

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 20 September 2005

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Mr D. Taylor, community development worker, Springvale Monash Legal Service; and
Mr M. Cannon, student;
Ms P. Giliberto, student; and
Mr B. Hodgson, student, Monash University.

The CHAIR — Welcome to this second day of hearings into coronial services in Victoria. I welcome representatives of the Springvale Monash Legal Service: Mark Cannon, Pauline Giliberto, Brendan Hodgson and Dave Taylor. I also welcome and acknowledge the presence of the state coroner, Graeme Johnstone, and the deputy coroner, Iain West, and other interested members of the gallery. We look forward to your presentation and then we will ask questions.

Overheads shown.

Mr CANNON — Good morning everyone. My name is Mark Cannon and we thank you for your time today in hearing our submission. Brendan, Pauline and I will discuss briefly some topics we have been reviewing — that is, the topic of the Victorian state coroner's web site, inquisitorial justice, police investigating police, the privilege against self-incrimination, admission of evidence and coroner's recommendations.

First of all, if we could briefly go through the Victorian State Coroner's Office's web site. It is our view and recommendation that this web site requires updating. The search engine is inadequate and there is no library or database. We found it difficult to locate inquests and there are only brief findings of public interest available on the web site. The dictionary leads to a blank screen and provides no useful assistance or any tool when searching the web site. We note that there are 19 coroners courts in Victoria. There is no link between the Victorian State Coroner's Office's web site and those other courts save for providing an address and a map. We believe the web site should link between all of the state coroners courts. In 2003–04, 284 inquests were held in Victoria. In the same year there were 3828 findings without inquest. We note that the web site refers to the National Coroners Information System, which is a database holding all findings and inquests. However, this system is only available to government and research agencies. It is our belief this creates a public perception of secrecy about the coronial process and findings. As the coroners court is a public court and a public forum, we believe the information contained in this database is within the public's interest.

On the number of recommendations, if we take even just two findings per inquest and we add that to the numbers above, approximately 4500 recommendations are made by the coroner in any one year. That is a vast amount of information and resource that should be available on the web site. It is our recommendation that the web site contain a database or library containing all inquests or findings and all recommendations. We believe this will assist with the enforcement of recommendations, and Pauline will talk to this issue a little bit later on. The database could be indexed in a very user-friendly format: as per other legal databases, starting off with a broad topic and then being broken down into more specific topics. We believe this database would be relevant for the public, public interest groups and interested parties. As an example of an interested party that could make use of this information, we at the Springvale Monash Legal Service have met with the state coroner, Graeme Johnstone, on a couple of occasions and an example he raised with us was the Ford Motor Company which approached the coroner and was able to obtain 60 cases. By reviewing those 60 cases Ford identified four areas in which it could improve the safety of its vehicles that it had not previously thought of. The database may also be relevant for other coroners and may also show patterns in findings that are useful for improving the safety, health and wellbeing of all Victorians.

This slide *Fatal Facts* refers to information that is published in the United States. In 1988 this was published indicating that there were some deaths of people working underneath these tip trucks. There is a cable which runs along underneath these tip trucks and if it is accidentally stepped on the tray falls down and crushes the person underneath it. A simple design change can prevent future deaths. We note that approximately eight years ago a death occurred here in Victoria under similar circumstances.

The CHAIR — It must be a favourite example. The coroner used this example yesterday.

Mr TAYLOR — That is where we got it.

The CHAIR — What comes around goes around.

Mr CANNON — We understand that this is a resource management issue, but a web site can be quite effectively and efficiently outsourced from a resource management perspective. In summary, the web site is a very powerful tool and can provide a lot of information that can help protect the public and the safety of Victoria and assist in preventing future deaths.

Mr HODGSON — I am going to be talking about inquisitorial justice and police investigating police. As we know, the coroners court is supposed to operate on an inquisitorial model. However, we have found the

experience of some, perhaps many, groups which have been involved in the coronial process has been that it operates similar to courts in the adversarial model. Lawyers are focused on avoiding blame and minimising liability and this conflicts with the coroner's role, which is to ascertain the truth. We believe specialist training for lawyers about the inquisitorial model would probably be well advised given that they spend most of their careers and education learning the ways of the adversarial model and therefore are not well versed in inquisitorial justice.

The second issue I am raising today is police investigating police. While it is not specifically related to all coronial process matters, the issue of police investigating police after fatalities that involve police members has been highlighted by Springvale Monash Legal Service's investigations of police and mental illness. Investigations into fatalities that involve police are currently conducted by the police force itself. This can give rise to, at the least, a perception of a conflict of interest. We would like to contrast that with the Police Association's position on the Office of Police Integrity where it has come out very stridently and said the Office of Police Integrity should not be investigating the leaking of files from its own body. Allowing police to investigate fatalities involving police represents a double standard in this instance. The secretary of the Police Association, Senior Sergeant Paul Mullett, has made frequent criticisms of this procedure involving the OPI. I would like to quote the Police Association's public position from its newsletter of 8 August. It states:

The association's position in relation to an investigation of the OPI and Mr Brouwer ... is that it must be undertaken by an external body independent of the OPI. It is a clear conflict of interest for such a serious investigation to be undertaken from within the OPI itself. This is totally inappropriate.

I contrast that again with the position relating to fatalities involving police. Coronial inquests into fatalities involving police which rely heavily on prior investigations undertaken by the police force can suffer from a perceived lack of impartiality, especially from the perspective of the deceased's family. This is because police are seen to close ranks around their members and protect their own, and families feel the investigations undertaken are, in some cases, less thorough than would occur were a normal member of the public involved in a homicide. In contrast, at the coronial investigation all aspects of the deceased person's family life and life in general are subject to scrutiny, whereas the police are allowed to claim the privilege and not be investigated as thoroughly. We believe that investigation of fatalities involving police by an independent body, separate from the police force, would overcome these problems and remove any conflict of interest. The coroner's office is well suited to performing this task but would require additional funding and resources to undertake the task.

Mr CANNON — On the privilege against self-incrimination, it is our recommendation that the privilege against self-incrimination be removed in Victoria. This removal is subject to some caveats and/or safeguards. We note that the privilege has been removed in other jurisdictions, including New South Wales, Queensland and Western Australia, and what we have found is that the privilege creates a negative public perception in relation to the coronial process. The perception is that the privilege affords protection to individuals directly involved in the incident, whereas the deceased is not afforded this same protection and throughout the coronial process and inquiry is completely exposed and scrutinised. Coronial investigations aim to find the truth and prevent future deaths, and we believe this privilege can hinder that objective. The scope of the privilege in Victoria is extremely wide. Legislation has increased and continues to increase the number of indictable offences, which broadens the scope of the privilege. The effect of this privilege throughout the coronial process means that often important witnesses are excused from giving accounts and evidence. This limits a coroner's capacity to investigate the death and often from a practical perspective can delay the inquiry. It is a very important piece of the jigsaw puzzle that needs to be fitted in. As we have seen, coronial processes are often delayed years until a finding and/or recommendations are made. Some of the caveats or safeguards that we would be recommending in relation to incriminating and derivative evidence could include some legislative protection for the witness, a coroner's certificate or an indemnity from the Director of Public Prosecutions, or the coronial inquiry could be conducted in a closed court with closed findings.

In summary, individuals are entitled to the privilege as a matter of law; however, we believe that the claiming of the privilege would not be common practice in relation to coronial inquiries. We believe it would generally be limited to cases relating to police shootings and workplace deaths. We understand there is a need to balance the social good of the coroners court with the justice system and we believe removal of the privilege with these safeguards would balance the social good of the coroners court with that of the justice system.

Ms GILIBERTO — I will be speaking about admitting further evidence by interested parties and then about recommendations. Currently only parties with a sufficient interest may make submissions regarding matters which may be a source of adverse findings concerning their interests. These parties have no right to make submissions on the general subject matter of the inquest. Springvale Monash Legal Service made a submission in a

recent inquest, and although the submission was admitted and other organisations were encouraged to view it, the coroner could not take the submission into account in making his findings as we were not an interested party within the definition of the Coroners Act. We acknowledge that there is a need to prevent the coroners court from being overwhelmed with submissions but suggest that excluding submissions is contrary to the need for the coroner to be fully informed when making his findings and recommendations. The full story would surely help prevent similar deaths, and incomplete information may reduce the validity of recommendations. We therefore believe it would assist the coronial process if special interest groups and others with valuable input could participate to improve the fact-finding process and ensure the coroner has all the relevant information. Also, interest groups, perhaps through a database, should be notified of inquests in which they may be able to offer advice.

Next I will be speaking about recommendations. As you know, coroners' recommendations are not required by the act, and if made they are not enforceable. Some feel that recommendations are pointless if they are not enforceable. We believe, however, that strict enforceability of recommendations could create problems. Firstly, someone would need to keep track of recommendations and compliance, and currently the coroners court does not have the resources for this. Also, if recommendations were enforceable, the focus may shift from the recommendations themselves to who had the power to make recommendations, and this may lead to litigation and appeals causing delays and further costs in the coronial process. Also, some recommendations may not be practical to implement; they may require input from concerned parties and modification. However, we believe recommendations are important. They are the instruments by which the coroner can serve one of his main functions — that is, to prevent future deaths in similar circumstances.

Currently coronial recommendations tend to be repeatedly ignored. In several cases it has been found that this may be due to recommendations never coming to the notice of relevant authorities, and in other cases recommendations were simply not acted upon. To illustrate we refer to the case of India Verity, with which you may be familiar. An inquest into the death of India Verity, a 3-year-old girl, was held by the New South Wales deputy state coroner in 2004. India was killed when a portable soccer goal in a local park fell on her. The coroner found that prior recommendations made after an almost identical death were not properly acted upon. He found that the guidelines on how to properly fix the soccer goals were produced but dissemination of the information was haphazard. The local council was aware of the issue but did not put in place policies or take action to ensure compliance.

Our suggestions for helping to ensure recommendations are not ignored include:

1. Having a requirement in the act for effective communication to the relevant parties by putting systems in place to ensure that the coronial recommendations are conveyed to the relevant parties and
2. Having a requirement for relevant parties to respond to the recommendations within a certain time frame. We believe requiring organisations to report on steps undertaken to implement recommendations or to respond to recommendations would encourage compliance. However, the coroner's office would need to establish a department specifically for compiling data on findings, recording recommendations and keeping track of compliance, and funding would be needed for this.
3. Finally, we believe the coroner's recommendations should be published in an annual report on a web site and as hard copy. This could foster transparency and accountability and create indirect pressure for action in areas of repeated concern.

In conclusion, our submission on recommendations and the example of India Verity's inquest emphasise the importance of ensuring that knowledge acquired through coronial processes is properly utilised. Only then can the coroner speak for the dead to protect the living.

The CHAIR — Thank you very much for your submission. Perhaps I could kick off by asking you about the question of the removal of the privilege against self-incrimination. You indicated it has been removed in other states. Do you have any evidence, information or research that would show what impact it has had on the jurisdiction in terms of the operations of the court, how the court functions or whether or not it then became subject to people not giving evidence at all? What happened as a result of the removal in other states?

Mr CANNON — As with research regarding inquests and findings in Victoria, it has been very difficult to ascertain an answer to that question. It was only recently removed in some of those jurisdictions. We certainly have not found evidence of any negative or adverse reaction from the removal of that privilege.

The CHAIR — On the question you raised in relation to self-interest, in terms of making a submission, you said that parties with a valuable input should be able to make a submission. How would the coroner determine what was valuable? The sufficient interest test obviously indicates some connection with the case or some standing in relation to the case, but how would the coroner determine what was valuable input? There would be lots of people who no doubt would like to offer the coroner lots of advice, but how would he make judgments about what was valuable?

Mr TAYLOR — If you had an ongoing issue — say there were repeated fatalities in a certain area — soon you would be able to derive which interest groups were interested in this information or would like to have a say in those matters. The coroner might well be able to identify those groups and they may be given an opportunity to make comments on that issue at the start of the inquest, after which they can be cross-examined by all other formal interested parties. It would not simply be like letters to the editor for the *Herald Sun* or something like that; it would need to be more closely guarded.

The CHAIR — Could you give me an example?

Mr TAYLOR — For instance, with deaths in regard to swimming pools, the companies that create swimming pools would be able to contribute. There would be quite a few private companies which might be able to add or have input into the inquest. You would not simply have, for instance, except in extraordinary circumstances, private home owners being able to write in. You can see the difference there.

Mr LUPTON — Would it not be better for people such as that to be called as witnesses?

Mr TAYLOR — That would be a possibility, I suppose, depending on the case. It would depend on their validity and how much they actually knew about that particular case.

Mr LUPTON — There has been some evidence given by groups to this inquiry already, particularly those that are involved on a regular basis in issues such as mental illness who have expertise in the area. Would they be the sorts of representative groups that you might have in mind?

Mr TAYLOR — Certainly.

Mr HODGSON — We also discussed that there are very established tests for standing in administrative law. Essentially, this is an administrative-type matter, so for those kinds of things there is no reason why that could not be brought across to the coronial setting.

The CHAIR — In your submission you also pointed to the delays in the coronial system. I think you indicated in your submission that the delays, on average, are about two years. Do you have any recommendations that you would make about how those could be reduced? Obviously there is a resource question, but did you look at the question of whether or not there were efficiencies that could be made in the process that would speed up the work of the coroners court.

Mr TAYLOR — I think higher levels of accountability with regard to organisations or interested parties who have input into the coronial process, whereby they have certain time limits to submit evidence. And yes, I think, by and large it is a resourcing issue.

Mr DALLA-RIVA — You raised the issue of police investigating police and you drew reference earlier to the police files. Whilst the police files is a political and topical issue, the nexus between police files and police shootings is a bit stretched. You also raised the issue about the coroner being more involved in the police investigations. I am just curious. The skill base that is required for the homicide squad and for investigators to get to being a homicide squad detective, which is considered to be the elite detective of the police, is 10 000 people. How do you propose in your recommendations to give a skill base to a group of people who would be better than the homicide squad?

Mr TAYLOR — They would not necessarily be better, but they would certainly have skills in investigating these matters.

Mr DALLA-RIVA — But where do you get those skills from? I am just curious.

Mr TAYLOR — They would need to be trained, probably through the police or through other areas.

Mr DALLA-RIVA — From the police?

Mr TAYLOR — The resource is there, but our comments with regard to the OPI draw a distinct comparison there with regard to a conflict of interest.

Mr DALLA-RIVA — I understand, but where does the skill base come from to enable police to be investigated? You made the comment that police should not investigate police. We are talking about the most specialised area of investigation required. I am just curious. I know the coroner attends and the scene of all police shootings, and he has an oversight at the time. I am just curious why you have this aversion to police investigating police.

Mr TAYLOR — I suppose with regard to the training, there are experts, and if there are road pursuits and a fatality results from a road pursuit there are experts in road vehicle accidents. Certainly, it is a given that it is very difficult to simply obtain that training and it would be a quite expensive resource to have a full-time equivalent to a homicide detective or detectives working within the coroner's office. Perhaps they could have a dual role and be able to investigate other deaths as well with regard to the coronial process. I think one of the most important things we need to point out here is that the way the coroner would investigate a fatality would be different from how a homicide detective would do it. The investigator would not be looking for findings of innocence or guilt; they would be looking at it in a more systemic manner to be able to identify ways of improving community safety.

Mr DALLA-RIVA — Not necessarily. With culpable driving you have speed involving death and a range of issues that could involve criminal elements where a motor vehicle is involved.

Mr TAYLOR — But it is not the coroner's place to determine guilt or innocence.

Mr DALLA-RIVA — No. I understand.

Mr TAYLOR — So it would be a police matter to look into that area.

Mr DALLA-RIVA — I am trying to work it out. You have the coroner having direct oversight in any police shooting. It carries a lot more weight in the community when the coroner has that oversight. I am concerned that with the police already having limited resources we would be proposing to establish a separate body waiting for a time when a police shooting occurred. Thankfully they do not happen very often. So I raise that as a point of issue and ask how you would challenge it.

Mr TAYLOR — If they had a dual purpose they would be able to investigate other matters as well.

Mr MAUGHAN — In your submission you talked about the prioritising of inquests and referred to an informal system that took account of public interest and suggested that there should be a more formalised system. Do you have any views about how that might be better prioritised?

Mr TAYLOR — Sorry, could we have the question again?

Mr MAUGHAN — The question is about prioritising inquests. You talk about some inquests being informally prioritised and suggest that there should be a more formal system of setting those priorities. How would you suggest that you could improve on the current system, where I think the coroner takes account of the public interest and deals with those matters as a matter of priority. You suggest there should be a more formal process.

Mr TAYLOR — We suggest high levels of accountability with regard to responding to these situations. They would be more accountable. There would be responsibility to answer for why an inquest was held at a certain time and how those things are prioritised. So I suppose it is just to have more transparency and accountability.

The CHAIR — In your submission you quote the Kaufmann case. Was the legal service representing the Kaufmanns in that inquest?

Mr TAYLOR — No, we were not.

The CHAIR — You indicated that they had minimal communication with the coroner's office during that time. What sort of communication would have been helpful to them?

Mr TAYLOR — I cannot speak for them precisely as to what happened throughout the period of time from the fatality to the inquest, but I understand they had only limited communication with workers within the coroner's office, and I suppose there could have been support workers in certain ways, people who explained the coronial process to them. That may have been useful. I do not know if we mentioned that in our presentation.

Ms MASON — We have your written submission here.

Mr TAYLOR — The written submission was put together without reference to this presentation. I now understand why my students are not answering any of the questions and I am dredging information back from something put together earlier this year.

The CHAIR — You have two submissions.

Mr TAYLOR — Yes.

The CHAIR — You talked about the publication of an annual report by the coroner together with recommendations, and I thought that was an interesting idea. Would you envisage that being a report to the Parliament?

Mr TAYLOR — I think it would be a report available to the public and would be a very transparent and easy-to-find document on a web site, whether it was organised internally through the coroner's office or whether the information was outsourced to another organisation. I suppose that would be something for more experienced people to decide. But we would want to have that sent around to all relevant organisations where that would have any sort of impact or who would be affected by any of the recommendations. So it would be quite a large-scope publication and hopefully a very well advertised and utilised web site.

The CHAIR — And in terms of responses to those recommendations, do you see that a being both from government and non-government agencies and would you table those responses in Parliament, for example?

Mr TAYLOR — Yet again, that would depend on the recommendations. On the face of it, there would be a need for organisations to respond to a recommendation within a certain time frame, depending on the scope of the recommendation. Some recommendations might be able to be responded to fairly quickly; others might involve quite a bit of research and investigation. So certainly time frames would need to be set, and what level of government it was accessed by would depend on the scope of the recommendation.

Mr HILTON — This is an issue that was raised yesterday about the training of lawyers in an inquisitorial rather than an adversarial system. How do you see that as being practical when lawyers are employed by certain interested parties, and their role is to protect the interests of those parties?

Mr HODGSON — Recommendations have been put forward before that there could be specialist lawyers within the coronial system itself. You can be accredited as a specialist in property law or environmental law; maybe there could be scope for accreditation as a specialist in coronial process matters so that as a member of the public you could retain a lawyer who is experienced in dealing with that sort of method of justice.

Mr HILTON — Are you suggesting therefore that interested parties should not have access to their own lawyers?

Mr HODGSON — Not at all. But if there were specialist lawyers provided or available, that could help facilitate a better outcome in the coronial process.

Mr LUPTON — These days there are accreditation programs where solicitors and barristers train in particular areas and can put themselves forward as being specialists in the area. That may be one way of achieving that kind of thing.

Mr DALLA-RIVA — Far be it for me to say that the world needs more lawyers, but it has been suggested that perhaps lawyers ought not be involved in the process. What are your views on that?

Mr HODGSON — In that case, I think that if you are really aiming for an inquisitorial system of justice you would have to exclude all lawyers. You could not have some people represented and others not. It is certainly a possibility.

Mr DALLA-RIVA — That is the adversarial nature of the coronial system. The way to exclude it is not to retrain lawyers who are clearly trained for that purpose.

Mr TAYLOR — It would be very daunting for some people to front up to the coroners court without any prior experience. It could be especially difficult for families to face up to that sort of process.

Mr DALLA-RIVA — So if you are going to have lawyers there then we should bring back the adversarial system.

Mr TAYLOR — If lawyers had training.

Mr DALLA-RIVA — You have to be realistic. Lawyers are trained in the adversarial system, and to retrain a lawyer would be like trying to retrain somebody who has been designed to deal with something in a specific way. I cannot understand your rationale.

Mr TAYLOR — The way the coroners court works is not adversarial, so there is obviously a miscarriage of logic if you have a system which is not adversarial which has the interested parties being represented by lawyers from an adversarial background. As Brendan said before, there is training for those who want to specialise in specific areas. If you look at the law institute diary you can identify which lawyers are best suited to a particular area. At this time we have lawyers who specialise more in coronial proceedings. But the long-term goals of the coroners court, and certainly of interested parties and organisations represented, is transparency, because it will prevent future deaths. So if an organisation has a lawyer trying to protect that organisation's interest to the extent of possibly making the coronial proceedings more confusing, then they are not doing their client a favour, because another similar death may occur and that organisation or body will be up in front of the coroner again. So transparency at an early stage in these proceedings is the best course of action, not just ethically but long term financially for the business as well as for the business's reputation. Otherwise it is by and large a waste of time.

Mr LUPTON — To take it further, there are now accredited mediators who are particularly trained in the resolution of disputes in a non-adversarial way. Yet they have been trained through our legal processes in the adversarial system. So it seems to me that it is quite possible to develop those processes. What do you say about the inquisitorial system not being a system that excludes lawyers? There are plenty of lawyers in Europe.

Mr TAYLOR — Certainly not. We were not hoping to exclude lawyers, we were just hoping to have lawyers with an obviously different practice from how they do it in the generic courts.

Mr MAUGHAN — In your submission you spoke about the delay with coroner's inquests, adjournments and so on. I wonder how much that is caused by interested parties — families, for example — having delays in getting legal aid to be represented at coroner's inquests. Did your research go into that at all?

Mr TAYLOR — That is a factor, and often you find that families are not ready to face the coronial system at that point in time and cause the delay themselves. That is certainly is a situation evident not just with organisations and a team of busy lawyers trying to find a time when they can all attend the coroners court. But certainly there are other factors such as the personal and psychological needs of families and interested parties.

Mr MAUGHAN — So even with the best will in the world, and legal representation being readily available, you are saying that some families would choose to delay anyway because they are not psychologically ready?

Mr TAYLOR — In some cases, but I think that would probably not be so in the majority of cases.

The CHAIR — I think we have asked all our questions. Thank you very much for coming in, Dave and the team. We appreciate the effort you have made and the presentation you put together, as well as the various issues you raised in your presentation and in your other submission.

Mr TAYLOR — Thank you for having us.

Witnesses withdrew.