

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Mr M. Zaccaro, civil law solicitor; and

Ms G. Jubb, research officer, Victorian Aboriginal Legal Service.

The CHAIR — I welcome representatives from the Victorian Aboriginal Legal Service (VALS). I think you have appeared before us before so you are aware it is a public inquiry. Your evidence will be on the public record unless you specifically request it to be in camera. You will have the opportunity to correct the transcript for factual errors. It will then be posted on our web site as an official public submission. If you would like to present your submission to us and then we will ask some questions.

Ms JUBB — Thank you for the opportunity to present before the committee. I want to acknowledge that we are meeting today on Aboriginal land of the traditional owners, the Wurundjeri people of the Kulin nation. I also want to pay my respects to people who are deceased, especially those who have died in custody.

I am going to try to provide an overview of the submission that we made in July and flavour that with the implementation review of the royal commission, which was released in November this year. Basically there are 164 recommendations of the implementation review, and in the majority of those that relate to coronial investigations, the recommendations take the form of requesting further information. Basically it is a fact-finding, inquisitorial recommendation for the state coroner and other relevant bodies to provide further information; that is what the majority of the recommendations suggest.

What I really want to get across today is that there is a wealth of resources available in making post-death investigations appropriate for the Aboriginal community — namely, firstly, the 1991 Royal Commission into Aboriginal Deaths in Custody and secondly, the implementation review. What is really significant about that review is that it is not just a government self-appraisal or self-investigation, which has been the case in the past. For the first time in Australia's history it has got flavours of being external, because two independent community chairpersons were appointed to conduct and represent this review. So what it has to say is really, really poignant. There is the royal commission and the implementation review, and even though we have these resources I think that still does not dispel the obligation to talk to the community and find out how to implement the recommendations.

Just talking about recommendations, I would also like to refer to the coroners findings and recommendations, in terms of their potential to have a preventive influence on deaths in custody. That is ultimately the aim of the royal commission, to prevent Aboriginal deaths in custody, which was sanctioned because of the over-representation rate in the prison system and the rate of death of Aboriginal people.

Unfortunately the implementation review does not paint the implementation of the royal commission in a positive light. I would just like to quote from the implementation review:

Overall the families believed, on the basis of their experience, that the implementation of the royal commission recommendations had not been adhered to.

VALS would have to agree with this quote, this opinion, across the board. There have been steps forward, but there is still room for improvement.

In our submission we recognised that it is 2005 and the royal commission was in 1991 and in that 14-year gap there have been changes in policy and changes in government, and problems have got better in some circumstances but worse in others. A clear message I want to put across, too, is that we have these resources, but they are in danger of being wasted, because there were 339 recommendations from the royal commission and there are 164 in the implementation review. For the purposes of today I cannot go into that much detail of the recommendations. I will concentrate on the ones that relate to VALS. This is a resource that we have, and it is in danger of being lost if it is not implemented effectively.

Particularly in relation to VALS there are some recommendations around the state coroner engaging the Victorian Aboriginal Legal Service about protocols. Firstly, recommendation 8 is about the conduct of the coronial inquests, and recommendation 38 is about autopsies. In terms of recommendation 8, on protocols around the conduct of coronial inquiries, there has been no formal engagement with VALS about protocols.

Mr MAUGHAN — How many inquiries have there been over that period, just to get it into perspective? Do you know how many inquiries there have been involving indigenous people over that period?

Ms JUBB — In terms of the royal commission?

Mr MAUGHAN — Yes.

Ms JUBB — The last one in Victoria was 1997.

Mr MAUGHAN — I mean the coroner rather than the royal commission. You are saying that the royal commission's recommendations with the coroner being involved with VALS have not been followed.

Ms JUBB — Yes.

Mr MAUGHAN — My question is: has there been one coroners inquiry into an Aboriginal death or have there been 50 or 100? Have you any idea how many?

Ms JUBB — Since 1991 I think there have been seven deaths in custody.

Mr MAUGHAN — And in none of those the coroner has contacted VALS?

Ms JUBB — Yes.

Mr MAUGHAN — Okay. Thank you.

Ms JUBB — And there have not been any since 2000. It is reported in the royal commission implementation review, but about three weeks ago VALS was actually informed that there was a death in custody at Dhurringile prison, and that was an informal way of notifying VALS. It was not sent to us in writing. We have a service that is 24 hours a day, 7 days a week. We have on-call client service officers, and in that particular situation — it was a Saturday morning, I think — the client service officer on call was notified, and then I think she informed our CEO that Saturday. But in terms of follow-up or any notification in writing, that did not occur.

VALS is the peak body. We service the whole state and have contact with other peak Aboriginal organisations, so we would be in a position of expertise to help the state coroner come up with some protocols. What is interesting is that the state coroner was given the opportunity to reply to the implementation review. The implementation review is in two volumes. In the first volume the government response is recorded, and if I can quote for you, the state coroner said a protocol has not been developed because:

... generally, all deaths in custody are investigated by full-time coroners in Victoria and as the circumstances of the deaths are variable, protocols are not seen as appropriate.

I looked on the web site of this parliamentary committee inquiry and saw the state coroner's submission in response to the Coroners Act discussion paper, and I saw that they saw their role as providing guidance and producing guidelines and that sort of thing, so I think there is a little bit of inconsistency in terms of that.

Another response of the state coroner is to recommendation 38, was around the objection to autopsies. The state coroner replied:

Whilst it may be considered desirable for a protocol to be developed between Aboriginal health services and the coroner, ultimately the decision whether to conduct an autopsy or not is a matter for the coroner.

It just seems that that is acknowledging the need for a protocol, but it does not seem to be in any hurry to engage with the Aboriginal organisations. I think the implementation review team recognised that, so it made a recommendation in response to this, which is recommendation 99, which says that the state coroner:

commence immediate discussions with the Victorian Aboriginal Legal Service and the Victorian Aboriginal Community Controlled Health Organisation on the development and implementation of cultural protocols ...

It was recognised that not much is happening and that it needs to be rectified immediately.

I just want to move on to preventive issues. In the discussion paper there were questions about the potential of the coroners findings and recommendations to have a preventive role in deaths in custody, and VALS would argue that that is really important, because unfortunately in terms of the Aboriginal community there has not been any prevention of deaths in custody. The Aboriginal and Torres Strait Islander Justice Commissioner notes that there have been 147 indigenous deaths in custody since the royal commission — that is, after 1991. In the decade before the royal commission there were 99 deaths, so there has been an increase.

Both the Royal Commission into Aboriginal Deaths in Custody in 1991 and the implementation review have suggestions around giving the coroner teeth, or power, to have a say in deaths in custody or deaths in general being

prevented. In particular, recommendation 15 of the 1991 royal commission suggests that responses to recommendations be mandated. It says:

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.

I suppose the implementation review simply adds fuel to that recommendation by repeating and endorsing it. I will read recommendation 87 of the implementation review, which states :

That the state coroner:

- (a) report annually to the Victorian Attorney-General and the Minister for Police and Emergency Services and the Minister for Corrections ... detailing the number of indigenous deaths in custody, findings and recommendations of the coroner, the responses to the findings and recommendations ...

Part (b) recommends that the report be tabled in Parliament and that:

... the Victorian government provide appropriate resources to the state coroner to facilitate the provision of annual reports ...

Basically VALS would argue that there is the power to prevent Aboriginal deaths in custody, but unfortunately that has not been occurring. There is still a real risk of Aboriginal deaths in custody; it is not something of the past. There is the danger that the resources or tools that we have at our disposal will be overlooked in talking about a tool or a resource, and I refer to the 1991 royal commission, the implementation review released in November and the recommendations of coroners themselves. That is basically what I want to put across to the committee. Are there any questions?

Mr DALLA-RIVA — Thank you for your input. I note we received a document headed ‘Section 6 findings of representation of the criminal justice system’ You indicated some of the areas that had not been recommended. However, I must say that the document I have, which I gather —

Ms JUBB — It comes out of the 2005 implementation report. It is an extract.

Mr DALLA-RIVA — While you pick out items that have not seen progress, quite a lot have been either partially or fully implemented. In particular, recommendation 20 says that ‘the appropriate Aboriginal legal service be notified immediately of any Aboriginal death in custody’. The implementation status says ‘fully implemented, SCV’. You are saying that is not —

Ms JUBB — I think the table you have is not the opinion of the implementation review team but of the coroner himself; it is a self-appraisal.

Mr DALLA-RIVA — Yes.

Ms JUBB — Scattered throughout the implementation review are instances of problems for Aboriginal families in navigating post-death investigations. I think you need to take it with a grain of salt; it is a self-appraisal.

Mr DALLA-RIVA — On that basis has VALS written to the coroner to say that the self-appraisal is wrong?

Ms JUBB — We have not at this stage.

The CHAIR — Greta, I just want to ask you about this whole issue of autopsies, because obviously we have a situation where the coroner is trying to establish how, why and what causes a death. In your submission I think you are basically saying that we should broaden the range of people who can object to an autopsy from the next of kin to — I take it — anyone in the Aboriginal community?

Ms JUBB — Yes.

The CHAIR — So they could object, and the coroner would need to follow that through if there were an objection and would not conduct an autopsy? Are there any circumstances in which the Aboriginal community would say — and perhaps this is the question you are trying to get at with protocols — that the interests of having

an autopsy in order to determine what happened would override the general objections to an autopsy? We deal with this with other communities as well. It is not just the Aboriginal community.

Ms JUBB — Yes. I guess it is an individual assessment, but I know there are cultural objections to autopsies for the Aboriginal community.

The CHAIR — I am trying to establish how deep seated they are.

Ms JUBB — I am not indigenous, so I am probably not the best person to answer the question, but from my understanding the reason for objections to an autopsy is that it affects transmission to the afterlife and also has implications in relation to the stories of the Dreaming. The whole community has ownership of the Dreaming stories, and if they are affected, then the whole community is affected, so it about the standing of the community, because it is its responsibility to protect culture.

Mr MAUGHAN — Understood. Do you think the Aboriginal community should be treated differently from the Jewish community and the Islamic community and the other groups in our society that also have very strong cultural beliefs that on some occasions need to be overridden in what is seen as being the interests of the broader community rather than the interests of those specific groups?

Ms JUBB — That is a really tough question. I know a lot of people respond to comments like this and say that if you are going to allow it for one person then why not allow it for the others? A lot of people say why is there a specific Aboriginal legal service? Is Victoria Legal Aid not for everybody and can Aboriginal people not access that as well? I do not know how to respond to that, because it is really vexed. Mike might be able to respond.

Mr ZACCARO — I am not indigenous, but I have been with the service approximately nine years and I am starting to get a feel. It is an education in life working for an organisation where you have been a solicitor for 32 years in different walks of life. It is an education in trying to understand and communicate with a group identified as having grassroots, whose members have nothing, are likely to have a very short life and have multiple problems — medical, psychiatric, financial, alcoholic. There is a great number of people and perhaps you might say, ‘How do I identify an Aboriginal or an indigenous person as compared to, perhaps, a Jewish person?’ I am part Jewish and born in Australia. But a Jewish person usually has a different intellect, a different background, a different heritage, a different understanding. Whereas if you look at the Aboriginal person you see he has nothing, is unlikely to have anything, has very few rights, is not accepted by the general public as such and is downtrodden.

I would say that you can put them into a class and identify them as having special needs, requirements, perhaps special consideration. When I approach the Victims of Crime Assistance Tribunal I use the words ‘compassion and understanding’ in extending the normal times that you would expect for a white person or a person from a different ethnic background who has better education, more expectations, desires and wants. Whereas when you put it on the side and look at the poor indigenous person, who I deal with on a daily basis, they do not understand anything. They do not understand money, budgeting — the basics.

The CHAIR — But Noel’s question was really about, for Australia’s first people would we make a special exemption that said if you object to an autopsy there will be none? That is the dilemma. It seems to me that theoretically we could make another recommendation which says that the coroner should develop protocols with VALS and other indigenous bodies around the question of autopsies, and that has not happened to date, or we could make a recommendation that said there should be special consideration for indigenous people bearing in mind that we have a number of other groups in the community who object.

Mr MAUGHAN — And you have put a powerful argument why we should; I accept that.

The CHAIR — The dilemma we are dealing with is how we will deal with this in recommendations. I guess that was behind Noel’s question.

Mr ZACCARO — I guess we are becoming a multicultural country.

The CHAIR — But it has not with other groups overrode the power that the coroner has to order autopsies if the coroner thinks it is appropriate, and that is what we are trying to get at. Should it, in this instance, with indigenous people?

Mr MAUGHAN — And you are arguing that it should.

Ms JUBB — Developing protocols is something that needs to be worked out between the community and the state coroner. In terms of us providing advice on it, it is a bit difficult. That is the reason why it was a recommendation in the first place that protocols be established; to work it out, to trial and error, to look into it a bit deeper. In a way that is an easier recommendation to make than saying special consideration. It may be that a protocol does.

The CHAIR — Or result in that.

Ms JUBB — Yes.

Mr DALLA-RIVA — Can I suggest that we do not do that? There is no need, because it is already recommended in recommendation 38, where there has been no progress. Our recommendation should be that recommendation 38 — —

The CHAIR — We are not here to debate our recommendation.

Mr DALLA-RIVA — You are talking about a recommendation that has not been implemented.

The CHAIR — No, I am saying we are faced with a dilemma.

Mr DALLA-RIVA — We can recommend what we like, but it was recommended back in 1991 and it has not been implemented. I could talk about it all day. It was in 1991 and there has been no progress.

The CHAIR — Which poses a particular dilemma for us as a committee. Are there any other questions?

Mr ZACCARO — May I just add a couple of small points? I have been involved in a couple of inquests before the coroner only, so I am coming from limited experience, but what I found was that the findings and then having recommendations, with recommendations they are not enforceable, they are only recommendations as such.

The CHAIR — That point has been well made to the committee.

Mr ZACCARO — Regrettably you can ignore them, put them to committees and then out to further investigation, but nothing gets done. What I am finding from the community is that it is wanting the answers. Yes, you go to a coronial inquest hoping you will find the answer — the cause, the contributing factor, what led to the death — but it may not be as simple as that. By making the recommendations I would like to see the Coroners Act changed to give the coroner more power, more teeth, so that if the coroner makes a recommendation then he has the power to enforce it. That would be a great help.

The CHAIR — What do you think of the view that natural-cause deaths which occur in custody do not require a mandatory inquest? That was something that the coroner expressed in his submission.

Ms JUBB — I mentioned in our submission that whatever you want to call it, perhaps systemic discrimination, there is word around the practitioners that Aboriginal deaths are classified as natural causes when they are not, so there is the danger that deaths that are not of natural causes are not inquired into. The implementation review hinted at this by saying that it was curious the Victorian deaths in custody that were analysed by the royal commission in 1991 were all seen as natural causes, whereas of the seven that have happened since 1991 in Victoria, some of them have been classified as by hanging or gunshot. The implementation review team says that is a marked departure from trend, that it is a positive trend and it is more attuned with what we know about Aboriginal deaths in custody and with the findings of the royal commission that deaths occur in this way. I guess the danger is if natural causes are not mandatory inquests, people will slip through.

Mr MAUGHAN — Would you therefore go to the next stage of mandating the coroner to inquire into every indigenous death in custody, custody being not just in jails but in the broader terms of being confined? Would that be a move that VALS would support?

Ms JUBB — Could I possibly get back to you on that blanket recommendation? I am not an authority to say that, but I cannot see why not.

Mr ZACCARO — May I give a small example of a recent date, just last week, of what is natural; what is a death by natural causes? A family told me about their grandfather who was in hospital — he was 89 years of age

with a catheter in him. He was in there having a bypass and with multiple other problems. His catheter was removed by another patient. He could have suffered, whatever. It could have come back from the hospital saying, 'Death by natural causes', or, 'Heart failure from the operation'; but it could have been the shock of what had happened to him by the actions of another patient. What is natural? Dare I say I would like to see a mandatory inquest by the coroner to find the findings where you have perhaps a patient in the hospital, who happens to see what goes on and reports it, or a relative who happens to come in just before his dad has his last breath. I would say, if you could explore what is natural; the hospital and the health services commissioner did their internal investigations and everything came back that he died of natural causes — but if there is the suspicion that it may not have been natural, that something caused it, that is one instance.

Another possible instance is where a person is in jail, in custody, is removed from jail and then dies of causes. What is natural? What happened to him in jail? He may have been sexually abused, bashed, assaulted et cetera; he comes out of jail and then dies. The question then is asked, 'He died of natural causes; what natural causes? It may have been through whatever. These are certain examples of recent date.

We had another one in the last couple of weeks where a prisoner died, which Greta just mentioned. He was sentenced to six months in jail. He died in jail. What was the cause? Before he went in there he was diagnosed with pancreatitis and an alcoholic problem, but from the information that has been passed to me he was given Panadol Forte. There will be questions asked as to how he died. Natural causes, a pancreatic problem, but why was he given the medication et cetera? The internal system may do its investigation and come out with natural causes, but what is natural? You have to then ask the family members who know of his past condition and history and who visit him in prison, and that may require the inquisitorial process.

The CHAIR — There are no other questions. Thank you very much for your time. We appreciate it and thank you for your submission.

Witnesses withdrew.