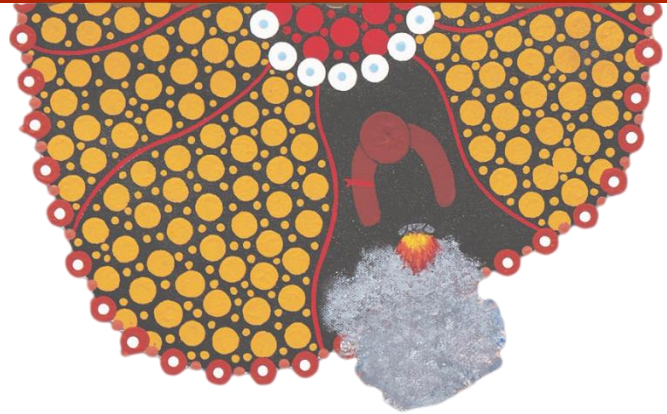


Resource: Investigating systemic racism

A Tanya Day inquest resource for advocates and lawyers

The resource covers:

- Systemic racism, the Coroners Court jurisdiction and how the Charter can assist in arguing for systemic racism to be investigated
- Sample oral submissions



What is systemic racism?

Systemic racism against Aboriginal and Torres Strait Islander people is defined as situations where what appear to be ‘facially neutral’ laws, policies and practices operate in an uneven or unfair manner that is detrimental to Indigenous people.¹ Put another way, systemic racism or discrimination may be described as a process that produces statistically discriminatory outcomes for particular racial or cultural groups.²

Systemic racism is not about whether individuals hold racist views but about the uneven impact of laws, policies or practices. Systemic racism can to some extent be measured by outcomes and results rather than intentions.³ It may involve laws, policies and practices that operate to produce such outcomes. It may also involve the unconscious bias in individual decision making by the agents of institutions such as in the exercise of discretion.

¹ Harry Blagg, Neil Morgan, Chris Cunneen and Anna Ferrante (2005), *Systemic Racism as a Factor in the Overrepresentation of Aboriginal People in the Criminal Justice System*, Report to the Equal Opportunity Commission and Aboriginal Justice Forum, 12. This definition of systemic racism was relied upon by the Coroner’s Court of Victoria in the Inquest findings into the death of Tanya Day (COR 2017 6424).

² See Inquest findings into the death of Tanya Day (COR 2017 6424) at [101].

³ Ibid.



As stated in the Royal Commission into Aboriginal deaths in Custody: an institution “which has rules, practices, habits which systematically discriminate against or in some way disadvantage Aboriginal people, is clearly engaging in institutional discrimination or racism”.⁴

The Victorian Government has long recognised that systemic racism is, and continues to be, a significant problem for Aboriginal and Torres Strait Islander Victorians. The first Aboriginal Justice Agreement acknowledged the issue of institutional racism,⁵ while Principle 10 of Burra Lotjpa Dunguludja (the current Victorian Aboriginal Justice Agreement 4) is to “[a]ddress unconscious bias: Identify and respond to systemic racism and discrimination that persists in the justice system”.⁶

How can Coroners investigate systemic racism?

The Coroners Court is an investigative and inquisitorial Court responsible for making findings concerning the cause and circumstances of reportable deaths. The Victorian Court of Appeal has made some helpful comments about the way that the Coroners Court should operate. It has said that “the Coroner must do everything possible to determine the cause and circumstances of the death”⁷ and it is obligatory “for the Coroner investigating a death to pursue all reasonable lines of inquiry”⁸.

The *Coroners Act 2008* (Vic) (**Coroners Act**) governs the powers and functions of the Coroners Court. Under that Act, in an inquest, the Coroner must find, if possible, a number of matters including the cause of death and the circumstances in which the death occurred.⁹

The Preamble and s 1 of the Coroners Act set out that the Court has an important preventative function: to contribute to the reduction of the number of preventable deaths through the findings of the investigation of deaths and the making of recommendations by coroners.

⁴ Royal Commission into Aboriginal Deaths in Custody (Final Report, April 1991) vol 2 [12.1.30].

⁵ Victorian Government, Victorian Aboriginal Justice Agreement (1999) 14(Aboriginal Justice Agreement 1999).

⁶ Victorian Government, Burra Lotjpa Dunguludja (2018), 18, available here: <https://www.aboriginaljustice.vic.gov.au/aboriginal-justice-agreement-phase-4> .

⁷ *Priest v West* (2012) 40 VR 521, [6] (Maxwell P and Harper JA).

⁸ *Ibid*, n 2 [4] (Maxwell P and Harper JA).

⁹ Section 67(1) of the Coroners Act 2008 states:

A coroner investigating a death must find, if possible—

- (a) the identity of the deceased; and
- (b) the cause of death; and
- (c) unless subsection (2) applies, the circumstances in which the death occurred; and
- (d) any other prescribed particulars.

The Coroner does not need to make a finding of the circumstances in which the death occurred in particular circumstances set out in s 67(2) regardless of whether it is possible or not to do so. A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice (s 67(3)).



Consistent with this legislative intention, the Court has power to make formal recommendations on any matter connected with a death which the coroner has investigated.¹⁰ In September 2020 a new Practice Direction 6 was introduced by the Court. The direction refers to a range of practices to ensure that inquests into Indigenous deaths in custody are conducted in a culturally appropriate manner, including a commitment to fully implement the Royal Commission into Aboriginal Deaths in Custody recommendations.¹¹

Each of these matters assists when making submissions that the Court should include systemic racism within scope, particularly where Aboriginal deaths in custody continue to frequently occur despite previously having been the subject of inquiries. Even before consideration of the *Charter of Human Rights and Responsibilities (Charter)*, the submission may be made that the Coroners Court should investigate systemic racism in order to properly execute its functions.

Useful precedents for investigating systemic racism in deaths and custody

There have now been a number of coronial inquests across Australia that have recognised the importance of investigating underlying factors, structures and practices involved in Indigenous deaths in custody.

Western Australian Coroners have accepted that their task when investigating an Indigenous death in custody is to expand the inquiry 'from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest in which the Coroner seeks to identify underlying factors, structures and practices contributing to avoidable deaths and formulate constructive recommendations to reduce the incidence of further avoidable deaths'¹²: *Inquest into the Death of Ms Dhu*¹³; the *Inquest into the Death of Mr Ward*¹⁴ and the *Inquest into the Death of Maureen Mandijarra*.¹⁵

In the *Inquest into the death of Tanya Day*, Victorian Deputy State Coroner ruled that whether systemic racial discrimination played a role in Ms Day's death should be investigated.¹⁶ The ruling was issued at the start of the inquest. During the inquest,

¹⁰ Coroners Act, s 72.

¹¹ See Coroners Court Practice Direction 6 of 2020, Indigenous Deaths in Custody, [1.2], available here: <https://www.coronerscourt.vic.gov.au/sites/default/files/2020-09/2020.09.21%20-%20Practice%20Direction%20on%20Indigenous%20Deaths%20in%20Custody%20-%20FINAL.pdf>

¹² Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death', Australian Indigenous Law Reform Journal (2008) 12(2) 6

¹³ State Coroner Fogliani, *Inquest into the Death of Ms Dhu* (Record of Investigation into Death, 16 December 2016), [32].

¹⁴ State Coroner Hope, *Inquest into the Death of Francis Robert Ward* (Record of Findings, June 2009), 116.

¹⁵ State Coroner Fogliani, *Inquest into the Death of Ms Mandijarra* (Record of Findings, 2017) 28-29

¹⁶ Deputy State Coroner, *Inquest into the Death of Tanya Day* (Ruling on Application regarding the scope of the Inquest, 25 June 2019).



witnesses were cross examined about the motivations for the decisions taken in respect of Ms Day and whether unconscious bias formed part of their decision making.¹⁷ The Deputy State Coroner found that the train conductor’s decisions made about Ms Day were affected by unconscious bias. Specifically, the Coroner found that the decision of the conductor to define Ms Day, who was sleeping on a train, as “unruly” and to call for Police rather than pursue other options was influenced by her Aboriginality.¹⁸

How to show the Coroners Court that systemic racism prima facie arises in the inquest

Whether the case involves an Aboriginal person or a person from any other racial or cultural group, when seeking to include systemic racism within the scope of an inquest it is important to explain to the Coroners Court how systemic racism prima facie arises in the inquest and why it is a reasonable line of enquiry.

It is important in each coronial inquest to consider the particular case before you, including all the materials in the Coronial brief and the issues already identified by the Coroner. What information can support the application for systemic racism to be investigated will depend on the unique factual and legal issues that arise in the inquest. It is not possible to give a uniform guide.

Demonstrating systemic racism will always involve a specific inquiry into the individual and systemic failures involved in a particular death, and how these relate, if at all, to the broader experiences of Aboriginal and Torres Strait Islander people.

In addition to material in the Coronial brief, you may wish to consider getting additional material together that supports your application. This evidence must demonstrate a link to the individual and systemic failures which led to the death. It is also important to be mindful of intersectionality and how the evidence relates to the particular experiences of the deceased person.

¹⁷ Deputy State Coroner, *Inquest into the Death of Tanya Day* (Finding into Death with Inquest, 9 April 2020), [100].

¹⁸ Deputy State Coroner, *Inquest into the Death of Tanya Day* (Finding into Death with Inquest, 9 April 2020), [225].



By way of example, in the *Inquest into the death of Tanya Day*, Tanya’s family relied on a range of additional material, in addition to materials contained in the Coronial brief, to support their application for systemic racism to be investigated in the inquest. The information included:

- An expert report on systemic racism prepared by a leading academic who was specifically briefed by the Family;
- published reports on systemic racism and reports of Royal Commissions;
- statements made in the Victorian Aboriginal Justice Agreement concerning systemic racism; and
- findings in prior coronial inquests demonstrating a pattern of systemic racism.

Tanya’s family also obtained data through freedom of information which it sought to rely on to support its application for systemic racism to be investigated. The data showed the statistical likelihood of Aboriginal women in Victoria being identified as an offender of public behaviour offences. The Coroner admitted this evidence but ruled that it was not evidence of causation: that is, the data could not be relied on to show that the deceased was charged with public drunkenness because of systemic racism.¹⁹

This list should not be regarded as an exhaustive or prescriptive list of what is required to support an application of systemic racism. These materials may not be relevant in your case. Or there may be other materials that are relevant that you could use. Each case will vary.

Relevance of the Charter to arguing that systemic racism is within scope

The Charter can assist in submissions that the scope of an inquest should include investigating systemic discrimination, where systemic discrimination issues are indicated in the Coronial brief.

In the *Inquest into the death of Tanya Day* the Coroners Court agreed to investigate whether systemic racial discrimination played a role in the circumstances of the death of Tanya Day, an Aboriginal woman who died from injuries sustained in police custody.

The Coroner did this by interpreting her fact-finding function in s 67 of the Coroners Act consistently with human rights, as required by s 32 of the Charter, including the right to life (s 9) and to equality (s 8). She decided that she would assess the evidence in this inquest through the lens of systemic racism after hearing submissions that to so would be

¹⁹ See Ruling, [68]-[76].



consistent with her duty to conduct a comprehensive, thorough, effective investigation.²⁰ The Coroner also agreed to consider at the inquest whether Charter obligations were complied with, the extent to which Tanya’s Charter rights were engaged and if they were infringed.²¹

Tanya was travelling on a train from her home at Echuca to Melbourne, when she was removed from the train at the Castlemaine train station. Her removal from the train happened after the train conductor decided in under a minute that she was “unruly” and that Police should be called to have her removed. At the time, Tanya was sleeping on the train. Tanya was arrested for being drunk in a public place and taken to Castlemaine police station. Whilst in custody, she suffered a head injury. Ambulance Victoria officers attended the police station and she was taken to hospital where she later died.

The Deputy State Coroner investigated whether systemic racism played a role in the circumstances of her death, and found that the train conductor’s decisions made about Ms Day were affected by unconscious bias. The Court also found that Victoria Police failed to treat Ms Day with humanity and respect for the inherent dignity of a human person as required by s 22 of the Charter.²²

Sample oral submissions

Note: These generic submissions have been prepared without reference to any particular case. They should only be used after you have fully considered and analysed the unique inquest in which you are considering making these submissions. This includes considering all factual and legal issues that arise in respect of the particular inquest.

We submit that the scope of the inquest should include an investigation into whether systemic racism contributed to the cause and circumstances of the death.

By “systemic racism” we mean the process by which statistically discriminatory outcomes are produced for particular racial or cultural groups. We refer the Court to the definition of systemic racism in the 2005 report prepared for the Victorian Equal Opportunity Commission, *Systemic Racism as a Factor in the Overrepresentation of Aboriginal People*

in the Criminal Justice System, which defines it to mean situations where what appear to be ‘facially neutral’ laws, policies and practices operate in an uneven or unfair manner that is detrimental to Indigenous people.²³ Put another way, systemic discrimination may be described as a process that produces statistically discriminatory outcomes for particular

²⁰ See Ruling [20]-[22], [84]-[85].

²¹ See Ruling [80].

²² Deputy State Coroner, *Inquest into the Death of Tanya Day* (Finding into Death with Inquest, 9 April 2020), [533].

²³ Harry Blagg, Neil Morgan, Chris Cunneen and Anna Ferrante (2005), *Systemic Racism as a Factor in the Overrepresentation of Aboriginal People in the Criminal Justice System*, Report to the Equal Opportunity Commission and Aboriginal Justice Forum, 12.

racial or cultural groups. This definition of systemic racism was relied upon by the Coroner's Court of Victoria in the *Inquest findings into the death of Tanya Day*, an Aboriginal woman who died after being in police custody, delivered on 9 April 2020.

At the outset, we recall that the Royal Commission into Aboriginal Deaths in Custody recommended an expansion of a coronial inquiry from a traditional narrow and limited determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths through a thorough consideration of circumstances of the death including the circumstances leading to a person being taken in custody, and requiring findings and the formulation of constructive recommendations to reduce the incidence of further avoidable deaths in custody.²⁴ This Court has stated its intention to implement these recommendations in Practice Direction 6 (September 2020). The functions conferred on this Court must be considered in light of this uniquely Australian context identified by the Royal Commission.²⁵

With that important context in mind, we submit that systemic racism should be included within the scope of the inquest for the following three reasons:

1. It is compatible with the Coroner's statutory duty to investigate and determine the cause and circumstances under the *Coroners Act 2008 (Vic)* (the **Coroners Act**);
2. Including systemic racism in the scope of the inquest will enable the Court to fulfil its important preventative function set out in the Preamble and s 1 of the Act; and
3. It is consistent with the Court's obligations under the *Charter of Human Rights and Responsibilities (Charter)*

Before expanding on each of these points, it will be important to explain how systemic racism prima facie arises in the inquest (see 'How to show the Coroners Court that systemic racism prima facie arises' above). Consider the particular case before you, including all of the materials in the Coronial brief and the issues already identified by the Coroner. The following submissions proceed to address point 3 only: how including systemic racism within scope is consistent with the Charter.

²⁴ The recommendations of the Royal Commission into Aboriginal Deaths in Custody include that investigations into deaths in custody should include a thorough consideration of all of the circumstances of the death (12 and 36), including the circumstances leading to the person being in custody (35), and the Coroner should make findings with a view to preventing further custodial deaths (13). The Recommendations are available at: www6.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html#Heading5

²⁵ See Coroners Court Practice Direction 6 of 2020, Indigenous Deaths in Custody, [1.2], available here: <https://www.coronerscourt.vic.gov.au/sites/default/files/2020-09/2020.09.21%20-%20Practice%20Direction%20on%20Indigenous%20Deaths%20in%20Custody%20-%20FINAL.pdf>

Investigating systemic racism is consistent with the Court's obligations under the Charter

Including systemic racism within scope is consistent with the Court's obligations under the Charter.

In particular, we contend that the way that the Charter applies in the Inquest is through the statutory interpretation rule in s 32 of the Charter.

In the *Inquest into the Death of Tanya Day*, the Coroner's Court agreed to investigate whether any type of racism played a causal part of Ms Day's death. The Coroner found that interpreting her fact-finding function in s 67 of the *Coroner's Act* to frame the scope of the inquiry in this way was consistent with human rights, as required by s 32 of the Charter.²⁶ Section 67 of the *Coroner's Act* sets out findings that the Coroner is required to make when investigating a death.²⁷

In our submission, the relevant rights engaged include the right to life (s 9) and equality rights (s 8).²⁸

Does the Coroner need to act compatibly with human rights and take them into account?

If the Coroners Court is a public authority, then s 38 of the Charter imposes obligations on it to act compatibly with human rights and consider human rights when making decisions. If you make this argument, you should consider the meaning of public authority in s 4 of the Charter and explain why the Court is acting in an administrative capacity.

Under s 4(1)(j) of the Charter, the Coroners Court is a public authority when it is acting in an administrative capacity. There is no judicial authority on whether the Coroners Court is a public authority when determining the scope of an inquest and making findings and recommendations. In the Day inquest, the Commission submitted these tasks are administrative, having regard to the decided cases on s 4(1)(j) (see [44] – [52] of the submissions of the VEOHRC in the Tanya Day Inquest, available on VEOHRC's website). We note that Coroner English did not expressly decide this issue.

²⁶ In the Matter of the Inquest into the Death of Tanya Day, *Ruling on Application Regarding the Scope of the Inquest* (COR 2017/6424) (**Ruling**) [84]-[85]. See also [20]-[22].

²⁷ Section 67 of the Act states:

67 Findings of coroner investigating a death

(1) A coroner investigating a death must find, if possible—

- (a) the identity of the deceased; and
- (b) the cause of death; and
- (c) unless subsection (2) applies, *the circumstances in which the death occurred*; and
- (d) any other prescribed particulars.

[..]

(3) A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

²⁸ NB: The Coroner's Ruling in Tanya Day does not expressly refer to ss 8 or 9 of the Charter. One interpretation of [84], after reading the decision as a whole, is that these *must* have been the rights that the Coroner relied upon. But this is not the only conclusion that could be made.

While every inquest will raise s 9 of the Charter, the identification of relevant rights is fact specific. It will be necessary to examine the particular case before you, including all of the materials in the Coronial brief and the issues already identified by the Coroner to determine what rights are engaged.

Investigating whether systemic racism was a cause or circumstance of the death is compatible with the implied procedural right to an effective investigation protected in s 9 of the Charter.

Section 9 of the Charter protects the right to life. We submit that this right protects an implied procedural obligation to properly investigate a death which may have involved the arbitrary deprivation of life and in which the conduct of a public authority may be implicated.

There is a significant body of case law from the United Kingdom and the European Court of Human Rights

concerned with the implied procedural right that makes clear that an investigation must be effective to be compatible with the right to life.²⁹ An effective investigation requires careful and thorough scrutiny that “takes into account all the surrounding circumstances”.³⁰

This Court has recognised the relevance of s 9 of the Charter in previous Victorian inquests. In the *Inquest into the Death of Tanya Day*, the Coroner ruled that she would investigate whether systemic racial discrimination played a role in the circumstances of the death of Tanya Day. The Coroner did so after interpreting the functions in s 67 of the Coroners Act consistently with human rights, as required by s 32 of the Charter. The relevant Charter rights include the right to life (s 9) and to equality (s 8) of the Charter.³¹

The Coroners Court itself can give effect to this right by providing an independent form of investigation into particular deaths in Victoria. Practice Direction 6 of the Coroners Court supports the implementation of the recommendations from the Royal Commission into Aboriginal Deaths in Custody, including that the Court conduct inquests in a culturally appropriate manner. We submit that in circumstances in which systemic racism arises on the materials, the investigation into the death should properly deal with these matters so that it is an effective investigation.

²⁹ *McKerr v United Kingdom* [2001] ECHR 329, [109], [115]; *McCann v United Kingdom* (1996) 21 EHRR 97, [157]-[164]; *R (Amin) v Home Secretary* [2014] 1 AC 653; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182.

³⁰ *Anguelova v Bulgaria*, ECHR, Application no. 38361/97, Strasbourg, 13 June 2002, [110].

³¹ See Ruling, [20]-[22], [84]-[85].

Consider other Charter rights that may arise and make submissions on how they are engaged.

For example:

- if facts raise discriminatory treatment of the deceased, the right to equality protected by s 8 of the Charter may be engaged
- if facts raise an inference of the deceased's right to enjoy his or her identity or culture, for example, if the deceased was denied the right to participate in a cultural activity, the right to enjoy his or her identity or culture protect by s 19 of the Charter may be engaged.

An example of the headnote of the submissions that you may make are below. You will need to explain how the Charter right is engaged on the facts and what you seek the Coroner to do. Consider the outcome that you are seeking in terms of the scope. For example, in respect of s 19, you may wish to submit that "consistently with this right, a sub-set of the inquiry that we contend should be investigated by the Coroner is whether the people who interacted with the deceased recognised the unique fears that they were likely to have experienced as [insert racial/cultural group, eg an Aboriginal person] in custody and whether they were given appropriate cultural safe and trauma informed care."

Examining systemic racism in this Inquest will also be consistent with the right to equality protected by **section 8** of the Charter. The materials raise for consideration whether the deceased was subject to discrimination. The Charter protects a right for every person to "enjoy his or her human rights without discrimination". It also protects in s 8(3) the right to "effective protection against discrimination". The latter right protects substantive equality, one that accommodates difference. It recognises that certain people may need to be treated differently in order to ensure that everyone has equal protection of the law.³² The equality rights have been recognised to have procedural implications for Victorian Courts in some contexts.³³

Finally, the deceased, as [insert racial/cultural group, eg an Aboriginal person], had a right in **section 19** of the Charter not to be denied the right to enjoy their identity or culture. [If it's an Aboriginal person: The Charter was enacted with an express legislative recognition that "human rights have a special importance for the Aboriginal people of Victoria, as descendants of Australia's first people, with their diverse spiritual, cultural and economic relationship with their traditional lands and waters."] There has not yet been much judicial consideration of this right in Victoria. Relying on its international equivalent – Article 27 of the ICCPR – we contend that the right confers a positive right to enjoy culture.

³² *Lifestyle Communities Ltd (No 3) (Anti-Discrimination)* [2009] VCAT 1869, [257]; *Victorian Toll v Taha; State of Victoria v Brookes* [2013] VSCA 37 [210] (Tate JA); *Matsoukatidou v Yarra Ranges Council* [2017] VSC 61, [50], [61], [105].

³³ *Matsoukatidou v Yarra Ranges Council* [2017] VSC 61, [40]-[46], [50]-[55], [61]; *Cemino v Cannan* [2018] VSC 535, [142]-[144].