SUBMISSION REGARDING THE ACT CHARTER OF RIGHTS FOR VICTIMS OF CRIME FROM THE CORONIAL REFORM GROUP

The Coronial Reform Group (CRG) was established in 2016. Our members are people from bereaved families who have been impacted by coronial processes in the ACT. The aim of the group is to advocate for improved coronial processes across Australia to ensure families can have an equal voice in the process and ensure systemic failings can be identified and acted on in a timely manner so future lives can be saved.

Whilst the majority of people in our group do not consider themselves to be 'victims of crime', we are cognisant of the fact that our experiences have some similarity to those of other families navigating the legal system where a crime has been committed. In view of this we make this submission for the ACT Charter of Rights for Victims of Crime. We would also urge the ACT Government to move to develop a similar Charter of Rights for those navigating the coronial system (who are not 'victims of crime').

In Table 1 below we address each of the questions asked by the ACT Government in the consultation papers. Our experience and reflections relate specifically to coronial processes, however, some comments have relevance to the broader justice system.

Table 2 outlines CRG's key recommendations for reform of the current coronial system in the ACT.

TABLE 1

CRG RESPONSES TO CONSULTATION PAPER QUESTIONS

Tell us what you think	Comments
1. How would you prefer to **access information** about how the criminal justice system works and what information and support is available to someone who has experienced crime?	A variety of information sources must be available to cater for the Victim Of Crime (VOC) individual's learning and comprehension styles. Dedicated Victim of Crime Liaison Officers (VOCLO) must be appointed to support and guide the VOC throughout the whole process, right from the time the crime occurred through to sentencing, and after VOC compensation is received. Face to face contact should be the key mode to access information. Many families and/or carers may have had very little contact with the justice system therefore the process can be a daunting and re-traumatising experience. The impact of trauma on an individual potentially will affect the victim's ability to process and understand information so information may need to be provided and explained as many times. We would also like to stress the importance of consistency. Having to explain your personal situation to a new person is tiring and stressful. Our group recommends the appointment of a VOCLO who is trained in legal processes and uses a trauma informed approach at all times.

	Also refer to a) in Table 2 below
2. How would you want to **be kept up- to-date** about your case as it moves through the justice system?	Regular phone and face to face contact with the VOCLO to check in with victims and to keep them up to date with how a trial is proceeding. Written information can be useful for the VOC's own record. Information sharing should be automatic and regular. In our previous experience the onus was nearly always on the family/carer to be proactive to chase up key people regarding developments relating to the inquest. Knowing who to contact, how to contact them and when to make contact should not be a constant battle.
3. How would you want to **access support** as someone who has experienced crime?	Regular face to face from VOCLO and phone contact as needed. Speedy referral to appropriate, professional and free trauma support/services. In 2010 an immediate, excellent trauma support person was made available 24/7 by the police officers who notified a family member affected by suicide. The trauma support person, an independent clinical psychologist, accompanied the family member on all required occasions following the death. This personal service provided support at the time of sudden grief and shock; she did not offer legal advice or assist planning to deal with the coronial process (a separate need). This was complementary to any later counselling offered by ACT Health. Unfortunately the trauma service has been withdrawn in recent ACT budgets and has been replaced by Relationships Australia's general counselling in business hours and by appointment only at a later date. For a person on their own to deal with the situation of suicide, this trauma support was key to coping with the shock.
4. When would you want to **be included** in discussions and decisions about your case?	Inclusion needs to happen right from the start, as soon as the crime is committed. It is essential the VOC is kept up to date, protected and supported throughout the whole process. (Members of our group experienced long periods of not knowing what was happening. Important decisions were often made with no consultation with the family members. Families felt very much 'on the outer' – someone expressed the feeling as 'an extra in a play about someone else'.
5. What would help you feel comfortable to **make a complaint** and how should it be handled?	VOCs have already been traumatised and may feel unable to complain for fear of reprisal, being judged, not listened to and are at risk at being further traumatised. The VOCLO can guide and reassure the VOC that their complaint will be taken seriously and support them through the process. There must be a clear process for complaints and families need to confidence that every complaint will be taken seriously, heeded and responded to.

	(Past experience indicates that during coronial inquests even simple complaints are often not responded to. For example, two families complained about CCTV cameras and microphones not being used in the court. They were asking to be able **to see what documents were being talked about and hear what was being said** about their family member. Not huge requests. There was no response to either of these complaints.) We also have on-going concerns about opportunities for families going through coronial inquest processes to correct factually incorrect information (especially before it is published). There needs to be a complaint process whereby family members can have the opportunity to appeal incorrect information without going to the Supreme Court. *Please see our more extensive comments at f) in Table 2.*
6. Have you experienced, or are you concerned about, any **barriers** or experiences of discrimination when accessing the ACT justice system and victim support services? What were they and how could they be addressed in order for you to have equal access and feel supported?	Many find government systems inherently discriminatory and judgmental. Attempts at accessing supports can further victimise the VOC, by the legal jargon, the lengthy wait lists and the often overwhelming paperwork needed to access supports. The most significant barrier for families is the prohibitive cost of obtaining expert, independent legal advice (often upwards of $30,000). There will be no equity or justice until families can access free legal representation. Currently families are aided by Counsel Assisting the Coroner, but that person is there primarily to support the coroner, not the family. It is not unusual in ACT Coronial inquests to have the family represented by one legal counsel (if at all), against a large team of lawyers/barristers paid for by tax payers dollars defending the government, during what is often quite an adversarial process. Families have little chance to have their voices heard. *Funding needs to be provided at a level that is consistent with the level of legal representation accorded to government and other institutional parties*. (ref p.70 *Saving Lives by Joining Up Justice*, March 2013, Australian Inquest Alliance).
7. Should information and support for people who have experienced crime be **opt-in**, so you can choose to access victim supports, **or opt-out** so this happens automatically?	Op-out. Traumatised VOCs may find it hard to ask for support and making that first call can be too daunting. Convoluted intake systems can further traumatise the VOC by having to tell their story again and again in order to access supports.

TABLE 2

CRG RECOMMENDATIONS FOR IMPROVING CORONIAL PROCESSES IN THE ACT

ISSUE	COMMENTS	SUGGESTED REFORM
a) Families need to be supported and guided through the coronial process and its aftermath.	Counsel Assisting the Coroner's role is to assist the coroner, not the family. In our experience this person is usually appointed just before the inquest so is not on hand to support and guide the family through the inquest process and its aftermath. Counseling services are just that and often short term. They do not provide guidance or advice through legal procedures and the coronial process overall.	A family liaison person, with a background in coronial process and bereavement support, needs to be available to support the family from soon after the death, to after the implementation (or otherwise) of the recommendations arising from the inquest.
b) Unacceptable time gap between the death and the coronial.	Families can wait for 3 years or more, for a coronial inquest to be held. This is unacceptable. Families are left in limbo, and mostly in the dark about where the investigation is up to. Also witnesses often say they cannot remember what happened and documents are lost after such a lengthy delay.	A dedicated coroner needs to be appointed in the ACT which should shorten wait times for coronial inquests.
c) Prohibitive cost of coronial inquests for families	For families to be fairly represented at coronial inquests in the ACT they need to get independent legal representation. The process is completely new for most families, often adversarial, certainly intimidating and time consuming. Written documents need to be produced, medical records often up to 3,000 pages need to be read and understood and often complicated family stories/ opinions need to be clearly presented in court. The usual cost from our experience is $30,000 and up. Many families feel that the onus falls primarily on them to 'come up with evidence', produce documents, find witnesses, make the case and follow the process through.	The ACT Government needs to fully fund the costs of independent legal representation for those involved in coronial inquests. *Funding needs to be provided at a level that is consistent with the level of legal representation accorded to government and other institutional parties*. (ref p.70 *Saving Lives by Joining Up Justice*, March 2013, Australian Inquest Alliance). (We believe a system operates in NSW in child protection cases – where funding for separate independent legal representation is funded for both the family and the child.)
d) The coroner needs to have the power to investigate cases fully. At present he/she only can look at events 'proximate' to the death.	In mental health cases, this means that the full story is not investigated.	Broaden the ACT Coroners ACT to allow the Coroner to make comments on any matter relating to the death and not just those relevant to public safety.

e) There needs to be more pressure on the government to act on coronial recommendations.	Coroners in the ACT are very reluctant to make recommendations. When they do, they are often not implemented and no explanations are provided to families or the community about why this decision was taken..	Change to ACT Coroners ACT required. When recommendations are not accepted by the minister, information explaining this decision should be formally provided by the government to all parties involved and should be publically available. When recommendations are approved, families/ interested parties should be regularly informed of the progress of implementation. *Families and Australian communities need to see the preventative system actually working, and so must be kept informed about what recommendations have been made, how those recommendations are being implemented and how implementation will be monitored*. (p21. *Saving Lives by Joining Up Justice*. March 2013, Australian Inquest Alliance).
f) Factually incorrect information has been included in coronial findings in the ACT that is damaging or distressing to families and errors have been published in the local media.	The Coroners ACT 1997 says *55.1 A coroner must not include in a finding or report under this Act (including an annual report) a comment adverse to a person identifiable from the finding or report unless the coroner has, making the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may—* *(a) make a submission to the coroner in relation to the proposed comment; or* *(b) give to the coroner a written statement in relation to it.* Families have no similar opportunity to comment on incorrect information that will be published in coronial findings. In the ACT there is no right to appeal to findings other than going to the Supreme Court. This situation is inequitable and breaches Australia's international treaty arrangements and the ACT Human Rights ACT 2004.	Families need to be provided with the opportunity to comment on / correct inaccuracies in coronial findings before they are published. Families/interested parties should have the right to appeal against inaccuracies in the coronial findings without needing to go to the Supreme Court. There should be a formal process by which families/other interested parties have the right to make a formal complaint about a coroner.
g) Opportunities for real systemic change are lost when a coroner is reluctant	It is evident from the coronial findings in our cases that there is an unwillingness to make adverse comments	The adversarial system needs to be dispensed with. A coronial inquest should be an open process with all parties

(unable?) to make adverse comments against individual professionals and government systems when there is clearly evidence that there are issues of public safety. **It seems that the same concerns do not apply when making adverse comments about the deceased person.**	about the practices of government agencies and the staff working in them. Teams of lawyers work to shield government agencies from censure of any kind. The ACT Health Directorate and other agencies are only mandated to respond to the formal recommendations. Contributing factors to the death identified during the inquest are rarely addressed and valuable information that may prevent further loss of life is missed. Family members who have died are dehumanised in the coronial process and there is a culture of blame the victim rather than looking at how to improve practices and systems to prevent further deaths. This lack of empathy causes further grief to families.	working together to see what changes need to be implemented to avoid further deaths. (In the UK many coronial inquests are now conducted in a 'round table' environment not a traditional court room setting.) A process should be established whereby 'contributing factors' arising during coronial inquests are seriously considered and acted upon (ie not just formal recommendations). NSW Coronial findings/reports are documented in a more considerate and respectful way. At the beginning of the findings the deceased is 'introduced' so there is some understanding of the background and life of the person who has died. The ACT Coronial system should adopt a similar approach.

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Coronial Reform Group
Truth, justice and accountability

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