling in the assistance of an Aboriginal inmate delegate or welfare officer[26]. Coroner Lee suggested that the prison guard who made the call had less violent alternatives open to him: he could have asked the IAT to remove the biscuits[27] or simply allowed David to remain in his cell[28]. The Coroner was critical of the fact that there was no meaningful attempt to de-escalate before force was used against David by the IAT.

38. The CCTV footage is confronting and the images have been viewed all over the world: a young man being held down by prison guards while being sedated, crying out that he can't breathe, while his pleas are ignored. It is the panicked voice of a young man who is dying. To this day the Dungay family wish that the full uncensored version of the death of David's death was available for them to continue their fight for justice.

39. After hearing extensive medical evidence, the Coroner found David died whilst being restrained in the prone position by a team of several Corrective Services New South Wales

[24] Inquest into the death of David Dungay at [13.19]
[25] Inquest into the death of David Dungay at [14.14]
[26] Ibid at [14.23]
[27] Ibid at [14.18]
[28] Ibid at [14.19]

(CSNSW) officers. As noted above, Coroner Lee's Findings contained substantial criticisms of both the CSNSW officers and medical staff.[29]

40. In the nine minutes David was being forcibly restrained by various members of the team of six Correctional Services guards, David cried out to them that he could not breathe over 20 times. His mother, Leetona will never forgive or forget the guards' failure to respond to David's pleas while he was in desperate distress and dying.

41. David's mother Leetona was scathing of the decision to withhold and protect the identities of the guards involved in David's death and the failure of the Coroner to hold anyone accountable for David's death.

42. The process of demanding the release of video footage of the lead up to David's death was traumatic and divisive. The legal representatives of David's parents each made separate submissions on publication. Ultimately, part of the footage was released but much of the evidence in David's case is still restricted from public view by undertakings made to the Coroner.

43. It added to the trauma of David's family that officers were referred to throughout the inquest by anonymised initials and to see their faces blurred on the CCTV that was played repeatedly in Court over multiple days.

44. Following the death of a loved one in custody, many families experience not only strong emotional trauma but a profound desire for justice and accountability. The outcomes of coronial inquests often fail to deliver justice or provide answers for families of victims who have died in custody. Where the manner in which those proceedings are conducted contributes to a perception that individuals are protected whose actions are rightly subject to criticism, it is no wonder that First Nations families can feel completely disengaged and excluded from the legal system.

Inquest into the death of Ms Dhu

45. Ms Dhu's arrest, incarceration at the South Headland Lock Up and her treatment at South Headland Health Campus cannot be separated from the long and enduring colonial histories, hierarchies and continuities of institutional racism, and other multiple, intersecting forms of discrimination and indifference that Aboriginal people, especially Aboriginal women, have experienced at the hands of police and health care systems in Western Australia, in life and in death.

46. Ms Dhu was only twenty-two years old when she died in custody. Her family testified to her strength, warmth and beauty as a proud young woman of the Yamatji Nation. Ms

[29] In Findings that demonstrates the pointlessness of David's death, Coroner Lee made it clear that: there was no need for David to be moved to another cell or for the IAT team to be called to use force against him; there was no need to move David onto the floor of his cell or continue to restrain him on the floor; bending David over as he was walked between cells was inappropriate when David was crying out that he could not breathe and that David had been adequately restrained on the bed in cell 77 and that continuing the knee ride (a guard's heavy knee in his back) in such circumstances was inconsistent with the provisions of the CSNSW Operations Procedures Manual (OPM) and the application of such additional force was unwarranted. Coroner Lee also criticised the failure to secure the cells as a crime scene and the failure to secure all video CCTV footage

Dhu was a beloved daughter, granddaughter, sister, niece, cousin and friend. “Her family describe her as "happy-go-lucky" and "always with a smile on her face". She was caring, full of love and cheer, with a fierce sense of loyalty to friends and family. In her spare time, she liked to paint and make artwork. She dreamed of travelling one day and studying health sciences. Ms Dhu was a young woman who was full of life and who deserved a long life. Ms Dhu’s maternal and paternal family have been relentless in their journeys for justice for Ms Dhu and in attesting to the profound and continuing the impact of her death in custody.

47. Ms Dhu’s death was a preventable one. Her arrest, incarceration and treatment were undertaken in a manner indifferent to the evidence that she was a victim of severe domestic violence.

48. Ms Dhu required safety, treatment, care and a timely, serious and effective investigation of the criminal family violence inflicted on her. Instead she was criminalised and died in custody.

49. Her incarceration for fine default and the conditions and treatment she was subjected to was a vastly disproportionate and punitive response driven by legislation and policy that have had extremely discriminatory and disproportionate impacts on the incarceration of Aboriginal people, especially Aboriginal women. Again, those issues, and the manner in which such approaches translate to the death of Aboriginal and Torres Strait Islander people in custody are precisely the kind of thing the public should know.

50. Whilst in the police lock up Ms Dhu’s health conditions became progressively more critical, and ultimately disabling. Ultimately, Ms Dhu died because she was unable to convince those around her – largely police officers and medical staff – that she was in a state of medical emergency. She died not surrounded by loved ones but by people who, until her last breaths, didn't believe her cries of pain were real.[30] Her treatment in custody at the South Hedland Lock Up (‘SHLU’) can be characterised by extreme and inhumane suffering.

51. The available CCTV evidence before the Court which captured Ms Dhu’s own words, her moans and screams and the words and actions of multiple police officers, are the best evidence of her treatment in custody.

52. The dispute against the publication of that CCTV footage documenting the final moments of Ms Dhu’s life can be recognised as one example of the poor dealings of Orders in the Coroners Court.

53. Initially, the Coroner made a non-publication order covering the CCTV footage. The family’s understandable perception was that such an Order impeded on the transparency of the Coroners Court, under the guise of care and cultural safety for the Dhu family and community. Shaun Harris, the uncle of Ms Dhu described the impact of this initial Order

[30] Amanda Porter: “On Deaths and Indifference”, SBS NITV, 15th April 2016. Available at: http://www.sbs.com.au/nitv/nitv-news/article/2016/04/15/amanda-porter-death-and-indifference

as a fear of the state – "they are afraid that the entire world will see racist Australia for what it truly is". [31]

54. A subsequent request was made by the family of Ms Dhu to release the footage to the public, so as to hold the state accountable for the inhumane treatment of Ms Dhu in custody. The importance of transparency, accountability and public knowledge of Coronial Inquests, specifically deaths in custody was echoed by the family in their request. Carol and Della Roe, Ms Dhu's grandmother and mother stressed -

> "Our child died a cruel and painful death. The world should see how she was treated…For the last two years, we have been suffering alone – everyone should understand out grief and make sure this never happens again"[32]

55. Between the Jumbunna Institute, NJP and ALS, we all have concrete examples of other cases we have worked on, in which Orders have been granted for the suppression and/or non-publication of identities, state guidelines (Police and Corrective Services) or other state documentation. However, given the existence of Orders on this information, we are unable to cite these examples.

2.3. How significant is the Coroners open justice problem?

Closed off by logistics

56. We are aware that this submission is largely anecdotal and based on our work in the field. We attribute this to two unique circumstances in the Coroners Court — the scant jurisprudence on the use of Orders in deaths in custody and a lack of internal documentation within the Coroners Court about Orders.

57. The Coroners Court in NSW has no central repository for suppression and non-publication orders, even for its own use. When called by the Jumbunna Institute on 2 February 2021, the registrar informed us there was no way they could give us the number of suppression orders issued over the past year because they had no centralised way to search for suppression or non-publication orders except to check folio-by-folio.

58. It should be of concern that any Court tasked with the conduct of open proceedings, including the NSW Coroner's Court, does not appear to keep records of either the frequency with which such applications are made, the frequency with which such orders are granted or the conditions in which they are granted or refused. A lack of such information also frustrates any academic or policy analysis of whether the legislative provisions are fulfilling their intended purpose.

59. Moreover, in the absence of uniform reportage of Coroners' decisions on these Orders, it is more difficult for the practitioners appearing in those jurisdictions to advice their

[31] Ethan Blue, 'Seeing Ms. Dhu: Inquest, conquest and (in)visibility in black women's death in custody' (2017) 7(3) Settler Colonial Studies 299.
[32] NITV News, 'CCTV footage of Ms Dhu's final days released by the WA coroner', *NITV News* (online, 16 December 2016) < https://www.sbs.com.au/nitv/article/2016/09/28/cctv-ms-dhus-final-days-released-wa-coroner>

clients, including family members, of the likelihood of those orders being made or the content of those orders.

60. The poor digitisation and publication of judgments and recommendations (with findings and recommendations prior to 2012 unavailable in NSW) also raises impediments to open justice in the Coronial jurisdiction.[33]

61. Speaking to the impacts of poor digitisation of Aboriginal and Torres Strait Islander deaths in custody documentation in this domain for both academics and Aboriginal and Torres Strait Islander families, Alison Whittaker has said —

> These gaps obscure analysis of many deaths scarred into the Indigenous public consciousness, which are either suppressed or not digitised. These include, across the country, the death of TJ Hickey (a young boy killed during an unlawful police pursuit); Ms. Baxter (a transgender woman who suicided in a male prison); Mr. Holcroft (who died of a heart attack in a prison bus, ignored by corrections staff); and Mr Ward (an Elder who was boiled alive in a sealed van during a heatwave).[34]

62. In an arena in which accountability and transparency are paramount for both Aboriginal and Torres Strait Islander families involved in death investigations and for the promotion of faith in the coronial inquisitorial sphere, the poor digitisation of prior judgments is worthy of attention.

Closed off by disciplinary bounds

63. The National Coronial Information System ('**NCIS**') is a commonly-cited alternative for researchers, academics and journalists to access Coroners Courts. Our experience of the NCIS is that it is simply too limited to provide an effective record of the Court's exercise of its jurisdiction. The NCIS stipulates anonymity as a condition of access (thereby defeating a case-by-case accountability function), has a significant annual fee, has disputed data quality[35] and is guarded by ethics processes that are inaccessible for many. Moreover, substantively the database closely mimics a standardised government longitudinal dataset, rather than a transparent court output.

64. The limited access to coronial files and documents has been well-documented anecdotally and in the literature.[36] In their 2019 study analysing deaths in custody in

[33] This raises the question of whether the Court is meeting its obligations under the *Court Information Act 2010* (NSW) in relation to both 'open access information' (s5), but also findings (s(5)(2)(f)).
[34] Alison Whittaker, 'Carried Like a Dead Kangaroo: Culpability & accountability in Australian justice system responses to Indigenous deaths in custody', LL.M. Long Paper submitted April 2018, Harvard Law School 6.
[35]Tamara Walsh and Angelene Counter, 'Deaths in custody in Australia: a quantitative analysis of coroners' reports' (2019) 31(2) *Current Issues in Criminal Law* 146.
[36] Lyndal Bugeja, Joseph E. Ibrahim, Noha Ferrah, Briony Murphy, Melissa Willoughby and David Ranson 'The utility of medico-legal databases for public health research: a systemic review of peer-reviewed publications using the National Coronial Information System' (2016) 14(1) *Health Research Policy and Systems.;* Tamara Walsh and Angelene Counter , 'Deaths in custody in Australia: a quantitative analysis of coroners' reports' (2019) 31(2) *Current Issues in Criminal Law*.

Australia, Walsh and Counter conveyed their difficulty in accessing coronial documents through NCIS[37] —

> The NCIS operates a user-pays system based on the type of access required, and its access costs are thousands of dollars a year, even for low-level, restricted access. Such costs may be considered prohibitive for anyone other than government departments and very large organisations. Further, ethical clearance is required to gain access, and this is exceedingly difficult to obtain, as multiple ethics committees must be satisfied, and strict confidentiality requirements can be imposed which limit researchers' capacity to report on their findings. The database also has significant functional limitations; indeed, in 2003, a report commissioned by the Australian Institute of Health and Welfare described its coverage as 'limited' and questioned the quality of the information it contained, noting that there were extensive inconsistencies and errors in the data and its coding.

65. In recognising this, we would urge the NSWLRC to consider the ways in which both the collection, and accessibility, of coronial information could be improved to facilitate the essence of open justice, namely the capacity of citizens and interested parties to access information. It is crucial that a jurisdiction that scrutinises circumstances of deaths in the custody of the state is positioned in a way that gives the greatest possible effect to open justice principles.

66. Currently, the capacity of the Court to meet the mandate imposed upon it in the aftermath of the RCIAIDIC is impaired, as is, the justification for mandatory inquests into deaths in custody.

Closed off from telling a story

67. Families also seek to use Coroners Courts as sites to contest the narrative surrounding the death of their loved one. Both civil claims and criminal prosecutions arising from Aboriginal and Torres Strait Islander deaths in custody are notoriously difficult and few in number[38]. For many bereaved, the inquest represents the only chance to visibly raise the death of their loved one in public consciousness, usually through media, set against the substantial control the State exerts in the conduct and scope of the inquest through investigating police, Counsel assisting and the Coroner. The barriers to this kind of open justice for Aboriginal and Torres Strait Islander families are outlined above.

68. The increasing use of suppression and non-publication orders, especially around the use of often-alarming or confronting CCTV footage, stymies the Courts' informal transparency role. The use of suppression orders to disguise or hide the identities of state actors involved in a death in custody also contributes to a vision of Aboriginal and Torres Strait Islander deaths in custody as inevitable consequences of race or deprivation, rather than products of a State process.

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[37] Tamara Walsh and Angelene Counter, 'Deaths in custody in Australia: a quantitative analysis of coroners' reports' (2019) 31(2) *Current Issues in Criminal Law* 146.

[38] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to NSW Parliament *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody.*

69. For example, in the CCTV footage around the death of David Dungay Jnr, only David Dungay Jnr himself is visible. Compare this with Victoria, a jurisdiction infamous for its fondness for suppression orders, where a comparable inquest into the death of Aunty Tanya Day permitted the unedited viewing of video footage capturing the circumstances of her death, which cumulated in a public campaign and a coronial referral to prosecutorial authorities.

Closed off from Information

70. In our experience, in most states and territories families are effectively blocked from making applications under Freedom of Information legislation and seeking the records (including health records) of the deceased from the Coroners Court. Most matters take many years to come to Inquest, and without such early access, families of the deceased cannot get a handle on the what happened to their loved ones for years and in some cases forever. For example, it is, in the experience of one of the authors, common practice for Police in Western Australia to refuse to comply with such applications even after an inquest has been held and finalised.

3. Miscellaneous restrictions

3.1. Sub judice contempt

71. In addition to the above issues, there are miscellaneous concerns about open justice in the Coroners Court that warrant attention.

72. As has been previously noted,[39] there is uncertainty for families, advocates and media organisations alike around the sub judice contempt rule and how it applies to inquests. That uncertainty carries a risk;

> for families who speak out about their loved one's deaths in a way that even implies something happened or someone did something. Sub judice contempt poses liability to them personally when they speak out, but also could jeopardise their push for justice.
>
> This puts First Nations peoples at the mercy of what can be raised before a jury, judge or coroner. With lengthy procedural delays, this can also mean a case is hard to talk about publicly for years.
>
> This is problematic given that timely publicity about deaths in custody is what drives attention.
>
> Greater clarity is desirable so that First Nations families and communities are supported, or at least not restrained inappropriately and unfairly, in their role as

[39] Jumbunna, submission to the *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* in 2020.

crucial participants in oversight bodies and as advocates in their own right after a death in custody.

3.3. Prohibition of photography

73. While not often considered as a matter of open justice, the standing prohibition on photography inside courts (including the Coroners Court)[40] has led to a perception among surviving families that courts are suppressive by nature.

74. Families who are represented at inquests into deaths in custody are firmly warned that taking photographs inside the Coroners Court precinct is unlawful and attracts fines or imprisonment. For many families, this warning by sheriffs or police can be intimidating. We have seen it issued to families in hallways, who are taking photos of children facing windows and featuring no court premises or witnesses in their photos. We have also observed it happening in family support rooms. Families are observing major family history events, and may, as any family would, seek to document their coming together as one might at a funeral or wake. It is inappropriate that they be prohibited from doing so and intimidated in the enforcement of the rule.

75. As a prima facie position, families are prohibited from recording family statements made to the Court in its consideration of the deceased. In NSW, these statements are not considered evidence and are often profoundly personal and sentimental records of the deceased and the love for them shared by family and community. It is questionable as to why they couldn't be filmed in a controlled way (without the need for months-in-advance applications), kept by families (who often go on to read the same statements to a press conference outside) and available (if the family consents) to media. Whilst it would be possible to record such statements with the Coroner's consent, we are not aware of any case in which such consent was sought or granted. Such an approach would presumably be easily achieved through a practice note distributed to families and/or their representatives.

76. There is a limited understanding amongst the judiciary of the unique experience of Aboriginal and Torres Strait Islander families in the coronial jurisdiction, even amongst engaged and well-meaning officers. This has been recognised recently by former Coroner Hugh Dillon speaking before the NSW Parliament:

> I have been frankly somewhat chastened by reading these submissions. Jumbunna, the ALS, Legal Aid and others have made very powerful submissions. It has been an education for me. I spent nine years in the system being a Coroner and I do not think anybody would accuse me of being callous or not caring but, as Mr Longman says, we do not have the experience...
>
> People like me do not necessarily see, feel or intuit the issues there that are very important to Indigenous families. They are kind of hidden in this milieu. I think you do

[40] Under *Court Security Act 2005* (NSW), ss9-9A.

have to be Indigenous or very closely attuned to Indigenous people to get the feel. It is the vibe, if I can use that phrase.[41]

77. In the absence of statutory provisions that identify for Coroners and Courts the heighted trauma that is commonly experienced during the coronial process by Aboriginal and Torres Strait Islander families grieving the loss of a loved one, it is essential that Coroners and practitioners are sensitive to the unique anguish of such families forced to engage with, and rely upon, an investigatory system which is not seen to be independent, and shares many traits of settler-colonial courts that have played a part in the colonial project in Australia. The unique consequences and exacerbating nature of the making of Orders on bereaved Aboriginal and Torres Strait Islander families is worthy of consideration.

4. Impact on Therapeutic function

78. It has been well established that the coronial jurisdiction and proceedings can exacerbate trauma for First Nations families, already grieving and mourning the loss of a loved one. First Nations families that we have worked with, along with experiences outlined in the existing literature, have expressed feelings of trauma and victimisation by coronial proceedings. The authors are aware that increasingly the Court is becoming concerned with opportunities to mitigate or alleviate such trauma.

79. Therapeutic jurisprudence has been discussed as a scheme through which to recognise, and attempt to address, that potential exacerbation of trauma done to court participants during an Inquest.[42] As an approach, we believe therapeutic jurisprudence can be used as a tool or foundation in which amendments to the Coroners Act and the practice of the Court are affected. Such an approach seeks to ensure procedural fairness and the statutory functions of the coroner in investigating deaths remain, whilst emphasising the social, emotional and psychological wellbeing of First Nations families engaging with the coronial investigation and inquest process.

80. Such an approach however, would require a recognition of the importance of transparency in enhancing the faith of bereaved families in the coronial death investigation process.

Conclusions

81. In our experience the current Act in combination with *the Court Information Act 2010* (NSW) and the surrounding regulatory framework does not adequately address the

[41] Transcript of Proceedings, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Legislative Council of New South Wales, 27 October 2020) 45.
[42] [3] Ian Freckelton QC, '*Minimising the counter-therapeutic effects of coronial investigations in search of balance*' (2016) 16(3); QUT Law Review 4; Michael King, '*Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model*' (2009) 16(3) Journal of Law and Medicine 442.

importance of open justice within the coronial jurisdiction for Aboriginal and Torres Strait Islander families.

82. We recommend the NSWLRC consider consulting with relevant parties to craft an amendment in the Act to recognise the unique importance of open justice principles in relation to Aboriginal deaths in custody.

83. Consideration should also be given to amendment of the Act to require Coroners to publish reasons for the making, or refusing, suppression and non-publication orders.

84. In addition, the NSWLC should consider amendments to relevant legislation to ensure:

    84.1. The establishment and maintenance of a consistent repository of Coronial judgements regarding suppression and non-publication orders;

    84.2. The rights of Aboriginal and Torres Strait Islander family members to make comments or submissions in opposition of such orders (this would address the current uncertainty and lack of clarity which exists surrounding the law);[43]

    84.3. We also recommend the NSWLRC focus in greater detail on the Coroners Court in its future reports on this matter.

Should you have any questions or wish to discuss any aspect of these submissions please do not hesitate to contact Craig Longman or Alison Whittaker at Jumbunna on 9514 9820.

[43] We note that in our experience, at least in NSW, Family's are routinely invited to make submissions on applications for Orders.

Annexure A — Who we are

Jumbunna Institute

The Jumbunna Institute of Indigenous Education and Research is unique in Australia.

Our Indigenous-led Research team operates throughout the continent, with staff working in communities in Victoria, South Australia, Northern Territory, Queensland and New South Wales, and collaborators in all States and Territories.

Our best work is focused around stories, campaigns, projects, and cases that consolidate our many different sets of skills and expertise towards a shared goal. We run by one key guiding principle — our work should be driven by Aboriginal and Torres Strait Islander peoples and nations in Australia, and contribute — whether directly or indirectly — to their strength, sustainability and wellbeing. We believe that our nations, peoples and people can use research as a tool to produce change and build capacity. We committed to excellence and agility as practitioners and scholars because that shapes our capacity to understand shifting landscapes and effect change within them.

This submission was prepared by two Hubs at the Jumbunna Institute: the Legal Strategies Hub and the Indigenous Policy Hub. Both Hubs work closely in the Coroners Court in NSW in the course of offering legal and strategic representation to First Nations families whose loved ones' deaths in custody are subject to inquest. This work informs our concerns with open justice in the NSW Coroners Court, which will be the focus of our submission.

Aboriginal Legal Service NSW/ACT

The Aboriginal Legal Service (NSW/ACT) Limited ('ALS') is a proud Aboriginal Community Controlled Organisation and the peak legal services provider to Aboriginal and Torres Strait Islander men, women and children in NSW and the ACT. The ALS currently undertakes legal work in criminal law, children's care and protection law and family law. We have 24 offices across NSW and the ACT, and we assist Aboriginal and Torres Strait Islander people through representation in court, advice and information, as well as providing broader support programs and undertaking policy and law reform work.

National Justice Project

The National Justice Project is a not-for-profit legal service. We apply our expertise to advancing human rights by representing and giving voice to the vulnerable who would otherwise be unable to find legal representation.

NJP was established by Adjunct Professor George Newhouse and Lt Col (ret) Dan Mori. Through court work, research, training and strategic advocacy we use our skills to build a fairer justice system and more equitable society.

We are committed to ensuring everyone has the right to equal access and status under the law and we work collaboratively with our community partners to identify systemic injustice and with individuals to run test cases. Our long-term goal is to bring change to systemic problems of abuse and discrimination.