

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: The Royal Australian and New Zealand College of Psychiatrists
(RANZCP)

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The Royal
Australian &
New Zealand
College of
Psychiatrists

Inquiry into the coronial jurisdiction in New South Wales– June 2021

Improving the mental health of the community

Summary of recommendations

1. The Coroner's Court needs to be adequately resourced to ensure it can conduct investigations independently and in a thorough and timely manner, and ensure family members impacted by such investigations have access to necessary supports such as Forensic Social Work, and where appropriate, referral to psychiatry.
2. Effective measures need to be developed that ensures accountability of government agencies responsible for implementing recommendations made by the Coroner's Court. This may involve the publishing of progress reports on the Coroner's Court's and relevant agencies' websites.
3. Related to Recommendation 1 and as a matter of priority, the Coroner's Court needs to be sufficiently resourced to ensure:
 - a. First Nations people and people from linguistically and culturally diverse backgrounds have access to culturally-safe and appropriate support services.
 - b. Witnesses assisting with an investigation are adequately supported to prevent any psychological harm. The principle of therapeutic jurisprudence should apply when witnesses are called upon to provide evidence.
4. An advisory panel should be formed, comprising professionals from the legal, psychiatric, general health and drug and alcohol fields, as well as First Nations and community members to help the coroner with the selection of cases that proceed to inquest.

Introduction

The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') welcomes the opportunity to respond to the Select Committee inquiry into the coronial jurisdiction in New South Wales.

RANZCP is a membership organisation that trains doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises governments on mental health care. The College has over 6900 members, including more than 5100 fully qualified psychiatrists (consisting of both Fellows and Associates of the College) and around 1800 members who are training to qualify as psychiatrists (referred to as Associate members or trainees). RANZCP NSW Branch (NSW Branch) represents more than 1200 Fellows and 400 trainees.

Our submission represents the collaborative views of psychiatrists who have a deep understanding of mental health issues affecting people with a mental illness in custodial care. It is important to note therefore that our submission concerns our experience of the coronial process involving a death in custody, in a mental health facility, or as a result of a police operation. We acknowledge that the issues raised in this submission are likely to be relevant to all (preventable) deaths that occur in other institutional settings, or crisis situations, which are then referred to the Coroner's Court for investigation.

General comments

Before addressing the terms of reference, we make the following general but important points regarding the mental health care of people in state care.

- People with a mental illness who receive mental care, including involuntary treatment, are a highly vulnerable group. The death of an individual due to involuntary psychiatric

treatment, enforced care, treatment in custody, or a failure to provide acceptable care or treatment is a tragedy that warrants external scrutiny.

- Psychiatrists have an important role to play in supporting processes that provide scrutiny and oversight of the provision of mental health services. Psychiatrists involved in such processes need to have confidence their involvement is impartial and upholds high ethical standards.
- All processes involving the scrutiny of clinical and systemic practices and procedures involve some level of discomfort for clinicians and administrators. The Coroner is well placed to identify opportunities for improvement and ensure the accountability of services or clinicians to an external independent body.
- The Coroner has an essential role in maintaining and ensuring that acceptable standards of care are provided to persons with mental illness or mental disorders within the public and private health care system. This is likely to involve making recommendations for increased resources as mental health services have been widely acknowledged to be chronically underfunded.

Terms of Reference

Based on our experience and expertise, we wish to address the following Terms of Reference:

(a) the law, practice, and operation of the Coroner’s Court of NSW, including:

(ii) the adequacy of resources

The College submits that there are two main areas in coronial investigations that may involve issues relating to mental health: where the deceased suffered mental health issues or had a mental illness, and secondly, in offering mental health support to family members of the deceased. Our concern relates to the adequacy of the resources of the Coroner’s Court in both areas.

Each case of death mandates examination by a forensic pathologist. However, there have been cases of deaths (including deaths in custody) involving mental health issues where the Coroner was not assisted by a forensic psychiatrist. Perhaps the example that most clearly demonstrates this shortfall was the coronial inquest into the tragic death of David Dungay Jr. A number of experts were involved in this case, but no independent forensic psychiatrist was assigned to the case.

The College is concerned that cases such as that of David Dungay Jr may be an indication that the Coroner’s Court is not adequately resourced to employ psychiatric experts when warranted. A lack of resources should not preclude, nor indeed determine, whether a particular coronial inquest requires the involvement of an independent forensic psychiatrist. The College would be pleased to assist the Coroner by maintaining a list of suitable forensic psychiatrists the Coroner could call on for assistance with cases involving mental health issues.

The second area the College would like to comment on is the mental health support available to bereaved families involved in coronial inquests. The Coroner’s Court has at its disposal a team of specialist social workers (the Forensic Social Work service). This team works directly at the court. We understand the service offers early intervention, support, and counselling, and has the ability to refer for further support. The College is unable to comment on whether the resourcing of the service is adequate, but notes that its primary

function is early intervention and support. The College supports this model and submits that the Forensic Social Work service should be adequately resourced to seek referral to psychiatrists to manage grief when considered warranted. The College would be able to provide the Coroner with suitable clinical psychiatrists (rather than forensic experts) for this purpose.

We make further comment on resources below, in relation to Term of Reference (a)(iii).

(iii) the timeliness of its decisions

Recent Inquests following the death of the individual have routinely taken several years to be heard, and reports are often not available for several months following the Inquest. It is axiomatic that the decisions of the Coroner's Court be as prompt as possible.

This timeliness of the Coroner's decisions is critical for a number of reasons. Delays potentially impact the reliability of witness evidence, and increase the stress of the proceedings experienced by affected individuals, including families of the deceased.

Furthermore, delays reduce the relevance of the Inquest to ongoing services and clinicians. Delayed decisions inhibit any meaningful changes that may have been identified to be implemented in a timely manner, to prevent further potential harm or adverse events.

The College understands the demands on the Coroner's Court and all the professionals and support workers involved in coronial inquiries. The significant amount of preparation and examination of documentation, and the number of professionals and administrative staff involved in these inquiries, dictates the time it takes to reach a decision in any given case.

The timeliness of decisions appears inextricably linked with resourcing of the Coroner's Court, and the cost involved in preparing and hearing a case. We acknowledge that there are time and budgetary constraints given the significant information that needs to be gathered and reviewed, but we submit that better resourcing would result in improved timeliness of decisions.

(iv) the outcomes of recommendations made, including the mechanisms for overseeing whether recommendations are implemented

An important role of the Coroner is to make recommendations. When someone in state care dies unexpectedly, the Coroner can investigate how that person died and recommend changes to prevent similar deaths happening in the future. However, even where strong recommendations are made, there is no requirement that responsible agencies (like Corrective Services, Police etc.) implement the recommendations and record or report on that implementation. Nor is there any power to enforce compliance.

It has generally been our experience with NSW Health that recommendations from the Coroner are taken seriously, and that there is a level of oversight with regard to implementation of recommendations and their reporting to the minister and/or departmental head.

Although our experience with NSW Health in relation to recommendations has been largely positive, we would support better governance around the implementation of coronial recommendations to increase agencies' accountability and transparency.

We believe there is a strong public interest in the disclosure of any agency's response to the Coroner's recommendations. Agencies should learn from the Coroner's recommendations and be accountable for their implementation. We note that on occasion the Coroner has made reference to previously made recommendations that appear not to have been

implemented, potentially resulting in a repeat of the same mistake or misjudgement by an agency. One potential explanation for this is a lack of an appropriate mechanism to monitor the implementation of recommendations.

Agencies that have been asked to implement reforms which may prevent future deaths have a responsibility to do so, and should be required to report publicly on that implementation, both on the Coroner's website and on the agency's website.

We acknowledge that there are instances where it may be impractical to implement a particular recommendation, or where responsibility should lie with a different agency.

We would therefore further advocate for agencies to show cause as to why particular recommendations may not be able to be implemented, and for those reasons to be published on the Coroner Court's website, as well as the relevant agency's website.

Accordingly, we submit that the Coroner (or another appropriate body) should also be adequately resourced to monitor and regularly review agencies' progress in relation to recommendations.

We make further comment on the formulation of recommendations under Term of Reference 1(d).

(v) The ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities

As noted in the NSW Parliamentary Select Committee's report into the high level of First Nations people in custody and oversight and review of deaths in custody, First Nations people deserve a higher standard of service from the courts and corrections systems when being informed of the death of a relative in state care.

Courts and relevant agencies need to be mindful that an unexpected death and delay from these agencies can be re-traumatising to a family and contribute to mistrust of the legal system and government. We submit therefore that appropriate culturally safe services need to be provided to ensure families are supported and not marginalised from the coronial process. Existing culturally-based services, such as the Aboriginal Legal Service and the Aboriginal Medical Service, need to be appropriately resourced to support their inquest functions.

Given the emotive context of a coronial inquest, particularly for marginalised sections of the community, we submit that the Forensic Social Work service of the Coroner's Court should include, or have ready access to, First Nations social workers, as well as social workers from culturally and linguistically diverse backgrounds.

(d) Any other related matter

In addition to the issues raised above, we wish to bring the following two matters to the Select Committee's attention.

Vicarious trauma and therapeutic jurisprudence

We would like to highlight the vicarious trauma experienced by many mental health professionals who have participated in coronial proceedings.

While the Coroner has the authority to refer people to other agencies, including criminal agencies, on findings of particular actions, the Coroner's first and foremost role is to ascertain the circumstances of a death.

People participating as witnesses in ascertaining those circumstances do so in order to improve the system. We accept robust questioning as not only welcome, but necessary. . However, we have reports from some Fellows and trainees that cross examination can be traumatic, and on occasion feels like it diverges from an inquisitorial process to a more adversarial approach. A continued emphasis on therapeutic jurisprudence principles by the Coroner's Court could minimise the potentially adversarial nature of some inquests.

In addition, with relevance to this point and our comments regarding the timeliness of findings, we note that protracted timeframes prolong the distress of the bereaved. It can also cause ongoing distress for the clinicians involved.

One concern is that vicarious trauma experienced by mental health professionals in the inquest setting potentially impacts their willingness to work in areas where they are more likely to be exposed to coronial cases.

Process improvement - selection of cases that go to hearing

The Coroner has a large number of cases that may merit an inquest. The College accepts that not all cases can be examined, and a selection must be made. We are concerned, however, that the selection process may be perceived as relatively arbitrary. We believe that a more considered process could improve transparency and the selection outcome.

Accordingly, we suggest the creation of some sort of advisory panel to help the Coroner with the selection of cases. Broadly speaking, the panel would help determine the cases that are subject to inquest, and the general questions that were raised by the case. The counsel assisting the Coroner would delineate the questions from there, including any new directions that become material to the case as it proceeds.

Such a panel could be chaired by the Coroner, with membership comprising professionals from the legal, psychiatric, general health and drug and alcohol fields, as well as First Nations and community members.

The advisory panel could function by considering all deaths related to psychiatric illness in a, say, three-month period, based on documentation presented to the panel. Based on these considerations and feedback, cases of significant concern or importance could be selected for hearing. In order to avoid a potentially narrow focus, the panel would also examine the questions that need to be addressed as part of the inquest, and those questions would subsequently be refined by the Coroner and counsel.

Should the Committee be minded to support a process such as this, a College-managed database could be established from which experts for such a panel could be selected .

The process could be further developed. One further area of refinement could be a regular forum to discuss significant recommendations arising from the hearing. The forum could potentially include the Coroner, assisting psychiatrist and counsel, as well as the Chief Psychiatrist and Area Director. This could also help with efficient and specific implementation of any relevant recommendations, for example their adoption by any responsible agency.