SUBMISSION OF THE FEDERATION OF COMMUNITY LEGAL CENTRES (VIC.) INC

TO THE VICTORIAN PARLIAMENT LAW REFORM COMMITTEE'S DISCUSSION PAPER, *CORONERS ACT (VIC)* 1985

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This submission was prepared by Katerina Poulakis, Linda Roberts in consultation with members of the Corrections Working Group and individual member centres, on behalf of the Federation of Community Legal Centres (Vic).

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The Federation of Community Legal Centres

The Federation of Community Legal Centres Vic. Inc ('the Federation') is the peak body for forty-nine Community Legal Centres across Victoria, including both generalist and specialist centres. Community Legal Centres provide free legal advice, information, assistance, representation and community legal education to more than 60,000 Victorians each year. We also work on strategic research, casework, policy development and social and law reform activities.

Community Legal Centres have expertise in working with excluded and disadvantaged communities and people from culturally and linguistically diverse backgrounds. We operate within a community development framework. We provide a bridge between disadvantaged and marginalised communities and the justice system. We work with the communities of which we are a part. We listen, we learn, and we provide the infrastructure necessary for our communities' knowledge and experiences to be heard.

The Federation, as a peak body, facilitates collaboration across a diverse membership. Workers and volunteers throughout Victoria come together through working groups and other formal and informal networks to exchange ideas and strategise for change.

The day-to-day work of Community Legal Centres reflects a 30-year commitment to social justice, human rights, equity, democracy and community participation.

Community Legal Centres have a long history of representing families at Coronial Inquests. These have included inquests related to deaths of people in the custody of police, prisons, juvenile justice centres and detention centres, deaths as a result of fatal shootings by police and deaths of people whilst on statutory orders and the responsibility of government. This experience provides that basis for the comments in this submission that address some of the questions asked by the Committee.

Introduction

The Federation does not seek to respond to all of the questions raised in the Discussion Paper. Rather, the Federation seeks to highlight issues relevant to the *Coroners Act (Vic)* 1985 and the people and values we represent.

The Federation strongly believes that recommendations made by coroners need to be treated with more weight. Coronial recommendations need to be implemented though appropriate follow up measures being taken by relevant agencies. This change is imperative to ensure the efficient workings of the coronial system and to ensure a method by which further similar deaths can be prevented. Without such measures the *Coroners Act (Vic)* 1985 falls short of allowing the coroner to act as a body capable of preventing further unnecessary deaths. We argue this point with particular reference, but not limited to, deaths in custody and in care.

Further the Federation holds the concept of access to justice as being a paramount foundation of the justice system. It is particularly important for the people we represent, many of whom are in disadvantaged positions in terms of income and other factors, that strategies to ensure access to justice are developed and implemented. The *Coroners Act (Vic)* 1985 needs to be amended to reflect this. Measures need to be put in place to ensure that families and others involved in coronial inquests can access adequate legal representation and are kept informed of the proceedings during an inquest. Similarly, the *Coroners Act (Vic)* 1985 needs to be amended to accommodate the special needs of indigenous people as well as people with disabilities and mental health issues. The Victorian system, unlike other jurisdictions in Australia, has failed to take these factors into account often with dire results.

Our work in this area has highlighted many deficiencies within the Victorian Coronial system and this inquiry provides an ideal opportunity for these deficiencies to be rectified.

The Specifics of the Proposal

Chapter 2 – Reporting Deaths to the Coroner

Question 4: Deaths in care and custody
Do you think the current definitions in the Act of "deaths in custody" and "deaths in care" as categories of deaths reportable to a coroner are adequate or should the categories be extended in any way – for example, to include deaths of other vulnerable persons?

The Federation supports very broad definitions of persons "in care" and persons "in custody" to ensure that deaths of vulnerable persons in a very broad range of circumstances are classified as "reportable deaths".

In the interests of public accountability and scrutiny, all deaths that occur as a result of police action while being detained, even if the person is not under arrest at the time of the death, should be reportable deaths. This should include where the death is caused or contributed to by traumatic injuries sustained or by a lack of proper care whilst in custody or whilst attempting to escape custody. It should not be left to the discretion of doctors to determine the definition of "reportable deaths", using the Victorian Institute of Forensic Medicine advice to doctors. The Act should include this broad definition.

The definition of "in custody" should be extended to include people evading or escaping from custody. Recommendation 6(c) of the Royal Commission into Aboriginal Deaths in Custody (RCADC) extends the definition to at least include people who die while police or prison officers are attempting to detain them. Section 10 of the *Coroners Act (Qld)* 2003 provides a definition of in custody that is consistent with Recommendation 6 of RCADC to include escaping, or trying to escape, from custody and trying to avoid being put into custody.

Because of their particular vulnerability, the definition of "in care" should be extended to include special requirements for people with disabilities as per section 9 of the *Coroners Act (Qld)* (2003). A report by the Office of the Public Advocate concludes that:

> "…offenders with a cognitive disability, particularly an ID, are more likely to experience: abuse; exploitation and manipulation by more intelligent inmates; be in some type of physical danger at some point; trauma; social dislocation; misunderstand what is expected of them; harassment and sexual abuse."1

The definition of "deaths in care" should also be extended to cover deaths of people with psychiatric disabilities, to whom a duty extends beyond involuntary

[1] Oliver, S., & O'Brien, M. (2003) "From corrections to the community: The need for transitional support services for offenders with a cognitive disability" Office of the Public Advocate at 17

treatment for a period of 8 weeks. Similarly, the definition should cover a patient who is in a private psychiatric hospital, or facility other than those noted in s.3(1)(c) of the *Coroner's Act (Vic)* 1985.

The definition of "persons held in care" should be also enlarged to encompass person held in detention under the *Migration Act (Cth)* 1958, the *Fisheries Management Act (Cth)* 1991 and any other Commonwealth legislation that provides powers of detention.

Furthermore we believe that "immediately released from care" should at least be extended to one-month post release. This is because of the increased vulnerability of those recently released from custody, especially during the first month. The Victorian Department of Justice released a Stats Flash in 2003 that indicated:

> "Female ex-prisoners were 27 times more likely to die unnatural deaths than were females of the same age within the general Victorian population. Male ex-prisoners were approximately seven times more likely to die than males of the same age in the general Victorian population. Ex-prisoners were more likely to die as a result of homicide, accident and suicide… In addition, the rate of ex-prisoner unnatural deaths was approximately double the 1996 and 1997 rates of deaths in custody for Victoria. This is in spite of the fact that the deaths in custody figures include natural and unnatural deaths…Risk of unnatural death varied according to release time. The majority of unnatural deaths occurred soon after the deceased left custody. 9.4 % of the 820 unnatural deaths occurred within the first week of release, and 15.5 % within the first month. Thus, ex-prisoners were at greatest risk immediately following their release from prison." 2

Chapter 3 – Independent Death Investigation

Question 13 – Guidelines for Coroner's Investigations

a) Are there any issues or concerns in relation to the State Coroner's guidelines and investigation standards?

The Federation is concerned at the lack of readily available guidelines and investigation standards for deaths in custody. We support the view that this

[2] Stats Flash. (2003), 'Post-Prison Mortality: Unnatural death among those released from Victorian Prison between January 1990 and December 1999', Victorian Department of Justice. At http://www.justice.vic.gov.au/CA256902000FE154/Lookup/Justice_Statistics_Stats_Flash_Pdfs_2003/$file/121sh.pdf

"blunts the effectiveness of the coronial process as a reliable means of identifying risk factors and developing remedial strategies."[3]

We support the inclusion in legislation of similar provisions to that which exist in Queensland, which require that the state coroner to issue investigation guidelines that coroners are required to comply with. This would go some way to achieving consistently high standards across Victoria.

The Federation believes that to properly meet the complex needs of people with disabilities held in custody, guidelines should be implemented in Victoria that direct coroners to extend their investigation to the appropriateness of the detention as well as its legality. The reason for this is because:

> "Arguably the mentally disordered are being preferentially selected into the new prison populations. This could reflect a greater willingness to imprison certain groups of offenders among whom the mentally disordered are over represented (eg. public nuisance, social security fraud and repeat thefts). It could represent a breakdown in formal and informal diversionary programs aimed to move the mentally disordered away from the criminal justice system back into the mental health system. It could paradoxically reflect the use of certain non-custodial disposals, such as suspended sentences and supervision orders, which the mentally disordered are more likely to breach. It could reflect the increasing number of prison sentences handed down for drug related crimes to which the mentally disordered are more prone. It could reflect a shift in public or judicial attitudes to mental disorder as a mitigating factor when it comes to sentencing."[4]

Through a thorough investigation of deaths in custody that includes an examination of how the person came to be in prison and an assessment of the appropriateness of that imprisonment, the coroner would be able to assess shortcomings in community services that are placing people with disabilities at a greater risk of imprisonment and death.

(g) Should the Act specifically require coroners to have regard to the recommendations of the Royal Commission into Aboriginal deaths in Custody relating to the investigation of deaths in custody?

The Federation strongly believes that the Act should specifically require coroners to have regard to the recommendations of the RCADC, relating to the investigation of deaths in custody. As was stated by the Australian Institute of Criminology (AIC), these recommendations provide a framework and appropriate

[3] Halstead, B (1995) "Australian Deaths in Custody: No 10 Coroners' recommendations and the prevention of deaths in custody: A Victorian case study" at p2

[4] Mullen. P (2001) "Mental Health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services prepared for the criminology resource council"

guidance on acceptable standards of general custodial health and safety, and a useful comprehensive accountability structure, which can minimise the risk of threats to the integrity of the coronial process, such as conflicts of interest, narrow legal focus and inexperience in deaths in custody matters. (AIC, p.17)

Question 14: Police Assistance with coroners' investigations

a) Should coroners have the power to require investigating police officers to report directly to coroners and to issue directions to police officers concerning investigations, as recommended by the Royal Commission into Aboriginal Deaths in Custody in 1991?

The Federation believes that the *Coroners Act (Vic)* 1985 should give specific powers to coroners, like in other jurisdictions to enable coroners to direct police in their conduct of investigations. The Federation supports the implementation of RCADC recommendation 29 whereby the coroner is given the power to require the officer in charge of the police investigation to report to the coroner and comply with directions given by the coroner about the progress of the investigation. This would ensure that the coroner is in a position where they are in control of the investigation.

Moreover, RCADC Recommendations 26, 27, 28, 30 and 31 should be implemented as they all emphasise the need for a solicitor or barrister to be appointed within 48 hours of a death to ensure that "all relevant evidence is brought to the attention of the coroner and appropriately tested" (Rec. 28); and that person "should have responsibility for reviewing the conduct of the investigation and advising the coroner as to the progress of the investigation" (Rec. 30). This does not occur in Victoria, and counsel are appointed only to assist the coroner during the inquest to ensure that relevant matters are raised then. In police shootings cases, barristers have been appointed at an earlier stage in recent years. Barristers may "raise defects or other matters which are then investigated prior to and during the inquest by the Victoria Police" (Victoria 1994, p. 66). In view of the fact that there is usually a delay of around nine months between a death in custody and the time of inquest (sometimes years elapse), the scope to remedy deficiencies in the investigation of a death after such a long period of time would be dramatically reduced. Indeed, it is highly likely that any person who became involved in a case at such a late stage would have a very limited awareness of any possible deficiencies, particularly if such curiosity is not welcomed by the agency under scrutiny.

Whether or not a barrister would have any more skills in preventative investigation than police officers is a moot point. At least such an individual would be able to provide independent guidance on the conduct of police investigations when potential conflicts of interest arise, as they do in deaths in police custody cases.

The inquest into the deaths of five prisoners in a fire at Pentridge Prison in 1989 and the subsequent Murray Report (1990) which reported on alleged corruption within the Victorian Office of Corrections testifies to the reality of an agency attempting to conceal evidence from the coroner, and the scope for attempted regulatory capture of the coroner by agencies under investigation. Many lessons were learned from this case.

Nevertheless, no matter how comprehensive such internal processes are, structural relationships between the coroner and other agencies would ideally ensure independent investigation of all deaths, to avoid real or perceived conflicts of interest in the information gathering process. Of course the extent to which this can actually occur is dependent upon available resources. [5]

We also support the implementation of the following RCADC recommendations:

> **Recommendation 32:** That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank.
>
> **Recommendation 33:** That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.
>
> **Recommendation 34:** That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer.

b) In your opinion, are there any kinds of coronial investigations where it is not appropriate for the investigations to be undertaken by police officers? What alternatives could be considered? Are there any resource issues to consider?

The Federation does not believe that it is appropriate for police officers to undertake coronial investigations where there has been a death in police custody. In such cases there is a potential conflict of interest and a perception of bias.

[5] Halstead, B (1995) "Australian Deaths in Custody: No 10 Coroners' recommendations and the prevention of deaths in custody: A Victorian case study" at p5

The conflict of interest is not assisted by the fact that the same police officers conduct investigations on behalf of both the Victoria Police and the State Coroner simultaneously. It would appear that there is no legal obstacle in Victoria to the coroner choosing not to use police officers, and that the present convention has arisen because of custom and the fact that police officers have access to resources, such as forensic photographers and specialist forensic equipment, which are not readily available elsewhere.

Question 16: Other assistance with coroner's investigations

a) Do coroners currently use other kinds of investigators? Are there any resource issues associated with using investigators?

The Federation is aware of coroners using specialists to gain a better understanding on the cause of death ie: expert in car crash logistics. We are concerned that the question of resources should not be used to prevent the use of such experts where they will achieve a better outcome from the coronial process.

b) Do you think that certain kinds of investigators should be appointed under the Act? What duties and obligations do you think this kind of investigator should have?

The Federation supports the appointment of experts to particular types of coronial investigations, in particular those dealing with deaths in custody. Such experts could be academics or others with knowledge and an in depth understanding of the experience of custody.

Question 17: Mandatory Inquests

a) Are there any issues or concerns with the current category of deaths in which an inquest is mandatory?

The Federation supports a very broad definition of persons "held in care" as outlined in question 4, to ensure that all such deaths culminate in a formal inquest conducted by the coroner into the circumstances of the death. As per RCADC recommendation 11, "unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings." This is to ensure that a formal inquest is held into the deaths of a very broad range of vulnerable persons.

In addition to that outlined in question 4, the definition of "held in care" should also extend to people with a psychiatric disorder who are:

- In voluntary (informal) detention;
- On leave from a psychiatric hospital; and

- In a private psychiatric hospital.

b) Should the current category of mandatory inquests be extended?

In addition to that outlined above, the Federation supports the extension of the current categories of mandatory inquests to ensure implementation of the RCADC Recommendation 6. Recommendation 6 provides that for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:

> a. The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;
>
> b. The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention;
>
> c. The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
>
> d. The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Question 19: Coroner's discretion not to hold, continue or recommence an inquest

a) Do you think that there are certain circumstances where it would be mandatory not to hold, continue or recommence an inquest?

b) Are there any issues or concerns regarding the way coroners currently exercise their discretion not to hold, continue or recommence an inquest?

c) Do you think the Act should indicate what factors a coroner should consider when exercising this discretion?

d) In your opinion, what factors should a coroner consider?

The Federation does not support the Coroner having a discretionary power to dispense with holding an inquest where a death "of a person held in care"[6] may have occurred.

The Federation supports the continuation of the Coroner's power to order a multiple death inquest.

[6] section 17(1)(b), *Coroners Act (Vic)* 1985

Chapter 5 –Coroner's Role in Injury and Death Prevention

Question 27: Systems for identifying similar kinds of deaths

a) How effective are the current systems for identifying similar kinds of death, such as the National Coroners Information System?

b) Are there any resource issues in relation to the National Coroners Information System?

c) Do all coroners use the system when investigation deaths to establish whether there are also similar kinds of deaths to the death which they are investigating?

The Federation supports the use of a database as an essential tool to assist coroners with their work.

> "The database provides coroners with information about deaths occurring in other parts of the country. It allows coroners to identify patterns in preventable deaths which, on the basis of the limited information within an individual coroner's jurisdiction, might otherwise go unnoticed. The database also reduces repetition of work. For example, one coroner might not hold an inquest into a particular type of death if s/he knows that a coroner in another state has already investigated that type of death in detail and that the lessons in terms of death prevention have already been learned."[7]

The Federation notes the following concerns that have been raised with NCIS:

- NCIS has had teething problems.
- Wrong codes have been applied to variables, so results are not entirely accurate.
- Short comings relating to analyse of suicides involving drugs – no codes relating to specific drugs used.
- Topics for general overview of injury surveillance do not include deaths in custody.
- Proper authorisation is required in order to access the database. Does a legal practitioner fit into the category of authorise bodies?
- NCIS does not include: transcripts of inquests, photographic evidence or statements by witnesses.[8]
- How effective is the data collected when the definition of 'reportable deaths' differs from jurisdiction?

In order that the database is used to its full extent, the Federation supports comprehensive training for coroners about the database and the development of mandatory guidelines about its use. The Federation also supports the database

[7] http://www.the-shipman-inquiry.org.uk/tr_page.asp?p=1&id=239

[8] http://www.nisu.flinders.edu.au/pubs/reports/2003/injcat60.pdf.

being made available online to parties involved in an inquest and more generally to the public for research purposes.

Other issues with identification of patterns
The current requirements for reporting deaths are satisfied if the death is reported to a local coroner or to an officer in charge of a police station: *Section 13(1)*. The coroner or officer in charge of a police station must then inform the State Coroner 'as soon as possible': *Section 13(2)*. The practicalities of using NCIS or identifying patterns are complicated where a local coroner does not have adequate facilities and local coroners and police officers do not have the requisite expertise in the area.

> "Once a death has been reported to the coroner, investigations are undertaken by the police, acting as agents of the coroner. A small team of five police officers is seconded to the State Coroner's Office in Melbourne. Those officers oversee investigations carried out by the local police force. They also carry out investigations into particular types of death which require specific expertise and knowledge. For example, they might investigate a small plane crash or scuba diving accident. Outside Melbourne, coroners are entirely dependent on local police officers to investigate deaths."[9]

The Federation believes that this is inadequate as it is too reliant on local resources.

The fact that the requirement to "report" deaths (*Section 13*) is satisfied merely by reporting the death to a local coroner or person in charge of a police station, can hinder possibilities for identifying patterns/similar deaths because of a lack of local resources and expertise. Until these issues are addressed, the Federation supports the requirement that all mandatory deaths be reported to the State Coroner.

Question 28: Implementing RCADC recommendations
Do you have any comments regarding the implementation of the 1991 RCADC recommendations relating to coronial investigations?

RCADC outlined the importance of the implementation of certain recommendations made by coroners in relation to the prevention of deaths in custody and well as the accountability and transparency of these recommendations. However, many of the recommendations of RCADC have not been followed[10]. For example, Recommendations 125 and 126 recommended that checklists be introduced to analyse a prisoner's behaviour for suggestions of

[9] http://www.the-shipman-inquiry.org.uk/tr_page.asp?p=1&id=239
[10] Halstead, Boronia, 'Coroners' recommendations following deaths in custody' in Selby, Hugh (ed), *The inquest handbook*, The Federation Press, Leichhardt NSW, 1998 at 186

suicidal ideas, drug dependence and so on before placing the prisoner in a police cell. However, in a case study on deaths in custody by alcohol related deaths between the years 1990 and 1994, its appears that the medical checklist was not being applied.[11] Similar shortcomings can also be seen in the recommendations relating to inspections of 'at risk' prisoners; hanging points in police cells and so on.

Further, the Federation strongly supports the implementation of the RCADC recommendations.

> Recommendation 6: That for the purposes of all recommendations relating to post death investigations the definition of deaths should include at least the following categories
>
> a. The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile
> b. The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention
> c. The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
> d. The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

The Federation supports the implementation of Recommendation 6 because of the protection it would provide for people with a disability. Recommendations 6c and 6d should be implemented using similar requirements as exist in Queensland, as discussed above in our response to question 4.

> Recommendation 8: That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to coroners appointed to conduct inquiries and inquests

We support this recommendation and refer to our response in Question 13 that outlines the need for Coronial Guidelines, especially for deaths in custody.

> Recommendation 12: That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.

[11] Halstead at 194

The Federation supports the implementation of this recommendation, in particular because of the benefits it will bring for people with a disability.

Quality and appropriateness of care is an issue for prisoners with a disability. A client of one of our member centres, the Disability Discrimination Legal Service, received substandard care and suffered from discrimination within the prison system when his medical condition was not properly accounted. As a result he suffered severe physical pain and was denied medical attention for extended periods of time.

Inadequacies with screening new prisoners upon reception into the system can affect the quality and standard of care available to prisoners with disabilities and place them at greater risk of suffering serious injury, which in extreme cases may result in death.

> "It is essential that upon entering the prison system that the offender with a cognitive disability is correctly identified in order to adequately respond to both the needs of the offender and the needs of the system. This refers to ensuring appropriate service provision for the offender, and encouraging an awareness within the prison system of the issues surrounding offenders with a cognitive disability"[12]

Corrections Victoria has a limited understanding of the prevalence of cognitive disability within its system[13] because of the inadequacies of intake screening processes. It is not possible for people with a disability to be getting appropriate care and treatment if they are not being recognised and appropriately referred on reception.

Extending beyond intake processes there are other "…distinct service gaps that are placing increasing strain on prison infrastructure, management and services and undermining positive rehabilitation outcomes for prisoners and offenders with disabilities. Significant gaps exist, for example in relation to:

a. The identification and service provision to offenders with a borderline intellectual disability
b. Adequate staff training
c. Identification and/or services to remanded prisoners with a disability
d. Offenders with age-related impairments such as dementia
e. Koori offenders with a disability."[14]

[12] Oliver, S., & O'Brien, M. (2003) "From corrections to the community: The need for transitional support services for offenders with a cognitive disability" Office of the Public Advocate at p16.
[13] Oliver, S., & O'Brien, M. (2003) "From corrections to the community: The need for transitional support services for offenders with a cognitive disability" Office of the Public Advocate at p16.
[14] Corrections Victoria, 'Corrections Disability Framework: Project Mandate' (2004) at p5

f. Identification and service provision to offenders with a psychiatric disability/psychiatric disorder.

These service gaps make it impossible for prisoners with particular needs to receive adequate care, treatment and supervision, which increase their vulnerability to injury and possibly fatal incidents while in custody. It is not just those with intellectual disabilities that are not being properly screened for:

> "There is also a likelihood of significant prevalence rates of acquired brain injury and hearing impairment, [that are] not screened for, nor recorded systematically in Victoria…A NSW (1999) study on hearing loss amongst prisoners found significantly higher rates of hearing loss amongst this population compared with the general community, and higher again for Indigenous prisoners"[15]

This lack of screening for physical impairments increases the risk of these people suffering from discrimination and not receiving appropriate care. These people then become vulnerable to sustaining fatal injuries.

If a Coroner was required to investigate not only the cause of death, but also the quality of the care, systemic problems could be addressed and recommendations could be made to improve the system to ensure appropriate care, treatment and supervision for all prisoners, reducing the likelihood of them suffering serious injury or even death whilst in custody.

Furthermore, the Federation strongly supports the implementation of RCADC recommendations 13-23 that:

- require a Coroner inquiring into a death in custody to make recommendations;
- require recommendations to be provided to relevant parties;
- require relevant parties to act upon the recommendations; and
- empowers the Coroner to take action to ensure that recommendations are acted upon.

[15] Corrections Victoria, 'Corrections Disability Framework: Project Mandate' (2004) in Appendix 1.

Question 29: The Coroner's role in death and injury prevention.

(a) How effective do you think the current system is in preventing death and injury?

In Australia, as well as many other common law countries, recommendations made by coroners are not enforceable.[16] This severely limits the effectiveness of the current system in preventing death and injury.

Currently, in Victoria, the Coroner only has the power to make recommendations. Under section 19 of the *Coroners Act (Vic)* 1985*,* the coroner can make comments on any matter connected with the death including public health or safety or the administration of justice. Pursuant to section 21(2) of the Act, a coroner has discretionary power to make recommendations to the Attorney-General on any matter connected with a death which the coroner has investigated, including public health or safety or the administration of justice. However, these are not compulsory powers, they are performed at the discretion of the Coroner.

Also, coronial recommendations are not given the status of findings of a judge and there are no penalties for the non-compliance or implementation of recommendations. Moreover, the coroner has no power to administer the execution of recommendations and the procedures for the Attorney-General to implement the recommendations are not outlined in the Act. This should be remedied.

By making coronial recommendations optional when in fact it's the recommendations themselves that are central to death prevention we are concerned that the Victorian system is putting the focus on blame rather than prevention.

(b) Do you think that the preventative role of the Coroner should be expanded in any way? Should the preventative role of a coroner be a specific function of the Act?

The Federation strongly supports an expanded preventative role of the Coroner specifically established under the Act. By highlighting the importance of the coroner's preventative role this may push coroner's to make more recommendations when the situation warrants them. For example, in the coronial inquest of a prisoner who committed suicide in the shower recess in the cells at Oakleigh Police Station by using torn up segments of a blanket, no recommendations were made on the issue of hanging points.

In the Northern Territory, '[w]here a Northern Territory coroner holds an inquest into the death of a person held in custody or who dies as a result of injuries

[16] Australian Deaths in Custody: http://www.aic.gov.au/publications/dic/dic10.pdf

caused or contributed to while in custody, the coroner is obliged to proffer recommendations with respect to the prevention of future deaths in similar circumstances.[17] The Federation submits that a similar system could be adopted in Victoria.

(c) Should the Act require a mandatory response to certain coronial recommendations? Should the State government be required to provide a written response to certain coronial recommendations within a specified timeframe? Should responses to recommendations be required to be tabled in Parliament?

The Federation believes that certain coronial recommendations, with particular focus on the issue of the prevention of deaths in custody, should be followed up and accounted for. We support the comments of others in this field, that "not enough advantage is taken of the opportunity to learn preventive lessons from investigations into deaths in custody, and this deficit is reflected in the lack of appropriate recommendations overall."[18] A mandatory response to coronial recommendations will ensure that the Act is fulfilling its goals with respect to the "distillation of the preventive potential of the coronial process. The action taken in response to such recommendations carries the promise of lives saved and injury averted."[19]

Requiring a response back from the relevant agency on action taken with regards to the recommendation "has major repercussions in terms of rendering the coroner into an entity with the capacity to have a substantial impact on reducing their incidence of avoidable death and injury." (Alt Law Journal, "Coronial Law")

The Federation supports the adoption of a system similar to that outlined in recommendation 15 of RCADC "That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person." The implementation of this recommendation will improve injury and death prevention in Victoria.

Alternatively the system which is legislated for in the ACT provides a useful model. Pursuant to section 75 of the *Coroners Act (ACT)* 1997 "a coroner is obliged to report a record of his or her finding in relation to a death in custody to the Attorney-General, the custodial agency where the death occurred, the

[17] *Coroners Act 1993 (NT), s26(2)*." (Alt Law Journal, "Coronial Law")
[18] Halstead at 205
[19] Halstead at 187

Minister responsible for the Agency, the Australian Institute of Criminology, and, if the deceased was Aboriginal person or a Torres Strait Islander, to an appropriate aboriginal legal service. The custodial agency to which the report is given has to respond within three months in writing to the relevant Minister: s.76(1). In its response, it is obliged to incorporate a statement of the action (if any) which has been, or is being, taken with respect to any of the findings contained in the report.

A potential problem we can foresee with the higher level of accountability with regard to implementing recommendations is that large organisations and government bodies will appeal inquests to the Supreme Court if recommendations can affect their practice. It is often the large organisations and government bodies that have the resources to be able to appeal these legal battles at the expense of the victim's families who usually lack the funds to be able to pursue such legal proceedings. If this occurs, resources need to be allocated to ensure that families involved in such proceedings are represented in such an appeal.

(d) Should anyone be responsible for monitoring the implementation of coroner's recommendations? Who do you think should be responsible?

It is difficult to measure whether or not coronial recommendations are being implemented because there is no formal process by which this is assessed. It is crucial to ensuring prevention that there be an open, transparent and accountable review process in respect of recommendations. By enacting a central body by which overlooks the implementation this task would be made easier.

Alternatively, the coroner could be made the person responsible of overseeing implementation as they will already have been involved in the investigation and be familiar of the facts of the situation. Coroners could make reports to Parliament, as with the Child Death inquiries.

(e) What are your views on alternative systems such as the Ontario system? Do you think this kind of system would be effective in Victoria?

In other jurisdictions such as Ontario, Canada, there are processes in operation for the implementation of recommendations made by coroners. Organisations which are subject to coronial recommendations enter into a **coronial agreement**. These agreements ensure that that the recommendations are implemented and fulfilled. We support the adoption of similar measures in Victoria to ensure effective application of recommendations.

Juries sit on all inquests in Ontario and are responsible for reaching a verdict and making recommendations in the light of the evidence and submissions from interested parties. In many cases, the submissions will include suggested recommendations, which can be adopted in full or in part and supplemented by the juries' own recommendations. The coroner then produces a letter of explanation, setting out the circumstances of death, the procedural history of the inquest, his/her interpretation of the significant parts of the evidence and the jury's rationale for making each of its recommendations. The letter is intended to supplement, not replace, the verdict of the jury.[20] A system involving juries might assist in educating the broader public about the important role of the coroner and lead to greater community involvement in the prevention of deaths.

Chapter 6 – Including the Family in the Coroner's Process

Question 32 – Right to be informed

(a) Should the Act give family members the right to be informed or to be kept informed of certain events in relation to the inquiry?

The Federation supports significantly improved processes to ensure that family members are kept informed of coronial processes. The *Coroners Act (Vic)* 1985 should require that the family be kept informed throughout the proceedings of the inquest. It is paramount that families know and understand the events that occur during an inquest. Families are generally in a disadvantaged position during a coronial inquest due to the lack of opportunity for input. It should be the responsibility of the Act to ensure that families are kept informed of inquest proceedings.

We support the implementation of the recommendations of RCADC in this respect:

> Recommendation 21:
> That the deceased's family or other nominated person and the Aboriginal Legal Service be advised as soon as possible and, in any event, in adequate time, as to the date and time of the coronial inquest.
>
> Recommendation 22:
> That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family's intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family.

[20] http://www.the-shipman-inquiry.org.uk/tr_page.asp?ID=240

(b) Should the Act define the term 'family member'? Who should be included in the definition?

The Act should have a very broad definition of "family member" that includes carers and other interested parties. This is particularly important where the deceased may have had a psychiatric disability as often there are tensions and unresolved issues of conflict between a person with a psychiatric disability and their carers or family. In such cases people with independent experience and knowledge and who can provide insight into the life of the deceased may be appropriate.

(c) Who should be required to inform the family? Should anyone be responsible for ensuring that this occurs?

The Federation believes that it is important for the family, carers or interested persons of the deceased to be properly informed of the happenings during an inquest. We support the implementation of the relevant RCADC recommendation:

> Recommendation 22
> That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family's intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family.

Question 35 – Accessing information

(a) Are there any issues or concerns regarding the requirement in the Act that a coroner may make available any statements that the Coroner intends to consider at an inquest to 'any person with a sufficient interest'?

Information needs to be provided to parties involved in the matter in a timely manner to ensure that parties have sufficient time to consider the information, prior to the formal inquest.

(b) Should the Act specify that family members should be able to access statements and other information as soon as it becomes available?

The Federation supports the implementation of the relevant RCADC recommendations.

> Recommendation 24:
> That unless the State Coroner or a Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroners Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death

> Recommendation 25:
> That unless the State Coroner, or a Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.

Question 42 – Right to legal representation
Do you have any issues or concerns in relation to the right to legal representation at an inquest?

The Federation believes that it is a fundamental right of all parties involved in an inquest to have legal representation. A lack of means should not be a reason for lack of representation.

Victorian Legal Aid (VLA) guidelines should be broadened and community legal centres should be able to access a specific pool of funds to provide legal representation for families at inquests. Such legal aid funding should allow for legal representation that is commensurate with the resources available to institutional and commercial interested parties.

Lack of legal representation at coronial inquests has far reaching ramifications for the families of the deceased. At the moment VLA guidelines grant assistance for coroner's inquests where there is a reasonable likelihood that the applicant will be charged with a serious offence and where it is in the public interest for the

applicant to be represented. We submit that these guidelines should be expanded to provide legal assistance in situations where a mandatory inquest has arisen and to appeal cases as well.

The family (broadly defined) of the deceased should be entitled to legal representation at the inquest and the government should pay the reasonable costs of such representation through legal aid schemes or otherwise. The coronial process is complicated and often drawn out with multiple parties involved. Family members unable to access legal aid can often not afford to fund private representation. Problems arise with regards to inquest outcomes for the family when such parties have no legal representation. Certain critical issues which will have a strong bearing on the outcome of the inquest may not be raised or deliberated on when a party is representing themselves. This in turn has ramifications on any further possible legal action being taken by the family in relation to the matter as the findings during inquest will be relevant to the further action.

Question 45 – Functions of the Coroners Act
Should accommodating the needs of families be a specific function of the Act?

The Federation believes that accommodating the needs of families should be a specific function of the Act. The inquest is often the only forum where families have a voice in regards to the death of their family member. As stated above the definition of families should be broad and extend to carers and other interested person.

It should be a strict requirement that families, and not the media, get the first news regarding the deceased.

There should be a duty on the Coroner's Office to inform families of the free counselling service.

We support the implementation of the relevant RCADC recommendations:

> Recommendation 4
> That if and where claims are made in respect of the deaths based on the findings of Commissioners governments should, whenever appropriate, make the effort to settle claims by negotiation so as to avoid further distress to families by litigation.
>
> Recommendation 5
> That governments, recognising the trauma and pain suffered by relatives, kin and friends of those who died in custody, give sympathetic support to requests to provide funds or services to enable counselling to be offered to these people.