National Deaths in Custody Database Proposal

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Table of Contents

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Executive Summary

David Dungay's repetition of "I can't breathe" in the lead up to his death defines the callous approach taken by some correctional staff towards the lives of incarcerated individuals. The disregard for the cries of a dying, vulnerable man provides insight into the practices in some of the darkest corners of the country: correctional facilities.

Following the 2009 death of Robert Plasto-Lehner in the Northern Territory, the 'prone position' restraining technique was identified as fatally dangerous. Regardless, the same technique was used on David Dungay six years later. Given existing knowledge, this obvious gap should have been easily identified and he need not have died.

Coroners' Inquests into Robert Plasto Lehner's death (Northern Territory 2009), and those of Carl Antony Grillo (Queensland 2011), Bradley Karl Coolwell (Queensland 2017), and Pasquale Giorgio (Queensland 2018) reveal that in each of these cases, the causes of death were the result of being restrained in the prone position. This led to eventual suffocation from positional asphyxia. Further deaths in similar circumstances could have been avoided had the information, and possible strategies for reform, been implemented across jurisdictions.

The current coronial systems across all Australian jurisdictions present significant gaps in the collation, accessibility, dissemination and response by affected authorities of coronial reports. The Dungay family, and the wider community, stress the urgency of using the available information to prevent death.

In discharging their duties, the Coroner bears the obligation to prevent further deaths from occurring. At present, the Coroner makes recommendations for reform which are distributed to the affected authorities in their state. These reports are made available on separate coronial databases. The inclusion of government responses vary, with Queensland being the only state that specifies whether a response was required.[1]

This data from the inquests is examined by two organisations; the *National Coronial Information System* ('NCIS') and the *Australian Institute of Criminology* ('AIC').[2] The NCIS is intended to serve as a centralised databases of deaths in custody, which includes some Coroners' findings and recommendations. However, it is not updated regularly and has restricted access. The compartmentalisation of information leads to each Coroner existing within their own silo. This is contrary to the Coroners' purpose of preventing further death.

[1] The State of Queensland, 'Findings – Coroners Court', *Queensland Courts* (Web Page, 31 July 2018) <https://www.courts.qld.gov.au/courts/coroners-court/findings>.
[2] See section 1.

In response to this issue, a new database system is proposed to include coronial findings on deaths in custody and recommendations from all Australian jurisdictions, distributed nationwide as well as published responses from state and federal authorities who are affected by the reccommendations.

The database should utilise a clearinghouse model to create one central agency for information collection, classification, and distribution.[3] The data would be collated and automatically distributed to all relevant government authorities, while also allowing for public access. It is crucial for it to be regularly updated, and require government responses to inquests, which will be searchable by catchword and report content.

It is proposed that the implementation of such a national database and follow up functions be facilitated by the NCIS and/or the AIC. The implementation of the proposed database would promote accountability among government authorities to address recurring issues that endanger the lives of incarcerated individuals. It is clear that by inducing collective learning, accessible solutions can be developed to prevent needless deaths across Australia.

[3] *Merriam Webster* (online at 11 February 2020) 'Clearinghouse' (def 2).

Current Use of Findings and Recommendations of Inquests

Currently findings and recommendations of coronial inquests are largely made available and utilised on a state-by-state basis, with very little collation of jurisdictions undertaken. Previous measures have been taken to address deaths in custody on a national level, yet these have not sustained in recent years. Similarly, current measures are inaccessible to the wider public and do not display the transparency needed to address the public interest of this issue. Each state government retains the ownership and maintenance of either a state coronial website or webpage that belongs to a larger government department.

AustLII

The Australasian Legal Information Institute (AustLII) currently provides the most comprehensive assembly of coronial reports, publishing coronial findings and recommendations from four Australian jurisdictions and New Zealand.[4] The jurisdictions under which these reports are made available are:

- the Coroners Court of Victoria from 2002 onwards,
- the Coroners Court of Australian Capital Territory from 2013 onwards,
- the Magistrates Court of Tasmania from 2002 onwards,
- the Magistrates Court of the Northern Territory from 2002 onwards, and
- the New Zealand Coroners Court from 2007 onwards.

The following Australian jurisdictions of which produce coronial reports, are not provided on AustLII:

- the Coroners Court of New South Wales,
- the Coroners Court of South Australia,
- the Coroners Court of Queensland, and
- the Coroners Court of Western Australia.

Inquiry has been put to AustLII as to why this inconsistency exists regarding the available jurisdictions.

AustLII also provides a search tool, in which allows the user to input free text and yield coronial reports as results from either a specific database (jurisdiction) or all databases (jurisdictions). For example, the term ‘positional asphyxia’ when searched, yields coronial reports as results when using either the all or selected database options (depending on the selected database). Similarly, specific coronial inquests can be searched and found using their catchwords. However, the accuracy to which this is achieved varies depending on the generality of the catchword used and whether one or all selected databases are searched. Catchwords used to search all databases generally will not result in desired/relevant documents.

[4] AustLII, ‘All Databases’, *AustLII* (Web Page) <http://www.austlii.edu.au/database-all.html>.

Australian Institute of Criminology

The Australian Institute of Criminology (AIC) has historically provided the 'National Deaths in Custody Program: Death in Custody in Australia Report'. This report is produced on an annual basis and records the nature and extent of deaths occurring in prison, police custody and youth detention in Australia.[5] The most recent of these reports covers the 2015-2016 year, however reports have yet to be published that address years 2016 through 2019.

The most recent of AIC's publications relating to this topic is the 'Indigenous Deaths in Custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody'[6] statistical bulletin that was produced in February of 2019.

The AIC also proclaims to compile a National Deaths in Custody Program database, which is composed of data collected by the National Deaths in Custody Program (overseen by the AIC) and coronial reports and information collected by the National Coronial Information System (NCIS).[7]

National Coronial Information System

The National Coronial Information System (NCIS) is a database that was established in 2002 and is currently managed by the Victorian Department of Justice and Community Safety.[8] The database contains a variety of coronial information from findings to legal, medical and scientific reports.[9]

Whilst the NCIS allows the user to input free text to search the database, the effectiveness of the search in yielding results depends upon the generality of the text used. For example, the term 'positional asphyxia' does not yield any results, however, the term 'death' yields ample results.
As the database is user restricted, only those who have been approved may have full access, thus the volume of results provided in response to a searched term also depends upon whether the NCIS has provided public material related to the term. The application process required to receive full access to the NCIS can only be described as extensive.

Alternatively, the NCIS provides access to a 'Coronial Recommendations: Fatal Facts' search engine. This search engine allows the user to filter their search according to pre-given criteria, whereby there is no option for the free input of text to guide the search. Unfortunately, it appears

5 https://aic.gov.au/publications/sr/sr13.
6 https://aic.gov.au/publications/sb/sb17
7 https://www.crimestats.aic.gov.au/NDICP/ndicp/.
8 https://www.ncis.org.au/about-us/.
9 https://www.ncis.org.au/about-the-data/data-sources/.

that either the database is not updated regularly or not all coronial recommendations are made available for public access, as the most recent coronial report provided using the criteria of 'Indigenous' and 'Law Enforcement' is from 2015. Given the findings of the David Dungay's 2019 Coronial Inquest, this is concerning.

Similarly, the NCIS provides Coronial Recommendations: Fatal Facts editions, in which contain summaries of coronial reports and recommendations from all jurisdictions that have taken place within a three-month span. The most recent Fatal Facts edition provided covers January through March 2017. Newer editions are yet to be published.

State Coronial Websites

As stated above, each Australian State and Territory maintains its own coronial website or webpage, most providing information and coronial reports and recommendations to the public. Each website or webpage is unique to the state and provides different levels of functionality. The effectiveness of each State's online offering will be analysed below.

South Australia

The South Australian Coroners Court webpage[10] is situated within the official South Australian Courts website.[11] Both the general Courts website and coronial findings webpage allow the input of free text in order to search, however both yield no results when the term 'positional asphyxia' is used. The findings of coronial reports are searchable via their content when using the general search bar, the coronial findings search bar on the other hand only allows the searching of names and the dates that coronial findings were handed down.

On the coronial findings webpage, reports are segmented by the year the findings were handed down and reports are identifiable by name only, with an absence of catchwords.

New South Wales

New South Wales offers an entire website dedicated to the Coroners Court,[12] with coronial findings located on a single webpage within the site.[13] All coronial findings from 2012 through 2020 are listed on the findings page, with only 'major' findings being available pre-2012. Each report is titled by the name of the deceased and accompanied by the name of the relevant coroner, the date the report was handed down and the catchwords of the case. The general Coroners Court website allows the input of free text in order to search, whereby the term 'positional asphyxia' yields relevant results, thus coronial reports are searchable via their catchwords.

10 http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/default.aspx.
11 http://www.courts.sa.gov.au/Pages/default.aspx.
12 http://www.coroners.justice.nsw.gov.au/.
13 http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx.

Queensland

Similar to South Australia, Queensland offers a Coroners Court webpage[14] situated within the official Queensland Courts website.[15] Both the general Courts website and the coronial findings webpage allows free text input to search. Both yield relevant search results when the term 'positional asphyxia' is used. All coronial reports from 2004 through 2020 are listed chronologically on the coronial findings webpage, each report is titled by name of the deceased and accompanied by the date the findings were delivered and the catchwords of the case. Interestingly, next to each report it is indicated whether a response from the Queensland Government is required and if a response has been submitted. After careful measure of all jurisdictions, Queensland currently offers the most accessible and efficient method of searching and sorting coronial findings.

Western Australia

Similar to NSW, Western Australia offers an entire website dedicated to the Coroners Court of Western Australia.[16] Coronial findings are segmented by year from 2012 through 2020, with each year having its own separate webpage dedicated to the findings delivered that year. Reports prior to 2012 are not available. Findings are listed via a drop down bar alphabetically and provide no further information beyond the name of the deceased. The website's search bar allows the free input of text, whereby the term 'positional asphyxia' yields one relevant result. It does not appear that Western Australian coronial reports use catchwords, thus catchwords are not searchable, similarly coronial reports are not searchable via their content.

Victoria

As above, the Coroners Court of Victoria is provided with its own website.[17] All reports are stored on the findings webpage[18] and can be accessed via an interactive grid, which spans over severall pages. Findings are titled by the name of the deceased, and although initially listed by date that the report was delivered in descending order, reports are also filterable by name, case ID, case type, date, coroner, related rulings and orders and responses to reports. Both the general Court's website and the findings webpage allows the input of free text to search, however, both searches yield no results in response to the term 'positional asphyxia'. Similarly, it does not appear that content of coronial reports is searchable via the general search bar, but searches of content may yield accurate results when using the findings webpage search bar in some cases.

14 https://www.courts.qld.gov.au/courts/coroners-court.
15 www.courts.qld.gov.au.
16 https://www.coronerscourt.wa.gov.au/
17 www.coronerscourt.vic.gov.au.
18 https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=&order=field_date_of_finding&sort=desc.

Tasmania

Tasmania offers a webpage dedicated to the Coroners Court of Tasmania[19] situated within the Tasmanian Magistrates Court's website.[20] Coronial reports are segmented according to time periods: Pre-2015, 2015 through 2018 and 2019 onwards. Each time period is given its own webpage, with corresponding reports listed in a table on the relevent webpage. Reports are listed according to date the report was delivered in descending order and titled by the name of the deceased. Accompanying the report is also the name of the relevant coroner and the relevant 'keywords' or catchwords of the case. Both the general Magistrates Court website and the findings webpages allow for the free input of text to search, with both searches yielding relevant results in response to the term 'positional asphyxia'.

Northern Territory

The Northern Territory's coronial findings are held on a webpage[21] within the Department of the Attorney-General and Justice's website.[22] Reports are all listed on the findings webpage but segmented by the year the findings were handed down and in chronologically descending order. The general Attorney-General and Justice website all allow free input of text to search, however the term 'positional asphyxia' yields no relevant results. Similarly, the content of reports do not yield relevant results.

Australian Capital Territory

The Australian Capital territory offers a webpage[23] dedicated to the Coroners Court within the ACT Court's website.[24] Coronial findings are not made available on the website or the webpage. Instead it is advised that copies of coronial reports can be requested from the coroner if you are a member of the immediate family of a deceased for whom an inquest (other than an inquest into a death in custody) has been held or if you were the owner of the property damaged or destroyed by the fire the subject of an inquiry.[25] Curiously, coronial reports under the jurisdiction of the Australian Capital Territory Coroners Court are available on AustLII.[26] There is no explanation available on this website as to the existence of this discrepancy.

Analysis and recommendations for inquests

The nationally coordinated mechanisms to collate coronial inquests are lacking the necessary support to perform as required. National database mechanisms are inconsistent and demand reform in order to improve centrality and the ease to which users can search causes of death from

19 https://www.magistratescourt.tas.gov.au/about_us/coroners.
20 www.magistratescourt.tas.gov.au.
21 https://justice.nt.gov.au/attorney-general-and-justice/courts/coroners-findings.
22 https://justice.nt.gov.au.
23 https://www.courts.act.gov.au/magistrates/o/courts/coroners_court.
24 www.courts.act.gov.au.
25 https://www.courts.act.gov.au/magistrates/o/courts/coroners_court
26 https://www.austlii.edu.au/cgi-bin/viewdb/au/cases/act/ACTCD/.

jurisdiction to jurisdiction.

Inconsistencies in the functionality and features of government databases at both a national and state level restrict user accessibility to public information and raise concerns about the capacity for cross-jurisdiction communication related to deaths in custody.

Purpose of the Coroners Act

Despite each Australian State and Territory having its own unique Coroners Act, a consistent thread runs through these legislations. More than this, a consistent thread runs throughout Australian society and throughout time. The prevention of needless deaths has been sought long-before the commencement of current coronial legislation, yet within these current acts, this purpose is clear. On some occasions this purpose is express. Such is the case with the *Coroners Acts 2003* (Qld) in which expresses an object of the Act to be to 'help prevent deaths from similar causes happening in the future'.[27] Alternatively, this purpose may be implied from the texts and the powers and functions these Acts imbue within the Coroner. For instance, each jurisdiction allows the Coroner to make recommendations in responses to deaths.[28]

Objects of *Coroners Acts 2009* (NSW)

S 3 Objects of the Act

(c) to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths,
(d) to enable coroners to investigate fires and explosions that destroy or damage property within the State in order to determine the causes and origins of (and in some cases, the general circumstances concerning) such fires and explosions,
(e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies),

Objects of *Coroners Acts 1997* (ACT)

S 3BA Objects of Act

(i) to hold inquests into particular kinds of deaths or suspected deaths, and to make findings about the deaths, including the identities of deceased people and causes of death;

[27] *Coroners Acts 2003* (Qld), s 3.
[28] NSW s 82, Tas s 28(2), Vic s 72(2), NT s 35(2), Qld s 46, ACT s 57(3)(c), WA s 27(3), SA s 25(2).

(ii) to hold inquiries into, and make findings about, the cause and origin of—

(A) fires that have destroyed or damaged property; and

(B) disasters; and

(d) allow a coroner, based on the coroner's findings in an inquest or inquiry, to make recommendations about the following:

(i) the prevention of deaths;

(ii) the promotion of general public health and safety including occupational health and safety;

(iii) the administration of justice;

(iv) the need for a matter to be investigated or reviewed by an entity.

(2) As far as practicable, the objects of this Act must be carried out in a way that—

(a) for an inquest into a person's death—recognises the interests of the person's immediate family—

(i) to have all reasonable questions about the circumstances of the person's death answered; and

(ii) to be kept informed of important developments throughout the inquest; and

(b) maintains the inquisitorial, non-adversarial nature of the Coroner's Court, and its function to inquire into and publicly examine the causes of death, fire and disaster; and

(c) promotes the development of a systematic and comprehensive public record of findings made by a coroner and any associated recommendations made by the coroner; and

(d) increases public awareness of a coroner's findings about—

(i) violent or unusual deaths; and

(ii) serious risks to public health and safety; and

(iii) ways to protect public health and safety by reducing the risk of death, fire or disaster

Objects of Coroners Acts 2003 (Qld)

S 3 Object of the Act

The object of this Act is to

(d) help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to

(i) public health or safety; or

(ii) the administration of justice; and

States guidelines on use of force

- NSW
    - Incident reporting is available but redacted
    - Use of force is available but redacted
- Qld
    - Held 'in confidence'[29]
    - Death in custody is available – "public version"
    - incident management report is available
- WA
    - Use of force manual is restricted – policy directive 5
    - "The rules below form the majority of the overall system of prisons and prisoner management derived from the *Prisons Act 1981*."
    - 48. Use of force on serious breach of security
        - (1) Where the chief executive officer is of the opinion that —
            - (a) a serious breach of the good order or security of a prison has occurred or appears to the chief executive officer to be imminent; and
            - (b) no other reasonable means of control are available at the prison, the chief executive officer may order the use of force against a prisoner or prisoners, including force which may cause death or serious injury.
        - (2) Before force is used under this section, steps shall be taken, where it is practicable in the circumstances to do so, to issue the orders necessary to restore or ensure good order and security within the prison and to give warning of the consequences of failure to comply with those orders.
    - Death of a prisoner is available
    - Reporting of incidents is available
- Vic
    - Use of force is either not made available or restricted

[29] https://corrections.qld.gov.au/documents/procedures/custodial-operations-practice-directives/

- Incident reporting is available
- Reporting and review of the death of a prisoner is available
- Corrections Act 1986
    - 9CB Use of reasonable force by staff—police gaols
        - (1) A person authorised under section 9A(1A) or 9A(1B) to exercise a function or power may, where necessary, use reasonable force to compel a person who is deemed under Part 1A or section 9CAA to be in the custody of the Chief Commissioner of Police to obey an order given by the first-mentioned person in the exercise of that function or power.
        - (2) Where a person uses force under the powers in subsection (1), the person must report the fact to the Chief Commissioner of Police without delay.
        - (3) A person who uses force in accordance with this section is not liable for injury or damage caused by that use of force.
    - 23 Control of prisoners
        - (1) An officer may give any order to a prisoner which the officer believes to be necessary for the security or good order of the prison or the safety or welfare of the prisoner or other persons.
        - (2) A prison officer may where necessary use reasonable force to compel a prisoner to obey an order given by the prison officer or by an officer under this section.
        - (3) Where a prison officer uses force to compel a prisoner to obey an order the prison officer must report the fact forthwith to the Governor.
        - (4) Where a Governor uses or orders the use of force to compel a prisoner to obey an order the Governor must report the fact to the Secretary.
        - (5) A prison officer is not liable for injury or damage caused by the use of force in accordance with this section.
    - 90 Powers and duties of officers
        - (7) A Regional Manager or a community corrections officer may use reasonable force to compel an offender to obey a direction, if

he or she believes on reasonable grounds that the use of force is necessary—

- (a) to prevent the offender or another person being killed or seriously injured; or
- (b) to prevent serious damage to property.

- Tas
  - Use of force is confidential
  - Incident reporting is confidential
  - Corrections Act 1997 - PART 4A - Use of Force
    - **34A. Managing use of force**
      - (1) The Director must ensure, as far as practicable, that the use of force in relation to the management of prisoners and detainees is always –
        - (a) a last resort; and
        - (b) in accordance with this Part.
      - (2) The Director must make standing orders or an operating procedure in relation to the use of force, including provision in relation to the following:
        - (a) the circumstances in which, and by whom, force may be used;
        - (b) the kinds of force that may be used.
      - (3) The power to make a standing order or an operating procedure includes power to make different provisions in relation to different matters or different classes of matters, and provisions that apply differently by reference to stated exceptions or factors.
    - **34B. Authorised use of force**
      - (1) A correctional officer may use force that is necessary and reasonable for this Act, including for any of the following:
        - (a) to compel compliance with a direction given in relation to a prisoner or detainee by the Director;
        - (ab) to carry out, in relation to a prisoner or detainee, a search or examination, or search and examination, pursuant to an order of the Director given under section 22 ;

- (b) to act under section 28 ;
- (c) to prevent or stop the commission of an offence or disciplinary breach;
- (d) to prevent the escape of a prisoner or detainee;
- (e) to prevent unlawful damage, destruction or interference with property;
- (f) to defend the correctional officer or someone else;
- (g) to prevent a prisoner or detainee from inflicting self-harm;
- (h) any other thing prescribed by the regulations.

- (2) However, a correctional officer may use force only if the correctional officer believes, on reasonable grounds, that the purpose for which force may be used cannot be achieved in another way.

- **34C. Application of force**
  - (1) A correctional officer may use force under this Part only if the correctional officer –
    - (a) gives a clear warning of the intended use of force; and
    - (b) allows enough time for the warning to be observed; and
    - (c) uses no more force than is necessary and reasonable in the circumstances; and
    - (d) uses force, as far as practicable, in a way that reduces the risk of causing death or grievous bodily harm.
  - (2) However, a correctional officer need not comply with subsection or (b) if, in urgent circumstances, the correctional officer believes, on reasonable grounds, that doing so would create a risk of injury to the correctional officer, the prisoner or detainee or any other person.
- **34D. Use of restraints or weapons**
  - (1) The use of force under this Part includes the use of restraints and weapons.
  - (2) The Director must ensure, as far as practicable, that the use of force involving a restraint or weapon is proportionate to the circumstances, and in particular that –
    - (a) the circumstances are sufficiently serious to justify the use; and

        - (b) the kind of restraint or weapon is appropriate in the circumstances; and
        - (c) the restraint or weapon is used appropriately in the circumstances.
    - (3) The Director must also ensure that restraints and weapons are only used under this Part –
        - (a) by correctional officers trained to use them; and
        - (b) in accordance with standing orders or an operating procedure that applies to their use.
    - (4) The Director must take all steps to ensure that potentially lethal force is not used under this Part unless the actions of a prisoner or detainee or other person are likely to cause death or serious injury.
    - (5) In applying force under this Part, a correctional officer may use a restraint or weapon, including any of the following:
        - (a) body contact, impact and restraint;
        - (b) a mechanical restraining device;
        - (c) a baton;
        - (d) riot control equipment;
        - (e) a chemical agent;
        - (f) an electro-muscular disruption device or a conducted electrical weapon;
        - (g) a distraction device;
        - (h) a firearm;
        - (i) any other thing prescribed by the regulations.
- **34E. Medical examination after use of force**
    - If force has been used under this Part, the Director must ensure that a prisoner or detainee affected by the use of force is examined as soon as practicable and that appropriate medical health care is available to the prisoner or detainee.
- **34F. Reporting use of force**
    - (1) The Director must keep a record of any incident involving the use of force under this Part that causes injury or death to anyone.
    - (2) The record must contain details of the incident, including the circumstances, the reason for the decision to use force and the force used.
    - (3) The Director must give a copy of the record to the Coordinator of the Official Visitors Scheme for the purpose of

informing the official visitors as soon as practicable after the incident.

- NT
    - No policies or procedures provided online
    - Correctional Services Act 2014
        - 138 Limitations of use of force
            - (1) This section applies when a correctional officer is permitted under this Act to use force.
            - (2) The use of force by a correctional officer is reasonably necessary only if the correctional officer reasonably believes that:
                - (a) the purpose for which the force is used could not reasonably be achieved in another practicable way; and
                - (b) the nature and amount of force used is reasonable in the circumstances.
        - 140 Commissioner to manage use of force
            - (1) The Commissioner must ensure that:
                - (a) to the extent practicable, force is used under this Act only:
                    - (i) as a last resort; and
                    - (ii) when the use of force is reasonably necessary; and
                - (b) correctional officers who use force do so in accordance with this Act.
            - (2) The Commissioner must issue Commissioner's Directions in relation to the use of force, including as to:
                - (a) the circumstances in which, and by whom, force may be used; and
                - (b) the nature of the force that may be used in those circumstances.

- SA
    - No policies or procedures are available online
    - Only legislation
        - Correctional Services Act 1982
            - 86—Prison officers may use reasonable force in certain cases
            - 86—Prison officers may use reasonable force in certain cases
                - Subject to this Act, an officer or employee of the Department or a police officer employed in a correctional institution may, for the purposes of exercising powers or discharging duties under this Act,

use such force against any person as is reasonably necessary in the circumstances of the particular case.

- ACT
    - Corrections Management Act 2007
    - Part 9.7 Use of force
        - 137 Managing use of force
            - (1) The director-general must ensure, as far as practicable, that the use of force in relation to the management of detainees is always—
                - (a) a last resort; and
                - (b) in accordance with this part.
            - (2) Without limiting section 14 (Corrections policies and operating procedures), the director-general must make a corrections policy or operating procedure in relation to the use of force, including provision in relation to the following:
                - (a) the circumstances, and by whom, force may be used;
                - (b) the kinds of force that may be used.
                - Note- The power to make a corrections policy or operating procedure includes power to make different provisions in relation to different matters or different classes of matters, and provisions that apply differently by reference to stated exceptions or factors (see Legislation Act, s 48).
        - 138 Authorised use of force
            - (1) A corrections officer may use force that is necessary and reasonable for this Act, including for any of the following:
                - (a) to compel compliance with a direction given in relation to a detainee by the director-general;
                - (b) to act under section 126 (Searches—use of force);
                - (c) to prevent or stop the commission of an offence or disciplinary breach;
                - (d) to prevent the escape of a detainee;
                - (e) to prevent unlawful damage, destruction or interference with
                - property;
                - (f) to defend the officer or someone else;
                - (g) to prevent a detainee from inflicting self-harm;
                - (h) anything else prescribed by regulation.
            - (2) However, a corrections officer may use force only if the officer believes, on reasonable grounds, that the purpose for which force may be used cannot be achieved in another way.
        - 139 Application of force
            - (1) A corrections officer may use force under this part only if the officer—

        - (a) gives a clear warning of the intended use of force; and
        - (b) allows enough time for the warning to be observed; and
        - (c) uses no more force than is necessary and reasonable in the circumstances; and
        - (d) uses force, as far as practicable, in a way that reduces the risk of causing death or grievous bodily harm.
    - (2) However, the corrections officer need not comply with subsection (1) (a) or (b) if, in urgent circumstances, the officer believes, on reasonable grounds, that doing so would create a risk of injury to the officer, the detainee or anyone else.
    - Example of urgent circumstances - the detainee is assaulting someone or engaging in self-harm
- 140 Use of restraints or weapons
    - (1) The use of force under this part includes the use of restraints and weapons.
    - (2) The director-general must ensure, as far as practicable, that the use of force involving a restraint or weapon is proportionate to the circumstances, and in particular that—
        - (a) the circumstances are sufficiently serious to justify the use; and
        - (b) the kind of restraint or weapon is appropriate in the circumstances; and
        - (c) the restraint or weapon is used appropriately in the circumstances.
    - (3) The director-general must also ensure that restraints and weapons are only used under this part—
        - (a) by corrections officers trained to use them; and
        - (b) in accordance with a corrections policy or operating procedure that applies to their use.
    - (4) A health practitioner appointed under section 22 (Health practitioners—non-therapeutic functions) may administer a drug as a restraint, or direct the use of another form of restraint, if the health practitioner believes, on reasonable grounds, that is necessary and reasonable—
        - (a) to treat a detainee, particularly where the detainee's behaviour cannot be controlled otherwise; or
        - (b) to prevent a detainee inflicting self-harm, or harming someone else, particularly where other forms of restraint are unlikely to be effective; or
        - (c) to prevent the escape of a detainee, particularly while being transferred to or from a correctional centre or other place.
    - (5) The director-general must ensure that firearms are not used under this part unless someone's life is under threat or a detainee or other person offers armed resistance to a

corrections officer or police officer exercising a function under this Act or another Act.

- (6) In applying force under this part, a corrections officer may use a restraint or weapon, including any of the following:
  - (a) body contact;
  - (b) handcuffs, restraint jackets and other restraining devices;
  - (c) riot control equipment;
  - (d) a chemical agent;
  - (e) a gas gun;
  - (f) a firearm;
  - (g) anything else prescribed by regulation.

- 141 Medical examination after use of force
  - The director-general must ensure that a doctor appointed under section 21 (Doctors — health service appointments) examines a detainee injured by the use of force under this part as soon as practicable and that appropriate health care is available to the detainee.
- 142 Reporting use of force
  - (1) The director-general must keep a record of any incident involving the use of force under this part that causes injury or death to anyone.
  - (2) The record must—
    - (a) include details of the incident, including the circumstances, the decision to use force and the force used; and
    - (b) be available for inspection under chapter 7 (Access to and inspection of correctional centres).
  - (3) The director-general must give a copy of the record to the inspector of correctional services.

Coronial Reports Acknowledgement and Response

- Is the coroner required to disseminate their reports and recommendations?
- Is acknowledgment of a report or its recommendations by a State official necessary?

State	Legislation and Section in Act	Acknowledgement of Coroner's Report/Recommendations
Queensland	*Coroners Act 2003 (Qld)* S 46A S 47	S 46A - findings by the coroner are published on the coroner's website. S 47(2) – if findings are made in relation to a death in care or a death in custody, the coroner must give a written copy of their coronial findings to: - the AG - the appropriate chief executive, and - the appropriate Minister
New South Wales	*Coroners Act 2009 (NSW)* S 82 S 37	S 82 requires the coroner to provide recommendations to: - the State Coroner - any person or body to which a recommendation is directed towards, and - the Minister, and - any other appropriate Minister S 37(1) requires the State Coroner to make a written report to the Minister containing a summary of the details of deaths that involved a person in custody. S 37(3) the Minister is to copy the given report to be tabled in each House of Parliament within 21 days after the report was made.
Australian Capital Territory	*Coroners Act 1997* (ACT) S 55 S 73 S 75 S 76	No acknowledgement of reports being addressed in the legislation. Only s 55 addresses the adverse comments and findings and what is allowed to be addressed. S 73 requires the registrar of the Magistrates Court to keep a record of the inquest into a death in custody for no less than 7 years after the completion of the inquest S 75 requires that once the coroner has completed an inquest into a death in custody, the coroner must report the findings, in

		writing to: - the AG, - the custodial agency in whose the custody the death happened, the minister for this agency, - the AIC, - an appropriate Aboriginal legal service (if deceased was ATSI), - any other appropriate person. S 76(1) requires the custodial agency given a report under section 75 must give a written response to the recommendations of the report, no later than 3 months after receipt, to the Minister responsible for the custodial agency. S 76(3) requires the Minister who received a report under s 75(1) to provide a copy of the response to the coroner as soon as practicable after receiving it
Victoria	*Coroners Act 2008* (Vic) S 72 S 73	Yes, a coroner may report to the AG on a death or fire, which the coroner has investigated. Coroner can make recommendations to any Minister, public statutory or entity on any matter. S 72(5) - specifically contends that the Coroner must publish the findings and comments on the internet and provide a copy of the written response to any person. S 72(4) - the written response is written to the coroner in response to their findings. S 73 requires that all coroner's findings and comments must be published on the internet unless stated otherwise by the coroner.
Tasmania	*Coroners Act 1995 (Tas)* S 28 S 29 S 30	No, there is optional acknowledgement of publication of the findings of the coroner by the AG. S 28 simply states what the coroner investigates deaths on and must make recommendations wherever required. S 29 notes only that all investigations and findings resulting from it must be recorded and kept by the coroner. S 30 - the Coroner may report to the AG on a death, which the coroner investigated. Recommendations can also be made, but acknowledgment and reporting to the AG is optional.

South Australia	*Coroners Act 2003* (SA) S 25	Yes, findings and recommendations of the coroners must be received by the AG and received and responded to by the appropriate Minister if relevant. S 25(4) requires Coroner's Court to forward findings and recommendations of an inquest to the AG, and in the case of a death in custody, forward findings and recommendations to a Minister or other agency if a recommendation is directed towards them S 25(5) requires the Minister or Minister responsible for the agency to create a report to be put before each House of Parliament within the next 8 sitting days after 6 months from the date of receiving the report. Report must detail any actions taken or proposed to be taken. Report must also be sent to the State Coroner.
Western Australia	*Coroners Act 1996* (WA) S 27	S 27(1) requires the State Coroner to report annually to the AG on the deaths, which have been investigated in each year, including a specific report on the death of each person held in care. S 27(2) requires the AG to create a report under s 72(1) to be laid before each House of Parliament within 12 sitting days after receipt of the report. S 27(3) the State Coroner may make recommendations to the AG regarding deaths in custody. S 27(4) where a recommendation made under s 72(3) is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.
Northern Territory	*Coroners Act 1993* (NT) S 26 and 27 S 35 S 46A S 46B	Yes, the coroner must send report to AG, where report regards a death in custody. Findings may acknowledge by AG and forwarded to the relevant minister. S 26 and 27 - The Coroner must hold an inquest and make a report to AG, where the inquest is into the death of a person held in custody S 35 - the coroner may report to AG on a death or disaster investigated. - S 35(2): A coroner may make recommendations to the AG on the matter

		- S 35(3): A coroner may report to the Commissioner of Police and the DPP if the coroner believes that an offence may have been committed. S 46A - S 46A(1): If the AG receives a report or recommendation from a coroner under ss 27 or 35 that contains a comment relating to an agency or the police force, AG must give the report to the CEO of the agency or the Commissioner of Police. - S 46A(2): AG must give a copy of the report or recommendation to the Commonwealth Minister responsible if the report contains comments in re to the commonwealth department or agency. S 46B - S 46B(1): If a CEO or Commissioner of Police receive a report or recommendation under s 46A(1), they must give to the GA within 3 months a written response to the findings of the report or recommendation - S 46B(3): On receiving this response, the AG must respond to the coroner's report or recommendation and the corresponding response

- Which states require mandatory publishing of a response on the Internet?
    - New South Wales
    - Queensland
    - Victoria
    - Northern Territory

Relevant authorities

- AIC
- NCIS
- NSW
    - Corrective Services NSW
    - Department of Justice
    - NSW Health
    - NSW Police Department
- Qld
    - Queensland Corrective Services
    - Queensland Health
    - Queensland Department of Justice
    - Queensland Police Service
- SA
    - Department for Correctional Services (SA)
    - SA Health
    - Attorney-General's Department
    - South Australia Police
- Vic
    - Corrections Victoria
    - VicHealth
    - Justice Vic
    - Victoria Police
- Tas
    - Corrective Services (Tas)

    - Department of Justice (Tas)
    - Department of Health
    - Tasmania Police
- WA
    - Corrective Services (WA)
    - Department of Justice (WA)
    - Department of Health (WA)
    - Western Australia Police Force
- NT
    - Correctional Services (NT)
    - Department of Health (NT)
    - Department of Attorney-General and Justice
    - Northern Territory Police Force
- ACT
    - ACT Corrective Services
    - ACT Justice
    - ACT Health
    - ACT Policing

Interstate Coronial Communication

There is assumed to be national communication between Coroners across Australia. Thereby this proposal and its findings should be directed to all those involved in this communication.

Interstate Corrective Services Communication

There is inter-jurisdictional communication between the Corrective Services agencies of all States and Territories at a ministerial and bureaucratic level, however little is shared with the public.

What is known is that the Commissioner or Chief Executive of Corrective Services from each and every Australian jurisdiction, as well as New Zealand's Department of Corrective Services collaborate to form the Corrective Services Administrators' Council (CSAC).[30] The CSAC meets twice per year and aims to promote best practice in the delivery of corrections services through the effective sharing of ideas and the addressing of key national issues.

This communication provides the opportunity for the proposal of a National Deaths in Custody Database proposal to be discussed and implementation to be considered.

[30] https://www.corrections.sa.gov.au/about/our-partners/interstate-corrections.

Allies

- National Coronial Information System
    - The National Coronial Information System (NCIS) is a secure database of information of deaths reported to a coroner in Australia and New Zealand.
    - The NCIS contains data on almost 400,000 cases investigated by a coroner including demographic information on the deceased, contextual details on the nature of the fatality and case reports consisting of coronial findings, autopsy and toxicology report and police notification of death.
- Australian Institute of Criminology (AIC)
    - The AIC is Australia's national research and knowledge centre on crime and justice. The AIC seeks to promote justice and reduce crime by undertaking and communicating evidence-based research to inform policy and practice.
- State Coroner
    - The State Coroner is responsible for the efficient administration and operation of the state's coronial system. The State Coroner is notified of all reportable deaths including those to be investigated by provincial coroners. Coronial investigations may include the conduct of a formal public hearing or inquest.
    - Coroners investigate sudden and unexpected deaths in order to determine the identity of the deceased and the date, place, circumstances and medical cause of death. The coroner also has power to make the recommendations following an inquest to improve public safety and prevent future deaths.
- Indigenous Social Justice Association (ISJA)
    - Indigenous Social Justice Association is an Aboriginal rights campaign group that focuses on sovereignty, social justice, deaths in custody and the right to live in relation to Indigenous Australians. Their work involves holding rallies and organising protests for a range of Aboriginal issues.
- National Justice Project
    - The National Justice Project is a not-for-profit legal service. The National Justice Project applies their expertise to advancing human rights by representing and giving voice to the vulnerable of whom would otherwise be unable to find legal representation.
- Common Ground
    - Common Ground is a website designed to build a foundational level of knowledge for all Australians, and be a go to resource for those wanting to learn more and connect with Australia's First Peoples. Common Grounds aims to help Australians see the value of Aboriginal and Torres Strait Islander cultures through

providing access to engaging and authentic content that will help bridge gaps in knowledge.

- Australians for Native Title and Reconciliation (ANTaR)
    - ANTaR has been working with Aboriginal and Torres Strait Islander organisations and leaders on rights and reconciliation issues since 1997. ANTaR is an independent, national network of organisations and individuals working in support of Justice, Rights and Respect for Aboriginal and Torres Strait Islander peoples in Australia.
    - ANTaR is an independent non-government organisation and is non-party-political.
- @IndigenousX
    - @IndigenousX is a multi-media platform designed to create a media landscape where Indigenous people can share their knowledge, opinions and experiences with a wide audience across the world
    - @IndigenousX is also a twitter account with more than 43,000 followers, and over 300 Indigenous hosts on the account have shared thousands of stories, facts, reports, pictures, and laughs with an ever increasing audience
- National Indigenous Times (NIT)
    - The NIT strives to be the most comprehensive Indigenous online news site in Australia by offering rigorous reporting on the issues that affect Aboriginal and Torres Strait Islander peoples.
- Human Rights Law Centre (HLRC)
    - The HRLC is an Australian human rights group that protects and promotes human rights in Australia and in Australian activities overseas. The HRLC does this using an integrated strategic combination of legal action, advocacy, research working in coalition with key partners, including community organisations, law firms and barristers, academics and experts, and international and domestic human rights organisations.
- Families Affected by Deaths in Custody
    - Dungay Family
    - Other families through the contact of ISJA