

Coronial reforms

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Abstract

As part of a study of the relationship between prisoner health and deaths in custody, 114 coronial inquests were examined. The most common reforms recommended by coroners are summarized in this article.

Most common reforms recommended by coroners

Contributing cause of death	Common areas for coronial recommendations
Poor supervision	<ul style="list-style-type: none">• Improve staffing to allow more stringent checks, monitoring and head counts so that non-responsive inmates are quickly identified• Improve staffing in critical areas, including aboriginal health workers and mental health workers at more prisons; supervisors to observe monitors at watchhouses; Indigenous negotiators or representatives when Indigenous person arrested; etc• Check alarms and communications more regularly• Do not place inmate in a cell on his/her own until safe to do so• Implement all required policies and procedures, e.g. in the aftermath of a death in custody
Poor recordkeeping/communication	<ul style="list-style-type: none">• Prisons, police and health services to obtain and share all inmate records (whether by consent or legislation), especially health, alcohol and drug records)• Police to keep records updated, e.g. uploading incidents to the Police Incident Management System in a timely manner• Hospitals to keep adequate records, e.g. re follow-up visits

	<ul style="list-style-type: none"> • Improve communication amongst authorities, e.g. acting quickly on intelligence and other information, as well as passing the information on as required • Make all required plans, e.g. Intensive Management Plans • Keep all required records, e.g. self-harm records • Improve communication with prisoners' families • Risk assessments with regular reviews of actions to be taken and outcomes
Drug overdose/ alcohol toxicity	<ul style="list-style-type: none"> • Test inmate for drugs before placing on a withdrawal program • Allow lower doses of Methadone and more strictly controlling increases in dosage • Provide culturally safe help, e.g. for history of chronic substance abuse • Adequately screen for incoming drugs • Arrest and detention for street drinking to be abolished or used as a last resort
Drivers licence challenges	<ul style="list-style-type: none"> • Provide greater opportunities for people in remote areas to obtain their licence and register their car
Hanging	<ul style="list-style-type: none"> • Remove all ligature points, including in common areas • Restrict the use of cords, laces, etc where considered an unacceptable risk • If a ceiling fan is essential, incorporate a load-sensitive mechanism • Refer also 'Poor supervision'
Positional asphyxia	<ul style="list-style-type: none"> • Provide adequate training in positional asphyxia awareness, restraint techniques, medical supervision, retaining CCTV footage, etc • Reduce or eliminate unnecessary shackling • Risk assessments, e.g. for falls risk • Cameras in police vans, common areas, etc
Police pursuits	<ul style="list-style-type: none"> • Continuous risk assessment, calling off pursuits for safety reasons • Use automatic number plate recognition cameras and in-car data capability • Use emergent video technology in police cars • Adopt technologies that permit the remote disabling of vehicles • Expand vehicle seizure laws for vehicles that fail to stop or have registration plates belonging to another vehicle