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.

Inadequacies of the law

Section 24 of the *Coroners Act 1958* (Qld) provides that the purpose of an inquest is to establish so far as is practical the fact that a person has died, the identity of the deceased person, and when, where and how the death occurred. Section 34 of the Act provides that no evidence shall be admitted by the coroner unless in his opinion the evidence is necessary for the purpose of establishing one of these matters.

In Shane's case the only matter at issue was how his death occurred. Traditionally, coroners in Queensland and elsewhere have sought to limit the extent of inquiry on this matter to the immediate cause of death. Shane's parents, however, required answers to questions going beyond the immediate cause of death and which went instead to the nursing practices and staff culture within the DPW, which they believed made such a death foreseeable.

The evidence

Despite the usually restrictive interpretation given to ss. 24 and 34 of the Act, counsel for Shane's parents was able to introduce evidence on a range of matters which would normally have been inadmissible in an inquest. This evidence related to the adequacy of nursing practices within the DPW, the adequacy of staff numbers, the lack of any 'socialisation' programs within the DPW and the corresponding reduction in residents' capabilities. It also addressed the philosophical divide between the 'medical model' of care for people with disability and a 'normative' model of care emphasising the residents' abilities and community inclusion. Introducing evidence of this sort was made possible by a coroner who allowed himself to be fully informed, and because of the police prosecutor's misunderstanding of and lack of preparation for his role of assisting the coroner. If counsel for the Department of Health had been present, as provided for in the Act, there would no doubt have been objections to much of the evidence given and the coroner would not have been free to make the riders he did.

The coroner's riders – a pointer to the future?

The coroner found the immediate cause of death to be aspiration of vomit with epilepsy, cerebral palsy and intellectual disability contributing to but not related to the cause of death. He then made 'riders', not deemed to be part of his finding but designed to prevent the recurrence of similar events (s.43(5)). They were:

- a finding that Shane would have participated in 'socialisation' programs if they had been available to him;
- an expression of concern that the situation in the DPW as at Shane's death had not changed;
- a recommendation that the depositions and exhibits be forwarded to the Queensland Minister for Health;
- a recommendation that the DPW be either upgraded in facilities and staff, or closed, to avoid any repetition of such a death;
- a recommendation that if the DPW is not to be closed, then the Minister's attention should be drawn to the current system of feeding and changing within the DPW, and that these procedures be reviewed to ensure that no resident is left unattended for any period of time in the vicinity of one hour and twenty minutes, as in Shane's case.

Conclusion

For so long as people with disability continue to live in institutions which exercise control over all or most aspects of their lives, they will remain vulnerable. Advocacy efforts should be directed to the properly managed and resourced closure of such institutions and enforcement of the right of people with disability to live within and fully participate in the community, with any necessary support. While these advocacy efforts are, of course, ongoing, advocacy efforts should also be directed to safeguarding the rights and lives of those people with disability still living in institutions. A comprehensive and coordinated system of investigation into and public hearings regarding institutional deaths is one such safeguard.

Shane's case is included here with the permission of his parents. Shane was planning to leave the DPW for supported accommodation in his local community, near to and with the support of his parents, shortly after the date of his death. The program which was to make this possible was placed on hold last year due to lack of funding and political will.

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CRIMINAL JUSTICE

'Shareware' for crime fighters

TONY WOODYATT argues that the CJC should establish a comprehensive database to underpin the policy-making process.

Good policy development requires a foundation of good information, yet Queensland criminal justice policy-makers do not have access to comprehensive and reliable data. Other jurisdictions, particularly New South Wales, South Australia, Western Australia, and New Zealand have established various systems to gather data across government and to verify its accuracy. However, while there have been recommendations to develop a database in Queensland, the Government continues to drag the chain.

The Fitzgerald Report observed that the former government's departments, particularly the Police Service, were able to mislead the public on crime and policing issues because of the absence of a publicly verifiable criminological database. For information to be usable by government and the public, a database must be properly designed, have uniform standards across agencies, must have reliable data collection processes, and must be publicly accessible so that it can be publicly accountable.

Commissioner Fitzgerald noted:

> A review of the criminal laws, particularly those affecting prostitution and SP bookmaking, needs more information if it is to make decisions with reasonable confidence that it is not simply creating more problems. At present, that information is not available to this enforcement body, Commission or Government in the country.