Coronership in the Colony: Aboriginal families, cultural recognition, and the coronial system in New South Wales

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Lindsay Kate McCabe

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Dedication

This thesis is dedicated to every Aboriginal Person who has died via colonial violence in the so-called state of Australia, and to the families and communities who every day continue to fight for justice.

Acknowledgements

So many people have supported me throughout this process. First, though, I want to thank Dr Allen George. If you hadn't tapped me on the shoulder and suggested I consider doing Honours, I might never have achieved this. Second, I want to acknowledge my supervisors, Rebecca Scott Bray and Aunty Christine Evans. I am so grateful for your guidance, your patience, and your support over the last four years. I could not have done this without you.

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To my son who spent more than half of his life with mum at uni, I am so lucky to have you. You saw every breakdown, every success, and all of the emotions in between. I hope you know how much I love you.

To my beautiful Grandma and Grandpa. It is on your shoulders I stand, and I could not have done this without you. I adore you both so much, and am forever grateful for all of the ways you helped me get to where I am. This doctorate is for all of us.

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As supervisor for the candidature upon which this thesis is based, I can confirm that the authorship attribution statements above are correct.

Rebecca Scott Bray

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Abstract

This thesis examines the interactions between Aboriginal families and the coronial system in New South Wales (NSW), highlighting the perpetuation of colonial violence through this system. It critiques how the coronial process continues to inflict trauma on Aboriginal communities by pathologising their experiences and obfuscating the role of colonial structures in their deaths. Centring Aboriginal voices, the research reveals that the coronial system, supported by police and legislative frameworks, often exacerbates the grief of Aboriginal families rather than providing genuine support or justice. The study utilises a combination of surveys, yarns, and insights from Aboriginal Coronial Information and Support Program (CISP) Officers, centred within an Indigenist research paradigm, to uncover systemic flaws and the inadequacies of current practices. Key findings indicate significant disparities in how Aboriginal families experience the coronial system, particularly in terms of respect for cultural protocols and communication. The research suggests that while the presence of Aboriginal CISP Officers has led to improvements, a more comprehensive reform, including the establishment of an independent Aboriginal-led body for death investigations, is necessary to address ongoing issues. This work advocates for culturally responsive practices and legislation, emphasising the need for systemic change to reduce harm and better support Aboriginal families and communities who are experiencing the coronial system.

... the coronial inquiry, the endgame of not caring; of neglect. Here, never let us forget the mothers, the children, the cousins and the spouses weeping outside coroner's courts, bearing photos of their loved ones in their hands and on their clothing, simultaneously appealing for care and for justice' (Bond et al. 2020: 248)

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Acronyms

ACISPO	Aboriginal Coronial Information and Support Program Officer
AIGCLU	Advanced Institute for Globalization and Culture
ALS	Aboriginal Legal Service
CAEU	Coroners Aboriginal Engagement Unit
CBD	Central Business District
CISP	Coronial Information and Support Program Officer
CSNSW	Corrective Services New South Wales
GP	General Practitioner
HREC	Human Research Ethics Committee
ICCPR	International Convention on Civil and Political Rights
LECC	Law Enforcement and Conduct Commission
NAIDOC	National Aborigines and Islanders Day of Observance Committee
NCIS	National Coronial Information System
NOK	Next of Kin
NSW	New South Wales
OCAP	Ownership, Control, Accessibility, Possession
OOHC	Out of Home Care
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SNOK	Senior Next of Kin
STMP	Suspect Target Management Plan
UK	United Kingdom
UN	United Nations

Definitions

Mob

'Mob' is a term used by many Aboriginal and/or Torres Strait Islander peoples. It can refer to family and community and is often associated with a particular place or Country. It can be used to connect and identify who an Aboriginal person is and where they are from (Australian Indigenous Health Infonet, n.d.).

Yarn

Yarns can be informal or formal. Yarning is a conversational process, imbued with protocols, whereby cultural and other knowledges are shared via the telling of stories. Yarning as a methodology is discussed in detail in Chapter 3.

Aunty/Uncle

In many Indigenous contexts, 'Aunty/Uncle' is a relational title used for a respected person whose role is defined by relational positioning, responsibility and ethical obligation within community, rather than by biological genealogy alone. Drawing on Wilson's (2008) account of relationality as ontology, the term illustrates how relationships constitute identity and social roles: calling someone Aunty/Uncle signals not simply kinship, but recognition of authority, care, guidance, and accountability in a network of reciprocal obligations. This relational framing aligns with Wilson's (2008) concept of relational accountability, wherein ethical practice, including research practice, requires honouring the responsibilities that arise through one's relationships with people and community.

Preface

I was born in 1986, the year *The Australia Act 1986* (Cth)[1] came into effect, marking the end of almost 200 years of legal power that the British Parliament had to legislate for Australia. Members of my family had withstood the practice of kidnap by whalers, had their identity obscured, endured the ignominy of not being counted as citizens, been prevented from voting in federal elections, being forcibly taken from their parents to grow up with a non-Aboriginal family, survived innumerable acts of covert, overt and institutional racism and suffered the avoidable deaths of relatives and friends through treatable ill-health. Many Aboriginal and Torres Strait Islander activists and other individuals had made Australia a safer place to be born into, but horrific incidents and tragedies continued to plague First Nations populations. Paramount in 1986 was the overwhelming concern related to Aboriginal deaths in custody.

In the four years surrounding my birth, three deaths in custody drew public attention and strengthened the call for a Royal Commission into Aboriginal Deaths in Custody. On 28 September 1983, John Pat, a 16-year-old Yindjibardi boy, died in a police cell after a confrontation with off-duty police officers in Roebourne, Western Australia. He was found to have suffered a fractured skull, haemorrhage and bruising and tearing of the brain. On 27 April 1986, David Gundy, an Aboriginal man, was shot dead in his home at Redfern, Sydney, when members of the Special Weapons and Operations Squad (SWOS) raided his house in search of another man. On 6 August 1987, Lloyd James Boney was found dead in a police cell in Brewarrina, New South Wales, some time in the 95 minutes after he had been locked up at the police station.

[1] This refers to two separate but related pieces of legislation, passed by two legislatures: the Parliament of Australia and the Parliament of the United Kingdom. They both came into force on 3 March 1986, and *Australia Act* is shorthand to refer to both.

On 10 August 1987, Prime Minister Hawke announced the formation of a Royal Commission to investigate the causes of deaths of Aboriginal people who were held in state and territory gaols. The Commission examined all Aboriginal deaths in custody that occurred in each state and territory between 1 January 1980 and 31 May 1989, and the actions taken in respect of each death.

The final report, signed on 15 April 1991, took place while I was quite young, at a time when I enjoyed my many visits with my beloved Grandpa. What I didn't know at the time was that my Grandpa had been the Aboriginal investigator with the Royal Commission.

I used to ask him lots of questions and received many significant answers. One was in relation to being fair-skinned with fair hair. At one point, I asked 'But Grandpa, how will people know I'm Aboriginal?' In true Grandpa fashion, he replied 'Well, my girl, it's a matter of who your relations are, who grows you up and who knows you. It has to do with who you are and what you feel; it has to do with family, and a lot to do with community and friends. It has to do with the kinds of things we do as Aboriginal people – not with what you look like.'

As I grew older and continued to ask questions – by now more complex questions – I discovered that Grandpa had investigated and reported on the death in custody of Malcolm Charles Smith on 29 December 1982. While there was more than sufficient information about how Malcolm Charles Smith died, in investigating Smith's life, Grandpa uncovered circumstances that contributed to why Malcom Smith died.

Grandpa found the life and death of Malcolm Charles Smith extremely traumatising, but what he also found incredibly troubling was the ways in which members of his family might be navigating their grief. He had interviewed Malcolm's brother Bobby and sister MaryAnn (who used to get Malcolm dressed and off to school) during

the Royal Commission and was aware that they had visited him in the hours before his death. Yet no relatives were present at his inquest, and they were not represented.

The inquest took place on 12 May 1983 at the Glebe Coroners Court with a police sergeant assisting the coroner, and officers of the Corrective Services Commission and the Health Commission of NSW appearing for those bodies. The Aboriginal Legal Service (NSW) had on 7 January 1983 sought copies of documents and reports so it could properly explain the death to the family, but it did not appear at the inquest. Its file could not be found and may have been destroyed in a fire. I kept returning to these questions: why were no relatives present at Malcolm's inquest? And why could his death not be properly explained to his family? The answers to these questions, and to the 'far more difficult question of *why* Malcolm Smith died', begins 'sometime between 26 January 1788 and 5 May 1965 when Smith was removed and isolated from his family at the age of 11' (Commissioner Wootten, cited in Cunneen 1989).

Introduction

The coronial system in New South Wales occupies a powerful yet often overlooked position at the intersection of law, death investigation and the daily realities of colonial governance. For Aboriginal families, contact with this system frequently magnifies long-standing structural inequalities, reproducing the violence of colonisation through bureaucratic processes that shape how deaths are investigated, explained and ultimately remembered. While coronial inquests are framed as neutral fact-finding exercises concerned with public health and safety, this thesis argues that they remain embedded within a wider colonial project, one that continues to pathologise Aboriginal lives, obscure systemic wrongdoing and legitimise the state.

Despite decades of inquiries, from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) to contemporary parliamentary reviews, there is still a dearth of research that centres the lived experiences of Aboriginal families navigating coronial processes in New South Wales. This thesis directly addresses that gap. It seeks to better understand how Aboriginal families experience and are impacted by the coronial system, and how coronial practices – legal, administrative, cultural and interpersonal – intersect with grief and the enduring structures of settler-colonialism. It also provides the first in-depth exploration of the experiences of an Aboriginal Coronial Information and Support Program (CISP) Officer, offering new insights into Aboriginal employment within death investigation contexts, as well as the complexities of 'Mob supporting Mob' inside state institutions.

Guided by an Indigenist research paradigm and grounded in decolonising methodologies, this research centres Aboriginal voices. Using online surveys, interviews and critical thematic analysis, the study reveals a coronial system marked by inconsistent communication, prolonged delays, inadequate cultural responsiveness and limited

support for bereaved families. At the same time, it highlights the transformative potential of Aboriginal-led roles and culturally embedded practices, demonstrating how even small shifts in approach can radically alter the experiences of families during their most vulnerable moments.

The research is guided by a number of research questions, primarily, 'What are the experiences of Aboriginal families who have contact with the coronial system in NSW?' Secondary to this is, 'How do Aboriginal Coronial Information and Support Officers experience their roles? What implications does this have for coronial practice?' Importantly, the thesis also asks, 'Does the coronial system perpetuate colonial harms, and, if so, how?' This work, in addition to seeking to answer the above questions, pursues two core aims: to create space for Aboriginal people to talk about their experiences; and to highlight how the coronial system operates as a facet of colonial violence.

This thesis illuminates how the coronial system, despite its stated aims of truth-seeking and prevention, often functions as another instrument of colonial power. It is about the colonial violence that the coronial system continues to mete out, and the narratives of dysfunction and the pathologisation of Aboriginal people that it (re)creates and perpetuates. Yet it also imagines what a culturally responsive, accountable and community-centred coronial system could look like. By centring the experiences of Aboriginal people, articulating the forms of harm that coronial practices can cause and identifying opportunities for meaningful reform, this research contributes urgently needed evidence to ongoing conversations about justice, cultural safety, and the future of coronial practice in New South Wales.

First, however, I must position myself in relation to this research and more broadly. I am a proud Aboriginal woman, a palawa woman born on Ngunnawal Country, and have been fortunate to raise my family on Darug Country. I offer my respect to my Elders and my Ancestors; to the Elders and Ancestors of Ngunnawal Country; to the

Elders and Ancestors of Darug Country, where I live and work, and where this research took place; and to the Elders and Ancestors of every Aboriginal person who has contributed to this body of work. I extend that respect to any and all Aboriginal, Torres Strait Islander and First Nations people who are reading this work.

I have been so lucky to grow up strong in the knowledge of who I am, who my family is and to whom I belong. I say 'lucky' because that is what it is – I am lucky to have been born when I was and where I was, and to not have the same shadow of colonialism controlling almost every aspect of my life that hung over so many generations before. I am so lucky to have had the upbringing I have had, with a family I treasure, and to have had the opportunities that have arisen along the way. I acknowledge that for many Aboriginal people, including generations of my own family, this luck has not always been present – and for many still is not, despite the jingoist rhetoric of 'the lucky country'.

I am lucky that, as a mature age student, I had the opportunity to begin university. I am lucky that my grandmother always encouraged me to write, and my grandfather and parents urged me to learn and to think, making university a place where I could thrive. It was at university that I developed the skills to articulate the colonial shadow that I recognise in so many spaces and places. One of these places where this shadow is cast is in the investigation of the deaths of Aboriginal people. In an undergraduate subject, the paucity of recognition given in the literature to the resistance of Aboriginal peoples to medico-legal autopsies immediately caught my attention. Why should our beliefs and practices around death and dying be denied or subjugated, and was this not part of the colonial agenda, the state-sanctioned elimination of the native (Wolfe 2006)? Why was this not a point of national outrage, or at the very least a subject of scholarly interest and indeed activism? The more questions I asked, the fewer answers I found, so I undertook an Honours study to try to find the answers I felt I needed. What happened instead was that I identified a complex issue, a Pandora's box highlighting the ways in which the

coronial system inflicted a kind of administrative violence on Aboriginal people, obfuscating the role of the colony[2] in the deaths of our people. What it also highlighted was the myriad ways in which the voices of Aboriginal peoples have been suppressed and subjugated when calling out this violence. This is what drove me to undertake this doctorate. I saw it as an opportunity to create a space to centre these voices and experiences, and to call out the system for what it is, and the violence and trauma it causes.

I have been lucky to have had many opportunities to teach at a tertiary level over the last few years. One of the things I ask my students is to consider how the knowledges of First Nations Peoples continue to be subjugated and suppressed. The coronial system is one of those ways. The knowledge about who a person was, and the circumstances that surrounded their life and their death, is an intimate knowledge held by their families and friends. The coronial system warps these intimate knowledges into a discourse of dysfunction, and pathologises the individual while invisibilising the structures of colonialism that impacted, and in many respects shaped, the circumstances in which that person lived and died (Razack 2015). These issues are discussed in detail in the literature review. The coronial system, I argue, is complicit in the continued colonialist subjugation of Aboriginal peoples.

Chapter 1 of this thesis provides a contextualisation specific to place – an overview of the invasion and subsequent colonisation of this continent, and the ways in which the historical informs and underpins the contemporary. It is imperative to understand this in order to understand the histories and relationships that are inherent to the current coronial system. Chapter 2, the literature review, accounts for the various scholarly influences on my research. The work of Sherene Razack has been instrumental in developing my understanding of the colonial coronial system, and the ways in which

[2] This continent remains a settler colony. First Peoples' sovereignty was never ceded.

it operates to absolve the murderous state while at the same time pathologising Aboriginal peoples as dying anyway, as beyond saving, unable to cope with modernity. Also influential has been the work of Alison Whittaker, a Gomeroi poet and scholar who showed me that there is not just one way to call out the violence of the state (Whittaker 2018). Integral to this work has been Lester Irabinna Rigney's (1999) framework, the Indigenist research paradigm that has shaped not only the way this research has been conducted, but in many ways has enabled me to understand my positionality in relation to the research, and to identify the responsibilities and obligations to community that this work entails.

This study began at an unusual and exceptional time – the very beginning of the COVID-19 pandemic. This frustrated all the plans I had, especially the ways in which I hoped to yarn with communities across New South Wales prior to the research starting. This is discussed in detail in Chapter 3. It forced me to think differently about the study, but again, this redirection allowed space for opportunity – being forced to shift to new methods actually created an opportunity to identify an online world of racism and misinformation about the coronial system that would not otherwise have been a part of this study. These form part of the findings in Chapter 3. This added another layer of complexity to the study, particularly when we consider expression of grief and bereavement in online spaces.

While the impacts of the pandemic certainly created significant barriers and resulted in fewer participants than hoped for, it did push me to consider methods of online recruitment and to use online survey tools, which is discussed in detail in Chapter 3. This also meant having to carefully think about people's access to the internet and to internet-capable devices, especially as the qualitative method also had to move to an online space. In all, these barriers have made me a better researcher, but at the same time dramatically altered the way the study

was conducted and the number of participants who might have been recruited using more traditional,[3] and certainly more culturally appropriate, methods.

Another thing that significantly altered the expected contribution of this study was the appointment of two Aboriginal Coronial Information and Support (CISP) Program Officer positions at the Coroners Court in New South Wales. The opportunity to yarn with one of the Aboriginal CISP Officers has contributed to how we might understand Aboriginal employment within death investigation contexts, and the complexities of these roles when you have Mob supporting Mob – albeit within the constraints of a state institution. Yarns with one of the Aboriginal CISP Officers have allowed insights into not only the coronial system itself, from the perspective of Mob, but also the legislative and other barriers impacting bereaved Aboriginal families and communities.

This work therefore has a number of components. The responses to the online survey began to paint a picture of some of the kinds of barriers and supports experienced by Aboriginal peoples who have had contact with the coronial system, while the racism and misinformation that materialised in the sharing of this survey online illuminated not only a lack of community coronial education but a kind of digital violence. The information and stories shared by those who participated in yarns delved deeper into many of the issues raised in the surveys. These stories weave a powerful and complex tapestry of the traumas inflicted at every stage of coronial processes, and I am so grateful to those who gifted their time to share their stories with me. The yarns with the Aboriginal CISP Officer were heartening – so many of the issues experienced by the participants have already been addressed simply by virtue of having an Aboriginal person in such a role. They did, however, raise some significant concerns, and highlighted the myriad ways in which the employment sector continues to fail Mob. These yarns also provided a starting

[3] By 'traditional', I mean in a sociological or qualitative sense.

point for developing an understanding of the experiences of Mob in identified positions working within death-investigation contexts – a starting point for much further research.

This is the structure of this thesis. Readers may note that while I have tried to adhere to the mores of academia, there is no independent discussion section following the findings. It did not make sense to me to separate discussion from the intimacy of the yarns, so I have tried to weave the discussion throughout. I think this better reflects the interconnectedness of the experiences of the participants with the literature more broadly. I will also honestly confess that the end-piece of the thesis, the recommendations for change, stymied me. What recommendation for reform could possibly lessen the violence that this system perpetuates, and the ways in which coronial findings are weaponised to pathologise us as Aboriginal people? At the same time, I recognise the need for the system to do the least harm possible, so have tried to consider what a contemporary culturally responsible coronial system could look like, despite the urge to 'burn it down'.[4]

It is important here to advise that this thesis is not light reading. It contains descriptions of historical and contemporary colonial violence, and the violence of racism and ignorance. It also mentions the names of Aboriginal and Torres Strait Islander Peoples who have died. This thesis also uses the terms 'died' and 'deceased', although I respectfully acknowledge that the preferred term for many Aboriginal and Torres Strait Islander Peoples is 'passed'. 'Passed' implies a peaceful death, a timely death. When someone dies at the hands of the State, either directly or via indifference, they die in violent solitariness. We need the harshness of 'die' here, rather than the softening of the death using a euphemism borrowed from the oppressor.

[4] Indigenous studies scholar and historian Dr Sean Carleton tweeted on 9 July 2021 that to burn it down is 'not the "ignition" of actual, literal fires, but – drawing on the long tradition of that phraseology – burning down the structures of injustice to create better futures'.

In the beginning: Settler colonialism and the importation of coronial law

To fully understand a contemporary problem, it is imperative that we understand the points in history that led to this moment. We cannot possibly fully understand the nature of the political, social, economic or coronial systems without an understanding of the history of this place. The contemporary Australian colony has been built on the lands of more than 250 distinct nations, by force and via genocidal tactics. It is argued that the coronial system, imported via the doctrine of reception (DiGiacomo et al. 2015), serves to legitimise the colony and to assert a narrative that presents the state as the benevolent caregivers of the abject, the Indigenous peoples of this place. In order to fully grasp the perfidious nature of this system, we must look first to the acts of invasion and the subsequent structures of colonisation that have been embedded into the very fabric of contemporary Australian society. This section of the introduction then explores the effects of the event of invasion and examines the myriad ways in which colonisation continues to operate. This is foundational to developing a critical understanding of the coronial system in New South Wales. Following this, Chapter 1 begins with a discussion of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991), and outlines the legislated role and function of the coroner and coronial system.

Colonisation is a structure

Colonisation is a structure, not an event (Wolfe 2006); however, its beginning is a moment that is clearly defined, and defining, in the history of this place. January 1788 marked the beginning of a process of so-called civilisation (van Krieken 1999), 'in the form of massacres, exploitation, repressions and cruelty' (Cowlishaw 2004: 128) that not only lingers today, but actively permeates all areas of this new society. I say 'this new society' as that is what it is – a 235-year-old nation that has attempted to erase the hundreds of Countries and peoples that have existed here since the beginning of time.

On 29 April 1770, Lieutenant James Cook sailed into Botany Bay, 'hoisted the English flag and solemnly claimed Eastern Australia' (Grassby & Hill 1988: 77), forever changing the future of this place by declaring sovereignty over land purportedly belonging to no one. Within a few short years, 11 ships carrying in excess of 1500 people, more than 700 of them convicts, would set sail from England to its newest colony. The First Fleet arrived between 18 and 20 January 1788, and over the course of mere days, the first act of land clearing was performed in the Sydney basin (Grassby & Hill 1988). King George III had instructed the fleet's captain, Captain Arthur Phillip, to encourage friendly relationships with the local Aboriginal peoples, who allegedly had no claim to sovereignty over this 'new' place: the common law arrived with the Fist Fleet (Reynolds 1987: 4). Some sources indicate that Aboriginal people who first encountered the invading population were welcoming, regarding them as ghost people – 'spiritual visitors from the spirit world' (Miller, 1985: 15) who would return to that spiritual world.

Lieutenant William Bradley, a naval officer who sailed with the First Fleet, noted that 'The Natives [sic] were well pleas'd with our People until they began clearing the Ground at which they were displeased & wanted them to be gone' (Bradley, 1788).Very quickly, it was understood that the invading population had no notion of bartering or trading with the local people; they took and gave nothing in return (Miller, 1985). Indeed, the first things the invading population shared would be infectious diseases, such as cholera, whooping cough and smallpox, to which Aboriginal peoples had no resistance (Grassby & Hill 1988). The first known conflict occurred less than five months after the first contact: on 29 May 1788, two convicts were killed after they attempted to steal a canoe (Bradley 1788). By November 1788, the invading population had travelled up the Parramatta River to Burramatagal Country, firmly establishing the foundations of total colonisation. What followed would be more than a century of frontier wars and massacres as the invading forces spread like wildfire over the continent.

Just 42 years after the arrival of the First Fleet, the Sydney clans had lost almost everything (Foley & Read 2020: 51). In 1813, the Blue Mountains range[5] was crossed by the invading population, reaching the central desert by the 1880s. Crossing the Blue Mountains meant heading into Wiradjuri Country, and a war was waged around Bathurst (Read 1988). By 1824, just 10 years after crossing the mountain range, up to 20 white stockmen, and more than a hundred Aboriginal men, women and children, had been killed. Stories of massacres began to spread, and martial law was declared on 14 August 1824 by Sir Thomas Brisbane 'as seventy-five mounted soldiers rode the ranges shooting at every Aboriginal [person] in sight' (Read 1988: 5). This would prove lethal to local Mob, and not even the skill of resistance leader Windradyne could save the Wiradjuri from the violence (Read 1988).

The massacres continued as the invading forces moved further inland. Between 1835 and 1865, several massacres of Aboriginal people occurred along the Darling River. In June 1838, 28 Aboriginal men, women, children and infants were massacred at Myall Creek, in northern New South Wales (Grassby & Hill 1988: 42). This massacre was publicised, published in *The Chronicles of Crime or the New Newgate Calendar* (Pelham & Browne 1841: 472); *see* Figure 1). Eleven white men were charged with murder following the massacre at Myall Creek; however, they were found not guilty on 15 November 1838 at the Supreme Court of New South Wales. On 27 November, a retrial was held for seven of the men, who were found guilty and sentenced to hanging. Despite the government's alleged desire that justice must be seen to be done, the message received on the frontier was that any future massacres must remain hidden from the public eye, with the result that nearly all further massacres went unrecorded, because the killings were 'designed not to be discovered' (Ryan, cited by Brennan 2017).

[5] The Greater Blue Mountains World Heritage Area is located on the Country of six sovereign nations: the Darkinjung, Dharawal, Dharug, Gundungurra, Wonnarua and Wiradjuri nations.

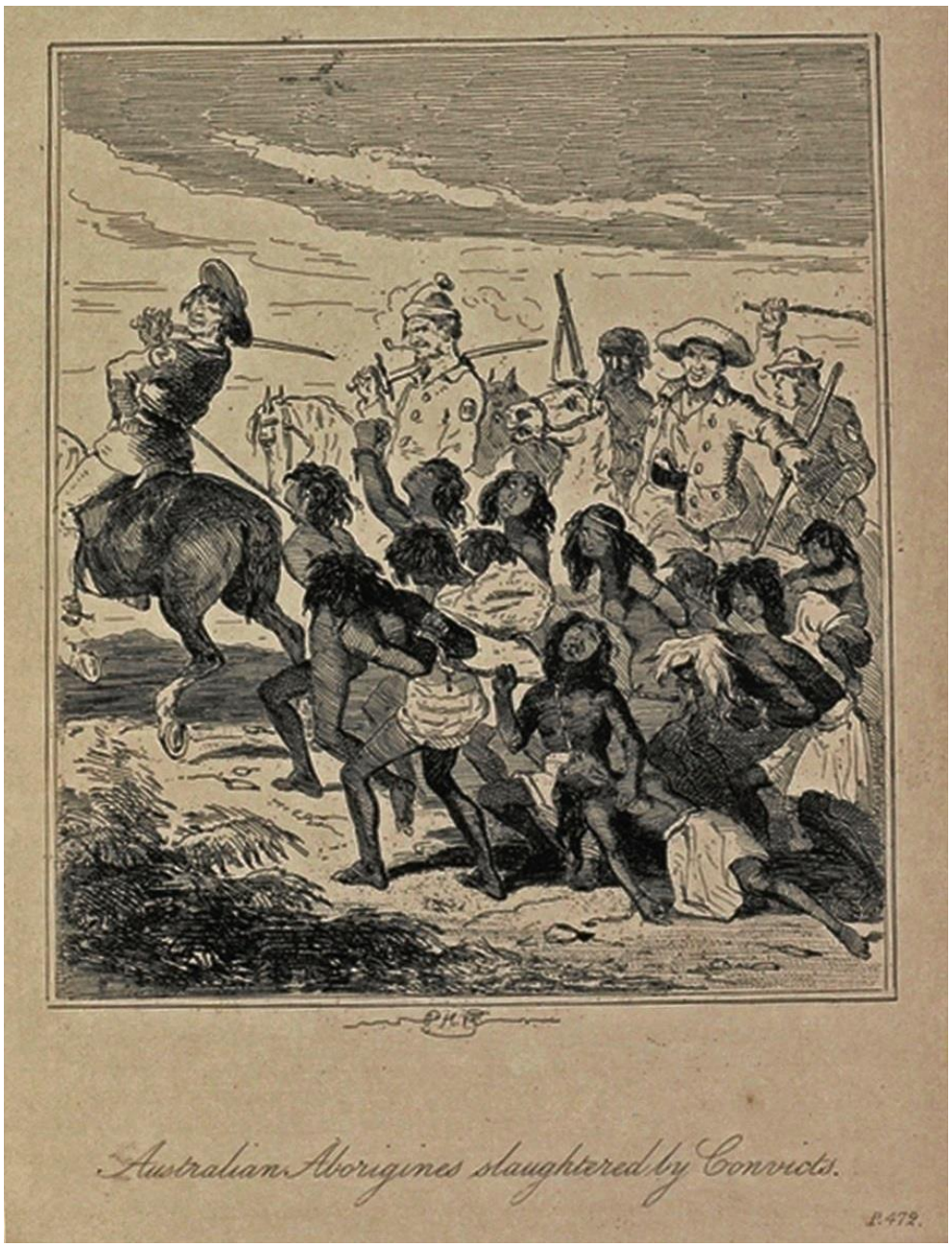

Figure 1: 'Australian Aborigines Slaughtered by Convicts' (Pelham & Browne, 1841: 472)

In my country, Lutruwita, the Black War had been raging since the 1820s, with the invading population ambushing palawa at night, and shooting them on sight (Clements 2013: 23). This would lead to the Black Line, a 300-kilometre cordon made up of over 2000 men, whose sole purpose was to move across the country 'rooting out the Blacks as they went' (Clements 2013: 19). The Black Line was to be the 'final solution to the war', the 'last best hope of the white community' (Clements 2013: 28–29). The failure of the

Line demonstrated that the skills of Aboriginal people gave them an infinite superiority over their pursuers and 'showed too plainly that nothing is to be expected from any effort on the part of the government and the people to capture or drive the Aborigines by force of arms' (Minutes of Aborigines Committee 1831, cited in Reynolds 1995: 118).

The Frontier Wars and the massacres of Aboriginal people were undoubtedly horrific. By 1928, the year the Coniston massacre occurred (Rogers & Bain 2016: 83), it is very conservatively estimated that over 20,000 Aboriginal people across the country had died violent deaths (Daley 2017: 244) in a war that had raged for 140 years (Rogers & Bain 2016: 83). The true number is estimated to be more than three times higher – 44 deaths of Aboriginal people for every death of the invading population (Daley 2017: 244). By this estimate, between 50,000 and 65,000 deaths occurred in Queensland alone (Daley 2017: 245; Rogers & Bain 2016: 87), although conservative estimates put this number closer to 10,000 (Evan, Sanders & Cronin 1973: 128). Perhaps the truest figure lies somewhere in between. There is evidence of Aboriginal people being hunted and killed for body parts, and many of those massacred were to become part of the collections held by museums, universities and medical institutions (Daley 2017: 250). There were also many instances of poisoned goods being given to Aboriginal people – for example, in Kilcoy in 1842, 60 Aboriginal people were poisoned like feral animals (Rogers & Bain 2016: 87). Even more deadly were the diseases that accompanied the invading forces (Hinkson, 2001). The Aboriginal population drastically declined, which had a tremendous effect on all aspects of Aboriginal life: knowledge, kinship arrangements, traditions, and languages died with many of the Elders and others infected by these previously unheard-of diseases (Hinkson, 2001). Yet this was just the beginning of the process of total colonisation. Indeed, the Royal Commission into Aboriginal Deaths in Custody ([RCIADIC] Johnston 1991: vol. 2 s 10.2.5) noted that the violence seen during the frontier period would 'set the tone' for what was to come – a legacy of fear and violence

that was ‘the most effective strategy in establishing control’ over Aboriginal peoples. By the 1890s, the ‘era of frontier violence’ in the eastern parts of Australia was considered over, ‘colonial “order” having been imposed’ (Johnston 1991: vol. 2 s 10.4.10).

Legislating the ‘Aboriginal problem’

From the 1890s onwards, the process of colonisation of both people and country was transformed from physical violence to a symbolic violence that tore apart communities and families in much the same way. It was commonly accepted across the country that Aboriginal people were a ‘dying race’ (Reynolds, 1997: 121; van Krieken 1999: 300), facilitating an ideological shift towards protectionism and segregation. This shift began formally in 1837 when a British Parliamentary Select Committee made recommendations for the ‘protection of Aborigines’ to the House of Commons (Horton & McKenzie 1994: 903). This included missionaries for Aboriginal peoples and the appointment of ‘protectors’, as well as special codes of law (Australian Law Reform Commission [ALRC] 2010: para. 25). Following this, protectors were appointed via executive order in New South Wales, South Australia – which administered the Northern Territory until 1911 (Rogers & Baird 2016: 86) – and Western Australia (ALRC 2010: para. 25). In 1910, the *Northern Territory Aborigines Act* came into force, and applied to ‘any Aboriginal native of Australia’, including those deemed as ‘half- caste’: a ‘half-caste’ was any person ‘either but not both of whose parents is or was an Aboriginal, and any child of such person’ (*Northern Territory Aborigines Act* 1910 [SA] s 3(1)d). The Act saw the establishment of the Northern Territory Aboriginals Department, charged with ‘controlling and promoting the welfare of the Aborigines’ (McCorquodale 1987: 68). This was followed by the Aboriginal Ordinance 1911 (Cth), and the Aboriginal Ordinance 1918 (Cth) – the 1918 Ordinance would replace the two earlier Acts. These three pieces of legislation would become known as the ‘lynchpins of protectionism’ (Howard-Wagner 2011: 102).

The Aboriginal Ordinance 1918 (Cth) legislated a vast array of powers. The Chief Protector became the 'legal guardian of every aborigine and half-caste child' (Aboriginal Ordinance 1918 [Cth] s 7(1)). The Chief Protector had a number of legislated duties: to distribute blankets and clothing (which remained the property of the Commonwealth, with it being an offence to dispose of them); to provide 'as far as practicable' food and medical assistance; to provide 'where possible' education; to manage and regulate reserves; and to 'exercise a general supervision and care over all matters affecting the welfare of the aboriginals' (Aboriginal Ordinance 1918 [Cth] s 5). The Ordinance also outlined the Chief Protector's duties in relation to reserves. The Chief Protector had the legislated power to remove any 'aboriginal or half-caste to be kept within the boundaries of any reserve or aboriginal institution', or to be removed from one and placed in another (Aboriginal Ordinance 1918 [Cth] s 16(1)). By 1939, there were over a hundred reserves in New South Wales alone (Human Rights and Equal Opportunity Commission [HREOC] 1997: 34). Failure to comply was an offence, unless exempt under section 16(3)a–d of the Ordinance. Exemptions included an Aboriginal person who was lawfully employed; who is the holder of a permit to leave the reserve or institution; an Aboriginal woman married to and residing with a European man; or any Aboriginal person for whom the Chief Protector had made other arrangements. Further, under section 18(1) of the Ordinance, loitering became an offence for Aboriginal people – this racialisation of space and time continues today (Razack 2000). The Aboriginal Ordinance (1918) allowed the Commonwealth and various state governments to begin to cement the structures and processes required for the next phase of colonisation: assimilation.

> In 1937, the first Commonwealth–State Native Welfare Conference was held in Canberra; it included all the states and territories except Tasmania. This followed concerns raised in 1936 by Chief Protector in the Northern Territory, Cecil Cook:

> *Unless the black population is speedily absorbed into the white, the process will soon be reversed, and in 50 years, or a little later, the white population of the Northern Territory would be absorbed by the black.* (Commonwealth of Australia 1937, cited in van Krieken 1999: 301)

The Commonwealth, states and territories agreed that something must be done, and that 'absorption' was key to the colonising project:

> *The conference believes that the destiny of the natives of aboriginal origin, but not of the full blood, lies in their ultimate absorption by the people of the Commonwealth, and it therefore recommends that all efforts be directed to that end.* (cited in HREOC 1997: 26)

Assimilation had begun. Throughout the 1950s, assimilation was a key policy and a 'widely accepted goal for all Aboriginal people' (ALRC 2010: para. 26). The policy of assimilation was further defined at the 1961 Commonwealth–State Native Welfare Conference, whereby Aboriginal peoples were expected to 'attain the same manner of living' as European Australians, and to live as 'members of a single Australian community' (cited in ALRC 2010: para. 26). The underlying message was that there was nothing of value in Aboriginal peoples' ways of knowing, being and doing, and all aspects of Aboriginal life were subjected to judgement by comparison with non-Indigenous standards (HREOC 1997: 27).

The forced removal of Aboriginal children from their families had been occurring for many years already – Aboriginal children were being removed and taken to an 'Aboriginal institution' established by Governor Macquarie in Parramatta since the early 1820s (Bostock 1991: 5) – and the state had long been the legal guardian of all Aboriginal children (van Krieken 1999: 303); however, the policy of assimilation strengthened the power of various states and territories to remove 'half-caste' and 'fair-skinned' Aboriginal children. Children were taken from their families and sent to institutions, or to white

families (van Krieken 1999: 303); some were unofficially placed with religious organisations or individuals (van Krieken 1999: 303). My own grandfather, an Arrernte man, was taken from his mother and given to a white family in Newcastle, near Sydney. Many children were taken after having been found 'neglected', 'destitute' or 'uncontrollable' by a system that viewed them through a non-Indigenous model of child-rearing (HREOC 1997: 26), using whiteness as the benchmark by which all else would be measured (Moreton-Robinson 2015: 130). It is also worth noting that neglect and poverty were considered synonymous with one another, yet the restrictions on the accessibility of welfare support for Aboriginal peoples were not lifted until 1966 – six years after my mother was born. Approximately one in three Aboriginal children were taken from their mothers between 1910 and 1970 (HREOC 1997: 37). Following a publication authored by Peter Read in 1981, these children would come to be known as the Stolen Generations. These policies of removal continue today: Aboriginal children are almost ten times as likely to be removed from their families as non-Indigenous children, and 81 per cent of those children are in state care until they reach the age of 18 (Allam 2020; Hamilton 2022). This devastating policy of removal continues to result in the loss of familial relationships for thousands of Aboriginal people, the loss of language, the loss of culture, and the loss of connection to Country. This was, and is, a systematic attempt by the state to destroy, in whole or part, an entire group of people. This is attempted genocide.

Genocide: Power in the colony

The attempted genocide of Aboriginal peoples in this country was, and arguably still is, a key feature of the colonial project. There has been much debate regarding whether or not the events of colonisation constituted genocide (see Roger & Bain 2016). It has been suggested elsewhere that the 'advancing a genocide hypothesis' over-emphasises frontier violence and invisibilises Indigenous agency; however, as Rogers and Bain

(2016: 90) point out, 'Indigenous agency does not change the fact that genocide occurred.' It is perhaps prudent to first examine the definition of genocide, as set out in the Convention on the Prevention and Punishment of the Crime of Genocide (United Nations 1948). Article II of the Convention sets out the meaning of genocide:

> *Genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:*
>
> *(a) Killing members of the group;*
>
> *(b) Causing serious bodily or mental harm to members of the group;*
>
> *(c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;*
>
> *(d) Imposing measures intended to prevent births within the group;*
>
> *(e) Forcibly transferring children of the group to another group.*

Perhaps the most detailed and influential examination of this definition when considering the existence of genocide in Australia is that of Colin Tatz (1999), who set out to systematically respond to each section of the definition given here. Regarding Article II(a), it has already been demonstrated here and elsewhere that Aboriginal people were killed from the time of invasion onwards *because they were Aboriginal* (Tatz 1999: 15, emphasis in original), thus meeting the first criterion for determining the occurrence of genocide. Items (b) and (c) can be applied to a number of rules and regulations that applied only to Aboriginal people – for instance, the removal of people to reserves and missions; inability to receive social service benefits; limited opportunities for employment; and 'statutory Aboriginal rates of pay' well below the minimum wage (Tatz 1999: 21) were all deliberate measures to inflict on the group conditions of life calculated to bring about its physical destruction, in whole or in part. Prohibitions on marriage, permits to move freely off reserves and missions, the removal of children; inadequate

medical treatment (if any) and the threat of being 'banished' from one part of the state to another (Tatz 1999: 21) all contributed to serious bodily and mental harm to Aboriginal people, not to mention the trauma of invasion and colonisation itself. The removal of Aboriginal children speaks to the last criterion for genocide: (e) Forcibly transferring children of the group to another group. The *Bringing Them Home Report* (HREOC 1997) highlighted this as a key element in proving the occurrence of genocide in Australia. Children were removed from their families with the sole intention of 'absorption or assimilation of the children into the wider, non-Indigenous, community so that their unique cultural values and ethnic identities would disappear' (HREOC 1997: 237). Whether or not this and other policies were motivated *male fides* or *bona fides* is irrelevant – the actions were themselves genocidal, were 'contrary to accepted legal principle imported into Australia as British common law' and 'constituted a crime against humanity' (HREOC 1997: 239).

If we consider the policies and practices of the colonising forces within the original definition of genocide as understood by Raphael Lemkin, it is even clearer that genocide did in fact occur here. Lemkin coined the term 'genocide' in 1944 to describe the abhorrent events that took place in Nazi Germany (Tatz 1999: 16). Taking the Greek *genos* (race) and the Latin *cide* (killing), Lemkin defined genocide as comprising the deliberate, systematic destruction of a racial, ethnic or religious group's essential foundations by either killing its individual members of by undermining the groups way of life (Tatz 1999: 16; Short 2010: 47). Aboriginal people were deliberately and systematically murdered, massacred, poisoned, dispossessed, relocated and removed – the destruction of essential foundations of Aboriginal life. These genocidal, colonising practices and policies attempted to clear so-called Australia of Aboriginal ways of knowing, being and doing (Watson 2011) – to clear the continent of Aboriginal people.

The violence of colonisation cannot be understated and continues today through the structures and continued processes of colonialism.

Indeed, violence has long been a tool with which to 'suppress and re-shape Indigenous individuals and societies' (Atkinson & Woods 2008: 1). Three broad types of violence are used against Aboriginal and Torres Strait Islander people: physical violence, structural violence and psycho-social dominance (Atkinson & Woods 2008: 1). These multiple, overlapping types of violence are inflicted on racialised, Othered Aboriginal bodies and psyches, defining and redefining the parameters of Aboriginality in so-called Australia today (Atkinson & Woods 2008: 1). This violence is justified using the logic of the colony, so deeply imbued with racism. The violence of colonisation itself is underpinned and fuelled by racist ideologies (Atkinson & Woods 2008: 1). Atkinson and Woods (2008: 6) describe these three types of violence in detail: physical violence includes invasion, disease, death and destruction; structural violence encompasses legislative practices, reserves and removals – and, I would add, surveillance and hyper-incarceration; while psycho-social domination is the cultural and spiritual genocide perpetrated against Aboriginal peoples. For Aboriginal peoples, this is the greatest violence, 'the violence that brings the loss of spirit and destruction of self, of the soul' (Atkinson & Woods 2008: 6). Certainly, it is cultural and spiritual genocide that 'attacks the very heart, the locale, or *who we are* more so than the physical violence' (Atkinson & Woods 2008: 7; emphasis in original).

This colonising violence seeps into every facet of Aboriginal lives, operating to dehumanise Aboriginal people while (re)creating 'truths' to support the civilising mission (Atkinson & Woods 2008: 7; van Krieken 1999). The colonising forces assert that our laws are mere myths, and even that our physical bodily belonging to place is a fallacy – that we originated from somewhere else (Watson 2014: 11). These fallacies delegitimise our law, our lore and our relationships (Watson 2014: 11). This violence cannot operate

without racism, nor can racism function without violence (Atkinson & Woods 2008: 7). These colonial processes of 'domination, subjugation and genocide' dominate and control Aboriginal people in Australia, ensuring the political sovereignty of the colonial state (Watson 1996: 108; 110). It is the violence, the dehumanisation and colonising processes that make racism work – to create a population 'available to be abused' (Atkinson & Woods 2008: 7). So the lives of Aboriginal people become objectified through a colonial lens, with 'multiple layers of violence … woven through the very fabric of Indigenous life experience' (Atkinson & Woods 2008: 16). Yet, despite this ongoing colonial violence, Aboriginal people have retained a 'strong identification with their Aboriginality', despite the political and social pressures (Gilbert 1995: 147). We survive and we resist the people and structures that seek 'through legal and social policies' to 'annihilate and separate Aboriginal society' (Gilbert 1995: 147).

The policies of protectionism, segregation and assimilation continued, and continue, in many forms; however, from the late 1950s a new discourse began to shape and inform policies regarding Aboriginal people. By this time, the 'assimilation program' taking place on missions and reserves was becoming untenable, financially, politically and intellectually (Rademaker 2020: 59). Financially, missions were almost entirely dependent on government funding, receiving an annual subsidy in conjunction with various grants (Rademaker 2020: 60). A raft of funding was available to the missions in particular, granting subsidies for teachers, nurses, mechanics, livestock and equipment, among other things (Rademaker 2020: 61), all with the intention of facilitating the assimilation of Aboriginal people into white society.

From 1948, the various missionaries came together for the Missions Administration Conference, attended by representatives from a number of missions as well as government representatives (Rademaker 2020: 61). By 1961, missionaries were beginning to question the pace and futility of the process of assimilation and began to argue that the will to

assimilate must come from Aboriginal people themselves (Rademaker 2020: 62). While Aboriginal people had been citizens since 1948, by way of the *Nationality and Citizenship Act 1948* (Cth), it was not until 1967 that a visible groundswell in support of equal rights for Aboriginal Peoples emerged (Attwood, 1997: 37–47). The American civil rights movement had been brought to Australia via the new technology of television,[6] and was influential in rights movements here (Perkins, 1975); however, it must be noted that there activism by Aboriginal people had existed for many years already. For instance, there had been political protests and a petition to the Queen as early as the mid-1840s by palawa people who had been forcibly transferred to Flinders Island in lutruwita/Tasmania (Ryan, 2012). In 1927, Wiradjuri man Jimmy Clements walked approximately 100 kilometres from Brungle Mission in Tumut, New South Wales to the opening of Parliament House[7] to demonstrate what he later described in *The Argus* newspaper as 'his sovereign rights to the Federal Territory' (National Archives of Australia, 2010).

In 1938, on what was known by the broader public as Australia Day, the first Day of Mourning was held to acknowledge the ramifications of the 150-year anniversary of the founding of Sydney Cove (Maynard 2007: 3). A number of activist groups were also established: the Australian Aborigines Progressive Association; the Australian Aborigines League; the Aborigines Progressive Association; the Victorian Aborigines

[6] It is worth noting here the impact of new technologies such as social media on contemporary generations of Aboriginal people, including the use of social media to spread the Black Lives Matter movement from the streets of America to the streets of Australia, again mobilising Black and Indigenous peoples globally.

[7] This continues to be a contemporary form of activism, drawing attention the plight of Aboriginal Peoples. In 2017, Noongar man Clinton Pryor walked approximately 3500 kilometres from Boorloo/Perth to Parliament House on Ngunnawal Country/Canberra to meet with then Prime Minister Malcolm Turnbull. Unfortunately, Pryor felt immensely disrespected by the Prime Minister and government, resulting in a breakdown of communication (Robertson 2017). More recently, Michael Long walked from Naarm/Melbourne to Parliament House to show his support for the upcoming referendum. This is the second walk undertaken by Long, who previously walked to meet then Prime Minister John Howard in 2004 to protest the abolition of the Aboriginal and Torres Strait Islander Commission (ATSIC) (Cross 2023).

Advancement League; and the Federal Council for Aboriginal Advancement, which became the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (Maynard 2007). These groups, and the activism of Aboriginal people and allies, informed the campaign for constitutional change in the hope that the circumstances of Aboriginal people would be transformed). This inspired the 1965 Freedom Ride, a bus tour of western and coastal New South Wales taken by the Student Action for Aborigines, a student group from the University of Sydney. The group was led by Arrernte and Kalkadoon man Charles Perkins, who was at the time a student at the University of Sydney, and went on to become, among many other things, deputy chairperson of the Aboriginal and Torres Strait Islander Commission, or ATSIC (Perkins 1975). The Freedom Ride brought attention to the racism rampant in regional New South Wales, holding demonstrations at the segregated Kempsey Baths, Bowraville Cinema, Moree Baths and the Walgett Returned Services League (Perkins 1975). Segments of the Freedom Ride were recorded and shared with news stations around the country, bringing the attention of those in the cities to the reality of regional towns. Over a hundred years of activism would lead to the Commonwealth referendum of 1967, where citizens were asked to respond to the question:

> *Do you approve the proposed law for the alteration of the Constitution entitled 'An Act to alter the Constitution so as to omit certain words relating to the People of the Aboriginal Race in any State and so that Aboriginals can be counted in reckoning the Population?*

A resounding 90.77 per cent said 'Yes' and every single state[8] had a majority result for the 'Yes' vote. It was one of the most successful national campaigns in Australia's history (Attwood 1997: 55). The hope of many was that the Yes vote would improve conditions

[8] The Australian Capital Territory and Northern Territory did not vote in this referendum.

for Aboriginal people; however this was not necessarily the case. In fact, the failure of the referendum to deliver meaningful change to the lives of Aboriginal people across the country led to a new wave of activism in the late 1960s and early 1970s (Foley 2001).[9]

The Whitlam Labor government ushered in a new era of policy governing Aboriginal people. From the early 1970s the discourse shifted from assimilation to self-determination (Perheentupa 2020: 189). Whereas the government was focused on reducing disadvantage, and thus creating equality, the emphasis for many Aboriginal activists and people was centred firmly on Aboriginal control of Aboriginal lives (Perheentupa 2020: 189–90). Following the creation of the Aboriginal flag (first flown in July 1971) by Harold Thomas, a Luritja and Wombai man, the Tent Embassy[10] was established outside Parliament House in Canberra in 1972. The claim to self-determination and sovereignty had been very publicly made and was broadcast around the nation (Perheentupa 2020: 190). The establishment of the Tent Embassy did two key things: it publicly demanded the reversal of 'paternalistic, racist and discriminatory practices'; and it declared that Aboriginal people are a 'distinct people, a distinct nation within the borders of the Australian state' (Behrendt 2001: para. 15).

From the early 1970s, several Aboriginal community-controlled organisations were established, including the Aboriginal Legal Service (ALS), the Aboriginal Medical Service (AMS), the Aboriginal Housing Company and Murawina pre-school and childcare, which was run entirely by Aboriginal women (Perheentupa 2020: 193). While

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[9] At the time of writing, we as a nation were preparing for another momentous referendum, a referendum that sought to establish an Aboriginal and Torres Strait Islander voice to parliament. Again, the hope was a successful outcome would improve the conditions experienced by Aboriginal and Torres Strait Islander Peoples. The referendum was held on the 14th October 2023, and was unsuccessful, with the majority of Australians votig no.

[10] The Tent Embassy was established on the lawns of Parliament House in 1972 by Michael Anderson, Billy Craigie, Toney Coorey and Bertie Williams. It was described by journalist John Newfong as 'one of the most successful press and parliamentary lobbies in Australian political history'. *See* https://www.nma.gov.au/defining-moments/resources/aboriginal-tent-embassy.

these organisations were based in Redfern, New South Wales, they lobbied for self-determination for all Aboriginal people, recognising that all Aboriginal peoples/language groups/nations are culturally distinct from settler-colonial society (Perheentupa 2020: 190). The Department for Aboriginal Affairs was established in 1973; however, it quickly became apparent that the government's ideas and Aboriginal peoples' ideas about the meaning of self-determination differed greatly. Self-determination was seen by many as a threat to the territorial integrity and sovereignty of the state of Australia (Davis 2008). The focus of the government was squarely on the elimination of disadvantage experienced by Aboriginal people, rather than recognition of the right of Aboriginal people to full self-determination (Perheentupa 2020: 197). By framing it in such a way, self-determination would be temporary in both time and space, whereas an Indigenous view of self-determination would see a permanent and effectual shift towards Indigenous rights. In other words, the self-determination understood by the government would lead ultimately to the assimilation of Aboriginal peoples.

Despite the rhetoric of various governments concerning self-determination and Indigenous rights, the violence of the colony was never far away. In 1983, 16-year-old John Pat was brutally murdered by police in Roeburn, Western Australia. John Pat was viciously assaulted by four off-duty police officers before being thrown into the back of a police van. He arrived at the police watchhouse only to be assaulted again. He died with a fractured skull, internal head injuries, a torn aorta, broken ribs, and severe bruising. While the police officers were charged with manslaughter (not murder), they were each acquitted after appearing before an all-white jury (Longman 2016: 6). John Pat's death would be the catalyst for the Royal Commission into Aboriginal Deaths in Custody (Johnston 1991).

1
Coronership in the colony

This chapter begins with an account of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). This remains one of the most significant inquiries undertaken in Australia. It is entirely relevant to this study, as it can be argued that the over-representation of Aboriginal people in the coronial system is a result of the over-representation of deaths of Aboriginal people that occur in custody. A number of recommendations were made regarding the coronial systems across Australian jurisdictions, and the continued impacts of colonisation were brought to light. It is for these reasons that the Commission is discussed here.

A Royal Commission is only one body that may make recommendations to improve the lives, and prevent the deaths, of a population. Similarly, the coronial inquest can result in recommendations. At its most basic, the role of the coroner is to investigate and to determine the identity of the person who has died or is missing and the circumstances surrounding their disappearance or death. The coroner determines not only the physical cause of the death, but the manner of the death; it is perhaps best positioned to make recommendations to prevent similar deaths from occurring. They are also required in some instances to hold a mandatory inquest – for example, where a death has occurred in any form of state custody or 'care'. This is not, however, a neutral process. The coronial system is a colonial system, and it operates within the settler-colony as yet another institution and tool of colonialisation. This system, and almost all actors within it, are imbued with particular normative ideas about whiteness and race, which intersect with indigeneity, and indeed the lives and deaths of Aboriginal and Torres Strait Islander Peoples, in specific and often violent ways.

Section 1 of this chapter provides an overview of the history of the role of coroner, including a discussion of what it is that the coroner is legislated to do. It does so through a critical lens, interrogating the role of the coroner as a weapon in the toolbox of the settler-colony. Section 3 focuses on current coronial approaches to examine the role of the coronial can system in the prevention of death.

1. The Royal Commission into Aboriginal Deaths in Custody

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established on 16 October 1987, following an alarming number of deaths of Aboriginal people in custody throughout the 1980s (Marchetti 2005: 106), with the *Interim Report* by Justice Muirhead being released in December 1988 (Cunneen 1992: 351). The activism of organisations such as the Aboriginal Legal Service[11] and Committee to Defend Black Rights,[12] as well as the families of those who had died and their supporters, was a key driver in the formation of the RCIADIC (Cunneen 2006a: 38). Initially, the RCIADIC was limited to investigating the deaths only, but this was later broadened to include 'a consideration of the underlying social, cultural and legal issues' that may have contributed to the deaths (Marchetti 2005: 107). This meant the RCIADIC was able to explore the original and ongoing effects of colonisation on Aboriginal people. The National Report of the RCIADIC was tabled on 15 April 1991 and contained 339 recommendations. At its most basic, the RCIADIC found that in order to reduce the number of Aboriginal people

[11] The Aboriginal Legal Service was established in 1970 following the activism and advocacy of Aboriginal people and allies. Following this, the Aboriginal Medical Service was established. These two organisations continue to be exemplars of how community-controlled services can have significant impacts for Aboriginal and Torres Strait Islander people.

[12] Instrumental to its establishment was the Committee to Defend Black Rights, founded by Yinggarda and Bibbulman woman Helen Corbett. During a listening tour around the continent, the Committee heard of more and more Black deaths in custody, and began to join the dots: these were not isolated cases it was a national disgrace. Corbett travelled to the Amnesty International headquarters in London and spoke with United Nations officials in Geneva, Switzerland in 1986 (Emery 2013). Following immense international pressure, the Hawke Labor government established the RCIADIC with the first hearings commencing in 1988 (Emery 2013).

dying in custody, there must be a reduction in the number of Aboriginal people entering custody in the first place (Cunneen 1992: 351). Further, the RCIADIC identified a number of 'significant police failures; inadequate police training and inadequate awareness of duty of care' (Porter 2016: 179). While the RCIADIC revealed no evidence of brutality on the part of police and corrections officers, it did uncover an overwhelming apathy and subsequent absence of any duty of care towards Aboriginal People in custody. Significantly, the findings of the RCIADIC also revealed a deliberate and systematic disempowerment of Aboriginal peoples by successive governments (Johnston 1991). As the main agents of enforcement of this disempowerment, police developed particular relationships with Aboriginal communities that continue to inform the ways many Aboriginal people interact with police (Johnston 1991). One of the most significant findings of the RCIADIC is that Aboriginal people are not necessarily more likely to die in custody than non-Aboriginal people; however, the grossly disproportionate rate at which Aboriginal people are imprisoned means an overwhelming number of our people are dying in cells and in watch-houses (Johnston 1991).

Despite this being in the national spotlight, the number of Aboriginal people in custody rose by 25 per cent during the four years when the RCIADIC was in progress, from 1987 to 1991 (Cunneen 1992: 351). In New South Wales alone, the number of Aboriginal people in custody rose by 80 per cent during this period (Cunneen 1992: 352), due in part to a 'massive increase' in the number of offensive language and offensive behaviour charges being laid (Cunneen 1992: 354). During the RCIADIC, 65 per cent of Aboriginal deaths in custody occurred in police custody, compared with 23 per cent in the seven years following the report's release (Harding 1999: 114). While a marked decline, during the same period the number of deaths in correctional facilities rose from 35 per cent to 77 per cent (Harding 1999:114). The lack of focus on the gendered dimension of incarceration was apparent here too, with the number of Aboriginal women

being incarcerated in Australia rising by 63 per cent between 1987 and 1991 (Cunneen 1992: 353). Moreover, at the time of the RCIADIC, nearly all women who died had done so in police custody, rather than in a custodial setting (Cunneen & Kerley 1995).

Between the finalisation of the RCIADIC in 1989 and Brooks' (1999) article, 11 Aboriginal women died in custody. At least 96 recommendations were breached in the course of the arrest and detention of these women (Brooks 1999: 272). Like those deaths investigated by the RCIADIC, the women were detained mostly for minor offences, their deaths the result of systemic and institutionalised racism (Brooks 1999: 258). As Brooks (1999: 253) declares, 'racism endures as a weapon of power in the war for Aboriginal and [Torres Strait] Islander subjugation and exclusion'. These deaths, and those since, are the direct result of racism, ongoing colonisation, and the 'haphazard and incomplete' implementation of the 339 recommendations made by the RCIADIC (Brooks 1999: 258; RIADIC 1991). Alarmingly, the number of deaths in custody in New South Wales rose following the release of the RCIADIC's report, from zero to four. This is despite New South Wales having a seemingly fair record of implementation of the Royal Commission's recommendations (Brooks 1999: 276).

Similarly, the number of Aboriginal women dying in custody in Victoria rose from zero preceding the RCIADIC to two in the ten years following, again despite a seemingly fair record of implementation (Brooks 1999: 276). These deaths were largely preventable, and occurred across jurisdictions. In one instance, Daphne Armstrong died in a Brisbane watch house on 25 May 1992. She had been apprehended and detained for public drunkenness, an offence that the RCIADIC recommended be abolished.[13] Daphne was not drunk – she had suffered a heart attack in the 24 hours prior to her arrest. At the inquest,

[13] The tireless work of the family of Yorta Yorta woman Aunty Tanya Day, who died after being arrested for public drunkenness, has seen public drunkenness be decriminalised across the state of Victoria. A key recommendation of the RCIADIC, this legislative change may contribute to fewer arrests of Aboriginal people, and thus fewer deaths in custody. See Brennan (2023).

however, the coroner appeared more preoccupied with the 'unfair and unrealistic onus' on police to have recognised this and to have sought medical attention (Brooks 1999: 264). Had medical attention been sought, rather than a heavy-handed police response being imposed, Daphne may still be alive. Had the recommendations of the RCIADIC been fully implemented, Daphne may still be alive.

Significantly, the RCIADIC found that in all the 99 deaths investigated, the 'Aboriginality of the person was a significant factor, and in some cases the dominant one, leading to the person's placement and eventual death in custody' (Cunneen 2006a: 38). Those whose deaths were investigated had experienced 'early and repeated' contact with the criminal justice system, with many having been arrested before they were just 15 years old; almost half of those who had died had been forcibly removed from their families as a child (Cunneen 2006a: 38-9). When a person is deprived of their liberty, the State has a heightened responsibility to exercise a duty of care and prevent harm to those in its custody (Cunneen 2006a: 49). Yet, the RCIADIC found that it was the failure of state actors to offer proper care that 'directly contributed to or caused' many of the deaths in custody that they investigated (Cunneen 2006a: 38). The crisis of over-incarceration of Aboriginal people is by no means unique to the Australian colony. Indeed, where globally there has been invasion, dispossession and colonisation, the over-incarceration of First Peoples seems to follow. Some 18 years ago, Cunneen (2006a) was already highlighting the consistency across colonies: in Aotearoa (New Zealand), the Māori population is approximately 14 per cent of the population but over 50 per cent of the prison population (Cunneen 2006a: 37). Similarly in Canada, First Nations peoples are approximately 3 per cent of the population but in some areas comprise more than 60 per cent of the prison population. The dilemma continues in the United States, where one in 25 First Nations people are trapped in the criminal justice system (Cunneen 2006a: 37).

Following the RCIADIC, in 1992 the Australian Institute of Criminology launched the National Deaths in Custody Program, with the sole focus of reporting annually on the number of deaths in Australian gaols, police custody and juvenile detention facilities (Porter 2023: 179). The program also monitors the number of deaths for associated trends (Porter 2023: 179). Again, this is by no means unique to Australia. In the United States, the Bureau of Justice Statistics (BJS) collects information via the Mortality in Correctional Institutions program, established in 2000 (Bureau of Justice Statistics, n.d.). In the United Kingdom, the Independent Office for Police Conduct (IOPC, formerly the Independent Police Complaints Commission) investigates serious allegations of police misconduct (www.gov.uk, n.d.). In Canada, the Correctional Services of Canada (CSC) is responsible for the investigation of deaths in correctional facilities (Martineau & Gagnon 2020). There are noticeable differences, however: while the AIC reports on the data, the BJS is focused on deaths in correctional facilities only, similar to the CSC, and the IOPC investigates police.

Despite their shortcomings, inquisitory Royal Commissions are 'an extremely powerful mode of inquiry' available to Commonwealth and state governments (Gilligan 2002: 292). They are strategic, and serve a 'valuable legitimation function for official discourses' (Gilligan 2002: 293) – indeed, they 'manufacture their own forms of legitimacy' (Gilligan 2002: 301). It is perhaps not surprising, then, that the RCIADIC failed to ameliorate the structural and societal issues that have seen more Aboriginal men and women die in custody than at any time before or during the RCIADIC. A qualitative study by Marchetti (2005) found a number of factors that may have contributed to the RCIADIC not fulfilling its potential. As with any Royal Commission, the sheer volume of information gathered by the RCIADIC was an obstacle in and of itself (Marchetti 2005: 116). There were reportedly disagreements across different groups of RCIADIC staff about what should be included in the reports, what was important and what was not

(Marchetti 2005: 116). According to Marchetti (2005: 117), the conservatism of a number of commissioners had an impact on what material was included and what was not. A lack of resources was also cited as a key issue, including the number and suitability of staff to complete the report (Marchetti 2005: 118). Some of those interviewed for Marchetti's (2005) study also cited an inability to adhere to cultural protocols, such as interviewing men and women separately, and the impact this had on the data – particularly concerning the gendered dimensions of racism and police violence (Marchetti 2005: 117–18). Importantly, the community was not educated about the limitations and parameters of the RCIADIC, leading to many being disappointed with the 'failure of the RCIADIC to apportion blame' for individual deaths (Marchetti 2005: 121). Furthermore, but the investigations themselves were re-traumatising for many families who had lost loved ones in police or corrective custody (Marchetti 2005: 122). At the heart of the failures of the RCIADIC to enact significant changes, however, is the failure of various and successive governments to meaningfully and completely implement the Royal Commission's recommendations.

A stark reminder of the futility of the unimplemented, or inadequately or partially implemented, RCIADIC recommendations to save lives is evident in *Appleton v State of New South Wale*s [2005] DCNSW. The case was brought about by the mother of a young Aboriginal man who had hanged himself in his cell at Cessnock Correctional Centre (Cessnock CC). On 3 March 2000, the 19-year-old man was assessed as being well enough to leave the Crisis Unit and return to the general population wing, despite reporting having swallowed razorblades and despite having self-inflicted lacerations on his arms. He was moved to a single cell, where the bed was broken and being supported by milk crates. The young man removed one of the milk crates, moved it to the door, and tied his bed sheet to a bar above the door, whereupon he hung himself (Smith 2005). He was not found for hours following his death (Smith 2005). His mother, Ms Appleton, was not notified by

Cessnock CC of her son's death. Rather, she was notified by a friend who worked at the Centre (Smith 2005). Distraught, the mother presented at Cessnock CC, where she was taken through the gaol to her son's cell. At no time was she warned of the condition of her son's body before being taken to his cell, nor was she prepared for the taunts of the other prisoners as she was led through the wing (Smith 2005).

Ms Appleton sought a finding against the state of New South Wales on the basis that her son's death was due to negligence, and that the state had breached its duty of care to both her son and herself (Smith 2005). Quirk J found that the state had indeed breached its duty of care towards the son, and that Ms Appleton had suffered greatly following her son's death, for which she was awarded over $50,000 dollars (Smith 2005). However, Quirk J found that the state had not breached any duty of care towards Ms Appleton, despite failing to warn her of the condition of her son's body or for failing to arrange counselling for her following the incident (Smith 2005). The tragedy of this young man's death is compounded by the fact that this was fourteen years after the RCIADIC. Despite the 339 recommendations made by the RCIADIC and endorsed at numerous levels of government, there were still hanging points in the cell. The bed was broken, supported by milk crates. There was such minimal monitoring of this young man, who had a history of self-harm, that only hours before released from the Crisis Unit he was able to hang himself and not be discovered for hours (Smith 2005). This is a failure of the state and CC officers to demonstrate any level of care for this young man. Again, we see the 'indifference that kills' (Razack 2012: 925), the result of a state-sanctioned and state-led apathy towards the 339 recommendations of the RCIADIC.

In direct contravention of the recommendations of the RCIADIC, which 'emphasised the need for arrest and detention to be a last resort' (Hunyor 2015: 5), punitive measures such as the Northern Territory's paperless arrest laws continue to be implemented. The paperless arrest laws see people imprisoned for up to four hours (or until

no longer intoxicated) for minor summary offences. For example, many of the offences for which paperless arrest laws can be utilised carry penalties of only a fine – offences for which a court could not impose a custodial sentence (Hunyor 2015: 3). Further, paperless arrest laws are applied overwhelmingly to Aboriginal people: in the first seven months of their implementation alone, Aboriginal people made up 70 per cent of those affected (Hunyor 2015: 3). This is not an aberration – in the Northern Territory, Aboriginal adults make up 85 per cent of the prison population, despite being only 30 per cent of the Northern Territory population (Hunyor 2015: 3). The disproportionate number of Aboriginal children in juvenile detention in the Northern Territory is even more stark – 95 per cent of those in juvenile detention are Aboriginal children (Hunyor 2015: 3). This is a clear indication that laws such as those concerning paperless arrest are felt most keenly by Aboriginal people: it is 'Aboriginal people [who] bear the brunt of the coercive power they give to police' (Hunyor 2015: 8).

Despite being touted as one of 'the most thorough legal inquir[ies] ever conducted into the lives of Indigenous Australians' (Marchetti 2005:104), it can be argued that the RCIADIC employed 'deep-colonising' practices that served to reiterate 'colonial dynamics' (Marchetti 2006: 452). These practices limited the knowledges he RCIADIC was able to gather, and the inquiry was influenced heavily by 'non-Indigenous modes of cultural hegemony' (Marchetti 2006:455), whereby non-Indigenous staff were left to analyse the data collected by the Aboriginal Issues Unit (AIU) staff (Marchetti 2006: 456). In this way, the RCIADIC can be viewed as a 'mechanism for reproducing the state's interests' (Marchetti 2006: 460). One must ask how the RCIADIC could have truly been independent from the government of the day – a government inherently and inextricably bound within a 'colonised society and culture' (Marchetti 2006: 459). Every facet of a Royal Commission is political, from the decision to establish one in the first place, to selecting a commissioner, and defining the terms of reference (Gilligan 2002: 295). The

Royal Commission also functions as a 'management strategy, in particular that of crisis management' for 'centralised authority' (Gilligan 2002: 290). While the RCIADIC appeared to be decolonising – that is, a way to 'deconstruct and reform race relations' (Marchetti 2006: 461) – it instead continued the 'colonising project by concealing and naturalising practices that are in fact detrimental for the colonised other' (Marchetti 2006: 461). The RCIADIC was ultimately only ever 'capable of hearing or seeing what fits within the dominant hegemony' (Marchetti 2006: 461).

Marchetti (2006) outlines several ways in which the RCIADIC employed deep-colonising practices and methodologies. For instance, despite one of the aims of the RCIADIC being to address the social subordination of Aboriginal people, the day-to-day operations of the RCIADIC actually reinforced that subordination in a number of ways. Aboriginal people employed in the AIUs were paid 'substantially less' than other RCIADIC staff, were situated physically on lower floors than other staff and were not able to freely contribute to decisions around the 'right' knowledge that should be acquired (Marchetti 2006: 465); rather, the 'right' knowledge was 'over-determined by the Western legal worldview' (Marchetti 2006: 466). This 'denial and devaluation of Indigenous knowledge' privileged the colonial and legal evidentiary rules over the knowledges of the world's oldest civilisation (Marchetti 2006: 466). This was exacerbated by the ignorance of many working on the RCIADIC of Aboriginal epistemologies and cultural practices, particularly those concerning death and gender (Marchetti 2006: 467; 462). Concerningly, the inability and assumed reluctance of RCIADIC staff to understand cultural gender protocols led to the 'silencing of Indigenous female voices', both for Aboriginal female RCIADIC staff and community members (Marchetti 2006:468-9). Interestingly, the only AIU to have an Aboriginal woman leading the unit was also the only AIU that produced a report containing a wealth of information about family violence, and the sexual assault of Aboriginal women by police (Marchetti 2006: 470).

Aboriginal staff working on the RCIADIC were regularly exposed to information about relatives who had died, and some instances personal information about their own lives (Marchetti 2006:467). Despite this, there was no counselling offered to staff, nor to the families of the deceased, as it was deemed 'unnecessary' (Marchetti 2006: 470). Further, the families of those whose deaths were being investigated were not considered 'interested parties', so were not provided with copies of the death reports prepared by the commissioners (Marchetti 2006: 471). It was instead largely left up to Aboriginal staff to distribute copies to families (Marchetti 2006: 471). This lack of communication was in stark contrast to the RCIADIC's own findings regarding the importance of police and coroners ensuring that families were kept informed (Marchetti 2006: 471).

Communication, or lack thereof, was also a key feature of the recommendations regarding the coronial system. The coronial jurisdiction was of concern to the RCIADIC due to the over-representation of reported deaths of Aboriginal peoples; deaths in custody, but also deaths due to systemic public health failures (Brazil 2008: 49). The coroner's inquest, like the Royal Commission, is a fact-finding exercise that can make a number of recommendations to prevent future occurrences of injury and death. Both are also part of the state apparatus, a tool with which to collect and store information about the lives and deaths of Aboriginal people Again, we see a mechanism of the colony that promises to improve the lives of Aboriginal people, yet – like the 1967 Referendum, and despite the 339 recommendations set forth by the RCIADIC – we continue to die earlier than non-Aboriginal people, we continue to die from preventable diseases and we continue to die at the hands of the state (AIHW 2021; Australian Indigenous HealthInfoNet 2021; AHRC 2021). The futility of the colonising state to adhere to, or even meaningfully consider, recommendations designed to improve the lives of Aboriginal people is no accident – it is evidence of a colony that still waits to smooth the dying pillow of Aboriginal people.

Thirty-four of the RCIADIC's recommendations pertained to the coronial jurisdiction. Not only were the RCIADIC's recommendations aimed at improving the communication of coronial recommendations to governments and other agenciesl the RCIADIC also sought to improve the accountability of government when in receipt of coronial recommendations (Brazil 2008: 45). The RCIADIC went so far as to propose a framework for mandatory responses to all recommendations made in coronial inquests (Brazil 2008: 45-6). The RCIADIC was not arguing for mandatory compliance, but a considered response 'giving an account of what measures were proposed to address the needs identified' (Brazil 2008: 47). Accountability for deaths that occur in state custody continues to be elusory. A significant barrier to the administration of accountability measures is the role of police in investigating deaths in police custody (Longman 2016: 5). This means 'conflict of interest is ever-present', and instances of 'collusion and corruption of the investigative procedure' (Longman 2016: 5) have been documented (e.g. *Inquest into the Death of Mulrunji* COR 2857/04(9), 95, 131, 132). Sadly, in addition to a lack of accountability framework or independent investigative body, various governments continue to create legislation that disproportionately affects Aboriginal people, including the imprisonment of people for unpaid fines and other infringements (Longman 2016: 7), in direct opposition to the recommendations of the RCIADIC. Indeed, respected barrister Craig Longman (2016: 7) notes that 'it is impossible to express how disheartening it has been to see the recommendations of the RCIADIC report disregarded time and again'. Perhaps the lack of enforceability and accountability regarding coronial recommendations is indicative of their real purpose: 'the inquest is meant to discover what happened rather than determine responsibility' (Bond et al. 2020: 249).

The Royal Commission, and indeed the coronial inquest, is perhaps nothing more than a performative exercise in self-legitimation, leaving 'those on the receiving end of state power and intransigence with a potent sense of injustice' (Hancock & Liebling 2013:

90). It is a site of power, wherein 'truth remains contested' (Hancock & Liebling 2013: 111). Ashforth (1990: 1) describes this as 'reckoning schemes of legitimation', whereby Royal Commissions 'produce a rational and scientific administrative discourse out of the raw materials of political struggle and debate' (1990: 3). Royal Commissions are 'symbolic rituals', 'theatres of power' that are 'fundamental to the legitimation of States' (Ashforth 1990: 4). They are less about the 'gathering of facts' and more about 'expressing the truth of [State] power' (Ashforth 1990: 12). As discussed, even the choice of commissioner is 'often made with specific aims in mind' (Hancock & Liebling 2013: 102), and these are largely political. This is particularly true in the Australian colony, whereby the Royal Commission functions to (re)legitimise the colonial state, and is evidenced in the futility of recommendations made by countless Royal Commissions and inquiries. Hancock and Liebling (2013: 92) provide a measure by which we can see just how ineffective the process is – if effectiveness is understood as the 'production of knowledge', or 'truth seeking', and 'effectiveness in reform' (Hancock & Liebling 2013: 92), then by and large Royal Commissions and coronial inquiries can be understood as ineffective. Were Royal Commissions, like coronial inquiries, effective, then we ought to see the production of knowledge – of truthful knowledge; rather, time and again we see the production of deficit narratives that seek to blame Aboriginal peoples for their own deaths. Similarly, were the making of recommendations effective, we ought to see serious reform and the reduction of deaths in custody and other forms of state 'care'. Instead, the number of Aboriginal people dying in custody, after police contact and in other state institutions continues to rise. While it is argued that Royal Commissions are indeed an exercise in legitimation, it must also be recognised that they are significant sites of 'political, legal, moral and discursive struggle', sites 'heavily traversed by power relations' (Brown 2013: 27) – much like the coronial inquiry. Commissioners themselves are acutely aware of this, and seek to secure 'the most favourable public, political and

media context for their inquiries and recommendations' (Brown 2013: 41). Unfortunately, this means 'any general legitimation repair function' that an inquiry may have is overshadowed by the commission's 'own reputation and standing' (Brown 2013: 41–2). No wonder, then, that Royal Commissions tend to have a 'striking inability to be reflexive' where it may harm their standing (Brown 2013: 43).

Several more examples of the performative and legitimising nature of royal commissions and inquiries are evident in other colonial states. For example, Stenning and LaPrairie (2013) note three significant inquiries in Canada: the Marshall Inquiry (1986, Nova Scotia), the Manitoba Inquiry (1988, Manitoba), and the *Royal Commission on Aboriginal Peoples* (1991, Canada-wide). In the Marshall Inquiry, three non-Aboriginal commissioners received numerous submissions highlighting the 'endemic, systemic and individual racial discrimination in the criminal justice system', with many calling for the 'establishment of separate Aboriginal justice institutions' as the 'only adequate means to ensure that such discrimination does not persist' (Stenning & LaPrairie 2013: 140). Despite this, the commissioners found that there did not exist 'an adequate information base … regarding the needs of Native communities' (Stenning & LaPrairie 2013: 139). The Manitoba Inquiry had one non-Aboriginal and one Aboriginal commissioner and was similar in scope to the Marshall Inquiry. Alarmingly, the Manitoba Inquiry provided 'no details as to terms of reference, sampling, methodologies or analyses for any of [this] research', making it almost impossible to assess the validity and quality of the research and its conclusions (Stenning & LaPrairie 2013: 147). The *Royal Commission on Aboriginal Peoples* (RCAP) was established in August 1991, following the release of the RCIADIC in Australia, and immediately following the submission of the Manitoba Report (Stenning & LaPrairie 2013: 147). The RCAP was uncritical of the two previous inquiries, accepting their findings as 'truth' about Aboriginal peoples (Stenning & LaPrairie 2013: 148). No new findings were presented in the RCAP report,

and no new empirical research was conducted; rather, the RCAP relied on select earlier literature (Stenning & LaPrairie 2013: 149). Instead of being a beacon of reform designed to prevent the deaths and over-incarceration of Aboriginal people in Canada, the report served to 'reinforce and support the broader political and self-government objectives of the commission', failing to identify 'real justice solutions to real justice problems' (Stenning & LaPrairie 2013: 149).

The RCAP also failed to acknowledge the multiplicity and diversity of Aboriginal people's worldviews and experiences, instead imposing a false universality (Stenning & LaPrairie 2013: 152). Broader policy areas such as health, education and employment were disregarded, thereby invisibilising their relationship with the phenomenon of over-representation in the criminal justice system (Stenning & LaPrairie 2013: 153). So, despite the considerable funding afforded to 'study' the problem of Aboriginal people in the Canadian criminal justice system, not only was little learned via the RCAP but little resulted from it in real terms for Aboriginal peoples in Canada (Stenning & LaPrairie 2013: 153). Surely, these failures are indicative of the performative nature of the inquiry – and so perhaps the failures are not failures at all but are symptomatic of a colonial legal process that serves no interest than that of the legitimising the colonial state, and (re)focuses the blame on those it purports to care for.

More than 30 years on from the RCIADIC, we must ask ourselves what, if anything, has substantively changed for Aboriginal people. The available evidence indicates that things are worse, not better, and the 'systemic racism exposed in that report still saturates criminal law processing in Australia' (Cubillo 2021: 763–4). Not only have the RCIADIC recommendations largely been ignored, resulting in 'partial or tepid implementation', but so too have the recommendations of various inquiries and coroners across all Australian jurisdictions (Cubillo 2021: 764). The result, stated clearly by Cubillo (2021: 764), is a 'catastrophic failure to address the impact of systemic and structural

racism' on Aboriginal and Torres Strait Islander peoples. This can be understood as 'deliberate strategy of distraction' (Cubillo 2021: 765) – again, an example of the largely performative nature of any investigation pertaining to Aboriginal peoples. Harding (1999) has argued that the ongoing prevalence of deaths in correctional facilities is due largely to the failure of the RCIADIC to investigate the correctional sphere as a problem in and of itself, rather than the 'classification of the problem … as Aboriginal rather than custodial' (Harding 1999: 111). Harding argues that 'prison regimes and processes in relation to both Aboriginal and non-Aboriginal prisoners [were] already a problem before the RCIADIC', and that 'a great deal' was already known about deaths in correctional facilities prior to the RCIADIC being established (Harding 1999: 115). The RCIADIC then repositioned the problem as an 'Aboriginal one', reinforcing the legitimacy of the colonising state and its processes. Indeed, the 'theory and history of settler law reflect a self-reinforcing system that is designed to justify continued settler supremacy' (Cubillo 2021: 767); this is evident in the lackadaisical and apathetic response by various governments to the recommendations of all kinds of inquiry that relate to Aboriginal people.

The RCIADIC continues to be one of the most significant inquiries ever undertaken into the lives and deaths of Aboriginal people. While many of its 339 recommendations continue to be ignored by successive governments, it still provides us with a template to reduce the incarceration of Aboriginal and Torres Strait Islander people in custody, thereby reducing the numbers of Mob who die in police watchhouses, during police operations, and in gaol cells. Its significance to understanding both the over-representation of Aboriginal people in coronial investigations and the ways the structures of colonisation continue to impact Mob cannot be overstated, and is wholly relevant to this study.

Establishing the historical forces that have shaped contemporary structures and relationships has been an important step in laying the groundwork for what is to come.

As mentioned above, we cannot understand the contemporary manifestations and impacts of the coronial system in New South Wales without grounding the analysis in what has come before. Colonisation is indeed a structure, not an event (Wolfe 2006), and the coronial system is just one of these structures. The next two sections will provide an overview of the coronial jurisdiction, situating it within this ongoing history of colonisation. Section 2 begins to provide an overview of the legislative requirements of the coroner and coronial jurisdiction, and the history of coronership more broadly. Section 3 brings this discussion into the present.

2. But what is the coronial system?

Most people are fortunate to have no contact with the coronial system over their lifetime. For those who do, understanding the role of the coroner and the processes and legal language used can be a 'daunting task' (Dartnall & Goodman-Delahunty 2016: 610). This section will outline what exactly the role of coroner entails before examining various configurations of coronership, both historically and contemporaneously.

What does the coroner do?

> *Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.* (*R v South London Coroner, ex parte Thompson* (1982) 126 SJ 625)

Across Australian jurisdictions, certain kinds of deaths must be reported to the coroner. These include suspicious deaths, homicides, suicides, accidental deaths and unexplained death (Abernathy et al. 2010). The kinds of deaths subject to a coronial investigation 'do not discriminate, drawing families into the system from a range of rural, regional and urban areas, social classes and religions' (Carpenter et al. 2022: 1041). The coroner is then tasked with determining the identity of the person who has died, when and where they died, and the cause and manner of the death (Ranson & Bugeja 2017: 568). Inquests are formal, often public, judicial hearings to ascertain the circumstances of a death, in which 'the parties involved present evidence, cross-examine witnesses', and where most, if not all parties, have legal representation (Studdert et al. 2016: 315).

In New South Wales, approximately 6000 deaths are reported to the coroner each year, with around 1800 of these requiring a post-mortem examination (Mowll et al. 2019: 163). Nationally, 5 per cent of all coronial cases proceed to an inquest (Studdert et al 2016: 317). Typically, it is the police who report the death to the coroner, and who are tasked with conducting an investigation into the death on the coroner's behalf (Mowll et al. 2019: 163). It is also police who notify the deceased's next-of-kin and are responsible for formally identifying the deceased. The coroner holds jurisdiction over the deceased's body, and will not release the body until the cause of death has been determined, usually by way of a post-mortem examination or autopsy (Mowll et al. 2019: 163). In New South Wales, where a person is missing and suspected to have died, police must report this to the coroner for investigation (Dartnall & Goodman-Delahunty 2016: 610).

The coroner's role is inquisitorial, rather than adversarial, and is 'situated at the intersection of trauma and grief on the one hand, and legal exploration and evidence gathering on the other' (Carpenter et al. 2022: 1040). This inquisitorial role of the coroner, and the jurisdiction more broadly, is 'exemplified not only in the search for the cause of death', but in its death prevention capacity via the making of coronial recommendations

(Martin 2017: 44). It must be noted however that while coronial investigations provide an opportunity to uncover the circumstances of a death and provide preventative recommendations, they can also 'exacerbate grief and trauma' for the bereaved loved ones left behind (Carpenter et al. 2022: 1040).

The coroner also serves a critical role in examining systemic failures in state facilities. Deaths that occur in state custody, such as in gaols, police custody or out-of-home-care (OOHC), are subject to mandatory coronial inquests. While the coroner is not responsible for attributing blame or criminal liability (McGuiness 2023: 19), the legislative requirement to investigate deaths that occur in any form of state custody serves two important functions. First, it is an opportunity to identify and address systemic failings that led to the death; second, it reaffirms 'public confidence in the State's compliance with the rule of law' (Easton 2020: 29). This in turn provides an opportunity for the state to 'respond appropriately' (Easton 2020: 29).

Coronial systems, investigation, inquests and coroners themselves are not neutral spaces. They are imbued with the underlying principles of the settler-colonial state. Across Australian coronial jurisdictions, 'whiteness undergirds State and society', structuring the experiences of every individual and community; 'the language of race permeates institutions' and is 'embedded in everyday life' (Bargallie et al. 2023: 1532–3). The coroner and their functions are by no means immune to this, and in many ways perpetuate continued colonial violence and narratives. For instance, the 'discourse of pathology' (Moreton-Robinson 2009: 77) is evident in the attribution of the term 'natural causes' to explain too many deaths of Aboriginal people (Porter & Cubillo 2021); this term obfuscates the role and responsibility of the state in the circumstances leading to the death. Coronial inquests can also be understood as 'a site of desecration', a 'place for the ritual that constitutes white settlers and the settler state as legitimate' (Razack 2023: 246). It is through the death-prevention function of the coroner that this relationship between

settler-colonial institutions and Aboriginal people becomes very clear. Razack (2023: 249) describes this as 'sorry happy': the state can show, via coronial processes, that it is 'sorry' the person has died; the state can then be 'happy' with itself in its 'pledge to do better', witnessed in the coronial recommendations and findings that follow. Underpinning this legitimation is pathologisation of Aboriginal peoples as 'primitive … illogical … violent and uncivilised' (Moreton-Robinson 2009: 65); if Aboriginal Peoples are 'always on the brink of extinction, death is only an end point of a natural process' (Razack 2023: 249). The coronial inquest then – to take a critical view – is a performance by the settler-colonial state in order to (re)position itself as legitimate.

The coronial system in New South Wales

As the nation, and in particular New South Wales, became 'socially and culturally constructed as a white possession' (Moreton-Robinson 2015: 1), British institutions and systems were increasingly imposed, further legitimising the settler-colonial state. Foremost amongst these is the New South Wales coronial system that has existed in some form since the early days of colonisation. Imported via English law, early Coroners Courts appeared very different from contemporary manifestations. The first recorded instance of the Office of Coroner in English law dates to 1194, where the role of the coroner was to be keeper of the pleas of the Crown (McKeough 1983: 191).[14] The coroner's role was to inquire into the facts of the case – whether the case be arson, shipwrecks or death – and this took the shape of an inquest (McKeough 1983: 193). Although much has changed in coronial law, modern coroners possess many of the same functions today. The role of the contemporary coroner can be understood as being twofold. The modern coroner, narrowly understood, can 'productively contribute' to the processes of bereavement, and

[14] The 'pleas of the Crown' encompassed anything that would today be included in the purview of criminal law and has been described as a 'cornerstone of modern criminal procedure' (McKeough, 1983: 192).

more broadly can ‘contribute to public health and safety and the prevention of avoidable deaths’ (Scott Bray 2013: 449). The key duty of the coroner is to ‘account for the context of death’ in the form of ‘fact-finding’ (Scott Bray 2010a: 567). Coroners perform this duty within an inquisitorial, rather than adversarial, framework (Scott Bray 2010a: 567–8), and are confined by their statutory responsibility as ‘guardians of the public interest’ (Dowd 1991: 54). The Coroners Court is part of the broader court structure within the jurisdiction of New South Wales. Listed as a ‘specialist court’, the Coroners Court sits within the local court structure, alongside the Children’s Court and the Drug Court (see Figure 2),[15] and manages approximately 6000 reportable deaths per year (Coroners Court New South Wales 2020). The Coroners Court is ‘not a single entity’ – it comprises a number of interrelated agencies and organisations (Dillon 2020: 2). It is made up of legal professionals, forensic medicine professionals and technicians, police, social workers, advocates and grief counsellors. Today, the Local Court, New South Wales Police, New South Wales Health and the Department of Communities and Justice form the key pillars of the coronial system at large (Dillon 2020: 2). However, the coronial system did not always have so many moving parts. This section explores early systems of coronial inquiry in New South Wales, bringing our analysis into the present organisational structure.

[15] The Rule of Law Centre used a variety of sources to create this diagram, namely: https://www.supremecourt.justice.nsw.gov.au/Documents/Publications/Annual%20Reviews%20+%20Stats/Annual_Review_2021.pdf; https://legalanswers.sl.nsw.gov.au/hot-topics-courts-and-tribunals/nsw-state-courts#:~:text=In%20New%20South%20Wales%20there,and%20the%20Industrial%20Relations%20Commission; https://protect-au.mimecast.com/s/NCP4C81V0PTX9j9MKS24puZ?domain=nswbar.asn.au

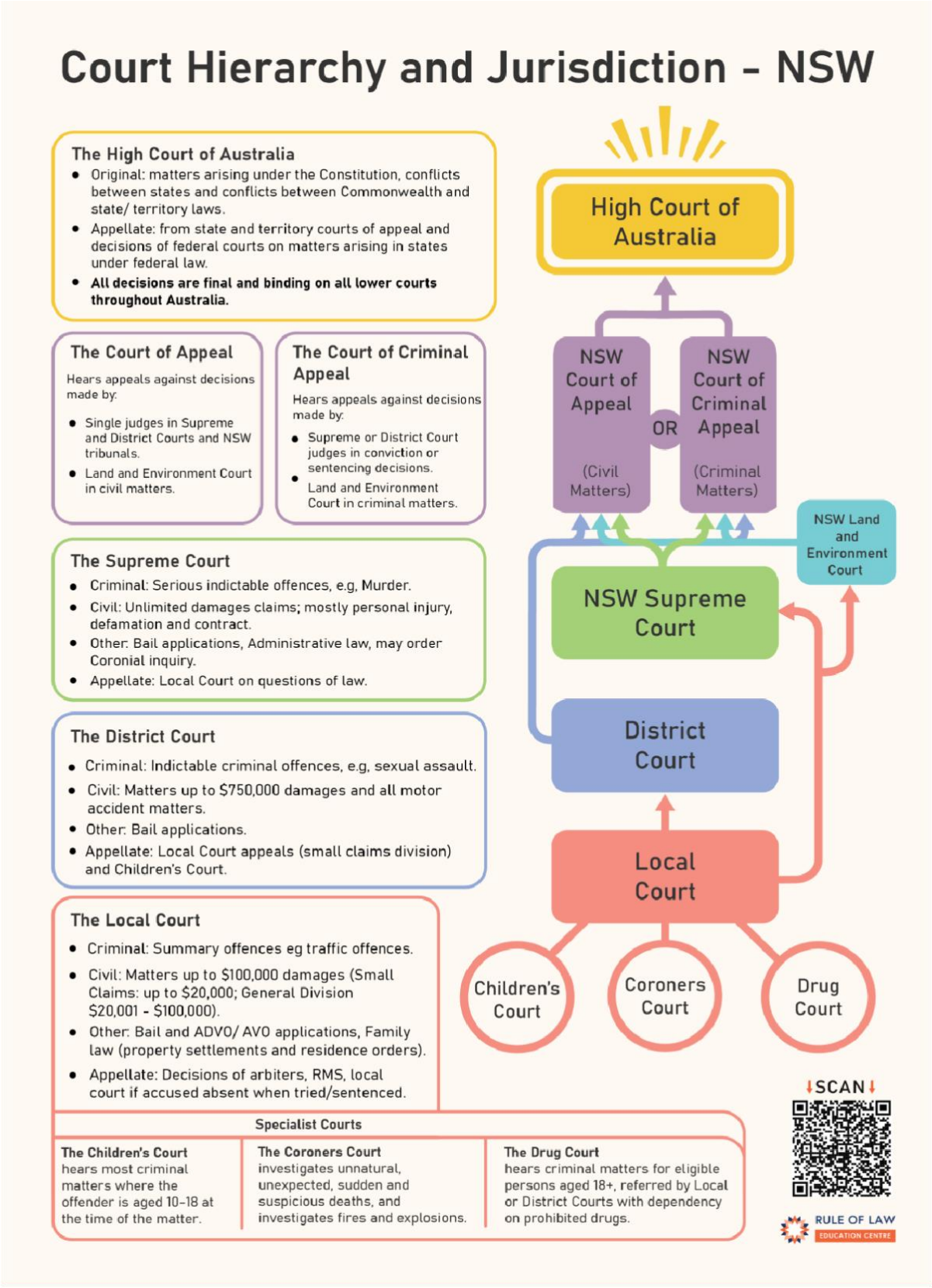

Figure 2: Court Hierarchy and jurisdiction – NSW (Rule of Law, n.d.)

In 1787, Governor Arthur Phillip was granted authority by the invading colonial powers to appoint justices of the peace, coroners, constables and other necessary officers, with the first coronial inquiry conducted in New South Wales in December 1788 (McLaughlin 1973). Specific coronial legislation was not passed in New South Wales until May 1861, whereby it was legislated that coroners be enabled to 'admit to bail persons charged with manslaughter' (No. XVIII. An Act to Enable Coroners to Admit to Bail Persons Charged with Manslaughter, 7 May 1861). This was followed by legislation to consolidate previous piecemeal Acts related to coronial responsibilities and inquests, as well as 'magisterial inquiries' into causes of death (*Coroners Act 1898*). However, the actual role of the coroner in Australia existed well before then, having been imported to the recently named 'Australia'[16] from English law (Freckelton & Ranson 2006: 50), with the jurisdiction of the colonial coroner largely being shaped by a 'combination of case-law and legislation' (Trabsky 2016: 198).

In colonial Sydney, coronial inquiries were carried out in hotels and public bars, with the deceased laid out to be viewed by both the coroner and a jury of 12 'good and lawful men' (Gilchrist 2019: xiii). The viewing of the body by the jury was required to 'legally validate the inquest', and medical doctors were required to give their opinion on the cause of death (Gilchrist 2019: xiii). The jury would then issue a 'rider', similar to today's coronial recommendations, both in scope and in their unenforceable nature. Despite riders, and recommendations, not being enforceable, it was inquests into fires and the riders that followed that led to the creation of the first official fire department (Gilchrist 2019: xvi). Even in the early years of the colony, inquests into deaths that occurred in state custody were required – 'part of the coroner's job was to investigate all

[16] Matthew Flinders, an English explorer, used the term 'Australia' in 1804. The term was also used in the *Australian Courts Act 1828* (UK). See the National Library of Australia for more information: https://www.nla.gov.au/faq/how-was-australia-named#:~:text=By%201824%20the%20British%20Admiralty,and%20Van%20Diemen's%20Land%20combined

deaths that occurred in gaols, and this included state sanctioned executions', such as court-ordered hangings (Gilchrist 2019: 42). These types of inquiries into deaths that occur in state custody are still required today. Additionally, deaths that occurred in hospital settings required a post-mortem examination to determine the cause of death and were also subject to a coronial inquest – it was intended that inquests into hospital deaths would 'reassure the public' that the deceased had received appropriate care, and that malpractice would be indentified (Gilchrist 2019: 81).

Prior to legislation that both standardised and defined the role of the coroner, there was little guidance for coroners operating in the colony. To recognise the specificity of their role and provide guidance to colonial coroners, manuals were created and disseminated. In 1875, the first of a series of manuals for colonial coroners were produced, including one specifically for the jurisdiction of New South Wales (Trabsky 2016: 195). These juridical devices were provided to coroners upon their appointment to the role and outlined the technical aspects of performing the duties of office (Trabsky 2016: 198). Trabsky (2016: 201) posits that the creation and dissemination of these coronial manuals 'professionalised the role of the coroner'; this was done by setting out the 'procedures, forms and rituals for assuming responsibility for the dead' (Trabsky 2016: 195). This professionalisation was further cemented in the creation of legislation specific to New South Wales, such as the *Coroners Act 1898*.

Since 1898, five major pieces of legislation have governed the coronial jurisdiction in New South Wales. The *Coroners Act 1901* endowed coroners and deputy coroners with the powers and duties of a justice of the peace. The Act allowed for every stipendiary (paid) magistrate or police magistrate to hold the same power as coroners across the state of New South Wales, with the exclusion of metropolitan Sydney. The Act also provided for the coroner to summon prisoners to attend inquests where necessary, and at the same time excluded prisoners from sitting on coronial juries following a death

in custody (*Coroners Act 1901* s 4). An interesting addition is found in section 5 of the Act, which notes that coronial inquiries could be held on Sundays if 'necessary or desirable', perhaps representative of the Christian faiths of many of the colonists. The *Coroners Act 1912* was far more comprehensive, covering much of the day-to-day responsibilities of the coroner. For instance, this Act sets out the parameters for coroners to hold 'inquisitions' either 'sitting alone' or with a jury of six men (*Coroners Act 1912* ss 5, 6). It also provides for some of the rights of those 'committed or held to bail by a coroner', such as being entitled to copies of depositions and the possibility of bail (*Coroners Act 1912* ss 9–10. Sections 11–15 of the Act concern the appearance of medical witnesses in coronial inquires, perhaps indicative of the growing reliance upon medical evidence and the burgeoning use of post-mortem examinations. There are numerous sections in this Act outlining the role of the coroner where a death had occurred in a mine, a key industry in the colony, and inquiries into the cause of fires – all too common occurrences in the colony in 1912. For example, the explosion at the Mt Kembla Colliery near Wollongong in 1902 killed 96 men and boys (Mining Accident Database 2023), necessitating a coronial inquiry. The *Coroners Act 1912* (s 19) also reiterated the abolition of the verdict of *felo de se*, a 'felon unto himself' (Jowett et al. 2018: 358), having been formally abolished in the *Verdicts of felo-de-se Abolition Act 1876 No. 2a* (NSW).[17]

Coronial legislation was not modernised in New South Wales until the passing of the *Coroners Act 1960*. This comprehensive Act provided more detail for the appointment and administration of the role of coroner. Significantly, it also set out the requirements for the holding of mandatory inquests and the jurisdiction of coroners in respect of inquests and inquiries, and provided much more detail regarding post-mortem examinations and exhumations. Accidents occurring in mines continued to constitute a significant portion of the Act. The legislation was again updated in 1980, with the introduction of the *Coroners Act*

[17] It did however remain a crime under the *Crimes Act 1900* s 31 until its decriminalisation in 1983.

1980. Section 3 examines the contemporary coronial legislation that informs coronership in New South Wales, bringing this historical focus into the present time.

3. Contemporary coronership

In 2009, a new Act came into force in New South Wales, the *Coroners Act 2009* (NSW), following a 'wave of reform' across Australian coronial jurisdictions (Scott Bray 2010). Much of the reforms purported to centre on the rights of the bereaved, aiming to centre the families and loved ones of the deceased in coronial processes. John Hatzistergos, the then NSW Industrial Relations Minister and Attorney General, described the then Coroners Bill as seeking to allow the bereaved a greater role in coronial decision-making process, thereby addressing some of the distress experienced by the bereaved. These reforms, according to Hatzistergos, would improve the ability of bereaved families to object to post-mortem procedures on cultural and religious grounds, and would ensure that the coronial system in New South Wales operated 'effectively and swiftly' (Hatzistergos 2009: 4–6). Paramount to these reforms was the preventative role of the coroner, and their legislative capacity to make recommendations to prevent similar deaths from occurring. Indeed, Hatzistergos asserted that 'the power to make recommendations means nothing unless governments and agencies give careful consideration to their implementation' (Hatzistergos 2009: 7), acknowledging the need for better accountability across government and private organisations.

Regrettably, very little of what Hatzistergos (2009) spoke of was ever enshrined in the *Coroners Act 2009* (NSW). The Act does indeed refer to the coroner's ability to make recommendations at section 82; however, there is no legislated capacity for mandatory reporting or an accountability framework with regard to those recommendations. Thus, many recommendations are made and never implemented, so we continue to see the same kinds of preventable deaths occurring, stifling the power of coronial recommendations to prevent injury and death. Despite much attention being given to the rights and needs of the bereaved,

very little translated into the legislation; there is only one reference to culture in the Act, and zero references regarding religion. Similarly, despite the stated aim of creating a 'swift and effective' coronial system, the delays between time of death and the culmination of the coronial investigation continue to rise.

Not only are we seeing the same kinds of preventable deaths occurring, due in part to a lack of implemented recommendations, but the bereaved families of the deceased are being excluded from key decision-making processes regarding their loved one, and are experiencing lengthy, often traumatic delays between the time of death and the beginning of an inquest or inquiry. While this affects every family engaged with the coronial system in New South Wales, the limited research available suggests that Aboriginal and Torres Strait Islander people are disproportionately affected, being more likely to die a reportable death – a death that necessitates a coronial investigation, such as suicide, homicide or accidental – than non-Indigenous Australians (Carpenter & Tait 2009: 34). Aboriginal and Torres Strait Islander people are also less likely than non-Indigenous Australians to receive appropriate, or even adequate, medical care (Allam et al. 2019). Further, both the families of the deceased and the police investigating on behalf of the coroner bring particular, specific relationships to death investigations, which is likely to affect how Indigenous families experience the coronial system (McCabe 2019).

The failure of the *Coroners Act 2009* (NSW) to address these issues means families continue to be impacted by lengthy delays, a lack of accountability and the legislated invisibilisation of culture and cultural protocols. Certainly, the coronial system and its processes must be understood within the context in which they occur – not only within a settler-colony, but 'a colonial legal system that is imposed on the lives and bodies of Aboriginal and Torres Strait Islander peoples' (Newhouse et al. 2020: 77).

In their examination of the experiences of Aboriginal and Torres Strait Islander Peoples across all Australian coronial jurisdictions, Newhouse et al. (2020) identified a

series of systemic failings. While much of the rhetoric both before and since the implementation of the *Coroners Act 2009* (NSW) centred on the role of families in coronial processes, in reality it is 'a façade of family participation', whereby in practice this means being restricted to 'narratives about their loved one's life' (Newhouse et al. 2020: 81). The lack of supports and resources available to Aboriginal and Torres Strait Islander families navigating the coronial system was also identified as a key failing (Newhouse, et al. 2020), and indeed appears to be absent from much of the discussions regarding coronial reform in New South Wales. Newhouse et al. (2020: 82) also identified a 'struggle' on the part of coroners across jurisdictions when encountering cultural concerns, and the 'plurality of personal and kinship interests that Aboriginal and Torres Strait Islander families hold'. The failings on the part of the coronial system to address the needs of Aboriginal and Torres Strait Islander people results in the bereaved feeling 'marginalised and excluded from the coronial process', due in large part to 'a lack of cultural sensitivity, a lack of institutional transparency and dissonance between the families' demands for justice and the statutory limits of the courts' (Newhouse et al. 2020: 82).

Most recently, Allison and Cunneen (2023) have described the coronial jurisdiction as 'institutionally racist', whereby 'the differential treatment it affords to First Nations peoples fails to acknowledge and respond to these perspectives and experiences', 'reinforcing and reproducing harmful experiences of racism and colonialism' (Allison & Cunneen 2023: 251). Drawing upon their own research, Allison and Cunneen (2023: 251) highlight the failure of coronial inquiries to consider the deaths of Aboriginal people in relation to 'State violence and other weapons of colonisation'. Their interview participants identified a failure of coroners courts to ensure cultural safety for Aboriginal people, with many feeling 'threatened and outnumbered' by police, corrections officers and others involved in the death present throughout coronial processes (Allison & Cunneen 2023: 252). Coronial processes

therefore have the potential to replicate and reproduce colonial violence, decimating any hope for a sense of justice or healing for the bereaved.

These crucial works begin to address an astounding gap in the literature – the lack of research exploring and documenting the experiences of Aboriginal and Torres Strait Islander Peoples with coronial processes across so-called Australia. What these works lack however is the specificity of place – both in terms of jurisdiction and Country. It is argued here that to reform the coronial jurisdiction, a focus on localised jurisdictions (such as New South Wales) may improve the likelihood of reforms. The work presented here focuses narrowly on the experiences of Aboriginal people with the coronial system in New South Wales following the introduction of the *Coroners Act 2009* (NSW). Many nations make up what is now known as New South Wales (*see* Figure 3),[18] and all these nations fall under the jurisdiction of the *Coroners Act 2009* (NSW).

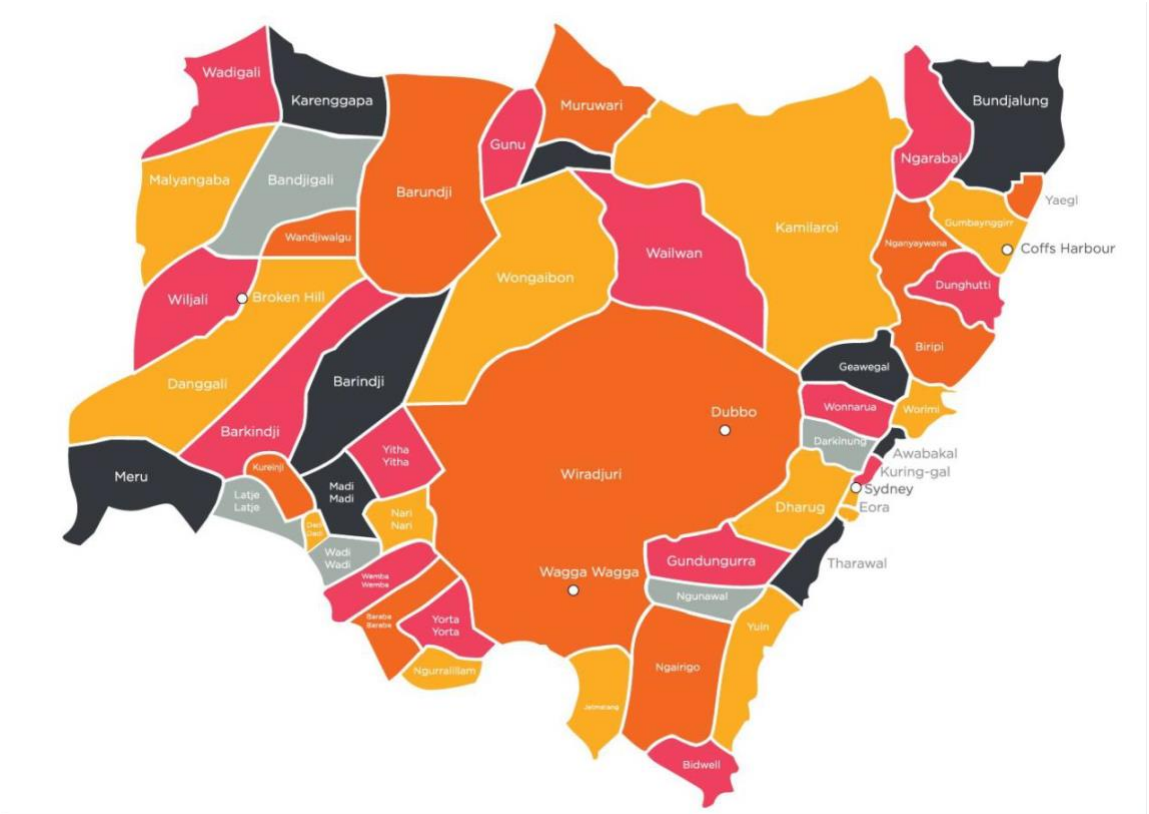

Figure 3: Language groups in NSW

[18] Image via Reconciliation at Transport for NSW.

This chapter has presented a number of facets: both the historical and contemporary iterations of the coronial system in New South Wales have been outlined, as well as a preliminary discussion of the ways in which Aboriginal and Torres Strait Islander people experience and are affected by this system. The coronial system, while often understood as a benign arm of the state, able to contribute to the prevention of injury and death, is too often a site of violence for Aboriginal and Torres Strait Islander people. The next chapter reviews the literature as it relates to the experiences of families, beginning with the presentation of the theoretical frameworks that have underpinned this study.

2

The literature

This chapter outlines the literature in relation to this study, which highlights the inadequacies of coronial systems globally to achieve the best outcomes possible for bereaved families and communities. The commonalities found in families' experiences across the globe provide us with a baseline of understanding and knowledge that can enable best practice, and are discussed in Section 2. Of course, when considering the experiences of Aboriginal families and communities, 'best practice' must be understood within the structures of colonisation that continue to impact every facet of our lives, and of our deaths. Thus, this chapter begins with an overview of the theoretical frameworks (Section 1) that have informed how I understand the operation of the coronial system in the continued subjugation of Aboriginal lives, and the narratives of dysfunction that it (re)creates and perpetuates.

Section 3 examines some of the most pertinent reviews, reports and inquiries that relate to coronial jurisdictions in Australia, and more specifically in New South Wales. It also examines the use of protocols and practice notes as internal instruments for coronial reform. This is important in continuing the narrative from the historical function of the coroner to the contemporary one, as it provides an overview of the most recent criticisms of coronial processes, as well as any changes that have followed.

Section 4 discusses the recognition of the need for culturally informed approaches in contemporary coronership and highlights the work done to create Aboriginal Coronial Information and Support Program (CISP) Officer roles in the NSW jurisdiction. This is a significant and welcome shift in the ways the coronial system interacts with and responds to the needs of Aboriginal families.

1. A critical understanding of the coronial system

Section 1 lays the theoretical groundwork for understanding how coronial systems operate within, and are sustained by, broader structures of settler-colonial power. While coronial processes are often framed as neutral, technical or even benevolent mechanisms for truth-seeking and death prevention, critical scholarship reveals that they are deeply entangled with the racialised logics, hierarchies and governing practices of the colonial state. Drawing on anti-colonial and feminist theorists such as Razack (2000, 2011, 2012, 2014, 2015, 2023) and Dei and Asgharzadeh (2001), this section examines the coronial system not as an administrative apparatus concerned solely with fact-finding, but as a site where colonial relations are reproduced, legitimised and obscured. Here, the literature helps illuminate how coronial inquiries participate in pathologising Aboriginal lives, minimising the role of state violence and constructing official narratives that often deflect responsibility. This critical foundation frames the analyses that follow, enabling a deeper interrogation of how coronial practices continue to shape, constrain, and harm Aboriginal families and communities within New South Wales.

This study and its analyses is informed by the theoretical and methodological frameworks developed by Sherene Razack (Bourgeois 2018), as well as in an anti-colonial theoretical framework. An anti-colonial framework allows for 'a more critical and nuanced' examination of the coronial system, a system which is, of course, situated within the colony of so-called Australia (Adefarakan 2011: 34). Further, it offers 'an understanding of social reality and practice as understood from the vantage point of the marginalized and subordinated' (Dei & Asgharzadeh 2001: 298). It is an 'epistemology of the colonized, anchored in the indigenous [*sic*] sense of collective and common colonial consciousness', allowing for the theorising of 'colonial and colonized relations' while still recognising Indigenous knowledges as 'an important standpoint' (Dei & Asgharzadeh 2001: 300).

Key to this framework and its relevance to this study is the acknowledgement of the role of institutional structures, such as the coronial system, in 'producing and reproducing endemic inequalities', sanctioned by the state (Dei & Asgharzadeh 2001: 300). In this framework, colonialism is understood not only as ongoing, but as both dominating and imposing (Dei & Asgharzadeh 2001: 308), while still centring the strength of First Nations peoples:

> *In short, the anti-colonial discursive framework appreciates, and therefore takes the position that Indigenous knowledges and identities carry crucial elements of empowerment, resistance, and the basic human right to simply be who one is.* (Adefarakan 2011: 42–3)

While employing an anti-colonial theoretical framework, Sherene Razack's work is also grounded in feminist theory, as is much of the work by Indigenous standpoint theory scholars (see Section 2). Her theoretical framework exposes the 'dominant interlocking systems of oppression' found in a colony such as this, and the operation of these systems as 'a form of violence' (Bourgeois 2018: 380). Razack's works are fundamental to how I have come to understand the coronial system and its impacts on Aboriginal people. Following is a detailed explanation of the theoretical and conceptual usefulness of their work.

The inquest reveals a great deal about the relationship between the settler-colonial state – which is still very much concerned with the theft of land and resources (Razack 2011: 357) – and Aboriginal people. It is future-oriented, nobly concerned with the prevention of future deaths and less with the bereavement and grief of the present, and certainly not with the past or the foundational history of settler-colonial violence (Razack 2011: 354). The foundational nature of this violence does not mean it is over – it continues in the present day, 'staged as goodness' via the coronial inquest (Razack 2011: 353), which sets the stage for a particular truth to be (re)created: that of the intransigent Aboriginal people, 'a dying race and a people unable to enter modern life', 'people that

no one can really harm or repair' (Razack 2011: 353) – and therefore a people for whom no one is held accountable should they perish. Indeed, each new inquest (re)affirms how far 'beyond saving Aboriginal People are', and 'how little can be done for them' (Razack 2011: 353). These are a people who, according to the settler, cannot possibly be trusted with land or self-governance, thus demonstrating the intrinsic relationship between the coronial inquest and the continued colonial occupation (Razack 2011: 353).

This ongoing colonialism is inextricably linked with heightened conflicts over land (Razack 2011: 356). Razack (2011: 356) describes the numerous outstanding land claims in British Columbia, Turtle Island/Canada, and the violence that is directed towards Aboriginal People within this province. This is reminiscent of the recent plight of Traditional Owners in Queensland to stake a claim over their lands. More than 15 years ago, a native title claim was put forward by the Wangan and Jagalingou Peoples to the Queensland Government. The state government extinguished native title over much of the proposed Adani mine site, in effect allowing the construction of the mine to go ahead, bankrupting Traditional Owner and staunch defender of Country Adrian Burragubba in the process (Robertson 2019). Following Razack (2011), we can see the violence directed at sovereign Aboriginal peoples in this jurisdiction, too. Aboriginal people are 3.7 times more likely to die in custody in Queensland than non-Aboriginal people (Gannoni & Bricknell 2019: 3). This, combined with the knowledge that 339 native title claims have been made since January 2000 alone (National Native Title Tribunal, n.d.) demonstrates the inextricable link between colonisation, land and the deaths of Aboriginal people.

This is perhaps symptomatic of 'racial spatial economies' that are produced and maintained by the structures of settler-colonialism (Razack 2014: 51). It is through this racial spatial economy that Aboriginal lives are devalued – a 'devaluation that law both produces and sustains' (Razack 2014: 54), from policing through to the inquest. By using force to organise Aboriginal bodies spatially, the coloniser is asserting their 'ownership'

and upholding the racial order upon which colonialism depends (Razack 2014: 60). The inquest, then, is a site where the devaluation and exclusion of Aboriginal lives and bodies is justified, wherein legal narratives are created that turn Aboriginal deaths into a story of a 'dysfunctional' population meeting a 'predictable end' (Razack 2014: 54). In the colonial, colonised city, Aboriginal people are '*in* the city but not *of* it' (Razack 2014: 55, emphasis added); this is seen clearly in the gentrification of areas such as Redfern and Surrey Hills in Sydney's inner city, where 'Aboriginal presence must be continuously policed' (Razack 2014: 55). This exclusion has been practised over generations, from the missions and reserves to housing commission estates – spaces that are 'in the city but not of it', where residents are 'deprived of services, private space, and public space, the latter accomplished by a policing that makes of the streets a militarized zone for Aboriginal bodies' (Razack 2014: 69). We have seen this play out in the lockdown of housing commission flats in Victoria, where most residents are Indigenous, Bla(c)k, or Brown (SBS News 2020). Thus, we see the racialised spatialisation of Aboriginal people in their own homes, as well as in the settler's cities.

This is exacerbated by government policies that seek to further racialise and criminalise Bla(c)k bodies. The Suspect Target Management Plan (STMP) was a NSW policing initiative that categorised 'suspects' via arbitrary measures such as a person's risk of offending or number of previous contacts with police (Bastable & Sentas 2016: 16). This style of 'targeted policing' is predicated on the idea that it reduces crime; however, there is little evidence that this is actually the case (Bastable & Sentas 2016). In practice, being a person subjected to STMP means having police – sometimes even riot police – surveilling your every move, whether in public places or in your own home. The

use of STMP was disproportionately applied to Aboriginal youth (Bastable & Sentas 2016) – yet another form of racialisation and exclusion.[19]

It is argued that violence is both gendered and racialised and operates spatially in areas designated by the law to be spaces of impunity (Razack 2000). Using the murder of Pamela George and the subsequent trial of her killers, Razack (2000: 94–5) highlights the removal of history throughout the trial – a removal that obfuscated the role of the 'colonial project' in the designation of respectable and degenerate spaces. Pamela George, a Saulteaux (Ojibway) woman, was 28 years old when she was viciously and savagely murdered by two white men in 1995 (Mallick 2020). Ms George was kidnapped, raped and beaten before being left face down on the side of the road. Her killers received a sentence of six-and-a-half years for manslaughter (Mallick 2020). Using the tragic death of Pamela George to illustrate her argument, Razack (2000) argues that in the law's refusal to accept the designation of respectable and degenerate spaces as anything other than 'naturally occurring', the hierarchies and violence of the ongoing colonial project are hidden (Razack 2000: 95). When 'various legal and social constructs' naturalise these hidden spatial designations, this serves to highlight what the law poses as 'white respectability and Aboriginal criminality' (Razack 2000: 96); it is these designations that allow for the simultaneous over- and under-policing of Bla(c)k neighbourhoods, and the gentrification of white ones. It is these spatial designations that underpinned the creation of reserves and missions. It is the designation of respectable and degenerate spaces that saw an Aboriginal woman, assumed to be a 'drug addict', refused admittance to the emergency department at a Melbourne hospital and left outside on the ground, alone and

[19] The Law Enforcement Conduct Commission (LECC) recently released a report into the use of STMP by NSW Police. Found to be intrusive and disruptive, the use of STMP was identified as being applied to Aboriginal and Torres Strait Islander young people in a discriminatory way, bordering on 'serious misconduct'. The program will continue to be used on adults; however, the use of STMP to target children and young people has now been paused. See Rose (2023).

semi-conscious (Hayman-Reber 2020). The violence inflicted on these women was one of patriarchy, but it was also intrinsically colonial (Razack 2000: 107). When Pamela George's killers removed her from the city limits, they occupied a racialised space, in which law is suspended and violence may occur with impunity (Razack 2000: 116).

Again and again, the law enables the construction of Aboriginal bodies as spaces of violence, an aberration in the (white) spaces of civility of the colonial state (Razack 2000: 118) that must be removed violently. In this way, whiteness is protected and reproduced (Razack 2000: 129), designated as respectable by structures of law that uphold the colonial project. We saw this gendered dimension of racialised violence play out in the inquest into the death of Yamatji woman Ms Dhu. Ms Dhu was just 22 years old when she was taken into custody for defaulting on fines. She arrived at Port Hedland lock-up with 'broken ribs, a developing case of septicaemia and pneumonia' (Blue 2017: 299). She was 'rendered sick, unwell, unruly and disorderly' by the very state agents that owed her a duty of care (Blue 2017: 300). It was the indifference to her basic humanity by those charged with her care that saw her murdered via the colonial state via its arm of policing. Indeed, her death was a direct result of the nation's failure to 'learn from past mistakes' (Porter 2016: 10), a failure facilitated by the removal of history – the obfuscation of the colonial project. Perhaps some of this is to do with the way that those who die in custody are written and spoken about – as a statistic, another death in custody. In doing this, we lose sight of the person: they are denied their 'basic humanity', not honoured in the same way as many others (Porter 2016: 8) – those who are remembered as kind and sweet and generous. When an Aboriginal person dies, they are a *death in custody* – no longer a person, but a death, their memory reduced to a statistic (Porter 2016: 8), a tool to continue the state's narration of our lives and deaths.

Razack also explores the relationship between colonialism and capitalism – in the eyes of the colony, the Aboriginal body does not produce profit, and is therefore

'superfluous to a regime of capitalist value' (Razack 2014: 59), marked as surplus humanity and subjected to policing that too often ends in death, which is narrated by law as 'waste disposal' (Razack 2014: 59), a tactic of the biopolitical. Since invasion and subsequent colonisation, the inquest has been used as a tool to demarcate the Aboriginal lives worth living and those that are not. According to Finnane and Richards (2004: 99), inquests were prompted where an Aboriginal person was 'already in some kind of relation to settler society' – for example, via employment. That the colonisers were dependent on the labour of Aboriginal people helped to 'shape the view that quiet and dependable Aborigines were entitled to legal protection and the benefits of justice' (Finnane & Richards 2004: 103). For Razack (2014: 66), 'legal processes such as inquiries largely function as performances of the laws, and thus colonial society's, essential goodness – a staging of its commitment to the rule of law'. For this staging of 'goodness' to be believable, the state 'requires a parallel staging of Aboriginal difference, a difference understood as a resistance to modern life and as a descent into alcoholism and criminality' (Razack 2014: 66; Scraton & Chadwick 1986). Stories that run counter to these narratives are strongly discouraged throughout the inquest (Razack 2014:7 1), removing ownership of the person's story from their loved ones and handing it over to the state. The inquest records the 'strangeness' of Aboriginal life, infantilising Aboriginal witnesses while valorising police (Razack 2014: 74). Razack (2014: 74) recounts the remarks of the coroner that Aboriginal witnesses are 'transient' and hard to contact. Incidentally, several of the participants in a previous study (McCabe 2019) used these exact words to speak of Aboriginal people as interested parties and witnesses called during coronial investigations in New South Wales. If nothing else, this serves to illustrate that the colonial narrative exists across space and time.

If the inquest acts as a regime of truth (Foucault 1980; Razack 2015), whereby personal truths and experiences are weighed and examined, carefully curated to form the

'absolute truth' (Scraton 1999: 274), then the 'process of marginalisation' serves to inform how those truths should be weighted (Scraton & Chadwick 1986: 94). People are sorted into a continuum, classified as rough or respectable, dangerous or conforming, undeserving or deserving (Scraton & Chadwick 1986: 94). For Scraton and Chadwick (1986: 95), where a person sits on this continuum has very real consequences, particularly in encounters with state agencies. This continuum informs how we construct identity, and this has a particular salience in terms of the coroners court: to understand the phenomena of contentious death investigation, we must first understand how the negative reputation is constructed via the continuum (Scraton & Chadwick 1986: 95). It is precisely where a death is controversial or contested that we see the continuum of identities employed. The deceased is placed on the continuum, their negative reputation established by the state, whereby the person who has died ultimately becomes responsible for their own death (Scraton & Chadwick 1986: 101) – a coronial, colonial, narrative of dysfunction (Razack 2011) – further marginalising and even criminalising the families of the deceased (Coles & Shaw 2006: 137). We saw this with the death of David Dungay Jr, the death of Aunty Tanya Day, the death of Rebecca Maher, the death of Tane Chatfield and many, many more. By utilising the 'negative reputation', it is understood that the person contributed to their own death, typifying previously contentious deaths as 'non-controversial – a 'normal or acceptable death' of an already marginalised person (Scraton & Chadwick 1986: 101), absolving the benevolent state of any role its actors may have played. By deflecting blame in this way, the state exposes its own 'institutional unwillingness' to approach deaths in custody as manslaughter or murder, creating a 'culture of impunity' and signalling to the community that in these instances state actors are above the law (Coles & Shaw 2006: 138).

This regime of truth (Foucault 1980; Razack 2015: 69) facilitates the 'contemporary colonial relationship', which is both 'racially and spatially organised as

one between modern subject and those who must be assisted into modernity' (Razack 2012: 908). Racially, Aboriginal people are constructed as 'vulnerable, rather than colonised' (Razack 2012: 910). Spatially, the Aboriginal body is 'so inextricably linked to the land that is stolen' (Razack 2012: 919) that it must be governed, either by the 'spatial fixing of whole categories of people so that they stay on reserves where life is so often not tenable' or by being scattered 'to skid rows where dying is the order of business' (Razack 2012: 928). Law, via the inquest, manages this governing of Aboriginal bodies, where the narrative of vulnerability and intransigence legitimises the settler-colonial state: 'not only did we do right stealing the land, but we need to keep doing it, they can't look after it' (AIGCLU 2011). This allows for 'attention' to be presented as 'care'; Razack asserts that 'while living, Aboriginal bodies can consume the attention of two or three state officials, including police officers, health care professionals, social service workers, and so on' Razack 2012: 927), promulgating the appearance of the benevolent state. Yet the Aboriginal men, women and children who die in custody (or, ironically, in *care*), 'are not people on whom considerable care has been lavished' (Razack 2012: 927). Rather, as seen in so many deaths of Aboriginal people, if anything is 'lavished', it is a callous indifference that kills (Razack 2012: 925).

Razack (2015: 58) positions the coronial inquiry as a structure of governance – a colonial process that, through a medicalised framework, masks the ongoing violence of the settler-colonial state. It is through the coronial inquiry that the colonial regime is legitimised as 'caring, civilised and modern, persons with the moral authority and knowledge to save Indigenous peoples from themselves' (Razack 2015: 59). Conversely, Indigenous populations are relegated by this governing structure to the realm of the intransigent, the abject, the 'less than human' (Razack 2015: 59). By positioning Indigenous people in this way, they become something that the colonial state must 'rescue', a suffering that must be ameliorated by the goodness of the state. It is this process

that creates an *us* and a *them*, a process of demarcation in which Indigenous peoples become the racialised Other. It is this Otherness that forms the basis of settler-colonial identity (Razack 2015: 60).

Razack illuminates the concept of 'Otherness' and the violence of the colonial state by exploring the death of Frank Paul, a Mi'kmaq man, and the subsequent coronial inquiry that investigated, and ultimately narrated, his death. Frank Paul was taken into police custody on 5 December 1998 and was left by Vancouver police in a cold wet alleyway where he later died (Razack 2015: 57). The inquiry focused on alcoholism, and the 'callous indifference' displayed by one of the police officers in particular (Razack 2015:5 8). When asked whether the 'less than ideal relationship' between Vancouver City Police Department and the local Aboriginal community was a factor in not pursuing a coronial inquest into Mr Paul's death, former Coroner Jeannine Robinson claimed to be 'offended' by the question (Razack 2015: 68). When comparisons between Mr Paul's death and that of another Indigenous man, who died just one month earlier, were made to Ms Robinson, she responded that she had been 'taught to treat each death as an individual matter' (Razack 2015: 68), obfuscating systemic failings. Razack (2015: 68) describes responses such as these as expressing the

> *individualism that pervades law, and they amount to a wilful denial of the pattern of violent responses to Indigenous peoples. To bring the violence into view requires attention to what collectively happens to Indigenous people.*

That colonial violence exists is without question. It is the ways in which the inquiry and the coronial inquest function as structures of colonial governance that maintain the settler-colonial state as the benevolent protector of the racialised Other, masking colonial violence as care wasted on abject lives – a regime of truth that serves to 'define the Aboriginal problem' (Razack 2015: 69).

It is this critical examination and understanding of (colonial) coronial processes that underpins and provides the framework of understanding for this study. The coronial systems operating across jurisdictions in the settler-colony called Australia must be understood as an arm of the state, a tool – or indeed weapon – only able to function as it does because of the continued structures of colonisation that affect almost every facet of the lives and deaths of Aboriginal people.

The next section of this chapter provides an overview of the literature as it relates to the experiences of the bereaved more broadly. Focusing largely on the United Kingdom, the next section moves from the general to the specific – from the experiences of families more broadly to the experiences of those in Australia.

2. The literature: A global phenomenon

The relationship between 'truth and justice' (Scraton 2013: 7) is perhaps never quite so fraught, or at least so complex, as it is in the coronial inquest. This is particularly true for contentious deaths, played out daily in the media and producing a 'daily diet of allegations and counter-allegations' (Scraton 2013: 7). The coronial inquest seeks to establish the 'truth', sorting through contrasting versions of 'truth' from a multitude of perspectives (Scraton 2013: 7). Whose 'truth' is given most weight varies according to 'hierarchies of credibility' (Becker 1967): victims and families at one end, state officials at the other. When 'crises in legitimacy' occur, challenging the 'political and ideological representations' of the state, the inquest can be utilised to 'represent failure as temporary, or no failure at all' (Burton & Carlen 1979, cited in Scraton 2013: 8).

Considered by some to be perhaps a cynical view of the coronial space, instances such as the inquest that followed the Hillsborough disaster in the United Kingdom serve as a reminder of the capacity of the state to 'engage in discourses of deceit, denial and neutralisation that protect and exonerate those in positions of power' (Scraton 2013: 24).

We see this time and again in inquests into deaths in custody, wherein the inquest is little more than a 'convenient mechanism of legitimation for the state' (Scraton 2013: 8). Rather than justice, understood in this instance to be truth, accountability and acknowledgement (Scraton 2013: 23), the coronial inquest too often serves as a site of injustice.

A number of studies have sought to highlight the often traumatic experiences of families engaged with the coronial system; however, few studies are limited to New South Wales and fewer still seek to explore the specificity of experiences with the coronial system for Aboriginal people, or Indigenous peoples more broadly. This section discusses a selection of these previous studies, organised around central issues experienced by almost all who have contact with coronial systems across jurisdictions, with much of the literature emerging from the United Kingdom. The discussion then moves from the broader coronial context to those studies focused on the experiences of Aboriginal people with the coronial system.

Common issues across coronial jurisdictions

Across coronial jurisdictions, we see a number of the same issues preventing families from meaningful participation in the coronial investigation into the death of their loved one, including but not limited to delays, lack of information and poor communication. The inquest itself has been described by some as 'interfering with necessary grief work' (Biddle 2003: 1033), with delays between a death occurring and the culmination of the coronial inquiry a key source of distress for many bereaved families (Spillane et al. 2019). Often, families do not understand why there is such a delay, leading many to 'fearful speculation' and a sense that the coroner is 'keeping things' from them, further complicating the grieving process (Biddle 2003: 1041). These delays can be as range from 12 months (Spillane et al. 2019), to a few years (Biddle 2003), to five years or more (McCabe 2019).

Where the coroner is investigating the circumstances surrounding a missing person, this can be even longer. A study by Dartnall and Goodman-Delahunty (2016: 624) found that it can take more than 20 years from the date a person has disappeared to the time the coroner closes the investigation. These delays, whether 12 months or 20 years, are often 'traumatic' and 'tormenting' for the bereaved and grieving families who are left waiting (Dartnall et al. 2019: 9), particularly when the reasons for the delays are not communicated to the families. This speaks to the importance of regular communication – in Dartnall et al.'s (2019: 10) study, participants explicitly articulated that 'frequent communication about the reasons for delays' would have improved their experience of the coronial process. People do not want to feel as though their loved one has been forgotten.

Timely and forthcoming communication can empower families to better understand what is happening, and why. Where families have regular communication from the Coroners Court, they can feel 'better prepared for' and 'less anxious' about the inquest process overall (Dartnall et al., 2019: 12). Bereaved families who have pre-inquest opportunities to receive and clarify information, as well as opportunities to ask questions about coronial processes, value these opportunities (Dartnall et al. 2019: 7). The information provided by the coronial investigation itself is highly valued by the bereaved (Ngo et al. 2020: 486), with inquests in particular understood as a way to ensure that 'all possibilities of accumulating information had been exhausted' via a thorough investigation (Ngo et al. 2021: 461). The coronial inquest can be viewed as the 'final chance to uncover the truth' and to 'set the record straight about how and why the death occurred' (Ngo et al. 2021: 453–4). Further, access to adequate information about the death allows the bereaved to apportion a degree of blame, thereby enhancing their understanding of 'why the fatality occurred' (Ngo et al.2020: 482).

Conversely, inquests can be experienced as 'distressing' for those who do not have these opportunities for information and engagement, particularly concerning coronial processes and systems (Dartnall et al. 2019: 5). A lack of information is a source of 'fear and anxiety' for many – not surprisingly, a lack of information and indeed proactive contact from the Coroners Court can cause significant 'distress', 'pain' and 'anger' (Dartnall et al. 2019: 7). For the bereaved, 'foreboding' and 'apprehension' about the inquest can be driven in large part by the lack of information about the inquest and related coronial processes (Spillane et al. 2019: 4). This lack of information not only causes considerable distress in the lead-up to the inquest, but can heighten the possibility of a traumatic inquest process (Spillane et al. 2019: 7). Where there is inadequate information and preparation provided to those bereaved both prior to and during the inquest, this can result in 'differing agendas' between them and the coroner, and a 'mismatch' between what they hoped the inquest would achieve and its 'actual legal scope' (Biddle 2003: 1041–2). A lack of communication and information provision to bereaved families can also mean they are not accessing supports. In a study by Dartnall et al. (2019: 8), interview participants were not aware that support services were available, and it was noted that the 'absence of timely referrals to counsellors was a source of concern', illustrating the importance of timely information and communication with families.

Of course, the way information is communicated to the bereaved also plays a significant role. A 'non-judgemental' approach by coroners and other Coroners Court staff minimises harm to family members that may be caused by perceived insensitivity (Dartnall et al. 2019: 14). For many, the quality of their experiences throughout the coronial process was predicated on the ability of staff at the Coroners Court to understand their grief (Dartnall et al. 2019: 5). Where families feel the system has failed to 'acknowledge their personal tragedy', this reverses their 'path through grief', 'resurrecting[ing] painful emotions' (Biddle 2003: 1036, 1039). Too many bereaved

identified feeling as though their grief was 'poorly understood' and felt pressured to utilise the coronial process to attain 'closure' (Dartnall et al. 2019: 5), resulting in their withdrawal from available support services. This is a significant outcome when considering the importance that access to support, and thus information, has, as well as how this strongly influences the quality of experience for families (Dartnall et al. 2019: 5). Too often, the bereaved feel anger at the inquest process, perceiving that 'no attempt had been made to disguise the reality that their enormous personal tragedy was no more than routine administration', a 'conveyor belt of inquiries' (Biddle 2003: 1038).

This can be especially true for those who are required to appear as witnesses in the inquest into their loved one's death. Not one of the participants in Biddle's (2003) study had received information in preparation to appear as a witness in the inquest, described by Biddle as placing 'their status as a witness … above their identity as a grieving person' (2003: 1038). The ways in which the coroner and other legal actors in the inquest questioned these bereaved witnesses also caused feelings of immense guilt, and many resented 'losing control of the story to a stranger' by being restricted to yes/no answers (Biddle 2003: 1040, 1037), with some participants describing the coroner as 'unsympathetic' and 'heartless' (Biddle 2003: 1038). The public nature of the coronial inquest itself can prevent families from preserving the 'intimate details of their loved one and the circumstances surrounding the death', sometimes resulting in feelings of shame (Spillane et al. 2019: 6). The need for the bereaved to preserve their knowledge of their loved one also highlights the importance of maintaining some sense of control over the narrative presented about the deceased, privileging their private knowledge of the person who has died (Chapple et al. 2012: 233). Maintaining a sense of control over the narrative presented about their person can be a key determinant in people's experiences of the coronial investigation, and particularly inquests. Indeed, the decision of the High Court in

Annetts v McCann ([1990] 170 CLR 596) recognised that relatives of a deceased person have an interest in preserving the reputation of their loved one (Freckelton 2008a: 20).

It is all the more difficult to participate in coronial proceedings without legal representation, particularly at the coronial inquest. Families that feel 'empowered to participate' in a coronial inquest have access to legal representation (Ngo et al. 2021: 457). This active participation can lead to a 'stronger sense that justice had been attained', and can result in families being more likely to 'trust and accept the final inquest findings' (Ngo et al. 2021: 457). In contrast, families that did not have access to legal representation during the inquest felt 'excluded from proceedings', and perceived that they were 'unable to have their voice heard' (Ngo et al. 2021: 457). These families 'often became vulnerable' during the inquest process, particularly as they felt unable to challenge witness statements, thereby limiting their satisfaction with the inquest process overall (Ngo et al. 2021: 460). This, in turn, led these families to feel as though justice had not been achieved (Ngo et al. 2021: 457). Unfortunately, families are too often dependent on community legal services for representation, or faced with paying huge amounts of money for private representation, because Legal Aid is not typically available for coronial matters (Walsh et al. 2022: 8), except where there is significant public interest. Coroners themselves have stressed the importance of 'providing the deceased person's family with legal representation', highlighting the role this plays in empowered participation (Walsh et al. 2022: 8).

It is clear that where families receive proactive communication and timely information, assisted by legal counsel, they are far more likely to have a positive experience of the coronial investigation, even when delays do occur. Where this does not happen, it contributes to counter-therapeutic coronial practice, further traumatising the bereaved (McCabe & George 2021). This is even more pronounced where deaths occur

in contentious circumstances – for instance, following a death that occurs in the custody of the state.

Deaths that occur in state custody

The complexities of coronial investigations are further exacerbated when examining the circumstances of deaths that have occurred in state custody, whether in correctional facilities, police custody, during police operations or in the various forms of state 'care'. These deaths are reportable to the coroner in New South Wales as per the *Coroners Act 2009* (NSW). Those held in any form of state custody become dependent on their captors to provide a duty of care; those in custody are unable to meet their own needs, instead having to rely on the state to provide basics such as food, medication and medical attention. Persons in state custody, particularly correctional facilities, have significantly poorer health than the general population, thus increasing the need for due diligence from those employed by the state to provide a basic duty of care (Freckelton 2009: 169). When a person dies in state custody, both the public and the family of the deceased have legitimate interests in learning about the circumstances that contributed to the death (McIntosh 2016: 141). The coronial inquest then provides a seemingly independent and inquisitorial space for an open investigation of said circumstances. However, the scope of the inquest can limit its efficacy, particularly for families who seek to hold person/s accountable for the death (McIntosh 2016: 142). Indeed, 'what is not investigated … is not opened up to scrutiny' (McIntosh 2016: 142–3).

When a person dies in custody, all the key issues affecting bereaved families are magnified: the delay between the time of death and the culmination of the inquest; the provision (or lack thereof) of information about the circumstances of the death and inquest process; and the impact of poor communication between state agencies, including the Coroners Court, and bereaved families all intersect with the specificity of a death occurring in state custody. Families seek transparency and accountability, which are often

thwarted by the limited ability of the coroner to attribute responsibility to agencies or individuals. This is made all the more difficult for Aboriginal families, for whom the mechanisms of the state cannot be separated from the ongoing structures and destruction of colonialism in this place. Many Aboriginal families reportedly feel that institutional racism plays a significant role in determining the adequacy of inquest proceedings and subsequent outcomes (Allison & Cunneen 2023: 250). The Coroners Court, as an instrument of the colonial state, is inherently racist – indeed, it 'fails to acknowledge and respond to [Aboriginal Peoples'] perspectives and experiences, ultimately reinforcing and reproducing harmful experiences of racism and colonialism' (Allison & Cunneen 2023: 251). The state, ultimately responsible for the deaths that occur in its 'care', becomes a site of administrative violence (Whittaker 2021), with the Coroners Court 'indivisible from other State institutions' such as police, healthcare, and child welfare – all sites of continued colonial violence (Allison & Cunneen 2023: 251).

Administrative violence at the hands of the coroner and the coronial system occurs in other jurisdictions too. In the United States, death investigation is a 'patchwork of medical examiners, freelance experts, and elected coroners with no medical training' (Dewan 2022). Yet, their decisions and findings can have significant consequences for families and communities. It is therefore crucial that they adhere with integrity to their quest of determining the cause and manner of death of a person's death. Gaby et al. (2021) argue that coroners, while appearing as neutral actors of the state, actually shape the possibilities of legal action following a death and contribute to the 'white construction of Black death' (Gaby etal. 2021: 2), particularly in the Postbellum South of the United States. In their view, coroners are empowered to facilitate 'white racial dominance' through their work by 'constructing white innocence'. This might also be understood as the state, via coronial functions, controlling the narrative concerning the person who has died, their loved ones and their communities. Their study examined the ways coroners

have been mobilised to 'rationalise sensational acts of collective violence', such as 'racial terror lynchings', and, contemporaneously, via the police violence exerted on Black bodies (Gaby et al. 2021: 2). The authors assert that this behaviour goes beyond a concern for the 'immediate interests of individual whites implicated in lethal violence', arguing that 'these exculpatory efforts serve to sustain a broader ideology of white innocence and institutional legitimacy' (Gaby et al. 2021: 2). Situating this within a broader context of medical racism and the 'normalisation of Black morbidity' – both insidious forms of epistemic violence – the authors argue that these 'distortions reify a racist caricature of People of Colour as always already sick, uniquely susceptible to death, and thus relatively incapable of an untimely or suspicious demise' (Gaby et al. 2021: 9). Moreover, too often deaths that occur in custody in particular are presented as in some way deserved – for example, the death of George Floyd and the subsequent post-mortem findings. An independent autopsy found that Floyd died of mechanical asphyxiation – he was suffocated to death by an external source. The coroner in this case, however, twisted these findings, designating the cause of death as 'cardiopulmonary arrest *complicating law enforcement subdual*, restraint and neck compression' (Gaby et al. 2021: 10, emphasis added). Here we see clearly how coroners can shape the narrative in such a fashion that not only exculpates the actions of state actors, but presents the death as Floyd's own fault.

We see this too in the designation of 'natural causes' as the contributing factor to many deaths. Post-mortem procedures and the pathologists who conduct them are not immune from bias. Kolsky (2020) notes that post-mortem procedures must be viewed within their specific historical contexts. Giving the examples of India and the United States, both of which were subjected to colonisation, Kolsky (2020) suggests that post-mortem procedures use the 'idea of the inwardly weak, the unknowingly frail', and the invisible phenomena of underlying health conditions, and that this in turn is used to exonerate 'white murderers who kill out of disregard for Black lives'. Indeed, recent

research by Shapiro and Keel (2022) appears to support this idea of racialised constructions of death. Studying the case files of post-mortem procedures conducted on 59 deceased persons who died in county gaols, they found that 44 per cent of these deaths had been attributed to 'natural causes' despite all but three of the deaths involving law enforcement actors. When examined along racial lines, 74 per cent of the deaths of Black persons in the sample were attributed to natural causes, whereas only 14 per cent of the deaths of white persons were described in this way. Importantly, all but three of the deaths investigated involved law enforcement agents, and 54 per cent of those deceased had evidence of physical violence on their bodies (Shapiro & Keel 2022).

Cultural considerations and the coroner

In addition to the many barriers to effective participation described above, the culture of the bereaved and how well, if it all, this is recognised in coronial decision-making can have a bearing on the entire coronial process. A crucial and timely study by Aspin et al. (2024) sought to build a picture of how, and the extent to which, coronial investigations are meeting the needs of bereaved Māori in Aotearoa. Conducting interviews with coroners as well as a review of coronial files, the authors identified several points at which coronial processes may be improved. A significant finding emerged from evidence extracted from communications between the coroners court and the family of the deceased, their whānau, concerning post- mortem practices and cultural protocols. Where post-mortem procedures are required, this delays the return of the *tūpāpaku*, the body of their loved one, and thus the grieving rituals, or *Tangihanga*, that must be performed to protect the *mana* (respect) of the *tūpāpaku* and their *whānau* (Aspin et al. 2024: 314). This can be incredibly distressing for grieving families and, while coroners in Aotearoa are aware of this and appear to be accommodating, it was not until the introduction of the *Coroners (Access to Body of Dead Person) Amendment Act 2018* (NZ) that coronial legislation explicitly recognised Tikanga Māori (the cultural protocol and responsibilities

of Māori). Not only does this now legislatively acknowledge Tikanga Māori, but the amendment also requires coroners to consider the 'ethnic origins, social attitudes or customs, or spiritual beliefs of the dead and their immediate family' (*Coroners (Access to Body of Dead Person) Amendment Act 2018* (NZ)). Despite this important legal recognition, Aspin et al. (2023) noted that coroners continue to engage only rarely with *whānau* to gather evidence, relying almost solely on documentation. Where there was communication with families, it was full of legalese, or legal terminology, effectively creating a barrier to understanding and thus meaningful participation. This then can be understood as 'a means of sustaining colonising behaviours that contribute to power inequalities faced by Māori' (Aspin et al. 2024: 329).

A report released by the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (Dudgeon et al. 2023) also notes the importance of cultural recognition in coronial processes and decision-making. A key feature of this report is the inclusion of people with lived experience of the coronial system: bereaved family and community members, coronial staff and coroners. The report highlights that 'all lived experience workshop participants, coroners, and staff agreed that strong understanding of Aboriginal and Torres Strait Islander cultures, and skills and knowledge to work compassionately and effectively with Indigenous family members are fundamental to the coronial role' (Dudgeon et al. 2023: 6). Indeed, the recommendations from this report are all imbued with cultural safety and cultural recognition – reforms needed across key areas. For instance, they note the impetus for coroners and court staff to improve their knowledge about Aboriginal and Torres Strait Islander cultures, including improving knowledge about kinship structures and cultural protocols. Maintaining adequate and appropriate contact with the bereaved is also described as an issue of cultural responsiveness, and there is a need for identified roles within the court to ensure culturally appropriate support. The recommendations urge policy-makers and coroners to embark on a form of truth-

telling, restorative justice and reconciliation by encouraging the jurisdiction to 'be willing to consider radically different coronial approaches' (Dudgeon et al. 2023: xi). At its heart, the report recognises the capacity of cultural recognition and safety in improving the experiences of Mob with coronial systems across Australian jurisdictions.

These cultural considerations appear across multiple jurisdictions and shape the lived realities of Indigenous families in coronial systems. The next section turns to scholarship that documents these experiences across Australia, before narrowing to NSW-specific literature.

Experiences of Aboriginal and Torres Strait Islander peoples across jurisdictions

The above section described some of the common issues experienced by almost all families who become entangled in the coronial system. This section begins to narrow this down, focusing specifically on the experiences of Aboriginal and Torres Strait Islander Peoples, before moving into a discussion of the experiences of Aboriginal peoples in New South Wales.

In their 2020 article, Newhouse et al. sought to identify the experiences of Aboriginal and Torres Strait Islander families across Australian jurisdictions. They have provided valuable insights into the failings of coronial systems nationally, and it is to their findings that we now turn. For Newhouse et al. (2020), the narrow scope of coronial inquiries is a key failure of the system. Aboriginal and Torres Strait Islander peoples have long fought for systemic changes to encourage the coronial system to both recognise and adequately comment upon the nature of state violence, and its impact upon Aboriginal and Torres Strait Islander peoples. Overwhelmingly, families want accountability for the death of their loved one – that someone be identified as having contributed to, or indeed directly caused, a person's death (Newhouse et al. 2020: 77). When this is denied via coronial processes, the system can appear 'complicit in their loved one's suffering', particularly in the refusal of a 'critical narrative of deaths in custody' (Newhouse et al. 2020: 78).

While the authors do note the very few instances where systemic issues such as racism have been explored in coronial settings, most coroners across Australian jurisdictions continue to avoid systemic issues in their proceedings (Newhouse, Ghezelbash & Whittaker 2020: 79). Where the full circumstances of a person's life and death are obscured via a reluctance ofcoroners to critically examine the ongoing effects of colonisation, this can surely only lead to a distrust of coronial processes, and a deep disappointment in the resultant outcomes. When the structural, systemic, and violent nature of colonialism is removed, then the deaths of Aboriginal and Torres Strait Islander Peoples can only ever be our own fault (*see* Section One*;* Razack 2015). However, there are a number of immediate practical concerns that can be addressed swiftly.

For Newhouse et al. (2020: 81), three key areas must be addressed sooner rather than later to achieve improved outcomes for Aboriginal and Torres Strait Islander families exposed to the coronial system: the barriers to family participation; the overly adversarial nature of coronial proceedings; and the reluctance of coroners to apportion blame and make recommendations in response to identified systemic issues. Despite a growing body of literature outlining the importance of meaningful family participation in coronial proceedings, across Australian jurisdictions this is often reduced to narratives about the deceased person's life, amounting to a 'façade of participation' (Newhouse et al. 2020: 81). Family members are thus marginalised, relegated to the sphere of 'sentiment rather than substance', creating 'new sites of trauma' (Newhouse et al. 2020: 81). This marginalisation is further entrenched when considering the lack of supports available to families experiencing the coronial system: despite (minimal) support being available via organisations such as Legal Aid NSW and the Aboriginal Legal Service, there is little information available for families about who to contact and when (see also McCabe 2019). Support from organisations such as these is also diminished by their lack of resources, increased demand and lack of institutional knowledge – for example, the

Aboriginal Legal Service does not have staff dedicated to coronial inquests (Newhouse et al. 2020: 82).[20] This means solicitors are often learning about coronial processes as they go (McCabe 2019).

The lack of legal supports for families is further exacerbated by the often adversarial nature of coronial inquests. Despite coronial investigations being inquisitorial by nature, inquests themselves are 'increasingly run in an adversarial manner' (Newhouse et al. 2020: 82). Combined with the lack of meaningful participation and lack of support, many families feel as though 'they are on trial', and 'and that the process is more about suppressing their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice' (Newhouse et al. 2020: 82). This is further highlighted by the disparities in resources available to families when compared with the resources employed by state actors and agencies. Many families have crowdfunded in recent years to attend the inquest of their loved one. Many inquests are held in metropolitan areas, requiring families from remote, rural and regional areas to pay large sums over extended periods of time for travel and accommodation in order to attend (Newhouse et al. 2020: 83).

The reluctance of coroners to address systemic issues in the scope of inquests is further complicated by a seeming reluctance to apportion blame for the deaths of Aboriginal and Torres Strait Islander people. This is true even where an individual or individuals may be clearly responsible for the death occurring. We have seen this in the death of David Dungay Jr, where a number of corrections officers held him down, asphyxiating him while he screamed that he could not breathe. For bereaved families, the apportion of blame should be a key consideration of coronial investigations – where an individual or individuals are not identified as being responsible for a death, it is even more important to critically examine the systemic issues, such as racism, that contributed to the

[20] The Aboriginal Legal Service NSW/ACT has now established a dedicated coronial unit for deaths that occur in custody. See https://www.alsnswact.org.au/deaths_in_custody.

death occurring (Newhouse et al. 2020: 83). As well as the deep disappointment felt by families (Newhouse et al. 2020: 83), the failure to adequately address both systemic and individual failings stifles the preventative function of coronial recommendations, enabling deaths in similar circumstances to occur again and again.

Although studies such as that of Newhouse et al. (2020) draw on experiences across several jurisdictions, their findings are directly relevant to the NSW context and provide an essential bridge between national patterns and NSW-specific evidence.

From the general to the specific: The coronial jurisdiction in New South Wales

A study by McCabe and George (2021) critically explored the experiences of Aboriginal families with the coronial system in New South Wales specifically, albeit through the eyes of the coronial professionals who work with these families. The occurrence of significant delays and the impact on bereaved families have been a theme throughout the literature discussed above, yet in New South Wales the delay between time of death and the beginning of an inquest continues to grow (McCabe & George 2021: 215). Delays of three to four years were most commonly described by participants in this study, with three participants noting delays of five or more years (McCabe & George 2021: 215). These delays were described by participants as 'compounding grief', 'retraumatising' and 'extremely distressing' for bereaved family members. One participant felt that these delays signalled a lack of respect to the families of the deceased, commenting: 'If you've got to wait five years for an inquest, how much respect do you think you're getting?' (McCabe & George 2021: 215).

The lack of timely and appropriate information was also a key concern shared by participants in this study (McCabe & George 2021). Indeed, every participant in this study found the lack of communication from the Coroners Court to be a 'significant barrier for families engaged in the coronial system', with participants calling the lack of

communication ‘atrocious’ and a ‘failure’ (McCabe & George 2021: 215). Certainly, ‘informed families are empowered families’; however, the participants stressed that ‘the complaint from families is that … no one’s giving them enough information’ (McCabe & George 2021: 215). One participant described the devastation and trauma that the lack of communication has on families, describing instances where families do not know where the body of their loved one is, and the difficulty in obtaining this information (McCabe & George 2021: 216). Surely this is a prime example of the counter-therapeutic impacts of poor communication. Some participants also cited a lack of community knowledge about the coronial system more broadly, with many of their clients having ‘little to no knowledge about the coronial system’ (McCabe & George 2021: 216).

Many participants recognised the impaired ability of the coronial system to fulfil its potential as a therapeutic process due to the severe lack of funding afforded to it in New South Wales (McCabe & George 2021). The lack of funding was understood by participants as evidence that the coronial system is ‘not a political priority’, and demonstrable of a ‘lack of political impetus’ (McCabe & George 2021: 216). As stressed by McCabe and George (2021: 217), the ability of the coronial system to enact its legislated responsibilities in a timely and therapeutic fashion is hampered by the extreme lack of adequate resources and funding. For many of the participants interviewed, the coronial system in New South wales was experienced as ‘under-resourced’, ‘under-funded’ and ‘under-everything’ (McCabe & George 2021: 216).

A further significant finding made by McCabe and George (2021) concerns the lack of a mandatory reporting mechanism by which to respond to coronial recommendations, a finding not fully explored in the previous literature presented here. In 2021, a Premier’s Memorandum[21] was issued outlining the process for government

[21] M2021-08 NSW Government submissions and responses to inquiries.

agencies and ministers regarding responding to coronial recommendations. A minister or NSW government agency must acknowledge receipt of coronial recommendations within 21 days. They are also required to notify the Attorney-General of any actions being taken in response to the recommendation/s, or reasons why no action is to be taken, within six months of acknowledging receipt of the recommendation/s. This, however, does not apply to private organisations or agencies, or to individuals, and McCabe and George (2021: 216) highlight this as a significant failing contributing to the stifled potential of the coronial system, asking:

> *What is the point of having a legislated death-prevention function if there is no way to hold State, and private, agencies accountable for responding to recommendations? What was the point of legislating, across all Australian jurisdictions, to give the coroner the capacity to make recommendations to prevent deaths if there is no mechanism for implementing those recommendations?*

This frustration was also felt by the participants in this study, many of whom felt as though they represent families in the same kinds of cases 'again and again', who were 'growing increasingly frustrated' at the seeming futility of coronial recommendations (McCabe & George 2021: 216). This frustration is certainly only magnified for bereaved families, many of whom hope that 'some good will come from the death of their loved one' (McCabe & George 2021: 217). Indeed, McCabe and George (2021: 217) argue that the power of coronial recommendations to prevent death can only be fully realised where they 'operate in tandem with purposefully designed accountability mechanisms to oversee the implementation or otherwise of coronial recommendations'.

While the literature discussed here is by no means exhaustive, it does serve to highlight commonalities in the experiences of bereaved families. Whether they are bereaved by suicide, grieving for those missing or those lost to workplace fatalities, or in

the context of state violence and colonialism, all families desire to uncover the 'truth' of their loved one's death. As evidenced by the above literature, much of what we know about the experiences of families with the coronial system is fairly general in nature, without any obvious consideration for cultural specificity and systemic issues, with the exception of the studies focused on experiences of Aboriginal and/or Torres Strait Islander people's experiences. I argue that to provide a best practice coronial system in New South Wales, we must understand the specificity and requirements of those with whom the system is having disproportionate contact, including systemic barriers to participation and the ongoing impacts and structures of colonisation. The next section will outline some of the key reports, reviews and inquiries that have taken place over the last couple of decades. We will look first to Victoria, whose coronial system is paving the way and moving toward having a best-practice coronial system, and who in many respects has been a model for New South Wales to aspire to. A discussion of the use of Practice Notes and Protocols in coronial jurisdictions is also touched on in this section. This section will also discuss two recent NSW reports: the findings of the NSW Parliamentary Select Committee inquiry into the coronial system and the statutory review of the *Coroners Act 2009* (NSW).

3. Reviews, reports, parliamentary inquiries and protocols/practice notes

This section will outline a selection of pertinent reviews, reports and parliamentary inquiries concerning the coronial jurisdictions in Australia. Starting with a key report into the Victorian coronial system, we will then look to the Legislative Council Select Committee inquiry into the coronial system in NSW and then consider the reform responses that follow these diagnostic processes, including the use of coronial Practice Notes and Protocols as internal mechanisms for operationalising change. The chapter also examines the recent review of the *Coroners Act 2009* (NSW). The Victorian report is included here as the Victorian system has been a leader in Australia for coronial reform.

Victorian report into the Coroners Act 1985 *(Vic)*

In 2006, the Law Reform Committee of the Victorian Parliament released its report into the *Coroners Act 1985* (Vic). The report sought to recognise the distinctiveness of the coronial jurisdiction, particularly the specific functions of the inquest and 'their potential to alleviate community concerns' and 'respond to family members' needs' (Freckelton 2006: 151). The report made a total of 138 recommendations, heralding a 'new generation of coronial reform' (Freckelton 2006: 152). Among the committee's recommendations were those pertaining to the verification of a person's death; the inclusion of psychiatric health outpatients and those in residential care or supported services in the definition of a 'death in care'; and the abolition of the privilege against self-incrimination (Freckelton 2006: 153–4). The report 'embraced the public health model of the coroner', especially in the avoidance of preventable deaths (Freckelton 2006: 154). It further recommended that coroners be empowered to refer 'findings and/or recommendations to any individual or agency' and require from that individual or agency a written response within six calendar months (Freckelton 2006: 154). It was recommended that these agencies include as a bare minimum government departments or agencies, as well as incorporated companies (Freckelton 2006: 154). Further, it was recommended that the State Coroners in Victoria be able to request further information or explanation in regard to the implementation of coronial recommendations (Freckelton 2006: 154). This allowed for a new degree of accountability to be built into the legislative framework.

The report has been described as a 'high quality', 'carefully reasoned', 'product of considerable consultation' (Freckelton 2006: 155). Not only has the public health capacity of the coroner in Victoria been expanded, but the State Coroner has the capacity to mandate responses from those who are the subject of coronial recommendations (Freckelton 2006: 155). This is an enormous step forward, a shift towards accountability not only for the families of the deceased and the wider community, but for coronial

jurisprudence more broadly, and perhaps signals the introduction of a therapeutic jurisprudential lens. Therapeutic jurisprudence recognises that legal phenomena – laws, processes, procedures, actors – can have either therapeutic or anti-therapeutic effects on the people who experience them (McMahon & Wexler 2002: 1). Rather than a rigid and precise framework, therapeutic jurisprudence is considered by some as a flexible approach that enables us to better identify and understand the impact of law and legal processes on people's psychological and emotional wellbeing (McMahon & Wexler 2002).

Indeed, an important aspect of mandating a response to coronial recommendations is the courts' capacity for therapeutic jurisprudence. Mandatory responses to recommendations would enhance the 'therapeutic potential for family members to be able to draw comfort' that there has been a positive outcome of the inquest or investigation (Freckelton 2007: 252). A record of coronial recommendations and the responses to those would also allow for 'data-based evaluation of the extent to which coroners' recommendations are implemented', as well as acting as a 'quality control mechanism' (Freckelton 2007: 251–2). While the first and foremost function of the coroner is to make findings about how deaths occurred, and to whom (Freckelton 2007: 246; see also *Harmsworth v State Coroner* [1989] VR 989), the making of recommendations represents a 'constructive and positive functioning of the law', 'explicitly attempting to manage social risks and reduce the potential for lethal outcomes' (Freckelton 2007: 245). Freckelton (2007: 244) argues that there may be 'adverse consequences' for the community if 'suitable remedial action is not taken to respond to [coronial] findings and recommendations', yet making it mandatory to respond to coronial recommendations remains a 'revolutionary' step (Freckelton 2007: 251). This is supported by McCabe and George's (2021: 215) study, which found that lack of an accountability mechanism leads many to see the coronial process as futile.

Legislative Council Select Committee Inquiry into the Coronial System in New South Wales

The specificity of place, and thus legal jurisdiction, set the parameters for the Legislative Council Select Committee on the Coronial Jurisdiction in NSW (2022; hereafter the Select Committee). The Select Committee was established following concerns raised during the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody during 2019 and 2020 (2021). The Select Committee made 35 recommendations pertaining to the coronial jurisdiction, including the urgent need for resources to reduce delays; to provide more timely information to the bereaved; better supports; and improved accountability and oversight of responses to coronial recommendations. In November 2022, the NSW Government responded to the Select Committee's findings, addressing each of the 35 recommendations put forward by the Select Committee (McCabe 2022). Despite receiving submissions from many Aboriginal families, professionals and academics, only a handful of the recommendations applied to the experiences of Mob – these recommendations were 'noted', not 'supported', thus the government has acknowledged that the recommendations have been made; however, it will take no further action (McCabe 2022). Many of the systemic failings affecting bereaved Aboriginal families will therefore continue to occur, despite the state having the knowledge and opportunity to correct these failings. It is therefore crucial that we continue to provide evidence of how the system is failing the bereaved, placing pressure on governments to make the necessary reforms. This reqires a specificity of research that can begin to build an evidence base in the NSW coronial jurisdiction.

As mentioned above, the limited research available suggest that Aboriginal and Torres Strait Islander people are being disproportionately affected by failings in the coronial system. Aboriginal and Torres Strait Islander peopleare more likely to die a

reportable death – one that is reported to the coroner, such as suicide, homicide or accidental death – than non-Indigenous Australians (Carpenter & Tait 2009: 34). Aboriginal and Torres Strait Islander people are also less likely than non-Indigenous Australians to receive appropriate, or even adequate, medical care (Allam et al. 2019). Further, both the families of the deceased and the police investigating on behalf of the coroner bring particular, specific relationships to death investigations, which is likely to affect how Indigenous families experience the coronial system (McCabe 2019).

Statutory review of the* Coroners *Act* 2009 *(NSW)

A statutory review of the *Coroners Act 2009* (NSW) was recently completed. Led by the Department of Communities and Justice, at the request of the NSW Attorney-General, the review sought to determine the validity of the policy objectives of the Act, and whether the Act remained appropriate for meeting those objectives. Overall, the review found that the Act was valid in meeting those policy objectives; however, it noted the inadequacy of the Act in providing a complete overview of the processes and procedures of the coronial jurisdiction. The review recommended a number of amendments to the *Coroners Act 2009* (NSW):

1. Establish the coronial jurisdiction as a standalone court within Local Court framework.
2. Modernise the policy objectives of the coronial jurisdiction.
3. Strengthen the death-prevention role of the coroner;
4. Assist in reducing inefficiencies in the current framework by recognising the prominence of coronial investigations and providing mechanisms to formally finalise the coronial process where matters do not go to inquest.

5. Better support deceased person's family by recognising impact that coronial investigations and proceedings have on them, enabling their views to be considered and recognising the need to consider different cultures and religions when making decisions under the Act.

6. Promote consistency in decision-making under the Act.

7. Enhance the transparency, effectiveness and accessibility of the coronial jurisdiction.

8. Make the Act clearer and easier to understand where there currently exists some ambiguity in its interpretation. (NSW DCJ 2023: 1–2)

Specific recommendations were made that speak to each of these broad points. Of particular interest is Recommendation 2d, 'that the object of the Act be amended to recognise the importance of … the unique status and needs of Aboriginal and Torres Strait Islander peoples' (NSW DCJ 2023: 3). While a welcome amendment, this appears to be a largely vague and unenforceable aspect of the proposed amendments. Recognising the unique status and needs of Aboriginal and Torres Strait Islander people does not necessarily translate to a legislative requirement to consider relevant cultural protocols in coronial decision-making, and thus risks becoming another 'tick-a-box' exercise. 'Unique status and needs' does not adequately encompass the multitude of cultural protocols concerning death, nor does it recognise the heterogeneity of Aboriginal and Torres Strait Islander cultural groups and practices within New South Wales. Recommendation 3b (NSW DCJ 2023: 3) does seem to speak to this concern, noting that 'different cultures and religions have different beliefs and practices surrounding death that should, where appropriate, be respected'; however, in the context of the deaths of Aboriginal and Torres Strait Islander people, neither of these recommendations requires coroners to consider the ongoing impacts of colonisation and dispossession, systemic racism or cultural protocols.

The lack of specificity and vague wording may allow for a cursory nod to 'unique status and needs' of Mob without any substantial incorporation of these into coronial decision-making and processes.

Recommendation 7a(v) (NSW DCJ 2023: 4-5) asks that the Act be amended to allow medical practitioners to issue a certificate of cause of death where the person is aged 72 years or older. This may have the unintended effect of drawing more Mob into the net of the coronial jurisdiction, given that we continue to die much younger than our non-Indigenous counterparts. Recommendation 13a (NSW DCJ 2023: 6) concerns the holding of inquests, noting that deaths by suicide should not require a coronial inquest. While this is an important amendment reflecting society's changing attitudes towards suicide, and the stigma still associated with it, again this recommendation has the potential to fail our people. Aboriginal and Torres Strait Islander men and women experience higher rates of suicide than the rest of the population, and account for almost a quarter of the deaths of our young people aged from birth to 24 years (AIHW 2023). To fulfil the preventative function of the coroner, these deaths perhaps should be subject to inquest in order for recommendations to be made to prevent similar deaths from occurring.

Importantly, Recommendation 17 of the review requires that 'the definitions of "relative" and "senior next of kin" [SNOK] be amended to recognise persons who are part of a familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures)'. A huge amount of discretion is still held by the coroner to determine the most appropriate next of kin, and while Recommendation 17 (NSW DCJ 2023: 8) is a very welcome amendment, without more explicit wording in Recommendation 2d requiring coroners to do more than consider our 'unique status and needs', this may still leave families exposed to the trauma of having an inappropriate person appointed SNOK according to cultural protocols. Evidently, much more work needs to be done to ensure that the Act is culturally informed and appropriate, and this

can only happen with meaningful consultation with Aboriginal communities and Aboriginal-controlled organisations.

Collectively, the reviews, reports and parliamentary inquiries discussed above function as diagnostic interventions: they identify persistent shortcomings in coronial practice, particularly delays, inconsistent communication, uneven family participation, limited cultural responsiveness, and weak accountability for coronial recommendations. However, these processes do not implement change; they make findings and recommendations about what should change and why. It is at this point that Practice Notes and Protocols become analytically significant. Unlike reviews and inquiries, which sit outside day-to-day court operations, Practice Notes operate as internal reform instruments through which the coronial jurisdiction can operationalise expectations about process, timeliness, and engagement, often more quickly than legislative amendment.

The role of Practice Notes and Protocols as internal instruments for coronial reform

This was recognised by the State Coroner Teresa O'Sullivan, who released Practice Notes in 2021 and 2022. Practice Note No. 3 of 2021[22] concerns the case management of mandatory inquests involving deaths that fall under section 23 of the *Coroners Act 2009* (NSW). Section 23 deaths include those that occur during or following a police operation or while in the custody of police or Corrective Services. Section 2.2 of the Protocol states that '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

[22] This was issued in August 2021. It is possible that this was influenced by a letter submitted to *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* by the Aboriginal Legal Service, dated 17 March 2021. The letter implored the Coroner to issue a Practice Note to 'ensure the importance of communication with First Nations families, the cultural understanding of the Court, the efficient use of resources and the need to mandate that the ALS is contacted to provide early advice to the next-of-kin' (Warner 2021). It is important to note however that, as of 24 March 2021, the State Coroner indicated to the Committee that they were working with the Chief Magistrate to develop a new Practice Note; however, this Practice Note would focus on deaths occurring in the custody of Corrective Services.

impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss'. The Protocol recognises the complexity of Aboriginal people's familial structures when determining SNOK; however, it does not indicate who or what will inform the coroner of cultural considerations when making a SNOK determination (Practice Note No. 3 2021 s 9). The Protocol also sets out a clear timeline for the reception and dissemination of information regarding coronial matters that are deemed to be section 23 deaths. For instance, once a death has been determined to be a section 23 death, the officer in charge must provide a preliminary brief within eight weeks of the determination. Within 12 weeks of a death being determined a section 23 death, the officer in charge must provide to the coroner the full brief of evidence, and the final post-mortem report must also be provided. Sixteen weeks after the determination of a section 23 death a Directions Hearing is required to set the procedural timetable and to allocate a date for the hearing. These important considerations mean in theory that all families will have information about the death of their loved one much sooner, although further research is required to identify whether this translates into practice, and therefore lived experience.

> Following the release of the Practice Note in 2021, the State Coroner issued the Protocol *Supplementary Arrangements Applicable to section 23 Deaths Involving First Nations People*, known as the First Nations Protocol. This Protocol builds upon the previous practice note, providing supplementary arrangements for Section 23 deaths where the person who has died is an Aboriginal and/or Torres Strait Islander Person (State Coroners Protocol 2022). The Protocol begins by acknowledging that the death of an Aboriginal or Torres Strait Islander person in custody must be 'understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations Peoples' (State Coroners Protocol 2022 s 1.1). The Protocol also commits the Coroners Court to 'giving full effect' to

Recommendation 8 of the RCIADIC (Johnston 1991): '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.' This Protocol, combined with Practice Note No. 3 (2021), aims to ensure that the 'impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss' (s. 1.6 State Coroners Protocol 2022). The stated objects of the Protocol are to ensure that:

1. 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.
2. 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:
    a. Any cultural considerations relevant to the conduct of the coronial investigation and inquest, and
    b. Any issues and concerns surrounding the conduct of the coronial investigation, including concerns in relation to the circumstances of death.
3. 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
4. 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 (s. 3.1 State Coroners Protocol 2022).

The importance of seeing these objectives formalised in this way cannot be understated. Many of these objectives address key concerns that have been outlined in previous sections, including cultural awareness, access to timely information and communication. Again without further research, it is difficult to know how these objectives actually translate into practice and the lived experience of bereaved Aboriginal families.

Read alongside the literature on cultural considerations and families' experiences of delay, communication failures and exclusion, these NSW instruments are best understood as attempts to formalise cultural responsiveness and early meaningful engagement within an otherwise colonial legal framework. Yet Practice Notes and Protocols do not implement themselves. Their effectiveness depends on the human infrastructure of the court – who makes early contact, who can translate coronial process, who can navigate kinship complexity and cultural protocols and who can sustain relationships with families across long timeframes. This is where Aboriginal employment, and specifically the creation of identified roles such as Aboriginal CISP Officers, becomes central rather than peripheral to coronial reform, and it is to this workforce dimension that the next section turns.

4. Aboriginal employment and the creation of identified roles

In addition to the Protocol and Practice Note, two identified roles were created in the NSW Coroners Court: the Aboriginal Coronial Information and Support Program (CISP) Officer roles. This section situates these roles within the broader landscape of Aboriginal employment in Australia. The two Aboriginal CISP Officers are responsible for liaising with families in a culturally supportive and responsive way in matters where the person who has died is an Aboriginal and/or Torres Strait Islander person (Gooley 2022). This

follows the lead of the Victorian Coroners Court system, wherein a Coroners Aboriginal Engagement Unit (CAEU)[23] has been embedded within its practice. Introduced in 2019, the Coroners Aboriginal Engagement Unit aims to ensure that Aboriginal families are respected and supported culturally, both as individuals and as members of the oldest continuing culture on the planet (Pearson 2020). Led by an Aboriginal manager and Cultural Support Advisor, the CAEU employs both male and female staff to ensure gendered cultural protocols are followed. The CAEU also provides 'culturally focused support and advice' to coronial professionals; provides culturally appropriate supports to grieving Aboriginal families; advocates for the needs of the Aboriginal community in Victoria; and works with the Coroners Prevention Unit to improve the accuracy of identification of Mob within the system (Dudgeon et al. 2023: 28).

The creation of the Coroners Aboriginal Engagement Unit in Victoria and the two Aboriginal CISP Officer roles in the NSW jurisdiction heralds a new era of culturally informed coronership.[24] How this is experienced by the Aboriginal CISP Officers themselves has, until now, been an under researched area, and is discussed in detail in Chapter 5. The establishment of the Aboriginal CISP Officer roles has occurred within a broader context of Aboriginal employment policy. The following is an overview of the policy landscape as it pertains to the employment of Aboriginal and Torres Strait Islander Peoples in New South Wales.

The creation of the Aboriginal CISP Officer roles occurred within a specific context – the time, place and political climate converged to make the creation of these roles

[23] Formerly the Koori Engagement Unit.

[24] Funding for dedicated support roles for Aboriginal and/or Torres Strait Islander people has also been established in the Australian Capital Territory, pending advertisement. A dedicated position was filled in Queensland in late 2023 and a dedicated identified position is pending appointment in Western Australia, although it is noted that this position will be located within the State Mortuary and Bereavement Centre, not at the Coroners Court itself (Dudgeon et al. 2023: 28). South Australia, the Northern Territory and Tasmania are yet to establish funding for or positions of this nature.

possible. This section will look at a selection of the various employment strategies in force at the time the Aboriginal CISP Officer roles were created. The Department of Communities and Justice, Department of Justice, Public Service Commission, and the NSW Government[25] more broadly have all published strategies to increase the recruitment and retention of Aboriginal people in the respective workforces. These Aboriginal Employment Strategies exist within broader NSW Government approaches. Key NSW strategies inform the priority areas for departments and organisations. The Driving Public Sector Diversity Premier's Priorities (Department Premier and Cabinet 2022) applies to all state government organisations, including but not limited to the public service, the NSW Police Force, NSW Health Service, Transport Service and other Crown services.

Across all sectors in New South Wales, there are at last count 154 Aboriginal people in senior leadership roles (Department Premier and Cabinet 2022). The task of increasing these numbers is demonstrated in the above employment strategies by various relevant departments, all of which are informed by the Driving Public Sector Diversity Premier's Priorities (Department Premier and Cabinet 2022). The NSW Closing the Gap Implementation Plan 2022–2024 (Aboriginal Affairs 2022) also informs many of the strategies discussed below, with a key priority area to increase Aboriginal employment across the public sector. Last, but certainly not least, is the influence of the *Reparations for Stolen Generations: Unfinished Business Report* (Aboriginal Affairs 2020). This report prioritises cultural awareness and safety training across workplaces in New South Wales, highlighting the commitment needed from the public sector to create a 'trauma informed workforce' (Aboriginal Affairs 2020: 5). Together, these three overarching strategies have informed Aboriginal employment strategies across the public sector in New South Wales.

[25] The *Court's Strategic Plan 2022–2025* (District Court New South Wales) was also examined; however, no references were made to Aboriginal employment.

The Public Service Commission launched its Aboriginal employment strategy in 2019, centred on three core principles: to 'build a talent pipeline'; 'improve Aboriginal cultural capability'; and 'engage with our Aboriginal workforce' (Public Service Commission 2022: 4).[26] Within these three core principles are three strategic focus areas. The first refers to 'attracting and recruiting a talented Aboriginal workforce' (Public Service Commission 2022: 9). While an Aboriginal representation of 3.7 per cent of the total workforce has been achieved, these roles sit predominantly at lower pay grades (Public Service Commission 2022: 9). The second strategic focus area is centred on 'creating inclusive and respectful workplace for our Aboriginal workforce' (Public Service Commission 2022: 10). Despite the Public Service Commission's apparent commitment to diversity and inclusion, such as its self-acknowledged responsibility to provide trauma-informed training for its workforce regarding the Stolen Generations, it is admittedly failing to reach its purported goals. In the 2021 People Matter employee survey (Public Service Commission 2021), there were numerous reports of Aboriginal employees experiencing racism in the workplace, and Aboriginal community members reporting negative interactions with government services when participating in community consultations (Public Service Commission 2022: 10). The third strategic focus area seeks to 'support the career Mobility and growth of our Aboriginal workforce' (Public Service Commission 2022: 11). This focus area seeks to increase the numbers of Aboriginal people in senior leadership roles; however, it does this by relying on 'senior executive sponsors' to 'champion Aboriginal employees into more senior roles', rather than by actively recruiting, retaining and promoting Aboriginal staff members (Public Service Commission 2022: 11). These areas for strategic focus are aligned with the Priority Reform areas 3 (Transforming Government Organisations) and 5 (Employment,

[26] The terminology used here must be addressed before proceeding – the use of 'our' when describing Aboriginal people is indicative of ownership. We are not the property of the Public Service Commission or any other employer.

Business Growth and Prosperity) of the New South Wales Implementation Plan for Closing the Gap (Aboriginal Affairs 2022). The Implementation Plan seeks to document the approach taken by the NSWGovernment to implement the National Agreement on Closing the Gap (Aboriginal Affairs 2022: 3). The Implementation Plan signals to all NSW government departments and organisations that Closing the Gap is everyone's business, working closely with the NSW Coalition of Aboriginal Peak Organisations (NSW CAPO).

The Department of Justice has also developed an Aboriginal Employment Strategy for the period 2019–22, aligning with key priority areas in the Driving Public Sector Diversity Premier's Priorities (Department Premier and Cabinet 2022) aiming for a world-class public service in New South Wales. The Department of Justice has performed well in recruiting and retain Aboriginal staff, with a representation of 5.9 per cent Aboriginal employees in 2018, higher than the sector average of 3.3 per cent (Department of Justice n.d.: 2). Similar to the Public Service Commission, the Department of Justice aims to improve recruitment and employment pathways for Aboriginal people.[27] In the first of its five key areas, the Department of Justice seeks to actively recruit Aboriginal staff by building relationships with Aboriginal employment service providers, holding information events at key institutions such as universities, and proactively advertising employment opportunities (Department of Justice n.d.: 4). The second key element of the strategy relates to the retention and career development of Aboriginal employees. To this end, the Department has established an Aboriginal Staff Network and Career Development Framework that seeks to recognise and reward the talents of Aboriginal employees (Department of Justice n.d.: 5). 'Cultural inclusion and competence' is the third key strategy area. This includes providing Aboriginal Cultural Inclusion training to all

[27] Note the difference in terminology – pathways, not pipelines; no use of 'our' or other indications of ownership.

employees in the Department, as well as ensuring participation in and the promotion of events such as NAIDOC Week and Sorry Day (Department of Justice n.d.: 6).

A key pillar of this strategy area, however, is to 'promote good news stories' – an inadequate approach to addressing the systemic barriers that see too many Mob excluded from paid employment, and continuing to face discrimination and racism in the workplace. The fourth key strategy area refers to the 'senior leadership and succession pipeline', whereby the Department seeks to implement Aboriginal employment targets and other initiatives into divisional strategic workforce plans. This, coupled with a directive to 'consider developing a secondment program for high potential Aboriginal staff to act in senior leadership roles', is perhaps in need of further consideration (Department of Justice n.d.: 7). It could certainly be argued that all Aboriginal people have 'high potential' – what is lacking is opportunity. The final key area within the Department of Justice's strategy entails the reporting and accountability mechanisms. The Department commits itself to the production of quarterly reports on Aboriginal employment representation in 'the succession pipeline and senior leadership' in accordance with the requirements of the Public Service Commission's Driving Public Sector Diversity Premier's Priority (2022; Department of Justice n.d.: 8).

The Department of Communities and Justice (DCJ) Aboriginal Employment Strategy 2019–2025 is perhaps the most pertinent to the Aboriginal CISP Officer role. The Aboriginal CISP Officer roles sit within DCJ under the newly created Transforming Aboriginal Outcomes Department. Led by Deputy Secretary Brendan Thomas, this division of the NSW Government is 'dedicated to improving Aboriginal outcomes[28] in criminal justice, child protection and housing' (DCJ 2021). The DCJ, at the time of writing

[28] The use of language throughout these government strategies is interesting. What is an 'Aboriginal outcome'? Surely, they are outcomes for Aboriginal Peoples and communities? Would they write 'Australian outcome'?

the strategy, had an Aboriginal employee representation comprising 4.5 per cent of the DCJ workforce, with a goal of reaching representation of 7.5 per cent or more by 2025 (DCJ 2022: 12). In 2020, six Aboriginal people were employed in senior leadership roles, with the DCJ professing a 'goal to increase' these numbers (DCJ 2022: 11). While it is not clear how they plan to do this, DCJ does commit to ensuring that 'Aboriginal people participate on interview panels for identified recruitment and targeted roles' (DCJ 2022: 19). However, despite the relatively high percentages of Aboriginal employee representation at DCJ, 27 per cent of Aboriginal staff members reported being bullied in the 12 months leading up to the writing of the strategy (DCJ 2022: 3). Thus, representation alone is not enough to stem racist and discriminatory practices in the workplace.

It is evident that the various departments and organisations across the public sector in New South Wales are committed to building a culturally informed workforce, which actively seeks to recruit, retain and recognise the talents and perspectives that Aboriginal people bring to the table. It is within this context that the roles of the Aboriginal CISP Officers were made possible.

This chapter has provided an overview of a number of key areas. The use of critical scholarship to inform the theoretical framework applied in this study was discussed. This was followed by an overview of some of the literature as it relates to the commonalities of experiences of families across a number of coronial jurisdictions. Complementing and adding to this was a discussion of the literature as it relates to the experiences of Aboriginal and Torres Strait Islander Peoples and coronial systems across Australian jurisdictions, before bringing the focus to Aboriginal families in New South Wales. The chapter also provided information about the various changes being made in the NSW coronial jurisdiction, including the use of Practice Notes and Protocols, and provided a summary of key reviews, reports and parliamentary inquiries that pertain to Australian coronial systems, particularly in New South Wales. It also demonstrated the shift in New South

Wales to a more culturally informed model of coronership, highlighting the creation of the Aboriginal CISP Officer roles, and situating these within Aboriginal employment more broadly.

Chapter 3 describes the methodology used in this study. Beginning with positioning, locating myself within the research as an Aboriginal woman, this next chapter outlines the methodologies and research paradigm before describing the methods used to elicit the information that has informed this study.

3

Making sense of it all

There is limited literature that seeks to understand the experiences of Aboriginal families who have contact with the coronial system in New South Wales. Thus, the research question that forms the basis of this study is:

> *What are the experiences of Aboriginal families who have contact with the coronial system in NSW?*

In addition, it asks,

> *How do Aboriginal CISP Officers experience their roles, and what implications does this have for coronial practice?*

Alongside these important questions, the core aims of this research is to create a space where these experiences can be shared, and to highlight the myriad ways in which the coronial system operates as another facet of colonial violence, asking:

> *Does the coronial system perpetuate colonial harms, and if so, how?*

This chapter sets out the methodological aspects of this study. Working from within an Indigenist research paradigm requires that I first acknowledge my location as an Aboriginal person. This underpins the methodological approach to this research study, and the methods used. This chapter consists of four main sections: doing research as an Aboriginal woman; research philosophy and design; research design – surveys and yarns; and racism and social media. While not a part of the methodology or method, the racism encountered as a result of using a particular method of participant engagement was an unanticipated result of this study, and so is included here. While unanticipated in the sense that this was not something the research was designed to elicit or capture, it is unsurprising that this occurred – for many Aboriginal people in online spaces, this is a regular

occurrence. I have decided to include this finding in the thesis because it speaks to the emotional and cultural strain placed on Mob simply for existing in online spaces, and the additional trauma it may cause for those using social media as a forum for grieving and memorialisation.

Integral to this research is a frank acknowledgement of my positionality as an Aboriginal person. Indeed, Wilson (2008: 12) notes that 'relationality requires that you know a lot more about me before you can begin to understand my work'. I begin this section by locating myself as such.

Before moving to the next section, it is important to acknowledge that this study was undertaken on Darug Country. My being here is a result of the colonisation of this place, and the dispossession of the many people who were already here, just as the invasion and subsequent dispossession of Mob from my Country means I am a long way from my home. I offer my deepest respect to Darug ancestors, Elders and community, who have maintained connection to Country and to Culture. I am forever grateful for the generosity shown to me by many Darug Elders and community members, and am profoundly aware of the need to walk gently on this Country. I offer my sincere thanks to Darug Country for holding me while this work was undertaken.

1. Methodological framework: An Indigenist research paradigm

Location

Location within Indigenous research methodology is a fundamental aspect. By locating yourself, you resist colonial models of research, and signal to the community that your research is being undertaken in the hope of making things better. Location is much more than naming your Mob – it is about locating yourself within particular political, environmental and linguistic contexts, as well as Country (Absolon & Willett 2005). It is about saying: 'The only voice I represent is my own and this is where I place myself'

(Absolon & Willett 2005). I am a palawa *luna*, an Aboriginal woman whose roots lie in lutruwita/south-east Tasmania, Australia. My mother and grandma are palawa women, and our lineage flows down from my great-grandfather, all the way from Pleenperrenner of Cape Portland. I was born on Ngunnawal Country, where much of my family lives today. Although we come from a family of mariners, and have connections to the sea, I grew up on Darug Country in Western Sydney. My Grandpa is an Arrernte man from Ntaria (Hermannsburg) in the Northern Territory, stolen from his mother and sent across the country to grow up with a white family in Newcastle, a beachside town that is a long, long way from Desert Country. On my father's side, I am of Irish descent, from another colonised peoples who suffered dispossession and violence.

It is these histories, and the histories of my ancestors, that intertwine to make me who I am today. I have grown up strong in the knowledge of my Aboriginality, and the strength, resilience and responsibility inherent in being an Aboriginal person, yet I do not know my language, nor do I have an intimate knowledge of my culture. These things have been taken from me, as they have from almost every Indigenous person, through the systematic, systemic and ongoing structures of colonisation. By locating myself in this way, I assert my sovereignty as an Aboriginal woman (Behrendt 2019).

Research as responsibility

Being an Aboriginal researcher examining systems that disproportionately impact Aboriginal communities is complex. Fredericks (2008) reminds us that Indigenous research requires ongoing interrogation of our daily practices and constant attention to whether our work perpetuates bias, colonisation or racism. This is not simply an internal ethical exercise: it is a methodological commitment to respect, reciprocity and accountability to community (Fredericks 2008). Accountability requires asking difficult questions: How will this research be useful? How will outcomes be returned in ways community can use? How do I ensure the work represents us well (Fredericks 2008)?

Indigenous epistemologies are relational; they recognise interconnectedness between physical, emotional, spiritual and social domains (Lavallée 2009). This shapes how I approach data: participants' stories are not isolated "units of information", but relational knowledges tied to family, community and Country. The responsibility to community does not end when the thesis is submitted; research relationships are ongoing (Lavallée 2009). I approach this work as a steward of knowledge rather than an owner of it (Lavallée 2009).

The question of 'status' and relational trust is also important. Loppie (2007) describes how an unknown status in community can be a barrier to trust, and how extensive pre-research engagement may be required.[29] In my own work, COVID-19 fundamentally constrained those intended forms of engagement, a limitation discussed below. I have nonetheless sought to maintain the integrity of the work through careful ethics design and transparent communication, and by privileging Aboriginal voices and participant control wherever possible (Loppie 2007).

Decolonising methodologies

There exists a tremendously rich conceptualisation of what it means to be an Indigenous person within the work of Alfred and Corntassel (2005). Their focus is on the 'peoplehood model', a 'flexible and dynamic alternative to static political and legal definitional approaches to Indigenous identities' (Alfred & Corntassel 2005: 610), and how this model of understanding indigeneity might be used as a starting point for decolonisation. Drawing on the work of many Indigenous scholars (e.g. Cherokee sociologist Matthew Snipp, Tewa author and professor Gregory Cajete and Maya/Yucateco scholar Feliciano Sanchez Chan), Alfred and Corntassel (2005: 611) assert that the peoplehood model creates the foundations of the decolonisation process, which must start with the self, a shift in one's

[29] 'Status' is a commonly applied term in American and Canadian First Nations communities. It is not used in Australia. Loppie is a First Nations researcher on Turtle Island.

own thinking and actions, which over time 'manifest as broad social and political movements to challenge state agendas and authorities'. They warn against accepting the term 'Aboriginality', arguing that it is a state-centric term used to distract from decolonisation. Speaking largely from within the Canadian context, they argue that 'aboriginalism' is a legal, political and cultural discourse designed to serve an agenda of silent surrender to an inherently unjust relation at the root of the colonial state itself' (Alfred & Corntassel 2005: 598). By accepting these terms as Indigenous peoples, we are centring colonisation. Indeed, Alfred and Corntassel (2005: 601) argue that by centring colonialism, colonialism becomes the reference point, the dominant narrative and paradigm by which Indigeneity is understood, erasing the existence of Indigenous peoples outside of colonisation and (re)enforcing a view of the world based on power. By accepting definitions of Aboriginality or Indigeneity, we are accepting 'identity constructions that reflect the colonized political and legal contexts in which Indigenous peoples are forced to live and operate' (Alfred & Corntassel 2005: 605). In contrast, by exploring and utilising the personhood model, we can begin to lay the foundations for a process of decolonisation, whereby we accept our own definitions of what makes us First Nations peoples.

This idea of 'identity construction' (Alfred & Corntassel 2005: 605) also informs the work of Juanita Sherwood. For Sherwood (2009), decolonisation means first recognising and addressing the assumption that there is only one way of knowing, being and doing in the colonised state of Australia. The 'amnesic discourses of settlement fuelled by colonial assumptions of white superiority' (Sherwood 2009: 24) facilitate the construction and problematisation of Aboriginality in Australia. A decolonising approach would mean acknowledging that this dominant ontological lens has been 'historically and institutionally contrived', and is 'no longer useful or healthy for any Australian' (Sherwood 2009: 24). Indeed, it is this lack of contextualisation wherein difference is constructed as

deviance that 'creates systematic violence', forming 'frameworks of trauma, pain, grief, loss, and poor health status' (Sherwood 2009: 25). It is only through a balancing of truth and history (Sherwood 2009: 24) that a decolonising movement might begin to dismantle these frameworks of colonisation.

Indeed, decolonising ourselves and our research, particularly as Indigenous people, is a crucial element of Indigenous Standpoint Theory (Foley 2003; Nakata 2007), which is discussed in more detail below. There are clear links here between Datta's (2018a) recognition that decolonising research must be action oriented and Foley's (2003) reminder that there must be a political element to our work as Indigenous researchers. It is through our research that we can 'speak up for our rights and justice and against oppression' (Datta 2018a: 19). We must move as far away as possible from the histories of research that 'aimed to further colonial control' (Datta 2018a: 10), and move towards a research paradigm that prioritises positive outcomes for community. This is the importance of decolonisation in academia, a decolonising paradigm that demands 'an Indigenous framework and a centring of Indigenous land, Indigenous sovereignty and Indigenous ways of thinking' (Datta 2018a: 1). For Datta (2018a: 2):

> *[D]ecolonization is a continuous process of anti-colonial struggle that honours Indigenous approaches to knowing the world, recognizing Indigenous land, Indigenous peoples, and Indigenous sovereignty – including sovereignty over the decolonization process. I argue that decolonization is an on-going process of becoming, unlearning, and relearning.*

Crucial to this is the notion of unlearning and relearning. Datta (2018a: 5) highlights some of the challenges faced when researchers receive Western research training. For example, within each discipline exist specific frames of reference, methodologies, conceptual frameworks and technologies (Datta 2018a: 5), which must be unlearned in order to

decolonise our research. Of particular importance is the concept of neutrality – 'we are taught that by remaining neutral in our research, our research would be valid and predictable' (Datta 2018a: 5). How can I, as an Aboriginal person, approach my research or my participants in a neutral way? Rather, I can acknowledge that I do not occupy a neutral space, yet still value and respect the participants' sovereignty over their own knowledge, and present findings in an honest and rigorous way. It is also important to give primacy to, and prioritise, cultural and community protocols and ways of knowing, being and doing, in conjunction with academic or research guidelines (Datta 2018a: 7). This also ties into to notions of ownership – collective ownership of research is crucial within a decolonising framework (Datta 2018a: 18), as is the prioritisation of community needs and voices (Datta 2018a: 17). The *community* owns the research findings, and this is perhaps one of the most critical signifiers that distinguishes decolonising methodologies from Western research paradigms (Datta 2018a: 18). I do not do this research for myself – I do it in the hope that the coronial system can be reimagined in order to better support all families, and in particular Aboriginal families. It is to the broader Aboriginal community that the findings presented here belong.

This 'unlearning' outlined above is perhaps what Wilson (2001) is referring to, arguing that we need to move beyond approaching our research from an 'Indigenous perspective' and focus on 'researching from an Indigenous paradigm' (Wilson 2001: 175). But what might this look like? What might constitute an Indigenous research methodology in this paradigm? Wilson (2001) encourages the novice researcher towards this by first breaking down what is meant by 'paradigm'. For Wilson (2001: 175), a research paradigm is a set of beliefs about the world that inform your actions, and the ways in which you gain knowledge. It is then using your way of thinking, or epistemology, to gain knowledge about reality, or ontology, according to your own moral or ethical compass, or axiology (Wilson 2001: 175). The major difference between an Indigenous

research paradigm and a Western research paradigm is that Western paradigms regard knowledge as individual – something that an individual can own – whereas an Indigenous paradigm is based upon the 'fundamental belief that knowledge is relational' (Wilson 2001: 176). As an Aboriginal researcher working within an Indigenous research paradigm, I must ask myself '*What are my obligations?* How can I maintain relational accountability? How might I fulfil my relationship with the world around me?' After all, 'research is not something that's out there: it is something that you're building for yourself and your community' (Wilson 2001: 179).

However, no matter how much we decolonise our minds and our daily practices, we are still locked into a system of academic knowledge production, whereby the academy reproduces the 'coloniality of power' (Reyes Cruz 2012: 141). By being part of a system of academic knowledge production, we are expected to 'submit to the theoretical, methodological, and institutional cannons' so firmly in place (Reyes Cruz 2012: 146). Thus, the academy remains complicit in reproducing this coloniality of power, stifling other ways of knowing, being and doing in order to maintain the status quo. This reproduction, however, is merely a pattern, and 'patterns endure because they are collectively recognisable', 'organising social life even in the most unbearable terms' (Reyes Cruz 2012: 148). So if we are truly committed to decolonising knowledge production, or at the very least ensuring that knowledge production occurs from a decolonising standpoint, we must consistently implement 'strategies of resistance' in our daily practices (Reyes Cruz 2012: 141).

Of course, to employ strategies of resistance – particularly where they concern the production of knowledge – relies on having an understanding of who we are and where we 'fit' in the world. A useful paradigm here is Indigenous Standpoint Theory. As First Peoples, our ways of knowing, being and doing are not static or heterogenous. It is posited here that our ways of knowing, being and doing inform our Indigenous standpoint, a

standpoint that is 'produced' (Nakata 2007: 214). For Martin Nakata (2007: 214), an Indigenous standpoint:

> *is not a simple reflection of experience and does not pre-exist in the everyday waiting to be brought to light. It is not any sort of hidden wisdom that Indigenous Peoples possess. It is a distinct form of analysis, and is itself both a discursive construction and an intellectual device to persuade others and elevate what might not have been a focus of attention by others.*

In understanding ourselves and the ways in which we produce knowledge, we must first recognise that our position as social beings is constituted within, and constituted of, 'complex sets of social relations' (Nakata 2007: 216), all located within a cultural interface. The cultural interface, as theorised by Nakata (2007: 199), is a

> *multi-layered and multi-dimensional space of dynamic relations constituted by the intersections of time, place, distance, different systems of thought, competing and contesting discourses within and between different knowledge traditions, and different systems of social, economic and political organisation. It is a space of many shifting and complex intersections between different people with different histories, experiences, languages, agendas, aspirations and responses.*

All these elements shape who we are as Indigenous people, as individuals who navigate the world each day within the constraints of colonisation. The cultural interface consists of ever-changing trajectories, a site where meanings are contested and our understandings of the world, ourselves and each other are constantly being enabled, constrained and informed (Nakata 2007: 199) as both Indigenous and non-Indigenous beings. Theorising this cultural interface allows for a deeper understanding and acknowledgement of the ways in which the past and the trajectories created by past events still inform our ways of knowing, being and doing in the present. Primarily, the cultural interface is a 'site of

struggle over the meaning of our experience' (Nakata 2007: 210). It is at once deeply personal and very public – it is a 'lived location' (Nakata 2007: 210). It is at the cultural interface that knowledges are created about us, 'shaping understanding about who and what' we as First Peoples are and 'how we can be understood' (Nakata 2007: 199).

How, asks Nakata (2007: 213), do we as First Nations students and scholars 'navigate the complexities of Indigenous experience within such contested spaces'? Nakata (2007) posits that this may be achieved by using an Indigenous Standpoint Theory. First, we must recognise that we exist within spaces of contested meaning, and build communities of Indigenous peoples within these spaces (Nakata 2007: 217). Second, we must have the agency to use our knowledges to 'elevate what might not have been a focus of attention for others' (Nakata 2007: 214; 217). Third, we must acknowledge the 'tensions, complexities, and ambiguities' as the conditions that inform what is possible within the spaces between Indigenous and non-Indigenous peoples (Nakata 2007: 217). It is by using these principles that we might begin to 'unravel and untangle ourselves from the conditions that delimit who, what or how we can or can't be, to help see ourselves with some charge of the everyday, and to help understand our varied responses to the colonial world' (Nakata 2007: 217). Thus, Indigenous Standpoint Theory is not simply an Indigenous way 'of doing knowledge' (Nakata 2007: 214), but rather a 'particular form of investigation' (Nakata 2007: 215).

No discussion of decolonising methodologies would be complete without acknowledging the contributions of Linda Tuhiwai Smith. Smith's (2012) work is widely recognised as foundational to the development of decolonising research approaches, providing both a rigorous critique of Western research traditions and a systematic account of their entanglement with colonial power. Smith's (2012) work demonstrates how empirical practices were historically used to classify, essentialise and objectify Indigenous people. She outlines how ethnographers constructed racial hierarchies, how

mapping and surveying technologies facilitated territorial claims and how linguistic documentation often contributed to cultural disruption rather than preservation (Smith 2012: 47, 64, 101). These examples illustrate her central argument that research has not been a neutral academic activity, but a mechanism through which imperial systems have defined, controlled and dispossessed Indigenous communities (Smith 2012). By grounding her critique in this way, Smith shifts the field from ethical critique to an epistemological challenge, asserting that decolonisation must address the very foundations on which Western research has been built.

Equally significant is Smith's constructive contributions, particularly her articulation of Indigenous-centred research methodologies that foreground self-determination, relational accountability and community authority. She provides detailed examples of Indigenous research practices such as collective dialogue (Smith 2012: 195) and genealogical analysis (Smith 2012: 68), emphasising their intellectual rigour and grounding in Indigenous epistemologies. Her discussion of kaupapa Māori (Smith 2012: 193) research offers a particularly influential model, whereby research agendas are set by Māori communities, guided by principles such as relational connection, care and responsibility, and sovereignty. Smith (2012: 15) also highlights research partnerships where communities determine appropriate methods, manage knowledge production and control dissemination. Through these illustrations, Smith (2012) not only critiques colonial research paradigms, but establishes a substantive framework for decolonising methodologies globally, reshaping research practices across the social sciences, humanities, education, health and policy.

An Indigenist research paradigm

> *[W]e do not engage in relationships, nor are we in relationships, but we are relationships. Our very being, and the nature of reality itself, is relational.*

> *We are relationships with people and communities, with the Land, with ideas, with everything. (Rix et al 2019: 259)*

The preceding works begin to build a complex picture of what an Indigenous methodology might look like in practice, and the different understandings of its constitution. This is not surprising – given the diversity of Indigenous nations, language groups, experiences and scholars, it is likely that we will never achieve consensus on what an Indigenous methodology *is* (Nakagawa 2017: 111). Put simply:

> *Indigenous research is not one method, nor even one methodology; rather, it is as diverse and unique as the many different cultural, geographical, and linguistic spaces that Indigenous people inhabit, as distinct as individual Indigenous researchers are.* (Nakagawa 2017: 102)

Indeed, Indigenous knowledges themselves represent 'different things in different places to different people' (Nakata 2007: 185). Fundamentally, however, there is perhaps great truth in the words of Nakagawa (2017: 95–6), who posits that the 'most important questions for qualitative research done within an Indigenous world view are those having to do with the integrity and intent of the researcher'. Intent refers to much of what has already been discussed here, and can be assessed in terms of the researcher's intention to work toward what the community wants, to advocate and to conduct the research within an Indigenous paradigm (Nakagawa 2017: 104). The integrity of the researcher is assessed via considerations of respect and reciprocity, as well as the prioritisation of disseminating the research to the community in an accessible form (Nakagawa 2017: 104–5). Nakagawa's (2017) understandings of integrity and respect are based on on the works of Rigney (1999), who devised an Indigenist research methodology and set of principles that may inform a decolonised approach to research. Rigney (1999: 113) recognised the role of colonisation in the construction of research epistemologies and the 'protocols of knowledge construction', and the need to 'deracialize', or decolonise, the academy. For

the last 200 years, knowledge construction in Australia has been shaped by 'legacies of racialization' and 'colonial research ontologies, epistemologies, and axiologies' (Rigney 1999: 114), a status quo that lingers like the structures of colonisation. To combat this, Rigney (1999) borrows from the 'liberatory epistemologies' of the feminist movement, arguing that 'Indigenous Peoples must now be involved in defining, controlling, and owning epistemologies and ontologies that value and legitimate the Indigenous experience' (Rigney 1999: 114). To achieve this, Rigney (1999: 116–17) sets out the three 'fundamental and interrelated' principles that inform an Indigenist research methodology:

1. *Research as the emancipatory imperative in Indigenist research.* Perhaps a clear link can be seen here to the emancipatory elements of the feminist movement from which Rigney (1999) borrows. There must be an emancipatory imperative in Indigenist research that can support the struggle for self-determination, uncover continuing forms of oppression, engage with the 'story of survival' and acknowledge that resistance to oppression continues.

2. *Political integrity in Indigenist research.* While Nakagawa (2017) speaks of integrity to ourselves and to community, Rigney (1999) applies integrity to the political context (although some would argue that being an Aboriginal person in the colony is inherently political). He argues that we must set our own agenda for liberation from oppression, we must decide what is important for our own communities, and to the 'extent that research contributes to that agenda, it must be undertaken by Indigenous Australians' (Rigney 1999: 117). Indigenist research, when undertaken by Indigenous researchers, allows for the research to be taken to the 'heart of the Indigenous struggle' (Rigney 1999: 117).

3. *Privileging Indigenous voices in Indigenist research.* Given that 'Indigenist research is research by Indigenous Australians whose primary informants are Indigenous Australians', with the goal being to 'serve and inform the Indigenous struggle for self-determination' (Rigney 1999: 118), this principle has particular salience. By privileging not only Indigenous voices, but Indigenous knowledges and experience, we can begin the process of decolonisation not only in the academy but in our society.

By utilising the principles of Indigenist research, we are developing what Rigney (1999: 110) calls an 'anticolonial critique', whereby not only are we are better situated to decolonising epistemologies and axiologies, but we have the opportunity to create new ones. These principles are also crucial to an understanding of yarning as a legitimate decolonising methodology, a methodology as old as time. Yarning is complex, and includes the principles of integrity (personal, community and political); it is a way to privilege Indigenous voices, knowledges and experiences. The yarn itself might be understood as an emancipatory act of sovereignty, a way of defining and reclaiming the epistemology, ontology and axiology of Indigenous ways of knowing, being and doing.

In conventional academic terms, I am using an Indigenist research paradigm as the worldview that informs the methodological strategy of this study and the methods selected to conduct it. The ontological assumption underpinning this paradigm is that reality is relational: people, Country, community, history and institutions are not separate domains but are mutually constitutive (Rix et al. 2019; Wilson 2001). From this follows an epistemological position in which knowledge is produced through relationship, story, responsibility and lived experience, rather than extracted as neutral data (Martin Mirraboopa 2003; Wilson 2001). The axiological implications are ethical: research must be culturally regulated, accountable to community and oriented towards reciprocity and benefit (Rigney 1999; Rix et al. 2019). These worldview commitments then shape my

methodology: an Indigenist, decolonising research strategy that privileges Aboriginal voices, holds political integrity and pursues an emancipatory imperative in relation to colonial harm (Rigney 1999). Put simply, the methods used in this thesis are not interchangeable techniques; they have been selected because they are consistent with the paradigm's assumptions about what knowledge is, how it is produced and what ethical obligations follow from it.

This relationship between paradigm and methodology has practical consequences for research design. Because knowledge is understood as relational, the study privileges methods that preserve relational accountability and participant control. Yarning is used as the primary qualitative method because it aligns with Indigenous ways of knowing and communicating, and it enables participants to determine what matters, how it is told and what is safe to share (Bessarab & Ng'andu 2010; Martin Mirraboopa 2003). The online survey is used pragmatically as a recruitment and scoping tool (particularly under COVID constraints), rather than as the primary authority over meaning-making; it functions to open pathways into yarning rather than to replace it. Finally, thematic analysis is conducted not as a claim to objective neutrality, but as a transparent and systematic way to identify patterns of meaning across stories while remaining reflexive about the interpretive role and power of the researcher (Braun & Clarke 2006). In this way, worldview informs methodology, methodology informs methods and the entire design is held together by relational accountability and responsibility to community (Rigney 1999; Wilson 2001).

Karen Martin – Booran Mirraboopa – is a Quandamooka woman and Indigenist research scholar. Keenly aware that Aboriginal peoples are the most researched on Earth, and that this research typically presents us as 'objects of curiosity' to be 'seen but not asked, heard or respected', Martin Mirraboopa has outlined their own approach toward an Indigenist research paradigm (Martin Mirraboopa 2003: 203). Following the work of

Lester Irabinna Rigney and errol West,[30] Martin Mirraboopa (2003: 211) highlights the core of Indigenist research:

> *To represent our worlds is ultimately something we can only do for ourselves using our own processes to articulate our experiences, realities, and understandings. Anything else is an imposed view that excludes the existence of our ontology and the interrelationship between our Ways of Knowing, Ways of Being and Ways of Doing.*

Thus, for Martin Mirraboopa (2003: 206), Indigenist research must 'centralise the core structures of Aboriginal ontology as a framework for research if it is to serve us well'. Recognising that 'western research is a western practice', Martin Mirraboopa (2003: 211) notes that an 'entirely Aboriginal' research framework may not be possible; however, it is entirely possible to create an Indigenist framework that centres 'Aboriginal Ways of Knowing, Ways of Being, and Ways of Doing in alignment with' a western research framework. Martin Mirraboopa (2003) outlines a number of key ways in which this Indigenist framework might be created and maintained. First, attention must be given to research assumptions. Within an Indigenist research framework, our research assumptions must be guided at all times by the 'protection and preservation' of our Country, as well as our ways of knowing, being and doing (Martin Mirraboopa 2003: 211).

Second, attention must be given to the research question: as Indigenist researchers, we must 'seek solutions to issues we prioritise' (Martin Mirraboopa 2003: 211–12). Even our approach to the most basic task of research, the literature review, can be designed through an Indigenist framework – Martin Mirraboopa (2003: 212) reminds us that we should begin compiling our literature review by first seeking out 'primary sources of the research location', as well as sources by non-Aboriginal scholars. The research design is

[30] errol West did not capitalise his first name.

another crucial element of this Indigenist research framework. More than simply 'a matter of matching methods of data collection to the research question', the relational ontology of Mob is celebrated starting from a position of flexibility and reflexivity (Martin Mirraboopa 2003: 212). As Aboriginal people, we must ensure flexibility in our research design that can account for and adhere to cultural protocols, particularly in 'times of crisis, grieving, celebration, ritual or maintenance of relations among Entities' (Martin Mirraboopa 2003: 212). Reflexivity allows the 'space' to decolonise the methodologies taught to us via the academy, while also 'harmonis[ing] and articulat[ing] Indigenist research' (Martin Mirraboopa 2003: 212). This reflexivity also allows for proper protocols to be observed when conducting our research – there are 'codes for communication' and 'protocols for interacting' that must be observed, and that vary across nations and language groups (Martin Mirraboopa 2003: 212-3). By being reflexive regarding our own practices as researchers, we might also critically reflect on our own worldviews, and acknowledge the privilege we hold as researchers (Rix et al 2019: 264).

Data analysis and interpretation can also be Indigenised by using Martin Mirraboopa's (2003) Indigenist research framework. We must facilitate a 'voice-centred' approach, allowing people, Country and Entities to tell 'their own stories, in their own ways' (Martin Mirraboopa 2003: 213). The final element of Martin Mirraboopa's (2003: 213) framework concerns the reporting and dissemination of the research findings; indeed, 'reporting is culturally regulated through respect of protocols to others' and includes things such as using preferred language and expressions, and asking permission. The ultimate aim, for Martin Mirraboopa (2003: 213) and for me, is 'maintaining relations'.

Similarly, Rix et al (2019: 257) remind us that collaborative decision-making with community, especially Elders, is a key facet of respectful research within an Indigenist paradigm. Acknowledging that an Indigenist research framework has emerged via scholars from Australia, Canada, Aotearoa, the Americas and increasingly Africa, Rix et al. (2019:

225) caution against conflating these emerging frameworks as homogeneous – indeed, it is vital to understand the diversity of Indigenous peoples and belief systems as an Aboriginal person, and certainly 'outsiders have no right' to erase or invisibilise this diversity. Yet, commonalities exist. For instance, a 'common feature of many Indigenous peoples' ontology is that we are relational' (Rix et al. 2019: 259). Also similar are the principles of reciprocity that 'underpin Indigenous cultural and social identity' (Rix et al. 2019: 260). The principles of reciprocity imply 'collaboration, choice, and respect', so 'must be deeply embedded within the research methodology and methods' (Rix et al. 2019: 260).

To reiterate, *paradigm* is used here to refer to the worldview assumptions (ontology/epistemology/axiology) that inform the study; *methodology* is used to refer to the overarching research strategy derived from those assumptions; and *methods* is used to refer to the specific tools used to generate and analyse material (surveys, yarns and thematic analysis).

Research strategy

In order to design this research study, I had to first consider all the above. First and foremost, however, was the question: What are my obligations? Perhaps it is the way I was raised, or perhaps it is the inherent worldview of being an Aboriginal person, but at the forefront of my mind throughout this process has been my obligations and responsibilities in this space. How do I use my privileged position as a PhD candidate to benefit my community? What is the point of doing this research? Throughout this study, and from the very beginning, I have aimed to honour my obligations and responsibilities. This research has never been about me or my career – I come to this research as an Aboriginal woman with a genuine desire and goal to improve the coronial system and its processes for the Aboriginal community in New South Wales. In doing this, I must remain honest about my positionality – I am a palawa *luna,* an Aboriginal woman whose Mob is not from this place. I do not have first-hand experience of the coronial system. I do,

however, have the tools of the academy and the responsibility to put them to good use. We will return for a moment to Rigney's (1999: 116–17) three 'fundamental and interrelated' principles that inform an Indigenist research methodology, and I will attempt to explain how I have centred these in my own work, before moving to the methods employed in this study.

Research as the emancipatory imperative in Indigenist research.

I first had to ask myself two questions: What is meant by an emancipatory imperative? And what is the emancipatory imperative in this research? An emancipatory imperative must seek to empower those who are the subjects of the research (Letherby 2014) – in this case, the Aboriginal families having contact with the coronial system in New South Wales. I might also argue that the coronial system itself requires emancipation from the shackles of colonisation that continue to constrain its effectiveness. To answer the second question, I had to uncover the issues requiring emancipation. I began with the hypothesis that there are systemic issues that affect all Aboriginal families that come into contact with the coronial system. This hypothesis was informed by the findings of my Honours thesis (McCabe 2019) – findings uncovered through a series of qualitative interviews with individuals working with Aboriginal families throughout the coronial process in New South Wales. In addition, there is limited research indicating that Aboriginal people are overrepresented in coronial systems across Australian jurisdictions, so are disproportionately affected. Carpenter and Tait (2009: 29) have noted that Aboriginal and Torres Strait Islander people are more likely to die a reportable death than non-Indigenous Australians. It is also true that both the families of the deceased and the police investigating on behalf of the coroner bring particular, specific relationships to death investigations, which are likely to affect how Aboriginal families actually experience the coronial system.

Once the emancipatory imperative of this study was clear, further questions had to be considered (Rigney 1999). How can I ensure that this research supports the struggle for self-determination? Am I uncovering continuing forms of oppression and the continued resistance to oppression? Supporting the struggle for self-determination can be considered in two ways: first, that the participants of this study are Aboriginal people. This contributes to self-determination by holding a space for Aboriginal people to tell our stories and share our experiences in our way. It also means that should this research influence coronial policy and procedure, that this is driven by Aboriginal people. Second, as an Aboriginal researcher striving to improve coronial processes for Mob, I am joining the struggle for self-determination that seeks to see us have control over the social, cultural, and economic issues that affect us – specifically, the coronial processes in New South Wales. This is the first study to explore the experiences of Aboriginal families with the coronial system in New South Wales, thus uncovering the continued forms of oppression in this space – the over-representation, the disproportionate contact and the state's narration of our deaths. Crucial here, too, is the identification and acknowledgement of the forms of resistance to this oppression – the families who speak out, and the activists and academics who support families, agitate for change and uncover colonial oppression across the country.

Political integrity in Indigenist research

Rigney (1999: 117) argues that we must set our own agenda for liberation from oppression – that we must decide what is important for our own communities and, to the 'extent that research contributes to that agenda, it must be undertaken by Indigenous Australians'. When undertaken by Indigenous researchers, Indigenist research allows for the research to be taken to the 'heart of the Indigenous struggle' (Rigney 1999: 117). I am an Aboriginal woman, a palawa *luna*, and I undertake this research for Aboriginal peoples across so-called Australia. This is one little cog in the machinery of the colony that I can

work to dismantle, or at the very least work to reform. Before undertaking this research, I had to be confident that it was something the community wanted. I spoke with family, with friends, with Aboriginal scholars, academics and activists. I read the work of Aboriginal people in this space, and listened intently to those speaking out about the damage caused by coronial processes. The aim of this study was never to let it sit on a shelf – I wanted to do this research because I had the privilege and academic tools to do so, and thus it is my responsibility to contribute wherever and however I can. I believe that, for these reasons, this research has the political integrity that Rigney (1999) describes.

Privileging Indigenous voices in Indigenist research

Given that 'Indigenist research is research by Indigenous Australians whose primary informants are Indigenous Australians', with the goal to 'serve and inform the Indigenous struggle for self-determination' (Rigney 1999: 118), this principle has particular salience. I have tried to embody this principle in the design of this research study. Participation in the study is open only to those who identify as Aboriginal people. The methodology employed, including yarning, has been designed in such a way that it aims to be responsive and respectful of cultural protocols. This thesis not only presents a number of findings and pursuant recommendations, but creates a space for Aboriginal people to share their experiences and stories, and to do so in their own ways. We know what does and does not work for our families and communities, and we are the only ones who know what needs to change in order to facilitate the changes needed to enable the system to work better for us. It is via the privileging of our voices as Aboriginal people that meaningful change can occur. I must also know when to quiet my own voice – I am not from here, my Country is far from this place and I have been fortunate to have not experienced the coronial system at first hand. Therefore, I cannot speak to the issues raised, or not raised, by the family members I yarn with. What I can do is hold this space

for them, and use my position to elevate their voices for the world to hear. This is how I centre the voices of Aboriginal people in this research.

Research design and ethics

The previous section outlined the methodology used in this study, presenting information about decolonising methodologies as well as a discussion of the main methodological approach, the Indigenist Research Paradigm. This section discusses the methods used to facilitate this study, surveys and yarning. The section regarding the use of surveys also includes information about the ways in which practices regarding death, dying and bereavement are increasingly moving into online spaces. First, however, this section provides a discussion of the key challenge to the ways this study was designed, within the context of the global COVID-19 pandemic.

Study design overview

This study uses two complementary methods of data collection: an online survey and yarning. The survey was primarily a recruitment and scoping tool designed to capture broad patterns of experience and identify participants willing to yarn further. Yarning was used to elicit deeper accounts of lived experience in ways that prioritise Aboriginal communicative practice and participant control.

A note on the HREC process and COVID-19

This research study received clearance from the Human Research Ethics Committee (HREC) on 27 September 2021 (see Appendix 2). The journey to receiving HREC approval was long and onerous, and included two amendments. This section describes the process of gaining HREC approval and the challenges faced along the way. This has been

recorded in my Research Journal,[31] and it is by using the entries in the Research Journal that I am now able to reflect.

Following acceptance into the Doctor of Philosophy program in March 2020, I started my Research Journal on 4 April 2020. From this date, I entered everything relevant to the PhD journey, including attendance at webinars, the impact of COVID-19, meetings with my supervisor, Associate Professor Rebecca Scott Bray, and anything else that might be related to the research. Many entries during 2020 trace my progress toward submitting the HREC application, including considerations of sensitive interviewing, using graduated approaches within the survey tool and notes from supervisory meetings. A key consideration throughout the completion of the HREC application was the sensitive nature of the research. Because of this, the completion of the HREC application took much longer than expected – despite beginning the process in April 2020, the HREC application was not lodged until 9 September 2021, approximately 19 months after the application began. This was due to a number of factors, including the sensitive nature of the research and the determination to 'get it right'. COVID-19 also played a key role in the ways my supervisor and I were able to meet, and how frequently. Both my supervisor and I were suddenly thrust into the pandemic. We both had to navigate online teaching, home-schooling our children and the other pressures that successive lockdowns brought. From my perspective, this was an isolating time. There was no induction for commencing Higher Degree by Research (HDR) students and no way to connect with, and thus learn from, other HDR students. Juggling work, study and children during the early lockdowns was a significant pressure on both my and my supervisor's time and capacity, and this is evidenced by the fact that we met only four times during 2020. In July 2021, a second primary supervisor joined the supervisory team, Associate Professor Aunty Christine

[31] I am indebted to my supervisor Associate Professor Aunty Christine Evans for the idea to keep a Research Journal throughout my PhD

Evans. Having a co-supervisor who is Aboriginal (Wiradjuri) was invaluable, not only for my own learning and grounding but for the integrity of the research. Their guidance ensured that the study was grounded in culturally appropriate methodologies and respectful of Aboriginal ways of knowing. They helped me to articulate why certain approaches, such as prioritising relational accountability, were essential, and supported me in navigating ethical considerations unique to research with Mob. This supervision strengthened the cultural safety of the project and affirmed its alignment with community expectations and values, which was critical to producing research that is both rigorous and respectful.

Limitations

As indicated above, this research was undertaken during the COVID-19 pandemic, which dictated considerable methodological and ethical constraints on engagement with NSW Aboriginal participants. COVID restrictions negated face-to-face interaction, eliminating opportunities for on-Country engagement, informal yarning and the kind of relationship-building that sustains culturally safe research.

As a result of the pandemic conditions, cultural protocols that are central to First Nations research practice were disrupted, particularly consultation with Elders and the ability to carry out community validation processes. Of these, the inability to discuss the research with a collective such as the NSW Aboriginal Education Consultative Group was a stumbling block.

Research participation occurred during a period of elevated stress for targeted Aboriginal individuals – those who self-identified and who had experience with the NSW coronial system. At the time, members of Aboriginal communities were prioritising community wellbeing; participant anxiety prejudiced recruitment and engagement, which limited the sample size and the scope of data collection.

Relying on social media during a time when Aboriginal respondents were most impacted by isolation introduced further limitations. Introducing myself via social media as a researcher raised the question of trust in my identity – that 'connection to culture' as opposed to an invitation to have a face-to-face yarn (Kennedy et al., 2022). This method also invited random racism/racist commentary.

Regardless of these limitations, culturally responsive approaches were employed where possible, highlighting not only the challenges experienced during the pandemic, but the resilience of Aboriginal communities during the pandemic.

I used periods of lockdown to attend and complete as many webinars and as much online training as possible. For example, webinars during the Black Lives Matter protests provided a way to stay focussed on the occurrences of state violence in Australia, and the specificity of Bla(c)k deaths. The 7 Secrets of Successful HDR Students, HDR Publications Workshop and HDR Catalyst webinars were a way to connect with other HDR students, and the webinar Decolonising the University with Uncle Wilo Muwadda reinforced my focus on Indigenous research methodologies, and what these might look like in the context of the academy. I also joined the Knowledge Makers program during 2020/21, delivered by Thompson Rivers University in Kamloops, Canada. This program featured workshops on decolonising methodologies and 'keeping your voice' as Indigenous scholars. This program was particularly helpful for providing me with the language to articulate my needs as an Aboriginal researcher to my non-Indigenous supervisor. I also undertook an online course via Future Learn, focused on end-of-life care and the systems in place that inform how we understand death and dying. During the long periods of lockdown, inquests began to be livestreamed, allowing me to attend inquests remotely, such as the inquest into the death of Gunditjmara, Dja Dja Wurrung, Yorta Yrta and Wiradjuri woman Aunty Veronica Nelson in Victoria. However, ongoing lockdowns

and the uncertainty of the early days of the pandemic also meant the research study had to be redesigned, and in many ways reimagined.

Initially, I had hoped to attend community events and gatherings to yarn about and inform community members about the proposed research. Leaflets and information sheets were to be distributed at these events to attract potential participants to take part in yarns about their experiences. Core to this plan was the need to be among community, and to develop relationships and rapport with community members. This could not happen during the early days of COVID-19, nor during the many protracted periods of lockdown. Thus, it was decided that recruitment would have to shift online – but what considerations then needed to be made to ensure that an online survey would be appropriate for sensitive research? How could I interact with community to introduce myself and the research? How could visits to regional towns be moved online? Could focus groups be reasonably anticipated when we did not know when, or indeed whether, the pandemic would end? These are just some of the questions that were at the forefront of my mind during 2020 and for much of 2021. Therefore, each element of the proposed study had to be revisited, new literature about doing research online had to be sourced and read, and decisions had to be made about how the study should proceed.

In the end, it was decided that the research study would proceed in the following ways. First, engaging with community in the way initially imagined was not possible, so I designed the first point of contact, and thus recruitment, to be via social media. As discussed in Section 4 of this chapter, Aboriginal and Torres Strait Islander people are prolific users of social media (Carlson & Frazer 2015; 2021). Two social media platforms were chosen – Twitter and Facebook. Texts to accompany the survey link on each platform were carefully written, and included in the HREC application. The online survey was also devised, throwing up more questions: How long is too long when conducting an online survey? What about people who might want to participate, but have limited digital

literacy, or no access to the technology required? There were also tensions between keeping the survey as short as possible, while still trying to capture as much information as possible – this is discussed in detail in the next section of this chapter. Once HREC had approved the study, the survey went live. The following quote captures some of the anxiety I felt at that time:

> *Feeling happy about this, but also very stressed. I am not where I wanted to be – I had hoped to have a significant piece of writing together by now, but all I have are fragments … I'm very worried now that I will run out of time. Once the survey goes live, I will be open to criticism – what will the community think? Will people hate it? Will it be seen as intrusive and unnecessary? Can I manage both the intellectual and emotional/cultural load of this work? And who am I to feel this is too much, when these families have lost loved ones? I need to get the survey up and live. Another fear – what if no one does it? What if only three do? What if 3000 do and all want interviews?* (Research Journal entry, 27/9/2021)

On two occasions, I applied to HREC to amend the original application. In the first instance, the HREC application was amended to ensure that people who asked for the link to the survey, rather than finding it online, were able to have it sent directly to them. The need for this amendment arose after I was contacted directly by members of the public seeking the link to the survey. The texts in the Facebook posts were also amended to allow potential participants to skip the survey if they so chose, and to contact me directly. This created a way for potential participants who only wanted to take part in a yarn to do so, without completing the survey. These amendments were submitted to HREC in December 2021.

The second amendment was submitted to HREC in October 2022. This was in response to two new roles being created at the Coroners Court – the roles of Aboriginal Coronial Information and Support Program Officers. The creation of these roles and their

subsequent appointments provided an invaluable opportunity to speak to Aboriginal people working inside the system, and to better understand what they see as the successes and failures of the coronial system in New South Wales. This amendment, and subsequent yarns, also took the research study in a new and unexpected direction – the cultural and emotional load of being an Aboriginal person working in a death-focused role. Further, the yarns undertaken with the ACISPO also brought questions regarding the organisational structure of the Coroners Court, as well as the nature and limitations of identified roles more generally.

Thus, COVID-19 impacted this study in a profound way. From feelings of isolation and frustration to having to redesign almost every aspect of this work, the pandemic forced me to undertake research in a way that did not come naturally to me – a way that felt in many ways disconnected from community. I want to pause here to thank the participants who took part in this study during what was no doubt an isolating and frustrating time for them too. Speaking about loss is never easy, and to do so both during and immediately after a pandemic adds another layer of discomfort, and quite possibly trauma.

The next section explains in detail the shift to using online surveys as a form of recruitment. It was hoped that surveys would be a less intrusive method, especially as lockdowns prevented those early discussions with Mob about the study. Following this, the use of yarning as a methodology is discussed.

2. Methods

Surveys: A less obtrusive method?

The key recruitment tool for this study was the creation and dissemination of an online survey (see Appendix 6). Online surveys are becoming increasingly common, however the use of these, particularly by marketing companies, has led some internet users to 'consider most online surveys as little better than spam' (Hooley 2012: 39). However, as accessibility to the internet increases, online surveys can provide a low-cost and relatively

quick way to access specific populations. The restrictions implemented during the pandemic also meant surveys would be the most efficient way to reach the greatest number of people, even during lockdowns.

Online surveys for research must exemplify good practice (Hooley 2012: 39); therefore, there are a number of considerations when designing a survey tool for exclusively online use. First, is the survey tool accessible and user-friendly? Hooley (2012: 45) describes accessibility as the 'elements of the design that either prevent, limit, or enable' participants to be able to respond to the survey, whereas usability 'relates to the design features that the respondent encounters' while accessing the survey. For instance, ensuring that the survey tool is accessible for people with disabilities who may be using software to enlarge the font, or who may be using screen-reading software, should be considered carefully (Hooley 2012: 45-6). In addition, the survey should be transparent: it must be clear who is running the survey, how the data will be stored and how results shall be disseminated. This information was included in the opening page of the survey tool, ensuring that consent to participate in the study was informed. Indeed, it is vital to obtain consent from respondents prior to them commencing the survey, and this is achieved by having an introductory or welcome screen (Hooley 2012: 46), such as the introductory page to this study's survey tool. The survey should also be consistent in terms of fonts, colours and navigation tools in order to avoid disorienting the respondent (Hooley 2012: 47); this was achieved by using the Qualtrics survey creator program. Brevity is important; ideally, the survey should take no more than 15 minutes to complete lest it become too onerous for the participant (Hooley 2012: 40, 47). The autonomy of respondents is another key consideration. While having complete data sets would be ideal, making questions compulsory 'should be avoided'; this is particularly true for sensitive research where 'respondent desire for autonomy is likely to increase' (Hooley 2012: 47). While these elements should inform best-practice survey design, they are no guarantee

against challenges in recruitment and response rates (Hooley 2012: 50), which is evident in the challenges experienced conducting the survey tool for this study.

The survey tool was chosen as the primary recruitment tool for several reasons. Given the sensitive nature of the research study, the survey tool was seen as the least obtrusive way to gather participants – participants had complete control over whether or not to click the survey link. I used Qualtrics, available through the University of Sydney's licence, to design the survey tool, chosen for its clean look and question-type options. At the end of the survey, participants were invited to voluntarily leave their name and email address to be contacted for an interview about their experiences. The survey tool was advertised on a purpose-made Twitter page and a purpose-made Facebook account, both titled 'Aboriginal Families & the Coronial System in NSW' (see Figures 4, 5 and 6 below). Recent research indicates that Aboriginal and Torres Strait Islander Peoples are prolific users of social media (Carlson 2021; Carlson & Frazer 2017), so the decision was made in the early stages of the research design to use two social media platforms: Twitter and Facebook.

The proliferation of social media sites and increasing accessibility is having 'massive consequences' for how Aboriginal Peoples manage death and grief, changing the 'norms of death' (Carlson & Frazer 2021: 143; 144). This proliferation has 'extended, challenged and transformed long-held forms of mourning and commemoration', presenting 'a range of both opportunities and tensions' for Aboriginal people (Carlson & Frazer 2021: 143). A vast multiplicity of death practices are sustained by Aboriginal peoples in Australia, generally referred to as Sorry Business (Carlson & Frazer 2021:146). Sorry Business encompasses the treatment of the body of the deceased, the 'form and content' of both mortuary and funerary practices and the 'social afterlife' of the deceased (Carlson & Frazer 2021: 147). Due to the disproportionately high rates of morbidity and mortality affecting Aboriginal peoples, and larger kinship networks compared with non-Indigenous Australians, it is perhaps not

surprising, but nonetheless upsetting, that for many Aboriginal people, 'death is a constant presence in social life' (Carlson & Frazer 2021: 147).

The relational and reciprocal aspects of Aboriginal cultures are evident in the ways Aboriginal communities respond to death. For instance, the 'convergence of extensive kinship systems and the moral values around Sorry Business' bring a tremendous amount of responsibility (Carlson & Frazer 2021: 148). These responsibilities 'reaffirm Indigenous cultural identity, sustain ontological systems and cosmological orders, and are a significant expression of social autonomy' (Carlson & Frazer 2021: 148). Social media use is changing the way some of these responsibilities are undertaken, 'challenging and destabilising long-established norms around death' (Carlson & Frazer 2021: 149). This can create tensions across communities and kinship networks. In Carlson and Frazer's (2021) study, the use of social media to notify people of a death was seen as particularly problematic by the participants of the study. Typically, those closest to the person who has died will be notified first, then others, signifying and respecting the 'significance of their relation and attachment' (Carlson & Frazer 2021: 151). What social media does, however, is 'flatten' this relational order (Carlson & Frazer 2021: 151), ignoring cultural protocols and practices.

The posting on social media of the name and image of a person who has died is also particularly contentious – there are many Aboriginal communities across Australia that practise name and image avoidance, whereby sharing photos of the deceased can 'constitute a serious social offence' (Carlson & Frazer 2021: 154). However, the use of social media has also broadened the ways many Aboriginal Peoples can fulfil their responsibilities. Consoling the bereaved, a 'significant social responsibility', is no longer hampered by distance, and can be performed via social media while still being considered culturally appropriate (Carlson & Frazer 2021: 154). Social media also allows for the commemoration of the dead, with Carlson and Frazer (2021: 158) finding that many of

the participants in their study were able to mourn and commemorate their loved one through sharing of stories of the deceased via their profile page – a way to control the narrative about the person who has died. Indeed, social media can provide a 'valuable way of managing trauma and keeping the dead alive' (Bell et al. 2015: 375), and thus is perhaps perfectly suited for a survey of this nature.

The survey tool used for this research study was accompanied by the texts shown in Figures 4, 5 and 6. The Facebook text (Figure 5) is noticeably longer than the Twitter text, due to the Twitter platform limiting the length of posts to 140 characters. There is also an alternative Facebook text that was shorter in length. It was decided that having two Facebook posts that varied in length may make the survey more accessible to those who might be unable to read through large chunks of text, or who may have been 'put off' by the longer text. The longer text (Figure 5) provided more information than that in Figure 6; however, both still took participants to the same survey with the same participant information and consent request.

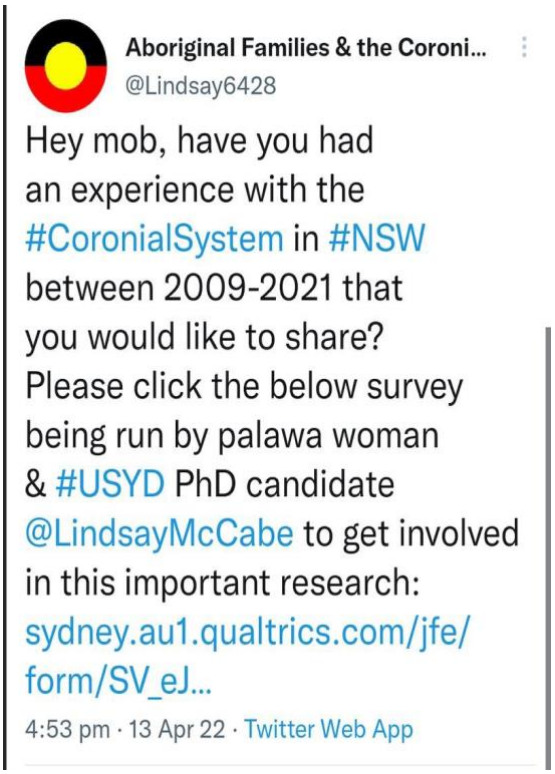

Figure 4: Twitter survey post

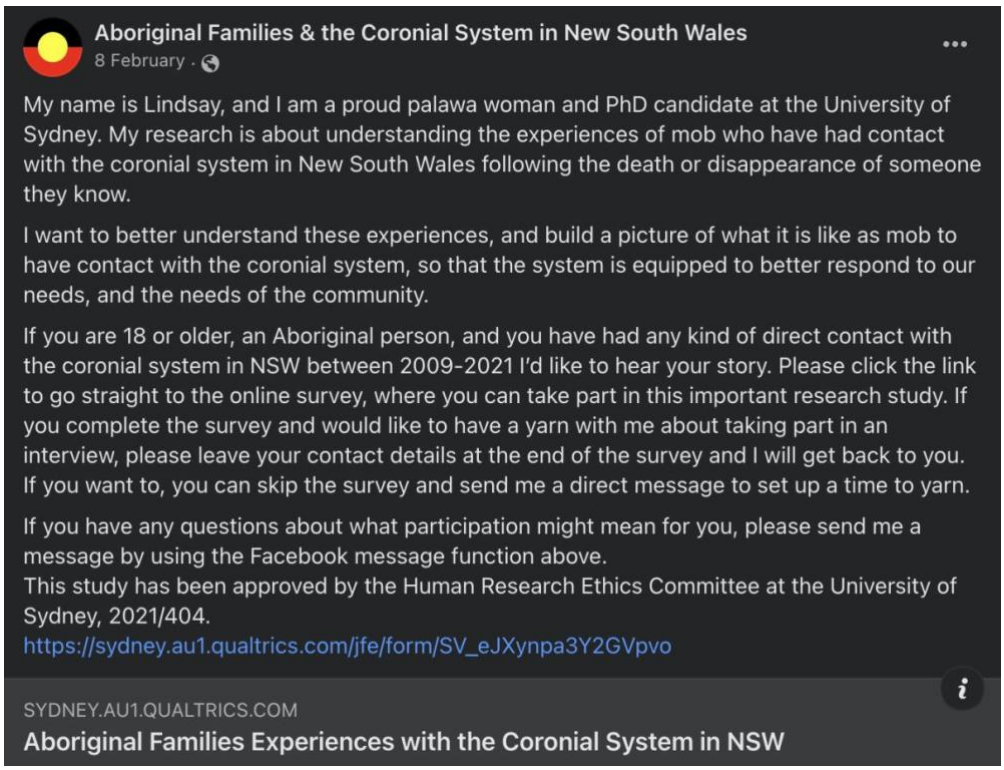

Figure 5: Facebook survey post

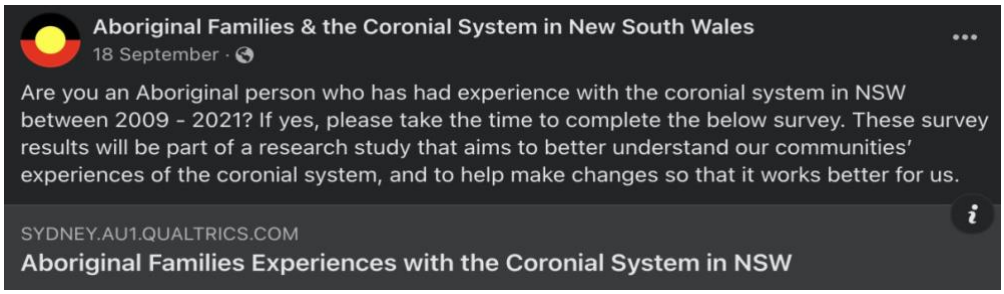

Figure 6: Facebook – alternate text

Upon clicking the link to the survey, participants were asked a number of qualifying questions. Participants had to identify as an Aboriginal person, be over the age of 18 and give consent to their survey data being used before they could proceed to the survey proper.

The survey consisted of 84 questions. While every effort was made to keep the survey as short as possible, in line with the recommendation of Hooley (2012), who acknowledged the importance of brevity, it was also understood that the survey might be the only way respondents participated in the study. Participants who responded to the

survey were under no obligation to take part in a yarn. Because of this, there were some tensions between maintaining brevity while also capturing as much data as possible.

The introduction and consent section of the survey consisted of one question. This section gave potential participants information about the study, similar to a Participant Information Sheet. Participants were then asked whether they had read the information provided, and whether they consented to take part in the survey. Respondents could not proceed to the next section without giving their informed consent to participate.

The second page outlined the structure of the survey, and provided phone numbers for both culturally specific and general support services and counselling hotlines. Given that the survey would go on to ask questions about a time of trauma in the participant's life – namely the death or disappearance of a loved one – it was appropriate and necessary to provide phone numbers for support services and counselling hotlines.

The third section of the survey asked for qualifying information: was the person completing the survey aged 18 or older and did they identify as an Aboriginal person? Should the answer to either of these questions be 'no', the participant was then redirected to a page thanking them for their interest in the survey, and notifying them that they did not meet the qualifying criteria to continue.

The fourth section, titled Part One, of the survey asked for demographic information about the person completing the survey – this included questions about the language group/s or Mob/s that they identify with, their gender, whether or not they live in New South Wales, and the date of their first contact with the coronial system in the state. These questions were asked to build a picture of who was responding to the survey – for example were more women than men completing the survey, and did they live in the state when they had first contact with the coronial system in New South Wales?

Part Two of the survey asked participants about their loved one who had died or was missing, thus necessitating contact with the coronial system. This section asked questions about the person who had died or was missing, including the person's age, the language group/s or Mob/s they identified with and the cause of the person's death in instances where the person had died. Participants were asked at the start of this section whether their loved one had died or was missing; depending on their answer, the survey then branched into two streams – the questions were similar, but referred to the person as either the person who was missing or the person who had died. Participants were also given the opportunity, by way of a 'free-text' box, to share any information they wanted to about the person who had died or who was missing.

Part Three, Section One of the survey focused on the experiences of the participant with the coronial system in New South Wales. This section had a variety of question styles; some were open-ended and allowed the participant to share their experiences in their own words. Some questions were multiple choice, and included scales such as 'Definitely not', 'Probably not', 'I'm not sure', 'Probably yes' and 'Definitely Yes'. Matrix tables were also used to elicit responses from participants.

Part Three, Section Two of the survey asked questions specifically about the coronial inquest process. The first question asked participants whether an inquest was held into the disappearance or death of their loved one. If participants answered yes, they were taken through a number of questions relating specifically to the inquest process, such as the duration of the inquest and whether or not they had legal representation. If they answered 'no' to an inquest being held, they were taken to the next section of the survey.

The next section of the survey was optional, and had a series of questions focused on the post-mortem procedures conducted on their deceased loved one. Participants were first asked whether they were comfortable answering questions about post-mortem practices. If they selected 'no', they were taken to the final section of the survey; if they

answered ‘yes’, they were directed to 15 questions concerning post-mortem practices. This section was designed to better understand participants’ feelings about post-mortem procedures, and to ascertain whether families had objected to an autopsy being conducted.

The final section of the survey asked participants whether they would like to be contacted for an interview. If they answered ‘yes’, they were asked to provide an email address and their name, or a phone number if they would prefer to be interviewed over the phone. Participants were also asked whether they had access to technology, such as a smartphone and internet, to better anticipate whether interviews could be held online, via Zoom. This was a key consideration, as the survey was designed and released during the height of the COVID-19 pandemic, so face-to-face interviews were not possible. If participants selected ‘no’ to being contacted for an interview, they were invited to leave their email address should they wish to receive information about the results of the study. Finally, participants were thanked for their time, and the phone numbers for both culturally specific and general support services and counselling hotlines were given again. The results of this survey are discussed in Chapter 4, Section 1.

The following section outline yarning as a methodology. Yarning is an important method of inquiry, and while perhaps on the surface is similar to qualitative interviewing methods, yarning is also very different. The next section discusses this in detail.

Maintaining relationality: Yarning as a method of inquiry

A way for me to maintain accountability, and to ensure the knowledge gathered in this study remains in the community, is by using yarning as a methodology of decolonisation. Yarning is ‘both a process and an exchange’, and provides an opportunity for participants to respond to the research topic in their own way (Walker et al. 2014: 1218). Yarning contributes to decolonisation by prioritising Indigenous ways of knowing and communicating in a respectful way (Walker et al. 2014). Although enormous diversity

exists among Aboriginal language groups and peoples, yarning as a way of sharing information seems to be common across this continent (Barlo et al 2020: 91). It is perhaps no surprise then that there is a growing interest in yarning as a methodology.

Geia et al. (2013) outline the ways in which research might be achieved through yarning and highlight its importance as a research methodology. I argue that yarning is indeed a methodology rather than a method, as it incorporates some of the epistemological and ontological principles of Indigenous research. For example, 'Aboriginal and Torres Strait Island yarns are rarely an individual construct; they carry within them the shared lived experience of their families, and communities' (Geia et al. 2013: 15). This is also supported by Barlo et al. (2020: 95), who state that 'when an Indigenous person shares a story, they will include their life, their life experiences', and may even 'include history from the beginning of time'. This is in contrast to individualised western conceptualisations of the qualitative interview, a method rife with 'negative Eurocentric implications' that has left a 'legacy of mistrust' (Geia et al. 2013: 13), wherein the focus of the interview, rather than the story that the participant wants to tell, is prioritised.

Bessarab and Ng'andu (2010) offer an insightful glimpse into their own research using yarning as a methodology. They acknowledge early on that many in the social sciences do not consider yarning to be a credible research method (Bessarab & Ng'andu 2010: 39), yet make a strong case for yarning as a legitimate methodology. Indeed, yarning is a culturally appropriate process of engagement in many Indigenous communities, as shown by the researcher's work in both Botswana and Australia (Bessarab & Ng'andu 2010). It is a process that 'requires the researcher to develop and build a relationship that is accountable' to those participating in the research, and is used as a way of sharing both information and stories (Bessarab & Ng'andu 2010: 38). Yarning is a 'dialogical process', 'reciprocal and mutual', and finds its strength in 'the cultural security it creates for Indigenous people' (Bessarab & Ng'andu 2010: 38, 47).

There are four key elements to yarning when used as a methodology: social, therapeutic, collaborative and research topic (Bessarab & Ng'andu 2010). Social yarning refers to the informal, unstructured yarn that takes place as a precursor, and lays the groundwork for, research topic yarning (Bessarab & Ng'andu 2010). It is more than establishing rapport – it is about locating each other as Aboriginal people, and developing a relationship whereby the researcher becomes accountable to the participant. Research topic yarning is 'yarning with purpose' (Bessarab & Ng'andu 2010: 40), although it is still relaxed and interactive and may be completely unstructured. Bessarab and Ng'andu (2010: 44) note that the shift from social yarning to research topic yarning is done both explicitly (verbally) and implicitly (behaviourally). There may also be therapeutic yarning, when a participant might disclose something particularly personal or traumatic. It is important that you as, the researcher, switch to just listening, and allow the participant the 'space to tell their story without judgement' (Bessarab & Ng'andu 2010: 45). The final element, collaborative yarning, refers to the yarns had between researchers, or between supervisor and student, whereby ideas and findings are shared and discussed. This is a reflexive space, where the researcher might reflect upon earlier yarns and the stories told within them, and what these might mean for the research and the researcher.

Walker et al. (2014) follow on from the work of Bessarab and Ng'andu (2010), building on the four main types of yarning to identify two more: family yarning and cross-cultural yarning. A way of establishing location, family yarning occurs as both researcher and participant uncover relationality (Walker et al. 2014: 1222). As discussed above, establishing location is important: we locate ourselves so that any Indigenous person reading the text will be able to situate us in relation to their own space. It is also a way of saying 'here we are and we are walking into your space, make way and don't hinder, because we have a story to tell, our story is also your story' (Geia et al. 2013: 15). Family yarning can also help the researcher to identify appropriate settings for the yarns to take

place. For example, having yarns in settings where children can be present and play helps to ensure the inclusion of women and children (Walker et al. 2014: 1222). Cross-cultural yarning refers to the communication between Indigenous and non-Indigenous researchers and participants, and 'requires specific attention to protocol and cultural respect' (Walker et al. 2014: 1223). Unfortunately, in contemporary society cross-cultural yarning often requires Indigenous researchers or participants to change the ways we communicate, rather than the non-Indigenous actors changing how they communicate (Walker et al. 2014: 1223). This is perhaps an example of the limitations of using Indigenous methodologies without changing the paradigm from which we are working, as described above by Wilson (2001). Indeed, it has been suggested elsewhere that a way to achieve this may be for 'the Western tradition to … turn towards the physical and the sacred', as opposed to 'abstracted value symbols such as money and related forms of economic capital' (Koomen 2020: 50).

Barlo et al. (2020: 90) take this methodology one step further again, explaining that yarning is structured, guided by a set of protocols and principles that provides participants 'control over the process and their stories', rather than by a rigid interview schedule. The protocols can be understood as a form of 'etiquette' (Barlo et al. 2020: 92) that must be observed. While this is perhaps an attempt by Barlo et al. (2020) to legitimise yarning within western institutions (a stated aim of the article is to establish the 'validity and reliability' of yarning), the key protocols and principles outlined are an important part of decolonising part of the research process, and indeed are a critical aspect of yarning as a methodology. The first protocol is 'gift', whereby the knowledge being shared with the researcher must be recognised as the gift that it is. The knowledge holder will know the gift is being received when the listener is visibly attentive, and values the gift being given. The second is 'control' – this applies to the participant, and allows them to control the direction, method and length of the yarn. Control over the method is important when

working within an Indigenous paradigm: as pointed out by Barlo et al. (2020: 95), it is not unusual at all for an Indigenous person to express themselves 'through drawings or some other form of physical expression'. In my own study, all participants have been encouraged to take control over the way the yarn proceeds, including opportunities to share artworks and poetry, and the level and length of participation. This leads to the third protocol: the freedom to choose how much to share and how to share it. Having control and freedom is part of the principle of self-determination. The space in which the yarn takes place is the fourth protocol, ensuring that all involved are comfortable and safe. The fifth protocol refers to inclusivity. As Barlo et al. (2020: 93) rightly assert, everyone is welcome in a yarning space. This protocol includes gender specificity. The gender, or even age, of those present may determine what can and cannot be discussed during the yarn. The observance of and adherence to these protocols is a demonstration of responsibility and integrity (Barlo et al. 2020: 93), and interacts with the key principles.

The key principles 'must be strictly adhered to' as a matter of cultural safety (Barlo et al. 2020: 93). These are reciprocity, responsibility, relationship, dignity, equality, integrity and self-determination (Barlo et al. 2020). As mentioned above, enabling participants to have control and freedom over their knowledge and level of participation can be understood in this context as self-determination. The researcher must behave responsibly and with integrity, treating the knowledge gained with the utmost respect. It is important to note here that the knowledge being shared 'was already a part of the participant's life prior to the research being introduced', and so 'remains the property of the participant' (Barlo et al. 2020: 94). It is up to us as researchers to 'give the knowledge a stronger platform from which it can be shared' (Barlo et al. 2020: 94), but this must be done with integrity and respect for both the knowledge and the participant. Ultimately, yarning is a decolonising, Indigenous methodology that is based on principles of integrity, respect and reciprocity. It is a way to decolonise the academy, and a way to assert

sovereignty. Yarning as a methodology facilitates the privileging of Indigenous voices and stories, and allows for rich descriptions, as well as providing a practical way to address the power imbalance between researcher/participant (Geia et al. 2013: 16). Perhaps most importantly, 'the non-Indigenous researcher, after listening to the yarns, will no longer consider Indigenous people as a number or statistic' (Geia et al. 2013: 16).

Yarning and thematic analysis

Thematic analysis was chosen as the core method for this study, due to its flexibility and theoretical freedom (Braun & Clarke 2006: 78). Thematic analysis can be used for a wide variety of qualitative inquiries, epistemologies and research questions (Nowell et al. 2017). At its most basic, thematic analysis requires the researcher to search across a data set to find 'repeated patterns of meaning' (Braun & Clarke 2006: 86). These patterns are not passively discovered, but purposefully identified. Indeed, Braun and Clarke (2006: 80) are quite clear that the active role of the researcher in analysing data must be explicitly acknowledged in the research. When searching the data for themes, I, as the researcher, make a number of decisions about what is included and excluded. It is therefore imperative that I am forthright and explicit in describing not only the 'how' of the data analysis process, but also the 'why' (Braun & Clarke 2006: 80). Indeed, the researcher is the instrument for analysis, therefore explicating how the data was analysed adds to the trustworthiness of the results (Nowell et al. 2017). Context is central to qualitative research (Carter et al. 2008: 1274); thus, the contexts of myself as researcher and the context in which data was gathered are key elements of analysis. It is certainly possible for one data set to engender multiple interpretations, so critical reflexivity by the researcher is an important requirement to demonstrate *how* and *why* interpretations were made in the way they are (King 2004: 257).

Critical reflexivity means first understanding my own standpoint – this has been discussed above at length. I am an Aboriginal woman, a mother, daughter, granddaughter,

sister and cousin, and have had the privilege of experiencing tertiary education. These things coalesce to inform the ways in which I understand the data yielded through both through the survey data and the yarns had with participants. Reflection on how these elements have informed my approach and understanding is a 'necessary component of knowledge production', recognising that 'different forms of knowledge … are generated by different forms of reflection' (Chiu 2006: 186). Chiu (2006) suggests that there are two primary forms of reflection – first person and second person. First-person refection is concerned with critical reflexivity, or self- questioning, whereby we interrogate our ways of knowing, being and doing to bring to the fore the 'cultural frame from which we understand or make sense of our own actions and interactions' (Chiu 2006: 195). Second-person reflection refers to the critical self-reflection that uncovers and acknowledges the power relations inherent in the researcher–participant relationship (Chiu 2006: 195). I acknowledge that while I am an Aboriginal person conducting research grounded within an Indigenist research paradigm, I am not from here; I do not know my language; and I do not have first-hand experience of the coronial system. I do, however, have the benefit of higher education and the tools of the academy, as well as the opportunity to conduct the research at hand. This means I hold a significant amount of power when undertaking yarns with participants, and indeed power over how their stories are analysed, discussed and ultimately presented. Keeping this at the forefront of my mind must remain paramount – certainly, with great power comes great responsibility.[32] I owe a tremendous debt to those who gave their time willingly to take part in either the survey, a yarn or both, and now have the responsibility to ensure that their experiences are represented truthfully and compassionately. All these things combine to influence how this study has been designed, approached and ultimately understood, and it is this reflexivity that 'affords the

[32] "Spider-Man," p. 13 (1962) ("[I]n this world, with great power there must also come—great responsibility").

"space" to decolonise western research methodologies, then harmonise and articulate Indigenist research' (Martin Mirraboopa 2003: 212).

The thematic analysis described here can indeed fall within an Indigenist research paradigm, provided the researcher – me – practises critical reflexivity. What follows now is a discussion of thematic analysis as a method. It will include examples of the themes and codes used to interrogate the data. Coding is a way for the researcher to simplify and begin to focus on distinct characteristics of the data (Nowell et al. 2017) – in this instance, the transcripts from the yarns with participants. The yarns were audio recorded, then typed by the student researcher into transcripts. The transcripts were then 'audited' – that is, they were read while listening to the recorded yarns several times to ensure they were accurate (Tuckett 2005: 80). The transcripts were then coded using key words and ideas – for example, in the yarns with family members, 'communication', 'information' and 'Country' were common codes. Different codes were used for the transcript generated after yarning with the Aboriginal CISP Officer; this will be discussed in detail in Chapter 5.

The following will outline the process by which the participant yarns were analysed. Each step will be discussed, from the first readings of the transcripts to the development of codes and themes. Finally, this section will highlight key findings of the thematic analysis, using the existing literature to better understand these pertinent issues.

As mentioned above, the yarns were audio-recorded, then transcribed by me. Transcription involved listening to the audio multiple times to ensure accuracy of the transcripts. Once completed, the audio was listened to several more times while reading through the completed transcripts to ensure accuracy. Every utterance, such as 'um' and 'uh', was included in the transcripts, as well as every pause, to capture the yarn in the transcript as truthfully and accurately as possible. In truth, sometimes much meaning can be found in the pauses between statements. Following the completion of the transcripts, each was read closely approximately five times. This was to ensure a

familiarity with the data. It was then time to begin coding. Similar comments and statements were highlighted using the same colour – for example, statements relating to 'Country' or 'culture' were highlighted yellow, while statements about coronial processes were highlighted orange. This allowed me to see the growing codes at a glance, while also illuminating codes that did not appear as often as expected – for example, 'family'. These codes were listed alongside the frequency with which they appeared. This can be seen in Chapter 4, where the findings from the yarns and subsequent thematic analysis are presented.

The above sections have outlined the methodologies and methods used to design and complete this study. First and foremost, this study has created an opportunity for the voices of Aboriginal people to be centred, while at the same time forcing me to consider my positionality. The next section discusses the unanticipated finding of this study: the racism encountered online just by advertising the study. Aboriginal and Torres Strait Islander readers, please be aware that there are some confronting materials in the comments left on the post by non-Indigenous people.

3. Racism and social media

As outlined previously, this study utilised an online survey as a primary data-collection tool, as well as a recruitment tool. The survey was advertised on both Facebook and Twitter using specially made pages and accounts respectively. The survey posts were able to be 'boosted' on Facebook, allowing for greater exposure. This greater exposure enabled thousands of Facebook users to see and interact with the posts, including being able to 'share' the post with their own friends, the ability to 'react' to the post and the ability to comment on the post. Unfortunately, most 'reactions' and 'comments' were negative, with some instances of racism. Racism is understood here as multifaceted, manifesting in 'structural, institutional, interpersonal, and internalised forms' (Ben et al. 2022: 2). The following section highlights some of the interactions recorded on the Facebook social

media platform, with an analysis of these interactions undertaken using the work of Carlson and Frazer (2015, 2017, 2021), Cunneen (2018), Matamoros-Fernández (2017) and Moreton-Robinson (2015). It is argued that the comments left on the Facebook post fall into two broad categories: criminalisation and white supremacy.

The impact of the proliferation of social media over the past few decades cannot be understated. Social media is used by billions of people the world over to connect with loved ones, to find love, to share their lives, to organise politically, to trade, buy and sell. Carlson and Frazer (2018: 1) highlight the prominence of social media in the lives of many Aboriginal and Torres Strait Islander people, noting that Aboriginal and Torres Strait Islander people 'use social media at rates higher than non-Indigenous Australians'. They warn, however, that 'being Indigenous online is no simple matter', and that interactions on social media can be both life- enhancing and sites of racism and aggression (Carlson & Frazer 2018: 1). Social media can provide online spaces for identity to be expressed and celebrated, such as through the use of flags and other iconography, and by explicitly identifying as an Aboriginal and/or Torres Strait Islander person in profile descriptions. Unfortunately, identifying as an Aboriginal and/or Torres Strait Islander person on social media platforms can attract questions about a person's indigeneity, usually based on perceptions of skin colour, as well as comments degrading Aboriginal and Torres Strait Islander people via tropes of criminality and inferiority (Carlson & Frazer 2018: 4). This can force many individuals to self-identify as an Aboriginal and/or Torres Strait Islander person on social media selectively to avoid the 'potential for vulnerability' (Carlson & Frazer 2018: 4). Issues such as these are further complicated by considerations of cultural protocols, particularly around the sharing of cultural knowledges, issues regarding cultural appropriation and Sorry Business.

In their 2017 study, Carlson and Frazer found that many of the participants were concerned about cultural practices being shared online, and gave the example of participants'

concerns regarding the sharing of cultural hunting practices (Carlson & Frazer 2017: 11). The threat of non-Indigenous people appropriating Aboriginal and Torres Strait Islander Cultures was also a key concern for their participants, as were instances where practices had been mis-identified as being grounded in Culture when they are not (Carlson & Frazer 2017: 11). Cultural protocols surrounding Sorry Business were also a key consideration. These protocols vary across Nations/Language Groups; however, the most common concern reported in Carlson and Frazer's (2017: 11) study was the sharing on social media of images and names of persons who had died, without the appropriate permissions. Where this had occurred, it could be a point of immense tension for communities and families; however, there were also instances described where social media had facilitated the fulfilment of cultural protocols following a death. Where family members live too far away to attend a funeral or other ceremony, they could still 'fulfill their cultural responsibilities across distance' by using Facebook to 'post' their condolences (Carlson & Frazer 2017: 9). Social media is also used by many as a kind of virtual cemetery, where the deceased person's profile can be viewed on anniversaries, and stories and photographs be shared. In this way, 'deceased kin were kept alive' (Carlson & Frazer 2017: 10).

However, despite the potential of social media for facilitating connections across time and space, social media is also where racial aggression lurks. Matamoros-Fernández (2017: 930) has developed the concept of 'platformed racism' to allow a deeper theoretical understanding of the ways social media can be used to (re)produce and amplify racist discourses, as well as the ways these platforms are governed, which allow the (re)production to occur. They argue that the specificity of national racism, such as that which occurs in colonised countries such as Australia, combines with the specificity of the medium – in this instance, Facebook (Matamoros-Fernández 2017: 931). Following an investigation by the Australian Media and Communications Authority (ACMA) and numerous complaints to Facebook, the creators of a Facebook page titled 'Aboriginal memes' were encouraged to

remove all content from their page. The page's memes were designed to denigrate Aboriginal people and were described as racially vilifying by many in the community, including then Communications Minister Stephen Conroy (Moses & Lowe 2012). Despite this, Facebook refused to remove the page from its platform, allowing it to remain after classifying the page as 'controversial humour' (Moses & Lowe 2012). This is a clear example of how the specificity of national racism (colonialism and systemic racism towards First Nations Peoples) combines with the specificity of the platform (Facebook) to (re)produce and amplify racist discourse with very little consequence.

With this in mind, we turn now to specific instances where the Facebook page created for this study became a space of racism. Some examples are overt, some less explicit; however, all these instances are representative of what it is like to engage with social media as a self-identified Aboriginal person. I chose not to report the posts to Facebook, instead taking screenshots before deleting or hiding the comments from other Facebook users. The names of the people who interacted with the post have been redacted.

Figure 7: 15 November 2021

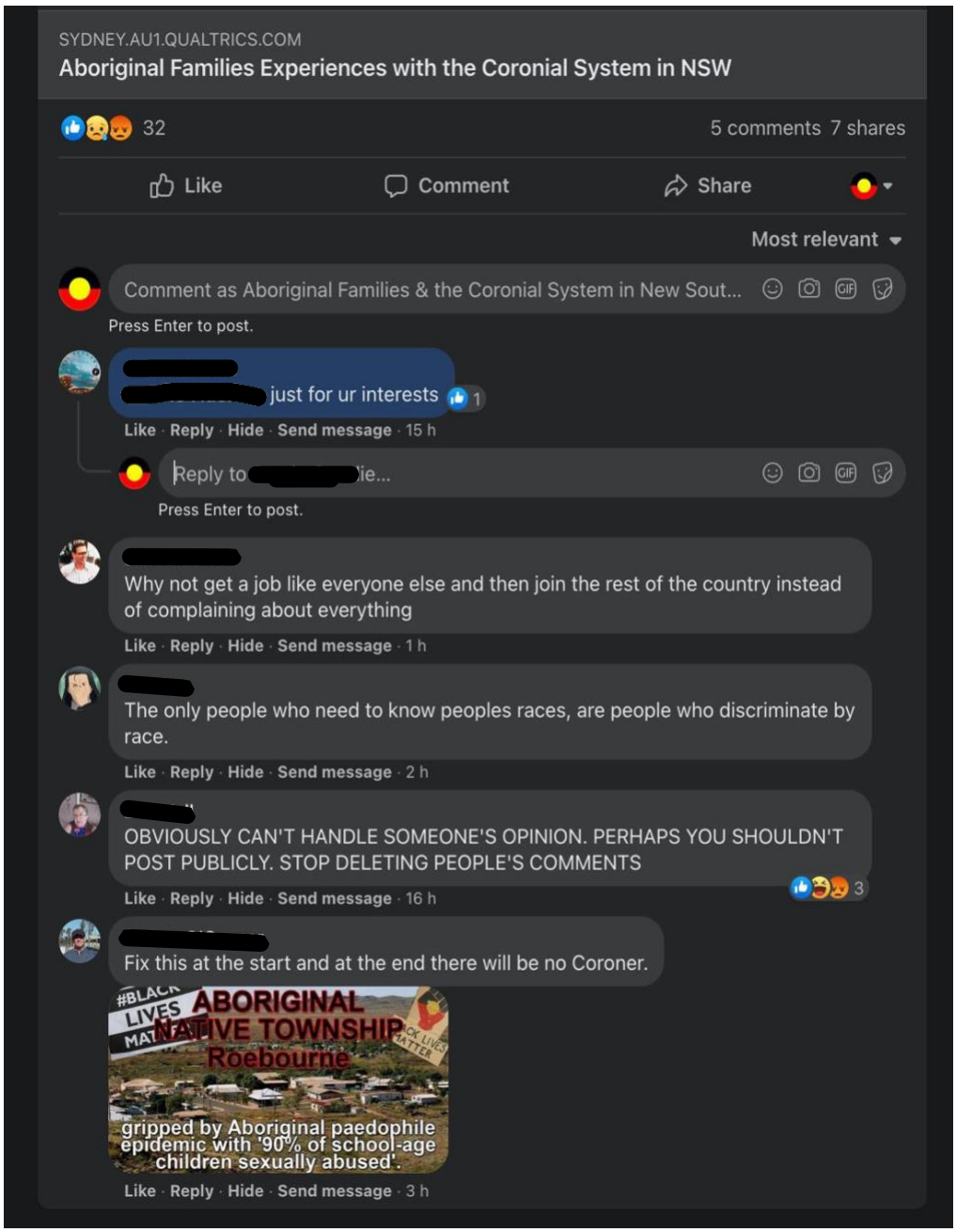

Figure 8: 16 November 2021

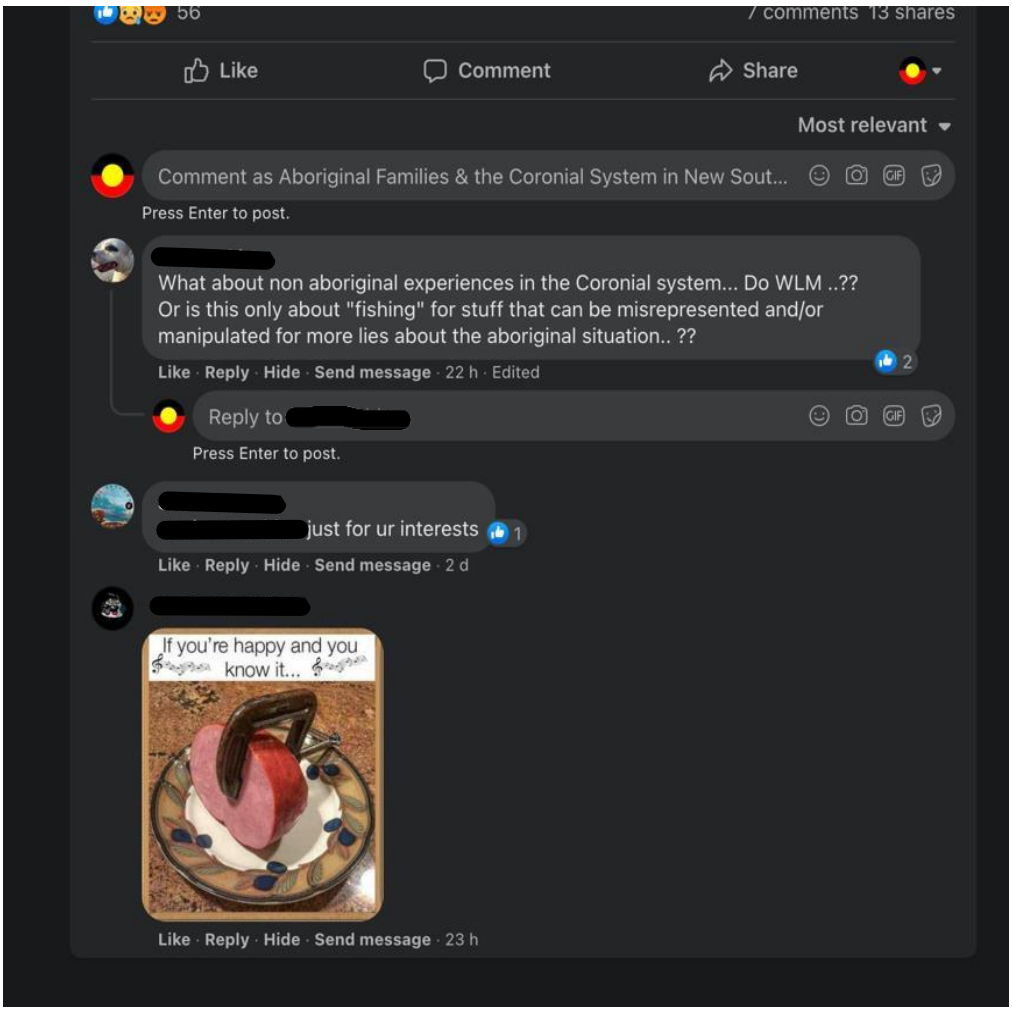

Figure 9: 18 November 2022

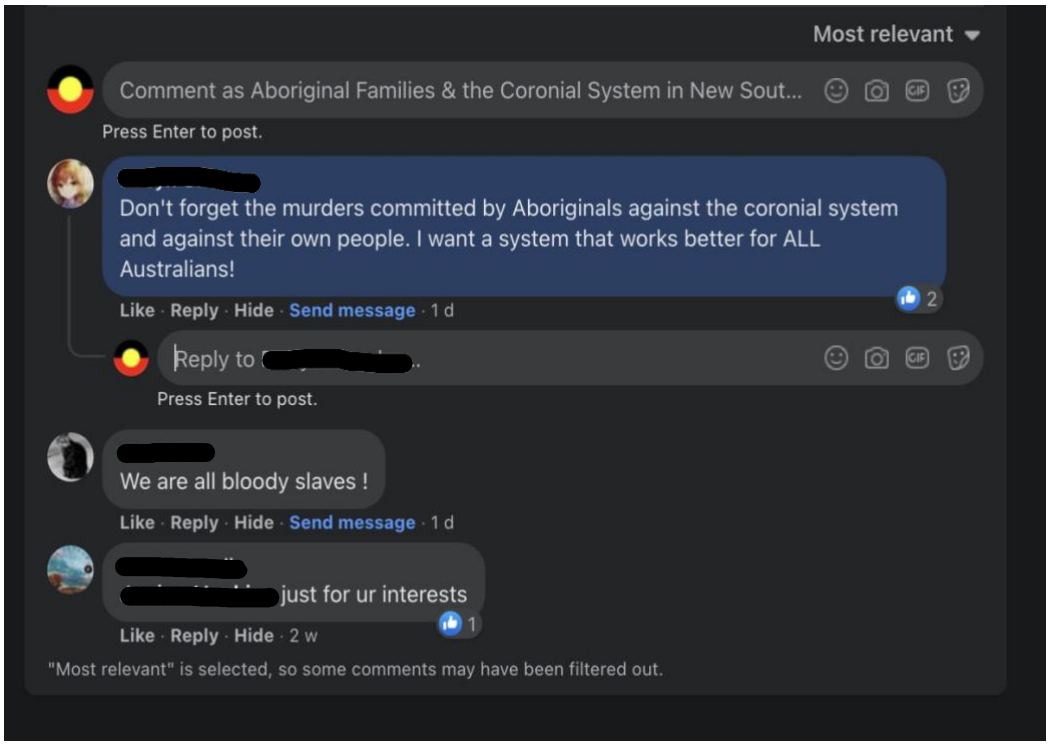

Figure 10: 6 December 2021

Figure 11: 7 December 2021

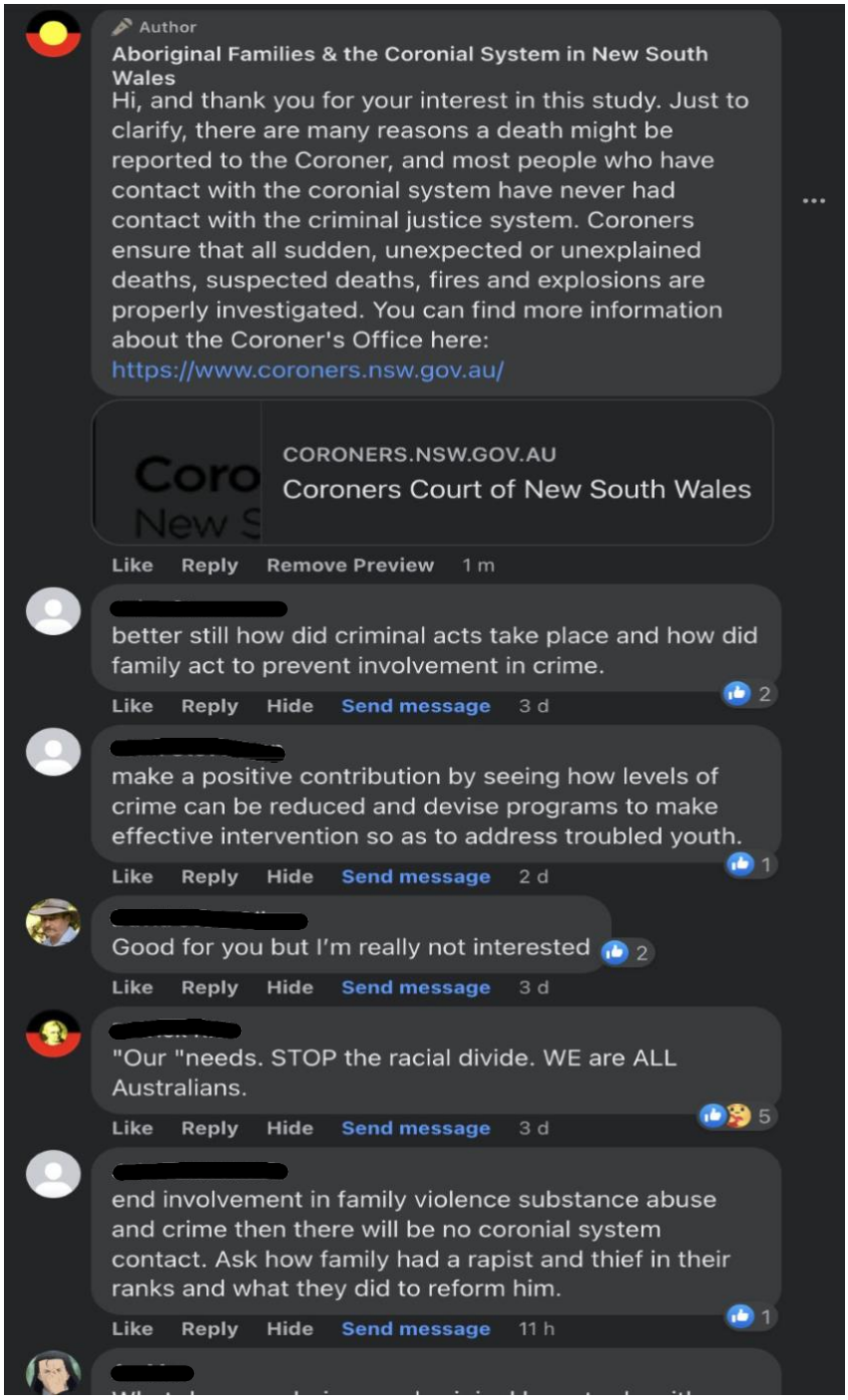

Figure 12: 7 December 2021b

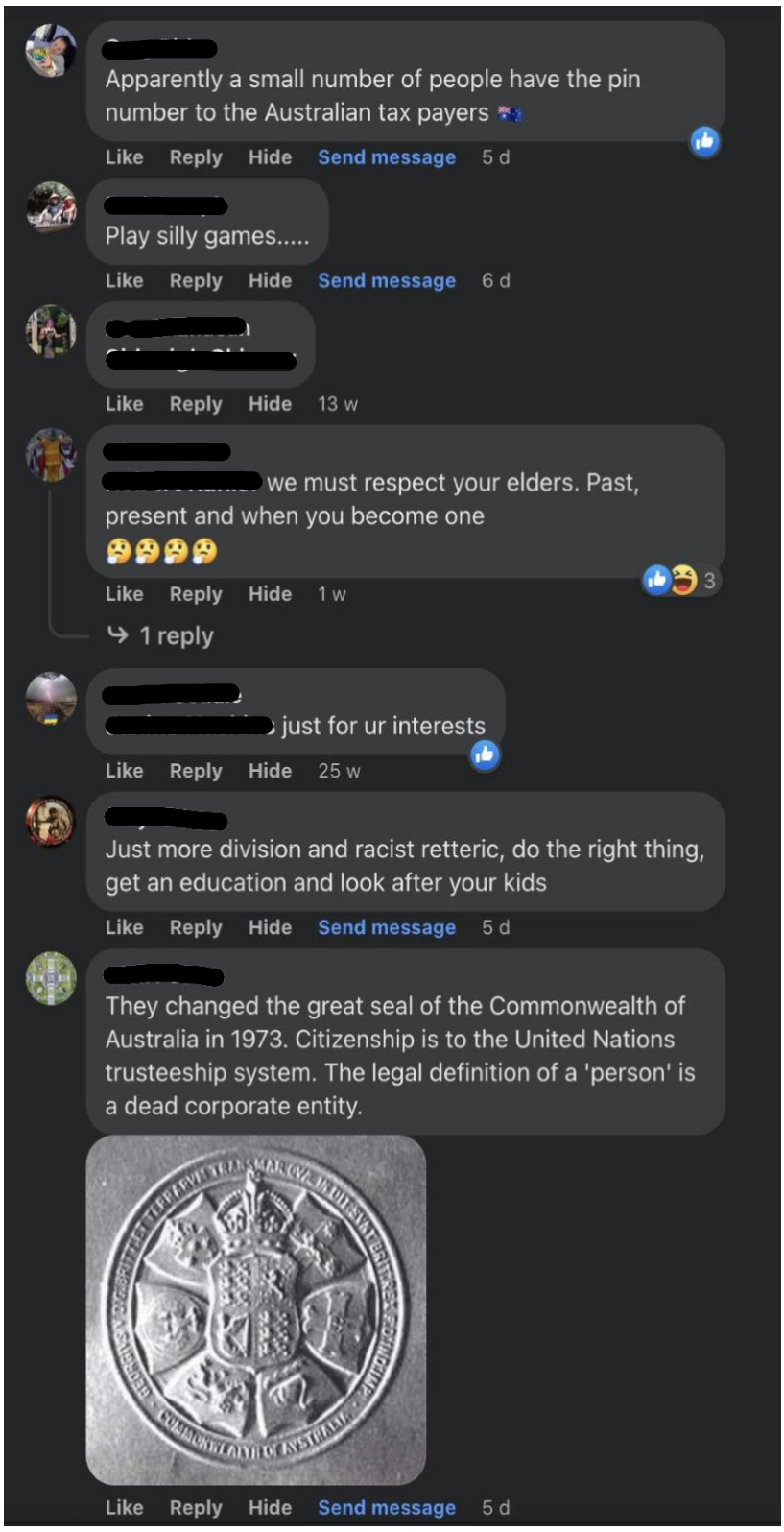

Figure 13: 11 May 2022

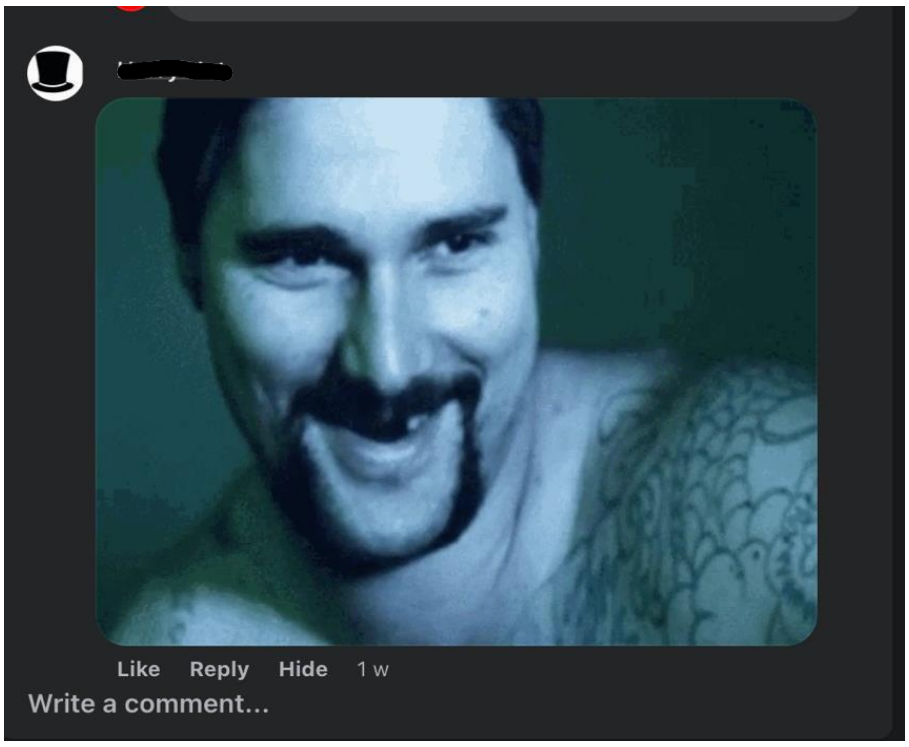

Figure 14: 11 May 2022b

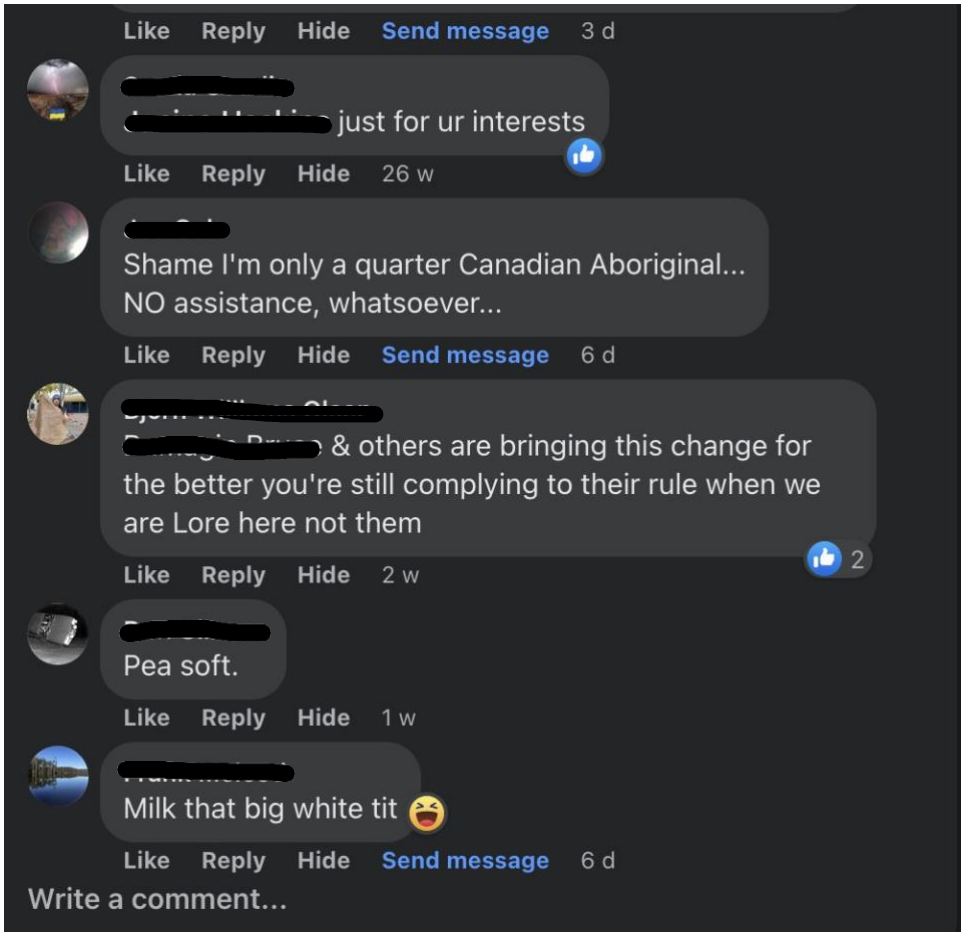

Figure 15: 20 May 2022

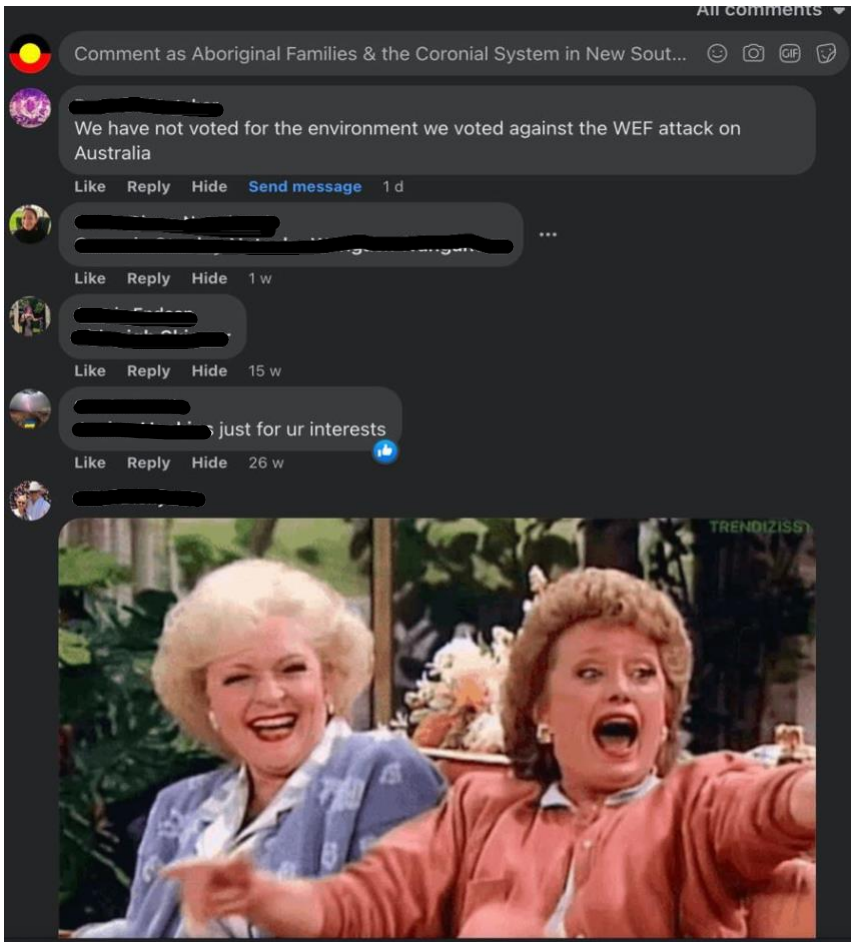

Figure 16: 24 May 2022

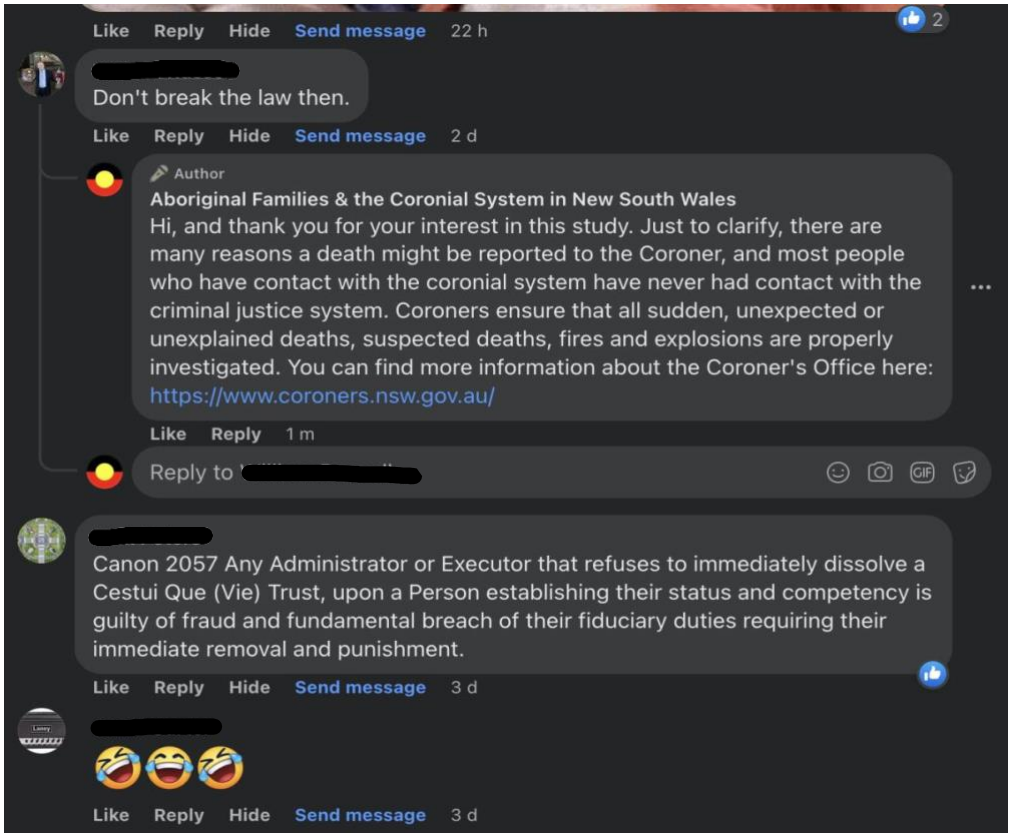

Figure 17: 24 May 2022b

As shown in the above screenshots, most of the interactions with the survey post on Facebook were negative. This was a disheartening result, and other than the one instance where I replied to a comment with further information about the coronial system (see Figures 12 and 17), the decision was made to 'hide' the comments after recording them. When comments were deleted, the original poster could see that their comment was deleted, thus inviting further negative engagement (see Figure 8). When comments were hidden, only myself and the original poster could see the comment, but for all other Facebook users the comments became invisible. Removing offensive comments was important – as the survey was intended to reach as many Aboriginal people in New South Wales as possible, the offensive comments could discourage Mob from engaging with the post, and may have been experienced as unsafe. Indeed, a participant in Carlson and Frazer's (2018: 12) study highlighted that to witness racism directed toward Aboriginal people is to experience racism. I certainly felt increasingly dismayed when the majority of posts were so misinformed and offensive, and did not want other Aboriginal people to be subjected to the same dialogue. Carlson and Frazer (2018: 13) describe this as a form of fatigue, constituting 'its own form of political silencing through overburdening'. This is perhaps not surprising, given that racism via social media (and elsewhere) is simply a 'manifestation' of the historic and ongoing exclusion of Aboriginal people (Cunneen 2018: 277).

The majority of comments shown in the above figures can be split broadly into two themes: criminalisation and white supremacy. The association of criminality with Aboriginal people was common among those who interacted in the post, with people incorrectly assuming that one must have committed an offence to have contact with the coronial jurisdiction – 'don't break the law then' (Figure 17), 'end involvement in family violence substance abuse and crime' (Figure 12). Of course, this is nothing new, with Chris Cunneen writing about the racialised criminalisation of Aboriginal people in the

media as early as 1987. More recently, Cunneen (2018) has continued to examine the nexus between lingering tropes of colonialism and the racialised criminalisation of Mob across media platforms, including both traditional media and social media. Social media allows individuals to express what can often be misinformed, uneducated, right-wing diatribe to hundreds of thousands of people with the click of a button. In the context of the colony of Australia, it is a space where racist discourses can be shared and garner support from like-minded people. This is strengthened and perpetuated by racism in more traditional media. Not-for-profit organisation All Together Now has studied mainstream media sources to ascertain the levels and types of racism present across Australian newspapers, news programs and infotainment programs such as Channel Ten's *The Project*. They found that 53 per cent of the 315 opinion pieces analysed featured negative depictions of (non-white) race, with 79 per cent of those pieces employing covert racism (All Together Now 2020). Forty-seven per cent of the opinion pieces analysed targeted Aboriginal and Torres Strait Islander people in a negative way (All Together Now 2020). This is significant, as too often media depictions of 'race' are perpetuated via racialised discourses of criminalisation (Cunneen 2018: 278), (re)producing and entrenching ideas about race and criminality. Indeed, these discourses 'reflect a long running trope of colonial ideology within Australia', one that perpetuates the harmful, offensive and fallacious notion that Aboriginal and Torres Strait Islander people 'are a racially inferior, crime-prone group who require either incarceration or removal' (Cunneen 2018: 288). Thus, the too-common discourse that aligns indigeneity with criminality is reproduced on social media, as evidenced by the screenshots shared here, bolstered by the efforts of mainstream media.

This is, of course, allowed – and indeed encouraged – within the ideology of white supremacy. White supremacy is the other key theme identified in the comments posted by individuals on the survey's Facebook link. It is white supremacy that underpins the

continued colonial ideology that constructs indigeneity and criminality as inherently bound. We have witnessed the (re)emergence of white supremacy explicitly in the wearing of 'Ku Klux Klan' style uniforms in Alice Springs among self-professed vigilantes (Cunneen & Russell 2017: 20), and with the tremendous growth in far-right terrorism investigations – a 750 per cent increase in cases in less than two years (Zwartz 2021). The resurgence of white supremacist ideologies in Australia cannot, and should not, be separated from the context in which it occurs. The invasion and subsequent colonisation of so-called Australia continues to structure almost every facet of our lives, from what we learn in school to whether appropriate medical assistance is given in times of need. Indeed, one of the first packages of legislation passed following the Federation of Australia was the *Immigration Restriction Act 1901*. The now infamous Act, better known as the White Australia Policy, demarcated the racial boundaries of the country by legislatively excluding non-white immigration (National Archives of Australia, n.d.).

The foundations of the State of Australia, and the structures and institutions built thereupon, are thus firmly grounded in colonisation and white supremacy. Comments left on the Facebook survey link post asked whether or not 'WLM' (White Lives Matter – see Figure 9), and used language referencing an 'attack on Australia' (Figure 16), both of which can be understood as markers of white supremacist ideology. References to using 'taxpayer money' and 'milk[ing] that big white tit' (*Fi*gures 13 and 15 respectively) conjure notions of belonging – who belongs and thus is entitled to access welfare support and other benefits, neither of which have anything to do with this study or the Facebook post itself. These kinds of comments are also evidence of the persistent fallacy that Aboriginal and Torres Strait Islander people receive benefits and privileges simply for being an Aboriginal and/or Torres Strait Islander person (Carlson 2016).

Returning to the notion of belonging, it is important to note that within the colony of Australia, 'who belongs, and the degree of that belonging, is inextricably tied to white

possession' (Moreton-Robinson 2015: 18). Belonging is 'tied to a racialised social status', one that 'confers certain privileges' (Moreton-Robinson 2015: 4), such as who is entitled to access taxpayer monies, and who is not. Who belongs and who does not are reinforced via the power relations premised upon ongoing colonisation, in turn reinforced via institutions and social structures (Moreton-Robinson 2015: 18). Attached to these power relations are privileges that denote who is the racialised Other, who is pathologised and who is not. Indeed, as Moreton- Robinson (2015: 172) argues, 'the discourse of pathology is a powerful weapon', deployed via patriarchal white sovereignty to demarcate who is a 'good citizen'. This discourse lays the foundation for the criminalisation of Indigeneity, the idea that we are inherently criminal, thus deserving of the hyper-incarceration, overpolicing, and otherwise/overall neglect by the State. The racialisation of belonging is supported by what Moreton-Robinson (2015: 172) terms 'white sovereignty', which in turn is supported by and indeed stems from white supremacist ideologies. After all, whiteness is the 'norm and measure for identifying' who belongs (Moreton-Robinson 2015: 5), and by explicitly identifying myself and the study as by and for Aboriginal people, I demarcated myself as someone who does not belong, and thus triggered the white possessive to rear its head.

This study did not intend to capture tropes of racism, criminality or white supremacy by utilising social media to distribute the study and associated survey. This finding has been included here intentionally, as it exists both as part of the research journey and as part of identifying as an Aboriginal person in an online context. The interactions captured and shared here were for the most part unanticipated side-effects of being visibly Indigenous online. The specificity of place, wherein lies a specific form of colonial racism, combined with the specificity of the medium, Facebook (Matamoros-Fernández 2017: 931), came together in the microcosm of the survey post to (unintentionally) provide space for white Australia to interrogate who belongs and who does not. The associated fallacy of inherent criminality was applied to measure me and

potential participants as not deserving of the study or its potential benefits for Mob. It was in the comments section that the measure of whiteness was applied, premised on white supremacy, reinforcing and (re)asserting the power relations built upon colonisation.

This chapter has outlined the methodological foundations and practical methods underpinning the study. Working within an Indigenist research paradigm has required me to locate myself as an Aboriginal researcher, to foreground relationality and accountability, and to remain attentive to the ethical and political responsibilities that accompany research with Mob, particularly in a research space shaped by grief, trauma and state institutions. Within these commitments, the study employed two complementary methods: an online survey as an initial, low-threshold recruitment and scoping tool during the constraints of COVID-19, and yarning as the primary method of in-depth inquiry that centres Aboriginal ways of knowing, being, and doing. The chapter also set out how the data were analysed using thematic analysis, with explicit attention to reflexivity, transparency in analytic decision-making, and the integrity of representing participants' accounts with care. Finally, it recognised that research methods do not occur in neutral contexts: the racism encountered through social media recruitment was an unanticipated but important contextual finding that speaks to the conditions under which Aboriginal people participate in research and narrate loss in public and semi-public spaces. Together, these methodological choices and constraints shape what is possible in the study and clarify how the findings that follow should be read: as situated, relational and ethically bounded accounts that nonetheless generate valuable insights into the systemic operation of the coronial jurisdiction in New South Wales as experienced by Aboriginal families and, later, Aboriginal workers inside the system. Chapter 4 now turns to the findings from the survey and the yarns, centring participants' voices to illuminate how coronial processes are lived, navigated and resisted.

4

Aboriginal families and the coronial system in New South Wales

This chapter presents the findings from both the online survey and the yarns conducted with participants. It is divided into two sections: the first is focused on the survey questions and the findings from the survey, while the second examines the findings from the yarns with families – people who were forced to interact with the coronial system following the death of a loved one. This section aims to represent their voices and experiences with integrity and compassion. I am extremely grateful to all those who so willingly shared their stories in the hope that another family will never have to go through what they did.

1. The survey

There were 22 recorded responses for this survey. Unfortunately, of the 22 recorded responses, only nine respondents completed the survey. It is perhaps likely that the survey elicited discomfort for some respondents, as it was asking them questions about a traumatic and grief-filled time of their life. Of the nine respondents who completed the survey, only one elected to be contacted for an interview.

This was a disappointing result. As the primary recruitment tool for the study, it was hoped that many more respondents would elect to be interviewed. As discussed ealier, the COVID-19 pandemic significantly impacted the number of survey responses. Further, reflection on the survey tool has allowed some insights into why it was not as successful as anticipated. First, the survey asked the participants to relive a traumatic time in their lives. Not everyone has the emotional capacity to do this. Second, the survey was too long. The attempt to capture as much information as possible was perhaps too onerous for participants, especially given the sensitive nature of the questions. While a great deal of attention was given to the wording of the questions, aiming to ensure that they were written in a sensitive fashion, it may be that the wording was at times too complex. Future

surveys would thus be much shorter, with more focus on how questions were framed. It may also be that the changing formatting of the questions, with a mixture of open-ended questions, matrix tables and multiple choice, may have been confusing for participants. Future research might initiate a focus group with a variety of surveys, varying in style and length, to determine which format and length is best suited for a particular group. It should be noted, however, that despite the survey being purposefully designed for Aboriginal respondents, there is huge variation in educational level, comprehension and general literacy levels across Aboriginal communities, and from individual to individual within those communities. There were also very few questions that required a response to proceed – only the qualifying questions at the beginning of the survey required a response to proceed, following Hooley (2012: 47), who notes that it is in sensitive research that 'respondent desire for autonomy is likely to increase'. It was hoped that this would give participants the freedom to decide which questions to answer; not all questions were answered by the nine participants who completed the survey, with some answering questions that others had not, and vice versa. As a data-capturing tool, this has prevented meaningful statistical analysis across fields of information; however, each survey response is still considered valid and important in its own right – each response records the experiences of the person who completed the survey, and this is important regardless of whether the findings can be labelled as statistically significant.

The survey also seemed to gain more traction on Facebook rather than Twitter. This may be because the survey was able to be 'boosted' on the Facebook platform. The student researcher paid a total of A$50 over six months to 'boost' the reach of the survey, ensuring more people were shown the survey link in their feed. According to the data report received from Facebook, or Meta for Business, the survey link was shown to 1400 people, resulting in 69 engagements with the post. Engagements range from 'liking' the post, including laughing reactions and angry reactions, to commenting on the post or

sharing it with the user's own network. There is some data available for the Twitter post – the tweet (Figure 4) was re-tweeted seven times; quoted twice; and received five likes. Unfortunately, Twitter does not provide the statistical information that Facebook does, but the information given above is indicative of Facebook being a platform that is able to reach far more people. This makes the number of respondents to the survey even more disheartening – over 1400 people saw the post, yet only 22 people clicked the link. This may be because of the specific, and sensitive, nature of the survey.

The survey post on Facebook elicited a number of 'comments' from members of the public. These were largely derogatory. The researcher 'hid' the comments, meaning the account holder (myself) could see them, but others commenting on the post could not. The decision was made to hide and record derogatory and offensive comments so other First Nations people would not be exposed to them. It was thought that leaving the comments there may discourage potential participants from clicking the survey link. Ensuring that the posts were as culturally safe as possible was a key consideration, and so each morning the posts were checked for new comments, with offensive and derogatory comments hidden immediately. Screenshots were also taken of the comments left by members of the public; these were discussed in Chapter 3.

Of the 22 surveys, only the nine completed surveys have been included in the analysis, although it is important to reiterate here that not every question was answered by all nine respondents. These nine surveys have still provided some interesting information. Respondents identified as being from a variety of language groups/Mobs. Two respondents (25%) identified as Wiradjuri, which was the most common language group/Mob recorded; two respondents Gamilaroi/Gamilaraay/Kamilaroi; one respondent from Yuin, Ugurapal and Darug; one respondent identified as English. Interestingly, one respondent identified their language group as English. The respondent may have interpreted the question to mean which language they speak, rather than which language

group they identified with, or it could mean that they identify as a person with an English background rather than identifying with a language group/Mob. That one respondent identified as both Wiradjuri and Gamilraay skewed the reflection of participating language groups.

The ages of respondents also varied, although most were older adults. The ages of respondents are shown in Figure 18. The older ages of the respondents are indicative of them being an older relative of the person who had died or was missing; five of the respondents were a parent of the person who had died or was missing; one respondent was a cousin of the person who had died; two respondents were the Aunty of the person who had died; and one respondent did not answer this question. Five respondents identified as female, three as male and one respondent preferred not to say.

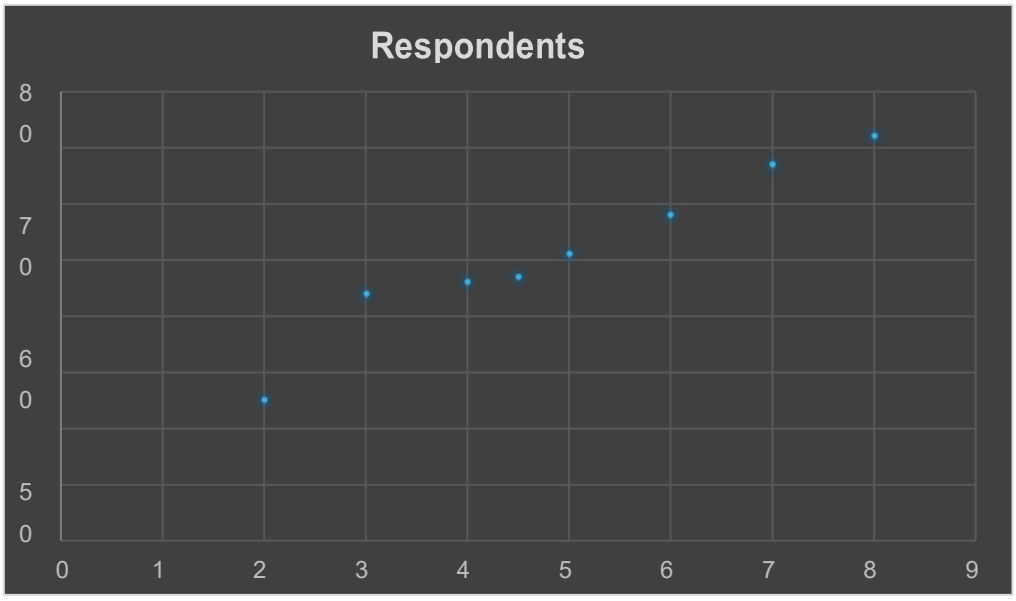

Figure 18: Ages of respondents

All nine respondents lived in New South Wales, with most (n = 4) having lived in the same area for more than 10 years. Many had lived in the same area for between five and 10 years (n = 3), with one respondent indicating that they had lived in their current suburb for less than five years, and one respondent choosing not to answer this question (total = 9).

The respondents had their first contact with the coronial system in different years, with most (n = 6) respondents having contact with the old Coroners Court at Glebe, and only two respondents indicated that their first contact with the coronial system was with the new Forensic Medicine and Coroners Court Complex at Lidcombe. One respondent did not indicate when their first contact was. Of those who did answer this question, five had their first contact after the *Coroners Act 2009* (NSW) came into effect, three had their first contact during the enforcement of the *Coroners Act 1985* (NSW) and one did not indicate the date of their first contact. The timing of the respondent's first contact is significant, as the purported aim of the 2009 legislation was to improve coronial processes for families (Hatzistergos 2009).

Of the nine respondents, most had contact with the coronial system in New South Wales following the death of a loved one (n = 7), with one respondent indicating that their loved one was missing and one electing not to answer this question. These data are shown in Figure 19.

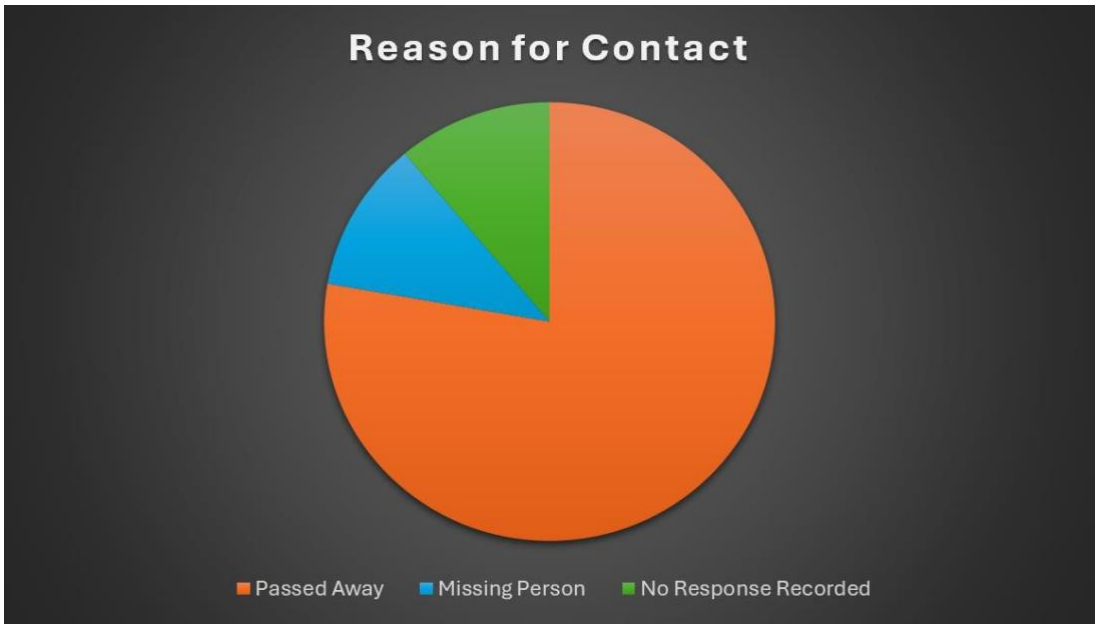

Figure 19: Reason for contact

Demographic information about the person who had died or was missing was also collected. This included the age of the person when they died or went missing, the language group/s they identified with and the area they were living in when they died or went missing. Sadly, most of the people who had died or gone missing were under the age of 30, including one child who was only five years old. The ages of adults who had died or had gone missing were 19, 20, 26, 38 and 53.

Those who had died or gone missing came from all over New South Wales, with most living in suburban Sydney (n = 4). One person was recorded as being detained in a correctional facility when they died; however, this may not mean they were the only person who died following police contact or in a correctional facility – the respondent may have listed their usual place of residence instead. Three respondents listed their loved one's cause of death as 'other'; one respondent was 'unsure'; one was a result of 'negligence'; and one was the result of a motor vehicle accident (total = 6). The respondent whose loved one was missing was not asked about the circumstances in which their loved one disappeared, and two respondents chose not to answer this question.

Five of the nine respondents answered the question asking when their loved was identified as an Aboriginal person. Of these, four indicated that their loved one was identified prior to the coronial investigation or inquest, and one respondent indicated that their loved one was identified as an Aboriginal person during the initial investigation. Four respondents elected not to answer this question. Respondents were then asked who identified their loved one as an Aboriginal person, and were given six options:

1. Their family/ I did
2. A community member
3. Police
4. Pathologist
5. Coroner
6. Other

Not all of the respondents answered this question (six did, three did not), and those who did gave multiple answers. The participant who responded 'other' gave further information – this respondent indicated that 'no one did'. The families of the person were the most likely to identify their loved one as an Aboriginal person (n = 4), followed by community members (n = 2) and investigating police (n = 2). These data are shown in Figure 20.

Figure 20: Who identified the person as an Aboriginal person?

Unfortunately, it was at this point in the survey that Participants #3, 4 and 9 discontinued their answers. Therefore, their surveys remain incomplete, so only the remaining six respondents are included from this point.

Participants were then asked whether they used any counselling services available through the Coroners Court – for instance, via the Coronial Information and Support Program (CISP). Only one of the remaining six respondents indicated that they had accessed counselling; four indicated 'no'; and one respondent was 'not sure'.

Respondents who answered ‘no’ were then asked why they did not use the counselling services available through the Coroners Court, and were invited to select all reasons that applied:

1. I didn’t know they were available
2. I wasn’t sure if there was a cost involved
3. I didn’t feel comfortable using counselling services through the court
4. I used community counselling instead

Three respondents did not know that counselling services were available; one respondent used community counselling services instead; and one respondent indicated that, in addition to not knowing the services were available, they were unsure about costs involved in accessing the service, and they did not feel comfortable using services via the court. One respondent chose not to answer this question. The hesitancy to engage with counselling services via the court is concerning, particularly where respondents did not engage with community counselling services either. In hindsight, it may have been useful to ask the respondents who did access counselling via the Coroners Court what their experience of this was like. Research by Carpenter et al. (2022: 1049–50) found that ‘coronial engaged professionals’ demonstrated an understanding of the ‘strong emotional states’ of families engaged with the system; further, the authors noted the valuable role of coronial counsellors in supporting and guiding families in coronial decision-making. This support, however, is provided to the next-of-kin (Mowll et al. 2017), so it may be that the respondents in this study were not eligible to receive such support. It is also important to note that the counselling service available through the court is a mainstream one. Further research is needed to assess how culturally safe this service is; after all, ‘a lack of cultural safety in mainstream services can be a significant barrier to providing support’ (Milroy et al. 2022: 773).

Participants were then asked whether they felt they were shown respect by the staff at the Coroners Court, and could choose on a scale from definitely no to definitely yes. The majority of respondents indicated ‘definitely yes’ when asked this question (n = 4), an

encouraging result, with one respondent indicating 'probably yes', and one who was 'not sure'. One respondent did not answer this question. Participant #1 entered text into the free text box to explain why they indicated 'probably yes'; they were pleased that staff at the Coroners Court had referred to their son by name, and that they were informed about the coronial process at each stage. They did, however, add that when they sought clarification 'around why things were going a certain way' (P1), staff did not give the sought-after clarification. Participant #6, despite not selecting an option from the choices listed above, also filled out the free text box. Participant #6 indicated that they did not feel respected by the staff at the Coroners Court, writing 'no as I was against the gov … and only I made noise and even then I got and [sic] inquest but … it was just to shut me up' (P6).

Participants were then asked whether they felt respected by the police investigating on behalf of the coroner. This question elicited more varied responses than the previous one, with one participant indicating that they were 'probably not' shown respect by police, two indicating 'definitely yes' and two who indicated that they were 'not sure'.

Participants #1 and #6 again elected to provide further information in response to this question. Participant #1 gave a number of reasons for why they answered 'Probably not'; they wrote 'a lot was hidden. Requesting evidence was a struggle. They didn't say my son's name. They took no responsibility' (P1). Participant #6 chose not to choose from the answers provided, but did complete the free text box, writing 'no they just don't care … they don't want to know …' (P6).

Participants were then asked whether they felt that Sorry Business had been respected by staff at the Coroners Court. Five of the six participants responded to this question, and again the results were encouraging, with three respondents recording 'definitely yes' in response to this question; one respondent answered 'probably yes', and one was 'not sure'. It was at this point in the survey that Participant #6 discontinued, leaving five participants for the next part of the survey.

Despite there being a free text box following this question to allow participants to provide further information about this, none elected to do so. The next question asked whether they felt as though investigating police had respected Sorry Business. Again, we see less satisfaction with how police engaged with the family members of the person who had died, and enormous differences across their experiences. Of the five remaining responses, each had a different answer to this question: one answered 'definitely yes'; one answered 'probably yes'; one was 'not sure'; one indicated 'probably not'; and, unfortunately, one participant indicated that they 'definitely [did] not' feel as though police respected their Sorry Business.

When asked whether or not participants felt as though their culture and beliefs had been respected throughout the coronial process, only four of the six remaining respondents elected to answer. Their responses were varied – one participant answered 'definitely not'; one responded 'probably not'; and two indicated 'definitely yes'. These responses were identical when asked whether their cultural practices were observed: 'definitely not' (n = 1); 'probably not' (n = 1); 'definitely yes' (n = 2); and one additional response 'I'm not sure').

Participants were then asked about their experiences in accessing information about the coronial process. Three respondents indicated that they knew who to contact for further information or if they had questions, with two respondents indicating that they did not know (*total* n = 5). For two respondents, it was 'neither easy nor difficult' to contact someone, with one respondent indicating that it was 'extremely easy' to contact someone for information (n = 3); two respondents did not answer this question (total n = 5). Table 1 shows how respondents answered the question 'Do you feel you had enough information':|

Table 1: Do you feel you had enough information?

Question	P1	P2	P5	P7	P8
a) In the days following the death, or them going missing?	Definitely not	Probably yes	Probably yes	Probably yes	Definitely yes
b) In the weeks following the death, or them going missing?	Definitely not	Probably yes	Definitely not	Probably yes	Definitely yes
c) In the months following the death, or them going missing?	Definitely not	Definitely yes	Definitely not	Probably yes	Definitely yes
d) In the years following the death, or them going missing?	Definitely not	Definitely yes	Probably not	Probably yes	Definitely yes
e) After the inquest or investigation was finished?	Definitely not	Definitely yes	Definitely not	Probably yes	Definitely yes

Here we see considerable discrepancies in respondents' levels of satisfaction regarding the information they received or were able to access in the days, weeks, months and years following their loved one passing away or going missing. Only two respondents indicated that they were satisfied with the amount of information they had after the inquest or investigation was completed, with two respondents indicating that they were dissatisfied. The next question was also formatted as a matrix table, allowing respondents to enter multiple answers for the same question. This question focused on the supports that participants chose to use throughout the coronial process. Participants were asked the question 'What supports were helpful to you during the coronial process?', and were

asked to indicate how helpful their chosen supports were. Their responses are recorded in Table 2.

Table 2: What supports were helpful to you in the coronial process?

Question	P1	P2	P5	P7	P8
Family	A lot	A little bit	A lot		A lot
Friends	A lot	A lot	A lot	A little bit	A lot
Partner	A lot		Didn't use	A little bit	A lot
Community	A lot	A lot	A lot	A lot	Didn't use
CISP	Not at all	A lot	Didn't use	Not sure	A lot
Forensic counsellor	Not very much		Didn't use	Not sure	A lot
Local GP	A lot	A lot	A lot	A little bit	A lot
Legal Aid (Coronial Inquest Unit)	Not at all	A little bit	Didn't use	A little bit	A lot
Aboriginal Legal Service	A little bit	Not very much	A lot	A little bit	A lot
Support After Suicide group	Didn't use	Not at all	Didn't use	A little bit	A lot
Families and Friends of Missing Persons support group	Didn't use	Not at all	Didn't use	A little bit	A lot
Social media	A lot	Not at all	A little bit	A little bit	A lot

As shown in the table, some questions were left unanswered by respondents. Four out of the five indicated that the support of their community was very helpful during the coronial process, as were friends and family members, and local GPs. Both Legal Aid (Coronial Inquest Unit) and the

Aboriginal Legal Service (ALS) received mixed responses about their supportiveness. These results also indicate that social media was helpful for the majority of respondents, supporting Carlson and Frazer's (2021) assertion that Aboriginal and Torres Strait Islander people are avid users of social media. It was at this point in the survey that Participant #8 discontinued, leaving four remaining respondents.

These respondents were then asked whether there were any supports that they needed throughout the coronial process but were not able to access. It would have been good to include free-text questions to encourage participants to elaborate on their responses; however, had every question been asked that I had wanted answers to, the survey would have been too long and thus far too onerous on participants. A variety of practical support mechanisms were presented as options for respondents to choose from. Legal support/advice, housing and transport to and from the Coroners Court were the key supports required by participants, but were not able to be accessed. Two participants also indicated that childcare and financial support were required but not able to be accessed.

The next question asked respondents about the kinds of things participants do to manage stress and grief. It was thought that this question might enable the student researcher to better understand how participants cared for their own emotional and social wellbeing, particularly those that did not utilise counselling services via the Coroners Court. Participants could select as many activities from the list as they wanted. Two participants spent time with friends and family to manage their stress and grief; one found spending time on Country to be helpful, as well as art making such as painting and creative writing; and all four remaining participants found sports and other outdoor activities to be helpful in managing their stress and grief. This finding may be significant in informing services that specifically support Aboriginal families engaged with the coronial system. Although these results are not representative due to the low sample size, this is a finding

that warrants further research. It was initially thought that being on Country would be a significant protective factor for grieving families, as is often seen in rehabilitation and other support settings (Verbunt et al. 2021); however, these limited results suggested that being active in outdoor spaces may be a better fit for bereaved Aboriginal families. Of course, being in in an outdoor space *is* being on Country, but it also raises the question of whether respondents considered the question to mean their own Country, which may not necessarily be where they live or where they enjoy being active outdoors. Again, while limited, further research may allow for a more nuanced understanding of this specific finding.

All four remaining participants indicated that there had been an inquest into the death or disappearance of their loved one. When asked how long after their loved one had died or gone missing an inquest was held, three participants responded. The respondent whose loved one was missing had waited eight years for the inquest to begin. The other two respondents, whose loved ones had died, waited between three and three and a half years before the inquests began. Of these three participants, the inquests went for a duration of one year 'off and on' (P1) and 'not long' (P2). Two of the four remaining respondents attended inquests at the old Coroners Court at Glebe, and two attended inquests at the new Forensic Medicine and Coroners Court Complex at Lidcombe. Two of these respondents had legal representation by Legal Aid (Coronial Inquest Unit), one was represented by the ALS and the fourth respondent was unsure whether they had legal representation. All four respondents attended the inquest into their loved one's death or disappearance. Three of the four respondents used public transport to get to and from the Coroners Court, and the fourth respondent used taxis/Ubers. All four remaining respondents also indicated that they did not require childcare while the inquest was running; however, two of the four did report that other members of their family did.

This section of the survey was specific to their experiences of the coronial inquest process. Thus, the question was asked: 'Did you feel you had enough information'. The results are shown in Table 3.

Table 3: Did you feel you had enough information

Question	P1	P2	P5	P7
Leading up to the inquest	Definitely not	Probably yes	Definitely yes	Not sure
At the beginning of the inquest	Definitely not	Probably yes	Definitely yes	Not sure
During the inquest	Definitely not	Definitely yes	Definitely yes	Not sure
At the end of the inquest	Definitely not	Definitely yes	Definitely not	Probably yes
In the days following the inquest	Definitely not	Definitely yes	Definitely not	Probably yes
In the months following the inquest	Definitely not	Definitely yes	Definitely not	Not sure

Notably, at the end of the inquest and in the days and months following its culmination, 50 per cent of the respondents felt they definitely did not have enough information. Only one respondent felt they definitely did. Perhaps this is indicative of the lack of wrap-around support provided to families after an inquest has finished. Participants were then asked which supports they found most helpful during the inquest process (Table 4).

Table 4: Which supports were most helpful to you during the inquest process?

Question	P1	P2	P5	P7
Family	A lot	A little bit	A lot	Not sure
Friends	A lot	A lot	A lot	A little bit
Partner	A lot		Didn't use	A little bit
Community	A lot	A lot	A lot	A little bit
CISP	Not at all	A lot	Didn't use	Not sure
Forensic counsellor	Not at all		Didn't use	Not sure
Local GP	A lot		A lot	A lot
Legal Aid (Coronial Inquest Unit)	Not at all	A lot	Didn't use	Not sure
Aboriginal Legal Service	Not at all		A lot	Not sure
Support After Suicide group	Didn't use	Not very much	Didn't use	A little bit
Families and Friends of Missing Persons support group	Didn't use	Not very much	Didn't use	A lot
Social Media	Didn't use	Not at all	A little bit	Not sure

Here we see the importance of family, friends and community in supporting people who are grieving, in addition to being subjected to the stressors of a coronial inquest. The local GP is again highlighted as a key support for the respondents. The ALS has not scored well, which is a surprising finding given its targeted, although severely under-funded, services.

The next question referred to the outcome of the inquest. Upon reflection, this perhaps needed to be better explained to the participants. One participant answered 'I was disappointed with this outcome' for every outcome scenario presented, despite some of them being in contradiction. Looking at Table 5, P1 was disappointed with each outcome, including the inquest being dispensed with (not held) and the coroner delivering findings, which would

not have happened had the inquest been dispensed with. The question was: 'What was the outcome of the inquest? Please only answer the outcome that applies to you'.

Table 5: What was the outcome of the inquest?

Question	P1	P2	P5	P7
The Coroner dispensed with the inquest (decided not to hold one)	I was very disappointed with this outcome		I was happy with this outcome	I'm not sure what the outcome was
The Coroner delivered findings	I was very disappointed with this outcome	I was happy with this outcome	I was happy with this outcome	I'm not sure what the outcome was
The Coroner delivered findings with recommendations	I was very disappointed with this outcome		I was happy with this outcome	I'm not sure what the outcome was
The inquest started, but was referred to the Prosecutor's Office	I was very disappointed with this outcome			I'm not sure what the outcome was

Participant #5 discontinued their participation in the survey following this question.

The next section of the survey was the optional section related to post-mortem procedures. Two of the three remaining participants elected to enter this section and answer the questions in it. As there are only two respondents for this section, their recorded answers are listed in Table 6 Unfortunately, the very small sample size and the discontinuation of participants has meant that generalisations cannot be extrapolated. However, a key methodological consideration of this study is the centring of Aboriginal

voices, therefore these responses are still important and valid in their own right. The respondents took the time to answer these questions, despite their potential to be distressing, so the integrity of the study required their answers to be recorded and reproduced here, no matter their level of statistical significance.

Table 6: Post-mortem procedure

Question	P1	P7
What are your feelings when you see the words 'autopsy' or 'post-mortem'?	numbing	scary
Do you know if the person who has died had an autopsy performed?	Yes, they did	I'm not sure
Were you, or their next-of-kin, contacted by someone at the Coroners Court to discuss an autopsy being performed?	Yes	I'm not sure
Did you, or their next-of-kin, object to an autopsy being performed?	No	
What was the outcome?	I'm not sure	I'm not sure
Were you, or their next-of-kin, told why an autopsy was or was not required?	I'm not sure	
Were there cultural considerations you, or their next-of-kin, needed to take into account when considering objecting to the autopsy?	I'm not sure	
Did you, or their next-of-kin, receive a report of the autopsy findings?	Yes	I'm not sure
Did someone support you when you received the autopsy findings?	Yes – the Aboriginal Legal Service	
Did you feel like there was more clarity about their cause of death following the autopsy?	No – I still don't have the answer to why a young man died	I'm not sure
Were funeral arrangements delayed due to an autopsy being performed?	Yes – 1 month or more	No

The survey findings present a number of key areas in need of investigation. Obvious here is the supposition that online surveys are not the most appropriate way to elicit information about people's experiences with the coronial system. This is a sensitive area of research, and to do this kind of research well with Mob requires the existence of a relationship prior to the survey being conducted. The original research design included spending time yarning with Mob about the proposed research, introducing the work to the community well before it was underway. This was made impossible – during the first month of my candidature, COVID-19 swept around the world. The first two years of this study were marred by lockdowns, uncertainty and all the stress and social isolation that came with it. This has had a significant impact on this work, and it is very likely that this affected the number of survey respondents. Indeed, why should someone trust a stranger with their grief and trauma? Despite the low response rate, I am very grateful to those who took part in this survey despite these serious shortcomings, and I acknowledge that an online survey was not the most appropriate choice for this work.

A notable finding from the surveys is the ways people access support following contact with the coronial system. Sixty-seven per cent of respondents did not use the counselling services available via the coroners court, but 80 per cent of respondents found their friends, communities and their local GP to be the most helpful supports. This raises significant questions about the role of local GPs in supporting bereaved people, and further research could investigate how prepared GPs are to give this kind of support. For instance, how much do they know about the coronial system and the lengthy delays involved for people? How much information do they have about supports for bereaved people – and indeed culturally specific supports? This could be an important line of inquiry. If GPs are indeed a common, and very helpful, support for bereaved Aboriginal people, as the findings suggest, then they should be supported to provided informed and

appropriate information. Another aspect is whether they realise they are performing this important role for people forced to interact with the coronial system in New South Wales.

The major life stressors that come to the fore throughout the coronial process are also a site for further investigation. This is already a harrowing time for people, made more difficult by not being able to meet some basic needs. For instance, 22 per cent of respondents required support to access housing while also being confronted with ongoing coronial investigations and processes. Thirty-three per cent were not able to access transport, either to and from the Coroners Court (22%) or more generally (11%), adding another layer of stress to an already stressful situation. Concerningly, 23 per cent of respondents were unable to access legal support and/or advice during this time. As discussed earlier in Chapter 2, the families that feel most empowered to participate in coronial processes are those with access to legal representation (Ngo et al 2021: 457). Conversely, families that are unable to access legal supports and advice can feel excluded, voiceless and vulnerable, limiting their satisfaction with coronial processes, and indeed the inquest (Ngo et al 2021: 460). Given that almost a quarter of respondents were unable to access this vital source of support and information, this finding requires urgent investigation to determine what the barriers are, and how this might be improved. Thus, while not representative, these findings offer important insights into the areas most in need if we are to improve people's experiences with the coronial system in New South Wales.

The next section offers the findings from the yarns with the participants who volunteered to take part. One participant of the 22 who responded to the survey asked to be contacted for a yarn. Another participant heard of the study via community networks and approached the researcher directly to take part. The findings of the yarns are discussed below. Again, while not necessarily representative, the stories shared here hold immense value, and provide incredibly important insights into how Aboriginal people experience the coronial system in New South Wales.

2. Yarning about the coronial system

The previous section outlined the findings from the online survey. This section presents the findings from the yarns with the two participants who so generously gave their time and shared their stories with me. It is an incredible privilege to be able to hold space for these people's stories, and again I must stress how grateful I am to have been entrusted with these.

This section also discusses the analytical method used to understand the different aspects of these stories as they relate to different aspects of the coronial system. Thematic analysis was used to code the 'data' from the yarns, and to develop the themes into which the information has been sorted. Following this, each theme is discussed in turn. The first theme, shorthanded as *external stakeholders*, discusses the participant's experiences with various external entities who are also engaged with the coronial system in New South Wales. Many of these entities intersect with coronial processes. For instance, the NSW Police, while external to the coronial system, are also heavily involved in coronial processes. It is the police who investigate on behalf of the coroner, so while an external stakeholder, they also have enormous potential to impact how a person experiences the coronial system. The ALS is also an external entity, yet is increasingly involved in coronial matters – particularly where there is significant public interest, such as coronial investigations and inquests following the death of a person in state custody. Another external entity with increasing involvement in coronial processes is the National Justice Project, a not-for-profit social justice legal service that is able to advocate for families and represent them at inquest. While these three entities are very different, they are grouped together here as external to the coronial system, yet they are often very much involved in coronial matters.

The second theme is termed *coronial processes*. This theme also encapsulates a variety of subthemes; the (in)adequacy of communication, provision of information to families, and next of kin determinations are featured here. As discussed throughout the

earlier literature, timely and effective communication is an important part of ensuring families feel both involved and respected throughout coronial investigations and inquests. This is true across each part of the coronial process, from the earliest days, during lengthy delays, and during and after the investigation or inquest has ended. Determining senior next of kin (SNOK) is also a key aspect of coronial processes, with a flow-on effect – who is determined to be SNOK has legislative ramifications regarding the provision of information and the ability for the court to communicate with families.

The determination of SNOK also impacts some cultural responsibilities, such as who has the legislated right to decide where a person is buried. Thus, while SNOK is included here under the theme of *coronial processes*, there is also overlap with the third theme, *culture*. This theme looks closely at the different aspects of cultural recognition that were important to the participants: Country, cultural awareness, access to culturally appropriate resources and support, the impacts of bias and discrimination, and the recognition of Sorry Business. Here, too, there is some overlap – the recognition of culture and cultural considerations can also be a key point of contention for external entities such as the NSW Police, just as the impacts of bias and discrimination can permeate interactions between bereaved families and police officers.

The final theme discussed here, *burdening the bereaved*, concerns the distinct forms of encumbrance that weigh on bereaved families: for instance, the administrative and financial burdens borne by family members and the emotional toll a coronial inquiry exacts.

There are aspects here that can be addressed in relatively simple ways, such as through the timely provision of information. As is no doubt already evident, while each theme focuses on a different part of people's experiences with the coronial system, these overlap and intersect in a variety of ways. Throughout this section can be found ongoing discussion of how we might understand what is happening at both the personal and

systemic dimensions of coronial investigations and inquests. First, however, I provide an overview of the method used, thematic analysis and how this was employed to generate the themes below.

Thematic analysis and the generation of themes

Thematic analysis was chosen as the core method for this study, due to its flexibility and theoretical freedom (Braun & Clarke 2006: 78). Thematic analysis can be used for a wide variety of qualitative inquiries, epistemologies and research questions (Nowell et al. 2017). At its most basic, thematic analysis requires the researcher to search across a data set to find 'repeated patterns of meaning' (Braun & Clarke 2006: 86). These patterns are not passively discovered, but purposefully identified. Following the recording, transcription and auditing of the yarns, the data were coded – I read and re-read the transcripts looking for repeated words, phrases, mentions and even feelings. A number of codes were identified and are listed below with the number of appearances also recorded (Table 7).

Table 7: Thematic analysis codes

Code	Number of appearances
Social media	3
Police	10
Aboriginal Legal Service	8
Legal Aid (discarded)	1
National Justice Project	2
Healthcare	3
Country	6
Family (discarded)	1
Cultural awareness	2

Culturally appropriate resources/support	7
Bias and Discrimination	10
Sorry Business	2
Accountability	7
Next of Kin	8
Recommendations	3
Communication	11
Information	14
Not feeling seen/heard	6
Disappointment	2
Altruism	3
Cost – financial and emotional	3
Administrative load	4

At a glance, the most common codes were information, communication, bias and discrimination, and police. The codes 'family' and 'Legal Aid' were discarded as neither was mentioned by either participant more than once. It is crucial to note here that these are the codes from the two respondents that participated in yarns – while it is recognised that this sample is by no means representative, this in no way discounts the importance of these people's experiences. Part of the allure of critical qualitative inquiry is that it allows us to better understand experiences, whether that is one person's experience or the experiences of a thousand people. It is also important here to reiterate that the nature of the yarns asked people to talk about a traumatic time in their lives, and the subsequent responsibility to honour what these participants have so willingly shared. Before discussing the similarities of their experiences, it may also be useful to highlight the differences. Both participants are the parent of a person who has died; however, their

children died in different circumstances – one at the hands of police, and one at the hands of the healthcare system. The similarity, of course, is that they have both lost a child through state violence, and these deaths necessitated a coronial investigation. This crucial similarity thus informed their experiences, which were not so dissimilar after all.

Following the coding of the transcripts, the codes were sorted into themes. These will now be discussed in turn. The first theme, *external stakeholders*, includes NSW Police, the ALS, the National Justice Project and healthcare. The coronial system is not included in this theme, but forms a theme of its own, *coronial processes*. *Culture* and *burdening the bereaved* are the third and fourth themes generated by the codes. These themes are represented in Figure 21 – the bereaved must be at the centre of everything that is done to improve the coronial system.

Figure 21: Centring the bereaved

Wrapped around bereaved Aboriginal families is and must be culture – without acknowledging and centring the crucial role of culture in delivering the best outcomes for Aboriginal people, best practice cannot be achieved. Secondary to this are coronial

processes themselves, followed on the periphery by the systems that impact the ways coronial processes are experienced, including interactions with police, healthcare systems, legal services, community supports such as the National Justice Project and contemporary supports such as those accessed via social media. By visualising the interacting spheres in Figure 22, we can build a picture of how these spheres affect the experiences of the most important stakeholders in the coronial space: the bereaved. The needs of the bereaved are second only to the needs of the dead, those whose deaths rely on the coronial inquiry to speak truth about the circumstances of their lives and deaths.

External stakeholders

Each of the codes in this theme is representative of different parts of systems or institutions external to the Coroners Court that have bearing on how families interact with the coronial system. Interactions with police are a significant part of this, so perhaps not surprisingly they were one of the more common aspects of their experiences. This is particularly true for Participant 2 (P2), whose child died following contact with police. It is also true for Participant 1 (P1), who found police to be helpful when negotiating who to call. P1 indicated that it 'was the police officer that gave us the information to contact the coroner' (P1: 7). This was a positive interaction that provided crucial information to P1.

The experiences of P2 with police were negative. Following a medical episode, an ambulance was called to assist P2's child. Instead of an ambulance, it was police who arrived at the scene – not just one police car, but 'every police car in the district musta come then, he wasn't committing any crimes … they called the ambulance not the police' (P2: 5). P2 was called to attend the hospital following this incident, where they were met by police – 'there's like all these police waiting there for us … all of a sudden there's five police officers … all high-level police officers with all their finery on' (P2: 3). Very little information was given to P2 regarding how and why their child was in hospital, and why there were so many police officers present. The lack of transparency and information was

distressing and a source of great confusion for P2, and infected the whole coronial investigation, resulting in a lack of clarity for P2 and their family – 'still no answers about this, how he died and you know like what was all this police doin there … he wasn't even in custody' (P2: 4). This lack of transparency led to a great deal of distrust for P2 – 'all we knew was the police were involved, they were covering themselves, you know I feel like looking back now I can see they're covering their arses' (P2: 4).

When considering the impact on families of deaths following police contact, transparency is key – indeed, the lack of transparency shown by police affects not only the perceived legitimacy of the police presence on that day but the legitimacy of the police as an instrument of the state (Easton 2020: 97). This is particularly true when police are involved in the death of an Aboriginal person. The relationship between police and Aboriginal people does not occur in a vacuum (Scott Bray 2008); it is informed and underpinned by historical understandings of the role of police in the lives of Aboriginal people. From the centralised and paramilitary structure of colonial police forces (Cunneen 2001: 53) to the contemporary removal of children from their families (Cunneen 2001: 107–8), police have long played a heavy-handed role in the lives of Aboriginal people. Deaths in police custody and following contact with police continue to be a scourge on our society, yet there seems to be a perceived normalcy and acceptance among non-Indigenous Australians when a death at the hands of police is the death of an Aboriginal person (Whittaker 2020). Given these complex and fraught relationships, police officers should be making every effort to assuage the concerns of families – particularly Aboriginal families – by practising the fullest transparency possible. For P2, the lack of transparency around the circumstances of their child's death, particularly the role of police in the death, continues to be a source of great distress: 'it makes you angry, it makes you sick to the stomach' (P2: 17–18).

The second code that falls in the theme of *external stakeholders* is the Aboriginal Legal Service (ALS). The ALS is one avenue for families to access legal support and advice during a coronial inquiry. Representation is typically limited to deaths in custody and deaths following police contact, as these cases are thought to be in the public interest. Increasingly, however, the ALS is being called upon to support all Aboriginal families who have contact with the coronial system, including providing legal support and assistance, as well as supporting witnesses appearing in coronial inquests (ALS NSW/ACT 2022). In 2022, the ALS created identified roles, both of which have now been filled by strong Aboriginal women who have first-hand experience of the coronial system (ALS NSW/ACT 2022: 36). Unfortunately, for the participant who had contact with the ALS prior to the creation of identified roles in the Coronial Unit, the ALS was a source of much disappointment and anguish. Following the death of their child after contact with police, P2 contacted the ALS – 'I called 'em cause I didn't know what was happening' (P2: 9). Much faith was placed in the ability of the ALS to assist P2 throughout the coronial process, yet this was not what happened – '[I was] thinking that the Aboriginal Legal Service can help you understand the um coronial process and … they didn't. They … yeah I'll never forgive em for that, I'll never forgive 'em' (P2: 9). P2 acknowledged the limited funding afforded to the Aboriginal Legal Service ('I know they're stripped of all their services and funding and things but shit … they're the reason why a lot of our Mob get locked up' (P2: 9)); however, the lack of support and communication from the Aboriginal Legal Services further devastated P2 during what was already a traumatic time – 'You know I been trying to get on to the ALS lawyer, nothing. Wouldn't even return my calls wouldn't do nothing! Nothin. I still haven't heard from him, a year later' (P2: 15). The perceived lack of support from the Aboriginal Legal Service led P2 to say 'I'd sell my car or anything if I needed a lawyer, there's no way on earth I'd call them again. Never.' (P2: 9). When discussing the lack of support experienced by P2, and the impact this had on

their experience of the coronial process, P2 felt that the Aboriginal Legal Service had contributed to their stress and trauma:

> *They [ALS] contributed to that because you know that's what they're paid for and they know our Mob goes through this trauma. It's a traumatic situation. You know and when you have ALS Mob, even though they're white, they been around Blackfullas they should know. You know … they're not criminals in there, they're dead! We their only voices you know and if ALS don't realise that they … they're not criminal going to criminal court, they're dead! And we gotta find out what the fuck happened to them why they died! If ALS don't realise that you know what the fuck are they there for?* (P2: 11)

As seen above, P2 felt strongly that they had been let down by the ALS, and was not able to ask the questions they needed answers to. Devastatingly, P2 felt as though they had failed their child, and that the ALS was partly to blame by not representing the family or their deceased child in the way P2 both expected and needed. It must be stressed here that the ALS receives wholly inadequate government funding, and has a tremendous caseload. The evidence suggests that culturally informed services such as the ALS have greater grassroots accountability, yet this is stifled when adequate funding does not exist (Moran et al., 2014: 6–7). Given that the ALS supported 28 Aboriginal families whose loved one had died in custody or during police operations in 2022 alone (ALS NSW/ACT 2022: 36), it is vital that the ALS be better funded. Without increased funding for coronial matters, families will continue to feel neglected by the very service that is there to support them. It is important to note here that adequate funding for families involved in coronial matters has been somewhat recognised in international court settings. In *Jordan v United Kingdom*, the court held that a family has 'legitimate interests' in coronial proceedings

where there loved one has died in custody (Tomczak & Cook 2022). Having appropriate legal representation is key to ensuring that families' 'legitimate interests' are protected.

Organisations such as the National Justice Project are beginning to fill this gap. P1 had contact with the National Justice Project following the death of their child, and found them to be supportive of their fight for justice – 'They've been really good' (P1: 12). In order to protect the anonymity of P1 and their family, very little of their experience with the National Justice Project can be discussed here, particularly as at the time of writing this case not yet been subjected to a coronial inquest. However, it is important to note that P1 was able to lodge a discrimination case with the Human Rights Commission due to the support of the National Justice Project, in addition to the negotiation of media releases, and has also received legal advice via this crucial service. This perhaps speaks to the public interest in the persistence and prevalence of the deaths of Aboriginal people, particularly when those deaths occur in state institutions such as the public healthcare system.

Indeed, Aboriginal people continue to face inequity in healthcare settings, influenced greatly by 'implicit racial bias', which too often results in the 'stereotyping of racial minorities and premature diagnostic closure' (Quigley et al. 2021: 9). For P1, this 'implicit racial bias' resulted in the death of their child – 'they were just putting him in a corner, they didn't want to deal with him, you know what I mean? Another Blackfulla … they just think another Blackfulla looking for a bit of painkillers'; '[they] just sedated him, filled him with painkillers and shoved him in a corner for nineteen hours' (P2: 4–5). P1's child died hours after being released from hospital. No diagnostic tests were undertaken to determine the cause of their pain. Following the death of P1's child, the hospital undertook a critical incident investigation – 'these doctors from the hospital rang up and said 'we've done an internal investigation and we wanna sit down with you and your wife over the phone and go through it' and I said yeah fine. And they did that and they come back and they admitted to being biased to him' (P1: 5). P1's child did not have any

medical investigation into the cause of their pain, but instead was given the anti-psychotic drug Droperidol – 'it's to calm people down, they even admitted in this report that he was kind to staff, polite and everything, so why were they trying to calm him down?' (P1: 5). In the end, the only conclusion P1 and their family could come to was that 'they just weren't interested in him' (P1: 6).

Racial bias was also a key contributor to the death of Wiradjuri woman Naomi Williams (Quigley et al. 2021: 15; NSW State Coroner 2016/2569). Ms Williams, a disability worker who had won a NAIDOC award for their work, and pregnant with their first child, died in January 2016. Ms Williams attended the hospital 18 times in the months before her death, and on her last visit was sent away with paracetamol despite having had no diagnostic testing done to determine the cause of her pain. She died 15 hours later of sepsis (Jackson 2019). The death of Ms Williams was at the forefront of P1's mind following the death of their child:

> *All them recommendations were made back then, and the Health Minister, that Brad Hazzard, said this will never happen in NSW, he promised the Williams family, it'll never happen in NSW again, and it still happened.* (P1: 15)

Despite the coronial recommendations made following the inquest into Ms Williams' death, and the proliferation of attention towards health outcomes for Aboriginal people, Aboriginal people continue to die in the very place that we expect to keep us healthy. Indeed, 'the statistical story of Indigenous health and death, despite how stark [it is], fails to do justice to the violence of racialised health inequities that Aboriginal and Torres Strait Islander peoples continue to experience' (Bond et al. 2020: 248) – a violence experienced firsthand by P1 and their family. Also significant here is the way P1 understood their very personal tragedy as part of a bigger issue – the violence of the colony.

Coronial processes

The second theme generated from the codes relates to Coronial Processes. Much of what will be discussed here supports what has already been outlined in the review of the literature. Issues around communication and information continue to be key barriers to effective participation and engagement with coronial processes, as will be discussed below. Also present in the yarns with participants were key concerns around accountability, SNOK determinations, and access to culturally informed and appropriate supports and resources. The following quote illustrates the frustration and fatigue many Aboriginal families face when subjected to colonial coronial processes:

> *It should be so smooth, you know, what we had fifty years of Aboriginal deaths in custody, you know fifty years and we still don't know what the fuck we're doin. You know, how many like four five hundred families have gone through this and we still don't know what the hell we're doin when we get to the inquest, you know. It's sad.* (P2: 12)

We will look first to issues raised regarding communication and information. Timely and effective communication between coronial actors and bereaved families, or the lack of it, has the potential to impact the ways in which the coronial process is experienced. When timely and effective communication[33] is lacking, it infects every aspect of coronial investigations. From the moment the death occurs, communication should be timely, transparent and forthcoming. This communication can take place in the hospital where the person has died – 'a doctor came in and told me, just blurted it out, you know 'your son died'. And I go what the fuck? And all these police are here and I'm like what the fuck are you doing here?' (P2: 3). Police are also responsible for informing families that their

[33] I want to acknowledge here that there can be regular and proactive communication with bereaved families; however, this communication must be coupled with the provision of adequate information.

loved one has died, and where the death follows contact with police this can be further complicated:

> *They said my son was evidence and I couldn't go near him … it was over twenty-four hours we just sittin there waitin he was right there and they wouldn't let me go into that room.* (P2: 3)

When communication with the coroners court is not forthcoming, the bereaved must initiate contact to find out what has happened and what happens next:

> *After that first meeting [the briefing] I rang that place [the Coroners Court] and I said well what happened, you know they don't call you you have to call them.* (P2: 10)

The ways in which this communication takes place is important:

> *The coroner's lawyers got in touch with us and right from the get go she was rude, when we went into the city, um, she said um straight up 'there's nothing going to come from this.* (P2: 4)

The time between communications from the Coroners Court is also a source of great stress for families – 'you know sometimes it was 12 months went by before you even hear anything' (P2: 10); 'we're still waiting' (P1: 4). Excessive wait times between communications from the court has a profound impact upon whether a family feels seen – 'all that we sent to the coroner, you know but that's what I'm saying was it ever read, were they really interested? Or they just too busy to take on you know someone who doesn't really matter?' (P1: 11). Of course, after the initial period immediately following a death, there is often a lengthy wait before a coronial inquest is underway, where one is granted – 'we're still waiting for an inquest, um, into the way that he died, cause um it was with the [local assistant] coroner, and they've only just sent it all to Sydney to the State Coroner, to get them to make a decision' (P2: 4).

When a matter does not proceed to inquest, this can also be a source of much frustration and disappointment, particularly when the reasons for this are not communicated to families effectively – 'um three years [after the death] … that's when they said oh it's not proceeding, and that was it. And I was jus t… we were just left.' (P2: 11). Communication with the coroners court can also be burdensome for grieving families – 'emailing back and forwards' (P1: 7); 'it was just back and forwards' (P1: 2) – particularly when families are not sure why the court requires information – 'I don't know why they were telling us to get all this evidence in' (P1: 7). This overlaps with the last theme discussed in this chapter, whereby families are burdened by the administrative load that these kinds of inquiries entail.

A large part of effective communication is the sharing of information. On top of 'minimal contact' (P1: 1) and being told 'the bare minimum' (P1: 1), knowing who to contact to get information can be confusing, especially as most people have never experienced a coronial investigation before – 'I don't know about the coronial process, it's a whole new ballgame when you're dealing with that' (P2: 14). P1 indicated that they knew who to contact for information because a police officer had told them – 'it was the police officer we first spoke to who put us onto the assistant coroner' (P1: 7). P2 was left to work out who to contact for information on their own – 'I called em [ALS] cause I didn't know what was happening' (P2: 9); 'thinking that the ALS can help you understand the coronial process and … they didn't' (P2: 9). When an adequate amount of information was not provided by the ALS to P2, they undertook their own research – 'I'm on my phone Googling shit because no one would tell you, you know?' (P2: 14); 'even when you um Google about what the processes are even that's complicated, you know, like layman people I can't understand much and I even work in the justice system and I found it hard' (P2: 16). This is a concerning finding, particularly when we know from the literature that informed families feel 'better prepared for' and 'less anxious' about coronial processes

when they have regular communication and thus information (Dartnall et al. 2019: 12). The findings here support earlier findings from others that highlight the 'considerable distress' (Spillane et al 2019: 7), 'pain' and 'anger' felt by bereaved families who do not have enough information about the process or what is to come (Dartnall et al. 2019: 7).

Particularly distressing for P2 was the lack of communication and information regarding post-mortem procedures – 'you know your child is there bein autopsied you know like explain something to me! You know they're cutting up my child for what?' (P2: 13). P1 also desired access to information about the post-mortem procedures conducted on their child – 'I want copies of the autopsy, I want copies of the police [brief], I said I wanna know what's going on' (P1: 12). The lack of communication regarding post-mortem procedures is not unique to the coronial jurisdiction. A study by Keys et al. (2008) found that the failure to communicate the purpose and findings of post-mortem procedures to families is rarely communicated effectively to families. They posit that this is a contributing factor in the decline of (hospital) post-mortem examination rates (Keys et al. 2008).

It also took longer than expected for both participants to receive the police brief – 'took about two years before we got the police brief' (P2: 4); 'the police brief, which I only just got' (P1: 12). Concerningly, neither participant had been given any information from the court about the Coronial Information and Support Program (CISP), or information about any counselling services – 'it's like they weren't interested, you know what I mean?' (P1: 14). The lack of communication and information provision experienced by these participants affected their ability to be involved – 'because you don't know what's happening you can't challenge it or question it you know, until it's too late' (P2: 8).

The lack of timely and transparent communication and information can sometimes mean that families have perhaps unrealistic expectations about what coronial investigations and inquests can achieve. The need for someone to be held accountable for

the deaths of their children was a paramount concern for both P1 and P2, and in particular for P1, who was in the early stages of the coronial investigation:

> *We want someone held accountable, we don't want all these recommendations like what keeps happening, we want someone held accountable, so this stops happening, you know?* (P1: 6)

The desire for accountability is for P1 closely linked with the likelihood of another death occurring in similar circumstances – 'if someone's not held accountable then they just think well we'll still get away with it' (P1: 6); 'someone needs to be held accountable and make this change so it stops happening' (P1: 6). For P1, who had prior knowledge of the inquest into, and recommendations stemming from, the death in similar circumstances of Naomi Williams, recommendations were not enough to spare their child – 'we wanna sit there in the courtroom, we wanna see the staff answer these hard questions, and I dunno who makes the decision, with the coroner saying well I think whether it's you or you or you who should be held accountable' (P1: 14).

For the participants, accountability, or the lack thereof, is tied closely to the recommendations that stem from coronial inquests – 'like I said if it's just gonna be a book full of recommendations it's just a waste of time' (P1: 15); 'the recommendations are not worth the paper they're written on' (P1: 15). For P2, no justice can be found in coronial recommendations:

> *I have no faith in the coronial process whatsoever, I'd rather send coppers straight to criminal law … um you know outside of the um the coronial process and I reckon you get a better outcome then, cause the coronial process is a joke, it's an absolute fucken joke. It's a joke. (P2: 11)*

The expectation for these participants is that someone should be held accountable for the death of their children, and that coronial recommendations are inadequate for preventing

deaths – there cannot be effective recommendations without accountability. It is possible that this expectation stems from the lack of communication and information about coronial processes.

Who is determined to be the SNOK of the deceased has great bearing on the amount of information and communication available to a bereaved person whose loved one has died. In New South Wales, pursuant to section 4(1) *Coroners Act 2009* (NSW), a SNOK is:

a. the deceased person's spouse, or
b. if the deceased person did not have a spouse or a spouse is not available – any of the deceased person's children who are adults, or
c. if the deceased person did not have a spouse or child or a spouse or child is not available – either of the deceased person's parents, or
d. if the deceased person did not have a spouse, child or living parent or a spouse, child or parent is not available – any of the deceased person's brothers or sisters who are adults, or
e. if the deceased person did not have a spouse, child, living parent, brother or sister or a spouse, child, parent, brother or sister is not available:
    (i) any person who is named as an executor in the deceased person's will, or
    (ii) any person who was the deceased person's legal personal representative immediately before the deceased person's death.

If a bereaved person does not meet these criteria, they do not have any legislated right to communications or information from the Coroners Court. For P1, the parent of the person who had died, it came as a great surprise that they would not be considered SNOK. The

mother of the deceased person's children was made SNOK, despite having not been in a relationship with the deceased for a lengthy period of time. P1 tried to fight the determination of SNOK – 'we were trying to prove that we were his next of kin at the time of his passing'; 'we were the ones who looked after him … she didn't have to prove anything to the coroner' (P1: 2). P1 understood the legal implications of the *Coroners Act 2009* (NSW) and how it impacted their fight to be recognised as SNOK – 'the way they looked at it was the person with the … because there was no will it's the person with the highest right' (P1: 9). To protect their grandchildren from being made SNOK, P1 and their family decided not to challenge the determination via the Supreme Court, made possible by section 8.2(97) of the *Coroners Act 2009* (NSW).

However, not being recognised as SNOK made accessing information much more difficult – 'he can just tell us the bare minimum because we weren't classed as Senior Next of Kin' (P1: 7); 'it wasn't us that heard from the coroner, we had to contact them, because we weren't Senior Next of Kin' (P1: 7). This became burdensome for P1 and their family, at a time already filled with grief and anguish – 'so yeah that continuous fight with the coroner, well, not fight but us trying to prove that … you know … we were the ones who looked after him' (P1: 2). Despite providing proof that their child was living with them at the time of their death, and letters from cultural organisations to support this, P1 was not made SNOK. Heartbreakingly, one of the consequences was that P1 and their family did not have the right to receive their child's body upon release from the mortuary. As a result, their child was not buried on their Country. This is a constant source of distress for P1 and their family, and was one of the reasons they chose to take part in this study – 'I would like one day to have that law changed, bring him home. It's a thought I don't really want to deal with, I don't … the thought of disturbing somebody gets … but if it ever happened, it happens, if it doesn't we've got those two plots next to him [where their child is buried] for some family to go there' (P1: 9). Not being determined to be

SNOK has resulted in P1 and their family being haunted by the thought of their child buried alone, on someone else's Country – 'it's colonial law that needs to be changed, it really does, it's just, just … madness' (P1: 4).

Disregarding the importance of burial on Country by the coroner was perceived by P1 as disregarding Culture. Recognition of the importance and protective nature of Culture is paramount to ensure a 'strength-based' approach, whereby it is acknowledged that 'stronger connection to culture and country builds stronger individual and collective identities, a sense of self-esteem, [and] resilience' (Lowitja Institute 2014: 2). Indeed, 'any real attempt to respond to Aboriginal culture[s] must be based on creating a social space in which the lived reality of Aboriginal culture[s] can assert itself over and against the social construction of that reality', the reality of non-Aboriginal peoples (Morrissey et al. 2007: 245). The coroner thus has the responsibility to prioritise considerations of Culture in coronial investigations into the deaths of Aboriginal people. Unfortunately, this was not the experience of either P1 nor P2. With *Culture* the overarching theme, the next section looks closely at the codes that generated this theme – Country, cultural awareness, culturally appropriate resources and support, bias and discrimination, and Sorry Business.

Culture

As discussed above, not being determined to be SNOK affected many aspects of the coronial process for P1 and their family. The most distressing aspect of this for P1 was not being able to bring their child home to Country following their death – 'all we want to do is bring him home and have him buried on Country' (P1: 10). The denial of SNOK status was seen as a denial of cultural practices for P1: 'in our heritage, culture and everything … the parents should just have legal rights to em, to bring em home to Country' (P1: 4); 'he should be brought back to Country, as part of the heritage, part of culture, all this sorta stuff' (P1: 3). P1 gathered letters from a number of cultural

organisations on their Country to support the importance of being buried on Country for Aboriginal Peoples:

> *All we want to do is bring him home and have him buried on Country and you know, the coroner should've took all that into consideration, but they got all the letters, cultural letters from all the organisations here. (P1: 10)*

For P1 and their family, the apparent lack of consideration by the coroner of this important issue led them to feel as though the coroner did not care about cultural matters, despite them providing evidence to support their claims – 'was it ever read, were they really interested?' (P1: 11). The distress and affront experienced by P1 cannot be understated – 'on an Aboriginal side of it I think it's very important because he's buried on someone else's Country now' (P1: 10).

Both participants spoke of the perceived lack of cultural awareness present in coronial processes, noting that 'coroners have just got to take that little bit of extra time when it comes to you know cultural awareness and things like that' (P1: 13). For P2, 'the way the coronial is set up … makes an absolute joke of being Aboriginal' (P2: 11), further stating that coronial investigation into their child's death was 'the worst worst worst. It was never culturally supportive, it was cruel, it was … they spoke of my child like he was some kind of criminal, 'the deceased', oh and I hated that when they spoke about him like you're talkin personal shit here why can't you say his name you know? Called him everything but his name, you know?' (P2: 6). This was further exacerbated by the lack of culturally appropriate resources and supports available to them – 'I thought there'd be Mob there that's always in the court system to meet you and explain some things to you' (P2: 13); 'why isn't there that automatically trigger Aboriginal staff there? Contact you, you know, break the ice make them feel like I'm going to be here walking you through this' (P2: 14). P2 was not aware of any supports available via the Coroners Court, instead seeking support from their local GP – 'my doctor did that, I did all that myself, yeah' (P2:

14). P1 was also not offered support via the Coroners Court, but did receive practical support from an external agency, the Partnership for Justice in Health – 'they said we know you gotta travel four hours to see where your son's buried and things like that so they gave us these two $500 gift cards to help out with travel and stay up there' (P1: 13). The Partnership for Justice in Health also arranged for P1 and their family to access culturally appropriate counselling – 'she's a clinical psychologist, Koori, yeah so she's our psychologist and she's good, you know' (P1: 13).

While the absence of forthcoming supports to these families is concerning, it is important to note here that both P1 and P2 had contact with the Coroners Court prior to the creation of two identified Aboriginal CISP Officer roles, and the appointment of people into those roles. As will be discussed in the next chapter, the creation of these roles appears to have significantly improved the cultural awareness and responsiveness; however, further research is needed to ascertain how these roles have been perceived and experienced by Mob. Certainly, improving cultural awareness and responsiveness is likely to improve coronial processes for *all* families, as well as for Aboriginal families – 'if we can change it for Blackfullas we changing it for whitefellas too, you know, so … no one deserves this, no one' (P2: 18).

Aside from the discrimination felt by participants in relation to Country and Culture outlined above, bias and discrimination were also key features of participants' experiences with external systems, in particular the healthcare system. P1 received communication from the hospital that failed to care for their child, 'where it actually says they were being biased against him' (P1: 5). This bias is linked inextricably to accountability – 'it's not the hospital that's the problem, it's the individuals that are racist' (P1: 6). Recommendations aimed at improving processes at a system level can only achieve so much when individuals are not held accountable for their actions, or lack of action. P1 spoke with great clarity on this issue – 'there's so many Blackfullas dying in the health system, just cause they've been ignored!

It's just … it's racial treatment it's systemic racism and that, and it's gotta stop' (P1: 6). The bias experienced via processes and systems external to the coronial system is then exacerbated when coronial processes and decisions are seen as not culturally supportive, responsive, or aware. Indeed, 'it's such an injustice to our Mob.' (P2: 11). All of these experiences coalesce at a time of great suffering for families, families that are in the midst of Sorry Business. Articulated for non-Aboriginal people as 'death related rituals', Sorry Business is a too-frequent occurrence in the lives of too many Aboriginal people (Nolan-Isles et al. 2021). When a person's child dies in contested circumstances, whether via neglectful hospital staff or via contact with police, Sorry Business is further complicated. P2 eloquently described Sorry Business in these circumstances as ongoing, not able to be completed until justice is seen to be done:

> *We're going through Sorry Business from the time they die to the time we get justice. I haven't got justice so my Sorry Business lastin me and everybody else who's gone through this you know because you can't put your child at peace until you get justice and so we're always in Sorry Business.* (P2: 13)

Burying their child is already a time of immense trauma and suffering for a parent. When the child has died at the hands of the colony, whether that be after presenting to a hospital or after being approached by police, the violence of the colony and ongoing colonisation simmers below the surface. The trauma of generations of colonial violence inflicted on Aboriginal people is witnessed all around us, encapsulated in the present in the deaths of these young people. It is an ongoing, relentless violence, a violence that enters the home of these families when their children die at the hands of the State:

> *We're already in trauma at the fact that you know our kids were supposed to be somewhere safe, you know? Why are they killing them? You know? Why are we dying from them? You know so we're always in Sorry Business.* (P2: 13)

Everything discussed here has a profound impact on the wellbeing on the bereaved individuals at the centre of these coronial process – the families and loved ones of the person who has died. Inadequate access to information and appropriate resources, failures in communication, the unrecognised (or perhaps undervalued) importance of culture and Sorry Business all weigh heavily on those closest to the deceased. This brings us to the final theme arising from these yarns. If the bereaved are not at the very centre of everything coronial actors do, wrapped in culture, they cannot be shielded from the anti-therapeutic elements of coronial processes and the systems that led them here. First, we will examine the practical elements of this burden, the financial, emotional and administrative load borne by the participants. In the second part, the disappointment and invisibility felt by these families will be discussed.

Burdening the bereaved

The financial burden on families can be significant, especially when they are required to travel from regional New South Wales to Lidcombe, Sydney to attend inquests. There is no funding available for these families. Again, we see community organisations, such as the Dhadjowa Foundation, stepping up to address shortcomings. Founded following the death in custody of their mother, Aunty Tanya Day, the Dhadjowa Foundation provides crucial supports for Aboriginal families who have lost a loved one in custody (Dhadjowa Foundation, n.d.). The Foundation can provide peer support, where families are linked with other families and community members who have similar experiences, as well linking people to other community organisations and supports. In addition, the Dhadjowa Foundation provides 'financial assistance for funeral support, Sorry Business, time off work and assistance with travel and accommodation during court proceedings' (Dhadjowa Foundation, n.d.). Led by Apryl Day, daughter of Aunty Tanya Day, this crucial, grassroots organisation has assisted many families since its inception in 2021.

While the assistance it provides to families following a death in custody is incredibly important, there is still a paucity of funding available to families whose loved ones have died in other reportable circumstances, such as by suicide or drowning, or in healthcare settings. Thus, these families bear the full brunt of the costs associated with attending inquests and meetings with legal representatives, such as travel and accommodation expenses. For P2, the financial burden included travelling from their community into the Sydney CBD – 'we went into the city, we had to go all the way into the city to meet her [legal representative]' (P2: 8). For P2, the financial burden of travelling across New South Wales to where their child has been buried, off their Country, was recognised and alleviated by another organisation, the Partnership for Justice in Heath, which provided $1000 for travel expenses to P2. The administrative burden discussed below can also be understood as a financial one – to undertake this administrative work requires access to a phone, to internet, to a post office – all these things require access to resources.

The administrative burden can perhaps be understood as contributing to both financial and emotional burdens. The financial burden involves being able to access phone and internet, and the emotional burden, and indeed cognitive capacity, weighs heavily on the bereaved. For P1, a great deal of information had to be gathered from various sources in an attempt to prove their right to be considered SNOK:

> *State Debt Recovery fines, notices, things like that, he was payin off, all that mail, everything was comin* here. *I produced all that, done a stat dec,* saying *how I was his administrator for the last five years, I got support letters from his drug and alcohol counsellors, his doctor, which is here … all this* evidence, you *know, just trying to show that they weren't a couple, at* least *at the time of* his *death, you know? (P1: 3).*

The administrative burden for P1 also included gathering evidence regarding the importance of burying our loved ones on Country – 'we even got letters from organisations down here where he grew up … stating how he should be brought home to Country as part of the heritage, as part of culture' (P1: 3). A recent study has sought to explore the administrative burden placed on the bereaved following a death, with one noting that 'high administrative burden within the context of significant grief and mourning' is a defining and common featuring of the early period following the death (DiGiacomo et al. 2015: para. 3). DiGiacomo et al.'s (2015) study, however, focuses on the experiences of administrative burden and bereavement following expected deaths, such as those after palliative care. There is a lack of research, particularly in Australia, that focuses on the financial and administrative burden of death on the bereaved. This is sorely needed in order to better understand how this is experienced by families, especially following contested or unexpected deaths, in order to influence policy making and assistance available to these families. For P1 and P2, the administrative burden during a time of tremendous grief only added to their distress – 'every day was just a battle I was doin hundreds and hundreds of emails … it was just non-stop and I thought we were getting somewhere and it just didn't' (P1: 11); 'months and months and months go by you don't hear from no one and go well what's going on like you're chasing people up constantly you know' (P2: 10). Illustrative of how inextricably positioned these burdens are, financial and administrative burden greatly affects the emotional burden carried by bereaved Aboriginal families. This is particularly salient when considering the compounded trauma experienced by families who have had multiple experiences with the coronial system – 'it shouldn't be this hard! You know, we … when it happens so often it shouldn't be this hard' (P2: 12).

The emotional burden for families is magnified when coronial processes are not communicated effectively to them, when information is not forthcoming, and when they

do not feel seen nor heard by the coronial system. P1 is at the beginning of their coronial investigation, yet already has questioned 'was anything ever read, were they really interested?' (P1: 11), feeling as though the coroner sees their child as 'someone who doesn't really matter' (P1: 11). P2, whose coronial investigation has been completed, felt excluded and invisible – 'I never even got to talk I never even … I didn't even get to say my thing' (P2: 7). This led to feeling disrespected by those meant to represent them and their child:

> *And I'm like no mate! No! You're not asking the questions you're not yelling out you're not … you can't just let people blurt shit out bullshit you know like without challenging it and I'm sitting there listening to that shit you know? And then disrespect me and tell me to be quiet?!* (P2: 13)

These feelings of exclusion, invisibility and disrespect caused a great deal of anguish – 'because of the way we were treated I let him [their child] down, I feel like they let me down, I've let him down, I'm still letting him down, you know?' (P2: 15). The greatest disappointment for P2 was never feeling as though they had the answers about the circumstances of their child's death, and the death of another family member in a sperate matter, that they so craved – 'But a lot of the times you don't find out why. Why your loved one's have gone. And the coronial process shouldn't be like that' (P2: 15).

3. Key findings: Bearing witness - Coronial harm and colonial violence

This chapter sits at the heart of what this thesis is trying to do: centre Aboriginal experiences of the NSW coronial system, and to show how, despite its stated purposes of fact-finding, public interest and death prevention, this system operates as a mechanism of settler-colonial governance in the present. The survey and yarns do not simply describe 'service gaps' or 'process issues'; they illuminate a system that routinely reorganises

Aboriginal people's grief into administrative categories, reconstitutes Aboriginal lives and deaths into official narratives, then calls that outcome 'care' or 'prevention'. This is precisely where Razack's work, discussed earlier, is analytically useful: it helps name the coronial jurisdiction as a site of governance – a place where the state produces legitimacy by staging its concern for life while simultaneously obscuring its own role in the conditions of death.

Across the earlier chapters, I have argued that coronial processes are not neutral. They are embedded within the same settler-colonial structures that shape policing, health, child welfare, and carceral systems. The findings presented here gives empirical weight to this argument. What looks like 'routine administration' from the institutional perspective (forms, timelines, briefings, determinations, post-mortems, and recommendations) is experienced by many Aboriginal Peoples as harm, during a time when families are trying to survive grief and fulfil cultural obligations.

This matters. The academic coronial literature has long documented the familiar problems: delays, poor communication, inadequate information and the distress these produce for families. These survey findings and yarns both support and extend that literature: families want to understand what happened, they need regular information, and when the system withholds this it becomes counter-therapeutic. The pattern is not new; what is new is how those same procedural failures are experienced through Aboriginal kinship, cultural protocols and the everyday reality of state power and violence.

The delays and information gaps are part of how settler law governs: by requiring families to wait, to chase, to prove, to translate legal language, to endure the slow grind of institutional time while holding fresh grief. In Razack's (2015) terms, the inquest and the investigation can become a performance of the state's essential goodness – its pledge to 'do better' – while the lived experience of families is indifference.

One of the clearest ways this chapter extends the earlier theoretical framing is its demonstration of the coronial system's power to control the story. In these yarns, both parents are trying to speak truth about their children: who they were, what happened and why accountability matters. Yet they keep encountering the structural, not accidental, limits of the system's imagination. They are produced by law's individualising logic (e.g. treating each death as isolated), by evidentiary rules that privilege institutional voices and via hierarchies of credibility that keep families at the margins (Becker 1967).

The participants have described this as invisibility, as *not being seen or heard*. This language in itself marks the point where the coronial system's proclaimed 'public interest' collides with a settler-colonial reality in which Aboriginal families must fight to have their knowledge of their person treated as legitimate. This is consistent with Razack's (2011, 2012, 2015) critique of legal processes as producing regimes of truth: not a neutral truth, but an authorised narrative that often absolves the state while pathologising Indigenous lives.

The survey's divergence between 'respect from court staff' and 'variable or negative experiences with police' also fits this analytic frame. Police are not simply an 'external stakeholder' to coronial processes; they are a governing presence that shapes what becomes knowable. When families describe evidence being hidden, requests for information being labourious, names not being spoken, and 'no responsibility', they are describing a familiar colonial dynamic – the state controlling the conditions under which its own actions can be scrutinised. The problem is not only that families experience the process as traumatic; it is that the structure of investigation is built in a way that repeatedly centres state narratives and fragments family and community knowledges.

If there is one place this chapter most clearly builds upon and extends the coronial literature discussed, it is in showing that culture is not merely a consideration to be 'respected' alongside legal processes; it is a contested field where settler law asserts

authority over Aboriginal relationality. The SNOK section is the sharpest illustration of this. SNOK looks like a technical determination. In practice, it is a mechanism by which the state decides whose grief counts, whose voice is authorised and whose cultural obligations can be fulfilled. The experiences of participants, whereby parents are forced to 'prove' their relationship to their own child, while a legally prioritised person does not, shows how the coronial system enacts a settler logic of kinship that can directly override Aboriginal kinship and community recognition. That is not a mere procedural problem; it is colonial governance in intimate form. It is the state deciding who holds the right to information, who receives the body and ultimately whether burial on Country can occur.

This is exactly why the theme of Culture cannot sit on the periphery of analysis. Figure 22 (wrapping culture around the bereaved) has deep theoretical alignment with Indigenous paradigms of relationality and with the earlier critique of the coronial system's capacity to warp intimate knowledges (Spillane et al. 2019). Put bluntly: in these findings, culture is not what the system sometimes forgets to accommodate. Culture is what the system is structured to subordinate unless it is deliberately centred and protected.

This chapter has also demonstrated how the coronial system burdens families in ways that are simultaneously administrative, financial, emotional and cultural. The theme *burdening the bereaved* is not simply descriptive; it is analytic evidence of administrative violence – the harm done through routine requirements, delays, proof demands and procedural labour imposed on bereaved families.

The survey responses about unmet needs, such as legal advice, housing support and transport, should be read alongside the yarns about 'hundreds and hundreds of emails', chasing updates, gathering documentary proof and doing the work of the system – work the system does not do. This is a key convergence with coronial literature about information and support deficits, but it also extends that literature by showing how the burden is amplified when families are Aboriginal and already positioned in relation

to state institutions through histories of surveillance and coercion (Cunneen 2001). This is where Razack's work again resonates: the state can appear to be doing a lot (investigating, documenting, holding an inquest) while families experience indifference: indifference to culture, to grief, to timely communication and to meaningful accountability. The administrative burden is not neutral paperwork; it is a form of governance that disciplines families into compliance with institutional timeframes and categories, even as families are trying to navigate and survive their loss.

The ways in which participants have shown scepticism about coronial recommendations ('not worth the paper they're written on', 'a waste of time', 'a joke') should not be dismissed as cynicism. It is a reasoned, and in my view reasonable, response to a system in which recommendations often function as a performance rather than a mechanism of change. Coroners can make recommendations, but without enforceable accountability mechanisms, the same preventable harms recur. P1's reference to Naomi Williams' death and subsequent inquest is particularly significant, because it shows families are tracking the system's failures across time; families are watching promises of 'never again' become 'again', and understand their own tragedy as part of a structural pattern rather than an isolated misfortune.

In Razack's (2023) terms, this is the 'sorry happy' logic: the state can be sorry a death occurred and happy with itself for pledging to do better, even when nothing structurally changes. The participants' insistence on accountability, such as someone being held responsible, not simply 'learning lessons', is therefore not just a demand for personal justice; it is a refusal of the state's legitimising performance.

This chapter has also presented evidence about where Aboriginal families actually find support. The survey shows that most respondents did not use court-based counselling, yet friends, family, community and local GPs were consistently rated as helpful. This is important because it shifts the analytic lens from 'what services exist' to

‘what care is trusted and accessible’, and it raises serious questions about cultural safety in mainstream court-linked counselling. This is also a relational finding: families are turning towards networks and practitioners embedded in community life, rather than to an institution that, for many, is synonymous with police, corrections and other arms of the state. That pattern makes sense within settler-colonial governance analysis: people seek safety where they are not subject to scrutiny, categorisation or institutional control. While the survey data is not representative, the suggestion that GPs may be acting as de facto coronial support workers is a compelling implication for practice and policy, one that also invites further research into what information and resources GPs need to support bereaved Aboriginal families navigating coronial timeframes and processes.

Finally, this chapter has made visible something that sits slightly outside conventional coronial scholarship, but supports the broader theme of colonial violence: the racist abuse that emerged through survey recruitment on Facebook. This is not incidental ‘background noise’; it is part of the context in which Aboriginal people grieve, seek information and attempt to tell their stories. In a practical sense, online racism is a barrier to participation, disclosure and community-facing research. In an analytic sense, it demonstrates how the colonial governance of the deaths of Aboriginal people extends into contemporary platforms where Aboriginal People attempt to connect, memorialise, and seek support. The decision to hide comments to protect other First Nations users is, in itself, a practice of cultural safety, necessarily performed because the platform did not provide it. This is another form of displaced burden: Aboriginal people doing the labour of making spaces safe(r) in environments structured to tolerate or amplify harm.

Taken together, the survey and yarns confirm key themes in the coronial literature discussed earlier in this thesis (delays, communication failures, lack of information, trauma), but also extend that literature by showing how those features operate as colonial governance when the families involved are Aboriginal. The findings demonstrate that:

- Coronial harm is not only located in 'big moments' (the inquest) but in the slow violence of waiting, chasing, proving, and being denied information.
- Culture is not a supplementary consideration; it is a decisive site where settler law asserts authority over kinship, Country, and the dead.
- Recommendations without accountability reproduce the state's legitimacy without preventing future harm, providing fuel for families' justified scepticism.
- Aboriginal families routinely seek care outside the coronial institution, through community, GPs, and culturally specific supports, raising questions about the cultural safety and accessibility of mainstream court services.
- The coronial system cannot be disentangled from policing and healthcare inequities; it is enmeshed in the very state institutions that shape the conditions of deaths of Aboriginal People.

These are not abstract points; they are grounded in the participants' stories of losing children to state violence, then being asked to navigate a system that reproduces their trauma rather than alleviating it. The participants are not simply 'respondents'; they are people insisting the system must change because no one else should be forced through the same harm. Their participation is itself a form of resistance: a refusal to let the state's narrative be the only narrative.

I want to take a moment to recognise the burden placed on these participants by being involved in this study. Their strength in the face of such trauma is certainly something to behold. Both participants chose to take part in this study for altruistic reasons – put simply, they do not want another person to go through what they have. When thanked for taking part in a yarn, P2 said 'this is why I want to so this doesn't happen, you know?' (P2: 15). For P1, their motive is clear – 'we can't bring him back I should say but the best you can do is try and change it, stop it happening to anyone else, cause yeah … it's just wrong, so wrong' (P1: 16). I am forever grateful to these participants for trusting me with their grief, and for sharing with me stories of their children in both life and death.

The findings in this chapter have clear implications for both coronial practice and reform in New South Wales. Taken together, the survey and yarns underscore that the most consistent sources of harm are not isolated 'bad encounters', but structural features of coronial governance: a lack of communication; prolonged delays; inconsistent information provision (especially after inquest); and the routine displacement of administrative and emotional labour onto bereaved families. These harms are intensified for Aboriginal families because they intersect with culturally specific obligations – Country, kinship, and Sorry Business – and with the long historical and contemporary entanglement of police and other state institutions in the life and death of Aboriginal people. The chapter therefore strengthens the thesis's argument that improving Aboriginal families' experiences cannot be achieved through symbolic recognition alone, but requires enforceable, system-wide standards for timely communication and wrap-around support; culturally competent decision-making that genuinely accounts for kinship and burial obligations; and reforms that address the limits of recommendations without accountability. Finally, it provides a baseline against which NSW Practice Notes, Protocols and the creation of identified roles can be evaluated. It clarifies precisely what those reforms must interrupt: opacity, exclusion, procedural burden, and culturally unsafe interactions.

The next chapter introduces the work of the Aboriginal CISP Officers. By virtue of these roles, many of the issues identified by the participants are now being addressed. The Aboriginal CISP Officers ensure timely and consistent communication with families, providing information about coronial processes and the supports available to families in a proactive way. They also work hard to ensure that the cultural responsibilities of families are recognised and respected, and that families are able to fulfil these responsibilities wherever possible. As will be seen, however, the Aboriginal CISP Officers themselves also carry heavy burdens in doing this work.

5

‘The only Blackfulla in the building’: Experiences of an Aboriginal CISP Officer

The previous chapter centred the experiences of bereaved Aboriginal families with the coronial system in New South Wales. A number of systemic issues were identified, including the potential for police to act as sites of trauma or as sources of information. The lack of proactive communication and the provision of timely information about the coronial system was a site of distress for both P1 and P2, as was the burdens placed on them throughout the coronial investigation. Significantly, the lack of cultural recognition and cultural safety afforded to these family members profoundly impacted the entire coronial process. This issue has started to be addressed by virtue of the creation of two Aboriginal CISP Officer roles within the NSW Coroners Court. This chapter provides an overview of the Aboriginal CISP Officer roles and will introduce the yarns I had with one of the Aboriginal CISP Officers. How these positions are situated within the broader context of Aboriginal employment in NSW is also discussed.

1. Creating the Aboriginal CISP Officer roles

The Aboriginal CISP Officer roles were announced to the broader public in 2022 (Gooley 2022). These roles were envisioned to assist Aboriginal families who have become entangled within the coronial system due to the death of a loved one. There has been a highly publicised increase in the numbers of Aboriginal people across New South Wales, and the rest of Australia, who are dying at the hands of colonial machinery, whether that be in the custody of police or corrective services (Demetriadi 2023), in other forms of state ‘care’ (Howarth 2023) or simply for daring to exist as an Aboriginal person in a public place (Menagh 2023); this all adds to an increase in the number of deaths being reported to the coroner. Between 2021 and 2022, 24 Aboriginal and Torres Strait Islander

men and women died in the custody of some form of custodial authority in Australia (McAlister & Bricknell 2022: 44). In New South Wales during the period 2021–22, 10 Indigenous people died in either police or prison custody. Five of these died in prisons, all of whom had their cause of death listed as 'natural causes' (McAlister & Bricknell 2022: 36). The other five individuals died either in police custody or during 'custody related operations' (McAlister & Bricknell 2022: 37). These five died from a number of possible causes, including gunshot wounds and external trauma; however, the causes of death in this category are not distinguished by jurisdiction. Since the RCIADIC (Johnston 1991), more than 516 Aboriginal and Torres Strait Islander people have died in custody, and the number continues to rise while this thesis is being written (McAlister & Bricknell 2022: 44). Thus, it can be surmised that the number of Aboriginal families having contact with the coronial system is rising in proportion, so it is imperative that they are met with culturally responsive services. This is the gap the Aboriginal CISP Officer positions are intended to fill.

In a letter to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (2020) on 24 March 2021, State Coroner Teresa O'Sullivan advised that 'two Aboriginal Family Liaison Officer roles have recently been created with recruitment to commence shortly' (NSW Parliament 2021: 138). By October 2021, both positions had been filled under the new title of Aboriginal Coronial Information and Support (CISP) Officer. The roles were advertised as providing practical culturally safe supports to Aboriginal people and families throughout coronial processes and during coronial inquests. The only essential requirements applicants should possess were to be an Aboriginal person, and to hold an unrestricted driver's licence with a willingness to travel to regional areas. The roles are, however, much more complex and nuanced than they first seem. The ACISP Role Outline provided by their employer to the Aboriginal CISP Officers sets out all of the distinct and varied duties expected from those

employed in the roles. There are approximately 28 key duties for which the Aboriginal CISP Officers are responsible, and at least 10 key stakeholders with whom they are to build and nurture relationships. The Aboriginal CISP Officers are required to:

1. Provide information, support and guidance to families and next-of-kin
2. Commence initial triage
3. Attend multidisciplinary meetings
4. Liaise with NSW Health Pathology
5. Liaise with NSW Police
6. Discuss post-mortem procedures and arrange viewings for the Senior Next-of-Kin (SNOK)
7. Facilitate repatriation of deceased to Country
8. Facilitate referrals to 'Aboriginal agencies'
9. Organise funeral assistance
10. Make arrangements that appropriately and safely accommodate large family and community groups at inquest
11. Embed 'responsive cultural protocols into the work of the Coroners Court'
12. Travel to regional areas to meet families and build rapport
13. Facilitate the viewing of traumatic materials
14. Provide therapeutic support
15. Liaise between interested parties and individual family members
16. Assist unrepresented family members to communicate needs to coroner
17. Engage support of community organisations to facilitate funding for travel and lunches
18. Co-ordinate services and communication

19. Co-ordinate interagency engagement with families, NSWHP, NSWPF and CSNSW
20. Responsible for initial contact with SNOK within 48 hours of a death in custody (DIC) occurring
21. Provide bi-monthly updates to families
22. Facilitate meetings meeting between legal representatives, the Crown Solicitor's Office, Officer In Charge, SCNSW, NSWHP and family 14 weeks after date of death (for DIC)
23. Contribute to professional and community education forums
24. Maintain ongoing communication with community support groups
25. Be aware of, attend and participate in 'First Nations conferences', community meetings and education seminars
26. Perform additional duties to provide education and information to media and other coronial staff about the nature of the role and advocacy for families
27. Assist with research and analysis –
    a. Identify First Nations cases
    b. Record data on spreadsheet
    c. Provide detailed record of First Nations cases reported each year
28. Provide an objective[34] and professional service

In practice, the Aboriginal CISP Officers do this and more, all while operating in an environment that is neither culturally responsive nor safe. Further, the demanding nature of the role, coupled with the complexities of being in an identified role in a white

[34] This is problematic in and of itself. How can an Aboriginal person, in an identified role, working with Mob, be objective? This perhaps speaks to the vastly different epistemological, ontological and relational perspectives between Aboriginal and non-Aboriginal people.

institution, has perhaps contributed to one of the Aboriginal CISP Officer roles being mostly vacant during the approximately 18 months[35] the roles have existed. Thus, one Aboriginal CISP Officer is tasked to do the work of two,[36] a workload that was already hugely demanding. With this in mind, we move now to the yarns had with the Aboriginal CISP Officer employed at the time of writing, ACISPO1.

2. What's really going on? Thematic analysis and yarns with an Aboriginal CISP officer

At the time of data collection, one person was employed in the Aboriginal CISP Officer role. The opportunity to yarn with them about their experiences has provided an additional insight not only into the coronial system and the ways in which its processes affect families, but into what it is like to be the only Aboriginal person working in an institution focussed on death investigation. The complexities of existing in this space can only be understood by using a multidisciplinary approach to the literature – scholarship on everything from cultural safety and responsiveness to the emotion work involved in working in death investigation settings has been utilised to tease out each element of the thematic analysis. This section will delve into the yarn with the Aboriginal CISP Officer followed by a discussion centred on key findings. First, however, we will look to the practical steps taken in order to thematically analyse the yarn.

The yarn with the Aboriginal CISP Officer was undertaken in a face-to-face setting at the Coroners Court in Lidcombe. The audio was recorded and transcribed by me. The resultant transcript was then read multiple times while listening to the audio of the yarn to 'audit' the transcription – in other words, to verify its accuracy. This also allowed me to engage deeply with the yarn, uncovering new areas for analysis with each reading. The de-identified transcript was printed and reread multiple times before preliminary coding began. Preliminary codes centred on the workload borne by the Aboriginal CISP

[35] Eighteen months at the time of writing, April 2023.
[36] At the time of writing. Both roles are now filled.

Officer; the emotion involved in the role; and complexities of being in an identified role such as this. Unfortunately, this is where a hurdle arose. This yarn covered a lot of ground, and the multiple and varied issues were not as familiar to me as the issues found within the yarns with family members. This forced me to consider this yarn in a different way, and to engage with literature from unfamiliar disciplines. This perhaps exemplifies the complexity of experiences as an Aboriginal person in an identified role working within a state institution to improve processes for Mob – the complexity of adapting to different ways of doing things while maintaining integrity and accountability. To overcome this hurdle, and stimulate the analysis of such a different piece, the qualitative software NVivo was used to verify preliminary codes and to see whether any new themes or codes emerged.

Four key themes emerged following close analysis of the transcript: *workload*; *emotions*; *culture*; and *stakeholder relationships*. *Stakeholder relationships* was not included in the initial rounds of coding for themes but emerged following the use of NVivo. Each theme will now be discussed in turn, separated into the sub-themes that inform it.

3. Workload

Workload: Day-to-day duties

The Aboriginal CISP Officer roles consist of two main parts – triage and inquest support. Triage occurs when 'someone passes away and they initially come into our care' (ACISPO1); it is the initial contact made with the next of kin of the person who has died, and the preliminary conversations that occur. The second element of the role is that of inquest support – 'when matters progress through the coronial process and they've reached that um that court hearing process' (ACISPO1); however, 'on a day-to-day [basis] it can differ, like depending on what sort of part of the role I'm doing for that day' (ACISPO1). Each day begins with a 9.30 am meeting, or 'huddle', where all new admissions are discussed in addition to active cases. This 'huddle' is followed by two more

throughout the day, at 11.00 am and 2.00 pm, the latter attended by the duty coroner. This is where the coroner may advise whether a person will receive a coronial death certificate, or whether a post-mortem examination will be required. Following each 'huddle', 'we just sort of keep the families updated' (ACISPO1). At the time of speaking with the Aboriginal CISP Officer, there were 42 open inquests into the deaths of Aboriginal people. In addition to these open matters and the three daily huddles, the role involves liaising with families and next of kin, and daily triage. For the Aboriginal CISP Officer:

> *every day is so different like some days you might have like five passings come in overnight and then other days I've had zero, but really it's really difficult to tell but those are the kind of like holistic numbers that we're working with but um yeah like my phone just doesn't stop.* (ACISPO1)

The triage that occurs immediately following a person arriving at the Coroners Court and Forensic Medicine Complex is significant. Aboriginal CISP Officers are expected to be the first point of contact for the families of the deceased, and to liaise between the coroner and the SNOK. Initial contact usually proceeds as described by the Aboriginal CISP Officer:

> *I'll make the initial call to that family on that day, and I'll say I'm the Aboriginal coronial support officer and I'm calling to let you know that your loved one is in our care here at Lidcombe, are you aware of that? Um, you know, we're looking after them, and you know as long as they know exactly where their loved one is then and um and who's caring for them and everything like that.* (ACISPO1)

This is often a lengthy phone call, wherein the fears and concerns of the family members are addressed and allayed wherever possible. This is an extremely important, but time-consuming, part of the role:

> *If you're doing the triage stuff it consumes your day, you're calling families, you're letting em know, hey, you're loved one's here, we're looking after them they're in our care, you're calling them giving them updates like hey this is the information from the coroner this direction's been given, um but then all the in- between stuff as well, so this is such a huge thing.* (ACISPO1)

There is also the liaison work that takes place, whereby the Aboriginal CISP Officers are required to contact the SNOK on behalf of the coroner. Typically, this relates to discussions around post-mortem procedures, including viewing the body of the deceased and the appointment of the 'correct' SNOK.

> *[I]t's flagged with me, like can you help resolve this SNOK dispute, or you can you clarify senior next of kin in this matter, cause … we have that hierarchy and you know and so there's things that I can do in one or two phone calls that the coroner hasn't been able to achieve in 8 hours and so they'll ask me to sort of follow up on that …* (ACISPO1)

> *[S]orting senior next of kin, um we do the viewings, so um if they want to come down and spend some time with their loved one we'll go for that, um, just anything that really pops up.* (ACISPO1)

The Aboriginal CISP Officers are also responsible for organising repatriation back to Country where required:

> *And like, for us, Sorry Business is like … the assistance, the financial assistance to try and help cover the cost of the funeral, we do like repatriations like back to Country within New South Wales … so I can organise that um on my end with our contract provider, so if a family wants to take their loved one back to Moree or something and I can facilitate all of that.* (ACISPO1)

All this falls within the scope of the initial triage undertaken. In addition, there is also the responsibilities undertaken for families who are moving through the processes of a coronial inquest.

> *[T]he day-to-day inquest side of things can be anything from liaising with families, giving them updates about their loved one, viewing sensitive material, like I'll go out and I've taken my laptop out and I've watched footage with people at a location of their choosing, um so all that kind of stuff.* (ACISPO1)

The triage and inquest support aspects of the role are only a small section of the approximate 28 duties assigned to the roles. It is crucial to remember here that, since the creation of the Aboriginal CISP Officer roles, only one position has been consistently filled. At the time of yarning with the Aboriginal CISP Officer, the other position was vacant – 'I mean at the moment it's only me' (ACISPO1). The day-to-day workload of the Aboriginal CISP Officers is significant – when there is only one person working in the role, the workload is crushing:

> *The workload is absolutely huge. Um, it's massive I honestly don't know how I do it … so um I've got 42 active inquests open at the moment that are progressing through a formal hearing um and when we've got 42 active inquests and yeah like we have the um the 338 passing this year.*[37] *So that's the kind of numbers that we're working with here, um plus all the extra stuff like I come and do talks and come to meetings and um the healing circle project um things like that are all extra add-ons to the role (ACISPO1).*

The workload itself is a pressing issue. Combined with the emotion involved in working in a death investigation setting and the complexities of being in an identified role, it is

[37] The end of 2022.

perhaps no wonder that the role has seen significant turnover in a relatively short amount of time. Before moving to the themes of *emotions* and *culture*, the other elements of the theme *workload* will be discussed – the specificity of Aboriginality within the Coroners Court; the idea of being an 'outsider professional; and issues with resourcing. All these issues impact the ability of the Aboriginal CISP Officers to successfully fulfil their responsibilities.

Workload: Aboriginality and the Coroners Court

Coronial investigations do not occur in a vacuum. Each reportable death of an Aboriginal person is a death that occurred within the colonised state, within a colony that continues to exact violence upon Aboriginal lives in a multitude of ways. While contentious deaths such as those occurring in various forms of state custody are obvious examples of the kinds of fraught histories brought to coronial inquiries, all deaths of Aboriginal people must be understood as occurring within the context of colonialism. The deaths of Aboriginal people are all tainted with the violence of colonisation and of the state, whether a death occurs in a gaol cell or in a hospital bed from so-called natural causes. Thus, when the death of an Aboriginal person is reported to the coroner, initiating a coronial investigation, the family and next-of-kin of the person who has died bring the whole history of colonisation with them to the coronial processes, both embodied and etched across Bla(c)k bodies. For the Aboriginal CISP Officers, who also bear the histories of colonisation, this requires them to both navigate and interrogate a colonial coronial space. The lived experience of the failures of government bodies to provide meaningful assistance is at the forefront of their mind:

> *[E]veryone's already going through like one of the most difficult times in their life, like they don't have time to hear lies like the last thing you need is to be let down by some government worker like um again.* (ACISPO1)

This violence too often leads to repetitious contact with the coronial system:

> *I've had a few families now where I've had three or five of their loved ones um, come through this office since I started a year ago.* (ACISPO1)

> *[H]aving to come back to this building, like this building makes people feel sick you know, and and the um yeah like it's just loss on loss on loss and grief on grief on grief and it's just all compounded um and then like it gets to a point where there might be several funerals going on.* (ACISPO1).

This over-representation in the coronial system is something that has to be proven, and driven by data that until the appointment of the Aboriginal CISP Officers was not being collected:

> *[E]verybody's always been like oh yeah you know we're over-represented, we're over-represented but when you actually really drill down into the actual numbers, and I think like since I've done that people are more like wow, we've got like real issues here – everywhere – um in all types of deaths reported to the coroner.* (ACISPO1)

> *I'll track sections from all deaths so um child risk notification or disability home, I'll track um Section 23 deaths, so deaths in custody or deaths resulting from a police operation, because we didn't have the data last year.* (ACISPO1)

> *I even had the like [government agency] contacting me about my data, um, because they don't track First Nations suicide rates, and I'm like how is that ... how can you call yourselves the [government agency] and not have that data?* (ACISPO1)

That this data were not being collected until now is perhaps indicative of the value the state and its machinery places upon Aboriginal lives.

All of this informs the relationships that the Aboriginal CISP Officers form with the families and loved ones of the person who has died. For the Aboriginal CISP Officer who took part in this study, the value of having an identified role for Aboriginal families cannot be understated.

> *I've seen the difference of a family's journey from me making that first contact and guiding them through the process where I'm able to carry them through it a bit, as opposed to a white social worker making first phone call, um and then um I'm just cleaning it up after that, because the language used is confronting, um the workload they're often quite abrupt in the way that they're talking to families, and they're like, you know, like just because they're doing this work every day doesn't mean families are having these yarns about do they want an autopsy conducted on their loved one and so it's really um it's a big difference.* (ACISPO1)

The Aboriginal CISP Officer is also keenly aware of the gravity of being in an identified role such as this:

> *It's just like the integrity of the role, and everyone's already going through like one of the most difficult times in their life… like I was saying like if you're in an identified role like if you want to be in it make sure that you're in it for the right reasons, otherwise get out and let somebody else do it. That's like that's my thinking.* (ACISPO1)

and of the impact that they have upon how a family experiences coronial processes following a death:

> *lot of families like in terms of deaths in custody know that like it will go to inquest, and um you know they want answers and well like they do for all types of deaths, um when it's like you know, other reportable deaths to the coroners everyone's like um what now, what's gonna happen now, and so*

that's why it's really important like that like I was saying that first phone call which you can really talk them through the process that way if you're making the first phone call. Um whereas if you're not then you don't have any sort of control over like things not being explained like in my experience um a lot of families the process is like very like you know daunting it's scary it's um, you know, they just want to know where their loved one is what's happening and how long. (ACISPO1)

It's tough, like um I'm generally just open and transparent and straight up with families and just like explaining the process as much as we can, I think that um having those yarns early on sets the tone for the rest of the process you know, they haven't really had that like a lot of families haven't had that direct experience like they might know like family or Aunties or whatever might have been through the process, but a lot of people are experiencing it first-hand like and they've never had to experience it before and so like you try to negotiate as much as you can like knowledge is power and just like try to be honest. (ACISPO1)

It is also the responsibility of the Aboriginal CISP Officer to navigate disputes concerning SNOK. The legislatively recognised hierarchy does little to account for Aboriginal kinship structures, and this can be a source of great distress:

It's hard, it's hard because it's a white definition of family, and the birth family always gets wild when when the defacto or whoever is listed, cause it defaults to them first right, and so um 100 per cent, I'm always just like are you sure they were living together like are you sure mum can't be SNOK (laughs) cause I just know that for us the family organises everything, and you know nine times out of ten the defacto is usually um consenting of that, so like even like if we call senior next of kin and the defacto it's legally

defaulted to them in the first half an hour hey I've been in contact with mum or dad, I want to relinquish senior next of kin to them, I want to be respectful, we can update that instantly, or like they go off like and the rows start happening and like they're being cheeky to each other. (ACISPO1)

Despite the legislated definition of SNOK being at odds with our own understandings of senior family members, the Aboriginal CISP Officer has devised ways to recognise and support these understandings while adhering to the legislative understanding of SNOK:

We might have like a senior next of kin appointed in terms of like the coroners court hierarchy, but sometimes we might have a point of contact listed and so a lot of that senior next of kin has said like hey I'm comfortable being senior next of kin but I would prefer that my brother be listed as point of contact or my son or my dad or um whoever, um so that's often done at triage stage. (ACISPO1)

Occasionally, when these details are not updated, it can be a source of great distress:

We do get the Uncles and that call and they're blowing up like what do you mean you can't talk to me? So the easy fix is having that person listed as next of kin on the system, and then we can talk to them. (ACISPO1)

Misunderstandings and miscommunications such as these can be a source of great distress for bereaved families engaged with the coronial system. The Aboriginal CISP Officer represents an opportunity to do things the right way, at every stage:

It's the approach in like calling them and telling them what to expect and giving them an opportunity for ceremony or coming in and you know picking out one of our blankets or you know having that level of care goes a long way for them, and like seems to empower them like decision making

> *processes like being able to be told like no like I object to a post-mortem and knowing what they're actually expecting to or um you know like giving them that decision making power um but also like you need that kind of stuff even at inquests like having acknowledgements of Country done by the coroners at the start of the proceedings, giving like sensitive warnings when that sensitive materials will be shown, referring to a deceased person in the way that the family wants them referred to, things like that around like approach rather than process.* (ACISPO1)

While the approaches taken by the Aboriginal CISP Officers cannot undo the harm caused by the colonial state, they can go some way towards alleviating the distress suffered by families.

Workload: Outsider professional

The legitimacy of the Aboriginal CISP Officer roles appears to be questioned by some coronial professionals, imbuing further complexity into how the Aboriginal CISP Officers themselves experience the role. There appears to be two parts to this phenomenon: perceptions concerning identified roles, and a perceived lack of professionalism or education. These combine to produce what I have termed the 'outsider professional'. The 'outsider professional' might hold the same level of qualifications and training as their peers, yet is not regarded in the same way as those not in identified roles. It would perhaps be easy to say that this is a result of racism, and while this may well be a contributing factor, there is perhaps more going on here. The 'outsider professional' brings with them a different perspective and understanding of their role, which challenges the hegemony or dominant narrative constructed within the workplace. The Aboriginal CISP Officers, by virtue of being Aboriginal people, bring a different perspective to the workplace than their non-Aboriginal peers. Ironically, it is this differing perspective that is key to being in an

identified role.[38] This has, however, created some tensions for non-Aboriginal CISP workers at the Coroners Court:

> *[I]t's really like um 'oh what can you do that I can't do' like that type of attitude, and they're all social workers and so they um are tertiary qualified social workers like um so am I which has helped me a lot, because I can turn around and say I have the same piece of paper that you have when they try to come at me with that, whereas I know some of the other ACISP Officers didn't, it's not a requirement to have a tertiary qualification to do this role, it's more like community experience and knowledge and you know our people come first and you know and so but that kind of um social work mentality is really valued and um it gives you like that's what they judge credibility on I guess.* (ACISPO1)

For the Aboriginal CISP Officer who took part in this study, their status as an 'outsider professional' was only slightly alleviated, or perhaps even aggravated, by their tertiary education. For the others who have filled the second Aboriginal CISP Officer role since its inception, things were have not been so simple:

> *[T]hat's where I think some of the other ACISP Officers have sort of struggled um in that space, because they felt like really shame because they've been like oh um [NAME] is a social worker, but not um whoever, and it's not nice and so um I think that they [the other CISP workers] just honestly think that they are more qualified to have these conversations and*

[38] For the two identified Aboriginal CISP Officer roles to be created, an exemption was required under section 14 of the *Anti-Discrimination Act 1977* (NSW) in addition to meeting the criteria for a 'special measure' under the *Racial Discrimination Act 1975* (Cth). To meet the requirements, the Aboriginality of the ACISPOs had to be a genuine occupational requirement (Triggs 2015). Given that the key role of the Aboriginal CISP Officers is to liaise with Aboriginal families and communities following the death of an Aboriginal person in New South Wales, this indeed met the requirements for the creation of the identified roles.

it's just not just okay in this kind of space at all … it makes it really difficult because they ask you like what can you do that I can't do. (ACISPO1)

As stated above, it may be that racism is underpinning this phenomenon of the 'outsider professional'. I argue that it is more than this – it is also whiteness. If whiteness is indeed the standard by which all else is measured (Moreton-Robinson 2004: vii), then it is whiteness by which identified roles, and their value, are measured. For Frankenberg (1993: 1), whiteness consists of a set of three interlinked dimensions; first, that whiteness is a 'location of structural advantage', a site of privilege; second, that whiteness is a particular standpoint, a way of making sense of the world; and third, that 'whiteness' can be understood as shorthand for the cultural practices that go unnamed and unremarked upon – the invisible mores by which all else is measured (Frankenberg 1993). We see this unfold in the coroners' courthouse, a location of structural advantage whereby most, if not all, employees hold tertiary degrees, and who until the creation of the Aboriginal CISP Officer roles likely did not work alongside any Aboriginal people. Thus, by their mere presence, the Aboriginal CISP Officers call out the unnamed and unremarked upon cultural practices within the space, simultaneously challenging and disrupting the dominant standpoint grounded in whiteness. This is likely magnified in professions where many have had an education in social work. As described by Walter et al. (2012: 227), 'whiteness is invisibly, but strategically embedded within social work practice in Australia', where it both manifests and is replicated in social work curricula and education. This embedded whiteness creates the conditions by which indigeneity is invisibilised, yet is also starkly visible:

Organisations want people there who are Indigenous and make a big 'hoo ha' about employing Indigenous people. But they don't make any room for people to be Indigenous. So what they really want is employees who just

> *happen to be Indigenous rather than Indigenous employees.* (Bennett & Zubrzycki 2010: 68)

It is the mores of whiteness that decides who is too visible – the 'activist' – or the not really Aboriginal – the 'token'. The 'activist' is an Aboriginal employee 'whose radicalism compromises them as public servant', who is too much (Ganter 2016: 4). The 'token', on the other hand, is *not enough*; they 'compromise their communities through a greater obligation to the public service' (Ganter 2016: 4). The onus then is on the Aboriginal employee to strike the balance, whereby responsibilities to community can be upheld while still appeasing white co- workers. Often, this requires a great deal of 'cultural agility' – a kind of 'intercultural code- switching' (Steel & Heritage 2020: 248). Code-switching is understood here as the 'act of purposefully modifying one's behaviour in an interaction in a foreign setting in order to accommodate different cultural norms for appropriate behaviour' (Molinsky 2007: 623). In other words, code-switching is temporarily giving up parts of who you are to fit the hegemonic norms of the workplace in order to be perceived as professional (McCluney et al. 2021). For those in identified roles, code-switching cannot be successful – you are either *too much* or *not enough*. Added to this are the responsibilities and obligations we have to our families and communities as Aboriginal people – navigating this is complex and can create a kind of identity strain (Steel & Heritage 2020). For Ganter (2016: 6), 'the Aboriginal public servant either takes on the system from the inside and leaves as a shining hero, or stays in some uncomfortable and shaming twilight zone, over promoted and ineffectual'. For the Aboriginal CISP Officer, this complex strain and code-switching makes them feel fraudulent:

> *When you're being portrayed to be doing a certain job it that you're not doing because systemic barriers are preventing you from doing that you're not gonna want to be put out there like in the community as a … fraud basically,*

like you feel like a fraud, yeah, so that's how I feel about it at this particular point in time (ACISPO1).

The differences in worldview and relationality between the Aboriginal CISP Officer and their colleagues is seen starkly in the following quote. Where we as Aboriginal people instinctively fulfil community obligations, when measured against the whiteness of the system, actions such as those described seem out pf place, jarring:

[Y]ou know to get the feeds and stuff like that like often I pay out of my own pocket ... to like get some cakes or put on a feed or just get some sandwiches and um so yeah I do that and people are like why are you doing that and I'm like you have to, like you have to and like youse aren't going to help me. (ACISPO1)

All this code-switching and identity strain is a result of the nature of the 'outsider professional'. No matter how interculturally agile one may be, being in an identified role may indeed mean that you will never be in 'inside professional' – you will always be too much or not enough, trapped between an ontological understanding of the world that is forcibly measured against the standard of whiteness.

Workload: The impact of inadequate resourcing

The workload of the Aboriginal CISP Officer is impacted by their access to resources, both financial and practical. The Coroners Court received $7,971,000 in funding in the 2020/21 period (Productivity Commission 2022; see Table 8). Very little, if any, of this goes towards the functions of the Aboriginal CISP Officers – the Aboriginal CISP Officer roles are funded not by the Coroners Court or local court funding streams, but by Transforming Aboriginal Outcomes, a division of the Department of Communities and Justice (DJC).

Table 8: Coroners Court funding[39]

Financial year/period	Funding allocation
2020/21	$7,971,000
2019/20	$7,013,000
2018/19	$6,857,000
2017/18	$6,933,000
2016/17	$7,268,000
2015/16	$6,252,000
2014/15	$5,938,000
2013/14	$6,123,000

As mentioned in the previous section, the Aboriginal CISP Officer who took part in this study acknowledged that they often had to use their own money to afford the small things that would make a big difference – for instance, the sandwiches or cakes provided to families during inquest proceedings. While the Aboriginal CISP Officer does receive allowances such as that provided for attending regional inquests (travel allowance), there is no funding allocated for the practical needs of families at any stage of the coronial process. Indeed, the only funding provided that impacts families directly is the funding for repatriation to Country services – 'at one point they even wanted to stop doing that' (ACISPO1). Grassroots community organisations such as the Dhadjowa Foundation[40] are thus crucial for providing the practical assistance that families need

> *[S]o deaths in custody matters or as a result of police operations have the Dhadjowa Foundation that Apryl Day runs, she is crucial because she*

[39] I was unable to locate the data for the period 2009–13, with 2009 being the first year of operation of the *Coroners Act 2009* (NSW).
[40] *See* https://dhadjowa.com.au.

> *literally is our only option for families for practical assistance, like accommodation, travel, food vouchers, fuel vouchers, that kind of thing.* (ACISPO1)

This practical assistance is not available to everyone, however; only those families of someone who has died in custody or following a police operation can access it. This, of course, does not minimise the incredible work that organisations such as the Dhadjowa Foundation are able to achieve; rather, it points to the systemic and structural failure of the courts, and indeed the NSW Government, to provide adequate resources to the coronial system.[41] This puts additional pressure on the Aboriginal CISP Officers to effectively support the families with which they are working. When yarning with the Aboriginal CISP Officer, there was a sense of affront, as well as disbelief:

> *I've had that experiences now where like they've tried to take the most basic like repatriations back to Country like the least you can do is like help us get back when we've passed on and like laid to rest and like I know if I had to fight for funding for that I don't have any hope of fighting for something like that [food for families] as well, like …* (ACISPO1)

The ability of families to get to the Forensic Medicine and Coroners Court complex continues to be a significant issue. The complex is not located near a train station, and the route taken by buses stops behind the complex itself – 'they drop you off round the back side, like where the mortuary entrance is, rather than the actual entrance' (ACISPO1). This, of course, can be incredibly confronting for grieving families. According to the Aboriginal CISP Officer, the court used to provide taxi vouchers to allow families to easily and affordably attend the court. These, however, have since been defunded – 'I don't

[41] See McCabe (2019). I first wrote about this when interviewing legal professionals and advocates working with Aboriginal families throughout coronial processes. It was a significant, and easily fixed, issue then, and continues to be some years later.

know they got rid of like taxi vouchers, they don't have them anymore' (ACISPO1). The lack of resources directed toward the most basic of issues only serves to alienate the families and to further burden the Aboriginal CISP Officer, who then takes it upon themselves to ensure that family members are able to attend the court:

> *[I]t's really confusing like if you've got a car it's great there's lots of parking and it's fine, but getting here is frustrating and there have been some instances where I'm just like I'll visit you like okay where are you I'll come and get you.* (ACISPO1)

Again, this speaks not only to the hidden workload placed on the Aboriginal CISP Officers, but also to the integrity of the Aboriginal CISP Officer who took part in this study:

> *It comes back to that you know how I was saying about that emotional hurt but if we can so something like hey A to B I'll get you here that that's what can help in times of grief.* (ACISPO1)

So, what might an adequately resourced and well-planned Aboriginal CISP Officer role look like? For the Aboriginal CISP Officer who took part in this study, the importance of 'my ideal sort of set up is to have an Aboriginal coordinator, and then three ACISP's sitting under that Blak coordinator and having like a part time project officer to do the [project] stuff, that's my ideal wish list' (ACISPO1). Having a significant increase in staff would help enormously. In the view of the Aboriginal CISP Officer, the officer who has spent much of their time in this role alone, at least three Aboriginal CISP Officer roles are required to avoid burnout and to develop and maintain additional projects. Without this, the role is simply not sustainable:

> *The numbers, the workload, it's not sustainable. And like I personally I don't even know how I can sustain myself, like I'm tired already, like um I feel very drained and the cultural and emotional load that you carry in a*

role like this where everybody is willing to tell ya is like how things need to be done and need to be handled and need to approved but like come work with me please, come work with me come help please like I'm hanging out for people to come and help. (ACISPO1)

Experiencing burnout can lead to post-traumatic stress disorder, sleep disorders and growing feelings of alienation (Pross 2006). This can then have a significant impact on the person's professional and personal lives (Steed & Downing 1998). Therefore, every opportunity should be taken to ensure that the Aboriginal CISP Officers are supported in their work, in a holistic fashion, including the provision of adequate resourcing. The limited practical resources have a significant impact not only on the assistance the Aboriginal CISP Officer is able to provide to families and communities, but contributes to the likelihood of burnout. The next section will discuss the second theme that emerged from the data: *emotion.*

4. Emotion

As described above, it is not just the immense workload that is contributing to risk of burnout, but the cultural and emotional loads that are an inherent part of this role. Indeed, the emotional weight carried by those working in the arena of death investigation is well documented; the court is a 'challenging place to work' not only because of its 'inquisitorial nature', but 'also because of the subject matter of death' (Trabsky & Baron 2016: 587). For example, coroners also experience 'raw and pressing emotions' in their work (Tait et al. 2016: 572). Expected to be dispassionate and impartial arbiters of the law, some coroners attempt to mitigate this emotion by creating a kind of 'emotional distance' (Tait et al. 2016: 576). In a study by Tait et al. (2016: 576), coroners were found to attempt to maintain social distance from the families of the deceased, cited as a 'crucial element of fair and impartial decision making'. The coroners interviewed recognised the impacts that liaising with grieving families could have on their own mental health, further

supporting their attempts to maintain distance (Tait et al. 2016: 577). Coroners were thus described as being 'wary of the emotion of death', noting that death investigations are 'confronting emotional experiences', imbued with the 'capacity to distress and disturb' (Tait et al. 2016: 576–7).

It is, of course, noted here that the Aboriginal CISP Officers do not have the capacity to distance themselves from the 'raw and pressing emotions' involved in liaising with bereaved and grieving families; indeed, it is their job to be involved. Lawyers and other legal professionals also liaise directly with families throughout coronial processes, and it has been established elsewhere that legal professionals experience 'abnormally high levels of depression, substance abuse and suicide' (Trabsky & Baron 2016: 582). Similarly to coroners, coronial legal professionals are exposed, by virtue of their profession, to 'representations of the deceased … forensic reports, witness statements and photographic evidence' (Trabsky & Baron 2016: 583). However, unlike coroners, they are required to liaise with the families of the deceased. Many thus experience significant levels of distress; however, they have been found to manage this distress by utilising 'informal communities' among colleagues, as well as relying on 'intimate relations', thereby collapsing the public/private divide thought to be a necessary part of the role – a kind of professionalism (Trabsky & Baron 2016: 593). The Aboriginal CISP Officers are limited in their ability to do the same – informal communities of support cannot be created when there are no other Aboriginal people working anywhere in the building, thus only a partial community can be formed, involving the sharing of emotional load only, rather than the associated, and perhaps paramount, cultural load.

Police who investigate death on behalf of the coroner also carry the emotional load inherent in death investigations. Where legal professionals and coroners are exposed to representations of the dead, police are required by way of their profession to engage with the physicality of death: those bodies 'which may be disrupted or decaying' (Carpenter et

al. 2016: 699). In addition, and similarly to legal professionals within the coronial system, they must also 'attend to a grieving and traumatised family' (Carpenter et al. 2016: 699). Scenes of death, often attended by inexperienced junior recruits, 'are overwhelmingly chaotic', resulting in high levels of anxiety; indeed, the 'anxiety and fear of exposure to a dead body' can often be 'exacerbated by feelings of horror, disgust and shock', particularly when the death is a result of violence or misadventure (Carpenter et al. 2016: 704). Thus, policing within the context of death investigation can cause immense 'emotional stress, anxiety and strain' (Carpenter et al. 2016: 705). Forensic pathologists, another professional group who encounter the physicality of death, are also affected on an emotional level by their work, with forensic pathologists experiencing higher rates of both depression and insomnia than other medical professionals (Iorga et al. 2016). Of course, it is not just those exposed directly to the representations or physicality of death who experience the tremendous emotional load – psychologists and others who work with the families of victims of violence 'carry a high risk of suffering from burnout and vicarious traumatization' (Pross 2006: 1), which can have severe negative effects on their personal and professional lives (Steed & Downing 1998). In addition, correctional health and forensic medicine nurses who witness violent incidents in the workplace, such as suicide, also show high levels of vicarious trauma (Newman et al. 2019: 191) – another example of the emotional weight borne by those exposed to death and its resultant investigation. I argue that the specificity of emotional load within the context of death investigation is both secondary to, and exacerbated by, the cultural load also borne by those who work in this space in identified roles, such as that of the Aboriginal CISP Officer.

This is supported by the Aboriginal CISP Officer themselves – 'I feel like we're at risk of burn out a lot quicker like than other workers anyway because we do carry that cultural and emotional load, it's not just an emotional load and the nature of the work' (ACISPO1). The Aboriginal CISP Officer spoke candidly about the nature of the role,

describing it as 'the most like the most difficult role that I've ever ever ever done … um and I really underestimated how difficult it would be coming into it' (ACISPO1). They also described the emotion involved in specific kinds of deaths – 'the youngest suicide I had is an eight-year-old… and so um numbers like this you … you just, like so … it's confronting' (ACISPO1). The distressing nature of the deaths encountered by the Aboriginal CISP Officer is exacerbated by the knowledge that these are our people – thus, the cultural load is made all the heavier by the emotionality of death investigation. The Aboriginal CISP Officer who took part in this study maintains a positive outlook in the face of all of this – they 'try to stay hopeful, and always try to stay positive that things will change', even though 'they haven't just yet' (ACISPO1). The acknowledgement of their work within the coronial space is also seen as a positive aspect of this work – 'I feel like the wider sort of coronial community values the work that we do' (ACISPO1). Of course, the recognition from Mob is especially important:

> *What means the most to me is like having the Elders reach out and the families reach out and say like they don't know what they would've have done if I wasn't here, or um or you know things like that and you know people like Tony McEvoy and people like that who are in prominent in their positions like reach out and say like we've heard about the work that you're doing, and like for them to come out take time out of their busy day and come out here like you're doing really good work here like you just think you're just like doing your work like how things should be done.* (ACISPO1)

The workload and emotional and cultural burden carried by the Aboriginal CISP Officer is made somewhat lighter by virtue of this humble recognition of the good work that they are doing for Mob. They know too that there are limits to what they can do for grieving families – not just because of the limitations of resourcing, but because of the nature of their contact:

> *[D]eath is like the one thing that's final like but, people can't say or do anything to make it better and I think that not enough people can sit with that and can accept that like hey like it is final, and that you don't have to do anything to make it better like you just have to sit with that and give them this time and what they need whatever they need from ya give it, like, and be okay with that like you can't fix it.* (ACISPO1)

The Aboriginal CISP Officer who took part in this study was very aware of the risk of burnout, and had built a number of protective factors into their daily practice:

> *I like chasing waterfalls and going for my river walks cause I live out at [NAME] so I've got the river walk and stuff so I'll just do that and like try to switch off for the day, and I'm getting better at turning my work phone off um, cause I realised that look you know I can't be everything to everybody, um and that's something I've always struggled with, so I'm getting better, like some days are harder but um I'm getting better. And so little things like that and trying to keep little bits of boundaries and doing nice things and like you know being around family and friends and just being in the moment with them um cause like here in a job like this it makes you really appreciate life because you see how fragile it really is so um you live it more fuller now.* (ACISPO1)

The reality of sudden death, and its impact on how relationships are experienced, is something that reoccurred throughout the yarn with the Aboriginal CISP Officer, who stressed that 'you value your loved ones too and how much time you have with them and how easy that can be taken away' (ACISPO1). Despite the immense and seemingly crushing workload, the weight of the emotion involved in death investigation, potential for burnout and vicarious trauma, and the cultural load borne by the Aboriginal CISP Officer, they remain overwhelmingly positive about their role and the work that they do:

‘I feel like I’m exactly where I need to be and I feel like everything has set me up to be able to be here to do hopefully what needs to be done’ (ACISPO1). The strength and humility of this individual cannot be understated, and I want to take this moment to express my gratitude to them for not only participating in this study, but for the thousands of ways they go above and beyond for Mob every day.

5. Culture

This section moves now to the third theme, *Culture*. The importance of Culture to Aboriginal people cannot be understated – indeed, as described by the Aboriginal CISP Officer, our strength comes from our people – ‘I kind of get my strength from working with my people’ (ACISPO1). It has been established elsewhere that Aboriginal children who grow up strong in their culture are much more likely to have a ‘high self-esteem and a nourished sense of identity’ (Bamblett 2006: 9). Indeed, strong connections between family, kinship and community offer ‘some protection against developing serious psychological distress’ (Kelly et al. 2009: 22), allowing for connection to culture – a crucial protective factor in the context of intergenerational trauma (Venner et al. 2024). The impacts of intergenerational trauma are profound – Williamson et al. (2020) describe this as a sense of perpetual grief. This perpetual grief is evident in the number of families who have multiple contacts with the coronial system – ‘I’ve had a few families now where I’ve had three or five or their loved ones um, come through this office since I started’ (ACISPO1). The impacts of colonisation, both as an initial event and an ongoing system and structure, are evidenced in the high rates of traumatic events experienced by Aboriginal people. Coupled with loss of culture, this contributes to what Spiwak et al. (2012: 206, 204) describe as complicated grief – a complex form of grief that ‘incorporates multiple symptoms such as anger and sadness, and varies by the individual, by culture, and across time’, often expressed in ‘complicated bereavement processes’.

Connection to culture, to Country, and to kin protects us from this complicated grief; this is what contributes to our resilience:

> *[Resilience is] the ability to have a connection and belonging to one's land, family and culture, therefore an identity. Allowing pain and suffering caused from adversities to heal. Having a dreaming, where the past is brought to the present and the present and the past are taken into the future. A strong spirit that confronts and conquers racism and oppression, strengthening the spirit. The ability not just to survive but to thrive in today's dominant culture.* (Kickett 2011: pii)

Culture, and all this encompasses, thus has the power to protect Mob as they move through each phase of the coronial process. Physical, psychological and spiritual health and resilience can only emerge where culture is recognised and reinforced (Hunter, Skouteris & Morris 2021: 747). Integral to this is an understanding by the Coroners Court and its actors of the power of culture for Aboriginal people. This is a profound aspect of the role of the Aboriginal CISP Officers – the ability to support the cultural needs of bereaved and grieving Aboriginal families. As we have seen above, this is often stifled by the sheer lack of resourcing provided not only to the Coroners Court, but to the operation of the Aboriginal CISP Officer roles. Of course, it should be acknowledged that the holding of some inquests on Country, and the funding to enable repatriation to Country, are significant acts of cultural recognition. What is concerning however, in addition to the issues raised in previous sections, is the lack of awareness shown by the Coroners Court when it comes to acknowledging the responsibilities placed on the Aboriginal CISP Officers by virtue of their role. While this was discussed in detail earlier in the chapter, there is an important facet of this that I want to raise here. Not only is it 'harder when you're in an identified role, you can't just switch off' (ACISPO1), but there are expectations placed upon the Aboriginal CISP Officer by community, whether explicitly

communicated or not. The felt and perceived need to do what is best for Mob, and to push back against the system where required, is an underlying and invisible, yet key, part of the success of this role. Where the expectations of families are not met due to resourcing, funding and staffing inadequacies, it is the Aboriginal CISP Officers who are the face of it, leading to complex emotional strain:

> *[W]hen you're being portrayed to be doing a certain job that you're not doing because systemic barriers are preventing you from doing that you're not gonna want be put out there like in the community as a ... fraud basically, like you feel like a fraud, yeah, so that's how I feel about it at this particular point in time*. (ACISPO1)

This next section discusses some of the intricacies of culture work undertaken by the Aboriginal CISP Officers – cultural considerations, cultural responsiveness and cultural safety.

Culture: Cultural considerations

As the preferred first point of contact for families following the death of an Aboriginal person, the Aboriginal CISP Officers must negotiate a number of issues. One is the appointment of a SNOK. As discussed previously, determining SNOK is not always a straightforward issue. According to the next of kin hierarchy outlined in section 6A(1)(a) of the *Coroners Act 2009* (NSW), the person with the highest right is the spouse or de facto spouse of the person who has died (see Figure 22).

6A Meaning of "senior next of kin"

(1) For the purposes of this Act, the senior next of kin of a deceased person is—

(a) the deceased person's spouse, or

(b) if the deceased person did not have a spouse or a spouse is not available—any of the deceased person's children who are adults, or

(c) if the deceased person did not have a spouse or child or a spouse or child is not available—either of the deceased person's parents, or

(d) if the deceased person did not have a spouse, child or living parent or a spouse, child or parent is not available—any of the deceased person's brothers or sisters who are adults, or

(e) if the deceased person did not have a spouse, child, living parent, brother or sister or a spouse, child, parent, brother or sister is not available—

(i) any person who is named as an executor in the deceased person's will, or

(ii) any person who was the deceased person's legal personal representative immediately before the deceased person's death.

Figure 22: Meaning of SNOK

For many Aboriginal people, however, the parents or family should be appointed SNOK – 'for us the family organises everything' (ACISPO1). This, then, is one of the first negotiations the Aboriginal CISP Officers must engage in with the family and partner of the person who has died, navigating cultural concerns within a colonial coronial framework – 'It's hard, it's hard because it's a white definition of family, and the birth family always gets wild when when the defacto or whoever is listed, cause it defaults to them first right' (ACISPO1). More often than not, the de facto of the person who has died will acknowledge the unspoken cultural rules here:

> *If we call senior next of kin and the de facto it's legally defaulted to them in the first half an hour [they say] 'hey I've been in contact with mum or dad, I want to relinquish senior next of kin to them, I want to be respectful'.* (ACISPO1)

Of course, this is not always the case, as was discussed in the yarn with P1 in the previous chapter.[42] More than one person can be listed as next of kin, which goes some way towards recognising the complex kinship structures that exist in our families and communities – 'we get sort of inquiries from people who aren't senior next of kin so as long as they [the SNOK] consent to it um we can list that person as like a next of kin, on the system' (ACISPO1). This can avoid anguish and distress when people are not recognised as next of kin to start with:

> *We do get the Uncles and that call and they're blowing up like what do you mean you can't talk to me? So the easy fix is having that person listed as next of kin on the system, and then we can talk to them.* (ACISPO1)

Once the SNOK has been established, the next issue to be negotiated concerns the necessary post-mortem procedures. There are many kinds of post-mortem procedures that might be conducted; however, the invasive autopsy is perhaps the most problematic. In Australia, there are two main kinds of autopsy procedure: those performed in a hospital and the medico-legal autopsies conducted by forensic pathologists for the purposes of coronial investigation (Carpenter & Tait 2010). Where there is more than one procedure available to establish the cause and manner of death, section 88(2) of the *Coroners Act 2009* (NSW) provides that the least invasive procedure should be used, provided it is appropriate in the given circumstances. This might mean toxicology and medical imaging instead of a full, invasive autopsy. The concerns of families regarding post-mortem

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[42] See also *In the Estate of Jones Deceased: Jones v Dodd* BC9803181. This unreported case appeared in the Supreme Court of South Australia in 1998. Debelle J was tasked with determining who had the legal right to determine where the deceased should be buried – their de facto spouse or their father. The father argued that it is 'Aboriginal custom that the head of the family is the person empowered to make decisions in respect of family issues and land issues', adding 'It is very important in our culture that the deceased is buried in the area so that his spirit can come back in animal form'. Debelle J found in favour of the plaintiff, the deceased's father. Of course, this case is specific to the cultural protocols of Mob from the Oodnadatta community, and is not necessarily transferable to New South Wales.

procedures must be weighed carefully with both the fact-finding purview of the coroner and the preventative principles of the jurisdiction (Scott Bray 2010b: 233). On the other hand, families are often unaware that they can even raise an objection to an autopsy, or other post-mortem procedures, being performed (Freckelton 2007: 249).[43] Thus, the provision of information to the SNOK and/or bereaved family members must be delivered in a 'culturally and religiously sensitive way' (Freckelton 2007: 250). In the context of the deaths of Aboriginal people, the Aboriginal CISP Officers are best placed to provide this information. The Aboriginal CISP Officers then liaise with the coroner investigating to ensure the best outcome for both parties:

> *I spoke to the family, the family are objecting to any cutting, for example, or the family are okay with an external examination but they don't want any invasive autopsy done, and so the coroners really take into consideration the families views and sort it all out.* (ACISPO1)

The Aboriginal CISP Officer who took part in this study acknowledged the importance of these early yarns, and the negotiations that ensue – 'you try to negotiate as much as you can like knowledge is power' (ACISPO1). Supporting families where cultural considerations are in place is experienced by the Aboriginal CISP Officer as an integral part of the role, and one that is both meaningful and empowering for the families of the deceased:

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[43] The capacity to perform any internal investigation on a deceased person in a hospital setting requires the consent of the SNOK. In the coronial setting, this capacity is based solely on the coronial order, however section 96(1) of the *Coroners Act 2009* (NSW) provides that: 'A senior next of kin of a deceased person may, by notice in writing, request a coroner or an assistant coroner not to exercise a relevant post-mortem investigative function in relation to the deceased person.' The coroner is within their legislative capacity to refuse such a request, at which time the SNOK may make an application to the Supreme Court of NSW to prevent a post-mortem examination from occurring. While not common, this does occur and is legislatively possible across Australian jurisdictions – for instance, in the case of *Green v Johnstone [1995]* 2 VR 176. Applications to the Supreme Court do not always result in such a positive outcome; for example, in *Wuridjal v The NT Coroner* [2001] NTSC 99, Riley J upheld the coroner's decision to conduct a post-mortem despite the wishes of the deceased's next of kin.

> *[I]t's the approach in like calling them and telling them what to expect and giving them an opportunity for ceremony or coming in and you know picking out one of our blankets or you know having that level of care goes a long way for them, and like seems to empower them like decision making processes like being able to be told like no like I object to a post-mortem and knowing what they're actually expecting to or um you know like giving them that decision making power um but also like you need that kind of stuff even at inquests like having acknowledgements of Country done by the coroners at the start of the proceedings, giving like sensitive warnings when that sensitive materials will be shown, referring to a deceased person in the way that the family wants them referred to, things like that.* (ACISPO1)

Everything referred to here by the Aboriginal CISP Officer shows the ability of the coronial system to incorporate cultural considerations into everyday practice. Meaningful involvement in decision-making, the recgnition of culture and Country, and the observation of cultural protocols all contribute to reducing the distress and discomfort experienced by bereaved Aboriginal families moving throughout coronial processes.

Culture: Cultural responsiveness

The successful incorporation of cultural considerations necessitates a level of cultural responsiveness. As discussed above, ensuring repatriation to Country, acknowledging Country and respecting families' wishes concerning the use of the deceased person's name all indicate a recognition of, and responsiveness to, cultural considerations and protocols. This is an excellent step in the right direction. The leadership of State Coroner Teresa O'Sullivan is an important part of this shift in the coronial space. State Coroner O'Sullivan has an extensive professional history spanning over 30 years, a career that includes having worked at the Alice Springs Aboriginal Legal Aid Service and leading the Legal Aid NSW children's legal service, as well as the Legal Aid NSW Coronial

Inquest Unit (Whitbourn 2019). Only the second woman to be appointed State Coroner in New South Wales, O'Sullivan has led a team of Deputy Coroners since 2019, and has presided over a number of high-profile coronial matters (Whitbourn 2019). She has been quoted as describing 'Indigenous deaths in custody' as a 'priority' (Whitbourn 2019: para. 2); this experience and focus have no doubt led to the creation of a number of coronial Practice Notes and First Nations Protocols by the State Coroner since her appointment.[44]

Shortly after her appointment, State Coroner O'Sullivan released a statement to the media regarding the high number of Aboriginal deaths in custody (O'Sullivan 2019). This significant act placed her firmly in this space as a coroner who endeavours to take action regarding the over-representation of Aboriginal deaths in custody in New South Wales – a welcome stance indeed. This statement, however, left much to be desired. In it, State Coroner O'Sullivan spoke of the importance of self-determination for Aboriginal people and shared the words from the Uluru Statement from the Heart[45] that she draws upon when making coronial findings following the death of an Aboriginal person in custody. State Coroner O'Sullivan went on to state that 27 Aboriginal people died in custody in New South Wales between 2008 and 2018; of these, 57 per cent were found to be of 'natural' causes. The framing of these deaths as 'natural' invisibilises and absolves the state of its role in the premature deaths of Aboriginal people.[46] If the structural and endemic causes that lead to the premature and largely preventable deaths of Aboriginal people are not meaningfully and truthfully acknowledged, good intentions will not be enough to actually create change.

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[44] Coronial Practice Note 1 of 2018 (General case management, time standards and procedure for hearing of inquests); Coronial Practice Note 2 of 2018 (Case Management of mandatory inquests involving Critical Incident Investigations); Coronial Practice Note 3 of 2021 (Case Management of mandatory inquests involving section 23 deaths); and First Nations Protocol (Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples). See Chapter 2 for a more detailed discussion of Practice Note 3 and the First Nations Protocol.

[45] The *Uluru Statement from the Heart* is available here: https://ulurustatemdev.wpengine.com/wp-content/uploads/2022/01/UluruStatementfromtheHeartPLAINTEXT.pdf

[46] Part of this paragraph has been published previously – see McCabe, L 2019, 'No justice, just us', *Indigenous X*, 15 April, viewed 26 June 2023, https://indigenousx.com.au/no-justice-just-us.

I raise these issues here because I believe they are a form of cultural responsiveness to the particularities of structural and cultural violence experienced by Aboriginal people, both inside and outside of the coronial system. To be culturally responsive is to recognise not only the protective factors of culture, but the harms caused by the dominant culture of colonisation. Despite this apparent shortcoming, State Coroner O'Sullivan does indeed appear to be leading the way in the right direction. The appointment of the Aboriginal CISP Officers is testament to this. Of course, each small step contributes to a ripple of change – this is acknowledged by the Aboriginal CISP Officer, too: 'you don't even need to change that much like to be able to make a wide reaching like difference' (ACISPO1). Each step, however, must be followed by another, the momentum must be kept – 'you do have to be mindful of like these experiences and actually just like realise that this is important' (ACISPO1). When the steps falter or hesitate, it can sometimes lead to questions about the veracity of purported aims – 'it gets me down a bit because … are you respecting like the Traditional Owners of this country' (ACISPO1). When coroners acknowledge Country at the beginning of an inquest, this is understood by most as a culturally responsive and respectful practice; without the next steps of respectful engagement with families, and the appreciation of other cultural protocols such as those concerning next of kin and the importance of Country, this can be seen as a kind of disrespect. The Aboriginal CISP Officer acknowledges, however, that the coroners do mostly get it right – 'they do think about that [how to show respect] and they do try to do that' (ACISPO1). That the coroners are seen to think about what to do in terms of respect shows a good level of cultural responsiveness, and again this is likely due to not only the dedicated educative work done by the Aboriginal CISP Officers, but also the leadership of State Coroner O'Sullivan.

Culture: Cultural safety

For the Aboriginal CISP Officers to do their job to the best of their ability, they must first work in a space that meaningfully acknowledges cultural considerations and demonstrates cultural responsiveness – they require a workplace that is as culturally safe as possible. One of the most important avenues to provide this is via those to whom the Aboriginal CISP Officers report – their supervisors or managers. The support, and thus safety, provided by managers can be limited when the manager is not an Aboriginal person – 'my manager's a white woman at the moment, like … and like although she tries her best to support me it's not the same, and she doesn't understand like some of the issues that I face' (ACISPO1). This is exacerbated when the role seems to be in a constant state of recruitment; as mentioned previously, the Aboriginal CISP Officer roles have seen quite a high rate of turnover since their inception. This is likely due to a number of factors. First, there is the cultural load inherent in being employed in an identified role in a non-Aboriginal organisation. Second, the idea of working alongside the dead may be off-putting to some – 'they've had to recruit for this role so many times and like I get it like why would you want to be around here … you know it's a bit morbid' (ACISPO1).

It is argued, though, that one of the key reasons is the lack of culturally safe support from the organisation more broadly – 'the head fuck of like you know people being like oh Closing the Gap we're culturally informed, we're supportive, but then in reality you're not getting that that' (ACISPO1). The two Aboriginal CISP Officer roles are the only identified roles in the building, and as far as the Aboriginal CISP Officer who took part in this study is aware, there are no other Aboriginal people employed anywhere else in the building. Without a strong base of culturally safe support, this then can be incredibly isolating – 'I feel like the role is a bit isolating, like you're here by yourself' (ACISPO1). This is further exacerbated by the position not actually existing within the court structure proper – 'position placement wise within government it's Transforming Aboriginal

Outcomes that [the ACISPO roles] sit under' (ACISPO1). Support is provided by those at Transforming Aboriginal Outcomes – 'I've got a lot of support from Transforming Aboriginal Outcomes like my role technically sits under them not court services within DCJ' (ACISPO1). However, this is somewhat limited in practice – as pointed out by the Aboriginal CISP Officer, 'they don't sit here they don't see what I go through every day' (ACISPO1). There have been instances where managers have recognised the load being placed on the Aboriginal CISP Officers, and have made efforts to protect them from this:

> *They're starting to see it for themselves um and there's been times where like you know they've gone straight in to bat for me and I haven't had to be the one like cause often you feel like you know, it's your responsibility it's not my responsibility.* (ACISPO1)

However, there is a sense that they are not forthcoming in this show of support. There is a relatively easy fix, one that the Aboriginal CISP Officer has put a great deal of thought into, and one that might also address the issue of turnover in these roles. When asked whether or not more people might apply for, and remain in, the role were an Aboriginal Unit established, or at the least an Aboriginal manager or supervisor, the Aboriginal CISP Officer who participated in this study replied:

> *I definitely think so, like, because you'd know that like you'd be part of a team and you'd have other people to lean on and support you, you wouldn't be facing it alone, um whereas now at the moment like if they were to interview you like the interview panel is a white woman on a panel of her choosing, where you'll come into a white team like essentially with like few qualifications as far as we're concerned like social workers take kids like that's what social workers do you know like why would you want to come into that team like you already have your back up a bit. And I think that*

knowing that your manager was Blak that they, you know, well you hope that they'll look after you … 100 per cent yeah. (ACISPO1)

This clearly indicates the importance of Aboriginal leadership within non-Aboriginal organisations, and the flow on effects this might have not only for recruitment but for the retention of Aboriginal staff. Of course, the possibility of promotion might also be a factor for those deciding whether or not to apply for these roles:

There is no room for progression, like if I wanted to like career progress the only way up is the CISP coordinator role, which is a white role, but then that would be overlooking the entire CISP unit including the non-identified roles as well, so um within like my unit that's the glass ceiling. (ACISPO1)

So a culturally safe(r) workplace within the Coroners Court may be achieved by creating identified leadership roles, both for the support they would engender for the Aboriginal CISP Officers and for the possibility of promotion they would provide.

Ensuring Aboriginal leadership at every level of the Coroners Court structure may also ensure cultural safety by being able to address what is culturally not safe, or indeed inappropriate. For instance, the use of gum leaves by non-Aboriginal people in a show of 'cultural care' comes across as tokenistic:

[T]hey have like some sort of tokenistic um sort of thing that they do like they've painted leaves up at Newcastle, it drives me absolutely crazy … And they're like oh cultural care was provided in the form of leaves and I'm like um maybe cultural care should fall to the Aboriginal worker, might be more appropriate than these leaves? (ACISPO1)

We had the Parliamentary Inquiry people come and visit us for a site visit, similar to what we did before, um like I had someone come down that I knew like come down and do like a Welcome to Country and everything, and like

> *he's getting ready to do this welcome in front of all these politicians and stuff, and they're coming out with painted leaves to give Uncle like the painted leaves with Aboriginal artwork to an Aboriginal man … I'm just like put the leaves away please!* (ACISPO1)

While this is, of course, just an example of where things are not quite right, having Aboriginal leadership throughout the coronial court structure, and indeed the NSW court structure more broadly, cannot be understated. This would no doubt lead to improved processes for Aboriginal people, for greater partnerships between Aboriginal-controlled and owned community organisations and the court, and better outcomes for all involved. The immense workload experienced by the Aboriginal CISP Officers might also be lessened, reducing the potential for burnout, and vicarious trauma. This would then create a culturally safer environment not only for employees such as the Aboriginal CISP Officers, but also, crucially, for the Aboriginal people who have contact with this place, in life and in death.

6. Stakeholder relationships

The final theme that emerged from yarns with the Aboriginal CISP Officer centres on the relationships between the Aboriginal CISP Officer and key stakeholders (other than families). These include legal professionals, forensic pathology employees and external stakeholders such as NSW Health, NSW Police and Corrective Services NSW. How these stakeholders engage with the Aboriginal CISP Officers can make their work much easier, or more difficult. For example, NSW Health updated its system at the Coroners Court from a paper-based system, 'which I think works really well', to 'a multi-disciplinary setting electronic system that only health workers have access to'. This had a significant impact on the work of other key stakeholders, including the Aboriginal CISP Officer – 'ourselves and justice and police are really sort of struggling at the moment, um because we're working half paper based half electronic, and so um it's a work in progress but it really is making the normal workflow a

lot more difficult' (ACISPO1). Change is a part of every workplace, and no doubt those at the Forensic Medicine and Coroners Court Complex will adjust to this new system. The referral pathway whereby the Aboriginal CISP Officers receive information from the forensic medicine specialists in NSW Health is, however, in need of change – 'the frustrating thing for me at the moment is the referral pathway with forensic medicine' (ACISPO1). Prior to the introduction of the electronic system:

> *I used to go through manually every piece of paper to identify my matters because they didn't tell me about them.* (ACISPO1)
>
> *I've been attempting to negotiate a referral pathway with them to be told about my matters, um and that's despite numerous meetings, numerous emails, like pleading um but that still hasn't happened, and it's frustrating like um and it really isn't helping like the family.* (ACISPO1)

This perceived reluctance to work with the Aboriginal CISP Officer to streamline referrals is understood as not just an information issue – 'I'd say that that's my number one issue in the role is like the reluctance of forensic medicine to actually work in a culturally safe way with me um yeah, yeah it's massive' (ACISPO1). Again, this is where leadership, and especially Bla(c)k leadership, in this space is important. Arranging for a streamlined referral process between NSW Health's forensic medicine team and the Aboriginal CISP Officers would allow for sooner contact between the Aboriginal CISP Officers and families, and faster information provision about their loved one. Without consistent access to the new electronic system, 'I have to um have to rely on them [forensic medicine/NSW Health], I'm now reliant on health to tell me about those matters. So I'm missing – I feel like I'm missing a lot of matters that I otherwise would have identified', which ultimately 'really isn't helping like the family' (ACISPO1). This seems to disproportionately affect families whose loved one dies outside of metropolitan Sydney:

> *[I]f in an ideal world if things worked the way I've asked for them to work I'd be that first point of contact, whereas in reality um I do as much as I can in terms of triage stuff that I see, in metropolitan Sydney, the matters that are referred to Lidcombe, so those families are more likely to get an initial call from me than the matters in regional areas where their loved one goes to Newcastle or Wollongong, um because forensic medicine kind of tell me on an ad-hoc basis.* (ACISPO1)

As discussed in previous sections, this can impact the entire coronial process for families when they are not contacted in the first instance by an Aboriginal CISP Officer. The Aboriginal CISP Officer who took part in this study is keenly aware of the time and energy that was being spent trying to fix this situation:

> *It's so horrible that this has to happen but I think that I just need to take a step back and let it happen to expose the gap, rather than fixating on it and raising it and raising it and raising it and not getting anywhere. (ACISPO1)*

It must be reiterated that having Aboriginal people in leadership roles may have prevented this situation from escalating to this point, thereby preventing possible distress caused to family members who were not contacted by an Aboriginal CISP Officer at the beginning of the coronial investigation.

On the other hand, some external key stakeholders are excellent in their provision of timely referrals to the Aboriginal CISP Officers. NSW Police have consistently referred matters to the Aboriginal CISP Officer in a timely fashion:

> *[L]ike police are literally my biggest allies here, and for a huge chunk of the meetings they're so proactive in telling me about um First Nations matters at the earliest opportunity like as soon as they're notified like literally, um is like*

> *a reportable death to the coroner and so um like they'll refer matters to me the same morning that um a death is referred.* (ACISPO1)

The irony of this is not lost on the Aboriginal CISP Officer – 'it's so odd for me to say that'. This proactive communication is experienced as support for the roles of the Aboriginal CISP Officers, and is extended to a number of external key stakeholders – 'I've had some pretty like blown away support from NSW Police, from corrections and Justice Health, and from Legal Aid' (ACISPO1). There also appears to be free and open communication between the Aboriginal CISP Officers and legal professionals – 'people from like the Crown, lawyers, stuff like they contact me because like they know okay you can actually help' (ACISPO1), and much of this appears to be centred on the crucial role the Aboriginal CISP Officers play in supporting families through the coronial process, as well as the advice they can give to these legal professionals. This appears to be quite common – 'a lot of agencies will contact me directly' (ACISPO1).

The positive relationships built with key stakeholders internal to the court are also important, and have been supportive – 'I feel like I have a really good relationship with the coroners where I'll walk up and they'll invite me to their lunches and stuff like that' (ACISPO1). These positive relationships are no doubt integral to achieving the best possible outcomes for the families with whom the Aboriginal CISP Officers work. Not only this, but the support from the coroners also ensures that the Aboriginal CISP Officers view their work as valuable and necessary, encouraging them to continue in this often-difficult role:

> *I feel like I have a lot of support from the State Coroner and the Deputy State Coroners, and I feel like without that I probably wouldn't have remained in the role um and have been able to achieve what I've been able to achieve.* (ACISPO1)

The workload of the Aboriginal CISP Officers is tremendous, fraught with concerns related to burnout, vicarious trauma, identity strain and cultural concerns. The relationships with stakeholders should, in a perfect world, serve to alleviate some of these stressors. While every workplace occasionally experiences difficulties, especially when undergoing system changes, it is argued that this should be minimised here possible in the context of death investigation. This is already an environment fraught with emotion, and the perceived reluctance of the forensic medicine professionals within NSW Health to refer matters to the Aboriginal CISP Officers in a timely manner adds to this already complex load. Where information is given freely and in a proactive fashion, and where respect and willingness to work together are shown, this may actually provide a level of protection around the Aboriginal CISP Officers, shielding them in some small way against the specific and complex issues that arise as the only Blakfullas in the building.

The Aboriginal CISP Officers are already addressing so many of the barriers experienced by bereaved Aboriginal families prior to the creation of their roles. They are actively responsive to cultural considerations and provide cultural safety as only another Aboriginal Person can. Not only this, but they are working to improve the level of cultural responsiveness across the NSW coronial system, in addition to the immense workload that comprises their day-to-day duties. In order for the Aboriginal CISP Officers to continue to do this important and vital work, they must be better supported. What follows provides a summary of this chapter, including key implications going forward.

Aboriginal CISP Officer work as coronial reform, and as settler-colonial labour management

This chapter has shown that the creation of the Aboriginal CISP Officer roles is not merely an administrative addition to the NSW coronial system, but a structural intervention with two simultaneous functions: (1) it is a mechanism aimed at improving bereaved Aboriginal families' experiences of coronial processes through cultural safety,

relational practice and timely information provision (Gooley 2022); and (2) it is a form of Aboriginal labour inserted into a colonial institution to manage, translate and often 'repair' the harm produced by that institution's ordinary operations. This duality matters analytically because it clarifies what coronial scholarship often implies but rarely shows in practice: that 'best practice' coronial processes (early contact, clear information, cultural responsiveness, trauma-informed engagement) are not neutral procedural improvements – they are *work*, and that work is increasingly being carried by Aboriginal staff inside systems that remain structurally organised around whiteness and colonial legal rationalities (Freckelton 2007; Tait et al. 2016; Trabsky & Baron 2016).

7. Key findings: What the ACISPO role reveals about the coronial system in practice

1. *The ACISPO role operationalises what the literature says families need – but at a cost.* Coronial literature repeatedly identifies the same best-practice family-centred requirements across jurisdictions: proactive communication; timely, comprehensible information; support before, during and after inquests; and culturally informed engagement that reduces counter-therapeutic impacts (Dartnall et al. 2019; Newhouse et al. 2020; Ngo et al. 2021; Spillane et al. 2019;). Chapter 4 demonstrated that these needs are not being met for Aboriginal families in New South Wales, especially in the lead-up to, during and after inquest processes, and in interactions with police or other state stakeholders. The ACISPO role exists precisely to address those gaps: from the first phone call, the explanation of processes, navigation of SNOK, cultural support during post-mortem discussions and ongoing updates effectively translate the literature's recommendations into practice. Yet the findings also show that this work is not sustainable when one officer is effectively tasked with two roles for extended periods,

managing high volumes of deaths, active inquests, triage work and community education simultaneously (Gooley 2022). The practical implication is clear: family-centred coronial reform cannot be treated as a policy aspiration divorced from workforce design. What improves family experience is labour-intensive, and under-resourcing reproduces harm, only shifting it to different points in the system.

2. *Identified roles improve cultural safety but expose the persistence of colonial structures.* This chapter reinforces the thesis's earlier argument that the deaths of Aboriginal people, whether in custody, in 'care' or narrated as 'natural causes', must be understood within the ongoing structure of colonisation (Johnston 1991; Wolfe 2006). The empirical context is stark: Aboriginal and Torres Strait Islander people continue to die in custody in large numbers, and New South Wales remains heavily represented (McAlister & Bricknell 2022). The Aboriginal CISP Officer's work takes place inside that structural reality: families arrive at the court carrying not only grief, but histories of police violence, institutional neglect and cumulative loss – 'loss on loss on loss' and 'grief on grief on grief'. This sharpens critiques about the coronial system's limited capacity to deliver what families understand as justice. Families want truth, accountability and recognition of systemic conditions (Allison & Cunneen 2023; Ghezelbash & Whittaker 2020; Newhouse et al. 2020). This chapter shows that even where cultural protocols are better observed, the deeper issue remains: coronial processes still sit inside a state architecture that is structurally reluctant to produce accountability and structurally prone to framing Aboriginal people's deaths through administrative categories (Johnston 1991; NSW DCJ 2023; Porter & Cubillo 2021). While cultural safety initiatives can

reduce harm, they do not automatically transform the jurisdiction's relationship with state violence.

3. *Stakeholder relationships determine whether families receive culturally safe support early enough.* Earlier in the thesis, I have explained that the coronial 'system' is not a single entity but a network of interdependent agencies (e.g. police, health, pathology, court staff, legal services), and that delays and information gaps often reflect systemic inefficiencies rather than isolated failures (McCabe & George 2021). This chapter advances this by showing how interagency referral pathways become determinative of whether Aboriginal families are contacted early and supported appropriately. The described reluctance of forensic medicine processes to reliably refer First Nations matters to the Aboriginal CISP Officer, especially outside metropolitan Sydney, demonstrates a structural barrier to best practice family support. This echoes earlier literature on how communication failures compound grief and anxiety (Biddle 2003; Dartnall et al. 2019), and it adds a new layer: even when an identified role exists, system design and under-resourcing can prevent that role from reaching families in time.

One of Chapter 5's strongest analytic contributions is that it makes visible how settler institutions maintain legitimacy through *governance practices that look like care*. Razack's (2011, 2015, 2023) work is central here: inquiries and inquests can operate as performances of state benevolence – sorry-happy governance – where the state appears to care through procedures, findings and recommendations, while obscuring deeper responsibility and sustaining colonial legitimacy. The preceding two chapters give this argument empirical texture.

The Aboriginal CISP Officer role can be understood as evidence that the system is culturally responsive – evidence of 'improvement'. Yet the chapter shows that this

'improvement' is often achieved by displacing repair labour onto the Aboriginal CISP Officers, who are expected to translate legal processes, carry relational obligations, manage cultural protocols and buffer families from institutional bluntness. The Aboriginal CISP Officer's accounts of 'cleaning up after' non-Aboriginal coworkers, paying for practical supports out of pocket or personally bridging transport gaps because institutional supports have been defunded illustrate how the state's 'care' is often constituted through the unpaid or under-recognised labour of individuals. This aligns with the broader critique of this thesis: that the coronial jurisdiction too often inflicts administrative violence, harm delivered through routine procedure rather than overt brutality (Allison & Cunneen 2023; Whittaker 2021). Thus, this chapter shows how settler-colonial governance is reproduced not only through coronial findings, but through the organisation of labour: who is made responsible for making the system humane, and at what cost.

Coronial scholarship often centres families' experiences and identifies reforms that would reduce distress: clearer communication, more timely updates, culturally sensitive practice, and better support services (Carpenter et al. 2022; Dartnall et al.; Spillane et al. 2019). The literature also emphasises the limited impact of coronial recommendations without enforceable accountability mechanisms (Freckelton 2006, 2007; McCabe & George 2021), and the value of systemic accountability frameworks, such as those outlined earlier in Victorian reforms (Freckelton 2006, 2007). This chapter extends this body of work in two key ways.

First, it reveals the organisational conditions required for reform to 'work'. Cultural safety and family-centred practice are not simply values; they require staffing ratios, stable resourcing, accessible referral pathways and institutional cooperation. Without those conditions, reforms are fragile and uneven. Second, it shows that cultural reform is constrained by structural reform limits. The Aboriginal CISP Officers can improve families' experiences, but cannot (and should not be expected to) solve a deeper structural problem identified earlier in the thesis: the coronial system's limited capacity

to deliver accountability, particularly where state actors and state institutions are implicated (Allison & Cunneen 2023; Johnston 1991; Newhouse et al. 2020). The ACISPO role therefore becomes a crucial improvement in the minimisation of harm, while simultaneously highlighting why harm persists.

The second major contribution of this chapter is that it highlights the Aboriginal CISP Officer role as a case study in Aboriginal employment within state institutions, rather than treating 'Aboriginal staffing' as uncomplicated and inherently beneficial. This aligns with and extends employment scholarship that shows how Indigenous employees are frequently recruited as 'diversity hires' while organisations fail to make room for Indigenous ways of being, wanting 'employees who happen to be Indigenous rather than Indigenous employees' (Bennett & Zubrzycki 2010). My conceptualisation of the 'outsider professional' speaks directly to how whiteness operates as a benchmark of legitimacy and competence, especially within professions that valorise credentialism and institutional norms (Frankenberg 1993; Moreton-Robinson 2004; Walter et al. 2012).

Several dynamics from the Aboriginal employment literature are sharply evidenced here. First, whiteness operates as the unmarked institutional standard against which credibility and professionalism are assessed, such that the Aboriginal CISP Officer is repeatedly placed in the position of having to justify their legitimacy ('what can you do that I can't do?'*)*, a dynamic consistent with analyses of whiteness as an invisible normative benchmark within workplaces and professional cultures (Frankenberg 1993; Moreton-Robinson 2004). Second, the chapter illustrates a familiar pattern of tokenism and cultural extraction, where institutions derive symbolic and practical benefit from the presence of an identified role while failing to provide the structural conditions that sustain Aboriginal staff – culturally safe supervision, peer support and credible pathways for career progression. These are conditions consistently linked to retention, wellbeing and meaningful organisational change (Bennett & Zubrzycki 2010; Ganter 2016). Third, the

kinds of ‘cultural agility’ described in the chapter, such as behavioural modification, careful self-presentation and the ever-present risk of being positioned as either ‘too much’ (the over-visible ‘activist’) or ‘not enough’ (the compliant ‘token’), align with scholarship on code-switching, identity strain, and the psychological costs of navigating white institutional norms (Molinsky 2007; McCluney et al. 2021; Steel & Heritage 2020). Finally, the chapter captures a specific form of organisational harm: when systemic barriers prevent the ACISPO role from delivering what communities reasonably expect of an identified position, the Aboriginal worker becomes the visible face of institutional failure, carrying an affective and ethical burden that employment literature frequently notes yet is rarely documented within coronial or death-investigation contexts specifically (Bennett & Zubrzycki 2010; Ganter 2016).

What emerges is a clear employment-policy implication – namely, that identified roles are not inherently protective or sustainable. Without Aboriginal leadership, culturally safe supervision, adequate staffing and progression pathways, identified roles can become sites of isolation and accelerated burnout, particularly where the work involves death, grief and state violence. This chapter has demonstrated that Aboriginal CISP Officers materially improve cultural safety and family experiences, but has also exposed that without structural resourcing and Aboriginal leadership, the coronial system’s ‘reform’ risks becoming another site where Aboriginal labour is used to manage colonial harm without transforming the colonial structures that produce it.

The final chapter will bring these findings together, and reiterate some key strategies for moving forward. These are by no means a list of recommendations; as discussed in the Introduction and throughout, the coronial system is a colonial system, and a site of violence for Aboriginal people. Thus, this is not a system that can be reformed; however, until we can envision a more effective alternative, we should strive to refine it to minimise harm to both the grieving families and the Aboriginal CISP Officers who support them.

6
Conclusion

This thesis has highlighted the myriad ways in which colonial violence continues to be perpetrated against Aboriginal people, identifying the coronial system in New South Wales as a key source of continued colonial violence. The voices of Aboriginal families are centred here, and I am extremely grateful and privileged to have been entrusted to hold space for their stories.

This study was conducted under the considerable constraints of the COVID-19 pandemic, which limited the possibility of building relationships with communities prior to data collection and created significant challenges early in my candidature. During this period, Aboriginal communities across so-called Australia were appropriately prioritising health and wellbeing, making this an unsuitable time for extensive fieldwork. Consequently, participant recruitment was necessarily limited. The findings presented here are not intended to be representative; rather, they reflect the tremendously valuable insights of the individuals who chose to participate despite the pressures of the pandemic and their own experiences of grief and trauma. Their contributions form the substantive basis of this study.

One of the most significant findings of this study, in my view, is how the families themselves understand the tragic losses of their loved ones. These are personal and private sites of grief and trauma, yet each family member situated these personal losses as occurring within a context of colonialism and colonial violence. There can be no 'decolonising' of a system that operates to obfuscate the role of the colony in these deaths, that serves to (re)position Aboriginal Peoples as *dying anyway* (Razack 2015).

Also significant here is the role of the police, and the opportunity they have to colour the entire coronial investigation. Too often, police infect the coronial inquiry with an

indifference, and disdain, afforded to grieving Aboriginal families. I argue that the police are not the appropriate people to investigate on behalf of the coroner. The relationships between Mob and the police are built on a foundation of terror, a foundation of violence premised on the 'elimination of the native' (Wolfe 2006). The role of police, both as coronial investigators and otherwise, must be understood within this context. It is therefore suggested that an independent Aboriginal-led body be established to investigate the deaths of Aboriginal people, particularly where a person has died in state custody or 'care'.

It must be noted, however, that when asked whether families felt as though Sorry Business had been respected by police, there was a huge variation in responses. Of five survey respondents, each had had a different experience with this, traversing the full spectrum from 'definitely not' to 'definitely yes'. This perhaps speaks to the 'luck of the draw' – it is simply chance what kind of police officer is assigned to your matter. This raises significant concerns in regard to how police are trained to liaise with bereaved families, and to conduct coronial investigations. There should not be such a breadth of experiences, and whether Sorry Business is respected or not should not hinge on chance. In contrast, 80 per cent of survey respondents indicated that Sorry Business was respected by the staff at the Coroners Court. This disjuncture is also evident when participants were asked about respect more generally. When asked whether they felt they were shown respect by the police, only 40 per cent of survey respondents said yes. Conversely, 80 per cent of respondents felt they were 'definitely' or 'probably' shown respect by staff at the Coroners Court. This discrepancy serves to further highlight the need for police to be better trained to engage with all bereaved and grieving families. Considering the ongoing complexities of the relationships between Aboriginal Peoples and police, this is even more imperative for those engaging with Aboriginal families, particularly during a time of grief and trauma.

The yarns with families provided invaluable insights into how Aboriginal families experience the coronial system in New South Wales. Delays between the time of a

person's death and the culmination of the coronial inquest continue to grow. This serves to further traumatise bereaved families, particularly where the reasons for the delays are not communicated to the families. Considering that we know that 'frequent communication about the reasons for delays' improves bereaved families' experience of the coronial process, this is a key area for improvement (Dartnall et al. 2019: 10). For Aboriginal families, this is now being addressed by virtue of having the Aboriginal CISP Officers at the court; however, it does pose questions about how this is communicated to non-Aboriginal families, and this perhaps warrants further research. People do not want to feel as though their loved one has been forgotten.

The available evidence tells us that timely and forthcoming communication empowers families to better understand what is happening and why. Where families have regular communication from the Coroners Court, they can feel 'better prepared for' and 'less anxious' about the inquest process overall (Dartnall et al. 2019: 12). This was another key concern of the family members who took part in this study, and this is now being addressed by the Aboriginal CISP Officers. Bereaved families who have pre-inquest opportunities to receive and clarify information, as well as opportunities to ask questions about coronial processes, value these opportunities (Dartnall et al. 2019: 7). The 'distress', 'pain' and 'anger' that a lack of information about coronial processes can cause is mitigated by virtue of the Aboriginal CISP Officers (Dartnall et al. 2019: 7), although further research to confirm this finding is perhaps warranted. Maintaining adequate and appropriate contact with the bereaved is an issue of cultural responsiveness, and there is a need for identified roles within the court to ensure culturally appropriate support (Dudgeon et al 2023). Too often, for too many, it seems that 'no attempt had been made to disguise the reality that their enormous personal tragedy was no more than routine administration', a 'conveyor belt of inquiries' (Biddle 2003: 1038). However, this too is being addressed by the Aboriginal CISP Officers, and I have witnessed some of the many ways they ensure families know their person is being cared for, that they matter to them too.

Of ongoing concern are the ways the coronial system is able to recognise culture and all it encompasses. Cultural recognition, or the lack of it, was a key concern of the participants in this study. Having both kinship and the importance of being able to bury loved ones on Country recognised is a key area that must be improved. While the Aboriginal CISP Officers do everything they can to uphold cultural protocols, and I acknowledge the crucial work that they do in this space, they are constrained by the laws of the colony, by the *Coroners Act 2009* (NSW). While I acknowledge the findings of the recent statutory review of the legislation (see Chapter 2), Aboriginal people and community organisations must be consulted in a meaningful way to ensure we have coronial legislation that is best-practice – legislation that explicitly recognises our connections to kin and to Country. Incorporating culture into legislation is not unheard of, as evidenced by the *Coroners (Access to Body of Dead Person) Amendment Act 2018* (NZ). However, I again stress that this must be achieved via meaningful consultation with Aboriginal people and community organisations.

Cultural recognition also means recognising the multitude and complexity of the roles of the Aboriginal CISP Officers. From providing informal cultural competency training to staff at the Coroners Court, to using their own vehicles to address the transport needs of grieving families, the Aboriginal CISP Officers are so many things to so many families. The coronial system has a responsibility to ensure they are properly supported to do this work, and that means recognising the colonial load placed upon them, and being keenly aware of the accelerated potential for burnout, or worse – the evidence suggests that those who suffer sustained burnout are much more likely to experience vicarious trauma, and even post-traumatic stress disorder (Pross 2006; Steed & Downing 1998). The Aboriginal CISP Officer roles are the single greatest improvement in the NSW coronial jurisdiction, in my view, and are already addressing almost every concern raised by the participants here. They must be supported holistically to continue to do this crucial work.

It is suggested that funding be increased as soon as practicable to employ a third, and even fourth Aboriginal CISP Officer. It is further suggested that an Aboriginal-led unit be established at the NSW Coroners Court, similar to the Coroner's Aboriginal Engagement Unit in Victoria. Not only would this lessen some of the workload on each individual, but it could also mean having Aboriginal people employed in more senior roles. This, in turn, could mean that the Aboriginal CISP Officers have Aboriginal supervisors, creating a culturally safer space for them to work, where they are able to have the support of other Aboriginal people, who 'get it' – not just people who understand working in a death-investigation context, but who understand the layered complexities of working with community, our communities, in a death-investigation context. Creating identified roles at every level of the coronial system in New South Wales could also mean creating a more culturally responsive and culturally aware coronial system.

This study also supports the findings of Dudgeon et al. (2023: 6), who identified that a 'strong understanding of Aboriginal and Torres Strait Islander cultures, and skills and knowledge to work compassionately and effectively with Indigenous family members are fundamental to the coronial role'. They urge policy-makers and coroners to embark on a form of truth telling, restorative justice and reconciliation by encouraging the jurisdiction to 'be willing to consider radically different coronial approaches' (Dudgeon et al. 2023: xi), and I echo this call. Both the report by Dudgeon et al. (2023) and this study recognise the capacity of cultural recognition and cultural safety in improving the experiences of Mob with coronial systems across Australian jurisdictions, and for the purposes of this study – in New South Wales in particular. I suggest here that to provide a best practice coronial system in New South Wales, we must understand the specificity and requirements of those with whom the system is having disproportionate contact, including systemic barriers to participation and the ongoing impacts and structures of colonisation.

However, we cannot, and should not, understand the coronial system as a neutral space. It is yet another lingering structure of colonisation. Razack (2015: 58) positions the coronial inquiry as a structure of governance, a colonial process that through a medicalised framework masks the ongoing violence of the settler-colonial state. It is through the coronial inquiry that the colonial regime is legitimised as 'caring, civilised and modern, persons with the moral authority and knowledge to save Indigenous peoples from themselves' (Razack 2015: 59). It is the ways in which the inquiry and the coronial inquest function as structures of colonial governance that maintain the settler-colonial state as the benevolent protector of the racialised Other, masking colonial violence as care wasted on abject lives, a regime of truth that serves to 'define the Aboriginal problem' (Razack 2015: 69). The coronial systems operating across jurisdictions in the settler-colony called Australia must be understood as an arm of the state, a tool – or indeed weapon – only able to function as it does because of the continued structures of colonisation that affect almost every facet of the lives and deaths of Aboriginal people.

Colonial coronial violence delegitimises our Law, lore and relationships (Watson 2014: 11). It is through the coronial inquiry that we continue to be objectified through a colonial lens (Atkinson & Woods 2008: 16), with the inquest serving as yet another deep-colonising tool of the state (Marchetti 2006: 452). The coronial jurisdiction is thus 'institutionally racist', failing to consider our deaths in relation to the violence of the state and the violence of ongoing colonisation (Allison & Cunneen 2023: 251). It is through the coronial inquiry that the law continues to enable the construction of Aboriginal bodies as spaces of violence, an aberration that upsets the 'civility' of the colonial state (Razack 2000: 96). These 'narratives of dysfunction' (re)construct us as 'vulnerable, rather than colonised', obfuscating the role of the state in our deaths (Razack 2011, 2012: 910). If 'justice' does indeed mean 'truth, accountability and acknowledgement' (Scraton 2013: 23), where is justice to be found here?

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Case law and legislation

Case law

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Coroners Act 1960 (NSW)

Coroners Act 1980 (NSW)

Coroners Act 1985 (Vic)

Coroners Act 2008 (Vic)

Coroners Act 2009 (NSW)

Coroners Bill 2009 (NSW)

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Practice Note and Protocol

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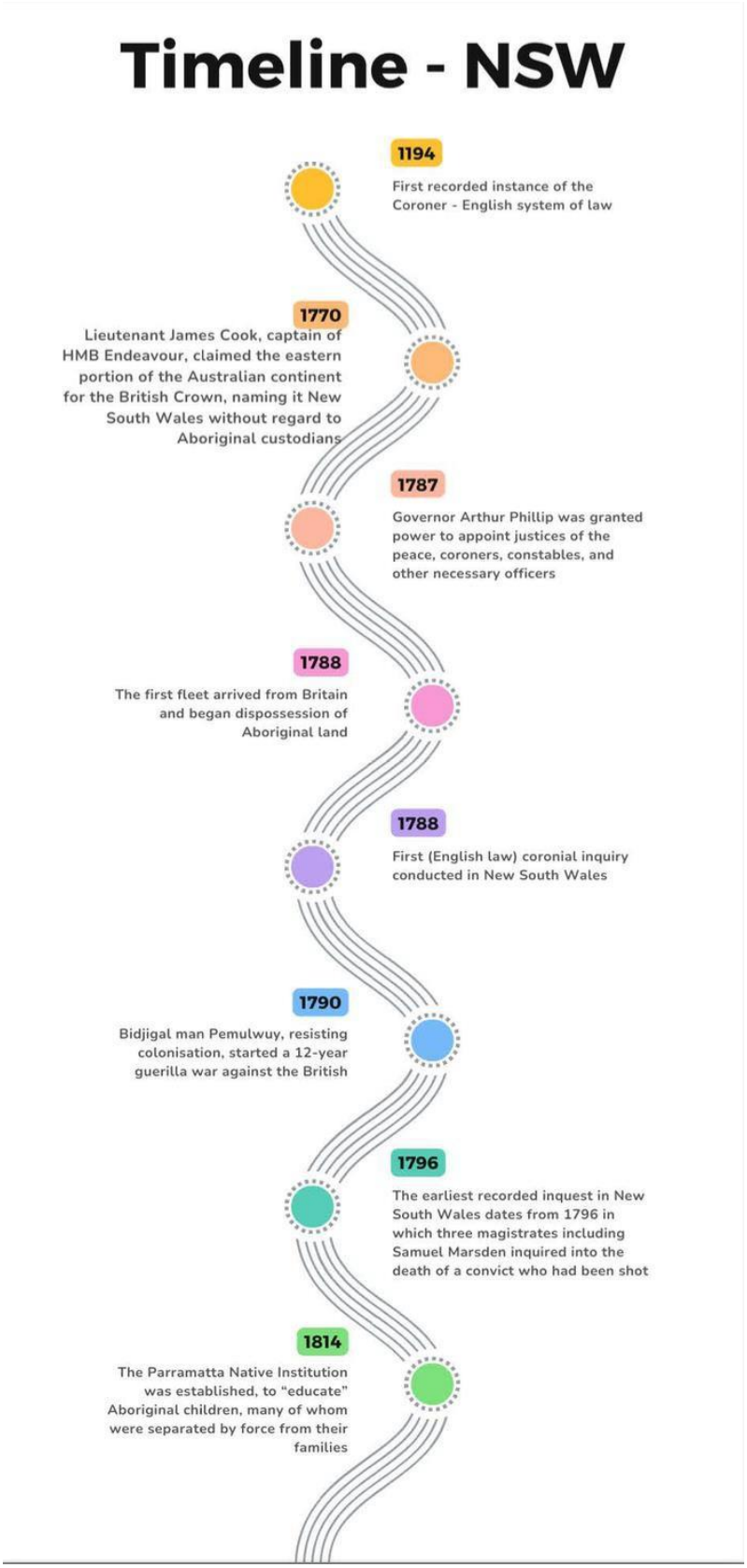
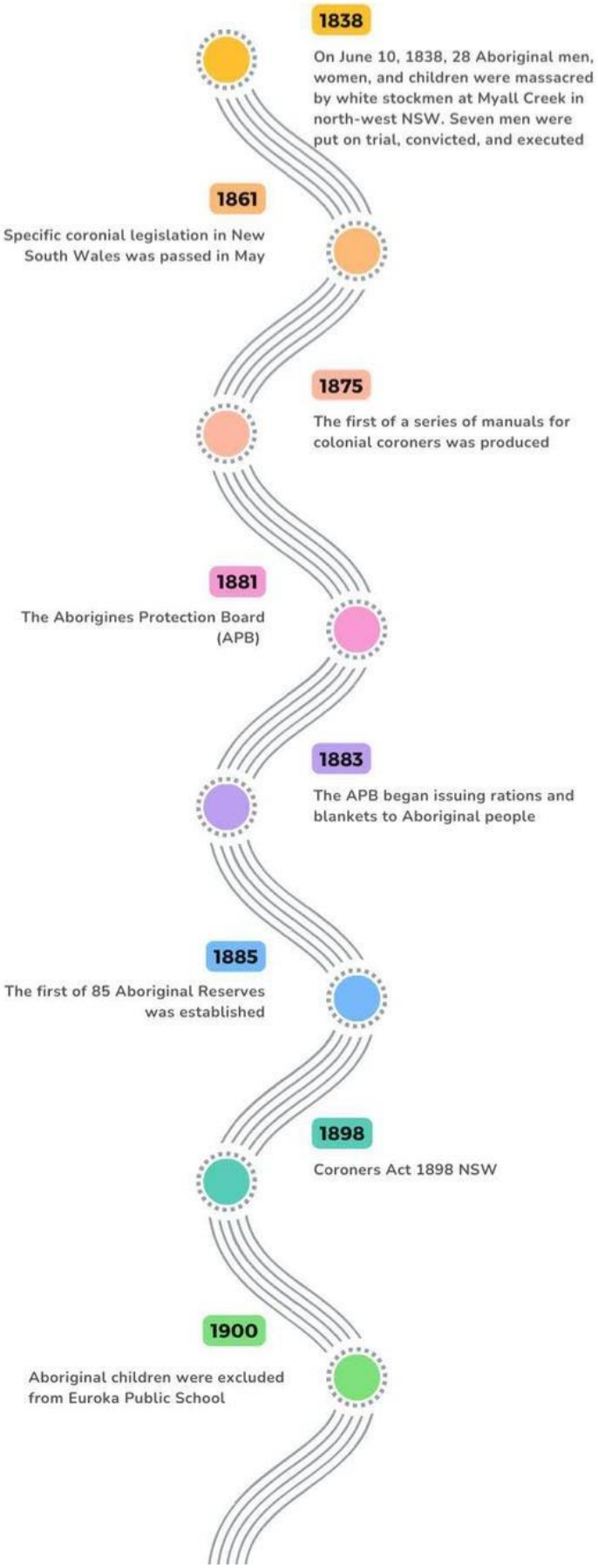
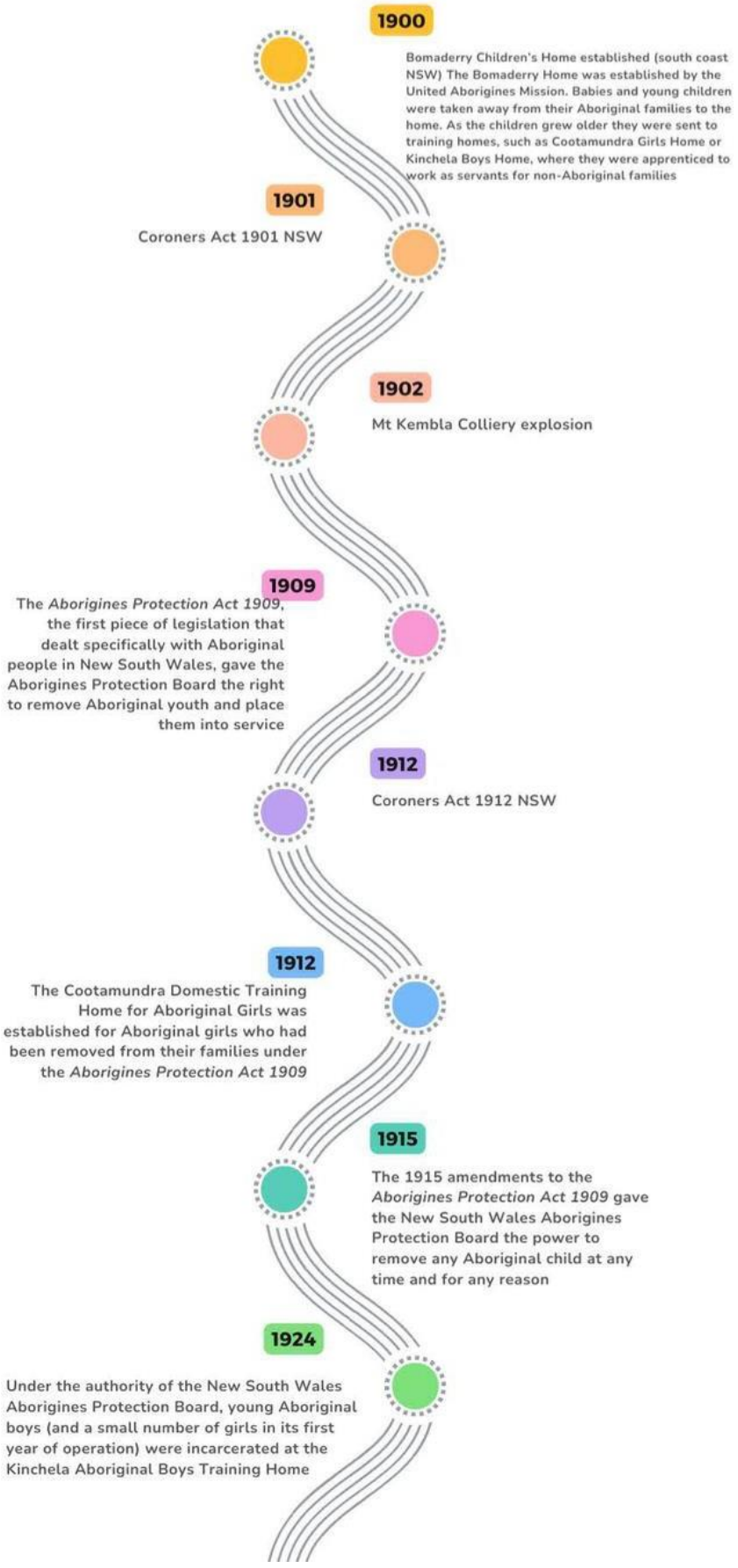
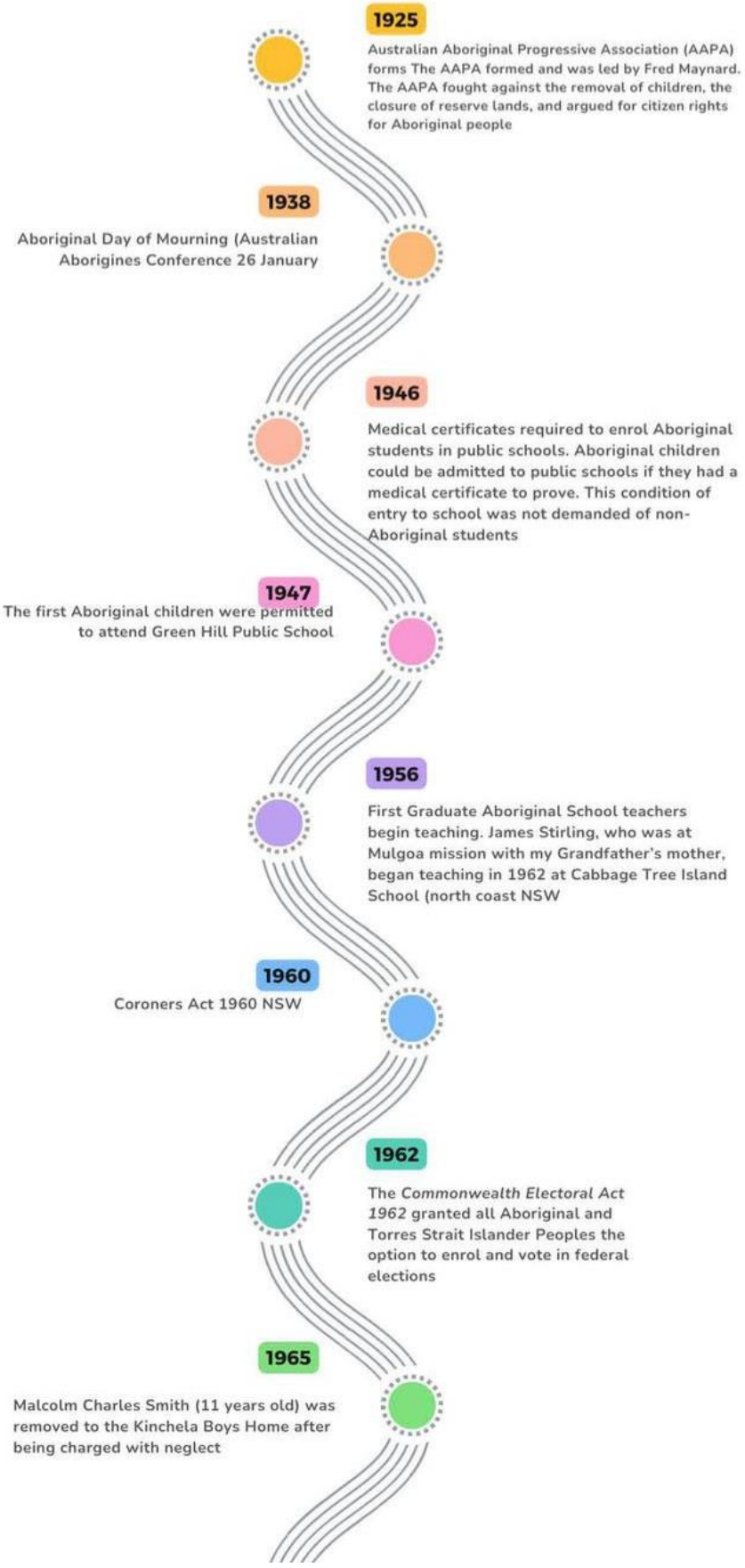
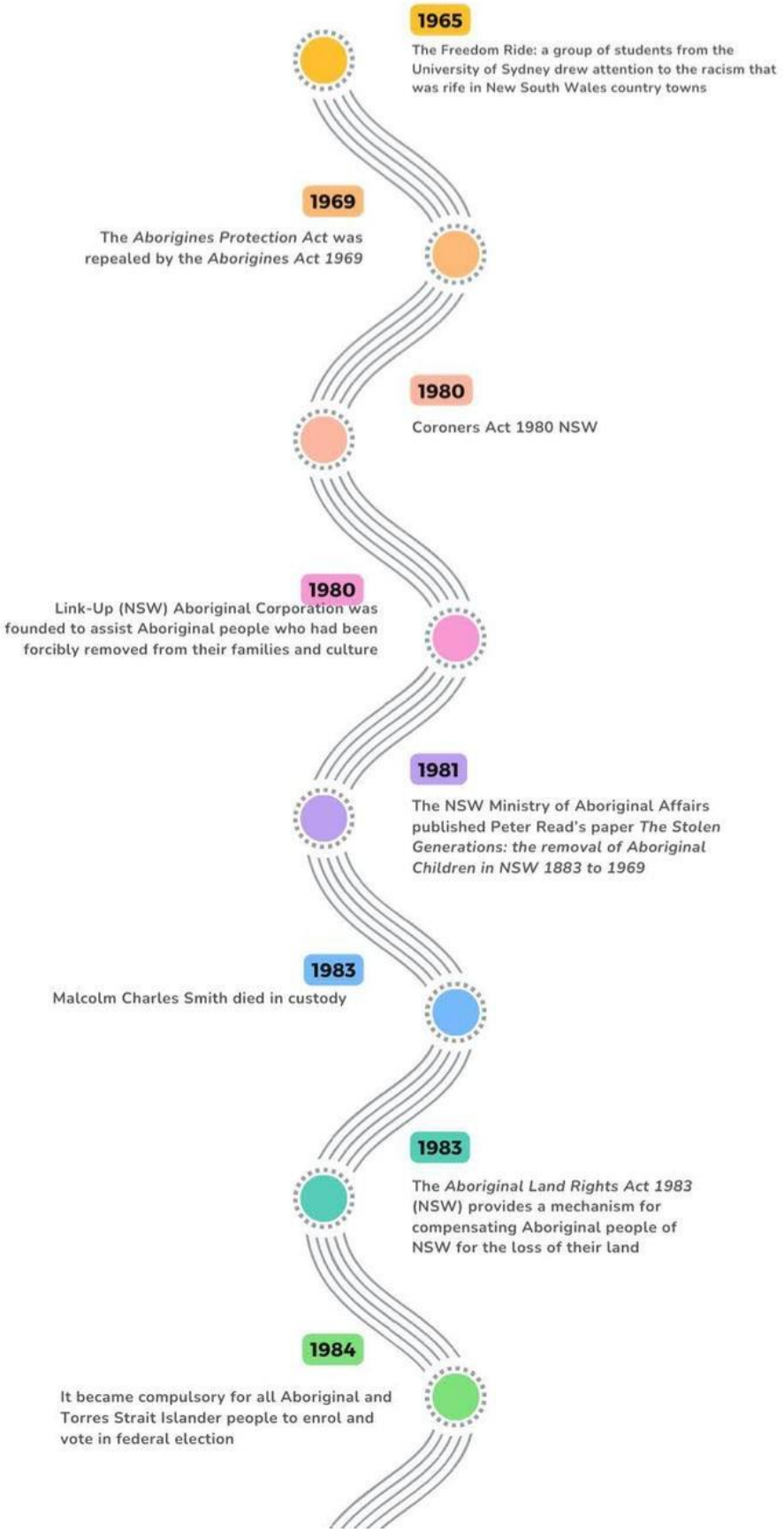
Appendix 1: A timeline in New South Wales

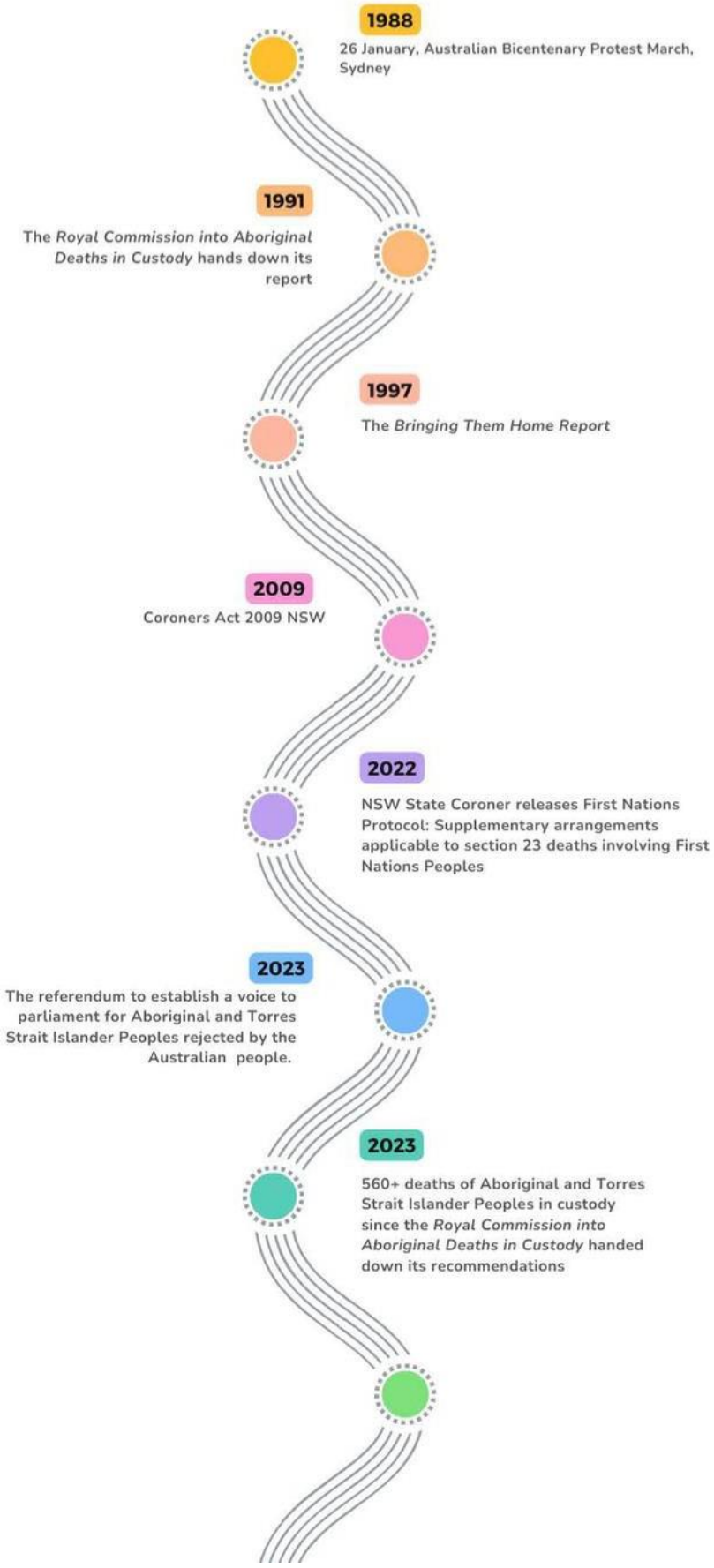



1838
On June 10, 1838, 28 Aboriginal men, women, and children were massacred by white stockmen at Myall Creek in north-west NSW. Seven men were put on trial, convicted, and executed
1861
Specific coronial legislation in New South Wales was passed in May
1875
The first of a series of manuals for colonial coroners was produced
1881
The Aborigines Protection Board (APB)
1883
The APB began issuing rations and blankets to Aboriginal people
1885
The first of 85 Aboriginal Reserves was established
1898
Coroners Act 1898 NSW
1900
Aboriginal children were excluded from Euroka Public School


1900
Bomaderry Children's Home established (south coast NSW) The Bomaderry Home was established by the United Aborigines Mission. Babies and young children were taken away from their Aboriginal families to the home. As the children grew older they were sent to training homes, such as Cootamundra Girls Home or Kinchela Boys Home, where they were apprenticed to work as servants for non-Aboriginal families
1901
Coroners Act 1901 NSW
1902
Mt Kembla Colliery explosion
1909
The Aborigines Protection Act 1909, the first piece of legislation that dealt specifically with Aboriginal people in New South Wales, gave the Aborigines Protection Board the right to remove Aboriginal youth and place them into service
1912
Coroners Act 1912 NSW
1912
The Cootamundra Domestic Training Home for Aboriginal Girls was established for Aboriginal girls who had been removed from their families under the Aborigines Protection Act 1909
1915
The 1915 amendments to the Aborigines Protection Act 1909 gave the New South Wales Aborigines Protection Board the power to remove any Aboriginal child at any time and for any reason
1924
Under the authority of the New South Wales Aborigines Protection Board, young Aboriginal boys (and a small number of girls in its first year of operation) were incarcerated at the Kinchela Aboriginal Boys Training Home


1925
Australian Aboriginal Progressive Association (AAPA) forms The AAPA formed and was led by Fred Maynard. The AAPA fought against the removal of children, the closure of reserve lands, and argued for citizen rights for Aboriginal people
1938
Aboriginal Day of Mourning (Australian Aborigines Conference 26 January
1946
Medical certificates required to enrol Aboriginal students in public schools. Aboriginal children could be admitted to public schools if they had a medical certificate to prove. This condition of entry to school was not demanded of non-Aboriginal students
1947
The first Aboriginal children were permitted to attend Green Hill Public School
1956
First Graduate Aboriginal School teachers begin teaching. James Stirling, who was at Mulgoa mission with my Grandfather's mother, began teaching in 1962 at Cabbage Tree Island School (north coast NSW
1960
Coroners Act 1960 NSW
1962
The Commonwealth Electoral Act 1962 granted all Aboriginal and Torres Strait Islander Peoples the option to enrol and vote in federal elections
1965
Malcolm Charles Smith (11 years old) was removed to the Kinchela Boys Home after being charged with neglect


1965
The Freedom Ride: a group of students from the University of Sydney drew attention to the racism that was rife in New South Wales country towns
1969
The *Aborigines Protection Act* was repealed by the *Aborigines Act 1969*
1980
Coroners Act 1980 NSW
1980
Link-Up (NSW) Aboriginal Corporation was founded to assist Aboriginal people who had been forcibly removed from their families and culture
1981
The NSW Ministry of Aboriginal Affairs published Peter Read's paper *The Stolen Generations: the removal of Aboriginal Children in NSW 1883 to 1969*
1983
Malcolm Charles Smith died in custody
1983
The *Aboriginal Land Rights Act 1983* (NSW) provides a mechanism for compensating Aboriginal people of NSW for the loss of their land
1984
It became compulsory for all Aboriginal and Torres Strait Islander people to enrol and vote in federal election


1988
26 January, Australian Bicentenary Protest March, Sydney
1991
The *Royal Commission into Aboriginal Deaths in Custody* hands down its report
1997
The *Bringing Them Home Report*
2009
Coroners Act 2009 NSW
2022
NSW State Coroner releases First Nations Protocol: Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples
2023
The referendum to establish a voice to parliament for Aboriginal and Torres Strait Islander Peoples rejected by the Australian people.
2023
560+ deaths of Aboriginal and Torres Strait Islander Peoples in custody since the *Royal Commission into Aboriginal Deaths in Custody* handed down its recommendations

Appendix 2: HREC Approval

THE UNIVERSITY OF
SYDNEY

- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.

- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.

- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential connicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research,* the *Australian Code for the Responsible Conduct of Research,* applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Sincerely,

Associate Professor Haryana Dhillon
Chair
Human Research Ethics Committee (HREC 3)

The University of Sydney of Sydney HRECs are constituted and operate In accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Human Research (20181 and the NHMRC's Australian Code for the Responsible Conduct of Research (20181

Appendix 3: Participant Information Sheet

THE UNIVERSITY OF SYDNEY

School of Social and Political Sciences
Faculty of Arts and Social Sciences

ABN 15 211 513 464

Rebecca Scott Bray
Associate Professor

Room 361
Social Sciences Building A02
The University of Sydney
NSW 2006 AUSTRALIA
Telephone: +61 2 9351 4086
Facsimile: +61 2 9036 9380
Email: rebecca.scottbray@sydney.edu.au
Web: http://www.sydney.edu.au/

Understanding the Experiences of Aboriginal Families in the Coronial System in New South Wales

PARTICIPANT INFORMATION STATEMENT

(1) What is this study about?

You are invited to take part in a research study about the experiences of Aboriginal families who have had contact with the coronial system in New South Wales following the death or disappearance of someone you have known. This study will build a picture of what it is like as an Aboriginal person to have contact with the coronial system. The purpose of this study is to better understand and respond to the needs of the community who have contact with the coronial system.

You have been invited to participate in this study because you have had experience with the coronial system in New South Wales between 2009 and 2021, and are an Aboriginal person over the age of eighteen. This Participant Information Statement tells you about the research study. Knowing what is involved will help you decide if you want to take part in the research. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary.

By giving your consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.
- ✓ Agree to the use of your personal information as described.

You will be given a copy of this Participant Information Statement to keep.

(2) Who is running the study?

Lindsay McCabe (palawa) is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney. This is taking place under the supervision of Associate Professor Rebecca Scott Bray and Associate Professor Christine Evans (Wiradjuri).

(3) What will the study involve for me?

An interview:

If you agree to participate in the study, you will be asked to take part in an interview of approximately one hour duration, conducted by the researcher at a time and place convenient to you.

The interview will be a yarn with you about your experiences. The aim of the interview is to hear your story and listen to your experiences of the coronial system following the death of someone close to you. The researcher, Lindsay, is interested in hearing about the nature of your experiences with the coronial system and its different processes. Lindsay may ask you some questions, for example about the first time you had contact with the coronial process, your experience of the coronial investigation, the inquest process, and coronial findings. Importantly though, the interview will be an opportunity for you to tell your story. This is also an opportunity to tell your story the way you want to, whether that be through the interview alone, or via art, poetry, or photographs. If you choose to contribute art, poetry or photographs, they will only be published with your permission. You are able to withdraw permission to publish at any time.

It may be that not all aspects of the coronial system **will** be relevant to your experience, and that is okay. Your yarn with Lindsay will only discuss what is relevant to you. The interview will only cover the issues and experiences that you want to talk about. You will be in control of what you talk about, and you can choose whether or not to answer specific questions. You can also stop the interview at any time. You are welcome to bring a support person or family member with you to the interview. If you would prefer to have a family interview with the researcher, this can also be arranged. This would be an interview where you and other members of your family all attend at the same time to have a yarn with Lindsay. The support person and/or family members **will** need to read this information sheet too and give their consent to be involved.

With your permission, the interview will be audio-recorded. At this point your recorded information will be de-identified, which will ensure that your identity remains confidential. In the findings and reporting stage, it is up to you if you remain anonymous or have your name attached to your story. The audio-recordings will be transcribed for analysis and stored in secure, password protected, online cloud storage, which is endorsed by the University of Sydney. You will be provided a copy of your transcript for you to confirm its accuracy. You can also add any further information that might have come to mind since the interview.

A yarning* circle *[optional]:

There is an opportunity in the final phase of the project to attend one of a series of 2-hour yarning circles, and it is up to you if you join or not. This will be an opportunity for you to meet with mob who have had similar experiences to your own, and to share your experiences with each other. The yarning circles, which may be an online experience due COVID-19 restrictions, will be arranged and observed by Lindsay, who may take notes during the yarn, but only with your consent. Lindsay may also write reflections after the yarning circles, but again, only with your consent.

It is up to you how you participate in the yarning circle: you might like to come for a cuppa and to listen, or you might want to share some of your story. It is completely up to you. You do not need to decide right now if you would like to join the yarning circle; this can be discussed with Lindsay after your interview, should you choose to have one.

The yarning circle will not be audio-recorded, but some notes may be taken by the researcher. If you choose not to join the yarning circle, this will not affect your participation in the study. Your story is important, no matter where you are when you tell it.

This research is being conducted with the intention of helping make the coronial system a better one for Aboriginal families and communities. The researcher **will**

provide you with a summary of the findings, but will also be available to meet with you to discuss the findings if you choose. The findings are for the benefit of families like yours, and belong to the community. If you choose to take part in an interview, your story will remain your property, and will only be used with your permission.

(4) How much of my time will the study take?

This is entirely up to you. Ideally, a one-hour interview **will** take place, however you can take more or less time, and can also choose to have a few shorter interviews over a number of days or weeks.

If yarning circles are used as part of the study, it is expected that they will run for 2.5 hours, but these are entirely voluntary, and you may join for some of the time or all of the time. You can also take part in the interview but choose not to participate in the yarning circle.

(5) Who can take part in the study?

You must be aged eighteen years or older, be of Aboriginal descent, and have had contact with the coronial system in New South Wales between 2009 and 2021. This research is focused on the experiences of the coronial system of Aboriginal peoples in New South Wales.

(6) Do I have to be in the study? Can I withdraw from the study once I've started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of Sydney.

If you decide to take part in the study and then change your mind later, you are free to withdraw at any time. You can do this by telling the researcher that you wish to withdraw. No explanation is necessary.

You are free to stop the interview at any time. Unless you say that you want us to keep them, any recordings will be erased and the information you have provided will not be included in the study results. You may also refuse to answer any questions that you do not wish to answer during the interview.

If you take part in a yarning circle, you are free to stop participating at any stage.

If you decide to withdraw from the study, the researcher will not collect any more information from you. Please let the researcher know at the time when you withdraw what you would like her to do with the information collected about you up to that point, including information provided via the survey. If you wish, your information will be removed from the study records and will not be included in the study results, up to the point that the researcher has analysed and published the results.

(7) **Are there any risks or costs associated with being in the study?**

Some people find talking about these experiences upsetting. Because contact with the coronial system usually follows the unexpected death of a loved one, or when a person is missing, participating in this study may raise feelings of grief and loss, which are a normal part of bereavement. It is important to know that you are in control of the interviews, and can stop at any time. Information about support services is included below.

If you feel as though your contribution will reflect on your community, please be assured that your contribution will be kept confidential, unless you ask to have your name included with your story.

(8) Are there any benefits associated with being in the study?

Many people who take part in this kind of research describe the experience as a valuable one. This is an opportunity for you to talk openly and honestly about your experiences.

Your experiences and stories are important, and are crucial for shaping arguments for reform of the coronial system. To work towards improving the coronial system for Aboriginal peoples, we need to know what does and does not work. This research aims to understand and document the experiences of Aboriginal families and communities that come into contact with the coronial system, and learn how the NSW coronial system can be improved to meet the needs of Aboriginal families and communities. There is no guarantee however that you will experience any direct benefits from this study.

(9) What will happen to information about me that is collected during the study?

Some of the key information about you that will be recorded and remain confidential is your name, your general location, and your contact details. This information will be strictly confidential, unless you explicitly ask to have your name made public. Your contact details will remain confidential and will only be known by the researcher.

The researcher, Lindsay, will ask for details concerning the year/s you experienced contact with the coronial system/Coroners Court, and the circumstances of your engagement with coronial processes. This study is primarily focused on your experiences, and the stories you share will be used to form the basis of the study. Some quotes may be used in the final publication of the study, but these will not include your name unless you specifically ask to be identified.

The voice recordings of the interviews will be held in secure storage on the University's Research Data Management system. Your recording will be deidentified unless you explicitly ask for your name to be made known. The transcripts, and any other data from this study will be stored securely in a password secured University cloud storage account. No hardcopies **will** be made or retained.

The results of this study **will** be published primarily as a PhD thesis, with the possibility of publishing articles in journals and in online and hardcopy publications. Your information will be kept strictly confidential, unless you consent to your name being included.

The results will also be used to inform the New South Wales Government and Coroners Court of ways they can make the changes as identified from the experiences recorded in this study. It is intended that this study, your stories and experiences, can make a difference for Aboriginal families and communities that might encounter this system in the future.

By providing your consent, you are agreeing to us collecting personal information about you for the purposes of this research study. Your information will only be used for the purposes outlined in this Participant Information Statement, unless you consent otherwise.

Your information will be stored securely and your identity/information will only be disclosed with your permission, except as required by law. Study findings may be published, but you will not be identified in these publications unless you agree to this using the tick box on the consent form.

The data acquired through this study will be kept in perpetuity. University of Sydney policy requires that data with community significance is retained permanently, unless alternate agreements are made.

(10) Can I tell other people about the study?

Yes, you are welcome to tell other people about the study. Ifthey have had contact with the coronial system in New South Wales and are interested in participating in the study, they can contact the researcher, Lindsay McCabe, directly. Telling other people about your involvement in the study is your decision but your sharing of the study may result in you being identified by others.

(11) What if I would like further information about the study?

When you have read this information, Lindsay McCabe will be available to discuss it with you further and answer any questions you may have. If you would like to know more at any stage during the study, please feel free to contact:
Lindsay McCabe
Student Researcher
lindsay.mccabe@sydney.edu.au
0403 265 764

(12) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You can tell us that you wish to receive feedback by ticking the relevant box on the consent form. This feedback will be in the form of a two page summary, but the researcher will also be available to meet with you, your family, and community. You will receive this feedback after the study is finished.

(13) What if I have a complaint or any concerns about the study?

Research involving humans in Australia is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this study have been approved by the HREC of the University of Sydney [2021/404]. As part of this process, we have agreed to carry out the study according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect people who agree to take part in research studies.

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the university using the details outlined below. Please quote the study title and protocol number.

The Manager, Ethics Administration, University of Sydney:

- **Telephone:** +61 2 8627 8176
- **Email:** human.ethics@sydney.edu.au
- **Fax:** +61 2 8627 8177 (Facsimile)

(14) What support services are available to me should I need it after participating in this research?

If participating in this study raises any issues for you, please reach out and have a yam to someone about it. Culturally appropriate support can be found via www.wellmob.org.au, which is run by and for Aboriginal and Torres Strait Islander peoples. Depending on where you live, researcher Lindsay McCabe will be able to assist you in finding other culturally appropriate supports if necessary.

The following is a list of services that can provide immediate help:

Yarning SafeNStrong	1800 959 563
Griefline	1300 845 745
Lifeline	13 11 14 (24 hours)
Beyond Blue	1300 22 4636
Mensline	1800 041 612
Kids Helpline	1800 55 1800

And websites where you can find online supports:

Well Mob: www.wellmob.org.au
Yarn Safe: www.headspace.org.au/yarnsafe

This information sheet is for you to keep

Appendix 4: Participant Consent Form

School of Social and Political Sciences
Faculty of Arts and Social Sciences

THE UNIVERSITY OF SYDNEY

ABN 15 211513464

Rebecca Scott Bray
Associate Professor

Social Sciences Building A02 The University of Sydney
Camperdown NSW Sydney NSW 2006
AUSTRALIA
Telephone: +61 2 9351 4086
Facsimile: +61 2 9036 9380
Email:rebecca.scottbray@sydney.edu.au Web:
http://www.sydney.edu.au/

Understanding the Experiences of Aboriginal Families in the Coronial System in New South Wales

INTERVIEW CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- The researcher has answered any questions that I had about the study and I am happy with the answers.
- I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researcher or anyone else at the University of Sydney now or in the future.
- I understand that I can withdraw from the study at any time.
- I understand that I may stop the interview at any time if I do not wish to continue, and that unless I indicate otherwise any recordings will then be erased and the information provided will not be included in the study. I also understand that I may refuse to answer any questions I don't wish to answer.
- I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.

- I understand that a transcript of my interview will be sent to me at the address(es) I have provided.
- I understand that the results of this study may be published, but these publications will not contain my name unless I consent lo being identified using the 'Yes' checkbox below.

C""Jves, I am happy to be identified.

C""J**No,** I don't want to be identified. Please keep my identity anonymous.

- I understand that due to my role as one of only two ACISP Officers in New South Wales that I may be identifiable, even without my name being published.

I understand and agree to participate in this study. I consent to:

• **Audio-recording**	**YES**C""]	Noc=]
• **Being contacted about future studies**	**YES**C""]	**NO** C=J
• **Permanent archiving of study materials**	**YES**C""]	NOc=]
• **Notes being taken during interview**	**YES**c=]	**NO** C=J

I **would like to receive feedback about the overall results of this study**

YES C""J **NO** C=J

Please indicate your preferred form of feedback, and the best postal or email address to send your

interview transcript:

c=J Postal: _____

_____

c=J Email: _____

CJ In person

Is there an alternative address we can use, in case you move from your current residence?

_____
_____
_____
_____

Signature

PRINT name

[Optional] Language group/s or Mobis

Date

Appendix 5: Interview guide

Interview Schedule

- Can you please tell me a bit about yourself, who you are, where you're from?
- Before we start, is there someone you will be able to yarn with later, or a support person you can contact?
- You referred to the person who has died/is missing as X; is it okay for me to refer to them that way, or is there another name you would like me to use?
- Can you tell me about your loved one [*name if appropriate*]? What they were like?
- You said in the survey that your first contact with the coronial system was in XXXX; can you tell me a bit more about that?

From here it will depend on each persons' survey responses, thus each interview will be tailored to each respondent. The questions will also be tailored depending on whether the respondent is considered next-of-kin, or is part of the family or broader community.

This is a general interview guide, covering a broad range of issues. The interviews are being conducted using 'yarning' as a methodology, as outlined in the application. Yarning uses a conversational approach, including a mix of open ended semi-structured questions to elicit information. The following are questions that may be used to direct the conversation where necessary:

The Coroners Court

- You said in the survey that your first contact with the coronial system was in XXXX; can you tell me a bit more about that?
- How often did someone from the Coroner's office contact you or your family?
- How often did you contact the Coroner's office? How was that contact made, such as via phone or letter?
- Did you know who to contact for information, or if you had questions?
- Do you feel like you had enough contact/information in the first few days/weeks/months/years?
- Did you get support from your local ALS (Aboriginal Legal Service)? Can you tell me a bit about why/why not?
    - If no, did you receive support from the Coronial Unit at Legal Aid? Can you tell me a bit about why/why not?
- You mentioned that you used/did not use the Forensic Medicine Social Work Services counsellor's services. Can you talk a bit more about why you did/did not use this service?
- You mentioned that you used/did not use the CISP (Counselling and

Information Support Program) team's services. Can you talk a bit more about why you did/did not use this service?

- What was your experience of the staff at the Coroners Court like? Were they approachable?
- How often did you have contact with people at the court?
- Did you feel that there was enough contact with them?
- Did you feel that the support provided at the Court was culturally appropriate?
    - Did you feel that your culture was respected throughout this process?
- Were there cultural things that you needed to do for your loved one (*name if appropriate*) that you weren't able to?
    - Can you tell me a little bit more about this?
- Do you think the Coroner and other staff at the Coroners Court showed an awareness of, and respect for, protocols of sorry business?
- This next question might be difficult, but it's important in understanding how the system is working for mob. If you don't want to answer it, just say 'next question'.
    - Was there a post-mortem conducted after your loved one (*name if appropriate*) died?
        - Were you notified beforehand?
        - Did you agree or disagree/ were you told you could object?
        - Did you feel like you could have disagreed if you wanted to?
- Were there any difficulties or issues you faced getting your loved one (*name if appropriate*) home/back to country?

The Investigation

- I'll ask you some questions now about the early days of the investigation. What did you think of the investigation? For example, what was your experience of the police who investigated your case?
    - Did you feel that they were respectful to you and/or the family?
    - Did you feel as though you received enough contact and information from them?
- How long was the initial investigation?
- Did the investigation go to an inquest?
- IF NO: What the outcome of the investigation? How do you feel about the outcome?
- IF YES: was the inquest held at Lidcombe/Glebe/somewhere else (regional/on Country)?

The Inquest

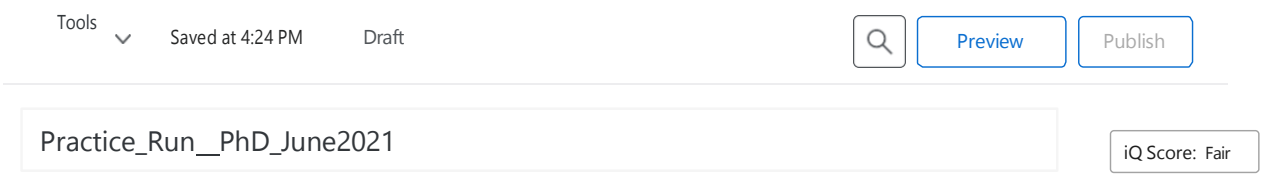
- How long after the death/disappearance was the inquest?
- Were you able to have all of the family and community members that you wanted with you at the inquest?
- Did you have transport to get to the Court?
- Did you need childcare to enable you to go to the Court?
- Tell me some more about what it was like at the Court.
    - *More will be asked here depending on the participant's response. For example, 'you mentioned that you weren't sure were to go when you got there. Did someone help you find out? Who?*
- What was the outcome?
- How do you feel about the outcome?
- Can you tell me a bit about the recommendations that were made?
- Did you have any contact with the court/CISP (Counselling and Information Support Program)/ALS after the investigation/inquest ended? Why/why not?
- How did you feel after the court process was over?
- How long has it been since the investigation/inquest ended?
- How do you feel about it today?
- Is there anything else you would like to share?

Closing the interview

- You have provided these details as your contact details; is there another way to contact you, just in case?
- Would you be interested in participating in a yarning circle with some of the other interviews at a later date?
- Would you like to share your name with the other participants of the yarning circles, so you will know who will be there beforehand?
- In case of COVID restrictions, would you be interested in joining a virtual yarning circle?
- Do you have access to Zoom capable technology?
- I'm going to turn off the tape recorder now (turn off recorder). How are you feeling?

At the end of the interview, a card with contact details for support services will be given to the participant.

Appendix 6: online survey



Introduction & Consent

Q1

The following survey is for Aboriginal people who have had interactions with the coronial system in New South Wales. This might have been following the death of a loved one, or because a loved one has been missing for a long period of time.

Who is running the survey?

This survey is being run by me – my name is Lindsay McCabe, I am a palawa woman and my family comes from southeast lutruwita/Tasmania. I am a PhD candidate at the University of Sydney, and I live on Dharug country in Western Sydney. I would like to better understand how mob are experiencing the coronial system in NSW. To learn what improvements are needed to make the system work better for us, our families and communities, we first need to know what isn't working.

Who can take part?

Any Aboriginal person who is 18 or older, and who has had contact with the coronial system in New South Wales between 2009 and 2021.

If I say yes, what will it involve?

You will be asked to complete an online survey that takes about 20 minutes. The survey questions will ask you about yourself and your experiences with the coronial system.

At the end of this survey, you will be asked if you would like to take part in an interview. These will run more like a yarn, where we will talk in more depth about your experiences. This is completely voluntary, and you do not have to take part in the interview if you do not want to. If you do want to yarn with me further, just check the box at the end of the survey and enter your email address, and I will contact you.

Are there any risks in being involved?

Some of the survey questions may be upsetting, as they will ask you to remember what it was like when you were in contact with, or were contacted by, the Coroner's Office. Feelings of grief, sadness and even anger are completely normal when thinking about someone we know who is missing or has died, and all the issues associated with this.

If anything here raises any issues for you, please go to www.wellmob.org.au for information and advice created by mob, for mob, or reach out to any of the following free services to yarn

with someone straight away:

Yarning SafeNStrong: 1800 959 563

GriefLine	1300 845 745
LifeLine	13 11 14
Mensline	1800 041 612
Kids Helpline	1800 55 1800

What will happen to my information?

It is important to know that your answers to this survey will be kept confidential. No identifying information about you will be kept, except for your contact information if you consent to being contacted by me. You can also stop the survey at any time by closing your browser window Please note that none of your answers will be included

in the study if you choose to leave the survey.

Only the researchers will see your answers to the survey. The completed surveys will be stored securely on the University of Sydney research data system. The results of the research study will be published as my PhD thesis, but may also be used to publish academic and other articles. No identifying information about you will be published, and you may request a summary of the research findings at the end of the study.

What if I have any concerns or complaints about this study?

If you have any concerns or complaints about the way this study is being conducted, or wish to make a complaint to someone independent from the study, please contact the university using the following details:

The Manager, Ethics Administration, University of Sydney:

Telephone: +61 2 8627 8176

Email: human.ethics@sydney .edu.au

Please quote the title, '*Understanding the experiences of Aboriginal families in the coronial system in New South Wales*', and the protocol number, *2021/404* if contacting the university about this study.

*

Add page break

Q2

I have read the above information, and agree to take part in this survey

Yes

No

Import from library Add new question

Overview

Q3

Thank you for taking the time to complete this survey, and for sharing your experiences with me.

This survey is in three parts.

Part One will ask you to give a bit of information about you, and the nature of your contact with the coronial system.

Part Two will ask you some questions about the person who has died or is missing, and the circumstances surrounding their death or disappearance. Please only share what you feel comfortable sharing, and take a break when you need to.

Part Three will ask you a bit more about your experiences with the coronial system, including the staff at the Coroners Court and the police.

Please only share what you feel comfortable sharing, and remember there are no right or wrong answers. I am interested in your story, and your experiences with this system.

If you need to reach out to someone and have a yarn, here are some good services touse:

Yarning SafeNStrong: 1800 959 563

GriefLine 1300 845 745

LifeLine 13 11 14

Add new question

Age

Q4

Part One

This part of the survey will ask you to give a bit of information about you, and the nature of your contact with the coronial system.

Q5

How old are you?

Import from library

Add new question

Indigenous Status

Q6 *

Do you identify as an Aboriginal, or Aboriginal & Torres Strait Islander, person?

- Yes
- . .

Import from library | Add new question

Part One

Page Break

Q7

Display this question

If Do you identify as an Aboriginal, or Aboriginal & Torres Strait Islander, person? Yes Is Selected

What mob/s or language group do you identify with?

Page Break

Q8

Do you identify as:

- Male
- Female
- Non-binary / third gender
- Prefer not to say

Page Break

Q9

Do you live in New South Wales?

Yes No

Q10

Display this question

If Do you live in New South Wales? Yes Is Selected

Q11

Display this question

If Do you live in New South Wales? Yes Is Selected

How long have you lived there?

More than 10 years 5

- 10 years

Less than 5 years

Page Break

Q12

Display this question

If Do you live in New South Wales? No Is Selected

What state or territory do you live in now?

South Australia

Australian Capital Territory

Queensland

Northern Territory

Victoria

Tasmania Western

Australia Other

Page Break

Q13

When did you first have contact with the coronial system in New South Wales? If you don't know the exact date that's okay, just the year or an approximate date is fine.

Import from library | Add new question

Part Two

Q14

Part Two

This part of the survey will ask you some questions about the person who has died or is missing, and the circumstances surrounding their death or disappearance. Please only share what you feel comfortable sharing, and take a break when you need to.

Page Break

Q15

Did the person pass away, or are they a missing person? *

- They passed away
- They are a missing person

Q16

Q17

Display this question

If Did the person pass away, or are they a missing person? They passed away Is Selected

What was your relationship to the person who has passed away?

- Mother
- Father Son
- Daughter
- Aunty
- Uncle
- Cousin
- Grandparent
- Carer
- Other

Display this question

If Did the person pass away, or are they a missing person? They are a missing person Is Selected

What was your relationship to the person who is missing?

- Mother
- Father Son
- Daughter
- Aunty
- Uncle
- Cousin
- Grandparent
- Carer
- Other

Page Break

Q18

Do you know if they identified with a particular language group/s or mob/s?

Yes

Not Sure

No

Q19

Display this question

If Do you know if they identified with a particular language group/s or mob/s? Yes Is Selected

Which mob/s or language group/s did they identify with?

Q20

Display this question

If Did the person pass away, or are they a missing person? They passed away Is Selected

How old were they when they passed away?

Q21

Display this question

If Did the person pass away, or are they a missing person? They are a missing person Is Selected

Page Break

Q22

Which town, suburb or area were they living in at the time?

Q23

Display this question

If Did the person pass away, or are they a missing person? They passed away Is Selected

Do you know what the cause of their death was?

- Yes
- No

Q24

Display this question

If Do you know what the cause of their death was? Yes Is Selected

If you want to and are able to, please indicate their cause of death

- Heart Disease
- Cancer Stroke
- Emphysema or Lung Disease (COPD)
- Suicide
- Drowning
- Motor Vehicle Accident Assault
- Other

Page Break

Q25

Would you like to share anything about what they were like? If yes, please do so here

Import from library Add new question

Part Three

Q26

The next part of this survey will ask you to tell me a bit more about your experiences with the coronial system, including the staff there, and the police.

Please only share what you feel comfortable sharing, and remember there are no right or wrong answers. We are interested in your story, and your experiences with this system.

Q27

Can you please tell me a bit about what your experience with the coronial system has been like?

Page Break

Q28

Was the person identified as an Aboriginal or Aboriginal & Torres Strait Islander person

- Before the investigation or inquest During the investigation
- During the inquest
- They were not identified as an Aboriginal or Aboriginal & Torres Strait Islander person

Q29

Display this question

If Was the person identified as an Aboriginal or Aboriginal & Torres Strait Islander person They were not identified as an Aboriginal or Aboriginal & Torres Strait Islander person Is Not Selected

Who identified them as an Aboriginal, or Aboriginal & Torres Strait Islander, person?

- I did
- Their family did
- A community member
- The investigating police
- The pathologist
- The Coroner

Page Break

Q30

Did you use any of the counselling services available through the Coroners Court?

- Yes
- No
- I'm not sure

Page Break

Q31

Display this question

If Did you use any of the counselling services available through the Coroners Court? Yes Is Selected

Was the counselling service you used

- Forensic counselling
- CISP - Counselling Information and Support Program Other
- I'm not sure

Page Break

Q32

Display this question

If Did you use any of the counselling services available through the Coroners Court? No Is Selected

Why not?

I didn't know they were available

I wasn't sure if there was a cost involved

I didn't feel comfortable using counselling services through the court I used a community counselling service instead

Page Break

Q33

Did you feel as though you were shown respect by the staff at the Coroners Court?

Definitely yes

Probably yes

I'm not sure

Probably not

Definitely not

Q34

Can you tell me a bit more about this?

Page Break

Q35

Did you feel as though you were shown respect by the police who investigated on behalf of the Coroner?

Definitely yes

Probably yes

I'm not sure

Probably not

Definitely not

Q36

Can you tell me a bit more about this?

Page Break

Q37

Did you feel that your sorry business was respected by the staff at the Coroners Court?

- Definitely yes
- Probably yes
- I'm not sure
- Probably not
- Definitely not

Q38

Was there anything in particular that made you feel this way?

Page Break

Q39

Did you feel as though the investigating police respected sorry business?

- Definitely yes
- Probably yes
- I'm not sure
- Probably not
- Definitely not

Q40

Was there anything in particular that made you feel this way?

Page Break

Q41

Did you feel as though your culture and beliefs were respected throughout the process?

- Definitely yes
- Probably yes
- Not really sure
- Probably not
- Definitely not

Q42

Were cultural practices observed that should have been?

- Definitely yes
- Probably yes I'm
- not sure
- Probably not
- Definitely not

Q43

Can you tell me more about this?

Page Break

Q44

Did you know who to contact for information, or if you had questions?

- Yes
- No

Q45

Display this question

If Did you know who to contact for information, or if you had questions? Yes Is Selected

Was it easy, or difficult to contact them?

- Extremely easy
- Somewhat easy
- Neither easy nor difficult
- Somewhat difficult Extremely

Q46

Display this question

If Did you know who to contact for information, or if you had questions? Yes Is Selected

Page Break

Q47

Do you feel as though you had enough information

	Definitely yes	Probably yes	Probably not	Definitely not
In the days following the death, or them going missing?	○	○	○	○
In the weeks following the death, or them going missing?	○	○	○	○
In the months following the death, or them going missing?	○	○	○	○
In the years following the death, or them going missing?	○	○	○	○
After the inquest or investigation was finished?	○	○	○	○

Page Break

Q48

What supports were helpful to you during the coronial process?

	Not at all	Not very much	Not sure	A little bit	A lot	Didn't use
Family Friends	○	○	○	○	○	○
Partner	○	○	○	○	○	○
Community	○	○	○	○	○	○
Coronial Information and Support Program (CISP)	○	○	○	○	○	○
Forensic Counsellor Local	○	○	○	○	○	○
GP	○	○	○	○	○	○
Coronial Inquest Unit - Legal Aid NSW	○	○	○	○	○	○
Aboriginal Legal Service (ALS)	○	○	○	○	○	○
Support After Suicide Group	○	○	○	○	○	○
Families and Friends of Missing Persons	○	○	○	○	○	○
Social Media	○	○	○	○	○	○
Other - please specify	○	○	○	○	○	○
	○	○	○	○	○	○

Page Break

Q49

Was there support that you needed during the coronial process, but weren't able to access?

- [ ] Financial support
- [ ] Legal support or advice Child
- [ ] care
- [ ] Housing
- [ ] Transport to and from the Coroners Court Transport in
- [ ] general
- [ ] Other - please specify

Page Break

Q50

What kinds of things do you do to manage stress and grief?

- [ ]
- [ ] Spend time with family or friends Spend
- [ ] time on Country
- [ ] Draw, paint or write
- [ ] Sports or other outdoor activities Other

Page Break

Q51

Is there anything else you would like to share with me about your experiences with the Coroners Court in New South Wales?

Import from library Add new question

Part Three, Section Two - Inquest

Q52

Skip to

End of Block if Yes Is Not Selected

Was an inquest held?

- ( )
- ( ) Yes
- ( )

Page Break

Q53

How long after your loved ones disappearance or death was the inquest held?

For example, six months, one year, 10 years

Q54

How long did the inquest go for?

Page Break

Q55

Where was the inquest held?

- Coroners Court, Lidcombe
- Coroners Court, Glebe Local
- Court - please specify

Q56

Did the family have legal representation for the inquest?

- Yes, Aboriginal Legal Service
- Yes, Coronial Inquest Unit - Legal Aid Yes,
- a private solicitor
- Yes, someone else
- I'm not sure
- No

Page Break

Q57

Did you attend the inquest?

- Yes
- No

Q58

Display this question

If Did you attend the inquest? Yes Is Selected

How did you get to the Coroners Court or regional court?

- Own car
- Someone else's car
- Public transport
- Taxi or Uber

Q59

Display this question

If Did you attend the inquest? Yes Is Selected

Did you need access to childcare to attend the inquest?

- Yes, but couldn't access Yes,
- and could access No
- No, but others in my family did

Page Break

Q60

Do you feel like you had enough information

	Definitely not	Probably not	Not sure	Probably yes	Definitely yes
Leading up to the inquest					
At the beginning of the inquest					
During the inquest					
At the end of the inquest					
In the days following the inquest					
In the months following the inquest					

Page Break

Q61

What supports were helpful to you during the inquest?

	Not at all	Not very much	Not sure	A little bit	A lot	Didn't use
Friends	○	○	○	○	○	○
Family	○	○	○	○	○	○
Partner	○	○	○	○	○	○
Community	○	○	○	○	○	○
Coronial Information and Support Program (CISP)	○	○	○	○	○	○
Forensic Counsellor	○	○	○	○	○	○
Local GP	○	○	○	○	○	○
Coronial Inquest Unit - Legal Aid	○	○	○	○	○	○
Aboriginal Legal Service	○	○	○	○	○	○
Support After Suicide Group	○	○	○	○	○	○
Families and Friends of Missing Persons	○	○	○	○	○	○
Social Media	○	○	○	○	○	○
Other - please specify						

Page Break

Q62

What was the outcome of the inquest? Please only answer the outcome that applies to you.

	I was very happy with outcome	I was happy with this outcome	I'm not sure what the outcome was	I was disappointed with this outcome	I was very disappointed with this outcome
The Coroner dispensed with the inquest (decided not to hold one)	○	○	○	○	○
The Coroner delivered findings	○	○	○	○	○
The Coroner delivered findings with recommendations	○	○	○	○	○
The inquest started, but was referred to the Prosecutors	○	○	○	○	○

Page Break

Q63

How do you feel about the outcome of the inquest process?

Page Break

Q64

Is there anything else about the inquest process that you would like to share?

Import from library Add new question

Autopsy Block - Optional

Q65

Skip to

End of Block if No Is Selected

The next set of questions concern post-mortem practices. If you want to, you can skip these questions by selecting 'No'.

Are you comfortable answering some questions concerning post-mortem practices?

Yes

No

Page Break

Q66

What are your feelings when you see the words 'autopsy' or 'post-mortem'?

Page Break

Q67

Do you know if the person who has died had an autopsy performed?

Yes, they did

I'm not sure No,

they didn't

Page Break

Q68

Were you, or their next-of-kin, contacted by someone at the Coroners Court to discuss an autopsy being performed?

Yes

No

I'm not sure

Page Break

Q69

Did you, or their next-of-kin, object to an autopsy being performed?

- Yes, in discussion with the counsellor at the Coroners Court Yes, in
- discussion with the Coroner
- Yes, in the Supreme Court No
- I'm not sure

Q70

What was the outcome?

- Successful - no autopsy was performed
- Not successful - an autopsy was performed despite objection I'm not sure

Page Break

Q71

Were you, or their next-of-kin, told why an autopsy was or was not required?

- Yes - please share the reason here if you want to
- No - please share any comments about this here if you want to I'm not sure

Page Break

Q72

Were there cultural considerations you, or their next-of-kin, needed to take into account when considering objecting to the autopsy?

- Yes
- No
- I'm not sure

Q73

Can you tell me a bit more about this?

Page Break

Q74

Did you, or their next-of-kin, receive a report of the autopsy findings?

- Yes
- No
- I'm not sure
- N/A

Q75

Display this question

If Did you, or their next-of-kin, receive a report of the autopsy findings? Yes Is Selected

Did someone support you when you received the autopsy findings?

- Yes, the counsellor at the Coroners Court Yes, the
- Aboriginal Legal Service
- Yes, Legal Aid
- Yes, family
- Yes, community
- No
- Other

Page Break

Q76

Did you feel like there was more clarity about their cause of death following the autopsy?

- Yes - please share why if you want to No -
- please share why if you want to
- I'm not sure
- N/A

Page Break

Q77

Were funeral arrangements delayed due to an autopsy being performed?

- Yes
- No
- Yes, but for another reason (please specify) N/A

Q78

Display this question

If Were funeral arrangements delayed due to an autopsy being performed? Yes Is Selected

For how long?

- 1 - 3 days
- 3 - 7 days
- 1 - 3 weeks
- 1 month or more

Page Break

Q79

Is there anything you would change about the process, or anything that you thought was particularly helpful about the process?

Page Break

Q80

Thank you for your answers. This is the final question for this section.

What would have been helpful to know, that you didn't know at the time?

Import from library Add new question

Final

Q81 *

Would you like to be contacted by me to arrange an interview? If you answer yes, you will asked to provide your name and contact details in the next question.

- Yes
- No

Page Break

Q82

Display this question

If Would you like to be contacted by me to arrange an interview? If you answer yes, you will asked t... Yes Is Selected

Your email address will be used to contact you to talk about further participation in the study. Your email address and any other identifying information will be kept confidential. Please leave your name and email address below

Name

Email address

Q83

Display this question

If Would you like to be contacted by me to arrange an interview? If you answer yes, you will asked t... Yes Is Selected

Please indicate if you have access to technology, such as a smartphone and internet, that could be used for an online interview if required.

- Yes
- No

Q84

Display this question

If Would you like to be contacted by me to arrange an interview? If you answer yes, you will asked t... Yes Is Selected

If you do not have access to email, or would prefer to be contacted by phone, pleaseleave your contact number here:

Page Break

Q85

If you do not want to have an interview, but would like to receive the results of this study, please leave your email address below. Your email address will only be used to send you the results of the study, and will be kept confidential.

Page Break

Q86

Thank you for completing this survey. Your responses will help me to better understand what it is like for families and community to experience this system.

If anything discussed here has raised any issues for you, please reach out and have a yarn to someone.

Culturally Specific Services:

Yarning SafeNStrong: 1800 959 563

WellMob: www.wellmob.org.au

Yarn Safe: www.headspace.org.au/yarnsafe Other

Services:

GriefLine: 1300 845 745
LifeLine: 13 11 14

MensLine: 1800 041 612

Kids Helpline: 1800 55 1800

Import from library Add new question

End of Survey

We thank you for your time spent taking this survey.

Your response has been recorded.