IN THE CORONERS COURT **Court Reference: COR 2017 6424**

OF VICTORIA

AT MELBOURNE

IN THE MATTER OF THE INQUEST INTO THE DEATH OF TANYA DAY

RULING ON APPLICATION REGARDING THE SCOPE OF THE INQUEST

Introduction

1. On 5 December 2017, Tanya Day was removed from a V line train at the Castlemaine Railway Station. Members of Victoria Police attended, and she was arrested for being drunk in a public place. She was taken to the Castlemaine Police station and placed in a cell.
2. Whilst in custody she suffered a head injury. Ambulance Victoria officers attended and she was taken to Bendigo Hospital, and then transported to St Vincent's Hospital. She died in hospital on 22 December 2017.

Jurisdiction

3. Ms Day's death was reported to the coroner as it appeared to have occurred as a result of an accident or injury pursuant to section 4 of the Coroners Act (2008) (**the Act**).
4. Pursuant to section 52(2) of the Act, her death is subject to a mandatory inquest, as immediately before her death Ms Day was a person placed in custody.
5. Section 67 of the Act states a coroner investigating a death must find, if possible, the identity, the cause of death, and the circumstances in which the death occurred.

Scope of the inquest

6. This case is listed for hearing on 26 August 2019 for just under three weeks. 27 witnesses will be called to give evidence.
7. The scope of the inquest, thus far, has been defined and agreed as follows:

    - The factual circumstances and appropriateness of the decision to remove Ms Day from the train by V line staff;
    - The factual circumstances and appropriateness of the decision by Victoria Police to arrest Ms Day;
    - The contact made by Victoria Police with the Aboriginal Community Justice Panel and the reasons for their non-attendance on Ms Day;

- The circumstances of the automated contact with the Victorian Aboriginal Legal Service regarding Ms Day's custody and whether it was managed appropriately managed;
- The contact made by Victoria Police with the Aboriginal Community Justice Panel and the reasons for their non-attendance on Ms Day;
- Ms Day's period in custody and whether it was appropriately managed by Victoria Police and in accordance with the Victoria Police Manual;
- The communication by Victoria Police to Ambulance Victoria, and whether her treatment by Ambulance Victoria officers was appropriate; and
- The mechanism of Ms Day's death and whether the death was preventable.

8. Ms Day's family (**the family**) has submitted that the scope of the inquest should also include a consideration of whether systemic racism was a contributing causal factor to Ms Day's death.

Directions Hearing 30 April 2019

9. On 30 April 2019, a directions hearing was held to hear submissions by Ms Day's family and the interested parties regarding the scope of the inquest and whether it should include a consideration of the role of systemic racism as a contributing factor to the circumstances and cause of Ms Day's death.
10. The court heard submissions from the Victorian Equal Opportunity and Human Rights Commission, the family, V Line, Ambulance Victoria and Chief Commissioner of Police.

Definition of systemic racism

11. The family's submission dealt extensively with the meaning of systemic racism:
    ''*…'systemic racism' refers to a process that produces statistically discriminatory outcomes for particular racial or cultural groups. It may involve unconscious bias, or laws, policies and practices, that operate to produce such outcomes. That outcome may occur without conscious racist intent, and despite individuals believing they are simply 'doing their job'. Critically, systemic racism can operate without any individual displaying expressly racist or discriminatory behaviour, and without institutional policies or practices that are expressly or openly racist.*' [1]
12. The submission noted the definitions used by other bodies.
13. The Royal Commission into Aboriginal Deaths in Custody referred to systemic racism as '*rules, practices, habits which systematically discriminate against or in some way*

[1] Family's submissions dated 29 March 2019 p 1

disadvantage Aboriginal people…' and '*the differential application of discretions,*' such as turning a blind eye to particular behaviour or in the exercise of the power to arrest.' [2]

14. The Equal Opportunity Commission defined it in their report on Systemic racism 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,*' and, '*...systemic racism can to some extent be measured by outcomes and results rather than intentions. Policies might not be racist in intent, but might have racist outcomes.*' [3]
15. Principle 10 of the current Victorian Aboriginal Justice Agreement is to '*address unconscious bias: Identify and respond to systemic racism and discrimination that persists in the justice system.*' [4]

Application of the Charter of Human Rights and Responsibilities

16. The Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) intervened in the proceeding pursuant to section 40 (1) of the Charter of Human Rights and Responsibilities (2006) (**the Charter**) and made submissions regarding the application of the Charter to the determination of the scope of the inquest.
17. The VEOHRC submitted the operative provisions of the Charter apply to the court namely: section 38(1) as a 'public authority,' procedural and substantive obligations are imposed; section 6(2)(b) applies to its 'functions' under Part 2 & 3; and section 32, the interpretative rule in the Charter, applies to s 67 of the Act.
18. I accept the submissions by the VEOHRC that the interpretative rule in section 32 of the Charter applies to section 67 of the Act requiring me to interpret that statutory provision compatibly with human rights.
19. Given I accept that part of the VEOHRC's submission, I do not propose to determine the submissions made in respect of the application of sections 38(1) or section 6(2)(b) of the Charter.
20. With respect to section 32, the VEOHRC submitted the Charter section 9, the right to life, applied, so the interpretation of the 'circumstances of death' in section 67 should ensure the investigation into Ms Day's death is comprehensive, thorough and effective. '*In the Commissions' submission, this requires the court to expand the scope of the inquest to examine whether the circumstances of [Ms Day's] death involved systemic racial discrimination.*' [5]

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[2] Family's submissions dated 29 March 2019 pp 7-8
[3] Family's submissions dated 29 March 2019 p 9
[4] Family's submissions dated 29 March 2019 p 11
[5] VEOHRC submissions 17 April 2019 p 21

21. Further, '*interpreting section 67(1) in a manner compatible with the rights to equality, the right to life and cultural rights is consistent with this purpose.*'
22. The VEOHRC submission was that investigating whether systemic racial discrimination contributed to the death is compatible with the application of the Charter to the inquest.

The family's submission

23. The family has submitted that systemic racism should be included within the scope of the inquest because:
'*As a potential contributing factor to Tanya's death, it falls squarely within in the court's duty to investigate; and,*
including systemic racism in scope will also allow the court to fulfil its important preventative function.' [6]
24. Further, the submission states:
'*The court is obliged to pursue all reasonable lines of inquiry to establish the cause and circumstances of Tanya's death...systemic racism may have been a contributing factor to Tanya's death. As a result, it must be included within scope in order for the court to properly discharge its function to find the cause of Tanya's death, and the circumstances in which that death occurred.*' [7]
25. Further, if systemic racism was a causal factor in Ms Day's death, then '*the court would be in a position to make findings and recommendations that could significantly contribute to the reduction in the number of preventable deaths.*'
26. The family further submits that Ms Day's human rights under the Charter are engaged requiring the court to interpret section 67 in accordance with section 32 of the Charter and that the court is a public authority and when it exercises its functions pursuant to section 6(2)(b) of the Charter. [8]
27. The submission states systemic racism is a 'live issue' – that it is essential the court should listen carefully to what Ms Day's family members have said '*because they can perceive directly causal factors at play that others simply cannot perceive directly...only through carefully listening and indirect evidence of statistical outcomes.*' [9]
28. In oral submissions, counsel for the family, Mr Nekvapil used one example, Ms Day's arrest, to illustrate the family's submission.

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[6] Family's submissions dated 29 March 2019 p 2
[7] Family's submissions dated 29 March 2019 p 3
[8] Family's submissions dated 29 March 2019 p 7
[9] Family's submissions dated 29 March 2019 p 14

29. He submitted Ms Day was arrested whilst drunk in a public place and she was treated differently than a white woman would have been treated.
30. Data provided to the court indicated that at least 9.3% of female offenders identified by Victoria Police for being drunk in a public place were Aboriginal or Torres Strait Islander women. This is in circumstances where Aboriginal and Torres Strait Islander women account for approximately 0.9% of the Victorian population. [10] Further data indicated that 85 % of Aboriginal and Torres Strait Islander women charged with being drunk in a public place attend the police station, compared with 77% of non-indigenous women. [11]
31. The submission was for the scope of the inquest to *consider that disproportion.* [12]
32. The family requested the investigation of a number of questions, such as *'... how Ms Day went from being asleep on a train to dying from a fatal injury sustained in police custody, what was the cause and what were the circumstances...the answer to that involves a lot of little steps.'* [13]
33. Mr Nekvapil submitted a '*series of small decisions and failures*' by people in positions of power led to Ms Day's death and those decisions and failures were '*affected by her Aboriginality.*' [14] There were four reasons supporting the relevance of systemic racism: the evidence of those people whom it directly affects, the Royal Commission into Aboriginal Deaths in custody and numerous other studies supports its existence, the data outcomes which prove disproportional outcomes and fourthly, human nature.
34. The family submits: '*...it is not possible to definitively determine whether systemic bias in fact contributed to the decision to remove Tanya from the train. However, it is submitted that these matters indicate that it is a 'reasonable line of inquiry' that the court is obliged to pursue.*' [15]
35. When asked what an inclusion of systemic racism in the scope of the inquest would mean, Mr Nekvapil stated he was not wanting to turn the inquest in to a '*commission about data'* but '*...to look at , whether in this case, the decisions made by these individuals were effected by that, and whether that's a cause of Tanya ending up in that place...*' [16]
36. Mr Nekvapil clarified: '*But we won't be troubling the court with any sort of data gathering exercise...We're not asking you to review or inquire into some abstract problem, some widespread cultural inquiry.*' [17]

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[10] Letter from the Human Rights Law Centre dated 26 April 2019
[11] Letter from the Human Rights Law Centre dated 10 May 2019
[12] T 30
[13] T 27
[14] T 31
[15] Family's submissions dated 29 March 2019 p 16.
[16] T 37
[17] T 37

37. A report titled 'A report on systemic racism in relation to the death of Tanya Louise Day for the Coronial Court of Victoria, Case No. 006424/17' by Dr Thalia Anthony, Associate Professor, Faculty of Law, University of Technology, Sydney, dated 26 March 2019 accompanied the family's submission.

V Line

38. The submission from V Line supported the family's submission that the coroner should consider whether discrimination, (overt or systemic racism), contributed to Ms Day's death and that it is within the court's remit to consider whether any form of racism contributed to the circumstances of Ms Day's death.
39. However, with respect to the scope, V Line cautioned that the analysis of the decisions made, and the policies and training informing those decisions and the conduct of a number of agencies '*must be viewed entirely through the circumstances of the case.*' [18]
40. V Line acknowledged Ms Day's cultural identity justified an enquiry as to whether it played any part in decisions and policies pertaining to interactions with her on that day and that this warrants consideration by the court as to whether discrimination (direct or systemic) was a factor that relevantly contributed to decisions made by parties on the day and ultimately to the circumstances of Ms Day's death.
41. However, it argued statistical data and other instances of systemic racism in the Anthony report is of very limited relevance to the court's inquiry, and the court should not involve reasoning drawing from the general (statistical data) to the specific (circumstances of Ms Day's death) nor should it look from the specific to the general – inductive reasoning invited by the family has no part to play in the coronial setting.
42. Deduction is about certainty, inductive reasoning is about probability, which suggests truth but does not ensure it.
43. I accept the submission that the court should act consistently with the Charter and the submission that the Charter does not expand the court's proper functions pursuant to the terms of the Act.

Victoria Police

44. The submission by Victoria Police opposed the inclusion of systemic racism in the scope.

[18] V Line's submissions dated 17 April 2019 p 2.

45. The submission cautioned against a consideration of factors which, even if relevant, may be too remote from the event to be regarded as causative and argued that many of the issues raised in Dr Anthony's report '*fall beyond this line.*' [19]
46. With respect to the family's submissions that racist assumptions contribute to police assessments that a person is or may be drunk, the submission argued are not relevant in this case: the fact is that Ms Day was '*in fact very drunk*' therefore whether police made incorrect assumptions *in other cases* is not of relevance here.
47. The submission detailed the factual matters of the case, and in respect of Ms Day's particular needs as an indigenous person in custody, stated:
'*A broad enquiry into whether the system has a general and unintended discriminatory effect is not warranted in the face of the evidence. The Coroner can of course consider whether the particular arrangements in place were sufficient or should be improved, but that is a different and narrower question than a review of the justice system across Australia.*' [20]

Ambulance Victoria

48. The submission by Ambulance Victoria opposed the inclusion of systemic racism in the scope.
49. The submission contended that as systemic racism is reflected in on going conduct over time based on generalised assumptions about cultural minorities, the isolated conduct by individual paramedics on a single occasion in this case cannot be a foundation for a finding of systemic racism.

Factors relevant to determine scope

50. The purpose of defining a scope to the inquiry of the Inquest is to focus the court proceeding on the relevant issues in dispute and provide a logical structure to evidence elicited at the inquest.
51. The issue in dispute regarding scope pertains to the 'circumstances' of Ms Day's death, and how broadly the examination of circumstances will extend.
52. Circumstances broadly refers to those facts proximate in time and relevant to the death. There is legal authority which refers to causation and remoteness in the coronial jurisdiction.
53. There must be a causal link between the death and the matter under investigation to bring the matter within the scope of the inquest. To determine whether that causal relationship

[19] Victoria Police submission dated 16 April 2019 p 2
[20] Victoria Police submission dated 16 April 2019 p 4

existed, coroners used a 'common sense' test of causation, limited by the principles of remoteness.

54. The Act contains several provisions that indicate coroners may now make broader inquiries than permitted under the previous legislation.
55. The Preamble, sections 1(c) and 9(f) as well as the Parliamentary debates on the Act arguably expands the scope of inquests by making comments and recommendations an integral part of the investigation or Inquest.
56. Judge Coate in the inquest into the death of Tyler Cassidy (court reference 5542/08) stated the 'circumstances' in which the death occurred is for the coroner to interpret in each case. The interpretation is guided by the scheme of the Act, with assistance from the Preamble and purpose provisions.
57. The preventative focus of the coronial process is a relevant factor to take into account when defining scope.
58. In the course of many coronial investigations and inquests, systemic problems may be identified, such as in prisons or hospitals, as having contributed to the death under investigation.
59. Having said that, an inquest relates only to an examination of the death in question, and is not a '*roving Royal Commission.*' [21] In R v Doogan; Ex parte Lucas-Smith [22]the Full Court of the Australian Capital Territory Supreme Court said at [29] that it was necessary to draw a line at some point beyond which, even if relevant factors which came to light would be considered too remote to be regarded causative.
60. In the past, the Royal Commission into Aboriginal Deaths in Custody was critical of coronial inquests for their narrow focus: '*The examination of wider issues was rarely seen as relevant. The lack of inquiry into systems issues such as custodial practices and procedures, resulted in a lack of findings or recommendations designed to rectify failures in these systems.*' [23]
61. The scope of an inquest is determined by three main issues. The first are the findings of identity, cause of death and circumstances of death a coroner must find, if possible. The second is where do the outer bounds of causation lie, beyond which any matter will be too remote to be investigated. Thirdly, are there matters of public health and safety, or the administration of justice the coroner should investigate?
62. The issue in this case is whether the scope of the inquest should include a consideration of systemic racism.

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[21] Harmsworth v State Coroner [1989] VR 989 at 996
[22] [2005] ACTSC 74
[23] Recommendations at 4.5.8

63. The obligation to make statutory findings, if possible, confers a duty on the coroner to pursue all reasonable lines of inquiry to investigate a death. The exemption of the rules of evidence displays a Parliamentary intention that the coroner not be constrained in carrying out an investigation.
64. Section 7 of the Act requires a coroner to *'avoid unnecessary duplication of inquiries and investigations'* and to investigate expeditiously.

Ruling

65. I am not determining whether systemic racism did play a role in Ms Day's death, but whether that question should be investigated as part of the scope of the inquest.
66. The family's written submissions argued systemic racism *was* a causal contributing factor to Ms Day's death. For example, the decision to remove Ms Day from the V Line train was based on the decision she was drunk and Police were called, rather than that she had a medical condition necessitating an Ambulance. Similarly, the decision to arrest her, rather than arranging for a medical assessment, was indicative of systemic racism. Further, her injury in custody, the failure by police to follow their own procedures and the lack of appropriate medical care '*are wholly consistent with disproportionate outcomes that can only be explained by systemic racism, unless another non-discriminatory causal factor can be identified.*' [24]
67. I note all of the above questions, such as the decision to remove Ms Day from the train, the decision to arrest her and her care and treatment in custody are all matters which are already within the scope of the inquest.
68. The family has submitted statistical evidence that shows Aboriginal women in Victoria are 10.7 times more likely to be identified as an offender in 'behaviour in public' offences - *the broader context of overrepresentation, historical and social context suggests the potential role of systemic racism in* the decision to arrest and therefore forms a 'reasonable line of inquiry.' [25]
69. Inductive reasoning is used to argue that there is evidence of 'systemic racism' so that it should form a 'reasonable line of inquiry.'
70. Statistical data whilst suggestive, is not evidence of causation.
71. The family submission goes on to state:

    '*For so long as there is statistical disproportion in the overall <u>outcomes</u> of the exercise of police powers of arrest for public drunkenness, systemic racism is necessarily a causative*

[24] Family's submissions dated 29 March 2019 p 22
[25] Family's submissions dated 29 March 2019 p 18

factor, unless some other non-discriminatory basis can be identified to explain that disproportion.' [26]

72. I reject the inductive reasoning that concludes through analogy that because Aboriginal people are overrepresented in public order offences, as a result of systemic racism, Ms Day was necessarily charged with a public drunk offence *because* of systemic racism. It is similar to saying Ms Day's poor outcome in custody is consistent with the statistics which show the disproportionate effect of the law against public drunkenness, therefore her outcome was caused by systemic racism. It might be consistent with, but that does not necessarily make it causal.
73. I am of the view that the statistical data provided by the family provides a reasonable basis for me to assess whether direct or indirect racism played a role in determining the facts comprising the circumstances of Ms Day's death. I am assisted by the definitions which will allow me to analyse the evidence of witnesses and the policies and procedures of the individual interested parties.
74. Mr Nekvapil urged me to use this lens or '*glasses*' to assess the evidence, '*...to try and see whether this issue arises as a cause in this case.*' [27]
75. I am conscious of the challenges in assessing whether systemic racism was a causative factor, if as has been argued, it is not readily apparent from the witnesses or the policies and procedures of the organisations. How do I assess evidence through the forensic process that cannot be seen or heard, but somehow perceived? I note the family's submission that, '*It sits below the surface of consciousness and is very difficult for those of us who are not subjected to it to see close up on the facts of a particular case.*' [28] Whilst the statistical outcomes raised by the family have raised this as a valid consideration in the scope, as I have stated, that data is not proof of causation and the evidence heard at inquest will be assessed in the usual manner.
76. I will make that assessment of the evidence through the usual rigours of the forensic process, namely considering the evidence of the witnesses in this case together with any relevant policies, practice or training from the relevant organisations.

77. Rather than this broadening the investigation, this merely clarifies the way the evidence at inquest can be assessed.
78. I accept Dr Anthony's report provides contextual framework and definition for 'systemic racism' – and forms part of the material through which decisions and policies connected

[26] Family's submissions dated 29 March 2019 p 18
[27] Transcript p 37
[28] Transcript p 32

with Ms Day's death can be critically appraised. I do not accept her analysis of the facts of this case and will be making my own assessment as I consider the evidence. I note several of the submissions refer to errors in Dr Anthony's report. [29]

79. Framing the scope of the inquest in this manner will ensure I meet my obligations to pursue all reasonable lines of inquiry pursuant to section 67 of the Act, without straying into a policy review beyond the circumstances of this particular case.
80. I will consider the action and behaviour by the various people who interacted with Ms Day on 5 December 2017 and whether her indigenous heritage played a role in that treatment. I will also consider whether Charter obligations were complied with and the extent to which Ms Day's rights under the Charter were engaged and if they were infringed.
81. I will allow witnesses to be questioned as to whether racism played a part of their decision making, including Ms Day's treatment, options considered, their motivations and potential unintended effects of their decision making. I will allow the organisations which are interested parties to be asked to produce the policies, procedures and training relevant to those witnesses who will be called.
82. Statistical evidence has been provided to support the family's submission. However, it cannot have an evidentiary or causal role in the conclusions I reach in my consideration of the evidence.
83. Evidence in the coronial process is assessed on the balance of probabilities.
84. I find that interpreting section 67 in framing the scope to consider whether any type of racism played a causal part in Ms Day's death is compatible with the section 32 of the Charter requirement that the section be interpreted in a manner consistent with human rights.
85. An examination of the evidence in this way will ensure I discharge my functions consistently with the Act and Charter obligations.

Signature:

CAITLIN ENGLISH
ACTING STATE CORONER
Date: 25 June 2019

Coroners Court of Victoria

[29] Attorney-General v Copper Mines of Tasmania [2019] TASFC 4 recently affirmed the coroner's inquisitorial discretion regarding receipt of evidence.