CORONIAL REFORM IN WESTERN AUSTRALIA

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I Introduction

The coronial system in Western Australia has implemented in the *Coroners Act 1996* (WA) ('*Coroners Act*') a majority of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody ('RCIADIC'). As a result of the amendments, coronial inquests are now relatively thorough when reporting on a death. All investigations are required by statute to include a summary of the circumstances surrounding the death and underlying issues that appear to have a bearing on the death. Specifically all deaths caused or contributed to by an act of the Western Australia Police Service must be investigated.[1] In these investigations, the quality of the care, treatment and supervision of the deceased prior to death must also be reported on by the coroner.[2]

However, despite many positive changes in Western Australia's coronial system, there are two fundamental problems with the current system that remain. The first is that police are the coroner's investigators. The consequence of this is that, in circumstances such as a death in custody, the Western Australia Police Service is often responsible for investigating deaths that occurred under its control. The Aboriginal Legal Service of Western Australia ('ALSWA') believes that the *Coroners Act* should be amended to make it mandatory for investigations into deaths in police custody or deaths concerning the conduct of WA police officers (currently serving or otherwise) to be conducted by personnel independent of the Western Australia Police Service.

The second issue is that there is no statutory provision in the *Coroners Act* that requires government agencies to respond to coronial recommendations. Nor is there a provision requiring that all coronial coroner recommendations be tabled in the Western Australian Parliament. ALSWA is of the opinion that the *Coroners Act* should be amended to make it mandatory for relevant government agencies to respond to coronial recommendations and for those responses to be tabled in Parliament.

This paper will discuss these two key issues in greater detail, with reference to a number of recent coronial investigations.

II Police Investigating Police

The police service should not have the prime investigative role in a case where there has been a death in police custody or where the conduct of police officers is in issue.

In Western Australia, coronial investigations are currently conducted by the Western Australia Police's Major Crime Squad and the Internal Affairs Unit. Previously, the Western Australia Police had a designated Coronial Investigation Unit and a Police Prison Unit, which specialised in the investigation of prison deaths. The Coroner's Office has recently advised ALSWA that these units brought considerable expertise into considerations in deaths in custody.[3] However, these units have now been subsumed within larger, more generalised police criminal investigation units. The Coroner's Office has expressed concerns that, since the implementation of these changes, it has not been able to work as closely with police investigators as it did in the past.[4] There is an additional concern that police officers less experienced in coronial investigations are now investigating deaths.

In 2006, concerns were raised by ALSWA with the Western Australia Police Service about the adequacy of a particular police investigation into a death in police custody. The concerns focused on the independence, objectivity and sufficiency of the police investigation. The Western Australia Police responded by asserting that these concerns were adequately dealt with by the Internal Affairs Unit, which reviews investigations into deaths in custody.[5] They also asserted that the Corruption and Crime Commission ('CCC') of Western Australia provides an independent review and, in certain circumstances, may elect to conduct their own investigation.[6] However, in ALSWA's experience, the CCC has never conducted an independent review of police internal investigations for the purpose of coronial inquiry.

A Internal Police Culture

The arguments against internal police investigations in the context of deaths in police custody are obvious and have long been recognised. RCIADIC commented upon the high level of tolerance for police untruthfulness within internal investigations, which included tailoring evidence, providing false information in statements of interview and lying in the witness box.[7] RCIADIC found that

> if police would reverse their strategy of closing ranks in blind loyalty, and instead assist inquiries and courts to get at the truth, their own reputation and level of respect accorded to them in the end would be greatly enhanced.[8]

RCIADIC also found that the police had an inability to investigate other police. Many police officers often had difficulties in investigating other police officers' conduct 'with thoroughness, objectivity and impartiality'.[9]

The Queensland Commission of Inquiry into Possible Illegal Activities and Associated Police Misconduct, commonly known as the Fitzgerald Inquiry, summarised what it saw as key aspects of police culture. These include a high degree of cohesiveness and solidarity amongst police; a sense of isolation and marginalisation from mainstream society as a result of the nature of their work; and a sense of powerlessness and frustration arising from the limitations of the effectiveness of law enforcement. These attitudinal characteristics were said to be coupled with a range of structural opportunities for corruption and misconduct, including abuse of police discretion, subversion of suspects' rights, and opportunities for illegal personal gain. The high value placed on a 'code of silence' in the police force protects misconduct, preventing police criticising, disciplining or enforcing the law against other police.[10]

In 2001, a joint report by the Western Australian Ombudsman, Western Australia Police Service and the Sellenger Centre, titled *Reporting Police Misconduct*, highlighted a relatively frequent failure of Western Australian police to report misconduct.[11] Survey evidence found that the decision by police officers to report misconduct is largely based upon their personal perceptions of the incident in question.[12] These perceptions were heavily influenced by police officers' loyalty to other officers, fear of reprisals, distrust of reporting procedures and their beliefs about what constitutes 'common practice' within the policing profession.[13]

What all of this research demonstrates is that there are inherent systemic and cultural issues within the police service that may give rise to substantial impediments to internal investigations into potential police misconduct being conducted in a thorough, objective and independent manner when a death in police custody occurs.

B Nature of Investigations

A further concern for ALSWA with respect to police investigating the conduct of police in the context of deaths in police custody involves the nature of the investigations themselves. For example, ALSWA recently acted for the family of a 16 year old Aboriginal girl who died as a result of a car accident. The car in which she was travelling had been stolen. The driver had been earlier pursued by police in a high speed car chase and, moments after the chase was abated, the car crashed causing the girl's death.[14]

The police investigation into the death was conducted by an Acting Sergeant from the police internal affairs Unit. The investigation was the first occasion on which the Acting Sergeant had been responsible for an investigation and for the compilation of a brief for the Coroner. Evidence at that coronial inquest established that the primary focus of the investigation was to determine whether police had obeyed the law, including the *Criminal Code Act 1995* (Cth) and the *Road Traffic Act 1974* (WA), and whether police had complied with the Police Commissioner's guidelines with respect to high-speed car chases.[15]

The investigation failed to consider whether it had in fact been necessary for police to pursue the stolen car; the type of criminal offences that the occupants of the car may have committed as a justification for the pursuit; the efficacy of a high-speed police pursuit in peak hour traffic on a week day through suburban Perth; how such pursuits might be avoided in the future; and what could be done to minimise the risks arising from such pursuits.

ALSWA believes that, if a body independent of the Western Australia Police Service were to investigate deaths that occurred in similar circumstances, this would minimise the risk of investigations having too narrow a focus, which inevitably arises whenever a death in police custody occurs, and would permit an examination of important thematic issues.

ALSWA endorses the findings of the South Australian State Coroner in a recent inquest into the death of an Aboriginal man, in which the State Coroner commented on the shortcomings of police investigating police.[16] A solution suggested by the State Coroner was that different jurisdictions enter into arrangements with each other so that a death in a particular jurisdiction is investigated by or under the supervision of police from another jurisdiction. It was noted that such an arrangement may result in a 'small inconvenience'; however, the Coroner concluded that this would be well justified if it avoided an investigation that is 'defensive, or lacking in enthusiasm'.[17]

ALSWA submits that the issue of police investigating police in coronial inquests urgently needs to be reviewed on a nationwide basis. The recommendations made by coroners and submissions to the coroners by legal services should be carefully considered.

III Government Consideration of Coronial Recommendations

Coronial inquests are official records of the cause and contributing factors of a death and should be considered as a valuable resource by State and Federal governments for preventing future deaths.[18] This is particularly relevant to Aboriginal deaths as Aboriginal people continue to die much younger and in more avoidable circumstances than non-Aboriginal people.[19]

In Western Australia, Aboriginal and Torres Strait Islander peoples comprise 3.6 per cent of the total population[20] but make up 41.1 per cent of the Western Australian prison population.[21] Young Aboriginal people make up 76.3 per cent of the total juvenile prison population.[22] Aboriginal people in Western Australia have poorer outcomes than non-Aboriginal people across every social spectrum. Aboriginal people experience poorer health, with the hospitalisation rates for Aboriginal people 14 times higher for care involving dialysis and twice as high for respiratory disease and injury.[23] In addition, Aboriginal people experience higher levels of unemployment, welfare dependency and general life stresses, and lower levels of literacy and numeracy. For example in 2005, a study by the Western Australian Child Health Survey noted that one in five Aboriginal children were living in families where seven or more major life stress events had occurred over the preceding 12 months; one in four children were living in families with poor quality of parenting; and one in five children were living in families that function poorly.[24] Most coronial investigations into Aboriginal deaths will invariably involve consideration of several of the factors mentioned above.

Recently in Western Australia, the State Coroner held a series of investigations, resulting in a joint inquest, which aimed to explore the reasons for a large number of deaths of Aboriginal persons in the Kimberley. The deaths appeared to have been caused or contributed to by alcohol abuse or cannabis use. The joint inquest also attempted to identify reasons for an alarming increase in suicide rates.[25]

During the inquest, personnel from every government agency charged with service delivery to Aboriginal people in the Kimberley were called to give evidence. Extensive recommendations were made by the State Coroner following the inquest,[26] which was detailed and specific. The recommendations focused on government accountability and sustainability of government agencies, long-term strategies and careful implementation of monies. The recommendations promoted the need for further inclusion of Aboriginal people in plans for their communities in terms of consultation, leadership and employment. The State Coroner strongly recommended the need for greater cohesion and inter-agency partnerships between State and Commonwealth government agencies.

In Western Australia, it is not a statutory requirement for government agencies to respond to government-directed recommendations nor is it a requirement that coronial

recommendations be tabled in the Western Australian Parliament. In contrast, the Northern Territory has legislated on government reporting requirements. Section 46A of the *Coroners Act* (NT) requires that the Attorney-General immediately forward any comments or recommendations from the coroner relating to a State or Commonwealth department or agency or the police force to the Chief Executive Officer of the department or agency, the Commissioner of Police or the appropriate Commonwealth Minister. Section 46B of the same Act requires a written response from the relevant State agency or the police force within three months of the report or recommendations being received. This must include a statement of the action that the agency or the police force has taken or is taking. Upon receiving the report, the Attorney-General must, without delay, report on the coroner's report or recommendation and the relevant agency's response. This report by the Attorney-General must then be given to the coroner and be tabled in front of the Legislative Assembly within three sitting days after completing the report.

ALSWA is of the view that only through the implementation of requirements similar to those contained under ss 46A and 46B of the *Coroners Act* (NT) can the Western Australian community have any confidence that those government departments responsible for service delivery will treat seriously and respond appropriately to coronial investigations. History has shown that, in Western Australia, police and government agencies regularly ignore coronial recommendations when it is convenient for them to do so.

The Coroner's recommendations following the Kimberley inquest generated widespread media attention and were met with a flurry of government proposals and strategies. ALSWA is concerned that with the lapse of time there is a risk that no meaningful change will come as a result of the recommendations and, in turn, there will be no discernable improvements in the lives of Aboriginal people in the Kimberley.

IV Conclusion

ALSWA applauds the diligence of the State Coroner's efforts in seeking to implement RCIADIC recommendations and endeavouring to make coronial processes accessible to Aboriginal communities. However, without further reform, some aspects of the coronial investigative processes will remain flawed. Internal police investigations should not be carried out when a death in police custody occurs. It is impossible for such investigations to be thorough, objective and independent. In addition, there is little point in coroners making recommendations if they are not read or adhered to. It should be a statutory requirement in Western Australia that all recommendations made by coroners be forwarded to the Attorney-General, the relevant government department and the appropriate State and/or Federal Minister. A government response to these recommendations should also be a statutory requirement. This response should then be tabled in Parliament for the member's consideration. These two key issues are impediments to the improvement of coronial processes in Western Australia.

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1 *Coroners Act 1996* (WA), s 22B.

2 *Coroners Act 1996* (WA), ss 25(1), 25(3).

3 Interview with the Administrator, Office of the State Coroner of Western Australia (Telephone interview, 20 May 2008).

4 Ibid.

5 Letter from Alan Carpenter, Premier of Western Australia, to the Woods family, 2 July 2007 (copy on file with authors), regarding the death in custody of a Woods family member.

6 Ibid.

7 Chris Cunneen, *Conflict, Politics and Crime: Aboriginal Communities and the Police* (2001) 144.

8 Commonwealth, RCIADIC, *Regional Report of Inquiry in New South Wales, Victoria and Tasmania* (1991), pt 6, ch 18, 'Police Culture: Truthfulness of Police Officers' <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/nsw-vic-tas/240.html> at 20 November 2008.

9 Ibid, pt 6, ch 18, 'Police Culture: Police Reluctance to Criticise Police' <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/nsw-vic-tas/240.html > at 20 November 2008.

10 Cunneen, above n 7, 143–4.

11 Ombudsman Western Australia, Western Australia Police Service and the Sellenger Centre, *Reporting Police Misconduct* (2001) <http://www.ombudsman.wa.gov.au/documents/reports/reporting_police_misconduct.pdf> at 20 November 2008.

12 Ibid 5.

13 Ibid.

14 *Inquest into the Death of N T Hayward* (Unreported, WA

Coroner's Court, 20 March 2008).

15 Ibid; Western Australia Police Service, 'TR-7.13 Police Driver/Rider Training/Re-qualification', Corporate Knowledge Database (2008).

16 *Inquest into the Death of C C Sansbury* (Unreported, SA Coroner's Court, State Coroner Johns, 12 July 2007) [19.2] <http://www.courts.sa.gov.au/courts/coroner/index.html> at 20 November 2008.

17 Ibid [19.3].

18 Ray Watterson, Penny Brown and John McKenzie, *Coronial Recommendations and the Prevention of Indigenous Death*, Report by Many Rivers Aboriginal Legal Service (2006) 2 (unpublished, copy on file with authors) (see now Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(SE2) *Australian Indigenous Law Review* 4).

19 See, eg, Brian Pink and Penny Allbon, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, Australian Bureau of Statistics and Australian Institute of Health and Welfare (2008).

20 See Australian Bureau of Statistics, *3238.0.55.001 – Experimental Estimates of Aboriginal and Torres Strait Islander Australians, Jun 2006* <www.abs.gov.au> at 20 November 2008. Of a total Western Australian population of 1 988 415, Aboriginal and Torres Strait Islander peoples total 70 966.

21 Western Australian Department of Corrective Services, *Weekly Offender Statistics Ending 10 July 2008* (2008) 1 <http://www.correctiveservices.wa.gov.au/_files/Prison%20Count/cnt080710.pdf> at 20 November 2008.

22 Western Australian Department of Corrective Services, *Weekly Offender Statistics Ending 7 August 2008* (2008) 1 <http://www.correctiveservices.wa.gov.au/_files/Prison%20Count/cnt080807.pdf> at 20 November 2008.

23 Pink and Allbon, above n 19, 107, 128.

24 Steve Zubrick et al, *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People*, vol 2, 101.

25 *Inquest into the Deaths of E J Riley, R Henry, C Atkins, T Beharral, M Brown, J Dick, L Dawson, B Dickens, I B Gepp, O G J Hale, E J Laurel, J Middleton, W R Miller, G Oscar, C A Shaw, S Surprise, D K Edwards, N M Cox, D Sampi, L Sampi, T J O'Sullivan, Z Yamera* (Unreported, WA Coroner's Court, State Coroner Hope, 25 February 2008) <http://www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Kimberley_Coronial_Report_Findings.pdf> at 20 November 2008.

26 Ibid 157–69.