

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Acting Commander Trevor Carter, policy and secretariat division, corporate strategy and performance department;

Senior Sergeant Anthony O'Connor, legal policy, corporate strategy and performance department; and

Senior Constable Susan Nolan, State Coroner's Assistants' Unit, coronial services centre, Victoria Police.

The CHAIR — I welcome to today's hearing of the parliamentary Law Reform Committee inquiry into coronial services in Victoria Acting Commander Trevor Carter, Senior Sergeant Tony O'Connor and Senior Constable Susan Nolan, all from Victoria Police. This is a public hearing. You have made a written submission, and we are very keen to hear your elaboration on that. We have got just over half an hour, and there will be an opportunity for us to ask questions at the end. Everything you say becomes part of the public record — unless there is evidence you would like to give in camera — and in time, after you have had an opportunity to correct the proof copy for any factual errors, it will be placed on the web site.

Acting Cmdr CARTER — Thank you, and our apologies again for being late. It was beyond our control.

Thank you for the opportunity to address the committee on the review of the Coroners Act. Victoria Police, through the State Coroner's Assistants' Unit, provides some of the legal, administrative and investigative services necessary to investigate unnatural deaths. As such, Victoria Police welcomes this chance to contribute to the committee's review of the current provisions of the act. Assisting me this morning are Senior Constable Sue Nolan from the State Coroner's Assistants' Unit and Senior Sergeant Tony O'Connor from the legal policy unit of Victoria Police. Victoria Police's written submission to the committee addresses key questions and issues in the discussion paper. However, I am pleased to have this further opportunity to expand on aspects of the written submission during this hearing and to the extent possible answer any specific questions the committee may have.

In the experience of Victorian police the current legislative framework has served the community well. The current act requires that all cases of reportable deaths and non-fatal fires must be reported to the coroner. When police attend a scene where there has been a death they must notify the coroner. If it is a reportable death, they must notify relevant investigators, authorities and relatives. Police must also ensure the preservation or collection of any required evidence and exhibits, arrange for the removal and identification of the body and care for any property of the deceased. The State Coroner's Assistants' Unit is responsible for liaison between the coroner and members of Victoria Police. It also carries out and coordinates investigation into certain deaths while overseeing all other reportable deaths in accordance with the act. The State Coroner's Assistants' Unit also performs an advocacy role when assisting the coroner at inquests and performs the role of reconciliation and mortuary coordination during disaster victim identification response.

Victoria Police supports the classification of the term 'unexpected death' as outlined in the discussion paper. As indicated in the written submission, Victoria Police would support the use of the expression 'sudden death, the cause of which is unknown' as an alternative to 'unexpected death'. It is the experience of Victoria Police that generally doctors do not have a good understanding of what is meant by the term 'unexpected death'. Their lack of clarity is evidenced by a number of cases referred to the coroner by the registrar of births, deaths and marriages, specifically following a fall where a patient dies from subsequent complications. Doctors will register such deaths with the registry as they deem them to be not reportable, but actually they are reportable due to the initial accident — that is, the fall — and as such should be reported to the coroner. Victoria Police suggests that guidelines similar to those issued by the doctors of the Victorian Institute of Forensic Medicine would be useful to assist doctors' understanding. It is also considered that the state coroner, perhaps in conjunction with the Clinical Liaison Service, would be responsible for writing, updating and publishing such guidelines.

In relation to deaths in custody and care, the act does not define what is meant by the term 'in custody' or whether this term includes a death which occurs when a person is evading or escaping from custody. However, the Institute of Forensic Medicine's guidelines advise doctors to report the death of a person which occurs as a result of a police action or while the person is being detained, even if they were not under arrest at the time of death. Victoria Police would support further clarification of what is meant by this term.

In relation to awareness of reportable deaths, the act was amended in 2004 to introduce a category of 'reviewable deaths', which must be reported to the coroner. This amendment arose as a result of concerns raised regarding the appropriate identification of situations in which more than one child in the one family has died. Given the relatively recent introduction of this amendment, Victoria Police believes there could be some confusion with the new provision relating to multiple child deaths in one family. For example, if the doctor who certifies the death is not the family doctor, they may not be aware of any history of related child deaths in the family. Victoria Police is of the view that this provision should be extended to include a requirement for the registry of births, deaths and marriages to report a subsequent death of a child from the same family to the coroner.

As a separate issue, Victoria Police believes the current provisions of section 13(1) in relation to the reporting of notifiable deaths is sufficient and would oppose the introduction of a separate penalty on police officers who fail to report to the coroner information relevant to an investigation. It is argued that there could be some confusion as to what is meant by 'report information relevant to an investigation' as currently there are no criteria setting out what would be considered relevant information. Victoria Police would support clarification on the stage of the investigation process at which failure to report would apply.

As outlined in our written submission, the State Coroner's Assistants' Unit plays a significant role in the monitoring of reported deaths and assisting members in their investigations, including liaison with the coroner when necessary. Victoria Police suggests that, despite our assistance to the coroner, the coroner should not have the power to issue directions directly to investigating police. It is important for Victoria Police to remain independent from the coroner while assisting the coroners office with its investigations. If the coroner were provided with the power to direct police investigations, it would create the potential to hinder other competing interests for which police are accountable. Currently, and in practice, if the coroner needs to review a matter and believes further investigation is required, the assistance unit will facilitate the provision of that information by liaising directly with the investigating member.

Victoria Police has noticed an anomaly in the act, in that it does not include a provision for police to investigate on behalf of the coroner. This has been a common practice for many years and as such Victoria Police would support legislative amendment to specify the role police play when conducting investigations on behalf of the coroner. Such an amendment would alleviate difficulties that may arise for police, particularly in the health sector, where resistance is often experienced by police acting on behalf of the coroner due to a lack of understanding or clear statute as to the role of police in this context.

Victoria Police currently relies on the broad definition under section 18A of the Police Regulation Act 1958 to outline the assistance of police with investigation and inquests. The Coroners Act does not refer to the role of Victoria Police in assisting the coroner at inquests. Victoria Police would support any amendments to the legislation which would reflect the current role of the State Coroner's Assistants' Unit and to appoint members of the state coroners office as police assistants to the state coroner. Victoria Police would suggest that an appropriate section for amendment might be section 46(2) of the act.

Our written submission includes a number of comments on other areas relating to the operation of the act and its impact on Victoria Police. These issues are detailed in the submission, and I am happy to expand on them or take questions in relation to our comments or suggestions for improvement. The specific issues relate to death certification, mandatory inquest, privilege against self-incrimination, rights of appeal, investigation of suspected deaths and some issues relating to the independent investigation of fires and inquests into fires.

Once again I would like to thank the committee for the opportunity to comment on the issues raised as part of the review of the Coroners Act. If you have any further questions for Victoria Police on the issues, we are happy to assist.

The CHAIR — Thank you very much for that. Perhaps if we deal with the question of police investigating on behalf of the coroner. You indicate in your submission that there are many competing interests that police have to take into consideration in those investigations. Could you give us some examples of those competing interests and how they are usually resolved in the course of investigation?

Acting Cmdr CARTER — I might get Sue from the coroners assistance unit to respond to that.

Sr Const. NOLAN — Primarily the competing interests would be that the police are investigating to determine if there are criminal offences involved, and if there are, then obviously there are obligations as to how that investigation will be conducted — the gathering of evidence, the relevant admissions and so on. So they have a very clear obligation to investigate from a criminal perspective. The coroners perspective is quite different from that and may not take into account the considerations that a criminal investigation would need to take into account. If the police were being directed purely down a coronial line, there would be the potential to miss, if you like, matters which are critical to a criminal investigation. That is the primary conflicting interest, I would imagine.

The CHAIR — We note also you state in your submission that the coroner does not have the power to issue directions directly to investigating police. We heard earlier that the coroner states in his submission he

believes he does have the power to provide such directions. Have you any comment on what appear to be two contradictory points? Have you had an opportunity to read the submission from the coroner?

Sr Const. NOLAN — I have read the coroner's submission. My understanding from the submission is that they preferred to remain with the working relationship that currently exists. I do not recall reading any reference to a direction or an ability to direct. In practice the situation is that the coroner will indicate that he or she requires further information about something, and it would be a very rare situation if the coroners assistance unit did not follow up on that sort of matter. I cannot identify anywhere where there is an actual power to direct.

The CHAIR — And you are indicating that you think there should not be?

Acting Cmdr CARTER — That is our position.

Mr MAUGHAN — And from a practical point of view it seems to be working pretty well the way it is — there is not the conflict there could be between the coroner and the police?

Acting Cmdr CARTER — I do not think there is any conflict. The working relationship between the coroner and our office is in my view very good, and the current arrangements work very well.

The CHAIR — Could I raise an area where there might be potential conflict — for example, we have heard from other witnesses about police shootings: one of the witnesses was concerned about the fact that in any investigation of a shooting the coroner was obviously highly dependent on the investigatory skills that the police force brought to that scene immediately afterwards and the way in which they went about that investigation. They suggested that it was a very difficult situation because the coroner was so reliant on the police for that in a very difficult situation. Have you any comments about any dilemmas or problems that might be posed for police in investigating things like police shootings?

Acting Cmdr CARTER — Obviously it is a dilemma, not only in the situation you raised, but also it is a dilemma for us. In that particular instance we had to investigate the cause of death. We had to start the initial investigation. I suppose one of the issues you are referring to is the impartiality that the police might have on those issues. Our processes are that in that sort of situation our ethical standards department has a very strong role in overseeing the way investigations are carried out. There is also the role of the coroner to oversee the investigation. Also at the moment if any issues arise the Office of Police Integrity has oversight and plays an investigative role as well. Although we have an initial response in terms of our investigation, there are a number of checks and balances in terms of our ethical standards to Parliament and the OPI.

The CHAIR — I just wondered whether, in suggesting in your submission in a sense that legislatively there should be more recognition of the group assisting the coroner by amendment to the act, it presumably would tend to place them more within the coroners jurisdiction. Are you suggesting that perhaps that might create slightly more independence in conducting certain types of investigations?

Sr Const. NOLAN — Primarily the police and members of the State Coroner's Assistants' Unit represent mostly the investigation in the majority of coronial cases and then the assistance provided to the coroner also in the majority of cases. There does not seem to be any recognition in the act of the role police play in either of those two capacities. The difficulty that creates in a practical sense is evidenced very much when police are dealing with death in a hospital. In the community's eyes police are obviously seen as investigating things which are suspicious.

When they turn up to take a report of a death in a hospital, it might be very obvious that there is nothing suspicious about it, but it creates an impasse because the medical profession often does not understand that the police are there investigating on behalf of the coroner. They immediately respond by thinking there must be something suspicious, and it creates some difficulties in the exchange of information.

If there were something in the act which clearly spelt out that the police were investigating on behalf of the coroner, it would alleviate a lot of those problems. At the State Coroner's Assistants' Unit we regularly receive phone calls from either police who have reached this impasse at a hospital or from the medical profession asking why the police are here wanting this information. We are therefore acting as a go-between, so it might alleviate that problem if it was clearer that that is why the police are there.

The CHAIR — If there was a clearer role?

Sr Const. NOLAN — That is right, yes.

The CHAIR — Back on the question of potential conflicts, you mention in your submission that you have been recently required to investigate incidents where WorkCover has served section 39 notices on the police, and you said there could be potential for conflicts of interest with police conducting investigations into these deaths that has an impact on the overall police organisation, and that that should perhaps be conducted by an external party. In relation to police shootings, would that be a similar situation where there might be the potential for conflict?

Acting Cmdr CARTER — The issue of conflict that you first raised relates to WorkSafe, particularly the instances this year of the deaths of Rennie Page and Tony Clark, where as you rightly point out Victoria Police has been served notice — in fact, we are subject to investigation by WorkSafe. It does present to us a perception of potential conflict where we have commenced the investigation into both those particular matters, oversights by the coroner, and we have been investigated again by WorkSafe, so we have seen that there is potential there, particularly when WorkSafe have the capacity to charge Victoria Police.

The CHAIR — I suppose what I was putting to you is do the same conflicts of interest arise in relation to police shootings where there is the capacity, potentially, for police to be charged in those circumstances?

Acting Cmdr CARTER — I think there are two separate matters — the issue of WorkSafe and the issue of the police shootings. We should separate them in terms of issues of conflict. With regard to the police shootings, I do not believe there is a conflict. We have the processes and practice in place that allow us to have sufficient oversight, which is separate to the issue of WorkSafe. I think they are two completely different matters.

The CHAIR — Do you have a copy of the procedures and so on we could look at as part of this inquiry and which apply to police shootings?

Acting Cmdr CARTER — We have not got them right here but we are willing to make them available to you.

Mr MAUGHAN — I have two questions. Following up on the situation of police investigating death in a hospital and the perception that there must be something wrong if police are investigating, do you think that stigma, that sense because the coroner and more so the police are being involved illustrates that there is something wrong, could be overcome if we went the way of other jurisdictions and had every death reported to the coroner? Would that be helpful?

Sr Const. NOLAN — I think it would create some interesting issues from a resource perspective.

Mr MAUGHAN — It does not mean they would all have to. The coroner could then choose which ones to investigate further.

Sr Const. NOLAN — I do not think it would overcome the issue of the police presence at the hospital. The reporting to the coroner is one thing; having the police at a hospital wanting information is seen as a quite separate thing altogether. I think the critical thing — it is most prominent in hospital deaths — is being able to convey clearly to the profession that they are there on behalf of the coroner. There is nothing in legislation that the members can show the hospital to support what they are saying — that they are there on behalf of the coroner. I am not sure it would be alleviated by having every death reported to the coroner. I still think there would be a perception because the police are there, there must be something wrong.

Mr MAUGHAN — The second question relates to essentially mental health issues where other submissions have suggested to us that when you have relatively inexperienced, technically inexperienced police officers interviewing medical officers, for example, on complex mental health issues that there are some concerns from a doctor's point of view. What is Victoria Police's experience on that one?

Sr Const. NOLAN — Has it been raised in terms of when a police member takes a statement from a psychiatrist or doctor?

Mr MAUGHAN — Yes, that sort of issue where you have a police officer who is not skilled medically taking evidence from a psychiatrist or psychologist or a professional of some sort.

Sr Const. NOLAN — I think in practice that actually does not happen a great deal. When statements are being obtained, I am talking generally, from someone within the medical profession whether they be a psychiatrist or a doctor, they generally are given a briefing, if you like, of the sorts of issues we would like them to cover, and this is the advice we give to police members as well, and they then have the time to go away and write their report for the coroner.

It is not often the case where a police member is actually sitting down with someone of the medical profession taking a statement. Certainly that gives them the opportunity to put in whatever information they believe is necessary and to explain the background of that information. I do not think there are any restrictions placed on what information they can provide in their statements.

Certainly if there is a situation where a police member is taking a statement and they think the police member does not understand, which may very well be the situation, there is nothing to prevent them from going on and wanting to expand further on what they have put in the statement. I am not sure how that has become an issue. Certainly once we get to the point of an inquest we may have a range of experts who are providing an expert assessment of the medical or psychiatric history. There is a lot of opportunity to expand on what might be initially said.

The CHAIR — You indicate in your submission that where a missing person has been missing for a particular period of time that there should be some mandated time frames after which that person would become a suspected death. Do you have any suggestions as to what the time frame should be?

Acting Cmdr CARTER — I will get Tony to address that.

Sr Sgt O'CONNOR — I do not believe we have developed it to the extent of nominating a particular period of time.

Mr MAUGHAN — Off the top of your head — is it 6 months, 12 months?

Sr Sgt O'CONNOR — It would be difficult to come up with it off the top of my head when the circumstances vary greatly. You have to consider what there are in other jurisdictions perhaps. We can certainly seek some input and come up with some suggestions for you.

Acting Cmdr CARTER — I think the issue is that not every missing person has the same circumstances, so it would be prudent for us to look at what the range of circumstances might be and provide some advice to you.

The CHAIR — I was thinking of that young woman in Queensland — I cannot remember her name — who went missing for three years or more. Everyone thought she was dead, but she was actually living with her boyfriend. I wondered how we would deal with that. Everyone thought she was dead for a number of reasons.

Sr Sgt O'CONNOR — I think that is possibly the point. It is difficult, I guess, to commence what you consider to be a coronial investigation if you think it is just a person who is outstanding or missing in some manner. We will certainly make some further inquiries.

The CHAIR — Thank you.

Sr Const. NOLAN — Can I just say something further to that? I think the critical issue is ensuring that there is a time frame where it is brought to the attention of the coroner, that there is this outstanding missing person, whether that be 12 months, for it to be first brought to the attention of the coroner, then the assessment can be made as to whether there is sufficient evidence for the coroner to be able to deem that person as being deceased.

It prevents the situation that has been arising in recent times where we will be holding inquests where the person may have been missing for 35 years. It certainly would need a time frame set maybe 12 months or thereafter for it first to be considered, then it can depend on the circumstances.

The CHAIR — Thank you very much for coming to talk to us today. We appreciate it.

Witnesses withdrew.