

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 22 August 2005

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Ms M. Stevens

The CHAIR — We welcome Marion Stevens. Thank you for taking the time to come and talk to us today. We appreciate your coming to talk to us about things that are quite difficult to talk about. I invite you to just talk to your submission and then we will ask some questions of you.

Ms STEVENS — Thank you very much for the opportunity and the invitation to come along today and speak to you about what I had provided to you in writing. I made this submission last month and sent it off. I felt it to be a good thing to take up the invitation as part of the process of me completing the big part of the grieving for my son.

The main concern that I have is that I have felt that in the four and a half years since Patrick died there has not been an opportunity for his voice to be heard. I feel this might be the only opportunity that my son does have to communicate so many of the values that he held dear to himself prior to his death. He was studying as a university student. He was working part time at the Bendigo mine. He was to a very large extent assisting his own funding of his degree. His long-term aim was that he would work his way up through the ranks in the mining industry and eventually become a mine manager. That, of course, will never occur now.

Since Pat's accidental death there has not been a way of effecting a voice for Patrick. We have a very clear understanding of the significance of his life because we talk about him every day; we remember him each and every day, but we are battling to understand the significance of his death. I feel there are two main reasons why this is the case. Firstly, the inquest took such a long time to occur — four and a half years — and secondly, because when we eventually did have that inquest there was no opportunity for the family, despite procuring the services of a barrister, to ask the coroner the questions that we wanted to ask and to have answered by the coroner. I understand completely why that has occurred but I feel that it needs to be made very plain that there are aspects of the structure of government that really need to be addressed, particularly in this day and age.

First of all, though, I would like to take the opportunity to thank Patrick's employers, Bendigo Mining and McMahons underground, for their support to me and my family over the years since Pat died. There have been some battles in accepting a lot of what has been reported in the press. When something is sub judice you are not allowed to talk to people who might be able to give you information about why your son died. But newspaper editors have a gift for using information selectively for their own purposes — you would probably be more than well aware of that.

When accidents happen at work and workers are injured and lose their lives and do not come home again, blame is really a very counterproductive thing to do, and there is no point in being vengeful. Part of the battle that I had over the years was coping with a very vengeful person in the family. That is no longer the case and that has been a very great weight off my shoulders particularly, and a relief to other family members as well.

Essentially, I feel that in the case of people dying at work, the role of the coroner must be to identify resources that are lacking. The coroner found that there were a lot of areas of resources that were lacking in Patrick's case. There were people resources, equipment resources, information resources and skill resources — all of those things were lacking. I feel that probably the most important resources that need to be addressed by the coroner and by the Law Reform Committee in reviewing the present Coroners Act are the resources of government itself. In our case the finding was too long coming. There was no surprise in what the coroner said to us on 1 April. There were no surprises there at all.

What was very surprising, and I suppose it is something that I understand now, is that you keep hoping that even though you are aware of the process involved in a coroner's investigation, when the finding comes down that the coroner will be able to exercise his or her own sense of conscience and that if they feel the process of government is wrong, they will actually speak from the heart. I now understand that that cannot happen; that is the process of government. But it begs a lot of questions.

In my written submission I responded only to questions 15, 16, 29, 31, 32 and 43 because I have absolutely no understanding of any of the other questions, and nothing to share with you about those questions. The Law Reform Committee is looking for some advice about whether legal assistance should be provided to a coroner in investigations, whether the law requires the state coroner to appoint lawyers to assist and should have the right to appoint lawyers to assist coroners with other kinds of investigations, and whether certain kinds of investigators should be appointed under the act; and also what duties and obligations such an investigator should have. I think the answer to both of those questions is yes.

In Patrick's case the Department of Primary Industries was legislatively entitled to lay charges against individuals, and I do not believe it was appropriate that the coroner stood aside passively while a government department executed its entitlement to do that. I also feel that it was not appropriate for the coroner to be guided by a magistrate's finding in this particular case, and I feel there should be some flexibility open to the coroner in looking at individual cases that come before him.

The coroner stood aside, reasonably confident that the Department of Primary Industries would conduct an investigation into my son's death that would be thorough by virtue of the experience of DPI officers responsible for safe practices in Victorian mines. Of course, it is rational to think that would be the case. The coroner could not have reasonably expected that the resources of the Department of Primary Industries would be inadequate for this task, and yet DPI officers freely admitted to me over a year after Patrick died, which was the first time that we as a family received any information about what had happened to our son, that there were only three or four staff members available in what was then called the Department of Natural Resources and Energy who were allocated to the supervision of mines and mine practices in this state.

My conversations with Pat's workmates in recent times indicate that that is still the case. There is a fundamental lack of people in DPI who may undertake regular reviews of mining practices in Victoria to see that things are happening as they should. The coroner and the magistrate who prosecuted the mine commented about the mine not having conducted a six-monthly audit. I feel that it is really quite wrong for the DPI to be laying blame at the foot of a mine when that does not happen. There really needs to be procedures in place to ensure that these audits are followed up by the DPI.

I was also aware from information given to me by Pat's workmates that they were horrified by the behaviour of DPI officers in their investigation of Pat's death on the day. They came in with an extremely aggressive and bullying manner. They did not show any understanding of what they had been through on the day. They men were very traumatised and the last thing they needed was somebody grandstanding and roosting about what had happened when they were trying to figure out what had happened themselves. I think a more collaborative and more gentle approach would have been a much better way to go. When mistakes happen they are an opportunity for us to learn. We are human; we juggle the balls and we drop them. That is not an excuse or an opportunity for somebody to come in and chuck blame around. It is an understandable stress reaction when people do that in a workplace situation, but it is not helpful. The response shows a failure to accept that operational procedures are constantly evolving; they are not perfect. They are never perfect. The law is never perfect, and I am not going to say it should be because it is always a work-in-progress, as you quite rightly pointed out in your discussion paper.

The committee's discussion paper talks about the powers given to doctors and police which may be open to abuse. Similarly, it is not inconceivable that a government department may have a vested interest in laying charges to deflect attention from its own inadequate resources, which, had they been adequate, may have prevented my son's death. It is not absurd to suggest that a government department may itself have a case to answer in respect of the death of a person, in that the department's own procedures, protocols and human resources were not adequate. At the time my son died, the Victorian WorkCover Authority was not entitled to investigate the death of a worker underground, so the investigation was undertaken by staff of the Department of Primary Industries.

I know from my discussions with those staff that they clearly took it personally. I know the very hard work that they had put in over the years to make sure that these accidents did not happen again after the Stawell incident. The reaction was for them to take it personally. When you take it personally, it means that you cannot look at things objectively. And if you cannot look at things objectively, you are never going to make improvements to procedures and protocols.

My son was crushed while assisting to jump-start a truck that had broken down underground. The Department of Primary Industries had approved delivery of this vehicle without a manual, and this was deemed by it as not a mandatory requirement at that time. I feel it is important to note that the investigating officer was also the officer who approved delivery of the vehicle to the mine with its warning decal painted over. The officer was also involved in the commissioning of this particular vehicle, a vehicle the coroner found to be less than safe in several respects.

I had many questions about the DPI's document titled 'Minerals and petroleum operations: use of engines underground', the Mineral Resources (Health and Safety) Regulations 1991 — regulation 2.77 — and about the DPI's role as the regulator of the mining industry in Victoria, including the commissioning of vehicles and overseeing of plant hire companies. Legal advice to me was that I had entitlement to instruct the family's barrister

to make submissions with respect to this document — namely, appendix E of exhibit U, which indicated the failure of DPI resources was the first domino to fall in the sequence of events which led to Pat's death.

I was worried about the deteriorating health of my family. I petitioned the coroner several times on compassionate grounds to conduct an inquest prior to the criminal trial, and I questioned the appropriateness of the DPI laying charges when the department itself may have been implicated in my son's death. The coroner was bound by the act which required criminal charges to be heard before an inquest could commence. The hearing for the criminal trial was set and adjourned four or five times between February 2002 and December 2003. Each time we thought we were going to have an opportunity to move on, and each time we were slammed down.

In September 2003 I wrote to the public prosecutor requesting that the OPP intervene and conduct a full and open inquiry, and again in December 2003. Similarly, the OPP was bound to observe the entitlement under legislation for the DPI to lay these charges, although staff there were frustrated that government departments unilaterally exercised this right and bypassed their expertise, as they were entitled to do also.

In February 2004 the family made a community submission to the Attorney-General, who said that the issues raised would be dealt with at the inquest. At the inquest hearing the evidence implicating the DPI was disallowed by the coroner, so I wrote to the Ombudsman who also told me that the DPI had the right to lay these charges under the act and it was not appropriate for the Ombudsman to intervene in any other government department's rightful duties. Far too late, the legislation was superseded by the new OHS act months before the matter went to trial, requiring that future investigations of deaths underground would be carried out by the Victorian WorkCover Authority. Had the Victorian WorkCover Authority had that right prior to 2001, to investigate deaths underground, I believe that we could have had a more open and transparent investigation into my son's death — perhaps.

It is my belief that wherever a government department is entitled to lay charges, it should do so under the strict supervision of the OPP. They are after all the government's legal people. However, it would appear that the implications of the separation of powers overrides all of these things. There is in effect no mechanism in the state of Victoria to bring a government department to account for its actions because the separation of powers would appear to provide very effective immunity. To my mind there is something very wrong with that picture. My feeling is that OPP intervention would also assist the coroner. However, it might be that the powers of the OPP may also need to be reviewed by the Law Reform Committee for this to happen.

The coroner's role is seek to find all factors contributing to person's accidental death — all factors. It is incredible to me that the coroner may in effect not be allowed to do this, which I see as the primary function of the coroner because of this separation of powers. I continue to take issue with the assumption that, when factors which contributed to Pat's death were quietly rectified prior to the inquest hearing, they no longer needed to be raised by the coroner. They were described by the coroner in the finding as known facts or background issues. It is plainly wrong that these factors are swept under the carpet, perhaps because they might reflect badly on government organisations and individuals. I do not know that that is in fact the case, because I cannot have these questions that I raised answered. I cannot even ask them.

I suspect the coroner was placed in an impossible situation of compromising the essential spirit of a coronial inquiry and being required to defer to judicial processes, which had poor informational outcomes. The criminal trial elicited no useful information due to plea bargaining, resulting in one witness being called and a day and a half in court. We were originally told by the DPI officers that that criminal trial would go for two weeks — it went for a day and a half and one witness was called. That witness was not even involved in the incident. On the basis of that testimony, a criminal matter seemed to be more about a punitive and self-serving act, the outcomes of which did not seem to improve resources that might enhance the safety of workers.

I continue to find it a nonsense that in all cases a criminal matter should be heard prior to an inquest because witnesses may refuse to answer on the grounds that they may incriminate themselves. I am not a lawyer, but I do not see any logical reason why these two particular matters could not have been conducted concurrently, or why the coronial process could not have proceeded prior to that. In fact, if any witness refused to give evidence in that criminal trial, then that choice they made would speak for itself. Discretion in this regard would certainly relieve families of these excruciating four and five-year waits.

In terms of the question of the coroner's role in death and injury prevention, I feel that the coroner could have a lot of influence in ensuring that all of the findings are in fact made public. What I see now with the media is that they

report with fear and with favour. I am not sure why that situation has transpired but I seem to see it more and more in recent years. In my son's case there appeared to be no reporting of the coroner's finding in any public way at all. When I did attempt to tell my view to the media, I discovered that they will select those pieces of information that are going to be useful to them. I have done quite a lot of thinking about that process. I do understand that you put your ego aside, you have a look at the big picture and you see that, yes, even though you have been used, it is going to have a beneficial outcome. Maybe if we can highlight the very grave situation that is occurring right now throughout Australia, it could help to reduce the number of workplace deaths.

I think that in terms of the right to be informed, the coroner should exercise some discretion and look at each case on its individual merits. After the criminal trial I developed an anxiety disorder; I am actually managing that very well but not right now at this particular point in time.

I would like to say that the most valuable thing that I have found with the coroner's office has been its counselling support service. I believe that if there is any way that that could be expanded and publicised this would really help the families of people who die in any situation. I was the sole income provider for my family for two years immediately after Patrick died. I was not able to take leave because I was self-employed. The most positive experience of the coronial process for me was the support I received from the counselling support service, specifically Sue Wilson who is the manager there. Before and after the coroner delivered the finding in April of this year Sue gave unstintingly of her time, knowledge and skills to help me understand the constraints under which the coroner operated, what was not possible and what was. She validated my experience and the enormous conflict of emotions that I needed to balance in order to come to terms with Pat's death and the coronial finding. I was grappling with the impact of paltry fines of \$6500 for my son's life arising from the criminal trial. I still feel that fine irrevocably devalued my son's life. No fine or a very large fine — or imprisonment if that had happened and we had had that new law in place — would have been equally destructive. I feel that the counselling and support service helped me to put all of that into perspective and to move on from that.

In concluding, there are assumptions implicit in legislative, executive and judicial powers which beg the question of honourable behaviour and integrity of government. I hope you do not take exception to what I say in this matter, but elected members of Parliament have a great responsibility to the little people. So often we see that there are individuals who take on, who evolve into, very important levels of office.

It is not just in government, it is in every area of society — it is in business, it is in schools, it is in workplaces. It is, as I have found, in families. Sometimes the system can perpetuate a lie. I think we have to be very mindful of what that actually means. There are increasingly character-disordered individuals in positions of power. The Queensland government has been experiencing what that has meant in being very brave and allowing a very full inquiry into Dr Patel and his behaviour. This happens when we do not regulate the powers that we give to people when they investigate deaths even. I think there has to be some mechanism put into place to ensure that there are these safeguards.

In my own experience, I do not mean to imply that any of the government officers with whom I had contact were character disordered. Rather it is the character and culture of the systemic organisation which needs reforming. My experience over the last four years is that, by and large, government, all institutions, even families — especially families — are made up mostly of good, genuine, hardworking people, but they can be compromised and constrained by present regulations. Every day they are forced to pay lip service to policies and practices which erroneously purport transparency and accountability. They are bound to enforce the hidden code of conduct because the culture insists that it is unconscionable above all else to betray these operational principles and practices. When you ask them why, their responses translate to denial, and denial is always about fear and risk and favour.

Patrick died through no callous or malicious act, and I am forever grateful for this. Nonetheless, in recent times both locally and abroad there have been so many examples of people — even here in Victoria — in positions of authority over others, across social spectrums, who display a pathological sense of entitlement, a lack of remorse, an incapacity to empathise and who will act unethically because they can and they choose to do so. It must always be in the front of our minds that with rights come responsibilities. The separation of powers has the potential to provide a safe haven for maintaining rights while evading responsibility and deflecting blame onto others when things go wrong. Blaming behaviour is not healthy; it is childish not to own up when things go wrong.

I liken a government to a parent. What sort of parent would behave like a six-year-old child just because they can? Is it not better to lead by good example, to teach by showing that sometimes we will drop the ball, but dropping the ball is human and this is an opportunity to learn and improve? Most of us can empathise with others when they drop the ball and feel compassion for them and want to help them going forward. If we do not do this we continue to project the lie of perfection, not tempered by the reality of imperfection and the need to strive for balance in our lives. When a child is rewarded for manipulating others to avoid accountability, then the integrity of parenting is compromised. So too government. It seems the department has a parent with inefficient coping strategies of denial and projection — that is, expect sanctions for being caught, not for poor behaviour. From where I stand now it is nothing short of an act of covert aggression against people who put trust in this system.

The absurdity of the separation of powers denies valid questions to be asked of and answered by a government department. We need to be more resourceful to make a difference. That means valuing the process and ensuring that its integrity is not compromised by some Machiavellian end point. When things go wrong, look at the quality and the quantity of the resources.

I began today sharing an irony of Pat's, that he had pointed out this very thing in one of his essays just before he died. In closing I note that this public hearing is located in the premises of the Victorian Commission for Gambling and Racing, and I see some irony in this. Life is a gamble. When we act in fear and favour we cannot take the risk and we do not move forward or backward. Yes, there is a risk that when we promote the people with the qualities and give them the power to make a difference they may abuse the privilege and implicit trust. We may just become flies to wanton boys who kill us for their sport, but that also is an opportunity to change the way things are and to find out what we are really made of. I know I have gone over time. Thank you for your time today. I sincerely wish you well with this important work of reviewing and reforming the Coroners Act.

The CHAIR — Thank you, Marion. We have a copy of your submission. I think the key issues which have emerged from it have been the time it took to make the finding in your son's case; the concern that you had that the coroner stood aside while the department investigated — you felt that something should have been happening and the coroner could have played a more active role; the fact that where a government department is entitled to lay charges often it lacks the resources to properly investigate and follow through, and that those charges should be laid under the supervision of the Office of Public Prosecutions; the fact that you believe the coronial process and the prosecution could occur at the same time, and ways should be found to do that and deal with the issues of self-incrimination and so on; that there should be mandatory responses to the coroner's findings; the importance of family members being kept informed of what is happening during that long process; and the valuable support that should be available through the support services at the coroners office. All of those things are very helpful to us. Thank you for making them available to us. We will reflect on those and take them into account in our final report. I thank you for your time and for coming to speak to us. I am sorry we have run out of time.

We now have a witness who wishes to be heard in camera. There will be a lunch break after that so in terms of our public hearing we will not be coming back until 2 o'clock. I thank those families who came and spoke to us this morning, in case you do not return this afternoon. It is obviously incredibly traumatic to talk about these things. In many instances it requires you to relive something you did not expect to happen in your life and which has had a profound impact on you. As a committee we appreciate that. Your submissions are very clear, the way you presented them was very clear.

There will be a transcript of what you have had to say and you will be able to review it. It will give us an opportunity to reflect on what you have said to us today. When we write our final report we will take into account the things you have said. Where we wish to quote you and to explicitly quote your material in our report, we will seek your permission and ensure that we accurately reflect the views you have put to us today. When we do make our final report, which will be early next year, the government is required to respond to it within six months. Hopefully in those recommendations there will be things that will give you as families a sense that something may happen in relation to some of the issues you have raised with us today. I thank you for your time. You are welcome to come back this afternoon. We look forward to hearing the rest of the submissions this afternoon. Thank you.

Witness withdrew.