

Rapid review of communication with First Nations
families following a death in New South Wales
Corrective Services custody

Dr James Beaufils (UTS)

Dr Tatiana Corrales (UTS)

Ms Lindsay McCabe (Western Sydney University)

Professor Chris Cunneen (UTS)

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Acknowledgement of Country

We acknowledge the sovereignty of the Gadigal, Bidjigal, Darug, Wiradjuri and Boon Wurrung peoples who's lands this report was written. We also acknowledge every First Nations Person who has died in State custody, and the families and communities who mourn them.

Disclaimer

This report includes the names of First Nations people who have died in CSNSW custody. The nature of this paper may also be distressing for First Nations readers.

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Acronyms

ALS	Aboriginal Legal Service
ASPU	Aboriginal Strategy and Policy Unit
BOCSAR	Bureau of Crime Statistics and Research
CSNSW	Corrective Services New South Wales
NOK	Next of Kin
NSW	New South Wales
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SNOK	Senior Next of Kin

Introduction

In 2023 Corrective Services commissioned the Jumbunna Institute for Indigenous Education and Research (Jumbunna) to undertake a project examining how next-of-kin are notified when a First Nations person passes in custody. This was in response to a number of factors, including a recognition of the need to focus on First Nations' family experiences and perspectives on the need for access to, and accessibility of, information and support following the death of a loved one in New South Wales Corrective Services custody; the broader influence of the Black Lives Matter movement and the ongoing systemic issues driving First Nations deaths in custody.

This review also sits within the broader context of the New South Wales (NSW) Legislative Council's inquiry into the over-representation of First Nation's people in custody, and the oversight and review of deaths in custody (NSW Parliament, 2021). Importantly, of the 39 recommendations tabled by the committee only nine deal with deaths in custody, and of these only one recommendation deals with notifications of a death in custody to relatives and kin. Specifically, Recommendation 23 states that:

Corrective Services NSW, Youth Justice NSW and the Justice Health and Forensic Mental Health Network conduct a comprehensive review of internal processes following a death in custody, with a view to:

- ensuring appropriate notification of death processes are in place
- establishing a single point of contact for families
- establishing clear communication protocols with families, including the provision of counselling and support services up to and including the coronial hearing
- ensuring all staff within facilities receive training in culturally sensitive and trauma informed care, with training prioritised for staff in roles specific to the investigation or oversight of deaths in custody.

This paper presents the results of a rapid review examining Australian and international literature on the processes surrounding next-of-kin notifications, and the experiences of bereaved families and communities. This literature review sits alongside a broader project into First Nations deaths in the custody of Corrective Services NSW. As part of this broader project, CSNSW have identified the need to *'capture the lived experiences and examine collateral*

impacts of Aboriginal deaths in custody on staff, families and inmates that may be exacerbated by the investigation process and unmet need for information and support following a death.”

The scope of work proposed by Jumbunna includes a review of existing literature on next-of-kin notifications, and consultations/interviews with bereaved families, First Nations communities and advocates to gain an understanding of the experiences of First Nations families when a loved one passes in custody. The focus covers the family experiences and perspectives, including the provision of access to and understanding of information following a death in new south wales corrective services custody.

Background

In New South Wales (NSW), First Nations Peoples represent 3.4% of the total population, yet account for 30.8% of people in custody. The over-representation of First Nations Peoples in criminal legal systems is not a new phenomenon(BOCSAR 2024). However, as Griffin (2024: 591) notes, over-representation in custodial settings in NSW has reached record highs, representing a ‘crisis of accountability’ (Griffin 2024: 591). This over-representation is the single most important contributing factor to the overwhelming number of First Nations Peoples who have died in custody both before and since the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC, 1991).

Across Australia, current research, advocacy efforts, policy briefs, and protocols focus primarily on two issues: preventing the deaths of First Nations People in custody through national monitoring systems that quantify the number of deaths, their causes and locations (see for example, Gannoni & Bricknell, 2021; McAlister et al., 2023), and a more rigorous process for coronial inquests, with a particular shift toward centring the bereaved (see for example, Allison & Cunneen, 2023; Newhouse et al., 2020; Walsh et al., 2022). While monitoring the prevalence and causes of First Nations deaths in custody is an important element of addressing the RCIADIC recommendations, an over-emphasis on the quantification of deaths necessarily excludes other, equally important considerations. In this context, First Nations bereaved families and advocates have consistently pointed to the way families are excluded in research, policy and practice when a First Nations person passes in custody (Newhouse et al., 2020).

Australian research on First Nations deaths in custody has also prioritised the coronial investigation and inquest. While this research does not directly address how a death in custody

is communicated to families, it nevertheless provides insights into some of the challenges that First Nations families have identified. This includes issues with the way a person's Indigeneity is (or is not) recorded within the prison system and the flow-on effects this has for appropriate notification of a person's passing in custody. Where a person's First Nations status is not recorded, cultural needs surround passing and Sorry Business cannot be considered, leading to further grief and trauma among First Nations families. There is a cultural significance and requirements of Sorry Business that is not understood and conceptualised appropriately by non-indigenous peoples and are needing to be supported (Glaskin, K. et al. 2008; Macdonald, G. 2008). Given the importance of understanding Kinship within First Nations communities (Beaufils, 2023), including extended and complex networks of Kinship, ensuring accurate and up-to-date identification of appropriate relatives to notify as Next-of-Kin (NOK) is central to supporting culturally appropriate practices. This by necessity involves the accurate identification of a person's Indigeneity.

Next-of-Kin notification processes when a person passes in custody

The Aboriginal Strategy and Policy Unit's (ASPU) Aboriginal Death in Custody Policy (Corrective Services NSW, 2023, p. 1) outlines the "policy and procedures that must be followed... where there is a death of an Aboriginal inmate [sic] in CSNSW custody."

When a death in custody occurs, it must be reported to both the NSW Police Force and the NSW State Coroner. The Governor of the prison, who has custody of the incarcerated person, is responsible for making this report which involves the appropriate CSNSW Duty Officer reporting the passing to the Principal Manager of the Aboriginal Strategy and Policy Unit (ASPU). The Principal Manager of ASPU then takes on a number of responsibilities in relation to the death, including confirming that the deceased person's NOK has been notified by police, as well as liaising with the NOK to provide information and support regarding financial assistance. In addition, the Principal Manager is required to organise a meeting with the family of the deceased person, and a meeting with community to facilitate a dialogue where questions and issues may be raised.

Depending on whether the NOK has been informed of the death by police, there are two courses of action available to the Principal Manager of the ASPU. First, if the deceased's NOK has not yet been notified, the Principal Manager may only provide the time of death and biological sex of the person. If the NOK has been notified, the Principal Manager may provide the deceased

person's name, date of birth, time of death, and where the death occurred. Recommendation 20 of the RCIADIC (1991) states that the Aboriginal Legal Service (ALS) should also be 'immediately notified' of the death, however it is unclear whether this is an established practice at CSNSW¹.

Beyond the ASPU policy on notifications of First Nations deaths in custody, there is a dearth of publicly available information on additional processes and/or compliance with existing protocols. In addition, it is unclear whether the ASPU policy is widely accessed by members of the community, particularly First Nations communities across NSW. Finally, it is unclear whether the ASPU policy has been communicated to First Nations communities in culturally appropriate and accessible formats.

Engagement with First Nations families following a death in custody

The New South Wales Legislative Council Select Committee on the high level of First Nations People in custody and oversight and review of deaths in custody (2021) provides some insights into the challenges experienced by bereaved families when a person passes in the custody of CSNSW. Evidence provided to the Select Committee by members of the Dungay, Chatfield and Reynolds families described the notification process as "chaotic and callous" (pg. 97) and highlighted significant issues in the way NOK are recorded by Corrective Services. In one example, the person who was recorded as a next of kin was not contacted, and instead, an elderly and terminally ill family member was notified of the person's passing in custody. In another instance, information about the circumstances surrounding a First Nations person's passing in custody was provided to the family by another criminalised person in the same prison, rather than officially through prison administrators. Families reported not being provided with information about critically ill family members in prison, and/or being provided with contradictory information from different sources within the prison system. Families also noted that counselling and support following a death in custody was either not offered or was offered but never followed up by Corrective Services staff.

Similarly, McCabe (2019) found that families experience significant difficulties – and consequently additional trauma – accessing information about the location of, and access to

¹ We note that while there are departmental (CSNSW) protocols in place surrounding how deaths in custody are notified and investigated, including that deaths of First Nations people must be notified to the Aboriginal Legal Service (ALS) and Aboriginal Affairs, and that notifications must be undertaken by NSW Police, these protocols are not in the public domain and therefore not accessible. Existing protocols need to be made easily accessible, culturally appropriate and understood by members of the public, particularly families impacted by deaths in custody.

their loved one's remains. This issue was also raised by family members in evidence provided to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (2021: 98), a family member of a person who died in custody told the inquiry that calls to CSNSW went unanswered and they were unable to locate the body of their loved one. These issues point to the systematic ways in which families and communities of those who have passed in custody are routinely excluded, their voices ignored, and experiences marginalised. Indeed, many bereaved families have 'negative experiences of post-death procedures at a time of great vulnerability' (Coles 2008: 30).

The exclusion of families is not just evidenced in policy and practice, but also in much of the research and reporting on First Nations deaths in custody (Mason, 2020). This is seen in the way that lived experience advocates continue to be marginalised from mainstream media when advocating for the rights of First Nations peoples (see for example, Lean, 2021 and Roach 2022). This exclusion begins at the point of a person's passing and continues through the coronial inquest and beyond. As such, many First Nations Peoples worry that 'Aboriginal deaths in custody have continued as common practice and, in fact, [are] normalised in prisons and police systems' (Rule 2019). Ideas about the need to defund police to reduce incarceration, and therefore deaths in custody, continue to be relegated to the margins, and presented as 'radical'. Furthermore, while the families, loved ones, and communities of those who have passed in custody are often the most staunch advocates for reforms in the criminal legal system, their voices are consistently marginalised and excluded from policy discussions. This systematic exclusion led a group of 15 First Nations families who had a loved one die in custody to come together in 2021 to create a list of demands, imploring the state and federal governments to 'listen to us and work with us to action our demands, so that no other family has to experience the injustice of living without their loved ones' (NATSILS 2021: 2). In the letter accompanying their demands, the families stressed that First Nations communities have the answers to prevent these injustices, yet feel as though successive governments have not prioritised the 'saving [of] Black lives' (NATSILS 2021: 2). The families asked for the urgent reallocation of public funding away from prisons and policing, instead using these funds to strengthen communities through education, healthcare, and healing programs. Most pertinent, however, is the following statement:

Families deserve to know if their loved one dies in custody they will be heard; that a timely, thorough independent investigation will occur, and they will be told of the progress of this inquiry. They deserve to witness any public investigation of their loved one's death. This includes being provided with the means to attend all hearings. Families also deserve to know that their deceased family member's body is being treated in a culturally competent and respectful manner, and where possible that they have access to their loved one's body to conduct ceremonial arrangements in a timely manner (emphasis added; NATSILS 2021: 2).

The passing of a First Nations person in custody has ripple effects that extend into communities and across time. While some have argued that in the 30 years since the RCIADIC there have been improvements in the rate and causes of First Nations deaths in custody (Gannoni & Bricknell, 2021), there remains a dearth of research and policy focus on the process of notifying families when a loved one passes in custody. This is a significant gap in knowledge and is inconsistent with the recommendations made by the RCIADIC. It also calls into question whether the rights of First Nations families when a loved one passes in custody are respected or complied with.

Aims

The aim of this review is to provide a narrative synthesis of available literature (peer-reviewed, grey literature, policy documents) on family experiences with corrective services when a family member passes away in prison, focusing on the policy and procedures of notifications. The outcome of the literature review will inform the development of interview schedules that will be used with families and community members of First Nations people who have died in custody, to gain their lived experience perspectives on how Corrective Services NSW communicates with families following a death in custody, the support that is provided, and possible areas for reform.

Methodology

The methodology for this rapid review is based on a modified version of the population-intervention-context-outcome (PICO) framework for systematic literature reviews. Systematic reviews are considered the 'gold standard' of evidence synthesis, but are resource and time intensive. They are also better suited to topics where there is a large amount of research and

where it is important to consolidate the findings to provide practitioners and policy makers with clear recommendations on best practice.

A rapid review is a condensed version of a systematic review and is particularly useful when there is limited research to inform policy and practice. It is based on the same *principles* as a systematic review, including the development of clear search terms that reflect the population-intervention-context-outcomes (PICO) framework (Bouck et al., 2022). Unlike a systematic review where there are clearly defined steps for each stage of the review process, including quality appraisals, risk of bias calculations, synthesis of findings, and often the addition of meta-analytic approaches, rapid reviews are more flexible. This enables a much quicker search of the literature, and a summary of key themes that can be used to inform policy development and future research (Bouck et al. 2022).

A rapid review was chosen for this project for two main reasons. First, a preliminary search of academic databases and Google Scholar resulted in very few references that were directly pertinent to the research question. While there has been some recent scholarship devoted to the topic of First Nations deaths in custody (Anthony & Blagg, 2021; Davis, 2011; McCabe, forthcoming; Newhouse et al., 2020; Walsh & Counter, 2019), very few studies have specifically focussed on the way that a First Nations' person's death in custody is communicated with kin, family and/or relatives, or the experiences of kin when dealing with corrective services – in NSW and elsewhere – when a loved one has passed. Given the absence of literature on this topic a standard systemic review was not considered appropriate.

Second, while there is an absence of published peer-reviewed literature on this topic, there is a much larger body of work in alternative sources – including newspaper articles, news stories and advocacy pieces. These sources are often excluded from systematic literature review as they are perceived to lack the necessary academic rigour. For this project however, the research team determined that in the absence of academic literature, these alternative sources may provide important insights into the experiences of *families* when a First Nations person passes in custody.

Literature search

A PICO framework was developed to assist with the identification of relevant search terms. The PICO elements and their associated eligibility and exclusion criteria are presented in

Table 1. Search terms were combined and tested in the Australian Criminology Database – Aboriginal and Torres Strait Islander Studies subset (CINCH-ATSIS) and ProQuest. Search terms were then modified based on the results of the preliminary search. The final search terms were: Aborig* AND Torres Strait Islander OR Aborig* OR First Nations OR Indig* Or Indig* Australians AND death OR die OR dying AND prison OR custody OR jail AND famil* OR kin OR Kin OR relative*. For some databases the following search terms were also added to ensure that resources focussing on communication with families were also captured: communicat* OR notif* OR inform*. Combinations of these search terms were used in the following databases: CINCH-Health (Australian Criminology Database – Health subset), CINCH-ATSIS (Australian Criminology Database – Aboriginal and Torres Strait Islander subset), CINCH, EBSCOhost Criminal Justice Abstracts, CINAHL Complete, Violence and Abuse Abstracts, ProQuest Criminology Collection, ProQuest Australian and New Zealand Database, and Web of Science.

Using a combination of the search terms detailed above, a total of 9068 resources were identified. These were imported into Covidence, a software platform for systematic literature reviews, and after duplicates were removed, 7937 references were included for screening. Screening was undertaken by the three authors.

Table 1
PICO framework and eligibility criteria

PICO Element	Eligibility criteria	Exclusion criteria
Population: Aboriginal and/or Torres Strait Islander adults	Aboriginal and Torres Strait Islander Peoples First Nations Peoples Aboriginal people Indigenous Australians Indigenous people	None
Intervention/Exposure: Communication with family members, kin and/or relatives following the passing of a First Nations person in custody	Communication with family Communication with kin Communication with relatives	None
Context: Deaths in custody	Death in custody Death in prison Death in detention Death in jail/goal	Death in police custody Death of children in juvenile detention

		Inquests into deaths in custody
Outcome: Experiences of family/kin/relatives when a First Nations person passes in custody	Experiences of family Experiences of kin Experiences of community Experiences of relatives	None

Process of screening resources

Table 1 (above) includes information on eligibility criteria for the screening of resources. These included that resources needed to have:

- An explicit focus on deaths of Aboriginal and Torres Strait Islander adults in custody in Australia. Deaths occurring in policy custody and deaths of Aboriginal and Torres Strait Islander children in youth justice detention were excluded.
- A focus specifically on engagement with a person's family/relatives/kin when a loved one died in custody
- Been published between January 2010 and May 2024 and to have been published in English.

There were no restrictions on study designs and methodological approaches (e.g., randomised controlled trials, qualitative studies, quantitative studies, longitudinal studies, mixed-methods studies etc). Grey literature, policy documents, editorials, newspaper stories and other resources were also eligible for inclusion if they met the PICO criteria.

Given the small number of peer-reviewed studies on the topic of communicating the death in custody of an Aboriginal and Torres Strait Islander person to family, relatives or kin, the inclusion criteria was expanded to include studies published outside of Australia and studies/resources that focussed on coronial inquests. This enabled additional resources to be searched for relevant insights into communication with relatives and kin following a death in custody.

The first stage of screening (title and abstracts only) was undertaken by the three authors. Where there was uncertainty about whether a reference met the eligibility criteria it was *included*

for more in-depth screening. This decision was made to ensure that relevant information was not missed, even if the publication may not have been directly addressing the review question.

The second stage of screening was undertaken by two of the researchers (Beaufils and McCabe). During this phase the research team met regularly to discuss inclusion/exclusion criteria and address any discrepancies in screening. Full-text extraction was undertaken by one researcher (Corrales). A data extraction template was developed and refined through discussion as a research team. Throughout the data extraction process the team met regularly to review, discuss and resolve any issues that arose during data extraction, and to refine emerging themes. Extracted information was subjected to narrative synthesis to identify key themes across publications, with a specific focus on the way that a person's death in custody is communicated to family, relatives and/or kin.

Summary of Key Themes

Of the 9,068 references identified through the original search, 23 were included for review (see Figure 1 for the PRISMA flow diagram). Given the breadth of resources in scope for inclusion and the preponderance of resources that have not been peer-reviewed, a quality appraisal was not undertaken. As such, the findings presented here should be interpreted with a degree of caution. Nevertheless, the absence of published research focussing on the way deaths in custody are communicated with family members is an important finding in itself.

Of the 23 resources included in the rapid review:

- Nine were peer reviewed articles or book chapters. Seven of these (78%) were qualitative, one employed a mixed-methods approach including secondary analysis of accounts by bereaved family members, reports, reviews and inquiries (Tomczak & Cook, 2023), with only one study employing quantitative methodologies (Iwai et al., 2022). Seven studies (78) were undertaken in Australia, one in the UK and one in the USA. Australian studies focussed on a range of jurisdictions, although these were not specified in any of the articles. One paper (Walsh & Counter, 2019), included all Australian states and territories. Only one study (Iwai et al., 2023) specifically addressed the issue of next of kin notifications following a death in custody, focussing on publicly available policies in the United States that outlined how next of kin are/should be notified.

- Nine resources were newspaper articles, all from the Koori Mail. Three (33%) focussed on the death of David Dungay (Kempsey, and two (22%) focussed on the death of Wayne ‘Fella’ Morrison (South Australia). The remaining articles (n=4, 44%) focussed on community calls for action to stop Aboriginal deaths in custody.
- Three resources were court documents. Two were from the Coroner’s Court (NSW and Victoria) and one was from the Local Court of New South Wales (*Practice Direction 6 of 2020: Indigenous deaths in custody*).
- The NSW Parliamentary Legislative Council’s report into *The high level of First Nations people in custody and oversight and review of deaths in custody*, and also included the NSW government response.
- A South Australian Ombudsman’s independent investigation into the death in custody of Wayne ‘Fella’ Morrison.

The included documents and peer-reviewed papers represent the collective, published information that informs an understanding of communication with family/relatives/kin following a death in custody, including of non-Indigenous people, and people outside of the Australian criminal justice system jurisdictions. The scarcity of published research on this topic highlights a significant gap in knowledge, which limits policy making and practice when notifying next of kin of a person’s death in custody.

A narrative synthesis of the key findings and recommendations across the 23 sources resulted in the identification of two major themes:

1. *Invisibility of families at the point of a person’s death in custody, and*
2. *Inadequate provision of support for families.*

These themes sit within a broader context where deaths in custody are predominantly addressed via research on and independent inquiries into the coronial process (Coroner’s Court of Victoria, 2020; Koori Mail, 23 September 2020; Local Court of New South Wales, 2022; New South Wales Coroners’ Court, 2021; New South Wales Parliamentary Legislative Council, 2021; Newhouse et al., 2020; Ombudsman of South Australia, 2020; Tomczak & Cook, 2023; Walsh et al., 2022; Walsh & Counter, 2019); and research that focusses on the *quantification* of deaths in custody (McAlister et al., 2023; New South Wales Coroners Court, 2021; New South Wales Parliamentary Legislative Council, 2021; Ross, 2018; Ombudsman South Australia, 2020; Walsh

& Counter, 2019). The focus on quantification and the identification of personal and organisational characteristics associated with those deaths is consistent with state and territory government intentions to monitor and address the prevalence of First Nations deaths in custody following the recommendations of the Royal Commission into Aboriginal Deaths in Custody. Within this body of research, the primary focus is on causes of death (Beacroft et al., 2011; Gannoni & Bricknell, 2021; Walsh & counter,), with a preponderance of research identifying that the majority of Aboriginal deaths in custodial settings (outside of deaths that occur in the custody of police) are due to natural causes (see for example Gannoni & Brickness, 2021) . This, however, has implications for the way First Nations deaths in custody are understood, both within correctional settings and broader society. By emphasising that that the majority of Aboriginal deaths in custody are due to natural causes the onus of accountability is shifted from the social, structural and systemic determinants of First Nations over-representation in the criminal legal system, to First Nations communities and individuals (NSW State Coroner, 2021; Walsh & Counter, 2019). Further, categorising a person's passing by natural versus unnatural causes obscures the role of carceral systems, including health care provided within these systems, of their role in contributing to the death by natural causes. This has been raised consistently in coronial inquests that highlight the systemic neglect that First Nations people experience in the lead up to passing in custody. Consequently, the social determinants of health that render First Nations people more likely to die prematurely than non-Indigenous people (Cox et al., 2022; Markwick et al., 2014) are not adequately addressed within this body of literature.

Due to the limited number of sources that focus specifically on the way families are notified about an individual's death in custody, some of the themes that have been identified in literature on families' experiences of coronial inquests is also included in the narrative synthesis.

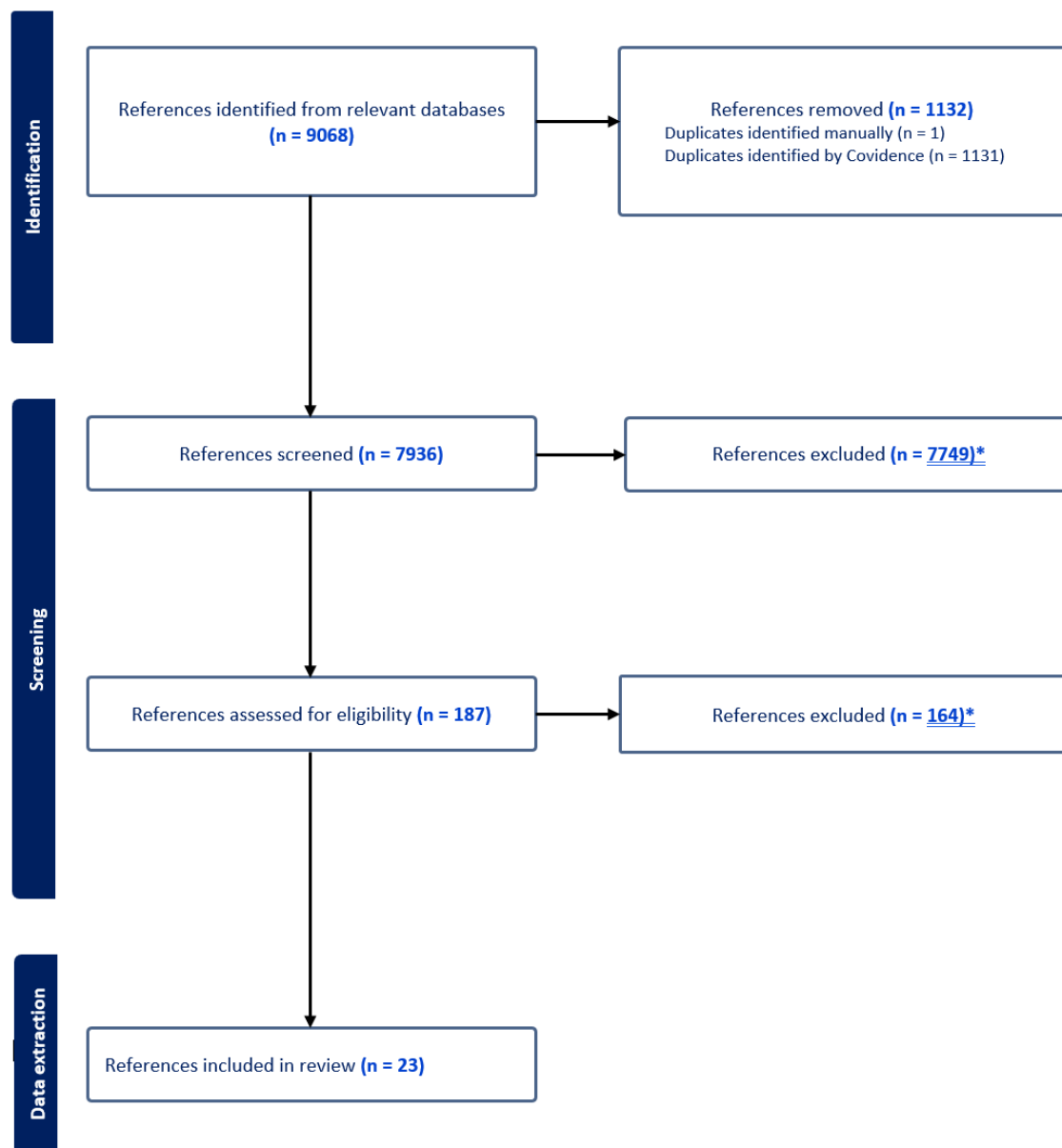
Theme 1: The invisibility of families when a person passes in custody

One of the most significant findings from this review is the way that families are virtually absent from research, policy and practice guidance on deaths in custody. This is distinct from research into coronial inquests, where communication with family (Coroners Court of Victoria, 2020; Newhouse et al., 2020; Walsh et al., 2022) and family participation in the inquests (Koori Mail, 2018, 2020; Newhouse et al., 2020; Tomczak & Cook, 2023) is more widely canvassed.

The experiences and perspectives of families who have had a loved one die in custody is mainly captured through non-academic and First Nations-led resources, predominantly the

Koori Mail. Our rapid review identified that both nationally and internationally, the only consistent avenue available to families to centre their experiences and to provide a counter-narrative about their loved ones and the circumstances surrounding their deaths in custody, is through non-mainstream media that plays a significant role in advocating for First Nations peoples (Koori Mail, 2016, 2018, 2019; 2020a, 2020c, 2021a, 2021b).

Figure 1. PRISMA flow diagram



Note: given the large number of resources that were excluded it is not possible to identify all of the reasons for exclusion. However, the main reasons included that the study/resource did not address the correct population or the correct context (i.e., the research did not specifically address Aboriginal deaths in custody and/or the way these deaths are communicated with family/relatives/kin). Additional reasons included that the resource focussed on the incorrect topic (i.e., health), had a focus on methodology, was a theoretical/conceptual paper, or was a book review.

The systemic invisibility of families when a person passes in custody is noted in international literature. Iwai et al., (2023) reviewed publicly accessible policies in the United States (all states and territories, and federal jurisdiction) and found that of the 53 ‘systems’ in scope for analysis only 35 had publicly available policies relating to next-of-kin notification. In these 35 states, notification of next-of-kin was mandated, but there was variability in the timing and the person responsible for notifying family. Predominantly, notification of next of kin was left

to prison administrators and/or prison chaplains (Iwai et al., 2023). Fewer states had publicly available policies on next-of-kin rights to take possession of the deceased person's remains ($n=31$). Here too there was wide variability in the timing associated with 'claiming' a loved ones' remains. The relative absence of publicly available policies, and the variability within existing policies raises "serious concern around decency, humanity, and transparency in communication surround the death of an individual during incarceration" (Iwai et al., 2023, pg. 4).

The NSW Government has provided support, or in principle support, to 16 of the recommendations, including Recommendation 23 of the *Report by the Select Committee on the high level of First Nations People in custody and oversight and review of deaths in custody*. It notes that its commissioning of a thematic review into First Nations deaths in custody includes the objective "to better understand the lived experience of families, inmates and staff when a death in custody occurs" (Parliament of NSW, 2021, pg. 3). As part of this work, the thematic review "will make recommendations for change as appropriate, including in relation to Corrective Services NSW's role in communication with, and support for, families" (pg. 3).

The majority of research and policies that were relevant to this review focussed on the coronial inquest following the death in custody of a First Nations person. Although limited in scope, the available research, advocacy and policies point to a neglect of First Nations families when an First Nations person passes in custody. Families are not provided with adequate or timely information or support to help them navigate the bureaucratic maze associated with death in custody investigations. Families are relegated to recipients of information, limiting their capacity to provide counternarratives about their loved ones and the circumstances surrounding their deaths (Tomczak & Cook, 2023; Newhouse et al., 2020; Walsh et al., 2022). This process starts with the way families are notified of a death in custody and continues through the lengthy process of establishing and undertaking a coronial inquest. The invisibility of families when a person passes in custody contributes to feelings and perceptions of systemic injustices, reflected in disrespect, indignity and denigration of their loved ones and of the family and community's grief (Tomczak & Cook, 2023; Newhouse et al., 2020; New South Wales Parliamentary Legislative Council, 2021).

Theme 2: Inadequate support for families when a person passes in custody

A key theme identified in research, advocacy, inquests and inquiries into deaths in custody relates to the absence of support for families (Newhouse et al., 2020; Wash et al., 2022). From the moment a family is notified of a death in custody, to the end of a coronial inquest, the psychological, emotional and physical impacts of dealing with a loved one's passing in custody are rarely addressed. This lack of support not only compounds families' grief, but also contributes to mistrust in the integrity and/or independence of the investigations into a person's death in custody (McCabe, forthcoming).

The available literature points to a number of issues that occur when families are notified of a death in custody. First, notifications are typically made by police officers or prison administrators and are experienced as cold, dismissive, callous, offensive and sometimes defensive (Tomczak & Cook, 2023; ref). This needs to be understood in the context of the harms (both historical and contemporary) caused to First Nations people by statutory systems (Newhouse et al., 2020; NSW Parliamentary Legislative Council, 2021). It is further compounded by the absence of culturally and trauma informed frameworks to guide the notification of a death in custody, and subsequent engagement with bereaved families (Carpenter et al., 2016). For example, Carpenter et al., (2016) drew on interviews with 234 coronial professionals in one Australian jurisdiction to explore how the religious and cultural needs of families are negotiated when police investigate non-criminal deaths. While this study did not focus on deaths in custody, it nevertheless provides insights into the way police practices and police culture can exacerbate a bereaved family's grief and cause further harm. This is particularly the case for First Nations families where not only are cultural practices associated with death and dying poorly understood by police, but where systemic racism and violence is entrenched in the relationship between police and First Nations communities (Carpenter et al., 2016; Cunneen, 2006). Carpenter et al., (2016, pg. 707) found that "a lack of understanding, awareness or interest in the more complex family structures found in Indigenous families, as well as adherence to a negative stereotypical portrayal of drunkenness and incapacity" leads to bereaved family members being treated with suspicion and hostility. Coronial professionals in the study noted that police were not appropriately trained to manage the trauma and grief of bereaved family, particularly when dealing with marginalised and overly criminalised communities.

Second, once a family has been notified of a death in custody, there is limited access to ongoing support. This includes support to manage the grief of bereavement, and more practical

support to access information and navigate the investigation process (Newhouse et al., 2020; NSW Parliamentary Legislative Council, 2021; Tomczak & Cook, 2023). Consequently, families feel that they are left in a state of limbo, without regular, timely and accurate information about the processes that are in place following a death in custody. This again contributes to a sense of distrust in official narratives about the ‘independence’ of investigations and the causes of a person’s death in custody (NSW Parliamentary Legislative Council, 2021). In evidence provided to the NSW Parliamentary Legislative Council’s inquiry into the high level of First Nations Peoples the National Justice Project noted that not only are First Nations families **not** properly notified of a death in custody, but also a “lack of support and legal services offered to families” (NSW Parliamentary Legislative Council, 2021, pg. 99). The absence of enforceable and detailed protocols that have been informed through community experiences, voices and needs means that First Nations families may miss critical windows of opportunity to exercise their rights following a death in custody. This contributes to families’ sense of loss of control, fear and widespread perceptions that subsequent investigations lack transparency or fairness.

Finally, while there are dedicated protocols in NSW to ensure that families are “meaningfully” engaged in a culturally appropriate and sensitive manner during a coronial inquest, there is no similar, publicly available protocol for notifications of a death in custody to family members. The *State Coroners Protocol* (Local Court of New South Wales, 2022), for example, includes provisions for families to be kept informed of the status and progress of coronial inquests, ‘ongoing exchange of information’ with families, and that cultural considerations ‘relevant to the conduct of the coronial investigation and inquest’ are considered. There are no provisions that guarantee the enforceability of the protocol, and beyond a recognition that First Nations’ conceptions of ‘family’ are fluid, there is little recognition of the multiple needs of families beyond the need to be kept informed and their right to participate.

International research similarly demonstrates a lack of commitment to meaningfully communicating with and engaging family when a person passes in custody. For example, Tomczak and Cook (2023) explored the factors that may contribute to ‘satisfaction’ amongst bereaved families following a death in custody investigation in England and Wales. The duty to investigate deaths in custody is enshrined in international legislation including Article 2 of the European Convention on Human Rights (European Court of Human Rights, 2021). Under this convention, one of the core purposes of death in custody investigations is to provide bereaved families with “the satisfaction of knowing that lessons learned [...] may save the lives of others”

(Kirton-Darling, 2016 cited in Tomczak & Cook, 2023, pg. 297). The experiences of bereaved families, including what they perceive to be in their own best interests during an investigation has not been adequately explored. The limited research that exists indicates that families perceive their 'legitimate interests' to be about establishing truth, securing compensation and/or an apology, preventing further deaths, providing a public record of the death, or meaning making/processing grief. In the Australian context, research points to the important role that families attribute to accountability, particularly for First Nations deaths in custody which are inextricably tied to ongoing colonial violence (Anthony & Blagg, 2021; Blue, 2017; Cunneen, 2009; Marchetti, 2006; Newhouse et al., 2020). The impact of investigations and inquests on bereaved families can be deeply re-traumatising, particularly when information is not adequately communicated, is not timely and is factually incorrect, contradictory and/or incomplete (Tomczak & Cook, 2023). The harm caused to families during the notification, investigation and inquest stages of a death in custody can be compounded by:

- Tokenistic involvement including as passive recipients of information in the absence of enforceable mechanisms to ensure the family's wishes or questions are addressed
- Representations of the deceased person and the circumstances surrounding their death, which can be used to divert attention away from systemic abuses and/or failures, focussing instead on individual 'pathologies'
- A lack of recognition of the importance of a "broader range of familial involvement" (Tomczak & Cook, 2023, pg. 311), which may extend beyond the nominated next-of-kin.

Although limited in scope, the available research and policy indicates that not only are notifications of deaths in custody poorly coordinated and communicated with bereaved families, but once notifications occur, families are not provided with meaningful or culturally appropriate support. As a result, families may miss critical opportunities to exercise their rights in relation to access to the remains of their loved ones, and to engage in cultural protocols when a person passes. The absence of detailed protocols on *how* a death in custody is to be communicated with families, and the supports that should be available to assist families through the bureaucratic maze of corrective services is likely to further exacerbate First Nations families grief and trauma.

Discussion

The aim of this rapid review was to determine the extent of research, policy and/or advocacy relating to the process of notifying First Nations families when a loved one passes in custody. Our findings speak to the systematic exclusion and invisibility of families, which contributes to a pervasive sense of injustice. The dearth of research and policy on the way corrective services notify families when a person passes in custody is significant given that more than 30 years ago the RCIADIC (1991) recommended that there be ‘immediate notification’ of the death to the family, noting that wherever possible, the notification should be made ‘in person, preferably by an Aboriginal Person known to the family’ (RCIADIC Recommendation 19). The information contained in this review raises questions about whether and to what extent, this recommendation is being followed in NSW.

Nationally and internationally the available evidence highlights significant gaps – in policy, practice and research - in the way NOK and family are notified when a person passes in custody. The absence of explicit policies, combined with a lack of research, means that family members are rendered invisible during a time of significant grief and trauma. Given that the state owes a duty of care to incarcerated people (Cunneen, 2009), the apparent lack of care in the notification process is concerning. The policies that do exist, and which are publicly available have a predominant focus on procedural ‘root and cause’ analyses that emphasise risk management over trauma-informed and culturally appropriate ways of engaging with families when a loved one passes in custody. This includes an absence of information about the timing, type and source of supports that are available to bereaved families to ensure they can exercise their rights, including cultural protocols associated with the treatment of a deceased person’s body. Further, it is unclear whether First Nations communities are able to access existing protocols in a way that makes them easy to understand.

The emphasis of much Australian research is on the coronial inquest following the passing of a First Nations person in custody. In the context of the notification of a death in custody, families have identified significant structural impediments within Australian prison systems. These issues include inappropriate communication between police, correctives services and family when notifying NOK and a lack of engagement with or understanding of cultural protocols surround a person’s passing (Newhouse et al., 2021; New South Wales Parliament, 2021),

which contributes to a further traumatising for First Nations families and communities (New South Wales Parliament, 2021). This in turn exacerbates a sense of mistrust in the official narrative about the cause of a person's death in custody, and a sense of injustice associated with the person's passing, the subsequent investigation, and even with the coronial process (Allison & Cunneen, 2023; Moore, 2021; Walsh et al., 2022).

In NSW, the Aboriginal Strategy and Policy Unit's (ASPU) protocol on Aboriginal deaths in custody (Corrective Services NSW, 2023) outlines the procedures that need to be followed, including notifying a person's NOK. However, the responsibility of CSNSW appears to be limited to ensuring that *police* have been informed of a person's passing in custody to enable notification of NOK. There is little information within this policy that provides insights into *how* NOK should be identified and notified. Further, it is not clear whether the policy has been developed in collaboration with First Nations people and communities, particularly communities that have been impacted by the passing of a loved one in the custody of CSNSW. As such, the intent behind the RCIADIC recommendations does not appear to have informed the development of this policy.

Importantly, once a family has been notified of a loved one's passing, there is a lack of coordination with the carceral system to ensure that families are provided with information about where their loved one's body has been taken, how to view and/or claim the body, the progress and outcomes of the investigation into the passing, and access to legal and financial supports for the family (Iwai et al., 2023; Newhouse et al., 2022). Families have consistently called for the establishment of a single contact point with CSNSW who would be responsible for supporting families to navigate the bureaucratic processes following a death in custody (Newhouse et al., 2022; New South Wales Parliament, 2021).

In contrast to the lack of detailed policy within prison systems, the Coroner's Court in Victoria and NSW have developed detailed protocols focussed specifically on First Nations deaths in custody. In both jurisdictions, the development of these protocols has been driven by a commitment to implement Recommendation 8 of the RCIADIC, and an acknowledgement of the need "to provide directions regarding cultural considerations and standards in the investigations of Indigenous people in custody" (Coroners Court of Victoria, 2020, para 1.5). Similarly, the NSW State Coroner's Protocol (Local Courts of New South Wales, 2022) aims to ensure that "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 (para 3.1(a)). Importantly, the NSW protocol explicitly acknowledges that

First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process (Local Courts of New South Wales, 2022, para 6.2)

This acknowledgement is important for an understanding of the challenges First Nations people experience with the notification process when a loved one passes in custody. Without a similar protocol that applies to Corrective Services, and that explicitly acknowledges the importance of accurate identification of a person's First Nations status, and concurrently, an accurate and up-to-date system for recording relevant NOK, families will continue to experience the notification process as inappropriate, and sometimes even callous. This is supported by research which has found that in the absence of clear and easily accessible protocols – including information provided via a variety of formats such as audio visual, and written in plain language – families' are left to set and manage their own expectations about what can/should happen following a death in custody (Tomczak & Cook, 2023). In essence, they are left to navigate a complicated and opaque process during a time of significant grief and trauma, with little support and little guidance on the processes that need to be followed.

A final issue raised by this relates to the voices and experiences that have been prioritised in discussions about First Nations deaths in custody. With the exception of recent research into the processes of coronial inquests (McCabe, 2019, forthcoming; Newhouse et al., 2022), the voices of families and affected communities are rarely prioritised. Rather, the voice of professionals (Walsh et al., 2022), including police (Carpenter et al., 2016), academics (Beacroft et al., 2011; Gannoni & Bricknell, 2021) and policy makers (New South Wales Parliament, 2021) are routinely elevated. The exception is in non-mainstream media sources, particularly the Koori Mail and IndigenousX, where the voices and experiences of families are prioritised, alongside the voice of advocates including those with lived experience of colonial carceral systems (Lean, 2021, Moore, 2021; Roach, 2022). Current research and policy, therefore, does not reflect the views, experiences or needs of impacted families and communities. As a result, existing

protocols, including provisions around support and assistance, reflect what other stakeholders *perceive* to be important for families, particularly First Nations families.

Recommendations

1. There is an urgent need for research into the way that First Nations families experience the notification of a loved one's passing in the custody of CSNSW. This research should prioritise the experiences of bereaved families.
2. Existing policies and practices related to the NOK notifications should be reviewed, with a specific focus on the way a passing in custody is communicated to families. This review should include a focus on the way that NOK are identified and the processes that are in place to ensure that NOK information is kept up to date while a person is in custody.
3. The review and redevelopment of any NOK notification policies needs to be done through an active process of collaboration with First Nations families and communities.
4. Consideration should be given to the way that Aboriginal Community Liaison Officers (ACLOs) can be consistently involved in NOK notifications, to avoid the use of police officers as the primary notifiers.
5. Corrective Services staff who have responsibility for communicating with family following the passing of a First Nations person in custody should undergo regular training to ensure that communication is done in a way that is respectful of First People's cultural protocols associated with death. This training should be trauma-informed, and grounded in an understanding of the harms experienced by First Nations peoples through carceral systems.

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