LOCAL COURT
OF NEW SOUTH WALES

STATE CORONER'S PROTOCOL

ISSUED 9 March 2022

COMMENCES 11 April 2022

Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples

1. PREAMBLE

1.1. This Protocol is established in recognition that First Nations Peoples are uniquely placed within the Australian community as the first peoples of this country. Every First Nations death in custody represents the loss of a valued individual, family and community member, and should be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations Peoples.

Royal Commission into Aboriginal Deaths in Custody

1.2. The final report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) made a number of recommendations across a wide range of areas, including in relation to practices and procedures within the coronial jurisdiction.

1.3. The Local Court has reviewed practices and procedures within its coronial jurisdiction against these recommendations and considers improvements can still be made. In particular, the Court is committed to giving full effect to Recommendation 8 of the RCIADIC:

> *That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.*

1.4. The Court recently issued Coronial Practice Note 3 of 2021 sets out case management arrangements which apply to all deaths occurring in custody or as a result of police operations, irrespective of the background of the deceased.

1.5. However, a considered response to Recommendation 8 requires the establishment of this Protocol to supplement the Practice Note when the death in custody is that of a First Nations person.

1.6. Through this Protocol, the Court is committed to maintaining cultural appropriateness at each stage of an investigation into the death of a First Nations person, particularly in ensuring that the impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss.

2. APPLICATION

2.1. This Protocol is issued pursuant to section 10(1)(d) of the *Coroners Act 2009* (the Act) and applies to all deaths or suspected deaths of First Nations People which fall within the scope of section 23 of the Act.

2.2. This Protocol is to be read in conjunction with Coronial Practice Note 3 of 2021 and sets out supplementary arrangements which apply where the deceased is a First Nations person.

2.3. The Senior Coroner may, after consulting with an Aboriginal Coronial Information and Support Programme (CISP) Officer and/or the family of the deceased, direct that this Protocol apply in whole or in part to an inquest or death or suspected death of a First Nations person.

3. OBJECTS

3.1. The object of this Protocol is to ensure that:

a. All coronial investigations and mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of First Nations Peoples.

b. The families of First Nations Peoples are engaged early and meaningfully in the coronial process and provided with a dedicated pathway through which they can raise:

   (i) Any cultural considerations relevant to the conduct of the coronial investigation and inquest, and

   (ii) Any issues and concerns surrounding the conduct of the coronial investigation, including concerns in relation to the circumstances of death.

c. The families of First Nations Peoples are provided with information about the coronial process and their rights in a timely manner, including facilitating legal advice and representation, and

d. The families of First Nations Peoples are provided with regular updates regarding the status of the coronial investigation, including advice in relation to delay and the reasons for the delay.

4. COMMENCEMENT

4.1. The Protocol will commence on 11 April 2022

5. DEFINITIONS

5.1. *Determination of jurisdiction* refers to the point at which a Senior Coroner makes a post-mortem direction pursuant to section 89 of the Act.

5.2. *Officer in Charge* refers to a member of the NSW Police Force nominated by the Commissioner of Police or any other person nominated by the Senior Coroner to assist with his or her investigation into a reportable death.

5.3. *Family legal representative* refers to the solicitor with carriage from the Aboriginal Legal Service NSW/ACT (ALS), Legal Aid NSW (Legal Aid) or other legal representative(s) nominated by the family of the deceased person who advises the family representative.

5.4. *Family representative* means the senior next of kin or other person nominated by the senior next of kin to act as a point of contact, including to receive and disseminate information to the family.

5.5. *First Nations Peoples* refers to all Aboriginal and Torres Strait Islander people in Australia.

5.6. *Solicitor assisting* refers to the solicitor from the Crown Solicitor's Office (CSO) or DCJ Legal who is instructed by the Senior Coroner to assist in relation to the coronial proceedings.

6. RECOGNITION OF FIRST NATIONS FAMILY STRUCTURES

6.1. First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

6.2. In recognition of the above, references to 'family' throughout this Protocol should be interpreted flexibly and with respect for these structures and systems. So far as is possible, arrangements should be made to accommodate the deceased's extended family and community, as is appropriate in the circumstances of each case.

7. INITIAL STEPS FOLLOWING DETERMINATION OF JURISDICTION

7.1. The below requirements apply in addition to those set out at Stage One of Coronial Practice Note 3 of 2021.

7.2. Following a determination of jurisdiction, a Senior Coroner will:

a. Ensure the Crown Solicitor's Office or DCJ Legal is instructed to assist in relation to the conduct of the coronial proceedings within 48 hours.

b. Ensure an Aboriginal CISP Officer is assigned as a liaison point for the family representative at the earliest opportunity or within 48 hours.

c. Ensure the family representative or family legal representative is contacted by the Aboriginal CISP Officer at the earliest opportunity or within 48 hours in order to:

(i) Provide initial information regarding the purpose of the coronial process and the role of the Senior Coroner,

(ii) Obtain consent for contact details to be provided to the ALS or Legal Aid (or alternatively, provide contact details for the ALS or Legal Aid) to facilitate legal advice being provided as to the family's rights in relation to the coronial process, and

(iii) Work with the family to identify any cultural and ceremonial considerations surrounding the viewing of the body, any proposed post-mortem examination and release of the body, and

(iv) Work with the family to identify any issues they wish to raise with the coronial investigation, including any issues surrounding the circumstances of death.

d. Ensure the Officer in Charge is contacted by the solicitor assisting at the earliest possible opportunity to determine appropriate arrangements for:

(i) Obtaining statements (such as to facilitate witness interviews being held in a location other than a police station, or for the presence of support persons at interviews with family members where requested),

(ii) The collection of time-critical evidence (such as CCTV footage), and

(iii) Any other relevant issue that requires early direction.

7.3. Where the deceased's status as a First Nations person is not known at the time a determination of jurisdiction is made, the Senior Coroner must ensure the steps outlined above at [7.2] are actioned within one business day of receiving confirmation the deceased is a First Nations person.

8. FACTORS TO BE CONSIDERED IN CORONIAL INVESTIGATION

8.1. When investigating the circumstances of the death, the Senior Coroner will consider any issues determined to be relevant within the scope of the coronial investigation. Where the death is a death in custody, this may include but is not limited to the quality of care, treatment and supervision of the deceased.

8.2. The Senior Coroner will ensure such matters are considered by making specific directions to the Officer in Charge to provide a comprehensive brief of evidence that includes statements from:

a. persons that can give evidence in relation to these factors, and

b. family members who wish to provide statements.

9. ONGOING EXCHANGE OF INFORMATION WITH FAMILY

9.1. In consultation with the Aboriginal CISP Officer, the solicitor assisting the Senior Coroner must ensure that the family representative, or if applicable their legal representative(s), are kept apprised of the progress of the coronial investigation regularly and at minimum intervals of 2 months, (unless the family would prefer less frequent contact) including:

a. Providing updates following completion of each of Stage Two to Stage Five of Coronial Practice Note 3 of 2021, and

b. Any delays arising in the completion of any of the abovementioned Stages and the reason for those delays.

9.2. The solicitor assisting must ensure the family representative, or if applicable their legal representative(s) is consulted on proposed hearing dates to ensure the family is able to attend (should they wish to do so).

10. FAMILY MEETINGS

10.1. Within 2 weeks of receipt of the brief of evidence (or partial brief of evidence) in accordance with Stage Four of Coronial Practice Note 3 of 2021, the Senior Coroner will ensure the family representative (and other family members of the deceased as appropriate in the circumstances) is offered an opportunity to engage in a family meeting with key persons involved in the coronial investigation.

10.2. The purpose of the family meeting is to discuss the following matters:

a. The coronial process, including case management steps and timeframes set out in Coronial Practice Note 3 of 2021,

b. The findings of any post-mortem examination, including initial findings where a final post-mortem report is not available,

c. Any cultural considerations relevant to the conduct of the hearing, and

d. Any other issue the family wishes to raise in relation to the coronial investigation.

10.3. Where the family representative (and other family members of the deceased as appropriate in the circumstances) wishes to participate in a family meeting,

the Aboriginal CISP Officer will ensure a meeting is facilitated with the following persons:

a. The family legal representative(s),

b. The solicitor assisting and counsel (if appointed and available),

c. The Officer in Charge,

d. Where the death occurred in Corrective Services NSW custody, a representative from Corrective Services,

e. The Aboriginal CISP Officer,

f. A Forensic Medicine social worker, and

g. The forensic pathologist who conducted the examination (if requested by the family or the solicitor assisting).

10.4. If the family representative indicates a preference that any of the above persons not attend the family meeting, the meeting must proceed as far as is possible without the person(s).

10.5. The Aboriginal CISP Officer will ensure the family representative is consulted as to the location of the meeting.

10.6. If the final post-mortem report is available, the solicitor assisting will ensure it is provided to the family representative at the family meeting.

10.7. If there is a delay in the provision of the final post-mortem report, the solicitor assisting will ensure the family representative is kept informed of the delay and the reason for the delay is explained.

10.8. Where the family representative (and/or other family members of the deceased as appropriate in the circumstances) does not wish to participate in a family meeting (or this meeting cannot be held for any other reason), the solicitor assisting, in consultation with the Aboriginal CISP officer, must make alternative arrangements to discuss the matters set out in [10.2] above.

11. HEARINGS

11.1. The Senior Coroner will ensure the hearing is:

a. Listed on a date(s) on which the deceased's family is available to attend (should they wish to do so), and

b. Conducted in a culturally sensitive and appropriate manner, including by adhering to any cultural considerations raised by the family of the deceased (so far as is practicable), such as:

(i) The name the family wish to use for the deceased throughout the duration of the hearing(s) (including any directions hearing where applicable) and appropriate warnings about use of the name, including in hearings convened via audio or audio visual link,

(ii) Whether it is appropriate to hear all or part of the inquest on Country, particularly if this would facilitate attendance at the hearing by the deceased's family and members of the community,

(iii) A Welcome to Country or an Acknowledgement of Country is made,

(iv) A smoking ceremony, and

(v) Display and use in court of symbols and items of cultural significance to the deceased and the deceased's family.

11.2. Where it is anticipated the hearing(s) (including any directions hearing where applicable) will be convened through the use of audio or audio visual links, the Aboriginal CISP Officer must make arrangements to ensure the family representative, and family can access and, where approved by the Senior Coroner, participate in the hearing (if required).

11.3. If there is a delay allocating a hearing date, or for any reason the hearing cannot proceed or is adjourned to a later date, the solicitor assisting must ensure the reason is explained to the family representative.

11.4. All legal representatives of interested parties will conduct themselves in the courtroom and in the court precinct in a manner that is respectful of the deceased's family and mindful of the grief and loss experienced by them.

12. FINDINGS AND RECOMMENDATIONS

12.1. Where possible, the Senior Coroner will ensure findings and recommendations are delivered within 6 weeks of receipt of any final submissions.

Magistrate Teresa O'Sullivan
NSW State Coroner