Reimaging Justice through the Coronial System

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Acknowledgement of Country

Overview

1. Coroners Court of Queensland and the Queensland Coronial Legal Service
2. Therapeutic and counter-therapeutic impacts of the coronial system & accessing justice through the coronial process
3. Human Rights and the Coroners Court of Queensland
4. Case studies

- Inquest into the deaths of Doreen Langham and Gary Hely
- RHD Cluster Inquest

5. Questions

Coroners Court of Queensland and the Queensland Coronial Legal Service

Inquest into Rockhampton death in custody during transport to watch-house in November 2019

A coroner will examine suggestions an officer placed his knee on a man's neck or head during an arrest before his death in custody. Here's what day one of the inquest heard.

Kerri-Anne Mesner Follow

@kalm80 6 min read September 5, 2022 - 7:57PM The Bulletin

Queensland Police Service. Picture: Zizi Averill

Police response beset by 'so many inadequacies' ahead of Doreen Langham's death, inquest hears

Gary Hely issued a chilling warning to his former partner 15 days before dousing her house in petrol and setting it alight

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Queensland forensic officers sift through the remains of Doreen Langham's home in Browns Plains, south of Brisbane on 23 February 2021. An inquest has heard that Langham's complaints to police were 'not properly investigated'. Photograph: Darren England/AAP

Health services failed in care for three Doomadgee women who died of rheumatic heart disease

ABC Far North / By Holly Richardson, Julia André, and Christopher Testa

Posted Fri 30 Jun 2023 at 2:28pm, updated Fri 30 Jun 2023 at 4:52pm

Family members of the three women followed inquest proceedings, which took place across Cairns and Doomadgee. *(ABC Far North: Holly Richardson)*

Before patient died, guard knelt on his head and put him in choke-hold

Matt Dennien

June 30, 2020 – 7.52pm

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An at-risk mental health patient died in a north Queensland hospital after being placed in an unauthorised choke-hold so he could be sedated, a coroner has found.

Taare Tamakehu Rangi died in the Townsville Hospital's Acute Mental Health Unit on July 7, 2018, after the incident sparked by his refusal of medication.

Northern Coroner Nerida Wilson ultimately found there had been a lack of compliance with hospital policies rather than any gaps.

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Therapeutic and Counter-Therapeutic Impacts of the Coronial System

THERAPEUTIC

- Invitation to provide information about loved one and concerns about circumstances of death
- Provided with draft findings for comment or to raise any concerns prior to receiving final findings
- Provided with as much information as possible when it is requested.

COUNTER-THERAPEUTIC

- Lack of understanding of the purpose and function of the Coroners Court and the rights of family members
- Lack of communication
- Views not taken into account
- Time delays

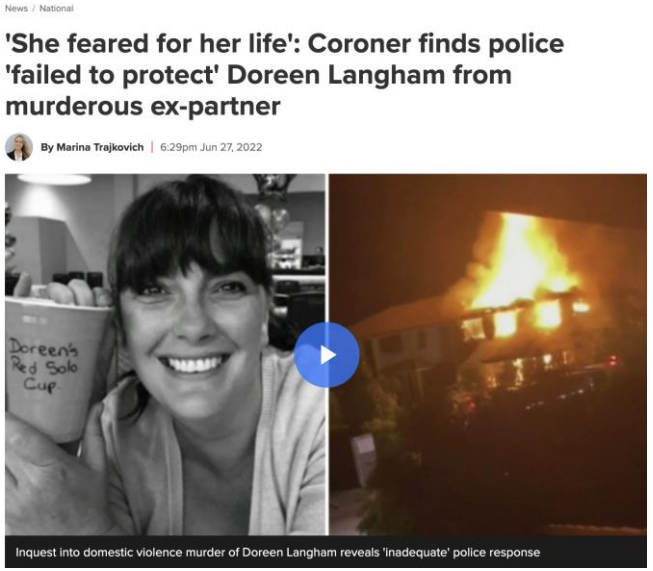
Accessing justice through the coronial process

Forcing systemic change

- Coroners may make comments (recommendations) on anything connected with a death investigated at inquest that relates to public health and safety, the administration of justice or was to prevent deaths from happening in similar circumstances in the future.
- Recommendations made by Coroners are not required to be implemented by the agencies they are directed at.

Human Rights and the Coronial System

Inquest into the death of Doreen Langham



A coroner has given a scathing review of the response of Queensland police, who were 'inadequate' in protecting domestic violence victim, Doreen Langham from her killer.

Langham, a grandma and mum from Logan, was killed by ex-partner Gary Hely after he doused her in petrol and set her Browns Plains unit on fire last year, killing them both.

Coroner Jane Bentley today revealed there were several missed opportunities to protect Langham from Hely's escalating behaviour, calling on the police service to do better in their treatment of domestic violence cases.

RHD Cluster Inquest

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Questions?