

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 22 August 2005

Members

Ms D. A. Beard
Ms E. J. Beattie
Mr R. Dalla-Riva
Ms D. G. Hadden
Mr J. G. Hilton

Mr R. J. Hudson
Mr D. Koch
Mr A. G. Lupton
Mr N. J. Maughan

Chair: Mr R. J. Hudson
Deputy Chair: Mr N. J. Maughan

Staff

Executive Officer: Ms M. Mason
Research Officer: Ms M. McDonnell

Witness

Mr G. Bond

The CHAIR — Welcome to those people who have come to this the first day of public hearings of the inquiry by the parliamentary Law Reform Committee into coronial services in Victoria. These proceedings are covered by the Parliamentary Committees Act, which means that they are covered by parliamentary privilege, and will be recorded by Hansard reporters. There will be an official transcript from the proceedings and that will be available on the web site after the hearings have concluded, unless of course we have anyone who wants to make a submission in camera.

In terms of the work that we are doing as a parliamentary committee, we are focusing on systems changes to the coronial services in Victoria, to the Coroners Court and the Coroners Act. I would like to say from the beginning that I know that there are going to be many families and friends who have had particularly traumatic experiences with the system. No doubt some of you here today wish that this parliamentary Law Reform Committee could review a coroner's decision or reopen a case.

Unfortunately that is not our role, we are not able to do that, but we are able to put the spotlight on problems with either the legislation, the operation or the procedures of the Coroners Court. It is our role to look at systems changes and legal changes to the Coroners Act and we hope that your experiences and the views that you offer us today will assist in those kinds of recommendations for change to government.

We will produce a final report. I know you have all seen the discussion paper and the government is required to respond to our report within six months of it being tabled in the Parliament. The coroner himself wanted me to convey to you that he is not going to be here today, not because he is not interested in what people have to say about their experiences or how the system has affected them, but because he thought it would be easier and better, and people would feel freer to speak if he or representatives of the Coroners Court were not here today. He will have the opportunity, like everyone else, to review the transcript and the proceedings.

In terms of the presentations, obviously we have got a lot of families who wanted to speak to the committee and we have got a fairly tight time line so could I suggest that those who are presenting spend 5 to 10 minutes on their presentations; we have copies of your submissions. The committee will have read those and will want to focus on those areas where you think improvements can be made. We would like to get to that from you in the last 20 minutes. You will want to allude to that on the way through. I welcome you all here and I particularly welcome Graeme Bond who is going to make the first presentation to us today.

Overheads shown.

Mr BOND — What I have to say is based on my experience as an aggrieved parent, as detailed in one of the appendices to my submission. I have spoken publicly on a number of occasions about it and written for the *Age*.

We hear a lot about rape victims having a trauma in the court and the coronial system claims to speak for the dead to protect the living. All too often the family perception is that they defile our dead and mock our grief, and I cannot emphasise that too strongly. There are a lot of families out there who find going through the coronial system almost as bad as the loss of their loved one. That is because in the first instance some people have cultural and religious objections — which I do not have — to autopsies. However, I was never asked if there should be an autopsy on my son, or I never had a right to object and I consider that it was totally unnecessary. I can only imagine what a family who had particular objections might feel. The defiling of my son was also carried out by the barrister representing the hospital and doctors, who sought to vilify my son and the whole family with a view to shifting the blame for his death on to us. They mocked our grief and the coroner let it happen.

The key issues I have had experience with and made observations about are deaths involving medical treatment including 'failure to treat'. I do not think 'failure to treat' is mentioned in the discussion paper, but it is very common and it is just as deadly if not more so than improper treatment, and it occurs all the time.

In one of the attachments to my submission I have made reference to a doctor at Maroondah Hospital who reported to his knowledge that 13 patients who had been turned away had committed suicide in about a 12 month period and 1 had murdered a partner. That is the sort of thing that is going on and is widespread throughout the state. I believe there is an under-reporting of deaths. The coroner's own paper has some evidence of that — the number of deaths in hospitals that occur compared to the number that are reported. There is a wide gap there.

Deaths in care should also include deaths post-discharge. A lot of suicidal patients are prematurely discharged in an unstable state and they go on to very shortly thereafter — within a matter of days or hours — commit suicide. They should be automatically counted as deaths that are reported and should be subject to an inquest.

Medical records are tampered with after patients die. It is difficult to prove that. It has been shown in some cases and there is considerable evidence that there was some tampering with the medical history of my son after he died. There appear to be extra entries squeezed in between other entries in an entirely different handwriting in a way that suggests they were added at some later stage.

Inadequacy of investigations - what in fact happens with these cases where there is a medico-legal issue is that the solicitor representing the hospital and doctors approaches the policeman doing the investigation. The policeman is totally out of his depth. The solicitor kindly offers to get the witness statements for the policeman. The policeman accepts the offer. In doing so, he places the decision as to who will be a witness and what will be the content of their statement into the hands of the legal representatives of the hospital and doctors. It completely corrupts the investigation.

The cover was blown on this in a case about a year ago in the tragic death of a baby where the mother was administered the wrong drug by an incompetent nurse. Two courageous nurses refused to sign the statements that were thrust in front of them by the hospital. That is the sort of thing that is commonplace. For once the cover was blown, and I am absolutely stunned that the media never picked up on it because that is the way investigations are corrupted.

With powers of investigation I think the only problem is the coroner often fails to adequately use them. Things like medical records should be immediately seized. I have never seen any guidelines; they should be public. There is a practice at the Coroners Court to have bogus independent witnesses. I can only term them that because in my son's case the independent expert witness was a close professional colleague of several senior doctors with an interest in the case and had just finished co-authoring a book with them. He was a so-called independent witness called at the behest of the court, and those connections were not disclosed. When we called an independent expert witness, that witness was disparaged and the so-called independent expert witness's evidence was accepted.

There is a failure to rely on published standards rather than the subjective opinions of professional colleagues who equivocate and duck and weave, and in the end have no opinion at all. There are secret protocols with DHS which only surfaced again in the press in another case. DHS is often a party in these inquests, and yet there are secret protocols that are not known to the public and not publicly exposed that were exposed in the press about a year ago. I would very much like to see them. I do not think the public can be confident in the integrity of the system where such protocols exist.

I have mentioned the outsourcing of investigations. There is an absence of investigatory skills and a need for training. The police attached to the Coroners Court are often junior, inexperienced and hopelessly out of their depth. I think some of the coroners themselves would have difficulty tracking an elephant through snow.

Injury prevention should be the major focus. Crimes with the suggestion of murder receive a lot more resourcing than systemic problems receive. Murder is a one-off event normally. You solve that one and it is not going to happen again. These systemic problems happen again and again. They kill hundreds of people. The recommendations should be responded to even if the response is to decide to take no action. That should be done formally, not just by default.

As to safety in the health care system — the coroners need a corporate memory. Each of these inquests is taken as if it were a unique event. It has no connection with anything past or present. You can have exactly the same things coming up decade after decade, not merely year after year. The coroners will make their recommendations based on the narrow focus of the particular death and they ignore the bigger picture. They do not get to the root cause. They should learn from the Auditor-General's reports. He does a fine job; he deals in important issues and one of them is root-cause analysis.

The coroner should refer to protocols, guidelines and standards wherever they exist instead of bogus independent expert witnesses who are just covering up for their mates. There are DHS protocols and guidelines. You have DSM 4, the diagnostic and statistical manual which describes mental illnesses, the prognosis and things like that. You have AS4360, the Australian standard on risk management which I do not think is known within DHS. You have techniques such as root-cause analysis where you try to get at the underlying root cause of the whole class of

deaths and not just focus on the little, particular, minute details of each one. The Auditor-General seems to get it right, and I commend his work.

The needs of the community — we should have transparency; everything should be out on the table and there should be none of these secret protocols. Let us see what the guidelines are and the deals with DHS and others. Let us have an outcome that is consistent with the evidence. That might seem a strange thing to ask for but coroners seem to have an ability to completely reverse the meaning of evidence, to ignore it and create evidence that was not given — all these sorts of things happen.

The right to legal representation is important. Currently the taxpayer is often funding a cover-up. DHS and the hospitals and doctors employ barristers and solicitors whose purpose there is to deflect any criticism and blame from the system. Families are left to fund a case that is actually serving the public interest by seeking to expose systemic failures. This is perverse and unconscionable. It should be ended.

I am conscious of the time so I will try to speed up. Back in 1992 Coroner Wilmoth identified problems in a number of cases she looked at and it boiled down to these essential points. These same things keep surfacing again and again. Coroner Wilmoth was led to believe there was a working party in DHS looking at her findings and those points she raised. DHS also managed to deceive the Health Services Commissioner into the same belief but in fact there never was any such committee. Coroners continue to make the same recommendations in an ineffectual manner couched in different words, but essentially the same.

A recent example is a case when a young man died in 2003. He basically was refused admission to hospital after being sent there by a private psychiatrist. The best the coroner could come up with were those recommendations I am now showing on the overhead.

The protocols that the coroner referred to already exist. They do not need to be developed. They exist but they are ignored. There have been numerous calls over the years about the CAT teams. It just keeps coming up time and time again. Why will that recommendation have any effect? It will just go into the departmental shredder like the rest. The final point is: isn't that what a mental health system is all about — upskilling them, getting them to do their job properly? They are just meaningless.

My son's case illustrates some of these points — going back to 1993 it could have been yesterday; the same issues keep cropping up — failure to meet relevant standards and measure the treatment against them, vilification of the family by legal representatives of the hospital and doctors. The coroner did not put a stop to it as she should have.

I knocked up a chart illustrating the deficiencies in his treatment. Essentially it was there in the evidence, but we had a situation where he was under the care of a person who had been psyche registrar for all of two months. He was never once assessed by a qualified psychiatrist; no risk summary was ever completed, as mandated by the chief psychiatrist, to get to a standard that was simply ignored. There were discharge planning guidelines that were completely ignored.

You can see all the noes there. About the third last one says:

Discharge plans supported by documented policies and procedures communicated to all relevant parties.

That is the chief psychiatrist's discharge planning guidelines that were in force at the time. No, no, no — not on any one of his three discharges did they complete discharge planning guidelines as mandated by the chief psychiatrist. And what did the coroner say:

I am satisfied that appropriate procedures and guidelines were followed on the admission and discharge of Jason Bond on each occasion of his admission and discharge.

Can you believe it? That sums it up.

The CHAIR — Mr Bond, thank you very much. I think it is a very clear and succinct presentation of the issues from your point of view, and I appreciate the effort you have put into doing that. In your submission you argue that there should be a broader definition of 'deaths in care', and I think you were indicating that basically anyone who is on a community treatment order as a patient in a public or private hospital or mental health facility should be brought within that definition. Is that what you are proposing?

Mr BOND — It is recognised that mental health patients are particularly vulnerable around the time they are discharged. When they are in the depths of depression, they are too unable to put together a plan and carry it out. But as they start to recover they become able to form plans and carry them out. So there is a period of particular vulnerability, which is when they are frequently discharged these days, right in the middle of that vulnerability. There is no effective follow-up care. An appointment with a psychiatrist in a month's time is not follow-up care in any meaningful sense. All too often, within a day or so, they have suicided. That is due to premature discharge and a failure to properly care for them.

The CHAIR — In your presentation you raise a number of issues about what you see as the lack of investigative standards and guidelines, and I think you make the comment in your submission that in your view the coroner is not really actively involved in the investigation. Do you want to elaborate on that point a little bit?

Mr BOND — Sure. We did not know who the coroner was that was handling my son's case. In fact, what happened was that a magistrate was wheeled in a couple of weeks before the actual hearing. Everything prior to that had been handled by the registrar and the policeman. No-one made any effort to get the medical history. I got some of that with an FOI request from the hospital. I did more investigating than anyone else. I sought to have the policeman investigating the case approach other potential witnesses at the hospital. He would not do it.

I FOI'd the duty rosters to try to identify such people. The solicitors acting for the hospital and doctors took me to the administrative appeals tribunals to oppose that. I was never able to get that. I was never able to identify any other witnesses other than those who were put forward by the solicitors representing the hospital and doctors, and the policeman doing the investigation made no effort whatsoever to follow up on that line of inquiry.

So the only people generally giving evidence were those who had really nothing to say — they were not really involved in any meaningful way — or those with something to cover up. There were others present who saw what went on but were not directly involved and might have had some interesting things to say. We were never able to identify them. It was suppressed.

Mr DALLA-RIVA — You mentioned 'perverse and unconscionable'. I am just curious in terms of the process going towards a coroner's court. The perception you have is that it is diminishing how you are feeling. The perception that you have is still bitter about the process of the court. You mentioned a number of times the fact that you were vilified, your family was vilified and that that was not stopped. I am curious as to how you would see the process to be better — to not have the feeling that you are leaving the court in such a way that you feel you have been vilified. Explain in a bit more detail the process that has formed your view — why you and your family feel personally vilified. I am just curious how you come to that conclusion.

Mr BOND — For instance, there was not one shred of evidence that my ex-wife and I had done anything but cooperate in trying to get our son admitted to hospital and treated there — returning him after each of his discharges and on the first occasion. There was not one shred of evidence by any witness that there was an atmosphere of acrimony between us, and yet the barrister representing the hospital and doctors consistently spoke about internecine conflict between my ex-wife and me.

The only evidence was directly to the contrary. It showed a high degree of cooperation and coordination trying to save the life of our son. So, there it is in the findings — the coroner refers to it. It was not evidence. They were merely insulting assertions by this windbag. It should have been stomped on immediately because there was no evidentiary basis for it. That is just one example.

Mr DALLA-RIVA — The issue that I am seeing from afar is that we have, as you say, the hospital and the barristers representing the doctors and the hospital. Weighed against that, of course, is this huge risk of litigation in terms of the hospital being sued for, as you rightly pointed out, failing to follow process. I am not saying it is right.

On one side of the ledger you have got the hospital trying to deflect and defend and defer any risk of liability, any risk of being sued, and we are now seeing evidence of substantial lawsuits being proposed. I am just wondering how you balance that avoidance of trying to be accused of vilifying you, against the balance of the barristers or lawyers defending the hospital to avoid risk.

Mr BOND — I understand what you are saying. The point is, in that case, there was not one witness that gave any evidence to that effect. There was not one shred of evidence. It was merely an assertion by this barrister. It

was contrary to all the evidence, and the coroner just should not have permitted it to go on. I understand what you are saying about fear of litigation. Lawyers argue that people are entitled to a defence, and I can accept that. However, what of the legal representatives of DHS? What is their role in this, and why are they party to this? Surely the role of DHS is to uncover where hospitals have not followed their protocols and not done things correctly, and fix it up. They had the opportunity as far back as Wendy Wilmoth's findings and probably earlier. I could probably go back another decade or so and find the same stuff occurring.

Why don't they take the view that it is their role to find out what the problems are, formulate corrective action, make sure it is implemented and do follow-up checks every now and again to make sure? In quality management there is a cycle: plan, do, check and act. You are constantly going around checking. You plan something, you execute it and you check that it has been done properly. If you find a problem, you act to correct it, and you go endlessly around that cycle. Here there is just no follow-up. These guidelines get handed out from DHS, they go out to the hospitals and just sit in the library. They do not get implemented.

Even months after my son's death the hospital did a review of its discharge planning guidelines. They made no reference to those issued by the department, and their revised guidelines were very substandard and did not measure up to what the department was proposing. The department's role should be to get to the bottom of these system failures and prevent them from happening again. That is how you save money, not by all the sorts of things that we experienced and others continue to experience.

The CHAIR — Graeme, your son died in 1993. In your opinion has there been any improvement over the 12 years? I understand you have been a keen observer of coronial processes and what happens in the mental health system over that time. Have there been any improvements from your point of view in either part of the system?

Mr BOND — There have been some. I believe that one of the things that state coroner Johnstone has done, and I commend him for it, is to establish a protocol where they get hold of the medical records very quickly — I think probably not quite quickly enough in some cases. But back in the days when my son died, in a lot of cases they did not even bother to get the medical history. I was the one who got the medical history from the hospital, and I was only given a part of it — not the whole lot. So there have been some improvements like that, but one of the things about it is that the Coroners Court has no corporate memory.

For example, the Patten case from a year ago was like hearing an echo from the past. The coroner is making these recommendations that have all been said in the past, but nothing has been done about them. The coroner should have been down on the department like a ton of bricks expressing outrage that these things had come up many times in the past, that nothing had been done and said, 'What is the department doing?'. But, no, it is as if this is a unique event that has just come out of the blue and never happened before, and you get the same sort of weak and ineffective recommendations — a waste of time.

The CHAIR — You have obviously recommended that there should be a report to Parliament on the coroner's recommendations and a requirement for a formal response from the relevant agency or government department?

Mr BOND — Yes. As I said, even if the formal response is to say, 'We hear what the coroner says, but we disagree for these reasons, and we are not going to follow the recommendations', that is fine. There is another Auditor-General's report into an IT project, Parlynet 2000, and the prominent decision-maker on that project is a person by the name of 'Unknown'. I think that is what happens with a lot of these reports. They go into the department, and they just disappear. It is like throwing them into a quicksand pit or something. There is nothing ever heard from them. There is no examination of them and no consideration of what should be done. You just never hear a thing. They just disappear. There is mention of this sort of thing in the paper this morning, I notice.

The CHAIR — We have run out of time, Graeme, but is there anything else you would like to cover or say before we conclude?

Mr BOND — The single most important point that I have made is the corruption of the investigatory process by the outsourcing for the solicitors for the hospital and doctors.

Mr DALLA-RIVA — I want to go to the investigations component of your submission. In particular you mention that the police have the role of investigations on behalf of the coroner. My having been in the police force for a number of years, there are a thousand other things you have got to do, and then you have got this investigation

on the side. With the greatest of respect, it is on the side; you have got other things that you need to contend with. Are you advocating that the coroner's office have within itself its own investigatory body or are you saying that the police have to have a greater understanding of investigations or what are you saying? I am trying to work out what your framework of investigations in the context of the coroner's — —

Mr BOND — Police training covers certain types of investigations, and I think that the average police officer — and let us be frank about it: in many cases we are dealing with constables who are either not too long out of the academy or have not made much of their career when they are given an investigation where there are all sorts of complex medical issues, and they are not trained for it and do not really have a capacity to do it. Coroner Hallenstein wrote a couple of pretty good papers, which I can make available through the secretary, where he pointed to the need in specialist cases like air safety, industrial accidents and medical cases the need to get experts who are familiar with that jurisdiction.

Elsewhere I have suggested that perhaps the coroner could look at getting resources or at least advice from places such as the Health Services Commissioner's office, where they have people who in a lot of cases have some sort of medical background and are familiar with investigating medical complaints; they understand a lot of issues. They could also go to the Mental Health Review Board for advice, perhaps. I am not sure of the practicalities of these ideas, but I merely point out that there are people around who do have this sort of expertise that the average policeman does not possess and are far better suited to know the issues and know what lines of inquiry should be looked at.

Mr MAUGHAN — Two questions following up on that: firstly, have you got any evidence to support your assertion that it is inexperienced constables, as you indicated, who carry out these investigations, given that the police force clearly does have some highly-trained people who carry out very complex investigations? Have you any evidence to support your assertion that it is, generally speaking, inexperienced police officers who carry out these investigations? The second question is: do you believe you would get better service from the Coroners Court if you had a coroner who had experience in medicine, for example, rather than law, a medical model rather than a legal model?

Mr BOND — You would get a better go if you had the Auditor-General running it, actually. You can tell I have a very high regard for the work he has done. As far as identifying systemic problems, that sort of approach where you look at a system, not just an isolated instance, is going to be much productive, and the coroner should move in that sort of direction.

To get back to your first question of the police: what happens is it was a detective sergeant at the Coroners Court dealt with my son's case but he did not get onto the case for quite some time and in the first instance — and this seems to be the case generally — it was the policeman who attended the scene of the death — that is, the constable — and he did not do very much at all. Month after month went by and nothing happened.

Finally the Coroner's Court police got on the job, and they sent a letter out to various police stations saying, 'This person is a witness; they live in your general area; can you get them in to make a statement?'. It was haphazard as to who you got. The local Glen Waverley police contacted me and there was a policeman there who was quite good, I have to say, but that is not always the case. It is not like when you have a suggestion of a murder or something like that and you get the homicide squad involved — then you have the good ones, the real, investigatory, highly skilled sorts of detectives. You do not get that. It is the ordinary police.

Mr MAUGHAN — Which comes back to your earlier point that if it is a crime, then it seems to get the skills but if it is a systemic problem you are arguing that you are not getting the skilled investigation.

Mr BOND — The crime is generally a one-off. A wife kills her husband or vice versa, or something like that; it is not going to happen again but these systemic problems are killing hundreds of people.

The CHAIR — And on Mr Maughan's second question about whether or not the coroner should be someone with medical qualifications, for example, or someone assisting in the investigation from the coroner's office?

Mr BOND — I think people with both medical and legal qualifications are fairly thin on the ground. I do not know if there are that many around, so you would have a very small talent pool to draw upon, but I think that one of the points that Hal Hallenstein made was that the coroner has the capacity to draw on specialist skills when

they are needed, and these medico-legal cases that do have bodies, such as the Health Services Commission and the Mental Health Review Board of Victoria and other boards, have skills and could advise as to how an investigation should proceed. You would have to get the police to do the leg work — not a problem there — but the issues of who should be witnesses and what sort of issues should be followed up — that sort of thing — needs someone who has medical knowledge and can work out the strategy for the investigation.

Mr HILTON — I would like to commend you for the strong interest you have taken in these issues in the last 12 years, which was obviously a result of your own circumstances but I think it is most praiseworthy that you wanted to keep it going for the length of time you have to improve the system. In all these situations when people do not feel they get the right results, they get frustrated and they want to do something more. There is a right of appeal from the Coroner's Court as you say in your submission but sometimes the cost is prohibitive and that has people saying, 'Well, why should I bother; I cannot afford this' and they leave with a feeling of frustration. How do you feel that that can be overcome in some way — that people do feel they have an opportunity to take it one step further — without it being limiting from the financial point of view?

Mr BOND — I did deal with that in my submission and there are sort of two issues there. You have to have a court with the standing to give some sort of finality to it, which tends to point in the direction of the Supreme Court; costs there are pretty steep for most people. You also have to bear in mind that in these medico-legal cases, you would be opposed immediately by the taxpayer of Victoria in the persona of a barrister representing the Department of Human Services. The hospital and the doctors would weigh in with a heavy-duty legal team and if you lost, you could be financially ruined; and because of these parties getting involved, it could go on for quite some time. Weigh that against the situation you had in the Tanner case where the Attorney-General had the deficiencies of the first inquest pointed out to him. He took it to the Supreme Court himself, and so I pursued that path with a couple of letters that I have sent to you showing how the coronial hearing was so deficient that the coroner could not even get the basic facts for the death certificate correct.

I am informed by the Attorney-General that the administration of the law is nothing to do with him so there is no avenue there. The only avenue really is to have legal aid for cases assessed as having some sort of merit. The Health Services Commissioner in her submission does make reference to people who are vexatious — I hope I am not vexatious or at least if I am, to the right people — so there is a need to weed out cases lacking in merit and that sort of thing, and perhaps there could be a process where cases were carefully assessed and then if judged to have merit, are given to the legal aid people to provide assistance.

Things have been rectified a little since some amendments a few years ago because the state coroner can now reopen an inquest on his own initiative. That did not exist before; it was straight to the Supreme Court.

Ms BEATTIE — In some other jurisdictions autopsies are more commonplace than they are here. Could you just expand a little on the experience of the autopsy that was conducted on your son as you seem to have some disquiet about it?

Mr BOND — As I said, I have no particular religious or cultural objections to it but I felt it was unnecessary and had I had such objections, I do not recall receiving any right to object to it or being told that I had such a right. I may be in error there but it seems to be an issue that some people have, from reading other submissions, and I felt the autopsy was quite unnecessary.

The cause of death was ingestion of prescribed medication and subsequent asphyxiation by inhaling vomit; that does not require a detailed autopsy to find the cause of death. I would think that you would verify the content of the drug by a blood sample and that you would not need much more. That was sort of steering the energy of the coronial system in the wrong direction; that was not where the problem lay — identifying the cause of death.

If there is any doubt about the cause of death, an autopsy is almost mandatory unless there are some compelling reasons not to have one. In this case that was not the real issue: the issue that lay behind this was, 'How on earth can a young fellow who has nearly killed himself and has been admitted to hospital, be discharged in the space of eight days — three times?'. On one of those occasions he walks out of the hospital and gets bashed and robbed, and then roughed up by a couple of psychiatric nurses on his return. There were all sorts of issues like that that were far more important than finding the exact medical cause of death.

The CHAIR — Thank you for that Graeme. I think we have covered the issues very well. Your presentation is excellent. With your permission, we would like to receive a copy of your slide presentation because

I think that very succinctly also summarises the issues that you have raised in your very detailed submission, and we thank you very much for taking the time to come and talk to us and so eloquently outline the deficiencies in the system from your point of view.

Witness withdrew.