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Submission to Royal Commission into Defence and Veteran Suicide

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SUBMISSION TO ROYAL COMMISSION INTO DEFENCE and VETERAN SUICIDE

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Abstract

Modern theorising of on coronial practice has identified four main purposes of coronial systems: (i) fact-finding concerning the causes and circumstances of reportable deaths; (ii) prevention of death and injury; (iii) providing therapeutic and restorative processes for the benefit of bereaved relatives and others; (iv) the protection of human rights, especially where state agencies are implicated in reported deaths. These purposes should be underpinned by a normative theory of coronial recognition of the dead, their bereaved families and others affected by reported deaths. The death preventive structures and resources of Australian coronial systems varies significantly. This submission to the Royal Commission into Defence and Veteran Suicide proposes ways in which coronial systems could work more effectively to prevent future deaths.

Keywords

Coroners – Death investigation – Coronial practice – Role of coroners – Purposes of coroners – Death prevention – Comparison of NSW and other coronial systems – Recognition theory – Therapeutic jurisprudence – Law reform – Suicide – Veterans

What do coroners and coronial systems do?

Note: Although we speak of 'coroners', when we do so we are generally referring not only to those who hold judicial office as coroners but also to the multidisciplinary complex which makes up the coronial death investigation system. Coroners, forensic pathologists and scientists, police investigators, family support and liaison staff, social workers and counsellors, legal assistants and counsel assisting, administrative staff and ad hoc experts, legal representatives and family members and their supporters are all part of this system.

A traditional English taxonomy of the functions of coroners identified five categories: administrative, investigative, judicial, preventive and educational.[1] An influential reconceptualization of the role of coroners was delivered in the Brodrick Report on the English coronial system in 1971. It identified five grounds of public interest coronial investigations can serve: determination of the medical cause of death; allaying rumours and suspicions; identifying preventable hazards to life; advancing medical knowledge; and preserving the legal interests of family members and interested parties.[2]

More recent commentators have laid emphasis particularly on prevention of future death and injury.[3] The objects of some Australasian coronial statutes now make specific reference to

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1 Gavin Thurston, *Coroner's Practice,* (Butterworths, 1958), 6.

2 UK. *Report of the Committee on death certification and coroners,* Cmnd 4810, 1971 ('the Brodrick Committee Report') cited in Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest,* (Oxford University Press, 2006), 23.

3 Graeme Johnstone, 'An avenue for death and injury prevention in Hugh Selby (ed.), *The aftermath of death,* (Sydney: Federation Press, 1992), 140; Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest,* (Oxford University Press, 2006); Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Edward Elgar, 2016).

death prevention.[4] Other relatively recent developments in theorising coronership have seen emphasis laid on human rights protection[5] and the therapeutic potential of the jurisdiction.[6]

In summary, modern thinking on coronial practice has focussed on four main purposes of coronial systems:

- Fact-finding concerning the causes and circumstances of reportable deaths
- Prevention of death and injury
- Therapeutic and restorative processes for the benefit of bereaved relatives and others
- Emphasising respect for life and protection of human rights (especially accountability of state agencies and agents; investigation of unsolved homicides and suspected deaths of missing persons).

In my view, other coronial purposes, such as allaying of unfounded suspicions, death certification following a coronial investigation, collation of data, and medical research are ancillary to these fundamental purposes.

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4 For example, Coroners Act 2003 (Qld) s 3; Coroners Act 2006 (NZ) s 3; Coroners Act 2008 (Vic) ss 1,8.

5 Ian Freckelton and Simon McGregor, 'Coronial law and practice: A human rights perspective', (2014) 21 *J of Law & Medicine* 584; David Baker, 'Deaths after police contact: Constructing accountability in the 21st century', (London: Palgrave Macmillan, 2016); Rebecca Scott Bray, 'Death investigation, coroners' inquests and human rights' in Leanne Weber et al., *The Routledge International Handbook of Criminology and Human Rights*, (London: Routledge, 2016).

6 Michael S. King, 'Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model', (2008) 16 J of Law & Medicine 442; 'Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice,' (2008) 32:3 Melbourne University Law Review 1096; Jennifer Moore 'The impact of Therapeutic Jurisprudence on the New Zealand coronial jurisdiction' in Warren Brookbanks (ed) *Therapeutic Jurisprudence: New Zealand Perspectives* (Thomson Reuters, 2015) 179; Lindsay McCabe, 'Improving Indigenous family engagement with the coronial system in NSW', (2021) 0(0) 1. See also Ian Freckelton, 'Minimising the counter-therapeutic effects of coronial investigations: In search of balance', (2016) 16 *QUT Law R* 4.

Why do we do these things?

Underlying these four functions is, I believe, a concept of recognition of the common humanity of the dead, the bereaved and those who investigate reported deaths.[7] The poet John Donne expressed this when he wrote his famous meditation on that theme:

> No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as any manner of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee. [8]

If we accept the concept of a common humanity as the guiding principle, and recognition of, and respect for it, as the fundamental value, of coronership, we must then also accept that the sudden, unexpected, unexplained or violent deaths of members of our community are, in a sense, public events. Most will not need to be discussed in public forums such as inquests. But, because all members of our society have individual and social significance, all deaths reported to coroners have inherent significance for our society as well as for bereaved relatives, friends and communities.

Those deaths may also have wider implications – they may have been preventable; they may raise questions about the conduct or systems of state organisations and agents; issues may be raised about how people – the dead or the living – have been treated; life-saving lessons may be available.

The philosopher Avishai Margalit has written, 'a decent society is one whose institutions do not humiliate people.'[9] Another philosopher, Simone Weil, has written, '"You do not interest me". No man can says these words to another without committing a cruelty and offending

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7 See Raimond Gaita, *A common humanity,* (Abingdon: Routledge, 2002).

8 John Donne, 'Meditation XVII', Devotions upon Emergent Occasions. https://web.cs.dal.ca/~johnston/poetry/island.html

9 Avishai Margalit, *The decent society,* (Harvard University Press, 1996), 1.

against justice.'[10] Coronial systems should reflect the decency of their societies. They should never be accused by families, communities or the wider society of humiliating those who rely on them to investigate and identify the lessons of preventable death or of failing to take an interest in those who have died, those who mourn them, and those who hope for lives to be saved in future. How well coroners and coronial systems recognise our common humanity *in practice* is the basic yardstick against which they should measure themselves and be measured by others. Everything else, it seems to me, follows from this.

My emphasis on a common humanity may seem, to some, to reflect a lofty and somewhat abstract or 'ivory tower' ideal. It does not. It has very practical purpose. My experience as a magistrate and coroner was that, within the Local Court, there was a constant emphasis on 'time standards', 'clearance rates' and other indicia of administrative 'efficiency'. In short, outputs rather than outcomes were the focus of management. In my view, in a high volume criminal jurisdiction, such as the Local Court of NSW, 'efficiency' could reasonably be regarded as a proxy measure of the quality of the work being conducted. And, in any case, the appeal system lay over the top of the Local Court as a form of quality control.

But that is *not* so in the coronial jurisdiction. Although the Supreme Court has a power to quash inquests or to order that inquests to be held, it is rarely exercised in NSW. Judicial review of other coronial decisions or practice is equally rare. The system is, therefore, largely unaccountable. And, because coroners have very wide and largely unguided discretion as to how they investigate deaths, the performance of individual coroners and others involved in the system is highly variable.

While efficiency and time standards are obviously important in coronial jurisdictions, the emphasis on quantity of work produced (outputs – cases opened and closed), in my view, distorted the effort to provide an excellent *quality* of coronial service (outcomes – families recognised, their concerns addressed, their burning questions answered, some solace given by

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[10] Simone Weil, "Human personality" in Simone Weil, *An Anthology,* (Penguin, 2005 [1986]), 70.

way of a genuine effort to find root causes of preventable deaths and recommendations being made to prevent future deaths.)

Reminding ourselves and the institution as a whole of the humanity of all those involved in coronial investigations has the practical effect of reorientating coroners and coronial systems towards the what is most important. It places the bureaucratic imperative of efficiency in its proper perspective as a *means to an end* rather than an end in itself. Doing this has practical significance, from the thoroughness with which we investigate or train ourselves to do better jobs, the way we think about outcomes of investigations (*systems thinking v blame*), down to the words we use in letters to families, (*are they empathetic or legalistic?*), the way we describe those who have died *('the deceased' or does he or she have a name?*) or the architecture of coronial courtrooms (*do we dominate the room or are families are given an important place in it?*). The legal responsibility of coroners can be thought of as caring for the dead and their relatives, on behalf of the community.[11] It is common humanity which should motivate us to seek to prevent future deaths.

The three largest Australian coronial systems compared

The Victorian system tops the coronial class for seven reasons:

- It is centralised and well-organised;
- All coroners are specialists in the jurisdiction;
- It has clear goals and statutory objectives, and strong cultural ethos of prevention;
- It is well-resourced with sufficient numbers of coroners to manage the load;
- It has a sophisticated research unit and strong connections with university researchers involved in death and injury prevention research;
- It also places emphasis on providing a therapeutic coronial system with strong family support, engagement with First Nations families, and cultural sensitivity;
- Finally, it produces a transparent account of its work in its annual reports and other publications.

Queensland is in the process of reforming itself and appears to be making headway:

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11 See Marc Trabsky, *Law and the Dead: Technology, relations and institutions,* (Routledge, 2019), 8.

- It is quite centralised and appears to be reasonably well organised now that friction between the multidisciplinary partners is being reduced through the establishment of a governance board;
- Its coroners are all specialists, despite being nominally members of the Queensland Magistrates Court;
- It has clear statutory objectives of preventing future deaths and supporting families;
- It appears to be under-resourced in numbers of coroners;
- It is not well-resourced for death prevention research, data collection and analysis except (like all Australian states) in relation to family violence homicides;
- It provides family support through its forensic medicine service and provides useful material through its (somewhat difficult to navigate) website;
- Its statistics are also less than transparent.

The NSW system, despite some genuine strengths, appears in a relatively poor light when compared with Victoria:

- Although it has a strong cohort of specialist coroners in Sydney, it is largely decentralised with 45% of reports of death being dealt with by non-specialist regional and country magistrates;
- Although the specialist coroners conduct inquests and make numerous recommendations, country magistrates rarely do, undermining the overall preventive potential of the system;
- Compared with all other systems surveyed, NSW is poorly resourced with specialist coroners;
- It is not well-resourced for death prevention research, data collection and analysis except (like all Australian states) in relation to family violence homicides and, starting in 2020, with a suicide register;
- It provides good family support through its forensic medicine service and the Coroners Court and, in July 2021, began to provide specialist support to Aboriginal families, especially in relation to deaths in custody;
- Its statistics are also less than transparent.

How can coroners and coronial systems contribute to preventing future deaths?

In 1907, an English coroner, William Brend, who was a doctor, lawyer and forensic pathologist, lamented that –

> The value of the [coroner's] statistics is diminished by absence of co-ordination. Hence we have the anomaly that while a full inquiry is conducted into deaths from violent and unnatural causes, *practically no subsequent use is made of the information for public health purposes*.[12] (Emphasis added.)

Although greater use is now made of coronial data in Australia for long-term public health policy, those observations could be applied to the NSW coronial system in the present day and possibly to most Australian coronial systems except for that of Victoria. This flows, I believe, from the case work model of coronial investigation in which each death is investigated as a single event and with an individual set of circumstances but is rarely seen as part of a pattern.

In my experience, and also in my research interviews with NSW coroners, it is clear that if patterns or trends are ever detected it is only very slowly and usually serendipitously by the accident of similar case files arriving on one's desk or the memory of a previous case. In this respect, coronial work in NSW resembles a 19th century cottage industry.

Despite the systemic flaws in the systems, ways in which contributions can or could be made by coroners to death prevention include the following:

(i) Reconceptualising coroners and the coronial system as part of the public health system[13]

(ii) Identification of physiological causes of death and presentation of those data through the NCIS to other bodies such as the Australian Bureau of Statistics and Australian Institute of Health and Welfare. (All Australian coroners do this.)

(iii) Identification of the 'manner' (the means by which the death came about) and circumstances of death with those data also going the NCIS. (Not all jurisdictions

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12 William Brend quoted by Graeme Johnstone, 'An avenue for death and injury prevention' in Hugh Selby (ed), *The aftermath of death,* (Federation Press, 1992), 140.

13 See Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest,* (Oxford University Press, 2006), 759; Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Edward Elgar, 2016); Lyndal Bugeja et al., 'Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention' (2012) 18 *Injury Prevention* 326–333. doi:10.1136/injuryprev-2011-040146.

do this. In NSW, the Coroners Act requires identification of 'manner' of death only in cases which go to inquest. This means that no formal finding concerning the manner of death, let alone in relation to the full circumstances of death in about 99% of cases reported in NSW.)

(iv) Recommendations following investigations and inquests

(v) Developing specific data bases such as suicide registers and sharing the data with relevant agencies

(vi) Developing review teams and research units to aggregate and analyse data

(vii) Analysis of incoming cases in close to real time to identify emerging patterns and trends (the Victorian Coroners Prevention Unit does this)

(viii) Promoting public health and safety by collaborating with researchers in public health and medicine and public safety to develop insights into preventable deaths.

Coronial data are collected by coroners courts in each jurisdiction and sent to the National Coronial Information System, a repository of coronial data collected from all Australian jurisdictions as well as from New Zealand. Those data are made available to coroners and researchers but the NCIS is not a research organisation itself. The quality of the data fed into the NCIS varies over time and from jurisdiction to jurisdiction.[14]

Ontario approaches its death prevention task in a variety of ways, making it, in this respect, one of the most sophisticated coronial systems in the world. The Ontario system has a strategic plan. One of its key strategic objectives is to collect and analyse coronial data to enable trends and patterns of death to be identified. Second, like other systems, it conducts mandatory inquests into certain categories of deaths.[15] Third, it utilises expert panels to review various types of deaths with a view both to providing advice to coroners in particular cases but also in bringing a systemic approach to death investigation. Fourth, rather than awaiting inquest

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[14] The NCIS Annual Report assesses the quality of inputs from each jurisdiction.

[15] Coroners Act 1990 (Ont) s 10.

findings, which may be subject to lengthy delay, the Chief Coroner can and does make public announcements concerning matters of immediate public interest.[16] For example, in 2020 a report on Covid-related deaths of temporary foreign agricultural workers was published.[17] Fifth, the Office of the Chief Coroner publishes detailed reports arising from the expert review committees.[18] Sixth, although its effectiveness has been questioned, Ontario has a strategic oversight council to provide advice to the Chief Coroner and Chief Forensic Pathologist.[19]

The Victorian coronial system is also highly sophisticated in its approach to death prevention. Like other Australian and international jurisdictions, such as England, NZ and Ontario, the Victorian Coroners Court conducts mandatory inquests in relation to deaths in custody or care, homicides and other matters. [20] It also conducts discretionary inquests.[21] In the 2019-2020 year, the court completed 58 inquests and made 166 recommendations, the majority of which were accepted.[22] Unlike other Australian coroners courts, the Victorian Coroners Court not only publishes inquest findings but, in many cases also, 'chamber findings' – findings made without an inquest.[23]

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16 Dr Dirk Huyer interview with Hugh Dillon, Sydney, 14 February 2020. See also Office of the Chief Coroner, 'Publications and reports' for a range of such announcements and reports. https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html

17 Office of the Chief Coroner, 'Publications and reports' https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html

18 Ibid.

19 Dr Dirk Huyer, in an interview with Hugh Dillon for this project in February 2020, commented that the Death Investigation Oversight Council had not performed to expectations.

20 Coroners Act 2008 (Vic) s 52(2). But note that inquests into deaths in custody or care are *not* mandatory if they are due to natural causes: s 52(3A).

21 Coroners Act 2008 (Vic) s 52(1)

22 Victorian Coroners Court *Annual Report 2019-20*, 3. At the time of publication 92 recommendations had been accepted, 9 had been rejected and 65 remained under consideration.

23 See Coroners Court 'Findings' webpage https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=&order=field_date_of_finding&sort=desc&page=0%2C5 Victorian coroners have power to comment in their findings on 'any matter connected with' a death they investigate, including issues of public health and safety: s 67(3)

Secondly, to contribute to reducing preventable deaths, the Victorian Coroners Court maintains a variety of death registers or databases: a drug overdose register; a suicide register; and a homicide register. It also contributes to the Victorian Family Violence Data Portal which deals with homicides due to family violence. A Coroners Court research team conducts the continuous Systemic Review of Family Violence. A senior coroner is also a member of the Victorian Judicial Advisory Group on Family Violence. The court is also a member of the Australian Domestic and Family Violence Death Review Network.[24]

Thirdly, it places a great emphasis on promoting public health and safety by collaborating with researchers in public health and medicine to develop insights into preventable deaths. The court has a research committee for this purpose.[25] It actively seeks to share coronial data with service providers, such as those involved in suicide prevention.[26] As noted above, the Coroners Prevention Unit, with a comparatively large staff of professional researchers, contributes to the death prevention work of the Coroners Court in a variety of ways. Apart from providing advice to coroners, and engaging with researchers in the wider community, it is arguable that the CPU, by incorporating a public health framework into its work, disseminates that approach throughout the whole coronial system.[27]

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24 Victorian Coroners Court *Annual Report 2019-20*, 24-34.

25 Victorian Coroners Court *Annual Report 2019-20*, 38.

26 Victorian Coroners Court *Annual Report 2019-20,* 37.

27 See Lyndal Bugeja and Jeremy Dwyer, 'Enabling Public Health and Safety Through the Coroners' Death Investigation System: The Principles and Practice of the Coroners Prevention Unit', (2016) *Grief Matters* 19(2) 2016

What are the impediments to realising the preventive potential of coronial systems?

In offering the following critique, I emphasise that I do intend directly or indirectly, to criticise coroners themselves or those who work with them to investigate deaths. On the contrary, I have the greatest of respect for their decency and professionalism. My critique is a systemic one.

With the probable exception of Victoria, some or all of the following factors affect the performance of all Australian coronial systems. This is essentially a resource issue. The resource issue, ultimately, is a government responsibility.

In NSW, impediments to optimising the preventive potential of the coronial system include:

- A lack of a clear normative theory of coronership – a clear conceptual framework of what coroners *should* be doing
- An outdated statute which is in urgent need of reform
- A hybrid structure which imposes coronial responsibilities on rural and regional magistrates. Country magistrates in NSW receive approximately 45% of reports of death
- Inadequacy of training and support for country magistrates undertaking coronial responsibilities
- Mediocre training and resources for new and continuing full time coroners
- Problems in co-ordinating a statewide system involving four major institutions (courts, the Department of Communities and Justice, NSW Health and NSW Police) where coroners individually have very wide discretion and little accountability as coroners for their decisions and practice
- An inferior system of mandatory response to coronial recommendations
- Unnecessary limitations on coroners' powers of recommendation – under the NSW Act, coroners only have statutory power to make recommendations if an inquest is conducted
- A lack of capacity to detect emerging trends and patterns of deaths (in contrast with Victoria)
- Inadequate capacity to collect and analyse coronial data longitudinally

- An absence of connection and co-ordination with other agencies and institutions involved in death preventive research and practice.

What can be done?

It is a fundamental axiom of systems architecture that form follows function: identify the function then design the system accordingly.

- Australian coronial systems should be expressly orientated towards a public health model with death prevention being one of their fundamental purposes

- Fix the NSW system by reorganising it along Victorian lines. It is Australia's most populous state. Many veterans and Defence personnel live and work in the state. Many Defence bases are sited in the state. NSW and Victoria combined account for approximately 53% of all deaths reported in Australia[28]

- Add in Queensland. Reorganising the NSW and Queensland systems along Victorian lines would result in about 75% of all reported deaths in Australia being dealt with by what is, at present, world's best practice[29]

- Raise the consciousness of the particular issues of Defence suicides with State and Territory Coroners. At present, it is likely that most such deaths are not differentiated systematically from other self-inflicted deaths. The Council of State and Territory Coroners could be invited to address the issue and advise the Commission on how this might best be done

- Recommend that the Victorian Judicial College, in partnership with the National Judicial College of Australia and the NSW Judicial Commission, develop a comprehensive training package, including materials, online training modules, seminars on the topic of

[28] Productivity Commission, *Report on Government Services 2021,* Table 7.9A.

[29] 2019-20 reported deaths: NSW 6506; Victoria 7323; Qld 5631 – ibid., Table 7.9A

Defence suicides. This package to be funded by the Commonwealth and to be made available to all Australian coroners and coronial systems

- Coroners should be trained to make recommendations using a public health framework.[30] Such recommendations would incorporate some or all of the following factors:

  (i) An identified priority population

  (ii) The specific risk or factors to be addressed by remedial action

  (iii) Suggested counter-measures

  (iv) The organisation(s) or persons to whom recommendations are made

  (v) Suggested strategy for implementation

  (vi) Time-frame for implementation

- Amend the standard police reports to incorporate defence history data where it is available.

- Train family support staff in state and territory coroners courts to identify such deaths where possible.

- Amend suicide registers specifically to identify Defence suicide deaths or suspected suicides where possible

- Recommend to all states and territories that their Coroners Acts be amended to incorporate preambles and objects modelled on the Victorian and NZ Acts, emphasising the centrality of the preventive purpose of coronial systems

- Recommend to all states and territories that their coronial systems incorporate research units, modelled on the Victorian Coroners Prevention Unit, one of whose tasks would be to analyse all reports of deaths in as close to real time to enable emerging patterns and

[30] Bugeja et al., n.10.

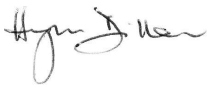
trends to be identified and for long-term trends, such as disproportionate numbers of suicides among Defence personnel and veterans, to be identified

- Recommend that all Australian coronial jurisdictions establish suicide prevention committees, with research support, preferably provided by a permanent research unit within the relevant coroners court, to guide and oversee the effort of coroners courts in relation to suicide. A specific term of reference for such committees would be analysis of, and the production of policy recommendations concerning, Defence deaths.

- Mandate that such committees include representatives of organisations advocating for prevention of Defence suicide deaths or others with special experience or expertise in this area.

Conclusion

I commend the Royal Commission for its work. If I can offer any further assistance in any way, I would be very happy to do so.



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