

**THE DISABILITY DISCRIMINATION LEGAL SERVICE INC  
(DDLS) SUBMISSION TO THE VICTORIAN PARLIAMENT LAW  
REFORM COMMITTEE on *THE CORONERS ACT 1985 (Vic)***



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**Special thanks to the members of the Corrections Working Group and the Federation of Community Legal Centres (Vic)**

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## 1. WHAT IS THE DDLS?

The Disability Discrimination Legal Service Inc (DDLS) is a statewide independent community legal centre that specializes 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 works actively towards the eradication of disability discrimination and facilitates and promotes justice for people with disabilities through community legal education sessions to professional and community groups to raise disability awareness and provide information on the *Disability Discrimination Act 1992 (Cth)* and the *Equal Opportunity Act 1995 (Vic)*. We also undertake community development research projects to investigate and challenge current social, economic and legislative issues affecting people with disabilities in the community.

DDLS came to be involved in this paper through their involvement with the Federation of Community Legal Centers' Corrections Working Group.

## 2. WHY THE DDLS IS INVOLVED?

The definition of disability under the *Disability Discrimination Act 1992 (Cth)*<sup>1</sup> as well as the *Equal Opportunity Act 1995 (Vic)*<sup>2</sup> is fairly broad. Briefly, it can and does include physical, intellectual, sensory and psychiatric disabilities. Not all disabilities are visible or obvious and creating awareness and access is one of the DDLS's aims.

According to the Australian Bureau of Statistics, approximately 20% of the Victorian population (986 941 people) has a disability.<sup>3</sup> Although it is not known exactly how many prisoners have a disability:

“The available evidence shows that the extent of disability among offenders and prisoners and the degree of the cohorts over-representation within corrections is likely to be significantly under estimated”<sup>4</sup>

This places prisoners with a disability at a greater risk of discrimination and at serious or even fatal injury risk. This is one of the driving forces behind the DDLS response to the *Coroners Act* Discussion Paper.

<sup>1</sup> *Disability Discrimination Act 1992 (Cth)* section 4

<sup>2</sup> *Equal Opportunity Act 1995 (Vic)* section 6

<sup>3</sup> Australian Bureau of statistics “Disability Ageing and Carers: Summary of Findings Australia” (2003) at p19 [http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/Lookup/978A7C78CC11B702CA256F0F007B1311/\\$File/44300\\_2003.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/Lookup/978A7C78CC11B702CA256F0F007B1311/$File/44300_2003.pdf) as at 14/7/2005

<sup>4</sup> Corrections Victoria, ‘Corrections Disability Framework: Project Mandate’ (2004) at p5.

The first motivating factor for our response is that the DDLS has worked with prisoners with disabilities that have experienced discrimination. This has alerted the DDLS to the shortcomings of the corrections system for people with a disability. Many of these shortcomings could be addressed through alterations to the coronial investigation process. The second reason for the DDLS' involvement is because of the lack of reference within the *Coroners Act 1985 (VIC) (the Act)* to people with disabilities. The DDLS believes that *the Act* does not provide enough protection to a group in our community that clearly needs it:

“The prisoner population displays high rates of tobacco and alcohol consumption, drug use and tattooing. It has hepatitis rates that are 30 times the community average. Respiratory problems are widespread. Mental health disorders affect between one quarter [on medications] and one half of the prisoner population. Half of the prisoner population have expressed a need and desire for assistance to break addictive patterns of behaviour in regard to gambling, drugs, drinking, and smoking. All of these indicators place the prisoner population at the high risk end of the health continuum.”<sup>5</sup>

Our final purpose in making this submission was to bring attention to prisoners with disabilities and how they do fall within the scope of *the Act*, and if they do not, where Prisoners with disabilities should be included. In our response to the Discussion Paper, we have specifically commented on certain questions and recommendations. This is by no means an exhaustive paper, it was written with the intention of raising awareness of the current shortcomings of *the Act*. We hope that law reform will improve the safety of people with a disability in custody and care.

### 3. DEATHS IN CARE AND CUSTODY

#### **Question 4 – Deaths in care and in custody**

*Do you think the current definitions in the Act of “deaths in custody” and “deaths in care” as deaths reportable to a coroner are adequate or should the categories be extended in any way—for example, to include deaths of other vulnerable persons?*

#### 3.1 Extend the definition of in custody to include people evading or escaping from custody

Our submission supports recommendation 6c of the Royal Commission into Aboriginal Deaths in Custody (RCADC) to extend the definition of deaths in custody to at least include people who die while police or prison officers are attempting to detain them.

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<sup>5</sup> Department of Justice, Victoria (2003) “Victorian Prisoner Health Study” Deloitte Consulting at p106

Section 10 of The Coroners Act 2003 (QLD) provides a definition of in custody that is consistent with recommendation 6 of RCADC:

#### 10 Death in custody defined

- (1) A person's death is a death in custody if, when the person died, the person was—
- a) in custody; or
  - b) escaping, or trying to escape, from custody; or
  - c) trying to avoid being put into custody.

Including 'escaping' or 'avoiding' custody within the definition of in custody would provide greater scope for investigation into a type of death that people with mental impairments are at greater risk of.<sup>6</sup> We submit that it is important that escaping or avoiding custody is included in the definition in *the Act* and not merely as a guideline of VIFM<sup>7</sup>. This is to provide clarity, consistency and greater protection for people with a disability who come in contact with the police.

### 3.2 Extend the definition of in care

Queensland *Coroners Act 2003* - Section 9 takes a broader view of "in care" to include specific requirements for people with disabilities:

#### 9 Death in care defined

- (1) A person's death is a death in care if, when the person died—
- (a) the person had a disability mentioned in the [Disability Services Act 1992](#), section 5,2 and—
    - (i) was living in a level 3 accredited residential service; or
    - (ii) was receiving residential services operated, or wholly or partly funded, by the department in which the [Disability Services Act 1992](#) is administered; or
    - (iii) was living at a place—

We support the adoption of a similar definition into *the Act* because of the particular vulnerability of those living in care.

<sup>6</sup> McCulloch, J (2000) 'Policing the Mentally Ill' *Alternative Law Journal* (25) pp241-244.

<sup>7</sup> Victorian Institute of Forensic Medicine, *Statement on Death Certificates and Reportable Deaths*. As cited in the Coroners Act Discussion Paper at p 18.

### 3.3 Define immediately released from care.

Our submission is that “immediately released from care” should at least extend to one-month post release. This is because of the increased vulnerability of those recently released from custody, especially during the first month. The Victorian Department of Justice released a Stats Flash in 2003 that indicated:

“Female ex-prisoners were 27 times more likely to die unnatural deaths than were females of the same age within the general Victorian population. Male ex-prisoners were approximately seven times more likely to die than males of the same age in the general Victorian population. Ex-prisoners were more likely to die as a result of homicide, accident and suicide... In addition, the rate of ex-prisoner unnatural deaths was approximately double the 1996 and 1997 rates of deaths in custody for Victoria. This is in spite of the fact that the deaths in custody figures include natural and unnatural deaths...Risk of unnatural death varied according to release time. The majority of unnatural deaths occurred soon after the deceased left custody. 9.4 % of the 820 unnatural deaths occurred within the first week of release, and 15.5 % within the first month. Thus, ex-prisoners were at greatest risk immediately following their release from prison.”<sup>8</sup>

Leaving prison can be a terrifying experience for many people being homeless or not having personal, family or financial support. It is important that the investigative powers of the Coroner do not end at the prison gates because of the important role the Coroner can play in minimising the post release trauma of many people.

### 3.4 That suicide be specifically included as a type of reportable death

*The Coroners Act* Discussion Paper cites one commentator who states, “what is meant by ‘unexpected death’ in the Act is not clear.”<sup>9</sup> The DDLS supports this and submits that because of the high risk of suicide for people with a disability and prisoners (both with a disability and without), suicide should be included specifically as a type of reportable death.

Research has shown that:

“If it is true [as they found] that almost 2% of prisoners would like to kill themselves or would kill themselves if they had the chance, the potential suicide

<sup>8</sup> Stats Flash. (2003), ‘Post-Prison Mortality: Unnatural death among those released from Victorian Prison between January 1990 and December 1999’, Victorian Department of Justice. At [http://www.justice.vic.gov.au/CA256902000FE154/Lookup/Justice\\_Statistics\\_Stats\\_Flash\\_Pdfs\\_2003/\\$file/121sh.pdf](http://www.justice.vic.gov.au/CA256902000FE154/Lookup/Justice_Statistics_Stats_Flash_Pdfs_2003/$file/121sh.pdf)

<sup>9</sup> Ranson D., “How effective? How efficient? – The Coroner’s role in medical treatment related deaths”, *Alternative Law Journal*, Vol 23, No. 6, December 1998. as cited in the Coroners Act 1985 Discussion Paper at p 8.

rate from prisoners would be dramatically higher than that which is found in the general population”<sup>10</sup>

This allows the well-founded assumption that there is a causal link between suicide and prisoners with a disability.

#### 4. CORONERS GUIDELINES

##### ***Question 13 – Guidelines for Coroners' Investigations***

After contacting the State Coroners Office, the Corrections Library and the Victorian Police Prison Squad, we could not locate any Coronial Guidelines that relate to investigations into the death of prisoners with disabilities. Lack of guidelines or standards “blunts the effectiveness of the coronial process as a reliable means of identifying risk factors and developing remedial strategies.”<sup>11</sup> If such guidelines or standards do exist then they should be made more readily available to the public.

Queensland guidelines provide a good framework for coroners that partly address the concerns for people with a disability being held in custody.

“In all cases investigation should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour. It should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention”<sup>12</sup>

To properly meet the complex needs of people with a disability held in custody guidelines should be implemented in Victoria that direct coroners to extend their investigation to the appropriateness of the detention, as well as its legality:

“Arguably the mentally disordered are being preferentially selected into the new prison populations. This could reflect a greater willingness to imprison certain groups of offenders among whom the mentally disordered are over represented (eg. public nuisance, social security fraud and repeat thefts). It could represent a breakdown in formal and informal diversionary programs aimed to move the mentally disordered away from the criminal justice system back into the mental health system. It could paradoxically reflect the use of certain non-custodial disposals, such as suspended sentences and supervision orders, which the mentally disordered are more likely to breach. It could reflect the increasing number of prison sentences handed down for drug related crimes to which the

<sup>10</sup> Deloitte Consulting “Victorian Prisoner Health Study” (2003) Department of Justice Government of Victoria at p 40

<sup>11</sup> Halstead, B (1995) “Australian Deaths in Custody: No 10 Coroners’ recommendations and the prevention of deaths in custody: A Victorian case study” at p2

<sup>12</sup> State Coroners Guidelines – Version 0 December 2003. Paragraph 7.2 Available at <http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>

mentally disordered are more prone. It could reflect a shift in public or judicial attitudes to mental disorder as a mitigating factor when it comes to sentencing.<sup>13</sup>

Incorporating an examination of how a person came to be in prison and the appropriateness of that imprisonment into an investigation – similar to the Queensland system – would enable a coroner to assess these shortcomings in community services and the justice system that are placing people with disabilities at a greater risk of imprisonment.

It is also our submission that there should be specific Coronial Guidelines for deaths of people with a disability. These guidelines should direct a coroner to look at whether the individual was receiving appropriate care and assistance in light of their particular needs. It has been the experience of the DDLS that people with a disability often do not have their needs appropriately met and are therefore at higher risk of discrimination and mistreatment. On certain occasions the DDLS has found that prisoners with disabilities suffer discrimination because prison officers are not privy to the prisoner's medical records because of privacy laws, therefore appropriate adjustments cannot be made. An investigation by the coroner that incorporated an examination of the appropriateness of care would no doubt uncover this issue and be able to make recommendations to eradicate this type of discrimination.

## 5. RCADC RECOMMENDATIONS

### Question 28 – Implementing RCADC recommendations

*Do you have any comments regarding the implementation of the 1991 RCADC recommendations relating to coronial investigations?*

Although the DDLS supports many of the recommendations made by the RCADC, we have chosen to comment on recommendations 6, 8, 12, 13 & 15 because of their particular importance for prisoners with a disability.

5.1. *Recommendation 6: That for the purposes of all recommendations relating to post death investigations the definition of deaths should include at least the following categories*

- a. *The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile*
- b. *The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention*

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<sup>13</sup> Mullen. P (2001) "Mental Health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services prepared for the criminology resource council"

- c. *The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and*
- d. *The death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.*

Our submission supports the adoption of recommendation 6 into the definition of death in custody because of the protection it would provide for people with a disability. 6c and 6d could be implemented in the same manner as Queensland, as discussed above in our response to question 4.

- 5.2. *Recommendation 8: That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests*

We support this recommendation. The Queensland Guidelines related to deaths in custody discussed above under question 13 are a model that could be adopted in Victoria to ensure that the appropriateness of care, as well as the legality of the detention is thoroughly investigated.

- 5.3. *Recommendation 12: That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death*

#### 5.3.1. Quality of care and inadequacies in screening for cognitive impairment

Quality of care is of particular concern for prisoners with a disability. The DDLS is aware of a prisoner with a disability that received substandard care and suffered discrimination when his medical condition was not properly accounted for. This prisoner suffered severe physical pain and was denied medical attention for extended periods of time.

Inadequacies within screening new prisoners upon reception into the system can affect the quality of care available to prisoners with disabilities and place them at greater risk of suffering serious injury. This can in extreme cases result in death, which could be avoided with adequate screening procedures:

“It is essential that upon entering the prison system that the offender with a cognitive disability is correctly identified in order to adequately respond to both the needs of the offender and the needs of the system. This refers to ensuring appropriate service provision for the offender, and encouraging an

awareness within the prison system of the issues surrounding offenders with a cognitive disability”<sup>14</sup>

Corrections Victoria has a limited understanding of the prevalence of cognitive disability within its system<sup>15</sup> because of the inadequacies of intake screening processes. Most prisoners are very ‘street smart’ and this tends to overshadow or hide the fact that they have a cognitive impairment. There needs to be a more thorough investigation into a person’s mental capacity to ensure that prisoners with a disability are receiving appropriate care and treatment. Prisoners with a disability are vulnerable to discrimination and injury if they are not recognised and appropriately referred on reception.

### 5.3.2. Quality of care and inadequacies of screening for physical impairments

It is not just those with intellectual disabilities that are not being properly screened for:

“There is also a likelihood of significant prevalence rates of acquired brain injury and hearing impairment, [that are] not screened for, nor recorded systematically in Victoria...A NSW (1999) study on hearing loss amongst prisoners found significantly higher rates of hearing loss amongst this population compared with the general community, and higher again for Indigenous prisoners”<sup>16</sup>

This lack of screening for physical impairments increases the risk of these people suffering discrimination and not receiving appropriate care. Prisoners with physical disabilities then become particularly vulnerable to unsatisfactory care that may lead to serious and possibly fatal injuries.

### 5.3.3. Quality of care and other service gaps

Extending beyond intake processes there are other

“...distinct service gaps that are placing increasing strain on prison infrastructure, management and services and undermining positive rehabilitation outcomes for prisoners and offenders with disabilities. Significant gaps exist, for example in relation to:

- a. The identification and service provision to offenders with a borderline intellectual disability
- b. Adequate staff training
- c. Identification and/or services to remanded prisoners with a disability

<sup>14</sup> Oliver, S., & O’Brien, M. (2003) “From corrections to the community: The need for transitional support services for offenders with a cognitive disability” Office of the Public Advocate at p16.

<sup>15</sup> Oliver, S., & O’Brien, M. (2003) “From corrections to the community: The need for transitional support services for offenders with a cognitive disability” Office of the Public Advocate at p16.

<sup>16</sup> Corrections Victoria, ‘Corrections Disability Framework: Project Mandate’ (2004) in Appendix 1.

- d. Offenders with age-related impairments such as dementia
- e. Koori offenders with a disability.”<sup>17</sup>

These service gaps make it impossible for prisoners with a disability to receive adequate care, treatment and supervision, which increase their vulnerability to injury and possibly fatal incidents while in custody.

If a Coroner is required to investigate not only the cause of death, but also the quality of care prisoners with a disability receive, systemic problems within the justice system could be addressed and recommendations could be made to improve the system to ensure appropriate care, treatment and supervision for all prisoners – especially those with a disability – improving their safety while in custody.

- 5.4. *Recommendation 13: That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.*

It is important to note that this recommendation requires a coroner to make a recommendation, rather than just allowing a coroner to do so if they wish – as is the current situation under *the Act*. It is important that this power be mandated in *the Act* to provide consistency and to create a proactive strategy because:

“Each unnatural death examined by coroners represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy therefore has the potential to prevent many deaths as well as to make a significant reduction in risks to health and safety more generally.”<sup>18</sup>

Our submission therefore supports the implementation of recommendation 13.

- 5.5. *Recommendation 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.*

This recommendation appears to provide a very workable approach that has been successfully adopted in other jurisdictions, including the ACT.<sup>19</sup> The Ontario system goes further than this recommendation by involving a public inquiry when a

<sup>17</sup> Corrections Victoria, ‘Corrections Disability Framework: Project Mandate’ (2004) at p5

<sup>18</sup> Halstead, B (1995) “Australian Deaths in Custody: No 10 Coroners’ recommendations and the prevention of deaths in custody: A Victorian case study” at p1

<sup>19</sup> *Coroners Act 1997 (ACT)* s76

subsequent and similar incident occurs. This is an important extension that should be made to this recommendation to ensure that not only are prison authorities issued with recommendations, but that they are held publicly accountable for their response, or lack thereof. It is important for prisoners with a disability that the prison system is made accountable to ensure their safety.

## 6. INJURY AND DEATH PREVENTION

### Question 29 – The Coroners role in death and injury prevention

- (a) *How effective do you think the current system is in preventing death and injury?*
- (b) *Do you think the preventative role of the Coroner should be expanded in any way? Should the preventative role of a coroner be a specific function of the Act?*
- (c) *Should the Act require a mandatory response to certain coronial recommendations? Should the State Government be required to provide a written response to certain Coronial recommendations within a specified timeframe? Should responses to recommendations be required to be tabled in Parliament?*
- (d) *Should anyone be responsible for monitoring the implementation of coroner's recommendations? Who do you think should be responsible?*
- (e) *What are your views on alternative systems such as the Ontario system? Do you think this kind of system would be effective in Victoria?*

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- (a) The current system is not nearly as effective as it could be. Having death and injury prevention as a subsidiary role to investigation is inappropriate. The Coroners unique position to make recommendations that will ensure death and injury prevention is currently being underutilised.
- (b) It is important for the prison system as a whole and prisoners with a disability specifically that the Coroner takes a preventative role. To make this shift we submit that death and injury prevention should be included as a function of *the Act*. This is important because making death and injury prevention a function of *the Act* will ensure that this important aspect of the Coroners work will receive the recognition it deserves. This will have the effect of generating a cultural shift to ensure that the Coroner's role is fully utilised to ensure vulnerable people receive the protection they deserve:

“There are currently some excellent initiatives being undertaken in corrections in the use of assessment and rehabilitation and in the use of the Treatment Community Approach”<sup>20</sup>

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<sup>20</sup> Oliver, S., & O'Brien, M. (2003) “From corrections to the community: The need for transitional support services for offenders with a cognitive disability” Office of the Public Advocate. At p38

However, we submit that working with the knowledge and resources of Coroners would enable these services to better address the needs of at risk groups identified in coronial investigations.

Coroners are in a unique position to generate recommendations that lead to a change in current practices to promote death and injury prevention, but there is presently no mandate to make those recommendations or for those recommendations to be taken into consideration, let alone be implemented. Making the preventative role of Coroners a function of the Act would ensure greater protection for prisoners with disabilities.

(c), (d) & (e) Our submission supports recommendation 15 of the RCADC:

“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.”

As discussed under question 28, recommendation 15 provides a good framework and the Ontario system ensures public accountability of agencies being investigated. It is submitted that recommendation 15 in conjunction with accountability requirements consistent with those utilised in Ontario be implemented in Victoria to improve injury and death prevention.

## 7.CONCLUSION

The DDLS is concerned that *the Act* as a whole does not meet the needs of people with a disability, especially those in custody and care. Our comments on particular sections of *the Act* are intended to highlight some of the critical areas where people with a disability are especially vulnerable or their needs are overlooked. Through highlighting these issues we hope to raise awareness of the need for *the Act* to specifically address the needs of people with a disability to ensure their safety as members of the Victorian community.