



**public interest**  
ADVOCACY CENTRE LTD

**Augmenting the role of the Coroner to enhance  
suicide prevention:**

**Submission to Senate Community Affairs Committee Inquiry  
into suicide in Australia**

**27 November 2009**

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# 1. Introduction

## 1.1 The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights;
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the (then) NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from Industry and Investment NSW for its work on energy and water, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

## 1.2 PIAC's work on coronial issues

PIAC welcomes the opportunity to make a submission to the Senate Community Affairs Committee's Inquiry into suicide in Australia.

PIAC takes this opportunity to highlight the importance of Coroner's Inquests in the prevention of suicide in Australia as well as to highlight the need for law and policy reform in this area.

PIAC submits that the Coroners in Australia's states and territories play a vital role in suicide prevention both in terms of their scrutiny of deaths by suicide and through making recommendations so that deaths can be prevented. Coroners play an important role in public awareness about suicide. Media reporting on the conduct of Inquests as well as of Coroners' finding and recommendations is the most common way the public are made aware of the circumstances of preventable suicides in Australia.

Coroners and Coroner's Court administrations also play a vital part in accurate identification and recording of suicides.

Coroners must be part of the National Suicide Prevention Strategy. All government agencies should listen and respond to recommendations that Coroners make about preventable suicide deaths.

In this submission, PIAC makes several recommendations for law and policy reform that will enhance the capacity of the Coronial system to assist in preventing suicides in Australia.

PIAC has an active interest in Coroners' Inquests both from a policy perspective and as a community legal centre that represents families of deceased persons in inquests in NSW.

In 1988, PIAC undertook a 'Coronial Project', producing several papers advocating law and policy reform of the coronial system in NSW. The project included the publication in 1991 of a guide setting out accessible information on the coronial system for families and friends of the deceased.

In 1989, PIAC also published *Death in the Hands of the State* highlighting issues around deaths in custody.

In 2005, PIAC succeeded in establishing in the courts that the NSW Department of Corrections had failed in its duty of care to a mother of a young Aboriginal man who suicided in custody.<sup>1</sup>

In 2006, PIAC established the state-wide Mental Health in Prisons Network for consumers, health professionals, lawyers and advocates to examine the issues of mental illness in NSW prisons. Also in 2006, PIAC represented the family of Scott Simpson at the Inquest into his death by suicide at Long Bay Correctional Facility.

In July 2007, Legal Aid NSW provided two years' funding for PIAC to commence a project to develop effective responses to the unmet legal needs of people with mental illness in NSW.

PIAC submits that the Australian Government, although it does not have direct responsibility for Coroners and the conduct of Inquests, does clearly have a role in the health and wellbeing of all Australians. This means there is a clear public interest in a whole-of-government approach to preventable deaths, including suicides.

PIAC argues in this submission that Coroners already provide a vital role in suicide prevention and that an augmentation of that role through law reform and a harmonisation of coronial law on the basis of adopting existing best practice will increase the effectiveness of Coroners in highlighting systemic problems and making recommendations that will have the effect of saving lives. PIAC also submits that there is a public interest, best promoted at a national level, in supporting Coroners in their role in making recommendations about preventable deaths, including deaths by suicide, and by providing support to families involved in the Coronial process.

## 2. The importance of the Coroners and coronial inquests in suicide prevention

Coroners do play a vital role in Australia in suicide prevention.

The Royal Commission into Aboriginal Deaths in Custody in its National Report stated:

... thoroughly conducted coronial inquiries hold the potential to identify systemic failures in custodial practices and procedures which may, if acted on, prevent future deaths in similar circumstances. In the final analysis adequate post death investigations have the potential to save lives.<sup>2</sup>

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<sup>1</sup> *Appleton v State of NSW* (Unreported, District Court of New South Wales, Judge Quirk, 28 July 2005).

<sup>2</sup> Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol 1 [4.7.4].

PIAC submits that this statement is also true for suicide deaths outside a custodial setting. That is, adequate and well-conducted inquests into suicide deaths have the potential to save lives.

Inquests prevent potential suicides by:

- determining and recording those deaths that are caused by self-harm;
- recognising and highlighting systemic failures to identify risk of self-harm and failures to adequately protect and treat those who exhibit at risk behaviour; and
- recommending systemic and policy changes, as well as possible law reform.

It is also said that the preventative role of inquests is also associated with a therapeutic jurisprudence approach to justice. There no doubt that in the 21<sup>st</sup> century, many Coroners recognise their role as part of the healing process for the family of the deceased and others involved in the inquest, as well as for the broader members of the community.<sup>3</sup> This is particularly so in the case of suicides.

### **3. Enhancing coroners' power to make recommendations**

All Australian jurisdictions give the coroner some power to make recommendations in addition to their power to make a finding on the manner and cause of death.

In the recent paper by the Australian Coronial Reform Working Group it was pointed out that Australian jurisdictions differ in the extent to which the different Coroners Acts have an express commitment to prevention of deaths through recommendations.

There is legal authority for a narrow view of the coroners' power to make recommendations. Cases such as *Harmsworth v State Coroner of Victoria*<sup>4</sup> in which the Court held that the power to make recommendations arises as a consequence of the obligation to make findings. The Court, referring to statutory provisions about coroners' recommendations, held that, '[t]hey are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.'<sup>5</sup>

This puts the onus on governments and parliaments to undertake law reform to allow coroners to conduct wider inquiries so that appropriate and evidence-based recommendations can be made in situations of preventable deaths, where the direct 'manner and cause' of the death may not be in question.

Jonathon Hunyor points out that this issue arose in the recent Queensland inquest into the death of Mulrunji on Palm Island (not a suicide death) where 'the question was whether a coroner could inquire into an issue or seek evidence on a point for the dominant purpose of making a comment'.<sup>6</sup>

Hunyor takes the view in the article that 'if a coroner is entitled to comment on a matter, he or she should be entitled to inform him- or herself appropriately in order to do so, not simply from the matters that have been adduced to make the required factual findings.'<sup>7</sup>

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<sup>3</sup> Australian Coronial Reform Working Group, *Australian Coronial Reform- The Way Forward* (2009) 9.

<sup>4</sup> (1989) VR 989.

<sup>5</sup> *Ibid*, 996.

<sup>6</sup> Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 (Special Edition 2) *Australian Indigenous Law Review* 64, 68.

<sup>7</sup> *Ibid* 68.

PIAC endorses this position and calls upon the state and territory jurisdictions to amend their coronial legislation to reflect this position and/or for this position be reflected in a national unified coronial law.

PIAC refers the Senate Committee to section 4(2)(b) of the *Coroners Act 2006* (NZ), which specifically gives New Zealand coroners the power to:

Make specified recommendations or comments that, in the coroner's opinion may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

Section 57 of that Act sets out the 'purposes of inquiries' under that Act. The first purpose is the familiar 'causes' and 'circumstances' of the death.

The second purpose is:

... to make recommendations or comments that, in the coroner's opinion may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

The third purpose is to refer appropriate deaths to investigative agencies.

The *Coroners Act 2006* (NZ) was enacted after recommendations in a report from the New Zealand Law Commission in 2000.

PIAC endorses the following comments of the Commission and submits that these comments are highly relevant to the way in which inquests are conducted in Australia today, and the possibilities for enhancing the role of Australian Coroners, particularly in making recommendations in order to prevent potential suicide deaths:

The inquiries of the Coroner should not be limited to matters of mere formality, but should be of social and statistical significance in a modern community.

Recent research into the investigation and analysis of accidents and death has revealed the crucial importance of not focusing exclusively on what seems to be the immediate cause of a fatality: the primary causes can and frequently do lie much deeper. In this context it has progressively become evident that the fundamental causes of fatalities, and therefore the measures needed to avoid recurrence, can require a much broader perspective than the one currently adopted by Coroners.

With certain notable exceptions ... deaths tend to be considered in isolation. There is no system for appraisal of the background factors contributing to the death to determine whether it is an isolated episode or an example of a deeper seated problem. The Commission considers it imperative that an investigation into the possibility of fundamental causes be a regular exercise of the Coroner's functions.

A true appraisal of apparently insignificant incidents can reveal, and then remove or reduce, the risk of disaster.<sup>8</sup>

The reports of the Royal Commission into Aboriginal Deaths in Custody, released over 20 years ago, recommended broader powers for Coroners in order to prevent deaths, citing recommendations from PIAC at that time:

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<sup>8</sup> Law Commission of New Zealand, *Coroners, Report No 62*, cited in Ian Freckleton, 'Reforming Coronership: International Perspectives and Contemporary Developments' (2008) 16 *Journal of Law and Medicine*, 379, 381.

A coroner inquiring into deaths in custody should be required by law to investigate not only the immediate cause and circumstance of death, but also the quality of the care, treatment and supervision of the deceased prior to death. A coroner inquiring into a death in custody should be required to make findings on those matters which are required to be investigated. The setting of precise statutory criteria is a matter for the government in each jurisdiction. I draw attention to a 'Preliminary Note to the Attorney-General of New South Wales: Review of the Coronial System in New South Wales' prepared by the Public Interest Advocacy Centre. In that paper, it is suggested that coroners be obliged to report on the following matters:

- the cause or causes of such death and any incident resulting in the death; the reasonable precautions, if any, whereby the death and the incident resulting in the death might have been avoided;
- the defects, if any, in any system of working which contributed to the death or to such incident; and
- any other factors which are relevant to the circumstances of the death.<sup>9</sup>

PIAC again submits that these principles should be at the core of national reform of Australia's coronial system.

### **3.1 Coroners prevention units**

Another way of enhancing the preventative role of coroners is to set up properly funded units to assist coroners in their recommendation-making role.

The Coroners Prevention Unit in Victoria is a specialist service for coroners created to strengthen their prevention role and provide them with expert assistance by:

- reviewing a range of reportable and reviewable deaths;
- collecting and analysing data relating to reportable and reviewable deaths;
- assisting coroners in the development of prevention-focused coronial recommendations; and
- monitoring and evaluating the effectiveness of coronial recommendations.

The central goals of the Coroners Prevention Unit are to:

- improve the quality and applicability of coronial recommendations
- increase the uptake and implementation rate of coronial recommendations
- contribute to the reduction of preventable deaths in Victoria.<sup>10</sup>

PIAC submits that the Senate Committee should recommend that all states and territories set up and adequately fund a Coroners Prevention Unit on the Victorian model.

## **4. Ensuring that government listens to and responds to the recommendations of coroners.**

Closely related to enhancing the power of Coroners to make recommendations is the need for uniform legislation that ensures that recommendations of coroners are:

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<sup>9</sup> Commonwealth, Royal Commission into Aboriginal Deaths in Custody, above n 2 [4.5.84].

<sup>10</sup> *Coroners Prevention Unit* (2009) Coroners Court of Victoria  
<<http://www.coronerscourt.vic.gov.au/wps/wcm/connect/Coroners+Court/Home/Investigations/Who's+Involved/Coroner's+Prevention+Unit/>> at 27 November 2009.

- made publicly available in an accessible way;
- referred to the appropriate government departments and agencies, statutory authorities and/or organisations;
- referred to executive government and, in some cases, parliaments;
- responded to in a timely manner by Government as a whole or the relevant department, agency or organisation.

The responses, including details of implementation, should also be publicly available and specifically provided to all interested parties at the inquest and their legal representatives, particularly the family of the deceased.

The inadequacy of both policy and law in Australian jurisdictions in this regard was highlighted early in 2009 by a study by Watterson, Brown and McKenzie published in the *Australian Indigenous Law Review*.<sup>11</sup>

The study tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004, arising from both Indigenous and non-Indigenous deaths. The survey revealed that fewer than half of coroners' recommendations to prevent future deaths are being implemented by governments across Australia. Less than half had been implemented in NSW (48 per cent), ahead of only Tasmania (41 per cent) and Victoria (26 per cent). The ACT (70%) and the Northern Territory (65%) had the best implementation.

The survey revealed what Watterson has called 'ad hoc implementation of coronial recommendations by State and Territory governments and agencies'.<sup>12</sup>

Watterson concludes that:

The fate of coronial recommendations is often left to media pressure, advocacy group intervention, and family and community action. The upshot of these systemic failures is that governments, coroners, families and the community know very little about whether or not coronial recommendations are in fact implemented.<sup>13</sup>

Australian jurisdictions vary with regard to mandatory government response to the recommendations of coroners. The Northern Territory and now Victoria, since the commencement of the *Coroners Act 2009 (Vic)*, are the only jurisdictions to legislate a mandatory response to all coroners' recommendations. South Australia requires a mandatory response from government after tabling in Parliament, but only with regard to deaths in custody.

In NSW, there is a Premier's direction with regard to responses by departments and agencies to coroner's recommendations<sup>14</sup>, but despite the NSW Parliament passing new legislation—the *Coroners Act 2009*

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<sup>11</sup> Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12 (Special Edition 2) *Australian Indigenous Law Review* 4.

<sup>12</sup> Ray Watterson, 'Coroners and Indigenous Death' (Paper presented at the 4th National Indigenous Legal Conference, Adelaide, 24-25 September 2009) 7 <<http://www.nilcsa2009.com/RayWatterson.pdf>> at 21 November 2009.

<sup>13</sup> Ibid.

<sup>14</sup> *M2009-12 Responding to Coronial Recommendations* (2009) NSW Department of Premier and Cabinet <[http://www.dpc.nsw.gov.au/publications/memos\\_and\\_circulars/ministerial\\_memoranda/2009/m2009-12\\_responding\\_to\\_coronial\\_recommendations](http://www.dpc.nsw.gov.au/publications/memos_and_circulars/ministerial_memoranda/2009/m2009-12_responding_to_coronial_recommendations)> at 27 November 2009.

(NSW)—there is no legislative enforcement of the principles in the Premier’s directive in the new (yet to be proclaimed) legislation.

Former Federal Home Affairs Minister, the Hon Bob Debus, announced at the launch of the report his intention to have the issue of a national response in this area raised at the meeting of state, territory and federal Attorneys-General but there were no follow-up public announcements on this issue.

Watterson, Brown and McKenzie highlight that calls for a legislatively mandated consideration and response to coroners’ recommendations are not new. They refer to recommendations 14–17 made by the Royal Commission into Aboriginal Deaths in Custody:

14. That copies of the findings and recommendations of the Coroner be provided by the Coroners Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate. (1:172)

15. 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. (1:172)

16. That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendation

17. That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.

18. That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.<sup>15</sup>

PIAC believes that these recommendations remain relevant today and submits that they should be adopted as part of national uniform coronial legislation.

PIAC further submits that to ensure that governments and their agencies properly respond to recommendations by coroners about preventable deaths, including deaths by suicide, that the following recommendations should form the basis of national uniform legislation.

- That both coroners’ recommendations and the official responses to them be publicly accessible through Annual reports and on the Internet.

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<sup>15</sup> Cited in Watterson, Brown and McKenzie, above n 11, 6-7.

- That in the case of mandatory inquests, such as deaths in custody, the recommendations of the coroner should also be tabled in the parliament or assembly of the relevant state or territory, with a legislative requirement that a government response be tabled within three months of the initial tabling of the recommendations.

PIAC also encourages the participation of the parliament as distinct from the executive in the scrutiny of the response to coroners' recommendations and suggests the establishment of designated coronial parliamentary committees in all states and territories or a mechanism whereby the government response to coroners' recommendations tabled in parliament be referred to appropriate legislative, estimates or policy committees.

With reference specifically to deaths by self-harm, it is vital that the preventative role that coroners can play is both protected and enhanced. Australian coroners have repeatedly made recommendations both to correctional authorities and health providers about how suicides could have been prevented. Australian law at least should mandate a response to such recommendations.

Responses to recommendations may well help to distinguish between preventable deaths due to avoidable systemic errors only and deaths at least partly caused by the lack of resources allocated to mental health and general health care. Governments find the former easier to solve than the latter, where resource allocations in health often conflict with public expectations regarding public expenditure in other areas.

## **5. Legal representation at Inquests: need for adequate legal aid**

While it seems that Australian coroners do not usually place barriers to families of deceased persons being given leave to appear in inquests, the funding of legal representation of families is more problematic.

Legal Aid NSW has in recent years set up a Coronial Unit that provides representation at inquests, including for families, subject to their usual legal aid guidelines. Legal aid for the representation of families in inquests is less available in other states and territories.

Given that there is both a forensic and therapeutic purpose in legal representation for families at inquests, it is essential that legal representation is available and affordable in all Australian jurisdictions.

PIAC supports the recommendations in the Australian Coronial Reform Working Group (ACRWG) Issues Paper about legal aid for families in inquests:

This paper suggests:

Unlike many other legal proceedings, costs are not usually awarded in inquests, because inquests are formally inquisitorial, and technically there are no parties. This is despite the fact that many families find inquest proceedings highly formal and intimidating, especially when there are issues involving government departments or corporations, whose interests are often advanced in an adversarial manner. The legal issues can also be very complex and the whole process may be the subject of intense media interest. Unrepresented families tend to rely on the coroner's assistant or police informant for legal advice, which raises conflicts of interest.<sup>16</sup>

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<sup>16</sup> Australian Coronial Reform Working Group, above n3, 26.

PIAC supports the following recommendations suggested in the ACRWG paper.

- Legal aid must be sufficient to enable all families to obtain, without financial hardship, legal advice and representation for investigations and inquests, as a fundamental component of Australia's international human rights obligations under the right to life.
- Legal aid must be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.
- A specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.<sup>17</sup>

## 5.1 A national Coroners Information System

The Australian Coronial Reform Working Group calls for the funding of an independent National Coroners Information Clearing House (NICH). Ray Watterson calls, in his paper, for a National Inquest Centre.

Both the ACRWG and Watterson see this organisation fulfilling the same functions, namely:

- providing a specialist legal advice, referral and support service for families and community groups entering the coronial process;
- maintaining a register of legal practitioners willing and able to undertake casework for, and experts willing to assist, these parties;
- acting as a forum for the exchange of information and experience;
- undertaking research and resource support for public legal services, including community legal centres, Aboriginal and Torres Strait Islander Legal Services and Legal Aid Commissions;
- monitoring and analysing coronial findings and recommendations and their implementation in the interests of family and community wellbeing, public health and safety and the administration of justice;
- conducting community legal education;
- developing policy proposals and engaging in law reform; and
- undertaking specialist coronial advocacy and support training, and professional development programs.<sup>18</sup>

The ACRWG paper cites the Coronial Inquest Unit of Legal Aid NSW, as expressing support for the NICH concept as potentially benefiting the Unit and its clients through:

- research support;
- access to a 'bank' of recommendations from all jurisdictions;
- access to a 'bank' of standard operating procedures, policies, protocols, memoranda of understanding, legislation, etc, from all jurisdictions;
- access to case law from all jurisdictions;
- being less likely to reinvent the wheel if information from all jurisdictions is shared and accessible;
- development of a network of practitioners practising in the coronial jurisdictions;
- development of expertise in the coronial jurisdiction;
- greater capacity for policy development, systemic reform and law reform; and
- greater capacity for media campaigns and community education.<sup>19</sup>

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<sup>17</sup> Ibid 33.

<sup>18</sup> Ibid 32; Watterson Brown and McKenzie, above n 11, 10-11.

<sup>19</sup> Australian Coronial Reform Working Group, above n 3, 32

PIAC draws the Committee's attention to the UK organisation INQUEST and its website<sup>20</sup>, which is a model organisation for these proposals. However, INQUEST provides direct legal representation for families at inquests in the UK, which is a model that may be difficult to replicate in a national body in Australia's federal system.

INQUEST's website advises that:

INQUEST was founded in 1981. It is a small charitable organisation with a staff team of eight and the only organisation in England and Wales that provides a specialist, comprehensive advice service to bereaved people, lawyers, other advice and support agencies, the media, MPs and the wider public on contentious deaths and their investigation.

Our casework priorities are deaths in custody (police, prison, immigration detention and deaths of detained patients) and our focus on deaths in custody and the monitoring of such deaths means that we are at the forefront of uncovering patterns and trends. Within this area we have particular concerns about the deaths of women, black people, young people, and people with mental health problems that reflect our commitment to challenging discrimination. This is both in terms of the treatment and care received by the deceased in custody and the experience of bereaved relatives following the death.

Arising from our casework and related areas we develop policy proposals and undertake research to lobby for changes to the inquest and investigation process, reduce the number of custodial deaths and improve the treatment and care of those within the institutions where the deaths occur.

PIAC supports the setting up and funding of such a service like INQUEST in Australian jurisdictions and believes that such an independent service would enhance the role of the coroner and Coroners Prevention Units in preventing deaths, including deaths by suicide. It would also enhance the therapeutic role that inquests play in providing representation, advice and support for families of individuals who take their own life.

## 6. Delays in inquests

Whilst PIAC acknowledges that it is vital that preventable deaths be investigated thoroughly and briefs to the coroners should be totally thorough and comprehensive, PIAC submits that long delays between a death of a person and the inquest into their death affects both the quality of findings by coroners as well as causing unnecessary extra distress to already grieving families and friends.

The phrase 'justice delayed is justice denied' applies to all aspects of the legal system, but it particularly applies to inquests where there is possible death by self-harm. Delays in the coronial process inevitably affects and delays the grieving process for family members of the deceased. The therapeutic value of a well-conducted inquest can be swamped by the negative effects of an inquest being delayed several years after the person's death. Witnesses' memories over this length of time potentially diminish significantly.

Sadly, this is not so for the direct family of a person has taken their own life, who, if there is a delay in the holding of the inquest, are forced to relive the time of their loved one's death both before and during the inquest in meetings with their legal representatives, meetings with counsel assisting the coroner, and with other family members. They then may have to give evidence during the inquest and perhaps be cross-examined on that evidence. They also have to listen to and concentrate on other evidence in inquests that can take days to complete. Delays exacerbate the pain of this process for families.

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<sup>20</sup> INQUEST (2009) < <http://inquest.gn.apc.org/>> at 27 November 2009.

Despite these negative outcomes from delayed inquests, coroners courts are often treated as poor cousins of other jurisdictions. In NSW, for example, there are greater delays in obtaining transcripts from inquests than in other court proceedings, further delaying the completion of inquests. PIAC recently represented a family at an inquest in NSW where the deceased committed suicide in May 2006 and the inquest only commenced in December 2008.

Westmead Coroners Court in Sydney has closed and only recently has that gap been filled by the use of a courtroom in the re-opened Parramatta Local Court complex.

The problem is currently exacerbated in NSW with unfortunate delays in the release of autopsy reports for the coroner, blamed on the shortage of forensic pathologists in Australia. PIAC is aware of one particular family which has been waiting for an autopsy report for approximately nine months after their relative's death. For some families, the autopsy provides the first comprehensive explanation of their loved one's cause of death. Also, delay in the production of autopsy reports inevitably leads to delay in the holding of an inquest.

PIAC calls on the state and territory governments to adequately fund their coroners' courts and for the various judicial commissions in the states and/or the Australian Institute of Judicial Administration to examine ways the delays in inquests can be shortened.

## 7. Working with families and communities

The therapeutic role that inquests can play is often acknowledged but is not formally recognised in Australian law. This has led to an uneven approach by different coroners to the needs of families and their communities outside the narrow focus of their role in declaring the 'manner and cause' of a death.

PIAC submits that this role of the coroner should be at least acknowledged in the purpose/objects clause of coronial legislation and/or national uniform coronial legislation.

In his article on '*Death Investigation, the coroner and therapeutic jurisprudence*', Ian Freckelton cites a recommendation of the Victorian Parliament Law Reform Committee in 2006 that one of the purposes of coronial legislation should be '... to accommodate the needs and provide support for families, friends and others associated with a death which is the subject of a coronial investigation'.

The article cites a study undertaken in Victoria for the Committee, which suggested there was:

... a problematic incidence of families being unclear about the roles, functions and processes of the coroner, as well about those of the police. Too many were also unaware of their ability to engage in the coronial process, and their ability to touch or view the body of the deceased, to be consulted about or give permission for an autopsy, and to view documentation considered by the coroner, including police briefs. The report emphasised the need for improvements in the frequency of communication between the coroner's office and family members, as well as the provision of information about matters such as counselling and support services.<sup>21</sup>

PIAC, both from its experience representing families in inquests in NSW, and from anecdotal evidence from the families of deceased persons, suggests that the same experience is had by people who have interaction with Coroners' Courts in NSW.

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<sup>21</sup> Ian Freckelton, 'Death investigation, the coroner and therapeutic jurisprudence' (2007) 15 *Journal of Law and Medicine* 1, 9.

This is particularly so with people from non-English speaking or refugee backgrounds, who are likely to come from countries where investigations of deaths may be conducted in an entirely different way to the model that Australia has inherited from the UK. Refugees, many who are victims of previous torture and trauma, can often have an inherent distrust of what we describe as the criminal justice system. They may have a particular disbelief with the suggestion that their family or community member has committed suicide, particularly if this death occurred in custody, in some other form of detention such as under mental health legislation, or when the police are involved. There are also particular cultural stigmas associated with suicide that need to be taken into account in dealing with families of deceased persons in these circumstances.

In all these situations, the therapeutic value of the coronial process could be assisted by the involvement of community leaders from beyond the deceased's immediate family as mediators and/or advocates in the coronial process. They could assist in taking special steps in explaining the coronial process to family members.

Watterson also highlights the particular challenges face by Aboriginal and Torres Strait Islander families face in dealing with the Australia coronial systems.

He observes that:

Inquests present Indigenous families and communities with a special experience of disadvantage. Indigenous people are precipitated into a devastating situation and have to deal with agencies and procedures unknown to them and from which they often feel totally excluded. Indigenous families and communities, searching for answers to Indigenous death during their grieving process, are dependent upon an inquest to find them.

Indigenous approaches to and understanding of death are distinctive. The customs and wishes of Indigenous people are sometimes not fully appreciated by the officials with whom they must deal.<sup>22</sup>

Coroners and the staff of coronial units and Coroners Prevention Units should work closely with families of deceased persons and members and leaders of their communities. They should undertake appropriate cultural training, with the participation of the various non-English speaking and the Aboriginal and Torres Strait Islander communities, to enhance this process.

An independent national Coroners Information System (see above) could play a significant role in this process.

## **8. Preventing suicide deaths in custody: responding to recommendations**

### **8.1 Inquest into the death of Scott Simpson**

PIAC represented the mother of Scott Simpson in the Inquest into his death in custody in NSW in 2006.

Scott Simpson committed suicide at whilst in custody as a forensic patient at Long Bay Correctional Centre.

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<sup>22</sup> Watterson, above n 12, 9

After Scott Simpson killed his cellmate, instead of being hospitalised for his mental illness, which his doctors had recommended, he was transferred to the Goulburn Correctional Centre.

The Coroner found it difficult to understand why Scott did not receive treatment at that time.

As Coroner Pinch stated:

... it seems that Simpson should have been very high on the priority list – he was demonstrably acutely mentally ill to the extent that he had killed another person. However, instead of receiving treatment in hospital he was sent to a segregation cell at Goulburn with minimal opportunities for adequate psychiatric care. That initial move to Goulburn typified how Simpson was dealt with during the rest of his time in custody, namely:

- a. mental health professionals in regular contact with Simpson advocated strongly for his hospitalisation;
- b. those making the decisions about priorities for admission to hospital did not accord him sufficient priority for the transfer to hospital to be effected; while
- c. DCS focused on security aspects and kept Simpson segregated.

The result was that while Simpson's condition fluctuated depending on whether he was compliant with his medication, the time spent in segregation led inevitably to a deterioration of his mental state until the crisis point was reached on 7 June 2004.<sup>23</sup>

Coroner Pinch made ten recommendations. One of the recommendations was that '[t]he Department of Corrective Services should adopt the policy that inmates diagnosed with a mental illness should be placed in segregation only in exceptional circumstances and for a limited period'.<sup>24</sup>

Despite this, the use of segregation remains relatively unchecked in NSW prisons, in particular in the high security units such as the High Risk Management Unit (HMRU) in Goulburn Correctional Centre.

Evidence of this was provided by the recent case of *Sleiman v Commissioner of Correctional Services*.<sup>25</sup>

In his judgement, Justice Adams of the NSW Supreme Court held that:

... Sleiman was locked in his cell for a significantly longer period each day compared with other prisoners, was permitted association only with a very limited number of other prisoners as permitted by the general manager and occasionally was held in complete isolation of other prisoners. In short (as alleged) imprisonment in the HRMU was synonymous with segregated custody, no less because the word 'segregated' was not used by the authorities to describe his placement: 'held in the HRMU' being doublespeak for 'held in segregation'.<sup>26</sup>

Whilst there was no suggestion that Mr Sleiman was either mentally ill or suicidal, the high incidence of people with mental illness in NSW prisons and the information currently available about practices in units such as the HMRU would suggest that the recommendations by Coroner Pinch in the Simpson inquest about segregation have not been followed.

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<sup>23</sup> *Inquest into the death of Scott Ashley Simpson* (2006) NSW State Coroner, (unreported, Magistrate D Pinch, 17 July 2006) 8-9.

<sup>24</sup> *Ibid* 21.

<sup>25</sup> *Sleiman v Commissioner of Correctional Services* (2009) NSWSC 304.

<sup>26</sup> *Ibid* 25.

The problem is that, for both Mr Simpson's family and the NSW public, the Government action on this recommendation is unknown because, to PIAC's knowledge, there has never been a public response to the recommendations in the Simpson Inquest. As referred to earlier in the submission, there is no legislative obligation in NSW for a government or even agency response to coroners' recommendations. PIAC is certainly aware that there has been a positive response by Government to many of the Coroner Pinch's recommendations in Simpson. There certainly has been no public response to the Coroner's recommendation about segregation.

This matter highlights the need, particularly in matters such as deaths in custody, for a whole-of-government response to coroners' recommendations with the maximum transparency that is provided by a system of tabling the recommendations and government response in the legislature.

## 8.2 The Royal Commission into Aboriginal Deaths in Custody

The Royal Commission played a significant role in highlighting the preventability of Aboriginal deaths in custody, including deaths from self-harm.

Watterson notes:

Thirty four of the Commission's three hundred and thirty nine recommendations concerned reform of the State and Territorial coronial systems. Major reforms of coronial systems recommended included:

- Ensuring that the coroner's powers and position were significant enough for the coroner to be able to control and supervise investigation of a death in custody.
- Strengthening coronial investigations.
- Ensuring adequate notification of deaths in custody to coroners and that all deaths in custody be the subject of a coronial investigation culminating in a public inquest.
- Enhancing the scope of coronial inquests to include proper custodial care.
- Instituting a public reporting and review system for coronial recommendations.
- Providing proper notification of family members and assistance in representing their concerns to the coronial investigation, particularly inquests.
- Resolution of any cultural conflicts raised by Aboriginal deaths in custody and the coronial process.
- Recognising the need to have Aboriginal legal and health services and communities involved in the coronial process.
- Establishing a uniform database for Indigenous deaths in custody.

Many of the Commission's reforms have been implemented, many have not. <sup>27</sup>

The Royal Commission also made specific recommendations about preventable suicide deaths in custody, including, for example, recommendations about hanging points in prisons that are also applicable to non-Aboriginal deaths and suicide deaths in detention centres, psychiatric hospitals, etc.

PIAC calls on the Australian Government, perhaps through a reference to a Parliamentary Committee, to revisit the recommendations of the Royal Commission that have not been implemented with a view to either recommending implementing the recommendations or providing an explanation as to why the recommendations are no longer appropriate in the 21<sup>st</sup> century.

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<sup>27</sup> Watterson, Brown and McKenzie, above n 11, 4.

### 8.3 Inquest into the death of Adam Douglas Shipley

The recent inquest into the suicide death in custody in NSW of the Aboriginal man, Douglas Shipley<sup>28</sup>, highlights the failure in implementation of recommendations from previous coroners and the Royal Commission into Aboriginal Deaths in Custody.

Despite a mental health history and very recent suicide attempts, Adam Shipley hanged himself at Kirkconnell Correctional Centre on 21 May 2007.

State Coroner Mary Jerram in her decision said the Inquest was about ‘...how an aboriginal man in the custody of a government department, known to be of high risk, and diagnosed as a schizophrenic, was able to take his own life without being discovered for several hours.’<sup>29</sup>

The Coroner, whilst acknowledging the efforts of the NSW Department of Corrective Services to reduce suicide deaths in custody, was particularly critical of the Department’s investigative processes.

The Inquest did highlight issues like positioning of hanging points; the fact that Adam Shipley had received disturbing personal news and no extra mental health care or monitoring was provided; and that other inmates were aware that he was depressed and potentially suicidal because of these exacerbating external factors, but neither Justice Health nor prison officers were aware of this change in mood.

The Coroner did not make recommendations specifically on these issues, but did recommend that the Department of Corrective Services review systems and protocols in place for inmates known to be at risk, to determine whether these presently provide for a co-ordinated and pro-active management plan for such inmates (including involving Correctional Officers and mental health professionals), particularly following release or discharge from a Risk Intervention Team protocol.

The Coroner also recommended that the Department of Corrective Services provide all reports of investigations previously undertaken by them into deaths in custody to the Office of the State Coroner immediately. This clearly indicates the Coroner’s concerns about the Department of Corrective Service’s ability to investigate deaths in custody internally and consequently implement systemic change to prevent further suicide deaths in custody.

This in turn highlights the importance of mechanisms external to internal government investigations in preventing deaths in custody and other preventable deaths such as the coroner. It also highlights the need for transparent investigations and inquests, backed up by a system of mandatory responses by government to recommendations by coroners with tabling in parliament to enable maximum transparency and opportunity for public scrutiny.

## 9. Preventing suicide deaths in the community: Tracking Tragedy

PIAC is currently representing the mother of a man who committed suicide in 2006 when in ‘care in the community’.

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<sup>28</sup> Magistrate Mary Jerram, *Finding in the Death of Adam Douglas Shipley* (2009) Coroners Court <[http://www.lawlink.nsw.gov.au/lawlink/coroners\\_court/ll\\_coroners.nsf/pages/coroners\\_findings](http://www.lawlink.nsw.gov.au/lawlink/coroners_court/ll_coroners.nsf/pages/coroners_findings)> at 26 November 2009.

<sup>29</sup> Ibid 14.

Despite a least one suicide attempt in the month after his release from a Sydney suburban public psychiatric unit, he was not readmitted to that unit despite his and his mother's pleas for him to be admitted. He killed himself approximately a month after his discharge. Some discussion was held during that month to place him in a rehabilitation program at Bloomfield Hospital, Orange, but no concrete arrangements were made. Despite a suicide attempt on the day before, a decision was made to only keep telephone contact with him over the next weekend by the Community Mental Health Acute Care Team. He had no further contact with the Acute Care Team apart from several short telephone calls and killed himself on the Monday.

PIAC has requested that the Coroner make the following recommendation regarding alternative care to community based care:

The NSW Government should provide more restrictive alternatives to community care, which can be accessed quickly and easily, once appropriate assessments are made under the *Mental Health Act 2007* and a patient is recognised as being at risk of self harm.

PIAC also made reference in its submission to the Coroner that recommendations in the *Tracking Tragedy* reports be fully implemented.

Recommendation 14 of *Tracking Tragedy: Second Report* states:

NSW Health develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high risk situations should be discouraged.<sup>30</sup>

PIAC, on behalf of its client, has submitted that the Coroner recommend:

That NSW Health review its standards in relation to the use of telephone contact with clients by mental health services in high risk situations. Following such review, NSW Health should put measures in place to ensure that all those involved with the care and treatment of acute and chronically ill mental health patients are aware of the standards. The standards should not be optional but mandatory.

PIAC submits that these recommendations could, and should, apply to all Australian states and territories.

PIAC acknowledges the significant difference that the NSW Mental Health Sentinel Events Review Committee and its several *Tracking Tragedy* reports made to suicide prevention in NSW. PIAC also notes that the last report of *Tracking Tragedy* suggested the continuance of the Mental Health Sentinel Events Review Committee and a continuation of its role in monitoring suicide deaths in NSW.<sup>31</sup> PIAC notes that very unfortunately the NSW Government did not take up this recommendation.<sup>32</sup>

PIAC submits that the Senate Committee should recommend the re-establishment in NSW of the Mental Health Sentinel Events Review Committee and that similar bodies be set up in other states and territories, to monitor and make recommendations about preventable suicide deaths.

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<sup>30</sup> Mental Health Sentinel Events Review Committee, *Tracking Tragedy 2004* (2005) 58.

<sup>31</sup> Mental Health Sentinel Events Review Committee, *Tracking Tragedy Third Report* (2007).

<sup>32</sup> NSW Health, *NSW Government's Final Response - Tracking Tragedy (2008)* (2009).

## **Summary of Recommendations**

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1. *That there is a public interest, best promoted at a national level, in supporting coroners in their role in making recommendations about preventable deaths, including deaths by suicide, and by providing support to families involved in the coronial process.*
2. *That there should be a Commonwealth-initiated process to harmonise Australia's coronial legislation based on best practice in the state and territory jurisdictions.*
3. *That coronial legislation should provide coroners with broad powers to make findings and recommendations on:*
  - *the cause or causes of such death and any incident resulting in the death; the reasonable precautions, if any, whereby the death and the incident resulting in the death might have been avoided;*
  - *the defects, if any, in any system of working that contributed to the death or to such incident; and*
  - *any other factors that are relevant to the circumstances of the death.*
4. *That coronial legislation should identify one of the purposes of an inquest is to 'make recommendations or comments that, in the Coroner's opinion may, if dawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred' as set out in the Coroners Act 2006 (NZ)*
5. *That all states and territories set up and adequately fund a Coroners Prevention Unit on the Victorian model.*
6. *That copies of the findings and recommendations of the coroner be provided by the coroners' office to all parties who appeared at the inquest, to the Attorney General or Minister for Justice of the state or territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the custodial agency or department (if relevant) and to such other persons as the coroner deems appropriate (based on a recommendation of the Royal Commission into Aboriginal Deaths in Custody).*
7. *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 (recommendation of the Royal Commission into Aboriginal Deaths in Custody).*
8. *That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 7, provide copies of each such response to all parties who appeared before the coroner at the inquest, to the coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendation (recommendation of the Royal Commission into Aboriginal Deaths in Custody).*
9. *That the State Coroner be required to report annually in writing to the Attorney General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by coroners and as to the responses to such findings and recommendations provided pursuant to the terms of the recommendation above (recommendation of the Royal Commission into Aboriginal Deaths in Custody).*
10. *That the State Coroner, in reporting to the Attorney General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody (recommendation of the Royal Commission into Aboriginal Deaths in Custody).*

11. *That in the case of mandatory inquests, such as deaths in custody, the recommendations of the coroner should also be tabled in the legislature of the relevant state or territory, with a legislative requirement that a government response be tabled within three months of the initial tabling of the recommendations.*
12. *That both coroners' recommendations and the official responses to them be publicly accessible through annual reports and on the Internet*
13. *That designated Coroners Parliamentary Committees be established in the states and territories to follow up coroners' recommendations and government responses or a mechanism adopted whereby the government response to coroners' recommendations tabled in parliament be referred to appropriate legislative, estimates or policy committees.*
14. *That legal aid be sufficient to enable all families to obtain, without financial hardship, legal advice and representation for investigations and inquests, as a fundamental component of Australia's international human rights obligations under the right to life.*
15. *That legal aid be sufficient to enable all advocacy organisations with a sufficient interest to intervene in inquests, as a fundamental component of Australia's international human rights obligations under the right to life.*
16. *That a specific pool of funds should be made available to enable community legal centres to provide legal representation for families at inquests.*
17. *That an independent National Coroners Information Clearing House, along the lines of INQUEST in the UK, be established and adequately funded.*
18. *That state and territory governments adequately fund their coroners' courts and for the various judicial commissions in the states and/or the Australian Institute of Judicial Administration to examine ways the delays in inquests can be shortened.*
19. *That coronial legislation should state that one of the purposes of the legislation is to accommodate the needs and provide support for families, friends and others associated with a death that is the subject of a coronial investigation.*
20. *Coroners and the staff of coronial units and Coroners Prevention Units should work closely with families of deceased persons and members and leaders of their communities. They should undertake appropriate cultural training, with the participation of the various non-English speaking and the Aboriginal and Torres Strait Islander communities, to enhance this process.*
21. *Government correctional authorities should adopt the policy that inmates diagnosed with a mental illness be placed in segregation only in exceptional circumstances and for a limited period (Coroner's recommendation in Simpson).*
22. *That the Australian Government, perhaps through a reference to a Parliamentary Committee, revisit the recommendations of the Royal Commission in Aboriginal Deaths in Custody that have not been implemented with a view to either recommending immediate implementation of the recommendations or providing an explanation as to why the recommendations are no longer appropriate.*
23. *That state and territory governments should provide more restrictive alternatives to community care, which can be accessed quickly and easily, once appropriate assessments are made under mental health legislation and a patient is recognised as being at risk of self harm.*
24. *That health services develop standards for the use and documentation of telephone contact in initial and ongoing assessment, treatment and post-discharge follow-up by mental health services. Reliance on telephone contact in high-risk (including risk of suicide) situations should be discouraged.*
25. *That the NSW Mental Health Sentinel Events Review Committee be re-established and that similar bodies be set up in other states and territories, to monitor and make recommendations about preventable suicide deaths.*