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

IN RESPONSE TO THE VICTORIAN PARLIAMENT LAW REFORM COMMITTEE

CORONERS ACT 1985 - FINAL REPORT+

December 2006

This submission was prepared for the Federation of Community Legal Centres (Vic) by students at Springvale Monash Legal Service in consultation with individual member community legal centres including Brimbank Melton Community Legal Centre, Darebin Community Legal Centre, Disability Discrimination Legal Service, Mental Health Legal Centre and Victorian Aboriginal Legal Service

Inquiries to Sarah Nicholson, Policy Officer, Federation of Community Legal Centres (Vic) on 9654 2204 or Sarah_Nicholson@clc.net.au

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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 fifty-two 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 welcomes the Victorian Parliament Law Reform Committee's *Coroners Act 1985 - Final Report*. The report contains a comprehensive set of recommendations that will assist to address deficiencies and improve the coronial system in Victoria.

The Federation has an interest in particular recommendations in the Final Report that are relevant to the issues we deal with and the people and values we represent. This submission seeks to highlight these recommendations.

The Federation looks forward to working with the government and stakeholders in the coronial system to see implementation of the Final Report.

Response to specific recommendations

Recommendation 12

We welcome the establishment of a computerised auditing system by the Victorian Institute of Forensic Medicine. A computerised auditing system can be used to analyse trends and patterns of unusual death rates amongst vulnerable groups, and provide a means of discovering the reasons and causes of these deaths, with a view to implementing preventative measures in the future. The increased vulnerability of recently released prisoners due to personal, familial or financial reasons could be adequately addressed if this system is appropriately used.

Recommendation 19

We welcome the extension of the definition of 'death in custody' to include deaths occurring in the process of escaping or attempting to escape from custody, or trying to avoid being taken into custody.

The recommendation makes allowance for deaths of vulnerable people in custody to include deaths of people with disabilities.

It also supports RCADC Recommendation 6, that investigations into deaths in relation to custody or detention be extended to include the above scenarios to make allowance for the types of death that 'people with mental impairments are at a greater risk of'.

Recommendation 20

The extension of the definition 'in care' will benefit Indigenous Australians in light of the over-representation of Indigenous Australians in the criminal justice and child protection systems.

Recommendation 24

We support this recommendation that would see the development and implementation of guidelines to cover deaths of people recently released from prison. Post release prisoners, particularly those with mental health problems and substance abuse problems are particularly vulnerable and are over-represented in post release unusual deaths including, homicides, accidents and suicides. This recommendation provides that a person is considered recently released for up to 12 months following their release from custody. This may go towards addressing concerns regarding the effectiveness of current community

based strategies for the prevention of unusual deaths having a limited impact on post release prisoners. It may also provide valuable information for those working to prevent unnatural deaths, particularly in relation to recently released prisoners, to implement strategies and policies that may reduce the incidence of unnatural deaths within the vulnerable classes of persons identified.

The investigation within 72 hours of death where that person has been released from custody within the preceding 12 months, will benefit Indigenous Australians in light of the over-representation of Indigenous Australians in the criminal justice and child protection systems.

Recommendation 26

The appointment of a lawyer or other appropriately qualified person to assist a coronial investigation and inquest into a death in custody is important given that according to the State Coroner in response to the Victorian Implementation Review of the RCIADIC, the RCIADIC Recommendation is generally not practiced.[1]

Recommendation 43

We welcome this recommendation which provides that a coroner holding an investigation into a death in custody, a police-related death or a death of an on-duty police officer, must appoint a lawyer or other appropriately qualified person to assist at an early stage of the investigation and at an inquest and that the State Government provide funding for this.

Currently, a coroner is advised primarily by police officers following a fatal police shooting. This reduces the impartiality of proceedings, and potentially reduces the integrity of any recommendations or findings.

Recommendation 46

We welcome recommendation 46 which says that in preparing guidelines, the State Coroner must have regard to recommendations made by the RCADC that relate to the investigations of deaths in custody. The potential incorporation of recommendation 12 (RCADC) into the Act via recommendation 46 is a positive development to improve the overall quality of care for prisoners with disabilities. If the Coroner is required to investigate the cause of death, as well as the quality of care prior to death, wider systemic issues within the corrections system may be improved.

[1] Victorian Parliament Law Reform Committee 'Coroners Act 1985 Final Report' September 2006, p.208

Recommendation 54

We welcome the recommendation that the present categories of death investigations which attract mandatory inquests under the Coroners Act 1958 be retained (including where it appears the death was due to natural causes)[2] and note that it is in line with the RCIADIC. We also agree with Professor Stephen Cordner that not investigating natural deaths in custody is a direct contradiction of recommendations 11 and 12 of the RCIADIC and the statement that "[f]or those who die in custody from whatever cause there will be at least one relative who thinks the person was murdered".[3]

Recommendation 70

We welcome the recommendation that the Coroners Act be amended to provide that a purpose of the Act is to help to prevent deaths or fires in similar circumstances happening in the future by allowing coroners to comment and make recommendations on matters connected with deaths or fires, including matters related to public health and safety or the administration of justice, and note that it is in line with recommendation 18 of the RCIADIC regarding prevention.

Recommendation 73

We welcome the recommendation that the rules governing access to the NCIS database be reviewed and consideration be given to whether access can be made more widely available. We submit that the database should be made available to the public.

Recommendation 74

We welcome the recommendation that a research unit be established within the Coronial Services Centre with the capacity to properly utilise the NCIS database, to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation. We submit that the identification of deaths requiring further investigation should not be limited to new data on NCIS but should be carried out on old findings. This could be done by the same research unit or through the employment of other officers/researchers.

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[2] Op cit 236
[3] Op cit 237

We also submit that there should be a clear process whereby specialist groups can either be nominated or nominate themselves if they have information or expertise relevant to prevention of further deaths related to the particular inquest.

Recommendation 77

We welcome recommendation 77, which proposes amendments to section 19 of the Coroners Act to ensure that whenever appropriate, the Coroner must make recommendations with respect to ways of preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.

Broadly speaking, such an amendment will ensure that the preventative role of the Coroner is strengthened under the Act. We believe it will ensure that prisoners with disabilities are protected from future deaths in similar circumstances. The effectiveness of such a provision however, will be determined by the interpretation of the words 'whenever appropriate'. This recommendation could be strengthened by deleting the words 'whenever appropriate'. Alternatively, 'whenever appropriate' should be given a broad interpretation.

We submit that the death and injury prevention role of the Coroner is currently being underutilized. The prison system as a whole, and prisoners with a disability would benefit from having the Coroner take a more "preventative" role. Death and injury prevention should be included as a function of the Act to accommodate this cultural shift in the actual and perceived role of the Coroner. The power of coroners to make recommendations needs to be further encouraged, especially if patterns in fatalities are evident.

Recommendation 78-79

We welcome these recommendations requiring the preparation of detailed guidelines and the provision of further training for coroners in relation to the formulation of recommendations.

We also submit that, before recommendations are actually formulated by the coroner, it is important to provide coroners with appropriate resources to enable them to identify patterns and trends in deaths requiring further investigation. Many coroners are not currently au fait with NCIS.

Recommendation 81

We welcome recommendation 81 which requires all coronial recommendations to be approved by the State Coroner and to be made available to the public.

Recommendation 82-85

We welcome the requirement of mandatory responses to coronial recommendations as they will ensure that a coroner's power to make recommendations is taken seriously by the agencies or individuals to which the recommendations apply.

We welcome a provision requiring the agency/individual to respond to the recommendation(s), in writing and within a particular timeframe, where the recommendations are relevant to the operation and/or practice of an individual or agency, however, we submit that the time-frame 'within six calendar months' should be 'within three calendar months', reflecting RCIADIC recommendations.

We submit that the written response to the recommendation should be reported to the relevant Minister who would then report to the Coroner, reflecting RCIADIC recommendations.

The improved monitoring of responses to coronial recommendations will ensure that where a coroner does make recommendations, there is public scrutiny and accountability on behalf of the agency or individual to which the recommendations were made.

We uphold the notion of therapeutic jurisprudence and public interest standing at inquests.

Recommendation 85

We welcome the recommendation that the Coroners Act be amended to require a summary of all coronial investigations in which recommendations have been made and a summary of responses to the recommendations made in the previous year, including those awaiting implementation or responses. We submit that there is a need to identify how readily the recommendations are adopted or implemented, and the impacts of such recommendations.

Recommendation 86

We welcome the development of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners. We submit that it would be beneficial for the recommendations to be published on a well-indexed public internet site.

Recommendation 91 and 93

The amended definition of 'senior next of kin' in Recommendation 91 and referred to in Recommendation 93, is welcomed as it is inclusive of an Aboriginal concept of next of kin in subsection (f): a person who had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the person who has died.

We submit that this recommendation could be improved by providing the State Coroner with adequate training to deal with cases that involve a collective nature of decision making in a sensitive manner (ie: cultural sensitivity).[4]

Recommendation 99

Whilst we welcome this recommendation which is modelled on Western Australian legislation, as it will benefit Indigenous Australians in light of the over-representation of Indigenous Australians in the criminal justice and child protection systems, we submit that it should also include learnings from s 69 of the Coroners Act 1997 (ACT), such as:

A requirement to notify the local Aboriginal legal service if the deceased is an Aboriginal person.[5]

The satisfaction of the Coroner that reasonable efforts have been made to notify the relevant people.

Recommendation 102

Recommendation 102 which requires the Coroner's Office to initiate a formal consultation process with VALS to develop a protocol for the resolution of questions involving the conduct of inquires and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased, is positive and is in line with RCIADIC 8, however, we note that such a consultation process has not happened to date.

Recommendation 102 should not only require that the State Coroner's office initiate a formal consultation process with VALS, but also with the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). This would bring Recommendation 102 in line with the RCIADIC Implementation Review Recommendation 99.

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[4] Op cit 445
[5] Op cit 475

Recommendation 103

We welcome this recommendation requiring a staff member of the Coroner's office to be designated to act as a cultural liaison officer, as it will benefit Indigenous Australians.

Recommendation 107

We welcome this recommendation requiring a coroner to allow a doctor chosen by the senior next of kin to be present at a post-mortem examination, which is in line with Recommendation 25 of the RCIADIC.

Recommendation 112

We submit that rather than follow Aboriginal Affairs Victoria protocol, this recommendation should follow the Tasmanian approach which requires the Coroner to refer to an Aboriginal organisation, any matter in which it is suspected that the human remains relating to that death may be Aboriginal remains. [6]

Recommendation 113

We welcome this recommendation which expands VCAT's telephone service by providing after-hours legal advice for next of kin on how to object to an autopsy. We submit that the legal advice should be culturally sensitive and that funding for legal advice should not detract from assistance in other areas of the law.

Recommendation 114

We welcome this recommendation but note that there is no explicit recommendation that the legal information kit be made available in accessible formats for people with disabilities. Downloadable formats may be suitable for vision impaired people with screen reading technologies. We submit that the document should be provided in other formats such as audio, Braille and also in simple language and/or basic English. The kit should also be made available in an accessible format for Indigenous Australians.

Recommendation 115

We strongly welcome this recommendation that tasks the government with investigating the feasibility of providing legal advice and assistance to families

[6] *Coroners Act 1995* (Tas), s.23

affected by a coronial investigation where this is necessary to enable them to effectively participate in the investigation. The Federation welcomes the opportunity to be involved in such an investigation. We remain concerned that the current system provides only limited access to legal representation at inquests for families and other interested parties. Until this is rectified, the coronial process will not be as effective at examining all of the circumstances surrounding a death or at providing access to justice for families.