Submission
No 10

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Name: Mr Robert Wade

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Failure to resume an inquest

It's 24 years since police killed Roni Levi on Bondi Beach.

The coroner stopped the Inquest after deciding that known persons could be prosecuted.

The DPP declined to prosecute.

I cannot find any findings and assume the Inquest hasn't been completed.

Two areas that could usefully be examined and recommendations made are:

1) why St Vincent's allowed an increasingly psychotic patient to elect to be a voluntary patient, and allowed him to walk out; and

2) what if any emergency treatment was provided to him, and what should have been done to at least protect him from leaving.

Yours sincerely

Robert Wade

Making more explanatory psychiatric findings

Courtney Topic was killed by police within a minute of their arrival. The Coroner accepted they were entitled to kill her as she advanced towards them with a knife.

The coroner described Ms Topic being assessed by a psychiatrist years previously.

But there was no account of why she had not been followed up after that psychiatrist assessment.

Understanding what happened may have led to recommendations for preventing such confrontations with police.

Yours sincerely

Robert Wade

Updating findings

There could usefully be an additional role to update findings.

With Courtney Topic the Coroner eventually found that her diagnosis was schizophrenia, and that police were entitled to kill her in self defence.

Years later, Channel 7 Sydney reported that police had apologised to her family, paid compensation to them, and the article reported that the family claimed the diagnosis was autism.

There was no account of what police were actually apologising for, or paying compensation for.

The coroner should maintain current awareness of developments in matters considered, and respond to questions from anyone, where findings have had doubt cast on them.

Yours sincerely
Robert Wade

Inexplicable failures to examine relevant matters

Miriam Merten died in Lismore Hospital. From multiple head injuries. From multiple falls. She was being treated for mania and the falls were apparently due to intoxication with prescribed drugs.

The coroner did not look into that prescribing.

Later, two nurses were disciplined. One died by suicide a day later.

An "independent" inquiry set up be the Minister for Health the day after Channel 7 broadcast video of Ms Merten grossly intoxicated, also didn't look at the causative prescribing.

There needs to be a powerful mechanism to compel coroners to address obvious matters, even after findings have been published.

Yours sincerely
Robert Wade