LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 22 August 2005

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Ms C. Smith.

The CHAIR — I welcome Carol Smith. Carol, do you want to introduce your friend and support?

Ms SMITH — This is my friend Rosie McMahon and she is just here because I got a bit upset in the last session.

The CHAIR — Sure. And your parents are with you as well?

Ms SMITH — I do have my parents with me: Hazel and Cecil Watt.

The CHAIR — Thank you for taking the time to come along and talk to us today. Carol, you have been here, you know how to proceed, so would you like to run us through your submission and then we will get on to asking you some questions?

Ms SMITH — I just want to say I am the mother of two sons who died in two separate motor vehicle accidents 10 years apart. I find it a personal challenge to be here today, and having listened to the two previous speakers I guess it has brought up some more vulnerabilities. I want to say that there is a likelihood that I will cry and that shifts my comfort zone. Regardless of that I want to say that this is my one and only opportunity to talk to you so I want you to shift your comfort zone if I cry, and just keep on keeping on. The third part of what I want to say is that for me it is a really big thing. While I understand that if we have a change of legislation it will change the drivers of the way the business is run, but for me the true challenge is going to be about how you change the culture of the court and the processes as much as the drivers of the legislation.

The major issues that I want to talk about are the autopsy process, the viewing process and the lack of information specifically for rural people. That is it.

The CHAIR — Would you like to go into each of those issues, Carol?

Ms SMITH — In the case of both of my sons, the first one died in 1993 in a single vehicle accident in Myrtleford and he was over 0.05. When I was told there would be an autopsy, I asked both the police and the clergy at the time could we not go through that, that I did not want to do that. I was told by both of them that there was no right of appeal and it was just a process that had to occur. I did not know anything other than that.

He had very significant injuries, obviously, and was clearly traumatised in that the external part of his body was very obviously wrecked, and I would question why and what use was the autopsy. I do not believe that it was of any use in terms of prevention. They could clearly get that by being over 0.05; he should not have been on the road. What did the autopsy process bring to that other than more grief and substantial difficulty for me or for my family?

About two years after that through my profession I found out other things, in that there is an appeal process, so when my second son was killed in 2003 I asked again. My second son was married and his wife and I talked at the hospital and asked there about the appeal process against the autopsy. There were questions from them, and I just said I knew that you could get the information and we did not want to go through this process to get it. We were told to go to the police at a certain time and what we got there was a one-off sheet of paper, a form that you filled out, and that was the appeal.

We were not told what the next process was or what any of the processes around that were. We were told to fill out the form and get it to the hospital as soon as possible, and there was no other information around what the process was. We arranged for the funeral — this happened in both of the kids' cases but in the first case there was not this appeal process going on so it did not affect it as much in the second son's case. He had died on the Friday night and we went to the funeral home on Sunday morning. The funeral director asked us when we wanted to have the funeral. I told him at the time that we had put in an appeal against the autopsy and we did not know how long that was going to take or what the process was; we had no other information. He said, 'That will not be a problem; it will be fine. When do you want to have the funeral?'. So we arranged for the funeral to occur on the Wednesday, which meant on Monday morning all the newspapers had all of the information in and the timetable of when the funeral was going to be et cetera.

On Monday, during the day my daughter-in-law and I had found out that the coroner had overruled the appeal, and I had some colleagues who had been negotiating during the day that the autopsy would occur in Shepparton — my second son was killed in Shepparton — rather than in Melbourne due to the time needed to take him from Shepparton to Melbourne, do the autopsy and taking him back. They had arranged for me to speak to somebody at

7 o'clock that night, and when I spoke to that person that was the first time that I was aware that the coroner wrote a paper — and we could have picked it up previous to 5 o'clock that day — that gave the reasons why she had overruled the autopsy appeal. This is Monday night at 7 o'clock, the funeral was arranged for 2 o'clock on Wednesday, and they said that they would not touch the body for the next 48 hours unless we wrote a statement rescinding the appeal. There is no form for that. There is a form to say, 'I want to appeal', but there is no form to say, 'I now withdraw the appeal'. At that very stressful and traumatic time you are supposed to sit down and write a letter and say, 'I now withdraw the appeal' or take it to the Supreme Court — which is still not going to be a time thing that will allow for you to go on with your funeral, let alone the expense or the emotional distress that you are in. My youngest son, my daughter-in-law and I decided it was too hard. The process was too difficult and it was too traumatic to try to take it any further, so against our better feeling we decided to go ahead. We wanted to go on with the funeral arrangements so we withdrew the appeal. But it was too hard even to do that, to allow the 48 hours — do not forget it is Monday night and it has got to happen before 2 o'clock on Wednesday. I was back in Melbourne, my daughter-in-law was in Shepparton and my youngest son had gone to Shepparton as well, and we had to coordinate or find some way to get the letter written, because none of us was capable of writing it, and get it on the desk at the court on Tuesday morning.

One of the huge impacts for me about all of this is the processes that you need to go through. There is no information around. I have read the coroner's submission and there is lots of stuff in there about what your rights are and what you can do, but how would you know this? You are not likely to sit on the computer and have a little look at what you can and cannot do in the couple of days after your son has died, or your husband or your brother has died, even if you happen to have a computer at your disposal. In my case I was not at home, so I did not have that, even if I was that way inclined. There is no easy information around about it. The whole process is extended in terms of not knowing what is going on.

The other bit that I wanted to say about my second son's death was that when we did get the paper from the magistrate, she said why she was overriding it. I work in a professional area where I can get legal information from people who know how to read documentation, and I took that to the lawyer and he told me that he did not understand it either. What we had to do was get out the act and have a look at section 29, which just tells you that she has the right as the coroner to overrule your decision. It does not tell you why. Apart from the fact that it is in jargon, it does not tell you anything anyway, and that is very distressing.

There is lots of toing and froing with the court. With the viewing process for my eldest son, the first one who died, due to the fact that he was having an autopsy and the timing again had been arranged for the funeral and whatever was going on — I do not know — in the pathology department, they could not do the autopsy when they thought they could, so they made arrangements to release. Because we wanted to have the viewing before the burial and they could not do the autopsy until the morning of the funeral the undertaker there arranged for the release of his body to the funeral parlour. We had our time with him, we could do whatever we wanted, we could be with him by ourselves, we could be with him as a group and we could do whatever we liked, then they took his body back to the hospital, did the autopsy in the morning and then he was buried in the afternoon.

With my second son, who died in 2003, it was a very different scenario. We consistently were told in relation to the autopsy stuff that the reason that was being insisted upon was because the police wanted to charge the driver of the car that hit my son with culpable driving. Because they wanted to charge him with culpable driving they had to make sure that he did not die of any other cause. He was 27 years old and in robust health. He was married three months and his wife was pregnant. He was very healthy and his injuries were horrific. Basically he was turned inside out from his fourth rib down, and his right arm was off, so he was okay from the neck up and he was okay from the knee down. The rest of him was not okay, yet they insisted on an autopsy. Again, he was over 0.05 and the cannabis levels — whatever they are that they measure — meant that he had been smoking dope very shortly before. So it was very clear that although the accident was not in any way his fault, again he should not have been on the road. Yet we had to go through this process because the police wanted to charge this man with culpable driving. My family had to go through more trauma to suit that purpose. I know that we do not have a right in that case, but none of us were of any desire to have that man charged because it was clear he was not speeding, he was not on alcohol and there was nothing in his system, so it was a misjudgement problem.

I go back to the viewing process. We were told out of all of that that the coroner was saying the body could not be touched until an autopsy occurred. The first time that we saw my son he still had his bike helmet on and he still had his eyes open. We requested to see him again, so they had taken his helmet off and closed his eyes, but they had not washed him at all. This supposedly was because the coroner had said that he could not be touched. We had to see

him behind a glass screen. We could not touch him, we could not be with him, we could not do anything. As a mother I just wanted to wash him myself, and would have been happy to do that if they could not organise it. I was told by two different police — one in Shepparton and one down here in Melbourne — that there was absolutely no reason or cause for that to occur, that they can take photos, that they can do any number of different things and that there was no reason for that. My bottom line is no family should ever — ever, ever — be exposed to those sorts of traumas at any time, let alone at that particular time. That is my thing about the Coroners Court.

I think you will note that in my submission, or in my letter that is attached to the submission, I have talked about three deaths. There was my eldest son in 1993 and then my younger son shared a house with a young man down here in Melbourne for six years. He was a Sydney lad, so his family was in Sydney. He died in April 2003 and then my second son died in May 2003, so there was five weeks between my younger son's best friend and my second son. That young man was identified by my youngest son because his family lived in Sydney. He was killed on a bike at 7 o'clock in the morning, and at 5 o'clock in the afternoon, when Paul identified him here at Southbank, he was clean, he was well presented and everything about him was presentable and the best it could be.

The situation when I went into the Southbank premises with Paul was that the counsellors came out, they sat with us, they talked about exactly what was going to happen, what would happen when he opened the door, how it would look — everything that you could want to know in terms of information was given and walked through before we went into the room. So Paul did that, came back out and was offered all sorts of services if he wanted to do that. That was in the metro centre.

Both of my own sons were killed in the country, and we dealt with the Magistrates Court — that is, the Coroners Court. I did not know that, and I work in an area where one would have thought if anybody would know I would know that. I did not know that, I do not think it is common knowledge and I do not think the information is available. The stuff about the appeal or the process — any information about autopsy or what happens when someone dies or what goes on — should be available at the funeral parlour, at the hospital and at the police. There is any number of places that you should be able to get this stuff.

After some months — you have the letter I wrote — I did meet with the state coroner. One of the things that he said to me was, 'Did you not get this booklet?', and he handed me a booklet that said what happens when someone dies. It is a great booklet. I said, 'How would I have got it?', and he said, 'They would have posted it to you'. Now you tell me. One of the kids died on Friday night and one died on Saturday morning. Steven, the eldest child, died early in the hours of Saturday morning. Even if the staff posted the letter on Monday morning, which I would think would be probably highly unlikely, I would be lucky if I got it by the end of the week and the funeral would be over. It is not good enough, and the services that you get between one place and the other are just totally different.

Those deaths all happened over a 10-year period, and all of them were entirely different. The viewing process is absolutely adding insult to injury. So is the autopsy stuff. I will go over that again. Both of them were over 0.05 and both of them were significantly externally traumatised. What use are the laws, which we have had for a very long time, saying that no-one is allowed on the road after 0.05? How does that weave into preventable death? What did it do for the system to chop up my kids? That is how I felt, and that is how I still feel. They had been through enough and did not need to go through more. Considering the difficulty with the appeal over the autopsy process with my second son and the length of time that went on, it was adding considerable insult to injury when we received the death certificate two months later and it had six mistakes on it, one of which said there had been no autopsy. That is pathetic.

I heard the last two speakers speak about the mental health system and raise questions about the Coroners Court and his recommendations and the lack of response from other departments. I respect that and agree with it, but I want to ask: what is the review process for the Coroners Court in terms of how it reviews what it does? Every other department has an audit or a self-review system where they consistently look at their own practices. What happens in the Coroners Court? Why don't they do that?

I was very pleased to hear the lady say that she had a very pleasant experience with the chief registrar. I did not. It was him who wrote the letter of response to my letter. I put a lot of time and effort, as I would imagine you should be able to see, into writing that letter to the state coroner. It took a long time and a I had a lot of emotional difficulty writing it. I am quite convinced to this day that a coroner did not read it; only the court clerk read it and responded to me. It is a very bureaucratic and ordinary response, shall I say. I do not believe that a coroner read that letter until I rang to try to make an appointment to see the coroner. Then I got a response.

It was the deputy chief coroner who rang me back, because the coroner was on sick leave. He said something about putting a lot of effort into the letter and having sent it to the coroner and others, which made me think, 'Somebody has read it'. I think that is very poor. Yesterday at home when I read the coroner's submission I saw a lot of stuff in there about how the administrative tasks are delegated to the court clerk or the court registrar. To my mind there are a number of issues about magistrates being coroners and not having the appropriate training, awareness or order of priorities on deaths or the coroner's process, and it seems to me that the same occurs in relation to the court staff at the coroner's office or the magistrate's office in the country areas where that is the Coroners Court. It is almost like they are dead and gone; there is nothing you can do about it, so who cares anyway? That is pretty brusque, but that is how it feels.

I also respect the fact that family members can be exceptionally difficult at this time. They are very confused, need to be told the same things over and over again and want to go over the same issues over and over again, so whoever is on the end of the phone or in front of you needs to have the patience of Job. But that is what the coroner's process is about, and those staff should be as helpful as they can in those circumstances. Where it is about a right of reply in relation to an autopsy, you should be able to feed into the process or be able to sit there and say why it is you want to go through that process. Again in my case they say it was about the culpable driving charge. That never occurred.

The legal proceedings in relation to that have gone through, and the man did not get charged with culpable driving. He got fined $1200 and lost his licence for 12 months. I will not talk about the Magistrates Court because it is not under the jurisdiction of this committee, but I could talk for another day about that. I believe our family went through very significant additional trauma for no reason. We were not able to get a dignified viewing except by my arranging for that in the hour before the funeral commenced. That was for a pregnant wife, me, his father, his youngest brother and his stepbrother, who happened to be his best friend. Yet at the viewing we had arranged the night before, his wife, Sarah, had arranged for a number of his mates to come, my mother was there, and it was exceptionally traumatic and very unnecessary additional pain. Then we had an hour for all those close people who wanted to have some time with him by themselves. It was impossible to do.

The CHAIR — Thanks for that, Carol. As a committee we are particularly concerned about and interested in services in the country and how they are offered. Obviously there were some very difficult circumstances around the death of your two sons in that it was on a Friday night quite late. Could you perhaps tell us who was your first point of contact? It would have been late Friday night or early Saturday morning that you were being alerted that you might have contact with the coroner's office — probably something, as you said, you had not thought about. Who was it, and in retrospect who do you think it should have been?

Ms SMITH — When my elder son was killed — he lived in Myrtleford with his father, and I was living in Shepparton — it was a police officer. My son came off what was called a fire road. I do not know if you are familiar with Myrtleford, but it does not matter. It is a hill where they grow pines. He came off the side of the mountain, and some people who live in a house down the bottom heard the crashing, so they rang the police. The police arranged for them to stay out the front of the house with a torch so they would find the general area. It was the police and emergency services who attended the scene of that accident. They went and told his father, and then the police there arranged for the police in Shepparton to come around and wake me up and tell me about it. At no point did I know anything about the Coroners Court, or any other court in that case, until such time as we got a letter saying that they were going to make the findings in chambers and if we had any objection to that we had 21 days to reply. That was my only dealing with the Coroners Court in that particular case.

Then with Marcus, the friend, it was actually the court that rang my youngest son. I do not know how they had found out their information, but they knew that he shared a house with Paul, and so they rang and asked him to come and identify the body. It might have been police who rang, but the Coroners Court definitely rang. With my second son I live here in Moonee Ponds and the Shepparton police rang. My youngest son at that point was living at Thomastown, I was living in Moonee Ponds and my second son and his wife lived in Shepparton. So the police who were at the scene of the accident spent some time with my daughter-in-law and my stepson — my son's best friend — and got a lot of detail about our lives and what had happened. The police had a long conference call, I believe, between Shepparton, Thomastown and Moonee Ponds, and then the police here timed everything so that they attended with my youngest son and myself at exactly the same time, and then they drove me over to Thomastown. So the police were very involved and they were wonderful. They were just very good. They offered to drive us to Shepparton, they did everything they could, and the first we heard of the court was again on the Saturday morning, when we went to see the body. The police took us to the hospital in Shepparton to do that, and it

was at the hospital where we asked about the appeal process. They talked about the Coroners Court at that stage. It was the next day, the Sunday afternoon, when somebody from the Coroners Court — it was the stuff about the tissue donation — rang up, and I believed they were from the Coroners Court.

Then the next contact I had was on the Monday night, and that was through my colleague at work who had been trying to negotiate about the autopsy occurring in Shepparton instead of Melbourne. I think then I spoke on probably four occasions on the one day, on the Monday maybe, to the court and it was Shepparton I was speaking to, and again on the Tuesday when I was trying to arrange a viewing that was the full facility, if you like. What they told me then on the Tuesday was that it was between the undertaker and ourselves, it had nothing to do with them, which I knew was wrong from my first encounter. I believe that conversation was frustrating and rude, adding all sorts of trauma. It was then I actually spoke to the undertaker again and said I could not deal with it, they needed to deal with the court and see what could be done about getting the body released so that we could do something. They rang back and said that the only way we could have time with the body was if they employed a security guard to be with us all the time while we were in there and they were not prepared to spend the money, all of which seemed pretty ridiculous to me. I do not know what they thought we were going to do.

Anyway, they were not prepared to do that and so we were given permission by the coroner to have a viewing after 5.00 p.m. on Tuesday night, behind glass. Again, that was when I asked the undertaker if he could please make sure that Doug had been cleaned. He said, 'Yes', that he would send someone up there that afternoon. When we got there that night — as I said, there were about 10 of us, including my mother, his wife and others — the male nurse came out and I asked if he had been cleaned. He said he did not know. I do not know where the gap was. Was it the coroner? Was it the undertaker? Was it the hospital? Where did the information go? He came back again and said he was sorry but he had not been cleaned; they had been told that no one could touch him until the autopsy occurred.

As I said, they had taken his helmet off and closed his eyes, but they did not even have the blanket pulled up properly and you could see where his arm had been ripped off, he had blood clots up his nose, he had blood on his teeth, he was not well presented. Then the only choice we had was for the next day. The funeral was at 2.00 p.m. and we got to see him at 12.30 p.m.

The CHAIR — In that process, obviously you were concerned about having an autopsy in the first instance.

Ms SMITH — I just do not see why you would bother. What was the game? When I spoke to the state coroner he talked about this preventive role. I understand the preventive role but I do not understand how a preventive role occurred in either of my son's deaths. It was clear from a blood test that they should not have been there. It was clear from the presentation of the body that they had been killed as a result of multiple traumatic injuries. Why did they need to carve them up as well? In the first case they just did not tell me there was a choice; I was told there was no choice. In the second case the court did not write anything to say that it was about a legal process, but I was clearly told by police it was about a legal process.

In relation to your previous questions to others about whether we think it would be better if there was more medical or legal experience, in my situation, having been through the legal process but not having got to an inquest yet, or the medical process, you read all the documents and it says that he died of this, blah, blah — in both my kids' cases: my eldest son died of massive chest and head injuries; my second son died of being cut in two, really. The medical process breaks everything down. His brain weighed so many grams and it was unremarkable; his lungs weighed this and they were unremarkable; his kidneys were flushed with blood consistent with having got a fright; his penis was hanging from a flap of skin from his left thigh and it was unremarkable — my son would not be too happy with that!

What does that prove? It is just a medical dialogue of a whole lot of stuff that does not give any information that will be useful for anybody who goes on. The reason I am here today is because I cannot change it for my family, but I do not want any other family to go through it, not like we did.

Mr MAUGHAN — I come from country Victoria and I am very grateful to you for pointing out the difference in services between the metro area and country Victoria. If you could change it tomorrow, particularly your experience in Shepparton, who is it that you would have, firstly, to contact you, and secondly, as the person

who could tell you about your rights of appeal and that minefield of procedures where you were not getting very much help in Shepparton?

Ms SMITH — In the initial stages I would not knock the police at all; I think they were fantastic. I have other issues with them going down the track later on with legal stuff, but in the initial stuff they were just wonderful on both occasions. Particularly the second time, you could not ask for more if you tried. Having had the experience of the counselling people in Melbourne, and even when they rang about the tissue donating I think they were great. I am not sure what the answer is. I do not believe the court staff, in my experience, are right — except for the counselling-type stuff — but my interactions with the court staff I would suggest were woeful.

Mr MAUGHAN — Would it have been helpful if the police, when they first contacted you, gave you that information brochure?

Ms SMITH — Absolutely! Or what is obvious to me is the funeral home or the hospital, the pathology part of the hospital, why have they not got it? It just seems strange.

Mr MAUGHAN — Clergy?

Ms SMITH — Definitely! I think I said in my letter that there needs to be a massive education campaign that takes in each of the areas that are involved. The obvious ones are the clergy, the police, the hospitals and the funeral homes, and the communication between them all. The funeral home that we used in the second case with my second son is a third generation family business, so they have been in the business for a very long time and in a rural area. It was Kittle Brothers; you would know them.

Mr MAUGHAN — I just want to reinforce your comments about the brochure and the lack of understanding with some city-based bureaucrats about communication and the time needed to get things in country areas.

Ms SMITH — The length of time — even in the coroner's submission he talks about having all this stuff on their web site. That is helpful!

The CHAIR — It is called computers, but you would not necessarily think to look there.

Ms SMITH — Yes, and Shepparton is a whole lot bigger than Myrtleford. Myrtleford is a small town but it is close-knit. I would think that if that information was available it should be when the police were there as well; I would have thought if that information was available you should be able to get it there very easily, probably even more easily than in Shepparton.

I think there is room for case management in these cases. If they cannot have it across the rural area, why can they not still do it from the metropolitan area? If they can ring us up from Melbourne to talk to us about the tissue donation stuff, then why can they not ring up and talk you through the process? They would need the skill base to make sure. The biggest thing for me that I learnt — it is unfortunate that I had two goes at it — was this: the first time there were a number of people I wanted to thank and I had no idea who they were afterwards: I had not got business cards off the police who came; I did not know who it was. The second time I asked for those things. I would think one of the no. 1 things that is important is if or when the court or someone rings, they actually ask the person to write it down so that you they have got that information. That is just a process, I guess.

The other bit that I wanted to talk about again certainly in this submission — and I am certainly not a medical anybody — is the stuff about whether it is a whole autopsy or part autopsy or whatever it is. Through that stuff about the tissue donating thing I became aware that they will not do that. That is just when the person is already dead; they can only take little bits of stuff, for example, around the heart. Yet they do a full autopsy and cut the whole body up before they will accept any of that stuff. What do you need to chop up someone's brain for to take some little valve from around the heart? It does not make sense to me. I understand that if you had a broader medical knowledge it might, but it defies commonsense in my mind.

The CHAIR — We have got towards the end of our time, but can I just indicate that in addition to the things that you have gone into very eloquently in terms of the situations you have had to confront, we are also conscious of the other things you have recommended. They were around consistent and reliable procedures to be developed across the state, information packages for family members, the information obviously needing to be

provided in a timely manner, particularly given the time at which these deaths occurred, and the fact that the coroner needs to make written rulings in a manner that can be understood by family members.

The issue we have discussed in a lot of depth here is the need for it to be really clear and justified why an autopsy is required, and also the point you have made about whether the Supreme Court is the most appropriate avenue of appeal, especially given the time frames, how long it takes and the cost involved when you have a funeral that is pending and you have a whole lot of things you have to get through. You have also raised the question about the annual independent audit or review of the operations of the Coroners Court. They seem to me to be the main things that you have raised in your submission.

I thank you for taking the time to talk to us. We will give consideration to all of those recommendations, and we appreciate the time you have given us today.

Ms SMITH — Thank you very much.

Witness withdrew.