DEATHS IN CARE

Then and Now

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Townsville Community Legal Service
Topics

• Our Experience
• Grave Concerns
  – Case Studies
• Reforms
• Opportunities for Systemic Reform
• CLC Involvement
• Resources
Our Experience

TCLS has been involved with deaths in various institutional settings:

• Accommodation Services
• Hospital Wards (Emergency, Psychiatric)
• Police Watchhouse
• Correctional Centre
• Aged Care/Nursing Homes
Experience in Context

- **Health Care Related Death**
  - Hospital Care/Treatment
  - Aged Care

- **Death in Care**
  - Residential Services
  - Mental Health Service

- **Death in Custody**
  - Correctional Centre
  - Police Watchhouse
20 years ago Townsville Community Legal Service published **Grave Concerns – Institutionalised Death in Queensland: A Review of the Coroner’s Act 1958**.

Grave Concerns used 3 case studies to critique the legal system's response to deaths in local institutions:

- a death in a psychiatric ward
- a death in a prison (Townsville) and
- a death in an accommodation service for people with disability.
Grave Concerns

“This report is about people living in institutional care. They are vulnerable. They often do not have a choice about where they live. They are shut away from the view of the public. As a consequence of their position, they do not have a strong and articulate voice to awaken public attention to instances of institutional abuse or neglect.

If they die, the fact of their death can be an important signal to the community that the care that has been given to them may be deficient…. However as a signal, these deaths have been, and continue to be, ignored.”
Inquiry into Deaths (Then)

Inquiries by coroners

7.(1) A coroner shall have jurisdiction to inquire …

(a) in the coroner’s opinion there is reasonable cause to suspect that the person—

(ii) has died in such circumstances as to require the cause of death or the circumstances of death or both to be ascertained or more clearly and definitely ascertained; or

(b) that the person has died within the State while detained in any prison or psychiatric hospital; or

(c) in the coroner’s opinion the person has died within the State in such a place as to require that inquiry; or
Inquests into Deaths (Then)

Inquests on death (4)
If as the result of a post-mortem examination, or otherwise as the result of the coroner’s inquiry the coroner is of the opinion that—

(a) there is reasonable cause to suspect that the person—
   (i) has died either a violent or an unnatural death; or
   (ii) has died a sudden death of which the cause is unknown; or

(b) the person has died within the State—
   (i) while detained in any prison or psychiatric hospital; or
   (ii) in such a place as to require an inquest to be held; or

(c) the person has died in such circumstances as to require an inquest to be held; the coroner shall hold forthwith an inquest into the death of that person unless, in a case specified in paragraph (a) or (b) it is decided, pursuant to section 16, that the holding of an inquest is unnecessary.
Deaths in care
Grave Concerns

“The case studies illustrated the need for mandatory coroners inquests when a person dies in an institution.

It is in the interest of the living that proper inquiry should be made about the standard of institutional care that had been extended to the dead.” (emphasis added)
Case Study 1: John

Cootharinga Society of North Qld: Accommodation Service for people with Physical or Intellectual Disability
Case Study 1

- **John**, 36, died after living in an institutional care for 27 years (p.21)
  - Was abused and neglected in care
  - Hit, pinched, clipped, slapped
  - Overmedicated and wrongly medicated (anti-depressants, tranquillisers)
  - Immobilised via Chair controls
  - Denied basics: food, teeth cleaning, shade, sweets
  - Tendons in fingers and legs cut, no physiotherapy
Case Study 1

• Cause of death was variously reported:
  – Progressive muscular dystrophy
  – Cardiac collapse

• He did not have a psychiatric illness

• Not a reportable death because the institution (the largest provider of care in the region) did not fall within the definition in the Act

• No investigation occurred in respect of his care
Case Study 1

• Exposed the deficiencies in the Coronial system:
  – Limits of definitions around institutional care
  – Deficiencies in what was a reportable death
  – Reticence of Coroners to investigate gray area cases
  – Absence of scrutiny of policy and practice
Case Study 2: Mark

Townsville General Hospital: Ward 10B Psychiatric Unit
Case Study 2

• Mark, 34 year old single man died by hanging in his room in Ward 10B (pp.11-12)
  – A Coronial Inquest had been held with findings 2 years before the Carter Inquiry
    • No specific recommendations made to diminish possibility of future deaths
    • Finding that the death by hanging was predictable and preventable
  – A case of neglect which culminated in death
Case Study 2

- Commission of Inquiry into the Care and Treatment of Patients in the Psychiatric Unit of the Townsville General Hospital between 2nd March, 1975 and 20th February, 1988
- 1991 Commissioner William Carter QC found:
  - 27 suicides linked to ward practices:
    - Informed staff of their intentions
    - Attempted immediately prior to admission
    - Discharged without pre-release assessment of risks
    - Lack of proper diagnosis and treatment
Case Study 2

- Exposed the deficiencies in the Coronial system:
  - Lacked a preventative role as a central purpose
  - Unable to identify systemic treatment problems
  - The systemic problems were compounded each time no inquest was held or no recommendations made
  - Eventually it took a Royal Commission to uncover the systemic issues
Post Script

• Similar cases in the Public system were uncovered by Royal Commission(s)
• Queensland Public Hospitals Commission of Inquiry initiated by concerns and complaints about Dr Jayant Patel
  – 13-17 Deaths
  – Convicted of Manslaughter of 3 Patients (Now Quashed)
• Also included the “fake” Psychiatrist Dr Vincent Berg
  – 259 “patients”, 1 death
Case Study 3: Stephen

Townsville Correctional Centre
HM Prison Townsville was opened in 1893.

The Sheriff of Queensland, William Townley, described it as "superior in its construction ... and ought ... minimise the great evils of association", while Comptroller-General, Captain Charles Edward de Fonblanque Pennefather claimed it to be "the best constructed prison in the colony".
Case Study 3

- Stephen, 20 years old, died by hanging (pp.16-17)
  - Accommodated in C Wing, widely condemned 1.5 x 2.5 metre cells with iron doors, barred window, not sewered and no running water, concrete floors…
  - Burdekin found they breached multiple international standards, “the violations of human rights involved in the appalling conditions in these facilities were so flagrant…they breached the Torture Convention”

- Inquest was held but no legal aid, no adjournment
Townsville Prison

• Exposed the deficiencies in the Coronial system:
  – Limited ability for family to participate
  – Limited resources for representation
  – Limited resources for costs associated with travel, accommodation
  – Reticence to look into issues in the public interest
Reform?
## Inquests in Context

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Reporting period</th>
<th>Deaths reported</th>
<th>Investigations without inquest</th>
<th>Inquests</th>
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<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>2006-2007</td>
<td>unknown</td>
<td>unknown</td>
<td>21</td>
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<tr>
<td>New South Wales</td>
<td>2010</td>
<td>5448</td>
<td>unknown</td>
<td>196</td>
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<tr>
<td>Queensland</td>
<td>2009-2010</td>
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<td>3667</td>
<td>78</td>
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<tr>
<td>South Australia</td>
<td>2010-2011</td>
<td>2148</td>
<td>unknown</td>
<td>36</td>
</tr>
<tr>
<td>Tasmania</td>
<td>2009-2010</td>
<td>571</td>
<td>555 (approximate)</td>
<td>11</td>
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<tr>
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<td>2010-2011</td>
<td>4857</td>
<td>5050</td>
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</table>
Reforms

- Obviously many issues with the *Coroners Act 1958*
- Multiplicity of problems
- Despite this, it took a decade to see the *Coroners Act 2003*

And yet, many issues still arise related to:
- Representation
- Definitions
- Sensitivities of the process
- Recommendations and Implementation
8 Reportable death defined

(3) A death is a reportable death if—

(a) it is not known who the person is; or
(b) the death was a violent or otherwise unnatural death; or
(c) the death happened in suspicious circumstances; or
(d) the death was a health care related death; or
(e) a cause of death certificate has not been issued, and is not likely to be issued, for the person; or
(f) the death was a death in care; or
(g) the death was a death in custody; or
(h) the death happened in the course of or as a result of police operations.
Deaths in Care

• The Coroner’s Court describes a “death in care” as follows:

Deaths of categories of vulnerable members of society (namely children in the care of Child Safety Services, the mentally ill and the disabled) are reported to a coroner, irrespective of their cause.

• A “death in care” is now defined by section 9 of the Coroners Act 2003 (Qld).
Deaths in Care (Now)

A death in care occurs when the person who has died:

• had a disability such as an intellectual disability or an acquired brain injury and resided in a residential service provided by a government or non-government service provider
• had a disability such as an intellectual disability or an acquired brain injury or a psychiatric disability and lived in a private hostel (not an aged care hostel)
• was being detained, taken to or undergoing treatment in a mental health service
• was a child under the guardianship of the Department of Child Safety or in foster care

These deaths are reportable even if the death occurred in a place other than where the person lived.
## Deaths in Care in Qld

<table>
<thead>
<tr>
<th>Year</th>
<th>Reported Investigated</th>
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<tbody>
<tr>
<td>2003-2004</td>
<td>31</td>
</tr>
<tr>
<td>2004-2005</td>
<td>36</td>
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<td>2005-2006</td>
<td>53</td>
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<td>2006-2007</td>
<td>56</td>
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<tr>
<td>2007-2008</td>
<td>Not Reported</td>
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<tr>
<td>2008-2009</td>
<td>33</td>
</tr>
<tr>
<td>2009-2010</td>
<td>98</td>
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</table>
Ongoing: Reporting Deaths

Underreporting of deaths in care is a common issue in Queensland.

- the statutory definition: limitations in scope, interpretation and application
- Reporters unaware of their obligations under the Act;
- Confusion about what facilities are subject to the Act
- whether a person suffers from a disability
Opportunities for Systemic Reform
Opportunities For Systemic Outcomes

CLC INVOLVEMENT

- Reportable
- Reported
- Investigated
- Inquest
- Prevention
• Commentary to ensure the Act keeps up with changes in the institutional landscape
• Agitate for consistent model definitions across jurisdictions
- Ensure that deaths are reported
- Educate and inform the community about when deaths should be reported, especially for vulnerable people
• Ensure investigations are conducted in a proper manner
• Represent and resource interested parties and families in the process
- Advise, represent and assist parties to Inquests
- Apply for Legal Aid
- Access pro bono assistance
- Follow up implementation with families
- Design law reform strategies to push for changes
- Build into specialist services (older people, consumer, disability, EDO)
Aged Care Cases

• The issues are still present
  – Storage of Equipment (Hoist)
  – Staffing levels
  – Patient supervision
  – Notification of infectious disease
  – Health management
Suicide Cases

• The issues are still present
  – Timing and adequacy of psychiatric review
  – Purpose and adequacy of clinical handovers
  – Collaboration with the families of mental health patients
  – Family understanding of suicide risk
  – Family role in suicide prevention
  – Treatment and discharge plans
Burdekin Inquiry (1993)
Forgotten Australians (2004)

Blaxell Inquiry (2012)

Mulligan Inquiry (2008)

Forde Inquiry (1999)
Carmody Inquiry (2012)

Slattery Inquiry (1988)

Cummins Inquiry (2012)
Parliamentary Committee (2012)


- CLAN
- Find and Connect
Individual CLC Involvement
Individual CLC Involvement

“Community Legal Centres have a long history of representing families at Coronal Inquests. These have included inquests related to deaths of people in the custody of police, prisons, juvenile justice centres and detention centres, deaths as a result of fatal shootings by police and deaths of people whilst on statutory orders and the responsibility of government.”

Federation of CLCs, 2006
Individual CLC Involvement

“However, many families who have lost loved ones experience the coronial process and its aftermath as traumatic, mystifying, frustrating and disempowering. Families need legal representation and other support in order to be able to exercise their human rights to fully participate in the inquest, …”

Federation of CLCs on Behalf of the Australian Inquest Alliance
Systemic Reform

- Australian Inquest Alliance
- CLC Policy Experts:
  - PIAC
  - Federation of CLCs
- Individual CLCs:
  - Flemington & Kensington Community Legal Centre
  - Caxton Legal Centre
  - Prisoners legal Service
CLSIS

- No specific codes for death investigation/inquest
- CLCs have no national data/picture
- CLCs need a Level 3 code for
  - Death Investigation
  - Inquest
  - DV death review
Individual CLC Involvement

• CLC involvement
  – Legal Representation
  – Court Support
  – Law Reform
  – Community Education

• Other Agencies
  – Legal Aid Commissions, Inquest Units
  – Pro Bono Assistance
Resources

• CLAN

• National Coronial Information System
  – www.ncis.org.au