Briefs

DEATHS IN INSTITUTIONS

Grave concerns

CHRIS RICHARDS examines a recent report from Townsville Community Legal Service which highlights inadequacies in the way deaths in institutional care are investigated.

As Australian state bureaucracies grapple with the prevention of Aboriginal deaths in police cells and prisons, Townsville Community Legal Service has upped the ante by calling for post-death investigations and inquests into the deaths of people in all forms of institutional care to be legally required.

This call comes as a Queensland interdepartmental committee formulates its recommendations to overhaul that State's *Coroners Act 1958*: a legislative framework which at present deflects the ability of coroners to inquire into practices, policies and procedures that can cause death in institutions. It also coincides with indications from Victoria that the role of post-death inquiries by coroners may be narrowed.[1]

The report of the Royal Commission into Aboriginal Deaths in Custody identified the importance of thorough investigation and inquiry by coroners of deaths in police cells and prisons:

> If the full range of issues thrown up by deaths of Aboriginal people held in custody are to be met by the Australian system of coronial inquiry, then coroners must be accorded the status and powers to enable comprehensive and co-ordinated investigations to take place which lead to a mandatory public hearing, productive of findings and recommendations which seek to prevent deaths in similar circumstances.[2]

The Deaths in Custody report then makes 34 recommendations designed to achieve these aims. They include –

- that a mandatory post-death investigation be conducted where a person has died either in police or prison custody, or as a result of police or prison officers attempting to detain that person; and
- that in post-death investigations of deaths in custody, a coroner should be required by law to investigate not only the cause or circumstances of the death, but also the quality of the care, treatment and supervision of the deceased prior to death and, in the subsequent inquest, make recommendations designed to prevent further custodial deaths.

In Queensland, there are welcome indications that the Aboriginal Deaths in Custody recommendations about coroners' inquests will be implemented. However, in a recessionary period, the Goss Government could be tempted to limit implementation of these recommendations to deaths in custody, rather than make them applicable to all deaths in institutional care. Such a decision would be inhumane, unprincipled and unjustifiable. A report written for Townsville Community Legal Service (TCLS) and released in September 1993 explains why.

The report, entitled *Grave Concerns – Institutionalised Death in Queensland*, critically evaluates institutional death in just one Australian provincial city – Townsville. It exhumes the bodies of those who have recently died in the mental health ward attached to Townsville General Hospital (Ward 10B), and a service accommodating people with physical disabilities. It also chronicles suicides and a murder that took place in Townsville Correctional Centre after the conclusion of the Royal Commission into Aboriginal Deaths in Custody, highlighting institutional and systemic problems in prisons which are additional to those identified in the Aboriginal Deaths in Custody report. The people accommodated in each of these institutions lived outside the public gaze. They did not control their own lives. They relied on others for the quality of care and accommodation that they were given. They were, through their powerlessness or disability, extremely vulnerable to abuse. When abuse occurred their voices were not heard.

These case studies highlight that 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. Proper post-death investigations, and recommendations to address identified problems in care, have the potential to save lives. If problems with institutional care are properly addressed, the standard of care extended to those who remain in the institutions must improve.

Without public inquiry, institutional carers are not accountable. It is not sufficient to leave government institutions to investigate themselves. The case study concerning the Townsville Correctional Centre demonstrates the failure by that institution, and prison institutions around the State, to rectify patently life-endangering circumstances highlighted by deaths. Nor is it sufficient to allow privately managed services for the aged, the sick, or those who have a disability, to avoid public scrutiny when doctors sign the death certificates of those who have died behind their walls. The case study which focuses on death in a service providing care for people with physical disabilities offers a chilling illustration that death certificates can justify the burial of disturbing allegations of institutional neglect. Institutions wield considerable power. They are entrusted with a public duty to provide properly for the (often vulnerable) people in their care. There must be mechanisms to ensure that institutions have exercised their power in a reasonable and justifiable way and without abuse or neglect. Death in an institution must function as a trigger for public review of the standard of institutional care.

The report recommends that, where a coroner receives a report of an investigation which clearly reveals that the death resulted from natural causes, then the coroner may choose not to hold an inquest. The public interest favours investigations and inquests in all other cases. In identifying institutional

abuse, the report highlights that it is not sufficient to investigate only those deaths that occurred when the deceased was accommodated within the institution. In the case study concerning Ward 10B, many of the deaths by suicide happened after the patients were discharged. Indeed, it was the absence of proper discharge diagnosis and adequate treatment after discharge that appeared to contribute to the suicides. For this reason, the report recommends an investigation should be conducted if there is reason to believe that the deceased had received institutional care at the time or shortly before their death.

The TCLS report approaches its task by endorsing the Aboriginal Deaths in Custody report and refashioning Aboriginal Deaths in Custody recommendations about coroners' inquests so that they can apply to all deaths in institutions. The TCLS report then goes on to put forward a range of original recommendations based on its case studies. The way in which the TCLS report deals with the involvement of family and friends in post-death investigations and inquiries – which is one of the most important reforms needed within the present system of coroners inquests – is illustrative of this approach.

The TCLS report recognises that the level of contact and intimacy that family and friends retain with people in institutional care varies markedly. Some will not have maintained any contact. Others will have maintained some personal contact but have severed any emotional commitment. Yet others will have maintained contact and feelings with relatives or friends in institutional care. The report then argues that despite (or because of) their distress, the family and friends of the deceased who had maintained contact with the deceased up until the time of death can provide important keys for unlocking whether inadequacies in institutional care or culture contributed to the death. Not only do family and friends have important information that can be used to guide an investigation, but they have the motivation: they are exposed to the senselessness of the deceased's death. They often explain that, if lessons are learnt from the deceased's death which will help to prevent future death, then they will feel that the deceased has not died in vain.

The TCLS report acknowledges that the Royal Commission into Aboriginal Deaths in Custody made important recommendations to better integrate the family of the deceased into post-death investigations and inquest. These included:

- providing family members with the date of an inquest within adequate time to prepare an appearance;
- precluding a coroner from hearing an inquest unless he or she is satisfied that the family has been notified of the inquest and does not wish to appear (either personally, or through legal representation);
- directing investigators and staff of the coroner's office to provide information and frank and helpful advice to the deceased's family on request; and
- providing family members with government funded legal representation if they wish to appear through a lawyer at the inquest.

The TCLS report supports these recommendations. However, it appeared to the TCLS that a much more meaningful role than mere appearance at an inquest could be given to family members. The report observes that family members can be consulted when the agenda for the investigation is being set. This is mutually beneficial. For those overseeing the investigation, it alerts them to potential causes of death (systemic or otherwise) and provides valuable insights about possible witnesses who could be approached. For family members, it means an involvement that is not merely artificial. They can point out their concerns at a time when something meaningful can be done. Family members and close friends of the deceased should be invited to discuss their perspectives of the cause of death at a formal, pre-investigation meeting, convened by the person who will oversee the investigation into the death. Where systemic problems are raised, which have the potential to have contributed to death, the investigators should be directed to make careful inquiries.

Although *Grave Concerns – Institutionalised Death in Queensland* focuses on Queensland institutions and law, many of its descriptions, factual conclusions, and recommendations will be equally applicable in other Australian States.

A copy of the report can be obtained by sending a request and $5.00 cheque to Townsville Community Legal Service, P.O. Box 807, Townsville Qld 4810.

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References

1. Victorian Premier, Jeff Kennett, advocated in June 1993 that coroners should restrict their inquiries to the immediate cause of death. Implicitly, Kennett proposed that coroners should not inquire about systemic problems which may have contributed to death. His resolve has no doubt firmed following the institution of criminal charges against 11 police officers whose conduct had been examined by Victoria's Chief Coroner, Hal Hallenstein, during the police shootings inquests.
2. AGPS Canberra, 1991, p.129. The Aboriginal Deaths in Custody recommendations cited in this article can be found in Chapter 4. See in particular recommendations 6, 7, 8, 9, 11, 12, 13, and 21-26.

In quest of reform

MATTHEW KEELEY discusses a recent inquest into an institutional death in Queensland.

A recent inquest into an institutional death in Queensland has highlighted both the potential for future inquests to make useful recommendations for the purpose of preventing future deaths, as well as the inadequacies of the present law.

The facts

Shane Pollock, a 20-year-old resident of Maryborough Base Hospital's Disabled Persons Ward (DPW) had lived there since 1985. On 27 August 1992, Shane died in the DPW after he aspirated (inhaled into his lungs) vomit. Since infancy Shane had been diagnosed as having epilepsy, cerebral palsy and intellectual disability. The post-mortem examination found that these conditions contributed to Shane's death but were not related to the cause of Shane's death, aspirating vomit. On the day of his death, Shane was given his usual medication at 3.30 p.m. He was seen again by nursing staff at 3.50 p.m. Shane was next seen at 5.10 p.m. slumped forward in his chair. He had no pulse or respiration. Despite attempts to resuscitate him, Shane was not resuscitated and was pronounced dead at 5.23 p.m.