Coronial Initiative of the Crossroads Group

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The Metaphor

It's 1854 in London, in a time of cholera, and the preponderance of scientific opinion holds that cholera is transmitted as an air born virus. But a certain Dr John Snow looked carefully at the evidence. This evidence pointed to the fact that cholera was spread by tainted water.

There were a lot of people dying of cholera in Soho, a suburb of London, and that is where Dr John Snow went. He had under his arm a map of the streets of Soho, paper and a pencil. He tracked down the families of people who'd had cholera and wrote down their stories. He tracked where they sourced their water. On his map of Soho, he put a black dot for the place of death of any person who had died of cholera. There were a lot of stories. There were a lot of black dots.

The dots clustered around the Broad Street Square. So Dr John Snow went to Broad Street Square to take a look. The square was empty except for one thing. In the middle of the square was a water pump; the Broad Street Pump. Women filled bottles of water from the pump, children drank from it on their way to school, the local tavern sourced water from it. In the immediate vicinity of the pump, there were 500 cholera fatalities in 10 days.

Dr John Snow took his map to the Board of Guardians of St. James Parish and insisted the handle be removed from the pump. After the handle of the pump was removed, the cholera deaths in the surrounding streets, of school children, their families, and the people visiting the tavern, dropped to zero.

It is a truism that if you have a good metaphor, you have a good case. Confronted with multiple deaths as we were, to prevent the cluster growing and the suffering spreading, we needed:

- A notebook, pencil and a plan;
- A map: getting at the stories of the deaths;
- Location of the handle of the Broad Street Pump;
- Secure standing in a forum with authority to order the removal of the handle, to stop supply of the poison.

Notebook, Pencil and a Plan

An approach to a problem of this gravity requires advice, input and discussion among a variety of agencies and individuals, on a regular basis. Those discussions must turn on applications to a Court, dealing with the media, and differences of political alignment, to name a just a few points of potential contention. In all likelihood, that stewardship may be needed for a period of years.

Accordingly, it is essential to establish a secretariat that is knowledgeable about the problem of suicide and may offer, in addition, mature and experienced stewardship. Without such a secretariat, the Crossroads Group would not and could not have succeeded.

Established in late 2018, the group was chaired by Ms Rachel Hughes of the EMPHN who, with the assistance of Ms Jane Schinas, steered the group through every difficulty and difference of opinion and at time of writing continues to do so. Ms Hughes and Ms Schinas provided knowledge, expertise and experience to moderate the group, with tact and courtesy being a hallmark of their approach. Such a dealing is essential to avoid the pitfalls of gaining consensus of approach to courts, media, risk and political difference.

A Map: Recording the stories

Regarding the deaths, we were unable to obtain further information from the Police, who were duty bound to report directly to the Coroner only. Since we knew little about the deaths, the only place we could obtain such information way by making formal application to the Coroner. This work is normally done by lawyers. A summary of the relevant procedure may be set out as follows.

Any death that may be designated as a 'reportable death[1]', triggers an enquiry by a Coroner, or alternatively, where there are contentious issues arising, a public inquest. Pursuant to S.4(2) Coroner's Act, where a death is *unexpected, unnatural or violent*, the Coroner must investigate.

By force of that section, a death by suicide will always a reportable death and thus, will always attract the jurisdiction of the Coroner's Court, and trigger a consequential investigation.

Enquiries with the Coroner's Court determined that, of the 5 initial deaths by suicide, the status before the court was as follows. The first two deaths had been investigated separately, which investigation was now concluded with Findings handed down. However, the Coroner had not noticed a pattern among the deaths and Findings made no reference to other deaths, nor given consideration to any pattern or systemic issues raised. The status of the matters is set out below:

Name:	Court Ref:	Status:	Findings
Withheld	COR2018 1248	Closed	Handed down - did not consider systemic issues
Withheld	COR2018 1270	Closed	Handed down - did not consider systemic issues
WX	COR2018 2583	Open	Investigation Pending
TP	COR2018 4780	Open	Investigation Pending
MH	COR2019 3839	Open	Investigation Pending

Two of the matters were closed and findings had been handed down. In order to obtain the fullest information possible, and armed with the names of the 5 women, WCLS lodged

[1]**Reportable Death**: S4(2)(a) Coroner's Act - In this Act, a death of a person is a reportable death if… a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

formal applications with the Coroner's Court with respect to all 5 matters, for the full Coronial Briefs. In addition, with respect to each of the 3 matters that were still open, it applied for:

1. access to the full coronial brief with respect to all matters[2];
2. Standing as an interested party[3];
3. For a public inquest to be convened in each of the matters.

The Coroner may release findings to WCC Inc., if satisfied it has sufficient interest in that document.[4] WCC Inc. argued that it met this test, for the following reasons:

1. WCC Inc. was advised by police that they held concerns that the circumstances of this cluster of deaths suggest systemic issues were at play;

2. Police Regional Command has properly kept the circumstances of the deaths confidential, beyond advice that the deceased:
   (a) are female;
   (b) have Indian ethnicity;
   (c) have children;
   (d) lived locally in Whittlesea;
   (e) died in a manner marked by an unusual nature of violence.

3. As a result, WCC Inc. remained ignorant about the fuller circumstances of the deaths;

4. Aware that the Coroner's Act provides for a third party such as WCC Inc. wished to apply for an Inquest to be held and seek leave to appear as an interested party, for the purpose of examining systemic issues.

5. Were WCC Inc. provided with: -

   (a) Inquest Findings in the two closed matters;

   (b) The full coronial briefs in the remaining matters.

   It would be well placed to settle a submission to the court as to why an inquest ought be held for the purpose of dealing with systemic issues, always assuming there is evidence they are indeed at play, and why and what orders sought should be made by the Coroner to prevent further deaths of this kind.

[2] **Access to documents:** S. 115(2)(a) Coroner's Act - A coroner may also release a document to— an interested party if the coroner is satisfied that the party has a **sufficient interest** in the document;

[3] **Interested party:** S. 56 Coroner's Act - A coroner may give a person leave to appear as an interested party at an inquest if the coroner is satisfied that—

(a) the person has a sufficient interest in the inquest; and
(b) it is appropriate for the person to be an interested party.

[5] **Reports and recommendations:** S72 Coroner's Act –

In response to these submissions, the court ordered that:

1. WCC be provided with the findings of both initial matters, on a strict 'eyes only' basis;
2. That it have party status with respect to the balance of the matters;
3. WCC not have access to the Coronial Briefs of the balance of the matters.

In under 12 months, we received notice of two further deaths. One of these was taken over by the same Coroner who already had carriage of the 3 pending matters. The final matter was given to a different Coroner and placed on hold, pending the outcome of the other 4 investigations.

Identifying the Handle of the Pump

When one considers the relationship between cause and effect, to identify the cause of the Soho Deaths, location of a single cause all but solved the problem. Not so with deaths by suicide where the relation between cause and effect is complicated. There will be a variety of indirect causes, together with factors with more or less degree of likelihood, which compounded the problem. The task before us is to identify as many of these as we can and settle upon concrete solutions to which the several powers at the disposal of a Coroner may be tailored.

For the following two years WCLS, with the rest of the Crossroads Group, set to work upon the problem. Our applications for the full coronial briefs had borne no fruit. But by order of the court, we were now party to the proceedings themselves, which would bring with it the right to make submissions to the Coroner. We knew no more about the facts than those we had been provided in the first place, namely that 5 deaths had occurred in Whittlesea. In the Indian Community. All women. All mothers. With respect to two cases, so police advised, there was evidence of family violence. These women, dying in this manner, offered hard evidence of despair, with every likelihood that the cluster would grow, which indeed it did, as over the following 12 months, 2 more deaths occurred.

Securing Standing in an Effective Forum

WCLS undertook to complete legal work associated with applications for party status in the open Coronial proceedings and, should it prove necessary, pressing the applications for a public inquest to be convened.

Where deaths by suicide occur, the Coroner's Court is an ideal forum for a third party to secure party status and to deal with the Coroner to provide advice that will tailor and fine tune effective findings.

The Coroner's Act provides for a system whereby reportable deaths are independently investigated to ascertain the identity of the deceased, the cause of death and the circumstances in which the death occurred. Where systemic issues are at play, the Coroner may seek these out and comment widely on those issues, exercising the court's 'preventative function'. Insofar as the Coroner may turn their mind to such issues, they are constrained to some extent by the law and will confine themselves to those circumstances which are sufficiently proximate to be considered relevant to the death or deaths under investigation.

With party status in the relevant matters, it was open to WCC to seek a round table meeting of all entities and individuals who were participating in the Crossroads Group, to meet with the Coroner and discuss what input they could have, about not only why these suicides were taking place, but also to offer a list of solutions which could save lives and prevent further deaths. The Coroner agreed and convened such a meeting in mid-2019. The Coroner heard from all participants at that meeting, was impressed with the degree of expertise of the participants, and invited written submissions to be lodged at a later date. That invitation was accepted by all participants and submissions lodged by each of them, by the end of 2019.

Power to Remove the Handle

It is a purpose of Coronial investigations to look for ways to save lives. This is the Coroner's prevention role. The vehicles for advancing that role are the powers to:[5]

(a) report to the Attorney-General on a death;
(b) comment on any matter connected with the death they have investigated, including matters of public safety and the administration of justice; and
(c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

Moreover, S 72 Coroner's Act mandates the need for any Statutory Authority, which receives recommendations made by the Coroner, to provide a written response and identify a statement of action that will be taken. It should be emphasised that the powers of a Coroner to recommend to the Attorney or a Minister, are not binding. But the mandatory response and the need for that response to condescend to particulars of exactly what action has been taken, are a statutory exercise in 'shame', in a nutshell, should a Minister or entity decline to take action. The act binds the Minster or entity to offer a written 'please explain', which must be forwarded to the Coroner upon a strict time limit of 30 days after the findings are received.

The recommendation by the Coroner was directed to the then Secretary of the Victorian Department of Health and Human Services. The recommendation has been fully

[5] **Reports and recommendations:** S72 Coroner's Act –

S72 (1) A coroner may report to the Attorney-General on a death or fire which the coroner has investigated.

S72(2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.

S72(3) If a public statutory authority or entity receives recommendations made by the coroner under subsection (2), the public statutory authority or entity must provide a written response, not later than 3 months after the date of receipt of the recommendations, in accordance with subsection (4).

S72(4) A written response to the coroner by a public statutory authority or entity must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner.

S72 (5) The coroner must—

(a) publish the response of a public authority or entity on the Internet; and
(b) provide a copy of the response to any person—
(i) who has advised the principal registrar that they have an interest in the subject of the recommendations; and
(ii) who the principal registrar considers to have a sufficient interest in the subject of the recommendations.

implemented; an officer of the newly formed Department of Families, Fairness and Housing (DFFH) has been detailed to consult and work more widely with the Crossroads Group and separately with those entities that form a part of it, where need be. This work is progressing very effectively.

It may be emphasised in conclusion, that where a cluster of deaths by suicide, or in some instances, a single case, is a clear marker of suffering in a community, the approach trialled in this instance of:

(a) convening an effective secretariat;
(b) seeking the help of a lawyer with knowledge of Coroner's Court proceedings who can take carriage of the relevant inquiries and liaise also with the secretariat and group members and appear in court applications where necessary;
(c) coordinating the input of local groups who are experts in community affairs in the locality where the deaths occurred, and identify causes of those deaths and concrete solutions;
(d) invoking the &72 recommendation powers pursuant to the Coroner's Act to best promote those solutions.

This approach is a model which best combines local and particular expertise on the ground with a forum capable of accepting and considering that expertise, and translating it into effective orders, thereby activating responses at the highest levels of government to liaise with the local services to prevent similar deaths and preserve lives.