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FOR WANT OF AN EFFECTIVE *CORONERS ACT*: *BELL V DEPUTY CORONER (SA)* [2020] SASC 59

Note: Aboriginal and Torres Strait Islander peoples should be aware that this case note contains the names of people who have passed away.

I Introduction

In 2020, the Black Lives Matter movement reached an all-time high. Emboldened initially by the death of George Floyd and subsequent protests across the United States, Australia-wide protests were held in the name of the movement. Tensions with police forces, heightened by arrests and fines associated with breaching coronavirus restrictions, have thrust Aboriginal[1] deaths in custody and issues of systemic racism in Australian police and correctional services back into the spotlight.

As at April 2021, there had been more than 470 Aboriginal deaths in custody since the National Report of the Royal Commission into Aboriginal Deaths in Custody ('Royal Commission') was released in 1991.[2] Despite recommendations from the Royal Commission intended to reduce them, incarceration rates for Aboriginal people have increased disproportionately since that time. Even more alarmingly, over half of the Aboriginal people who have died in custody since 2008 had not been convicted of a crime.[3]

Recurring themes for families of those who have died in custody include delays in investigations and inquests, a lack of available information, and the failure to

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1 This term is used respectfully as an all-encompassing term for Aboriginal and Torres Strait Islander peoples.

2 Lorena Allam et al, 'The 474 Deaths Inside: Tragic Toll of Indigenous Deaths in Custody Revealed', *The Guardian* (online, 9 April 2021) <https://www.theguardian.com/australia-news/2021/apr/09/the-474-deaths-inside-rising-number-of-indigenous-deaths-in-custody-revealed>.

3 Calla Wahlquist, Nick Evershed and Lorena Allam, 'More than Half of 147 Indigenous People Who Died in Custody Had Not Been Found Guilty', *The Guardian* (online, 30 August 2018) <https://www.theguardian.com/australia-news/2018/aug/30/more-than-half-of-147-indigenous-people-who-died-in-custody-had-not-been-found-guilty>. For information on increasing incarceration rates, see Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (Discussion Paper No 84, July 2017) 26 [1.29]–[1.30].

bring to account those responsible for the death.[4] What happens when correctional services, prison or police officers — those we trust to protect people in custody and often the only witnesses to the events — refuse, during a coronial inquest, to give evidence regarding their personal knowledge of the cause and circumstances of a death in custody, for fear of disciplinary or criminal proceedings? The answer lies in the decision of Blue J in *Bell v Deputy Coroner (SA)* [2020] SASC 59 ('*Bell*'). His Honour held that penalty privilege is available in such circumstances, and is not abrogated by the *Coroners Act 2003* (SA) ('*SA Act*'). However, his Honour found that the Deputy State Coroner ('Coroner') did not deny the plaintiffs penalty privilege on any of the alleged occasions. This decision casts a pall over the future of coronial inquests, especially death in custody inquests, potentially allowing officers to refuse to answer questions of the Coroner on matters which go to the heart of the coronial jurisdiction.

Unlike other coroners' courts in Australia, the South Australian Coroner's Court cannot balance the common law privileges of individuals against the broader interests of justice. This is particularly egregious in light of the epidemic of Aboriginal deaths in custody, which led the Royal Commission to include Recommendation 36, that '[i]nvestigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner'.[5] The ruling of the Supreme Court of South Australia in *Bell* illustrates these issues and their consequences.

This case note considers the Court's decision in *Bell* from Aboriginal justice and law reform perspectives. It argues that the decision highlights the longstanding issues faced by Aboriginal Australians in the context of law enforcement, compounding delays in inquests and the lack of accountability of police and correctional officers, and that the decision also undermines the role of the Coroner in conducting inquests. Further, this case note suggests that *Bell* is the result of a legislative failure: the *SA Act* does not provide a mechanism by which a Coroner can require a witness to answer questions concerning the cause and circumstances of a death, while at the same time preserving the legitimate interests of a witness in claiming privilege. This case note discusses how the *SA Act* neglects to preserve the very function of the Coroner's Court and examines proposals for legislative change to modernise the *SA Act*, in line with legislation in other jurisdictions.

It should be noted that the *Coroners (Inquests and Privilege*) *Amendment Act 2021* (SA) received royal assent in early 2021. Its effect, law reform context and relationship to *Bell* is analysed and discussed below. The authors propose that lessons from *Bell* and issues identified in this paper are of continuing relevance to coronial efficacy and ought to be considered in assessing the effectiveness of this new legislation.

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4 Lorena Allam, '"Why Does It Take So Long?" The Desperate Wait for Answers after a Death in Custody', *The Guardian* (online, 25 August 2019) <https://www.theguardian.com/australia-news/2019/aug/25/why-does-it-take-so-long-the-desperate-wait-for-answers-after-a-death-in-custody>.

5 See *Royal Commission into Aboriginal Deaths in Custody* (National Report, April 1991) vol 5, [36] ('*Royal Commission*').

II Background

A *Facts*

Wayne Fella Morrison was a Wiradjuri, Kokatha, Wirangu man.[6]

On 17 September 2016, Mr Morrison was arrested and held at the Holden Hill and later, at the Elizabeth Police Station.[7] He appeared at the Magistrates Court at Elizabeth on 19 September 2016, where the Magistrate ordered a home detention bail inquiry report. Mr Morrison was remanded in custody to reappear on 23 September 2016.[8] After this hearing, he was transferred to the Yatala Labour Prison.[9] At about 9am on 23 September 2016, Mr Morrison was awaiting his appearance in the Magistrates Court by audiovisual link.[10]

At about 11:25am — less than an hour before Mr Morrison was scheduled to appear before the Magistrates Court — there was an altercation between Mr Morrison and two correctional officers.[11] This escalated until up to 12 officers wrestled Mr Morrison to the ground,[12] and pinned him to the floor with cuffs applied to his hands and ankles.[13] A spit mask was placed over his head and he was carried by five officers to a prison conveyance van in the prone position, where he was placed face down on the floor.[14] Mr Morrison was in the van for approximately three minutes.[15] By the time he was removed from the van, he 'did not respond to verbal directions … and his skin was blue'.[16]

Mr Morrison died early on the morning of 26 September 2016.[17]

6 Paul Gregoire and Rachel Evans, 'Justice for Wayne Fella Morrison: An Interview with Caroline Andersen', *Sydney Criminal Lawyers* (Blog Post, 8 July 2020) <https://www.sydneycriminallawyers.com.au/blog/justice-for-wayne-fella-morrison-an-interview-with-caroline-andersen/>.

7 *Bell v Deputy Coroner (SA)* [2020] SASC 59, [8] (Blue J) ('*Bell*').

8 Ibid [9].

9 Ibid.

10 Ibid [12].

11 Royce Kurmelovs, 'Three Missing Minutes, and More Questions: Why Did Wayne Fella Morrison Die in Custody?', *NITV News* (online, September 2018) <https://www.sbs.com.au/nitv/feature/three-missing-minutes-and-more-questions-why-did-wayne-fella-morrison-die-custody-1>. See *Bell* (n 7) [13].

12 Kurmelovs (n 11). See *Bell* (n 7) [13]–[19].

13 *Bell* (n 7) [19].

14 Ibid [20], [21], [26]–[27]; Kurmelovs (n 11).

15 *Bell* (n 7) [27], [33].

16 Ibid [34].

17 Ibid [56].

Certain correctional officers refused to provide police statements on the basis of the privilege against self-incrimination,[18] and declined to provide incident reports or answer questions in interviews.[19]

The Coroner opened an inquest into Mr Morrison's death. During the hearing, the seven officers associated with the incident at the van refused to give evidence, on the ground that it might incriminate them.[20] Further, Correctional Officer Shirley Bell, who observed the scene, applied for a discharge of her obligation to attend on the ground that she would invoke penalty privilege in answer to all foreseeable questions.[21] While the other correctional officers' claims of self-incrimination privilege were a complete response to the Coroner's powers to compel answers to questioning under the *SA Act*,[22] no such provision is explicitly made in respect of penalty privilege. Thus, the merits of Ms Bell's claim of penalty privilege were considered by the Coroner.

B *The Decision of The Coroner*

On 17 December 2018, the Coroner ruled that, on the proper construction of s 23 of the *SA Act*, penalty privilege was not available to witnesses required to answer questions during an inquest.[23] This was because penalty privilege, unlike self-incrimination privilege, is not among those privileges explicitly available under s 23 of the *SA Act*, and was thus abrogated.[24]

The decision of the Coroner was appealed on a number of grounds to the Supreme Court, including that the Coroner had exceeded her jurisdiction in ruling that penalty privilege was not available to witnesses in an inquest.[25]

C *Applicable Legislation*

The *SA Act* provides for the appointment of the State Coroner and the holding of inquests, and establishes the Coroner's Court.

Section 21(1)(a) of the *SA Act* states that '[t]he Coroner's Court must hold an inquest to ascertain the cause or circumstances of … a death in custody'. Section 24(a) provides that the Coroner's Court 'is not bound by the rules of evidence and may inform itself on any matter as it thinks fit'.

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18 See ibid [58].

19 See ibid [59], [77].

20 Ibid [87]–[88].

21 Ibid [91], [268].

22 *Coroners Act 2003* (SA) s 23(5)(a) ('*SA Act*').

23 *Bell* (n 7) [95].

24 Ibid [95], [155], [164].

25 Ibid [132]–[134].

Bell turned on s 23 of the *SA Act* and whether it expressly or impliedly abrogated penalty privilege. Section 23 relevantly provides:

> **23 — Proceedings on inquests**
>
> (1) The Coroner's Court may, for the purposes of an inquest —
>
> …
>
> (e) require any person appearing before the Court (whether summoned to appear or not) to answer any questions put by the Court or by any person appearing before the Court.
>
> …
>
> (5) However, a person is not required to answer a question, or to produce a record or document, under this section if —
>
> (a) the answer to the question, or the contents of the record or document, would tend to incriminate the person of an offence; or
>
> (b) answering the question, or producing the record or document, would result in a breach of legal professional privilege.
>
> (6) This section does not derogate from Parts 7 and 8 of the *Health Care Act 2008*.[26]

Part 7 of the *Health Care Act 2008* (SA) ('*Health Care Act*') requires confidentiality to be maintained over certain information relating to medical research, while pt 8 deals with the investigation of certain incidents. Sections 66(3) and 73(3) of the *Health Care Act* expressly state that persons to whom the relevant provisions apply cannot be compelled to disclose any information in court.

D *Penalty Privilege (and the Privilege against Self-Incrimination)*

Penalty privilege, sometimes referred to as the 'privilege against self-exposure to a penalty',[27] was developed alongside the privilege against self-incrimination. It is that 'a person shall not be obliged to discover what will subject him [sic] to a penalty',[28] and its roots stem to 17th century equity and common law courts.[29]

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26 *SA Act* (n 22) s 23.

27 *Environment Protection Authority (NSW) v Caltex Refining Co Pty Ltd* (1993) 178 CLR 477, 517–19 (Brennan J) ('*Caltex*').

28 *Smith v Read* (1737) 1 Atk 526; 26 ER 332, 332 ('*Smith*').

29 Nick Yetzotis, 'Illuminating the Privilege against Exposure to Civil Penalties' [2008] (May) *Law Society Journal: The Official Journal of the Law Society of New South Wales* 70, 70. See also *Smith* (n 28); *Pye v Butterfield* (1864) 5 B & S 829; 122 ER 1038; *Redfern v Redfern* [1891] P 139 ('*Redfern*').

Although practically similar, penalty privilege is theoretically a different privilege to the privilege against self-incrimination. Importantly, the emergence of penalty privilege is not rooted in the protection of human rights, but rather the limitation that courts have placed on the exercise of their own powers.[30] The policy of the privilege is that 'no one is bound to answer so as to subject himself [sic] to punishment'.[31] In practice, the two privileges have historically been considered together,[32] though it is unclear whether this is still the practice. Justice McColl in *Rich v Australian Securities and Investments Commission*[33] said that the two privileges were 'manifestations of the same core principle that no person should be obliged to accuse themself'.[34] The modern penalty privilege 'serves the purpose of ensuring that those who allege criminality or other illegal conduct should prove it'.[35]

E *Issues*

To determine whether penalty privilege was available under s 23 of the *SA Act*, Blue J was required to consider the following issues:

1. the standard for abrogation of common law rights in curial and non-curial settings (while the non-curial nature of the Coroner's Court's was not in issue, Blue J deemed it necessary to make 'brief observations' on this matter);[36]

2. whether, on the proper construction of s 23 of the *SA Act*, common law penalty privilege was abrogated during inquests;[37] and

3. if penalty privilege were indeed available, whether the privilege had actually been unlawfully denied to the plaintiffs by the Coroner.[38]

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30 *Caltex* (n 27) 519.

31 *Brownsword v Edwards* (1751) 2 Ves Sen 243; 28 ER 157, 158.

32 See, eg, *Redfern* (n 29) 147. Cf *Pyneboard Pty Ltd v Trade Practices Commission* (1983) 152 CLR 328, 335–7 ('*Pyneboard*'). See also *Trade Practices Commission v Abbco Iceworks Pty Ltd* (1994) 52 FCR 96, 129 (Burchett J): the privileges 'should not be seen as separate props in the structure of justice, but rather as interlocking parts of a single column'.

33 *Rich v Australian Securities and Investments Commission* (2003) 203 ALR 671 ('*Rich*').

34 Ibid 729 [322].

35 *Daniels Corporation International Pty Ltd v Australian Competition and Consumer Commission* (2002) 213 CLR 543, 559 [31] (Gleeson CJ, Gaudron, Gummow and Hayne JJ) ('*Daniels*'), quoted in *Rich* (n 33) 677 [32].

36 *Bell* (n 7) [155].

37 See ibid [164].

38 Ibid [202]–[204].

There were several other grounds of appeal[39] which were of secondary importance, and each failed.[40] They are outside the ambit of this case note.

III Justice Blue's Decision

Justice Blue held that the Coroner erred in finding that penalty privilege was not available to witnesses at coronial inquests in South Australia.[41] However, his Honour found that the Coroner did not deny penalty privilege in relation to any specific question on the occasions alleged by the plaintiffs.[42] In reaching this decision, his Honour first considered whether penalty privilege was available in a non-curial context, then whether the *SA Act* abrogated penalty privilege, and finally whether the Coroner in this case denied any plaintiff the benefit of penalty privilege on the alleged occasions.

A *Issue 1: Curial and Non-Curial Standards for Abrogation*

Justice Blue noted that the case law regarding the availability of penalty privilege in a non-curial context is unclear.[43] His Honour noted that, in *Pyneboard Pty Ltd v Trade Practices Commission* ('*Pyneboard*'),[44] and *Sorby v Commonwealth*,[45] the High Court used an identical approach in addressing penalty privilege and self-incrimination privilege.[46] This is despite the former case having concerned penalty privilege in a non-curial context and the latter having considered self-incrimination privilege in a curial context.[47]

In contrast to this, his Honour recognised that a majority in *Daniels* had 'said that "there seems little, if any, reason why [penalty] privilege should be recognised outside judicial proceedings"'.[48] The Full Court of the Federal Court in *Migration Agents Registration Authority v Frugtniet*,[49] considering the above decisions, stated that 'it is not open to regard *Pyneboard* as continuing to be authority, if it ever truly was, for the proposition that the starting point is that penalty privilege is capable

39 Ibid [5].

40 Ibid [588]–[689].

41 Ibid [195], [266], [314]–[316].

42 Ibid [200]–[291].

43 Ibid [163].

44 *Pyneboard* (n 32).

45 (1983) 152 CLR 281 ('*Sorby*').

46 *Bell* (n 7) [156].

47 Ibid.

48 *Bell* (n 7) [160], quoting *Daniels* (n 35) 559 [31] (Gleeson CJ, Gaudron, Gummow and Hayne JJ).

49 (2018) 259 FCR 219.

of applying in a non-curial setting'.[50] This statement, however, was considered by Blue J to be obiter, because the Full Court confined their decision to the availability of penalty privilege in proceedings before the Administrative Appeals Tribunal, under the *Administrative Appeals Tribunal Act 1975* (Cth).[51]

Justice Blue recognised the tension between the decisions described above. However, his Honour declined to resolve this issue, stating instead that '[i]t is preferable that this tension be resolved by an authoritative decision of the High Court'.[52]

B *Issue 2: Was the Penalty Privilege Abrogated by the SA Act?*

Having established the standard for abrogation, Blue J engaged in a process of statutory construction to determine whether penalty privilege had been abrogated by s 23 of the *SA Act*. His Honour found there was no express provision, nor necessary intention, to abrogate penalty privilege in the *SA Act*.[53] Thus, his Honour held that the Coroner had erred in ruling that penalty privilege was not available.[54]

The starting point for this consideration is that there is a presumption that Parliament does not intend to abrogate fundamental common law rights, freedoms and immunities unless the 'legislative intent to do so clearly emerges, whether by express words or by necessary implication'.[55] In *Bell*, the State conceded that penalty privilege is not expressly abrogated by the *SA Act*, instead arguing that it is abrogated by necessary intendment, in that ss 23(5) and (6) of the *SA Act* provide the grounds on which a person is not required to answer questions or provide documents, and all other 'personal privileges' are therefore abrogated.[56] Justice Blue found this argument unconvincing,[57] especially because the State presented the argument that 'public' privileges (such as public interest immunity) are *not* abrogated by s 23.[58]

In Blue J's view, to accept the State's argument would be to impute an intention to Parliament:

- [F]irstly to draw a distinction between personal and public privileges or immunities;
- secondly to cover the field of personal privileges;

50 Ibid 235 [52].

51 Ibid 222 [7], 235 [53]. See *Bell* (n 7) [162].

52 *Bell* (n 7) [163].

53 Ibid [165]–[169].

54 Ibid [195].

55 Ibid [170], quoting *Pyneboard* (n 32) 341; *Sorby* (n 45) 309.

56 *Bell* (n 7) [169].

57 Ibid [170].

58 Ibid [173].

- thirdly to exclude from that covering of the field an exemption created by section 23 itself (tendency to incriminate of an offence); and

- fourthly to exclude from that covering of the field legal professional privilege which is to continue to operate by force of the common law.[59]

Justice Blue felt that this was 'an artificial and overly complex … intention to impute to Parliament'.[60] His Honour stated that '[t]he mind and will of Parliament is an objective construct of the law'.[61] Thus, it is not appropriate to examine the 'subjective knowledge or intent of individual members of Parliament',[62] and one should not impute complex reasoning to Parliament without any express evidence of such contemplation.[63]

In particular, the distinction between 'personal' and 'public' privileges was considered to be convoluted and obscure.[64] Furthermore, Blue J noted that the exception carved out by s 23(6), referring to the *Health Care Act*, certainly falls on the 'public' side of the dichotomy. If Parliament were to abrogate personal privileges only, the enactment of s 23(6) would be superfluous.[65]

Further, his Honour referred to the lack of contextual clues indicating an intention to abrogate penalty privilege, including a lack of statements to that effect in the *SA Act* or its second reading speech.[66] If Parliament intended such a complex construction of the *SA Act*, this would be evident in these sources. His Honour was similarly not convinced that, because penalty privilege was of lower status than self-incrimination privilege, it was more likely to be impliedly abrogated.[67]

Finally, Blue J rejected the argument that, if penalty privilege was not abrogated, the work of the Coroner's Court would 'grind to a halt', as the privilege against self-incrimination was more likely to impede the Court's function in this way.[68]

Accordingly, Blue J reached the conclusion that s 23 of the *SA Act* does not abrogate penalty privilege.[69] This means that penalty privilege was, and is, available as a ground for declining to answer questions at an inquest, provided that the witness has

59 Ibid.

60 Ibid [174].

61 Ibid [175].

62 Ibid [175].

63 Ibid [177].

64 Ibid.

65 Ibid [176].

66 Ibid [178]–[182], [187].

67 Ibid [190].

68 Ibid [194].

69 Ibid [195].

established an entitlement to the privilege in answer to a specific question or request for production of a specific document.[70]

C *Issue 3: Was Privilege Denied?*

Notwithstanding that the Coroner had ruled in December that penalty privilege was not available to the plaintiffs, the State contended that the Coroner had not actually denied penalty privilege to which the plaintiffs might otherwise have been entitled.[71]

Justice Blue restated a number of principles relating to claims of penalty privilege: first, a witness seeking to rely on the privilege must 'make a specific claim to entitlement to the privilege as a ground for not answering a question or producing a document';[72] second, 'the privilege must be claimed in respect of individual questions or documents rather than a blanket objection';[73] third, the onus of establishing an entitlement lies on the person claiming the privilege;[74] and finally, the apprehended danger of being subject to a penalty must be real and appreciable for a claim to be established.[75]

The plaintiffs in *Bell* were not themselves the subject of any ruling by the Coroner in relation to penalty privilege. However, Blue J held that the plaintiffs nonetheless had standing to impeach the Coroner's general ruling that penalty privilege was not available during the inquest. That was because the plaintiffs could reasonably anticipate that, given the general ruling that had already been made, the Coroner would deny them penalty privilege if they sought to rely on it.[76] On the facts of the case, his Honour found that, aside from this general ruling, the Coroner never actually rejected claims of penalty privilege. Further, Blue J held that the Coroner had not asked questions designed to elicit privileged answers, nor had the Coroner failed to intervene in such questioning alleged by the plaintiffs to have been put by counsel.[77] Finally, on none of the alleged occasions did the plaintiffs make a specific claim of the privilege before answering a question, nor did the plaintiffs demonstrate a real and appreciable danger of being subject to any penalty.[78] However, Blue J noted that further questions in the inquest could potentially impinge on the privilege.[79] As a

70 Ibid.

71 Ibid [199].

72 Ibid [150].

73 Ibid.

74 Ibid.

75 Ibid.

76 Ibid [197]–[198].

77 Ibid [202]–[203], [315]. Justice Blue considered in detail the Coroner's alleged overruling of claims of privilege, and the alleged non-intervention in questions designed to elicit privileged answers: at [273]–[279], [280]–[291].

78 Ibid [202]–[204].

79 Ibid [312]–[313].

consequence, declaratory relief was granted and the appeal succeeded on the ground that the Coroner had erred in ruling that penalty privilege was not available.[80]

IV Comment

In this section, we discuss how *Bell* exposes fundamental weaknesses in the *SA Act*. We then analyse the implications of those deficiencies for the functioning of the Coroner's Court, particularly in light of the Royal Commission. Finally, we discuss equivalent legislation in other Australian jurisdictions, and potential law reform models to ameliorate the deficiencies of the *SA Act*.

A *Implications for the Functioning of the Coronial System*

Bell highlights the need to balance individual rights against the functioning of the Coroner's Court. The *SA Act* unnecessarily raises barriers for the Coroner's Court by restricting the questioning of witnesses who invoke self-incrimination or penalty privilege. As Craig Longman notes, in practically every situation in which a death has occurred on the watch of responsible officers, there is a threat of a civil penalty.[81] Thus, the *SA Act*'s implicit restrictions on coronial powers, as reflected in its failure to provide for the abrogation of various common law privileges, are deleterious to the effective function of inquests, particularly when key witnesses refuse to testify, and evidence must then be examined without the benefit of their testimony.[82]

The coronial jurisdiction is ancient and unique in the common law tradition, dating back at least, it has been said, to the year 1194.[83] It is a jurisdiction that conducts inquiries of a more inquisitorial character and is concerned mainly with fact-finding and with ascertaining what exactly occurred in a given situation, rather than the resolution of disputes and legal questions. This central function[84] is reflected in ss 13 and 21 of the *SA Act* as the essence of the Coroner's mandatory jurisdiction: to make findings about the cause and circumstances of the event under inquest, and to provide commentary and recommendations for the purposes of the prevention of further avoidable deaths. This function gained greater prominence as a result of the Royal Commission, in particular Recommendations 12 and 13 of the Royal Commission's National Report. Recommendations 12 and 13 were (respectively) to allow coroners

80 Ibid [316].

81 Craig Longman, 'Police Silence and Aboriginal Deaths in Custody' [2020] (July) *LSJ: Law Society of NSW Journal* 66, 67. This is notwithstanding the fact that no penalties were applicable on the evidence already heard by the inquest in *Bell*.

82 Ian R Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) 583–5.

83 Chief Justice Wayne Martin, 'The Coronial Jurisdiction: Lessons for Living' (2017) 44(2) *Brief* 42, 42.

84 Rebecca Scott Bray, '"Why This Law?": Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(Spec Ed 2) *Australian Indigenous Law Review* 27, 28–30.

to investigate the circumstances and causes of deaths thoroughly, and to make appropriate recommendations to prevent future deaths, as well as on the subject of matters arising in the course of the inquest.[85] This unique role allows a coroner the important opportunity to question and reprimand government officials for their failings, intentional or not, in circumstances such as those in *Bell*. The coroner is uniquely placed to 'contextualise individual deaths within a wider social and historical sphere' and thus has obvious relevance to the prevention of Aboriginal deaths in custody.[86] However, one may argue that the capacity of a coroner's court to effect preventative change may already be strictly limited by its retrospective view and the non-binding nature of its recommendations. Thus, it is suggested that *all* legal privileges, which serve to impede this important yet limited jurisdiction, ought to be constrained in order to preserve the effective functioning of coroners' courts.

Interestingly, Blue J in *Bell* was of the view that the availability of penalty privilege would not cause coronial proceedings to 'grind to a halt',[87] in part because his Honour considered that *self-incrimination privilege* would have farther-reaching effects in this regard. Moreover, Blue J reasoned that, on the facts before the Court, penalty privilege only prevented the Coroner from hearing evidence of events *after* the death occurred, which are of 'incidental, and secondary relevance'.[88] Notwithstanding that penalty privilege could be used in other cases to withhold relevant information from the Coroner, there was already a paucity of evidence before the Coroner

85 See generally ibid for an overview of the changing roles of Australian coroners' courts. See also discussion of coronial reform to allow coroners to perform this function better in Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(Spec Ed 2) *Australian Indigenous Law Review* 45. See *SA Act* (n 22) s 25, in which the powers of the Coroner to make recommendations and findings are enumerated. See *Royal Commission* (n 5) vol 5, [12]–[13] for Recommendations 12 and 13. It should be noted that Recommendation 12 (for coroners to investigate causes and circumstances of death as well as the relevant quality of care, treatment and supervision) has been uniquely implemented in South Australia through wide judicial interpretation of the relevant provisions, notwithstanding a lack of specific implementation in the *SA Act* (n 22). See *WRB Transport v Chivell* (1998) 201 LSJS 102, 106–7 [21]–[26] (Lander J), in which it was said that South Australian coronial inquiries can consider facts beyond those 'immediately proximate in time' to the relevant death, including any facts which relate to the cause of death (even circumstances which explain 'the interaction between a number of causes of death'). For a more in-depth consideration of the South Australian implementation of the Royal Commission's Recommendations, and particularly case law surrounding the investigation of deaths, see Christopher J Charles, 'The *Coroners Act 2003* (SA) and the Partial Implementation of RCIADIC: Consequences for Prison Reform' (2008) 12(Spec Ed 2) *Australian Indigenous Law Review* 75, 76–7.

86 Bray (n 84) 28. See Charles (n 86) 82–5 for a more specific discussion and evaluation of South Australian coronial law as it relates to the implementation of the Royal Commission's Recommendations (particularly relating to the publishing of reports of the Coroner and delivery of recommendations to the relevant persons).

87 *Bell* (n 7) [194].

88 Ibid.

in *Bell*.[89] Indeed, Blue J acknowledged that '[i]t is conceivable that an issue or issues in relation to penalty privilege may arise in relation to the balance of the evidence yet to be adduced'.[90] These excerpts from *Bell* illustrate that the gravamen identified in this case note is not penalty privilege per se. All legal privileges that may be used to reduce evidentiary material supplied to the Coroner's Court can have critical impacts on its effective functioning — including more fundamental privileges, that are invoked to avoid graver consequences for witnesses, than penalty privilege.

Notwithstanding the efforts of the Coroner in *Bell*, South Australia's coronial system is uniquely susceptible to the issues identified above. It is also uniquely inefficient. First, the South Australian Coroner's Court has the longest average time between death and resultant inquest, 'with 3.3 years'.[91] Mr Morrison's inquest, the subject of the decision in *Bell*, is set to resume in 2021, five years after his death.[92] Second, in nearly every other Australian jurisdiction, coroners are able to balance the benefits of privilege (when claimed) to the claimant, against the interests of justice. This tempers the potentially obstructive effects of legal privileges and removes barriers to the efficacious functioning of the coronial system, although it is noted that the effect of the relevant legislation is also to allow claimants to maintain privilege in future proceedings through the use of certificates, perhaps only transferring the dilemma of privilege to another forum.[93] *Bell* illustrates that the *SA Act* is, by comparison, ineffectual, as well as outdated. We will now briefly consider how these insufficiencies have particular importance in light of the Royal Commission.

89 Ibid [27], [32], [79].

90 Ibid [313].

91 Helen Davidson et al, '"People Will Continue to Die": Coroners' "Deaths in Custody" Reports Ignored', *The Guardian* (online, 31 August 2018) <https://www.theguardian.com/australia-news/2018/aug/31/people-will-continue-to-die-coroners-deaths-in-custody-reports-ignored>.

92 'Critical Report into the Death in Custody of Mr Morrison Is Released', *National Justice Project* to (Web Page, 10 September 2020) <https://justice.org.au/critical-report-into-the-death-in-custody-of-mr-morrison-is-released/>.

93 See *Coroners Act 1997* (ACT) ss 43, 51B; *Coroners Act 2009* (NSW) s 61 ('*NSW Act*'); *Coroners Act 1993* (NT) s 38; *Coroners Act 1995* (Tas) ss 53, 54; *Coroners Act 2008* (Vic) s 57 ('*Vic Act*'). The *Coroners Act 2003* (Qld) contains a similar provision regarding the inadmissibility in criminal proceedings of incriminating evidence given at an inquest: at s 39. See discussion in Northern Territory Law Reform Committee, *Privilege against Self Incrimination* (Report No 23, 2001) 8, 9. The powers under the *Coroners Act 1996* (WA) ss 46, 47 are relatively similar to those in South Australia. See the balancing act under the *Coroners Act 1980* (NSW) s 33AA, the predecessor to s 61 of the *NSW Act* (n 93), being performed in *A-G (NSW) v Borland* [2007] NSWCA 201.

B Bell *and Aboriginal Deaths in Custody*

It is well recognised by the judiciary that law enforcement and correctional officers play an important role in society.[94] It is equally well recognised that there exists a 'high public policy' in ensuring public confidence in the administration of criminal justice.[95] Justice Brennan in *Police Service Board (Vic) v Morris*[96] acknowledged that '[t]he effectiveness of the police in protecting the community rests heavily upon the community's confidence in the integrity of the members of the police force'.[97] His Honour stated that '[t]he purpose of police discipline is the maintenance of public confidence in the police force', and that permitting an officer 'to refuse to give an account of his [sic] activities while on duty' under a claim of privilege would 'subvert the discipline of the police force'.[98] This view rested heavily upon what his Honour considered to be the 'incompatibility of a claim of privilege with the duty of a police officer to reveal information acquired in the course of his [sic] duty'.[99]

Coroners' courts, in particular, perform an important function in the pursuit of justice for Aboriginal people who have died in custody, as well as the prevention of such deaths in future, by investigating the causes and circumstances of death and making recommendations.[100] Such deaths may, in some cases, already be difficult to investigate because of institutional stubbornness as to the provision of evidence.[101]

The pattern of silence and withholding information evident in *Bell* is reprehensible.

Detective Sergeant Lisa Pettinau, who was in charge of the initial police investigation of Mr Morrison's case, described feeling 'frustrated' due to misinformation.[102] Ms Pettinau explained waiting to speak to witnesses and victims on the day that Mr Morrison was restrained. She was told that they had gone home. Later, she would be informed that this was false, and the correctional officers were still on site.[103]

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94 See, eg, *Gaston v Police* [2004] SASC 222, [12] (Gray J).

95 *Pollard v The Queen* (1992) 176 CLR 177, 202–3 (Deane J), cited in *Nicholas v The Queen* (1998) 193 CLR 173, 195–6 [33] (Brennan CJ), 252–3 [198] (Kirby J).

96 (1985) 156 CLR 397.

97 Ibid 412.

98 Ibid.

99 Ibid 413.

100 Prue Vines and Olivia McFarlane, 'Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody' (2000) 4(27) *Indigenous Law Bulletin* 8; Raymond Brazil, 'The Coroner's Recommendation: Fulfilling Its Potential? A Perspective form the Aboriginal Legal Service (NSW/ACT)' (2011) 15(1) *Australian Indigenous Law Review* 94, 94; *Royal Commission* (n 5) vol 1, ch 4, [4.5.1]–[4.5.3].

101 See Longman (n 81); Freckelton and Ranson (n 82) 578–9.

102 Kurmelovs (n 11).

103 Ibid.

Ms Pettinau further noted that she had not been told of the extent of Mr Morrison's injuries until near the end of her shift.[104]

While Mr Morrison was initially admitted to the Royal Adelaide Hospital under his own name, the Department for Correctional Services changed that name to 'Ben Waters' after the Hospital received inquiries seeking Mr Morrison's location.[105] The Department refused to give Mr Morrison's family information or access, and they were escorted out of the Hospital.[106]

Silence and a lack of accountability are common features in the way Aboriginal deaths in custody are treated. For example, during the Inquest into the Death of David Dungay in the Coroner's Court of New South Wales, the media was ordered not to publish any identifying features of 21 New South Wales correctional staff.[107] *Bell* is an unsatisfactory decision that perpetuates the pattern of institutional silence, which is too often present in cases of Aboriginal deaths in custody.

The Royal Commission in 1991 identified issues surrounding the effect of the privilege against self-incrimination on coronial powers to investigate Aboriginal deaths in custody, suggesting it formed part of a series of 'fundamental questions relating to the administration of criminal justice'. However, the Commissioners interpreted their Terms of Reference as restricting a broader inquiry into this topic.[108] Conversely, the Royal Commission's investigation into the death of John Peter Pat was scathing of the prevailing practice in Western Australia of allowing witnesses to decline to give evidence on the basis of the privilege against self-incrimination (particularly in circumstances where that State's Coroner had the ability to compel testimony despite such claims). The Royal Commission described this practice as 'totally wrong' and as curtailing 'the effectiveness of the inquest as those who may have very important evidence to give are permitted not to give it'.[109] Despite the conclusion that the broader questions were outside the scope of the Commission's Terms of Reference, the Commissioners recognised the importance of coronial investigations in addressing the systematic dangers facing Aboriginal people in custody, and thus recommended that coroners' courts be structured in such a way as to ensure a sufficient evidentiary base for investigation.[110]

104 Ibid.

105 Ombudsman SA, *Ombudsman's Own Initiative Investigation in Relation to Issues Surrounding the Death in Custody of Mr Wayne Fella Morrison* (Report, August 2020) 95 [349].

106 Ibid 32 [111], 95 [350].

107 *Inquest into the Death of David Dungay* (Coroner's Court of New South Wales, Magistrate Lee, 22 November 2019) app B.

108 *Royal Commission* (n 5) vol 1, ch 4, [4.5.65].

109 Ibid Individual Death Reports, John Peter Pat, [14.8].

110 Ibid vol 5, [36].

While the Recommendations of the Commission call for broad structural changes to state coronial systems, they naturally do not include specific recommendations regarding the stymieing effect of the privilege against self-incrimination. Regardless, what occurred on the facts in *Bell* is particularly egregious as it had the effect of diluting the recommended evidentiary base for the investigation in that case. It is an example of institutional resistance (manifested in the actions of the correctional officers and their union, as well as in the failures of the Department for Correctional Services, discussed in depth below) to provide information surrounding Aboriginal deaths in custody, and illustrates the *SA Act*'s failure to implement effectively the Commission's broader Recommendation. The *SA Act* also fails to contemplate the vital matter of such privileges and their potential effect on coronial investigations. Moreover, *Bell* highlights the imperative need for reform to address this avoidable tragedy.

C *Law Reform*

The real issue with penalty privilege and the *SA Act* is that penalty privilege bestows a complete objection to correctional officers presenting evidence. Not only does this undermine accountability, the process of claiming and establishing penalty privilege will further delay already problematically inefficient coronial inquests.

In this section, we consider coronial powers of investigation in other Australian jurisdictions that demonstrate how an effective *Coroners Act* ought to be structured. We then analyse two different law reform efforts in South Australia in light of models in other Australian jurisdictions. We note that the Supreme Court acknowledged the need for reform to follow those models as early as 2008, albeit in the context of another aspect of coronial investigation.[111] We suggest that this early warning perhaps foreshadows the type of legislative failure that precipitated the outcome in *Bell*.

First, most other Australian jurisdictions have moved away from traditional common law models of privilege, allowing courts to compel witnesses to answer questions in spite of claims of privilege. The catalyst for these changes is said to have been the decision in *Decker v State Coroner (NSW)*,[112] handed down over two decades ago, in which a geologist who possessed unique knowledge and responsibility with regard to a project linked to a landslide which resulted in 18 deaths successfully invoked privilege against self-incrimination to refuse to provide information to the Coroner's Court of New South Wales. These 'new' legislative schemes balance individual

111 *Saraf v Johns* (2008) 101 SASR 87, 101 [43] (Debelle J). See also South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2020, 601–3 (Connie Bonaros).

112 (1999) 46 NSWLR 415 ('*Decker*'). For a discussion of the effect of *Decker*, its subsequent appeal and how it became a catalyst of legislative change, see Ian Freckelton, 'The Privilege against Self-Incrimination in Coroners' Inquests' (2015) 22(3) *Journal of Law and Medicine* 491, 496.

rights with the interests of justice in receiving evidence.[113] We suggest that the same powers should be available to coroners' courts.[114]

This shift in the judicial system has prompted a legislative bolstering of coronial powers in every state and territory except South Australia. Each allows coroners to compel witnesses to answer questions, even in spite of claims of the privilege against self-incrimination and penalty privilege, if the interests of justice require it.[115] For example, s 61 of the *Coroners Act 2009* (NSW) ('*NSW Act*') and s 57 of the *Coroners Act 2008* (Vic) ('*Vic Act*') confer a right to invoke the privilege against self-incrimination and penalty privilege,[116] but also empower the Coroner to decide whether there are 'reasonable grounds' for invoking the privilege.[117] If there are reasonable grounds, the Coroner must inform the witness that they are not required to give evidence unless ordered to, and that they may be provided a 'certificate' against incrimination or penalty.[118] These certificates provide some degree of immunity against criminal or civil consequences for giving evidence.[119] While these provisions already go far beyond the *SA Act*, the *NSW Act* and *Vic Act* go further. They require witnesses to give evidence, even if they have reasonable grounds to object on the basis of privilege, if there is no evidence that a penalty will actually arise, or if the interests of justice require it.[120] In this manner, notwithstanding the fact that this model is a compromise solution, in that the person giving evidence over which privilege has been claimed may be protected in future proceedings through the issue of a certificate, these statutes ensure that coronial investigations are not 'hampered' by the invocation of privileges.[121] Their expanded powers provide multiple opportunities for coroners to assess claims of privilege and override them if necessary. By contrast, the inflexible and severely outdated *SA Act* does not permit the Coroner to investigate the merits of claims of self-incrimination privilege and fails to address penalty privilege whatsoever. While, as previously mentioned, the Royal Commission does not make specific recommendations as regards privilege, and thus may not have provided sufficient impetus for legislative amendments of this kind, the interstate models provide clear examples that ought to have been emulated by the *SA Act*.

113 Freckelton and Ranson (n 82) 578. See *Evidence Act 1995* (Cth) s 128; *Evidence Act 1995* (NSW) s 128; *Evidence Act 2001* (Tas) s 128; *Evidence Act 1906* (WA) ss 11, 13.

114 See Northern Territory Law Reform Committee (n 93) 7.

115 See above n 93.

116 *NSW Act* (n 93) s 61(1); *Vic Act* (n 93) s 57(1).

117 *NSW Act* (n 93) s 61(2); *Vic Act* (n 93) s 57(2).

118 *NSW Act* (n 93) s 61(3); *Vic Act* (n 93) s 57(3).

119 Freckelton and Ranson (n 82) 497.

120 *Vic Act* (n 93) ss 57(4)(a)–(b); *NSW Act* (n 93) ss 61(4)(a)–(b).

121 See Northern Territory Law Reform Committee (n 93) 7–9; Jumbunna Institute of Indigenous Education and Research, Submission No 115 to Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales (7 September 2020) 27–8 [89].

A useful practical example of the use of the New South Wales provisions can be found in *Rich v Attorney-General (NSW)*.[122] This case examined a decision of the New South Wales State Coroner to compel a police officer to give evidence about his involvement in the death of a vulnerable man with a history of mental illness.[123] Justice of Appeal Leeming, with whom Bathurst CJ and Beazley P agreed, examined and affirmed the decision of the Coroner, who had found that the 'minor disciplinary consequences' the witness may have faced were outweighed by the interests of justice in the investigation of the death of a person with a history of mental illness, particularly in light of systematic failures of police in 'dealing with' vulnerable people.[124] This case provides an illustration of the successes of coronial legislative reform and is particularly salient in the context of *Bell*, given Mr Morrison's history of mental illness.[125]

It is worth mentioning, in the context of reform, the Recommendations of the South Australian Ombudsman following its investigation into the death of Mr Morrison. The Report reveals that the Department for Correctional Services, for its part, acknowledged that 'certain matters could have been better handled' in the involvement of a large number of its staff in Mr Morrison's death, and in subsequent attempts to avoid giving evidence to internal investigators, police and the Coroner's Court.[126] The Ombudsman relevantly found that the Department had failed to identify Mr Morrison as an 'at risk' prisoner as an Aboriginal man, had acted 'unreasonably' in transporting Mr Morrison in a van without audiovisual recording capacity, failed to record 'meaningful footage' of the restraint and transport of Mr Morrison, and failed to retain official records of the death.[127] Among its various Recommendations, the Ombudsman suggested that cameras be used inside prison vehicles without dedicated 'recording capacity', body cameras be worn by prison officers in all State prisons, and that the Department for Correctional Services review and improve its records management systems.[128] These suggested reforms were also linked to the Recommendations of the Royal Commission.[129] It is our view that they ought to be implemented. Unlike the bills for reform of the *SA Act*, no legislative reform reflecting the above Recommendations has been presented in Parliament. The Department for

122 [2013] NSWCA 419.

123 Ibid [3]–[5], [11].

124 See ibid [24], [42].

125 Mitch Mott, 'Scathing Ombudsman Report Recommends Corrections Apologise to Family of Wayne Fella Morrison for Death-In-Custody Failures', *The Advertiser* (online, 10 September 2020) <https://www.adelaidenow.com.au/truecrimeaustralia/police-courts/scathing-ombudsman-report-recommends-corrections-apologise-to-family-of-wayne-fella-morrison-for-deathincustody-failures/news-story/474133742c5f1a2b693be188d3044298>.

126 Ombudsman SA (n 105) 3.

127 See ibid 107–11.

128 Ibid.

129 Ibid 5.

Correctional Services says that it has adopted at least 16 of the 17 Recommendations of the Ombudsman's report.[130]

To that end, the Correctional Services (Accountability and Other Measures) Amendment Bill 2021 (SA) has recently been passed by both houses of the South Australian Parliament. The Bill inserts a new pt 6A into the *Correctional Services Act 1982* (SA) ('*Correctional Services Act*'). The Bill establishes an accountability mechanism wherein the act of failing to comply with a notice to appear, produce a document, or answer a question, constitutes an act of misconduct under the *Correctional Services Act*.[131] However, the Bill also expressly preserves self-incrimination privilege and, if the decision in *Bell* is applied, penalty privilege.[132] Further, the Bill does not deal with the issue of correctional officers simply refusing to make reports, which was notably an issue in *Bell*.[133] While expressly making an officer's refusal to comply with such a request an act of misconduct is a step forward for the South Australian corrections system, the Bill should be making more progress towards the goal of accountability.

D *South Australian Law Reform Models*

Having provided a consideration of interstate models, we will now briefly discuss two recent law reform efforts in South Australia: the Coroners (Miscellaneous Amendments) Bill 2020 (SA) ('CMAB') and the Coroners (Inquests and Privilege) Amendment Bill 2020 (SA) ('CIPAB') (now the *Coroners (Inquests and Privilege*) *Amendment Act 2021* (SA)).[134]

The CMAB, introduced by the Hon Connie Bonaros of the South Australian Legislative Council, attempts to bring the law 'in line with all other states and territories',[135] and includes provisions allowing the Coroner to compel witnesses to provide evidence despite claims of penalty privilege or the privilege against self-incrimination if 'the interests of justice require'.[136] The CMAB does not stipulate

130 Brittany Evins, 'Wayne Fella Morrison Was Failed by SA's Prions Department when He Died in Custody, Report Says', *ABC News* (online, 10 September 2020) <https://www.abc.net.au/news/2020-09-10/prison-mangement-failed-wayne-fella-morrison-death-incustody/12651264?utm_source=abc_news_web&utm_medium=content_shared&utm_content=link&utm_campaign=abc_news_web>.

131 Correctional Services (Accountability and Other Measures) Amendment Bill 2020 (SA) cl 36.

132 Ibid.

133 Ibid. See, eg, *Bell* (n 7) [664]–[678] for a demonstration of issues with the creation and provision of reports and police statements.

134 Coroners (Miscellaneous) Amendment Bill 2020 (SA) ('Coroners (Miscellaneous) Amendment Bill'); Coroners (Inquests and Privilege) Amendment Bill 2020 (SA); *Coroners (Inquests and Privilege*) *Amendment Act 2021* (SA).

135 South Australia, *Parliamentary Debates*, Legislative Council, 29 April 2020, 602 (Connie Bonaros).

136 Coroners (Miscellaneous) Amendment Bill (n 134) cl 8.

that the Coroner should assess whether the witness has 'reasonable grounds' to claim privilege, unfortunately precluding this safeguard against undue denial of privilege, as provided in the equivalent provisions in other Australian jurisdictions, discussed above. However, the CMAB similarly allows the Coroner's Court to issue a certificate of protection to witnesses.[137] The CMAB also contains, as its name suggests, miscellaneous provisions, including provisions which allow the Coroner to make broader recommendations in its findings, publicly identify persons involved in the death, and request Ministers to prepare further compliance reports, which may have the effect of increasing the influence of the Coroner, as well as allowing further public scrutiny of compliance with recommendations, and of institutions involved in deaths.[138]

The CIPAB, having received royal assent and being enacted as the *Coroners (Inquests and Privilege*) *Amendment Act 2021* (SA), more directly mirrors the provisions in New South Wales and Victoria. The CIPAB empowers the Coroner's Court to determine whether there are 'reasonable grounds' for an objection,[139] and was at all times the most likely candidate for enactment, due to its support from the government.[140] This Act is a direct response to the decision in *Bell*, with South Australian Attorney-General, the Hon Vickie Chapman, acknowledging the fact that the functioning of the 'coronial process' ought to take precedence over the privilege against self-incrimination and penalty privilege.[141] The CIPAB, and now the *Coroners (Inquests and Privilege*) *Amendment Act 2021* (SA), is nearly identical to the provisions in the *Vic Act* and the *NSW Act*, which ought to provide confidence to those interested in a robust and strong Coroner's Court. It will help implement the Royal Commission's Recommendations and bring South Australia in line with other Australian jurisdictions.

V Conclusion

Bell has arisen during a time when tensions with law enforcement are at an all-time high, making the decision particularly pertinent. It follows a long history of confusing

137 See ibid cl 8, inserting *SA Act* (n 22) s 23A(3).

138 Coroners (Miscellaneous) Amendment Bill (n 134) cls 4, 5, 9. Indeed, the proposed expansion of the Coroner's power to investigate the causes and circumstances of death and to make recommendations concerning matters arising during the inquest would better implement Recommendation 12 of the National Report of the Royal Commission: see above n 85.

139 Coroners (Inquests and Privilege) Amendment Bill (n 134) cl 7.

140 Mitch Mott, 'Laws Introduced to Parliament Will Prevent Witnesses in Coronial Inquests from Refusing to Give Evidence on the Grounds it Will Incriminate Them', *The Advertiser* (online, 16 October 2020) <https://www.adelaidenow.com.au/truecrimeaustralia/police-courts/laws-introduced-to-parliament-will-prevent-witnesses-in-coronial-inquests-from-refusing-to-give-evidence-on-the-grounds-it-will-incriminate-them/news-story/92ab2b0fc15372245ed4ce322cbc34c2>.

141 Ibid.

case law regarding the application of penalty privilege. The decision clarifies how penalty privilege applies to coronial inquests in South Australia, in light of the fact that the *SA Act* does not abrogate penalty privilege, allowing correctional officers and those questioned at coronial inquests to refuse to answer questions on this basis.

The mere fact that the Coroner's ruling that penalty privilege was not available in the inquest was appealed arguably provides a disappointing commentary on institutional responses in Australia (and particularly South Australia) to Aboriginal deaths in custody. The appeal of the nineteen plaintiffs in this case has served to delay the inquest into the death of Wayne Fella Morrison in custody, which occurred in September 2016. The inquest will resume in 2021. The correctional officers concerned are still working in our prison system.

Moreover, *Bell* highlights fundamental flaws in the *SA Act* that, thankfully, are in the process of being addressed. The *SA Act* must be amended to ensure the efficacious functioning of the Coroner's Court, in particular by allowing claims of privilege to be assessed against the interests of justice. Such reform would be a step in the right direction of implementing the Recommendations of the Royal Commission. This legislative reform ought to emulate successful models of other Australian jurisdictions. However, current proposals do not implement changes that strike directly at the issue of Aboriginal deaths in custody, as do the measures recommended by the Ombudsman. Further attention ought to be given to the proper identification and supervision of vulnerable people under the care of State institutions, and the proper oversight and scrutiny of these institutions and those employed by them.

All things considered, the outcome of *Bell* is unsatisfactory, highlighting the need for legislative reform. While the failures encapsulated in *Bell* have already caused significant damage, *Bell* presents an opportunity — which seems likely to be met by current attempts at reform and through the additional Recommendations of the Ombudsman, which are yet to be incorporated into any legislative proposals — to provide South Australians with confidence that Coroners can effectively address the deaths of Aboriginal people, and other vulnerable people, in State institutions.