Coronial Responses to Suicides of Aboriginal and Torres Strait Islander People

REPORT from the
LIVED EXPERIENCE WORKSHOP

OCTOBER 2023

The Centre of Best Practice in
Aboriginal & Torres Strait Islander
Suicide Prevention

About the cover artwork

Moortang Yoowarl Dandjoo Yaanginy Families (Cultures) Coming Together for a Common Purpose (Sharing) – Shifting Sands
Aunty Roma Winmar

This artwork represents our people doing business on country that is recovering from colonisation, our lands taken over, our cultures decimated, and our families separated causing hardship, despair, and loss of hope.

The many years of oppression to our cultures that our families and our Elders have had to endure has meant that we have needed to adapt and learn to engage and address a wide range of issues impacting on our families, in both traditional and contemporary ways. We are concerned with strengthening and reconnecting to our countries, cultures and families, to nurturing cultural identity and pride whilst still trying to carry our immediate and collective business as First Peoples of Country, but, on Shifting Sands.

About the artist

Aunty Roma Winmar, Noongar artist, was born in Gnowangerup, a small town in the southwest of Western Australia, in 1944. Her artwork has been presented nationally and internationally with numerous exhibitions. Aunty Roma is a Noongar Language teacher at the Moorditj Noongar Community College in Middle Swan, Western Australia.

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Aboriginal and Torres Strait Islander readers are advised that this publication may contain images or information about people who have passed away.

Coronial responses to Aboriginal and Torres Strait Islander Suicides

REPORT from the LIVED EXPERIENCE WORKSHOP

October 2023

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Dedication

We acknowledge the loved ones lost across Country, and how Country has guarded their spirits. We also acknowledge First Nations people who have lost loved ones and engaged with the Coroner's Court. Imposed systems have impeded our natural grieving and healing cycles and caused us pain. We recognise our resilient cultural grieving processes that have helped us to heal when systems have failed us or harmed us.

This report is dedicated to those who have not got closure and are lost for answers. This is our call to action, our way forward.

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About our group and this report

We are members of the Black Dog Institute Aboriginal and Torres Strait Islander Lived Experience Network. We came together on 23 February 2023 to discuss our experiences with the Coroners' court systems in Australia's States and Territories.

Most of us had not met others in the group previously, but we are sadly united in one experience: losing family to suicide. We spent the whole day talking and sharing, crying and sometimes laughing. We felt the warm support and understanding of other Aboriginal and Torres Strait Islander people who have been through their own losses of children, parents, brothers and sisters.

Some of our losses are recent, others many years ago, but we still feel the pain of missing our loved ones, and that pain is held throughout our families and communities.

We are writing this report together because we want Aboriginal and Torres Strait Islander people who find themselves in this situation to receive better support than we did from the Coroners and their staff. When official processes are not culturally safe, it compounds our grief. We want others to experience cultural safety, respect and support at one of the most difficult times in one's life.

Some of us have chosen to include our names as authors of this report and others prefer not to, but we have all worked together on the ideas that follow, which come directly from our own experiences and observations. They need to be adopted by governments, coroners and court staff to make a big difference to supporting our people.

Definition of Aboriginal and Torres Strait Islander Lived Experience

Over the course of 2020, the Indigenous Lived Experience Centre engaged a wide range of Aboriginal and Torres Strait Islander lived experience representatives in a co-design process to develop a working definition of Indigenous Lived Experience.

The purpose of the following definition is to demonstrate how and why Aboriginal and Torres Strait Islander lived experience of mental health and suicide is unique and therefore essential to the design and delivery of services to our communities.

"A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing."

Source: Aboriginal and Torres Strait Islander Lived Experience Centre

1 Cultural understanding of Coroners and court staff

We have lived on this land for 60,000 years and have long standing ways of living well. Sadly, when a loved one passes away suddenly our status as First Peoples is not officially recognised and we are forced into the authority of Coroners' Courts. Coroners' Courts are part of the judicial system, which has been responsible for many wrongs towards our people. They are part of the continuing colonisation of our lands that began more than 200 years ago, and their words and processes can be extremely traumatising for us to experience while we are grieving. They are confronting and unfamiliar, usually they do not provide space for our cultures, and they remind us of all that has been taken away.

We believe it is up to Coroners themselves, and State and Territory justice departments, to ensure they have knowledge and understanding of our cultures, including our diverse cultural practices when someone passes away. Then they can work respectfully with families and communities and not make things worse. It's time for them to make that commitment.

What we said:

"We all have different cultural practices. It's not generic."

"Take the responsibility to make sure that you get trained in that community too, because the layout of the community is completely different, or if training is not available, go and sit and ask those important questions about how you work with that community."

"We haven't got one coroner in all of these years sitting in that space to say, 'I haven't got enough to know about these people. And I really want to know about these people before I hand down this report'. And that's like a disrespect to us."

"They need to understand how to work with our people. They need to have that first and foremost because once they have that cultural understanding, that cultural safety, then they're going to have that respect for who we are and how we do our business."

"Several different kinds of positions need to be created to support the coroner's office to provide a safe and respectful service to our people."

Our advice:

- Cultural awareness, cultural competency and cultural safety training must start at the earliest point in a Coroner's career – while they are at law school and earlier.
- All coroners and coroner's court staff must have regular and locally relevant cultural awareness, cultural competency and cultural safety training.
- Coroners must have cultural supervision e.g. from local Elders, so they continue to learn under the guidance and authority of Aboriginal and Torres Strait Islander people.
- Coroners must be prepared to travel to communities to make investigations, hold hearings and meet families. When they do, they need to know and follow cultural protocols.
- All Coroners' courts have to employ Aboriginal support/liaison workers, so all Aboriginal and Torres Strait Islander families can have access to culturally safe supports through the coronial process. The Aboriginal Engagement Unit in the Victorian Coroner's Court could be a model for this approach.

2 Communication with bereaved families

After a sudden passing, people are often highly distressed, confused and distracted. We need help to understand the role of the Coroner – what they can and can't do, and what rights we have to say about what should happen with our loved ones. The system is very complicated, and we need to know what to expect and how to navigate it.

Brochures and websites developed for mainstream Australia may not have much meaning for us, if English is not our first language, or if they do not address our cultural concerns.

Family members' interactions with the Coroner's court can have a major impact on how we adjust to our loss. Culturally unsafe interactions, or an absence of any communication, can prolong and complicate our grief and retraumatise us.

We think processes which are inclusive of communication – both the method and the content – need to be a priority in improving the cultural responsiveness of Coroners' courts to our people.

What we said:

"An inquest was just a word. We didn't know what that meant. It's like, 'well, what the hell is that?' It's something you see on the TV or on a movie."

"We never got any notification about the actual inquest. And the letters were addressed to the wrong people."

"People from the remote desert areas, many of them didn't even understand there was going to be a report. I know of a situation where someone unknowingly threw their report in the fire, not understanding how important the document was."

"They're not mindful of the literacy levels of our people. It's not only that people can't speak or read English really well. The coroner's office needs to understand that most Aboriginal people are bilingual and English is a second language."

"In terms of the toxicology report or the post-mortem report, could we have it in simpler language or translated into plain English, and can we also look at how we put it to [families]? What about having Aboriginal and Torres Strait Islander workers sit with the family and help them understand what it is?"

"We have to deal with the shock and the blame and the anger, but for the acceptance side, that's in our own time and that's through communication. If you don't understand something, you will carry that anger and blame for the rest of your life."

"Because for us it's like the coroner was only there at that time. After the letter, nothing. He put the impact on us - to work out that letter by ourself. And we didn't know that you can ask them a question or things like that, because we were still grieving."

Our advice:

- Coroners' courts must provide information resources using language and concepts appropriate to local communities. These could be brochures or videos, and they need to include:
  - information about the role of the Coroner
  - explanations of different coronial processes eg inquests and written findings
  - information on families' rights, including how to make objections or complaints
- Culturally responsive assistance must be available to interpret complex or scientific information e.g. toxicology reports.
- Culturally responsive assistance must be available for practical requests e.g. having a loved one's property returned.
- The Coroner's court has an obligation to make direct compassionate contact with families before and at important points in the process. People should not just receive a letter or report without any warning.
- Face to face communication is essential at key points e.g. the delivery of the Coroner's findings.
- It is the responsibility of the Coroner's office to make sure they have the correct contact person, address etc. This is a matter of basic respect.

3 Working alongside our communities

Supporting bereaved people through the coronial process takes time and commitment. We need continuity and we need to be able to seek support with our grieving after the coronial findings are complete, as well as during the investigation into our loved one's passing.

What we said:

"We need to get First Nations people in different AMSs and ACCHOs trained up so they understand what actually it is that this coroner was saying, and then they can work closely with the coroner's office and with families."

Our advice:

- Social and emotional wellbeing support should usually be provided in the community eg by ACCHOs
- This means Aboriginal engagement workers or family liaison staff at the Coroners' courts need to have strong connections with community organisations, so they can work together.
- There needs to be dedicated funding for this role. It can't just be an add-on to the job of SEWB staff in ACCHOs who are already over-stretched.
- Trained Aboriginal Health Workers could be employed in community coroner liaison roles. They would need appropriate professional development and support, and clear boundaries around their responsibilities.

This means Aboriginal engagement workers or family liaison staff at the Coroners' courts need to have strong connections with community organisations, so they can work together.

4 Aboriginal and Torres Strait Islander cultural practices, knowledges and beliefs

Aboriginal and Torres Strait Islander cultural practices and obligations after a passing are diverse, and very different from those of other Australians. It is critically important to us to honour our loved one by carrying out our obligations, including laying them to rest on their Country.

The appropriate person or people within our kinship structures needs to lead these processes, even though they may not be the next-of-kin in western terms.

We may also have a different understanding of the reason for a sudden passing, and sometimes families attribute this to supernatural causes or payback.

The Coroners' Courts are responsible for learning how we do things, and ensuring their processes make space for our cultural needs.

What we said:

"It's not just an isolated thing where you're hurting. It's felt by your immediate family members and by the broader community, so I think having that conceptual understanding from the coroner's perspective is really, really integral."

Our advice

- Coroners need to appreciate different cultural understandings. Some families may not always accept that a passing was suicide.
- Coroners need to understand kinship structures so they can work respectfully with families and communities.
- Coroners need to appreciate that a sudden passing affects not only immediate family members but is deeply felt through whole communities.

5 Financial impacts on families

When a loved one's passing is referred to the Coroner there may be many additional expenses, for example for travel to attend meetings and inquest hearings. If a family challenges a coronial investigation or finding, or campaigns for an inquest to be held, the costs are much higher.

In some States and Territories there is financial assistance to repatriate the person to their Country, if they have been taken to the city for an autopsy. In other places we have heard that families sometimes receive a bill.

Aboriginal and Torres Strait Islander families are often financially disadvantaged and may not be able to meet these extra costs (on top of paying for a funeral), especially if people have to stop working while they are dealing with their sudden loss.

The financial responsibility is felt by not only the immediate (biological) family, but is likely to be felt by the whole community in accordance with kinship connections. In many communities, kinship relationships are considered as having the same level of responsibility as the immediate (biological) family.

In particular, community and cultural protocols may require the establishment of a Sorry Camp which may need to be established for a couple of months. This is a key customary practice for many communities. Cultural protocols require that those participating in the Sorry Camp must reside in the Sorry Camp and cease regular work activity, which has significant financial impacts. This financial burden is compounded when communities face multiple losses.

Within Aboriginal and Torres Strait Islander communities which establish Sorry Camps as well as communities which gather to grieve in less structured way, there are family and kinship obligations to provide meals and accommodation for visiting family and connections.

Money worries at a time of grief can compound our distress, and we think there are practical ways that some of this burden could be relieved.

What we said:

"And it's so hard, if you've got no money and you've got a family that's not working and there are older people, you got to all rally together to get that money to get that funeral happening, you know, and the longer it takes, the longer it sits there and it's more stressful."

"If you're having to pay for the funeral, on top of that you're having to pay to bring them back home. That's a lot of money."

"Nobody else pays for them mob to have an autopsy. And when our mob are getting flown away, then I'm paying for that. They don't pay for that. That should be a given. How come you mob have to pay?"

Our advice:

- The cost of repatriation of a person after a coronial investigation must be paid by the coronial system (or another government service) in all States and Territories.
- A mechanism must be established to meet the costs of families and community members who need to travel to attend an inquest.

6 A national framework for accountability

We are concerned that there is not enough accountability for improving the responses of Coroners' courts to Aboriginal and Torres Strait Islander families, including following up recommendations from inquests.

Too often, inquiries into issues that affect our people come up with findings and recommendations that don't get implemented. Recommendations from the Royal Commission into Indigenous Deaths in Custody, more than 30 years ago, have still not been enacted. So who will take accountability for Coroners' recommendations about Indigenous suicides?

We believe there needs to be a national framework of agreed expectations and commitments to ensure our people are always treated with respect and consideration, no matter where they live, and to follow up Coroners' recommendations to prevent more losses. We appreciate that there are differences between States and Territories in their legislation and how coronial systems are organised, but a national framework would give people a clear understanding of the expected standards.

What we said:

"When you've got recommendations coming from the coroner, who keeps an eye on those recommendations to make sure they get implemented?"

"I mean, look, how many recommendations come out of the royal commission into Black deaths in custody? And how long ago was that? It's one thing to have a report. It's one thing to have recommendations. Who follows those recommendations up to make sure that those police are going to do it right? To keep them accountable?"

"For accountability, it's got to become law."

"It's one thing to, you know, put in systems and processes and try and make change … but then, making sure that we're actually measuring that and making sure that the accountability is there, and making sure that we're seeing the results that we need to see."

"If the coroner has recommended this and this, and if it's specifically to do with what's happened with your family member, I think that they have a responsibility to come back and say, 'well, this has been implemented'. So then you know that all of this was not in vain. It's a big slap in the face when nothing changes."

Our advice:

- Reforms to Coroners' courts, to make them more culturally safe and responsive, need to be developed under Indigenous governance.
- Coroners must be made accountable to answer racism complaints through their oversight body. There need to be mechanisms to provide feedback and a transparent process to show that the feedback has been addressed.
- Independent assessors are needed to oversee improvements to cultural safety of Coroners' courts e.g. through rigorous, culturally-informed annual or six-monthly reporting against a national framework, conducted under Indigenous governance. They should also report on the progress of reforms based on Coroners' recommendations.
- Coroners have a duty to advocate for better responses from police, who are usually first on the scene of a sudden passing. Police responses are known to be racist and traumatising.
- Many families were bereaved decades ago. At the same time as making improvements, Coroners must acknowledge the continuing hurt and trauma from past practices.

Conclusion

We have shared our stories in sincerity and good faith. To share our lived experiences of some of darkest moments of our lives has taken great sacrifice and courage from our group.

Our group has chosen to use our pain to come together and look at a way forward, using the heartache and lessons within our stories in the hope that future families do not suffer in their time of need like we did.

We hope our coming together will help to make real and meaningful change to the way coroners work with our people and the system responds to our needs. We share and we hope that you will listen.