

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 20 September 2005

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Ms A. Mohummadally, community legal education and volunteer coordinator; and
Ms S. Staub, student, Disability Discrimination Legal Service

The CHAIR — I welcome to the inquiry from the Disability Discrimination Legal Service, Alyena Mohammadally and Sarah Staub. Thank you very much for taking the time to come along to represent your organisation. I think you were here earlier when we introduced ourselves. We are governed by the Parliamentary Committees Act. It is a public hearing. Your evidence is being taken by our Hansard reporters, and it will form part of the public record. If you would like to talk to your submission, then we will ask you some questions.

Ms MOHUMMADALLY — The Disability Discrimination Legal Service is a statewide independent community legal centre that specialises in disability discrimination legal matters. We provide free legal services in several areas, including information, referral, advice, casework assistance, community legal education and policy and law reform. The DDLS became involved in this inquiry because we believe the coroner can play a vital role in improving the current standard of care provided to prisoners with a disability. In particular the DDLS was concerned about the lack of accurate numbers of people with a disability within the prison system. We believe, despite people with a disability being overrepresented in the prison system, the number of prisoners with a disability is being significantly underreported due to poor intake procedures. This places prisoners with a disability at greater risk of discrimination and suffering serious or even fatal injury.

When we began research for this paper we started off with a very basic search of the Coroners Act to find reference to disability, disabled, mental, people with disabilities, people with a disability. We did not find anything, and this caused great concern for us. Although the DDLS has not worked directly on a coronial investigation, we became interested in this discussion paper because of our work with clients who have been discriminated against within the prison system. These cases have involved a failure to make proper adjustments for prisoners with physical disabilities that prevent them from complying with standard prison procedures. An issue of great concern to us is that we are currently working on a case that has a virtually identical fact scenario to a case that was mediated in 2001. Details of the 2001 case — and we cannot give you a citation or name — cannot be disclosed because of the requirements of mediation, but what we can say is that the case is virtually identical in fact to the case we are currently working on.

The case we are working on now is to do with a client who has a urine and bladder problem and combined with medication it makes it very hard for him to urinate on demand. The Victorian prison drug strategy says that prisoners are subjected to random urine analysis and they have to urinate on demand. He cannot do this. As a result of his being unable to provide a urine sample he was placed in solitary confinement. He was there from 29 December 2004 until 7 January 2005 when a Supreme Court order was made for him to be returned to the general prison population. He has also been denied contact visits for a period of two years because of his classification now as an identified drug user, which directly stems from the fact that he could not provide urine on demand. We were, after the 2001 case, given guarantees that changes would be made and policies would come through that would prevent this from ever happening again. However, it is 2005 and, as I said, we have virtually the same identical case before us. This highlights the need for more support in the prison system for addressing systemic problems. The prison system has not been made accountable for earlier incidents so prisoners with a disability continue to experience discrimination that is seriously jeopardising their health and safety.

We believe when investigating deaths in custody and care the coroner is in an ideal position to assist in the elimination of these forms of discrimination. If the coroner were to take or be granted the power of a more preventive approach to death and injury prevention they could inform policies and procedures to be implemented so that they adequately address the needs of prisoners with a disability. Despite their overrepresentation within the prison system prisoners with a disability do not appear to be properly accounted for in prison practices or in the Coroners Act.

Ms STAUB — In light of these client experiences and further research undertaken by the DDLS we would like to highlight the particular areas of concern we have with the Coroners Act and possible alternatives and amendments to the current system that we believe would improve the safety of people with a disability. Firstly, we believe the definitions of ‘deaths in custody’ and ‘deaths in care’ need to be extended to better address the particular vulnerabilities of people with a disability. We believe ‘evading and escaping from custody and care’ should be included in the definition. The definition of ‘in care’ should be extended to many more environments where people with disabilities often reside and receive services not simply those prescribed under the Mental Health Act. The term ‘immediately released from care’ should be more precisely defined, and we believe it should extend at least one month post release because of the particular vulnerability of people during that time. We believe redefining the types of reportable deaths in a clear and practical way would ensure greater protection for people with a disability.

Secondly, in our research for this submission we were unable to locate any coronial guidelines for investigating deaths of people with a disability. If they do exist, we believe they should be made more readily available to the public to enable public scrutiny. If guidelines do not exist, we believe they should be developed in consultation with peak bodies to ensure that coroners are directed to consider the particular needs and vulnerabilities of people with a disability. We would advise that guidelines direct coroners to investigate the appropriateness of the detention and the quality of care, treatment and supervision because of our concern that prisoners with a disability are not receiving appropriate treatment as indicated by our clients' experiences.

Any coronial guidelines need to be coupled with amendments to the act, which would include making death and injury prevention a function of the act and requiring relevant organisations to respond to coronial recommendations. Our clients' experiences highlight the importance of giving greater recognition to death and injury prevention within the act. The discrimination and serious risks to health and safety experienced by prisoners with a disability are often the result of systemic problems within the prison system with the reported death being, as the cliché says, simply the tip of the iceberg. There needs to be a cultural shift towards the prevention of death and injury, which could be generated by making death and injury prevention a function of the act. Mandating responses to coronial recommendations would also support this cultural shift. As is once again highlighted by our clients' experiences, the prison system needs to be made accountable for death and injury that occurs while people are in its custody and care. Real changes have to be made so this cycle of discrimination and serious risks to prisoners' safety does not continue. These are just some of the provisions of the Coroners Act that we wanted to highlight, because of the particular importance they have for people with a disability. We believe if amendments are made to the act that address the needs of people with a disability, the coroner's role could be better utilised to inform and support practices in the prison system and mental health care to improve the safety of people with a disability. Do you have any questions?

The CHAIR — Thank you for that. It gives us a unique insight into the particular issues that confront people with a disability, so we appreciate the time you have taken to put that to us. Can I just pick up one of your latter points first, which is this question of someone in custody? You suggested an extension of the law to include someone escaping custody. I understand the Queensland law also refers to someone who might die while trying to avoid being put in custody. I note also that in the Northern Territory it also extends to someone detained or escaping from detention under commonwealth law. Is that something you would like to see more explicitly dealt with in the Victorian context?

Ms STAUB — Yes, I think we would, both under commonwealth and state laws, because the research is out there indicating that people with a disability are often at greater risk of fatalities when they come in contact with the police. Some of the things we read were quite blatant in that that was almost the greatest risk to their health. It was a satire, I suppose, but coming into contact with the police was one of their biggest dangers. I know changes have been made in Victoria in regard to the way police deal with people with a disability in the community when they are called to a scene, but still it is not adequately addressing the needs. If the coroner could investigate those and it was clear in the act that they were reportable it would be good. I think it being placed in the act is a very important thing towards this cultural shift; it has to start from the top. That is why I think it is explicit in the act.

The CHAIR — I think in both Queensland and New South Wales the definition of a death in care extends to a person with a disability living in a residential service or a hostel. Apart from deaths in care, would you see that as extending to encompass those forms of accommodation as well?

Ms STAUB — Yes, we would definitely like to see that. The submission of Victoria Legal Aid was quite simple and clear in that way — that is, we would like to see it when people are living and receiving care. Because even in those situations where it is not a formal or prescribed care arrangement they are still away from the public eye to a certain degree and at a greater risk. I just think once again that if it was clear that the coroner could investigate in those situations it would just help develop policies and strategies and enable people with disability to live in more safety and security.

The CHAIR — I have just one final point on that. Yesterday in his submission in relation to mandatory inquests, which currently covers deaths in care, the coroner suggested that perhaps he should have the discretion to determine whether or not an inquest should be held into those kinds of deaths. Do you have any views about that? To give you a bit more information, he referred to only requiring inquests where the cause of death in this group of people is unknown or not a natural cause of death, so I suppose it is that question of how you would establish that. Do you have any views on that submission from the coroner?

Ms STAUB — Probably the only thing I would say is that sometimes, similarly to what we were discussing in regard to prisons — that is, the treatment, quality and standard of care — we would probably be more inclined for the coroner to investigate more often than not just because the standard of treatment and care could sometimes contribute to a death in ways that would not be immediately obvious. If it was at his discretion, and you may need to investigate to find these sorts of things out, I think that might be an important aspect.

Mr DALLA-RIVA — You raised the issue about the case in 2001. Was it subsequent to that case that the prisoner was subject to a coronial inquiry? Is that where that came from?

Ms MOHUMMADALLY — No, actually it was a bit of a discussion, shall we say, that we had with Corrections Victoria about how we wanted changes to be implemented in terms of the Victorian prisons drug strategy. I should probably say that we do not oppose the drug strategy; we understand why it is in place and we support it. But because our focus is on people with disabilities, we believe people with disabilities suffer extreme hardship under the policies that apply to people without disabilities. What happened in 2001 meant that this prisoner was actually put in an isolation cell as well and he suffered greatly until we got involved. There was a promise, let us say, or an agreement made that changes would take place. The prisoner is not deceased.

Mr DALLA-RIVA — I am just trying to put it in the context of our inquiry into the Coroners Act. I have concerns about the notion of making people with a disability who have died automatically subject to a coronial inquiry. I note your definitions of some of those, and again I might be going up the wrong path, but for people who have a variety of disabilities, not necessarily ID — they could have sensory disability, or whatever — you cannot seriously say that every death involving a person with the range of disabilities that you have outlined in your submission should be subject to coronial inquiry because that would seem rather unnecessary and a bit over the top. I understand what your intentions are, but I am grappling again with the practicalities and the application of what you say in your submission. How do you apply that, and who determines what person has what level of disability that therefore is subject to a coronial inquiry? I am just trying to get some guidance from your verbal submission today how you make that determination and give guidance to the coroner in respect of that matter.

Ms STAUB — We are interested in ensuring that the deaths of people with a disability are properly investigated, probably more so than the limitations of the Coroners Act — not just people with a disability but people with disability who have come in contact with the prison system, the mental health system, those who are living in care, or those who are involved somewhere in the government system. That is fairly broad, but we are quite happy to limit it to —

Mr DALLA-RIVA — As you are say we all know there are some people with disabilities that are not immediately recognisable. I am just conscious about how you would apply it. So it is more specific to where there is governmental care?

Ms STAUB — If someone becomes involved with an agency, and that contributes in some way to their death, so the agencies can be held accountable and changes can be made.

Ms MOHUMMADALLY — Basically if we go according to the commonwealth Disability Discrimination Act, discrimination is unlawful in areas of service provision. Although this has been contested, prisons are seen as service providers, so we would say that is an area where discrimination is unlawful. I hear what you are saying: disability being so broadly defined in Australian law means that, I would say, nearly everyone in this room might have a disability that is not visible.

Mr LUPTON — Could I just follow that up and perhaps clarify it a bit more. It is the sort of thing that you might be getting at that you would like the coroner to investigate death where someone's disability may have been a factor in their death in a more transparent way?

Ms MOHUMMADALLY — That is definitely a point that we are to pick up on because, for example, our current client cannot comply with these policies, and these policies are overriding everything else. So we want the coroner to have more power to say there have to be exemptions for people with, say, in this case, a physical disability.

Mr LUPTON — Clearly there will be many cases where someone dies purely of natural causes and the fact that they have a disability is irrelevant to their death. I would not see it as being necessary or good public policy to have the coroner simply investigate the death because they happened to be a person with a disability per se; but

rather that the coroner should be able to take into account issues where the disability may have been a contributing factor to their death.

Ms MOHUMMADALLY — We definitely have that issue in terms of mental health and illnesses that perhaps are not so visible. We have an issue that a lot of prisoners — and we mentioned this — are street smart. Perhaps the general intake procedure might not pick up on the fact that they have a certain illness and they end up self-harming or suiciding. Unfortunately I think it ends up becoming a cost issue. What we are proposing is a systemic change and perhaps expanding guidelines and creating a bit of awareness that prisoners with disabilities are more likely to reoffend, that they are more likely to self-harm, and that they need greater protection. I know that is coming up against walls like, ‘It will cost a lot’ and ‘It will be very hard to change’, but obviously our portfolio is recognising that we keep on getting clients who are discriminated against on the basis of their disability, be it direct or indirect, and we are hoping that the reform of the Coroners Act can address that.

Ms BEATTIE — You talked about post-release care and in your submission you mentioned the role the coroner can play in minimising post-release trauma for many people. How do you think the coroner can go about doing that? I will get you to expand on that whole notion of the coroner having care for people after they leave prison.

Ms STAUB — Maybe ‘care’ is not the right word. With the current definition the coroner can investigate the deaths of people who have been immediately released from care. I suppose I would like clarification of what ‘immediately released from care’ means placed in the act because I think it should be extended to a period of one month post release because of that particular vulnerability. If the coroner does investigate a death in that one month post-release — and I suppose this feeds into the coroner’s ability to make recommendations that need to be responded to — the coroner could therefore assist people in that post-release period through his recommendations and through those recommendations being adopted by agencies that assist people post release, or prisoners in prisons in their pre-release preparations for people. I suppose that is how I see the coroner being able to assist people post release.

Ms MOHUMMADALLY — We came across so many statistics that horrified us of how many prisoners actually suicided or died quite soon after being released. We wanted to put it out there — that if there is the power for the coroner to help with a preventive mechanism, then we would like to see that in place.

The CHAIR — I suppose it is this question of: would it be formally on an order, someone on some sort of supervision or community-based order or let us say there is someone who is on — —

Ms BEATTIE — Part of their parole provisions?

The CHAIR — Parole, or is it someone who once they leave prison is under no formal legal supervision but might then go and stay in transitional accommodation services run by many community agencies — I am just trying to get a sense of the breadth of what you are talking about. You have given a specific time frame which is one month after release, but I am trying to understand the various settings in which you believe the jurisdiction of a coroner should extend.

Ms STAUB — All those places are important, which you just mentioned, if they are informal, but I suppose maybe a bit idealistically that people just released from prison at all one month post release — because it is not the people who have the assistance and that have residential care set up when they come out, it is the people who do not have homes to go to and the people who do not have family support who are the most vulnerable, so I suppose idealistically it would extend once there was a death of someone who in the previous month had been released from prison, it would be investigated by the coroner.

Ms BEATTIE — I am just wondering why you think that role would be better fulfilled by the coroner in that post-release period than any other agency in overseeing the health and wellbeing of those people?

Mr MAUGHAN — Following on from that, it is not overseeing that you are suggesting — —

Mr LUPTON — It is being able to investigate a death.

Ms STAUB — Yes.

Mr MAUGHAN — Are you suggesting that if the coroner did this, then you might be able to establish a pattern in the prison system's failure to correlate training for pre-release? Is that basically what you are getting at?

Ms STAUB — Basically, yes.

Ms MOHUMMADALLY — We are big on preventive roles.

Ms STAUB — We see the coroner's role as feeding in to a lot of others and supporting a lot, just through investigating, just more clearly defining where they can investigate and taking more preventive and proactive recommendation approaches. It can just feed in to a lot of strategies. The prison drug strategy is one example that we have come across. It does not reflect the specific needs of people with a disability, and I do not know whether there has been a coronial investigation into someone who has died as a result of that but if there was to be one, I suppose, we would see that they would recommend, and that would then feed into the development of stronger and more appropriate policies that reflect the needs of people with a disability.

Mr LUPTON — If someone died by suicide now, having been released from prison or some such, there does not seem to be any reason that the coroner could not now investigate that or that that would be the sort of death that the coroner has the power to investigate currently?

The CHAIR — Have a mandatory inquest?

Mr LUPTON — Yes, are you trying to strengthen the power so that it is more common that those be investigated and is trying to establish things like trends over a period of time important in that consideration?

Ms MOHUMMADALLY — We are definitely trying to increase the workload of the coroner!

Mr LUPTON — I can see both of them smiling back there, so that is good. I assume it is a question of the number of these sorts of investigations that are carried out but more particularly rather than just the number of them, the ability to look at trends over a period of time which would hopefully help in greater prevention.

Ms STAUB — Yes, we would definitely like to see that. It is important. As Alyena was saying, we see the same issues come up again and again. You really can see that there is a need for someone, and I think the coroner has this unique role, to be able to feed into that and to help develop these strategies.

The CHAIR — You also mentioned that you think suicide should be more specifically listed as a reportable death. Obviously, an unexpected death — suicide is an unexpected death — and you are saying you do not think that is an adequate provision in the current act?

Ms STAUB — I think throughout the act we found in a lot of the definitions that we would have liked to see more clarity and more practicality, because a death cannot be investigated until it is reported. We would like to see it more clear for people who are to report and make it more practical. I suppose we were just once again highlighting that suicide is a great problem for people with a disability, and we were once again highlighting the shortcomings of the Coroners Act in dealing with people with disabilities that does not address their particular needs. That was probably what that suicide was about — just more clarity in the act, I think.

The CHAIR — Yesterday we had a considerable discussion about under reporting. Are you saying in a sense that if the act used plainer language about the types of events that should be reported, that that would improve reporting? Is that what you are suggesting?

Ms MOHUMMADALLY — Definitely, like when we used the Act to just look up and see if disability was mentioned at all, we think that it should be and we think that it is important to include it in definitions, and it does become more specific and not so broad, but obviously since we see that or we have put in a submission that there is that causal link between suicide and prisoners with a disability, that these words should be defined and made clearer so that the public know exactly what is covered by the act.

The CHAIR — I think we have covered all the key issues you have raised. I thank you taking the time to bring that unique perspective to us, we appreciate it.

Ms STAUB — Thank you very much.

Witnesses withdrew.