LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Ms V. Topp, lawyer, Mental Health Legal Centre.
The CHAIR — Vivienne, welcome to this supplementary hearing of the parliamentary Law Reform Committee inquiry into coronial services. It is a public hearing subject to the Parliamentary Committees Act, and therefore the evidence you give us is subject to parliamentary privilege. It will be on the public record unless you desire to give any of your evidence in camera. After you have had the opportunity to correct factual errors in the transcript it will be put on our web site as a public submission.

If you would like to talk to the key points of your submission, we would like the opportunity before the end of your time to ask questions and engage in some discussion with you.

Ms TOPP — Thanks. That is fine. Our submission was brief, and I indicated in it that we actually supported the Federation of Community Legal Centres and had some input into their submission, but there were quite a number of issues that I was really keen to raise from the perspective of the Mental Health Legal Centre.

Just by way of background, the Mental Health Legal Centre is up to 20 years next year, and the centre was funded at the same time as the Mental Health Act and the Guardian and Administration Board Act and the changes to the State Trustees act were all put together as legislation that protected the rights of Victorians.

At that time in Victoria we still had a mental health system that was largely hospital based, so the legislation was there to protect those people. That is significant in terms of what the act does to protect people with disabilities because in 1986 people were involuntarily detained in hospitals. Now they are involuntarily detained in the community. Hospital stays are short and brief, and people are discharged either voluntarily, having had a hospital admission, or involuntarily on community treatment orders, which are reviewed every 12 months. Sometimes people stay on those orders for up to 10 years with an annual review. That is relevant specifically in terms of reportable deaths in your question 4, in that we believe ‘death in care’ should include situations where the person is actually detained in the community, and we would make that one of our recommendations.

The other part of people being detained is that under the Mental Health Act it is of course only people in public hospitals who are deemed to be detained. Everybody else in the private system is not detained, cannot be detained, as involuntary. They are consenting and voluntary patients, so if you are in the private system you are not a public patient, you are not involuntary, but we would think the deaths of those people also should be reportable. That is quite hard to define, and I grappled with some sort of support and recommendation in relation to that, but I think all I can do is raise it and say that it is a real concern for us that people in the private health system who are deemed to have a mental illness do not have the same protections as other people and that they are not going to be reportable deaths.

The other issue with reportable deaths is the flow-on effect. Under the Mental Health Act eight weeks after detention, if the person is still involuntarily detained, they have to be reviewed under the act. What happens with short hospital stays is that people might be involuntarily in hospital and then discharged, not on a community treatment order but discharged voluntarily. We know anecdotally from clients of many circumstances where the person really is not well, and if we are going to be examining the deaths of those people, how can we do it? How can we ensure it? If you are involuntarily detained on Thursday and on Friday you are not, and you are dead on Saturday, then in our submission that should be a reportable death too.

In our submission I suggested eight weeks as the sort of flow-on after discharge from involuntary detention in the community. I spoke to Ian Freckelton last week. I said, ‘What do you think?’ People kind of thought three months might be a more reasonable period than eight. The reason I chose eight weeks is that that is the review time under the Mental Health Act as it stands at the moment, so it seemed as though that was an argument.

Our centre does not represent people in coronials. We act on a model of taking instructions from the person. We do not act for carers and we do not act for family. We are very strict on that. It is the legal centre. Who else is the voice of the person except for a legal centre for people with disabilities? Having said that, however, there are often families who will ring me particularly or one of the other lawyers at the centre and ask for support when a family member has died, and we will just refer them on, but we will not act for the person. That is a real gap, I think, in what is happening down at the coroners office — you know, who acts for the person; who reconstructs the person’s life in terms of what were their expectations for services; and what were their disappointments? — but we cannot act in that capacity because there are a lot of people we act for in many other different jurisdictions who do not want to be obliged to have treatment and care, who do not want mental health services, who do not want to
recognise that they have got, or to be labelled or stigmatised as having, a mental illness. So you can understand where the Mental Health Legal Centre is coming from.

It is the same also if there is an issue of somebody committing suicide. If we are trying to reconstruct, from the legal centre’s perspective: would they have wanted us to ask questions about why were the services not supporting us? We cannot know without taking their instruction beforehand. Having said that, though, there is one that I was particularly keen to work on, and my committee of management said that would be possible. She was a woman who died not from suicide; but because she was obviously at an area mental health service and getting support from a doctor and she was also getting support from a number of different doctors in the community. The area mental health service was really concerned that she was doctor shopping and had sent letters to the local community about whether or not they could commit to communicating with the area mental service about whether she was coming in and misusing medication — it sounded to me, towards her death. I actually took instructions from her the day before she died, but she was overweight and there were a lot of other issues that were physical health issues, and I felt she would have wanted me to ask some questions about her general medical care.

The only way you can then be a party to a coronial hearing is if — and I did contact her family. She was a Koori, and her family was most concerned not to have anything to do with the coronial process. I just assured them that I would be pleased to act and I probably would have got legal aid on public interest, but that is up to the family. I think that in terms of the person being represented, it is really difficult to capture their voice. As far as the family is concerned, in our submission we recommend that there ought to be a legal service to support families. When families do come to us, the only way we can get funding is either if they fund themselves — because a lot of them are not eligible for legal aid — or if you have a public interest argument.

A lot of people just brief a barrister to appear for them on the day and do not get a lawyer. That is really difficult. The coronial files are vast and difficult to negotiate. It is hard to know what questions to ask. I am sure you have heard all this before, and I am just reinforcing what other people have said. You have got my submission, have you?

The CHAIR — Yes.

Ms TOPP — I think in terms of the rigour, we believe the coroner has a duty to look at systemic issues and to ask questions about recommendations that are deemed appropriate with a view to preventing further custodial deaths. People with mental illness often live isolated lives. They are socially isolated. Often they do not have family who show up to a coroner or even take much interest when they die. Given that they are so disempowered or detained under the act and detained in the community, the coroner must assume a responsibility in asking questions about what sort of supports this person had and what were the circumstances surrounding their death.

Your report is great; it is so useful and easy to read. We would like a lot of the recommendations under appendix 1 — the Royal Commission into Aboriginal Deaths in Custody — to apply to people with mental illness, particularly recommendations 12, 13, 14, 15, 17, 18, 23, 24, 26 and 32. These are issues that are relevant to our clients as well. Recommendation 24 — the Victorian government is at the moment looking at developing a victim’s charter, and I see the coronial process as being part of the victim’s charter that we should incorporate too.

For many people with mental illness the last opportunity to raise complaints is the in coronial process, and we cannot not hear what complaints have been raised. People raise complaints whilst they are in care, and they fall on deaf ears. There is no-one with determinative powers in Victoria to hear complaints. We need those recommendations to be heard and someone with determinative powers and a power to review to hear the complaints.

In terms of the coroners office we would want more public accountability and scrutiny, proper statements of reasons — they vary so much in terms of what the coroner is saying. They just need a pro forma to answer questions and to cover all the areas.

The other big issue for us is suppression of details that identify parties. That is a big issue for people with mental illness. I do a lot of work with people who have been found not guilty of serious offences because of mental impairment. I would say that of the 50 clients in Victoria at the moment who are held under the Crimes (Mental Impairment and Unfitness to be Tried) Act all bar one has a suppression order in place. You go through the
criminal justice system and your details are suppressed. You go down to the Coroners Court, however, and the whole coroners inquiry is sprinkled with the alleged offender’s name.

I had success down there one day, however, with a woman who had come to the centre and had had a suppression order. They were investigating the deaths of family members. I ran a suppression argument to the coroner, and we were successful. That was probably because the Herald Sun and the Age were there and both reporters were pretty sympathetic to the case. If you were going to go for a suppression order, if you were going to hang a notice outside the door that you will be applying for a suppression order, then I think it could be difficult, because there are no grounds under the act to do that.

The real difficulty in terms of people with mental illness is trying to reconstruct the person, unless there is somebody who knows the person and who cared about the person or who is sufficiently savvy about the system to pick out what is on the file. We appear in front of the Mental Health Review Board — that is primarily what our service does — and the report in relation to somebody’s continued detention will be on the grounds that they pose a serious risk to others. You can go through 8 to 10 files and find that there has never been an incident of that; it becomes folklore. Dangerousness and mental health become folklore. If the coroner has a quick look at the files or the hospital is protecting, they might conclude all sorts of things about the person which are not founded and are not tested because the files on psychiatric patients are filled with hearsay evidence.

Lastly, I think there are some wonderful families and carers who go down to the Coroners Court. They have paid for themselves and had fantastic representation — I respect them — but many adults with mental illness are in conflict with their families. Their families are not necessarily the best people to ask questions on their behalf; they are two voices.

Mr MAUGHAN — Coming back to your instance of somebody who may have been detained against their will earlier in the week or even have been there for a long time and who is discharged on a weekend and dies or suicides — there seem to have been a number of these cases — are you satisfied, from the mental health point of view, that the coroner does look at the systemic failures that could well have led to that death in the first place rather than just finding that the person died by an overdose or jumping in front of a train or whatever it might have been?

Ms TOPP — I am not satisfied that the coroner does that. It is probably because the person is removed from the system. You will not necessarily have a lot of the case managers that have known the person there. The coroner might read the last file, but you do not have that same sort of history because the issues are not alive and on the table. No, I am not satisfied.

Mr MAUGHAN — How then do we get a better outcome, because it would seem that there is a deficiency in that area? How do we get the facts out to prevent further similar deaths because of problems with the system rather than with the individual?

Ms TOPP — I think there is a real role for advocacy organisations to monitor what deaths are being investigated and to get standing to ask questions on behalf of the person. That would assist the coroner. Unless that happens there will be a lot of deaths that are not even perceived to be deaths of persons that should have been reportable deaths.

It is really difficult to define, even inasmuch as people are voluntary. Some people are involuntary for a long time. Their psychiatrist might give them a so-called chance to be voluntary — often that is coercive involuntary detention — and say, ‘I will take you off the order if you promise to continue to take your medication, you promise to go to Clarendon Clinic and you promise to see this person and this person’. Is the person voluntary or involuntary? For some of those people, if there was standing for an advocacy organisation and lawyers to ask questions on the person’s behalf, more vigilance and more transparency in terms of the death, I think that is what would be needed.

The CHAIR — Could I just clarify a jurisdictional question. You said that private services do not come within the ambit of the act. Is that right?

Ms TOPP — That is right.
The CHAIR — They do not fit within the definition of a reportable death where the death is of a person who immediately before death was held in care and was a patient in an approved mental health service. Are you saying that private services are not approved under the Mental Health Act?

Ms TOPP — They are approved, but they are voluntary patients. They are not held in care, they are not obliged to undertake treatment and care.

The CHAIR — So it is that question of ‘held’?

Ms TOPP — Yes.

The CHAIR — What about, though, the question of their being a patient within the meaning of the Mental Health Act but not held in care?

Ms TOPP — They are not within the meaning of the Mental Health Act.

The CHAIR — Because they are not subject to a formal treatment order, is that what you are saying?

Ms TOPP — That is right.

Mr MAUGHAN — You spoke about the need to have a suppression order on the identity of people who have been inquired into by the Coroners Court but have committed a serious offence — murder, manslaughter, whatever — and where that identity can be suppressed in the court system. It seems a major anomaly that that cannot continue in the Coroners Court. Presumably what you are concerned about is that when that person is subsequently approved for release to the community the media plays up all the horrific crimes committed by that person when they were mentally unwell.

Ms TOPP — That is right, yes. Fortunately it does not happen a lot because often the coronial inquiry might be three years after the event. It is fairly Sleepy Hollow down there, and you do not often have reporters who are picking up issues. But certainly I think it is a real oversight, and it would be very simple to remedy I would think. It would just be an application. Section 75 of the Crimes (Mental Impairment and Unfitness to be Tried) Act is applied very generously by the Supreme Court in terms of suppressing people’s details, because it is counter to their rehabilitation, as you have identified.

The CHAIR — You raise grave concerns about the practice of plea bargaining where a hospital or a department might agree to certain actions in exchange for concessions, and you make particular reference to Kew Cottages and what happened there. Can you explain a little more about what you mean by that practice and what actually happens?

Ms TOPP — I think there — —

The CHAIR — What happened at Kew Cottages, for example.

Ms TOPP — Do you know the Kew fire?

The CHAIR — The fire.

Ms TOPP — Yes. I think there were some concessions in terms of who essentially was going to be responsible for that at the end of the day. There was a keenness to protect some of the workers, some of the stuff. For a little while I worked in the Department of Human Services coordinating the coronials from the perspective of young people who had died. It was interesting, and I think that is why I refer to the department assisting people in preparing and presenting their statements. There are deep pockets and there are big fish involved with coronial inquiries. It is an inquisitorial process, and the coroner should be equipped to know exactly what is going on and be able to ask free and frank questions. Sometimes cases are elevated — because barristers negotiate or whatever — and the coroner must be vigilant about any negotiations in whatever is happening.

The CHAIR — And the question of who takes a statement from, say, Department of Human Services staff in the case of the Kew fires. Who should do it if not the department? Should it be police, for example?

Ms TOPP — I think that would be much more appropriate.
The CHAIR — Or police assisting the coroner or in a special role?

Ms TOPP — Or a separate investigative arm. It seems to me that you need a separate investigative arm for this. It is really hard. You get a coroners brief and you go through it and you know a bit more about the story and the circumstances that people live in, and there are half a dozen people you want to hear from. The police are terrific and are really helpful, but they have other, more important work. These files are not urgent; the person is dead. They do not have that sort of urgency of inquiry, and they do not necessarily know the service system. So I think it is really important that there is a specialist investigative arm to look at that.

The CHAIR — In your submission you raise concerns about a lack of consistency in terms of the rigour with which different coroners approach matters. In your experience is that a country-city divide, or do you think it is something that operates even with the metropolitan jurisdiction of the Coroners Court?

Ms TOPP — I think it varies very much in the metropolitan area as well. Some coroners are very experienced. It is a huge area to know, for instance, what is offered to people with a mental illness — just that in itself, and if you are looking at children in care and juvenile justice, it is a huge area.

The CHAIR — Yes.

Ms TOPP — And some coroners do not know the service system or which questions to ask. So it behoves the rest of us to provide them with that information.

The CHAIR — Is the solution to that to have someone assisting the coroner, who may also even assist the families, who has special expertise in the mental health system?

Ms TOPP — I think there is a role for someone to assist the coroner. I think it should be different to the role of someone who is assisting the family, as it is a different role to the person who is representing the person.

The CHAIR — I was going to come to that because I am curious about that notion, because if it is not the family, if it is not you, presumably it cannot necessarily be the case worker — —

Ms TOPP — No.

The CHAIR — The mental health worker who has supervised the community-based orders or the involuntary detention orders, because they may be subject to the investigation. Who would it be?

Ms TOPP — I think ideally it would be Community Legal Centre. For a person with a head injury it could be Headway; for a young person it could be Youth Law; for a person with an intellectual disability it could be Villamanta, it could be us.

The CHAIR — Yes.

Ms TOPP — It has to come from people who know and who are able to reconstruct as much as possible.

The CHAIR — And would that be the case even if you had had no direct dealings with that individual?

Ms TOPP — I think — —

The CHAIR — Are you seeing it as a public interest advocate in some senses? Is that how you see the role?

Ms TOPP — Yes. The Office of the Public Advocate sometimes has standing to appear in particular matters. It had standing to assist the coroner in the Kew fires. It did not have a role, but it had standing. Now there is not the ability to do that, and I think we should have the ability to do that.

Mr MAUGHAN — Do you think the public advocate or other bodies such as that play a sufficiently important role where you have an organisation — a hospital or a government department — that takes statements from people associated with working for that organisation and presents to the coroner? There is certainly the perception that there could be some tilting of the evidence in favour of the organisation to protect its own interests rather than the truth coming out?
Ms TOPP — That is right, yes.

Mr MAUGHAN — How do we overcome that perception, at least? It may be that the reality is that the evidence is slanted to make an organisation look better than it otherwise would if all the facts came out?

Ms TOPP — Like the recommendations in relation to Aboriginal deaths in custody, there needs to be more accountability and reporting to Parliament. There needs to be more transparency in terms of the process. There needs to be broad standing for interested people to ask questions. The Office of the Public Advocate comes from a different perspective than we do, for instance, because it acts on a best interests model, whereas we act on instructions. So it will ask questions about what it perceives to be the person, so it says, ‘This person ought to have been detained because they were not well’. We would say, ‘Well, they did not like that medication’ or ‘They did not like this treatment’ and all those other issues.

The CHAIR — In your submission you indicated that lawyers often direct pleas to people outside the usual run of those interviewed for statements and evidence critical to proceedings. Have you got any examples of where that has happened in your experience?

Ms TOPP — Yes. The police might not know that someone was seeing a GP, and they might say, ‘They did not come for their medication to the area mental health service’. The family might know that they saw the general practitioner weekly, who spent 25 minutes with them, and we really want a statement from them, because they have been monitoring the person’s mental health and they knew they were unwell or were fearful of their lives or whatever. So there are a lot of examples.

Mr MAUGHAN — Just a final question on the practice of relatively inexperienced police officers cross-examining expert medical witnesses. You expressed some concerns about that. What is the answer to that one to get the cooperation? Firstly, are you suggesting that the medical officers do not cooperate because the person who is cross-examining them does not have deft skills? If that is the case, how do we better resolve that issue?

Ms TOPP — I think your suggestion of somebody assisting the coroner to cross-examine, and then if you have other parties being represented as well there are other barristers or people cross-examining the doctors present. I would not want to be critical of doctors. If you think about people with mental illness, a lot of our clients want to see a GP, they do not want to see a psychiatrist. A lot of the psychiatrists will work with a general practitioner — they might only see the person once every six months to review their medication, and the person will be monitored by the GP. There are often areas in the person’s life where the GP, for whatever reason, does not cover even their general medical needs. There are a lot of women with disabilities who never have a smear test, because the doctor does not think about it — ‘That is not something I do for all my clients automatically’ — whereas that is what well women can go there for. The person may have cancer. There are a lot of times when people with psychiatric illness have undiagnosed and untreated physical illness. That needs to be discovered, it needs to be known, it needs to be monitored. I do not want to say we want to attack doctors for being inadequate, because I think that is the nature of general practice.

Mr MAUGHAN — The point is well made.

The CHAIR — Thank you very much. We appreciate your coming today and making your expertise available to us.

Witness withdrew.