LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Ms P. Spencer, Executive Officer; Federalino of Community Legal Centres and
Mr C. Singh, Human Rights Advocacy Worker, Federation of Community Legal Centres; and
Mr H. de Kretser, principal community lawyer, Brimbank Melton Community Legal Centre.
The CHAIR — I welcome the Federation of Community Legal Centres here today and welcome in particular Pauline Spencer and Charandev Singh who are representing the federation, and Hugh de Kretser who is with the Brimbank Melton Community Legal Centre. The committee is subject to the Parliamentary Committees Act. This is a public hearing and there will be a public record taken by Hansard. You will have an opportunity to correct any factual errors, otherwise it will form part of the record on our website. I suggest that you speak to your submission for 20 to 25 minutes and then leave us with an opportunity to ask you some questions. I should also indicate that the coroner is in the public gallery, but he is not allowed to ask any questions.

Ms SPENCER — My name is Pauline Spencer. I am the Executive Officer of the Federation of Community Legal Centres. I am losing my voice a little but I will try to speak up. The Federation of Community Legal Centres is the peak body for 49 community legal centres across Victoria. We work with disadvantaged and vulnerable Victorians. In performing that role in the community it is not uncommon for community legal centres to act for families or in the public interest in coronial inquests. Unfortunately, because there is not adequate legal aid for representation in these matters, it does fall on really, I would say, the goodwill of community legal centres to pick up this very important work in the community and to provide representation for families. Most of the time community legal centres, community lawyers and advocates are doing this work in addition to their normal work and over the time we have developed quite a lot of expertise in dealing with an increase in the areas of police shootings, deaths in custody, the Kew Cottages inquest et cetera.

I will briefly introduce my colleagues. Charandev Singh is a Human Rights Advocacy Worker with the Federation and with several community legal centres. He has worked on numerous inquests and has a wealth of knowledge in this area, so we are pleased that he could join us today. Hugh de Kretser is the Principal Community Lawyer at Brimbank Melton Community Legal Centre. We have provided a written submission that I am sure you have all read. We are going to touch on three areas today. The first is the issue of the effectiveness of the coronial process and achieving systemic change, particularly focusing on implementation. The biggest thing for the families we work for, and the comment we hear most often from them, is that they do not want what happened to their loved one to happen to others, so that is always at the forefront of our minds in achieving systemic change.

The second issue we would like to focus on is around integrity and investigations; and the third issue is around support and involvement of families in the coronial process, including legal representation. I will pass over to Hugh de Kretser who will talk about the implementation issue.

Mr de KRETSER — I am the principal community lawyer at the Brimbank Melton Community Legal Centre. We have a strong tradition of working on issues concerning the human rights of imprisoned people, in particular inquests into deaths in custody. In particular I have been involved in two inquests in the last year concerning deaths associated with the prison system. Charandev will also introduce himself, but he has had a strong involvement in many inquests, some of which have been run through the Brimbank Melton Community Legal Centre.

I wanted to provide a case study to the committee that I thought would demonstrate some of the issues we wanted to make today. I think all the committee have the case study before them. It concerned the death of Garry Whyte, a prisoner who was shot dead by a prison guard in May 2002. At the time Mr Whyte was remanded on burglary charges. He was unarmed and handcuffed when he was shot while he was attempting to escape from custody at St Vincent’s hospital where he was getting medical treatment. In the document you have before you — and I am not going to this in detail — there is a time line of events leading from the shooting in May 2002 up to essentially what is the second murder charge of the prison guard in April this year.

After the shooting occurred it became a highly political issue. The prison guard’s union went on strike in protest over the murder charge which had been brought against the prison officer who had shot Mr Whyte. The then corrections minister, André Haermeyer, arranged for the former police commissioner, Neil Comrie, to conduct a review into the use of force and firearms in Victorian prisons. Neil Comrie, with two others, delivered a report in December 2002 which was highly critical of the framework surrounding the use of firearms and the use of force in Victoria’s prison system. Some of the criticisms in the report are highlighted in the document before you. They were inadequacies in training, lack of a clear organisational philosophy, argument that the relevant legislation about firearms use was too open-ended, inconsistency between policy and practice and a criticism of the legacy of privatisation, saying it presented some significant barriers for systemic reform.
Essentially Neil Comrie was coming from the position where he had overseen a radical reform of the use of firearms by police in the 1990s following the high levels of police shootings. The systemic change he was able to oversee contributed to a drastic reduction in police shootings. In his report he was essentially criticising the Victorian prison system for not having adopted many of the lessons the police had learned about the use of firearms and organisational philosophy aimed at safety first and use of firearms as the last resort in a scheme of tactical options when a risk or a threat presented itself.

The prison officer was discharged at committal in November 2003. The magistrate essentially accepted that the prison guard had acted in self-defence and threw the charges out. The inquest occurred over eight days in November 2004. Our centre represented Whyte’s wife and children at the inquest and Victoria Legal Aid represented the mother. The inquest concerned what actually happened in the shooting, but it also concerned broader issues of the systemic reform that was needed in connection with the use of firearms in prisons.

In January 2005 Coroner Byrne delivered his findings and he essentially found that Whyte presented no real or immediate threat to the prison guard and that the escape could have been prevented easily without the use of a firearm. More importantly in a system sense, Coroner Byrne exercised his discretion to make preventive findings. He backed the key recommendations of the Comrie review. He highlighted examples of poor information sharing between the police and Corrections Victoria, noted criticisms of the apparent inordinate delay in implementing the key recommendations made by Neil Comrie, expressed concerns about Corrections Victoria’s view that Federico, the prison officer, had acted lawfully, backed criticisms of deficiencies in training and recommended review of the relevant legislation.

About three weeks or a month after the inquest Corrections Victoria released an amended firearms policy which contained substantial and significant amendments from the policy and from the draft it had introduced at the coroner’s hearing. This was a critical example of how the coronial inquest had been able to effect policy change in a significant way, aimed at reducing a preventable death by a prison officer shooting in the future. I wanted to highlight that as an excellent example of the way the coronial process can achieve significant policy reform.

Change of the policy was only one of the issues that the coroner recommended and that Neil Comrie had recommended. There were numerous other issues concerning the framework for the use of firearms in the prison system in Victoria, and after this amended policy was released we wrote to Corrections Victoria and said, ‘Great work on changing the policy, but how about all these other issues? Can you please give us an update on all those issues’?

They never wrote back to us. I have spoken to the correctional services commissioner recently to ask him personally about the update on these changes, and he gave me some assurances that the amended firearms training was being rolled out some two and a half or three years after the shooting and after the recommendations of Neil Comrie. But the other key point I wanted to make coming out of this inquest is that the lack of mandatory reporting really hinders the coroner’s ability to prevent deaths in the future. The coroner had backed important criticisms by Neil Comrie and recommendations to achieve systemic change in Victoria. Of those recommendations one had been adopted by Corrections Victoria; the others, we do not know. There is no mandatory report back.

Corrections Victoria could choose to ignore those recommendations. We chose, as the community legal centre representing the family, to seek to pursue the response to that, but we do not have the resources to do that in a systemic way, and we do not have the status and the position that the coroner has to encourage compliance with those recommendations or seek an explanation when those recommendations are not complied with.

The three points that came out of this inquest are that: inquests can have a significant impact on policy change; that impact is hindered by the fact there is no mandatory report back; and finally, it also demonstrated how important it is for the family to be represented at an independent, impartial coronial investigation. This was a highly political issue. The Office of Public Prosecutions had not done a good job at the committal, and the charges had been thrown out. The family sought the truth and was able to get us to engage senior counsel to represent them at the hearing, and the hearing made significant findings of fact that would not have been achieved if the family had not had proper legal representation.

The point I have been asked to speak to today is the coroner’s role in injury and death prevention, and there are three main areas where we encourage the committee to make recommended changes. The first is in relation to the
purpose of the legislation. I think the state coroner in his submissions has made recommendations that the purpose of the legislation be amended to better reflect the preventive role of the coroner, and we support that submission.

The second area is to expand and encourage that preventive role. The legislation as it currently stands is, in my view, ambiguous. Sections 19(2) and 21(2) give the coroner discretion to make recommendations but give very little guidance about in what circumstances recommendations should be made. We would support a recommendation that the act be amended to make it mandatory for the coroner to make recommendations where the coroner considers that the recommendations may prevent a recurrence of similar injury or death. I think in the Northern Territory there is legislation that makes it mandatory with a death in custody for the coroner to make preventive recommendations. We support a similar legislative amendment here in Victoria. At the very least we say sections 19(2) and 21(2) should be amended to encourage and promote the preventive role of the coroner in preventing further injuries and death in similar situations.

The final point I wanted to make is about monitoring implementation, and I alluded to this in the case study. We say it is critical that there be some report back, some mandatory requirement to report back to the coroner following the coroner’s recommendations. The coroner in his submissions has suggested a six-monthly report back time frame; we have suggested three months in ours based on the Royal Commission into Aboriginal Deaths in Custody and, I think, the ACT legislation. You could leave it to the discretion of the coroner to say six months or such other time as appropriate, but the critical thing is that there be some mandatory reporting back either to a government body or, in my opinion, preferably to the coroner who has presided over the inquest. That is not to say that the recommendations the coroner makes should be complied with, but there should be an explanation if the relevant government agency does not comply with them.

Going back to the case of the Whyte inquest, we saw delays of years after the recommendations of Neil Comrie, and we still do not know whether the amended firearms training has been implemented. So it is critical, we say, to have this report-back requirement to put pressure on the government department to explain itself and keep it accountable for responding to the recommendations that came out of the inquest. There are a variety of options which have probably been discussed before you, such as the Ontario model with non-binding but monitored agreements. In my opinion the best option is for the coroner to monitor the recommendations and make directions for a report back, whether by way of written submission or a further hearing. It is important that when that occurs all the parties at the inquest are involved and that information is shared with them.

The final issue I want to allude to is that the state coroner in his submissions suggested that the report back only be a requirement for government agencies. We would be concerned that, for example, private prison contractors would be excluded from the requirement to report back on the recommendations of the coroner, so in appropriate cases we would say that the report-back requirement should cover not only government agencies but appropriate private agencies as well, and there could be something in the legislation that says words to the effect of ‘the resources and ability to respond of an organisation should be taken into account’. But when we have got a situation with private companies operating two prisons in Victoria and operating immigration detention centres around Australia, it is important that they not be excluded from the requirement to report back on coronial recommendations.

Ms SPENCER — We might go to Charandev Singh and then me, and then we will break for questions, if that is okay.

Mr SINGH — I have worked with families and, on a few occasions, other human rights organisations in about 25 inquests, mainly in Victoria but also in Western Australia, the Northern Territory and New South Wales, and we continue to act in the New South Wales jurisdiction. I have also got some awareness of inquests and deaths in custody issues in the UK, Ireland and increasingly in Canada. My experience in the Victorian jurisdiction goes back to the 1980s, in terms of coroners inquests, back to 1986 and 1987, particularly around the fires and deaths at the Jika Jika unit. I lived through the Royal Commission into Aboriginal Deaths in Custody and have seen deaths in custody and police shootings for most of my life in this country, particularly in Victoria.

I am happy to address any of the issues that span those experiences, but I will be mainly focusing on the issue of the integrity and the effectiveness of investigation and the importance of standards and party-to-party agreements to facilitate effective investigations. That flows a lot from my experience working in other states on very similar deaths in custody involving similar agencies, particularly around immigration deaths in custody, where we have acted in four states now in five different deaths in custody. We see certain patterns occurring with the involvement
of the exact same agencies, whether they be the immigration department or their contractors, Australasian Correctional Management and Group 4. We have constantly had to advocate systemic investigatory responses to deaths in custody because of the systemic features in terms of post-death investigations in those deaths and also in prison and other deaths in custody cases.

My starting point goes back almost 15 years ago with the final report of the Royal Commission into Aboriginal Deaths in Custody, and it is a comment that has been adopted and reinforced many times by state coroners and other coroners in Victoria. The royal commission concluded that:

… in human terms, thoroughly conducted coronial inquiries hold the potential to identify systemic failures in custodial practices and procedures which may, if acted upon, prevent future deaths in similar circumstances. In the final analysis adequate post-death investigations have the potential to save lives.

That is really the starting point. I think that statement encapsulates the spectrum of potentials that can be achieved or prevented in this jurisdiction, given the very narrow scope of investigations. The spectrum is effective prevention to effective perpetuation of deaths, through either effective or ineffective investigations, and there is a lot at stake there for everyone involved in the inquest process and the prevention of deaths.

Through my experience I believe that standards and structural frameworks for post-death investigations are becoming increasingly critical for consistency, integrity, effectiveness and accountability of post-death investigations, including the inquest — all the investigations that occur from the second of death until the making of the finding. There do exist some standards and frameworks around workplace deaths and hospital fall deaths, and I note in the state coroner’s submissions that those standards have not been audited to test their effectiveness, but I think that the devising of multilayered standards and frameworks for investigations will also enable the State Coroner’s Office to really test the systemic and individual effectiveness and accountability of its own investigations.

You will know that Queensland has adopted a system of guidelines that guide the coroner’s inquiries and must be followed unless in conflict with the act. We would support that basis, but in order for the investigation to be really responsive and really apply itself to individual circumstances and features and institutional issues that impact on different types of deaths in custody, we believe it is really important for memorandums of understanding or bilateral binding agreements to be set up between agencies responsible for institutions or where deaths have occurred and may continue to occur and the State Coroner’s Office for the reason of improving consistency of investigations — whether they happen in the city, or rural and regional settings — improving the effectiveness in terms of setting out a very binding framework for collection of evidence, collection of witness evidence, collection of forensic evidence, time lines for collection of evidence and transparency of that evidence, and it provides an audit framework for investigators and, in the end, the inquest.

I will give you one example where such multilayered frameworks may have had an impact. It came with the first death in an immigration detention centre in Victoria. It is just a case example of where I think the coroner’s capacity to investigate was really challenged by the institutions and the context of the events that occurred. Villiami Tonginoa was a 53-year-old Tongan national who had been in Australia for 17 years. He had overstayed a visa. He came in 1983, and he was substantively here to earn money to support his very impoverished family back in Tonga. He was picked up in an immigration raid with his son Antonio in August 2000 and was detained at Maribyrnong mandatorily under the Migration Act for five months. On 22 December 2000 he was due to be removed back to Tonga, and that removal was a coercive removal. He did not volunteer for that removal. He, in the early morning at about 8.03 a.m., scaled the one basketball ring in the court at the detention centre to avoid his deportation, but there he remained for 8 hours, from 8.00 a.m. to 4.00 in the evening, through torrential rain, through quite extreme sort of weather conditions. ACM and the department did not institute a structured process to themselves resolve that incident without loss of life or serious injury; neither did they call police negotiators, whom they had recourse to in their own protocols, to resolve the incident without injury or death. By 4 o’clock Villiami dived from the pole, sustained horrific head injuries and died in full view of numerous asylum seekers and detainees and staff. He became the first death in immigration detention custody in Victoria.

There have been 14 other immigration deaths since that time in this country and in Nauru, most of which we have had an involvement in and in four of which we have also acted for families and human rights organisations. The issue that confronted the whole investigation was that this is a situation analogous to a prison, but people held under the Migration Act were not defined strictly under the act as people held in care. The court treated it as a death in care, but there were quite unique and challenging circumstances that impacted on the investigation.

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I must go back to the fact that the coroner, Phil Byrne, made very critical findings against ACM. He found that ACM contributed to the cause of the death by failing to manage the situation and Villiami contributed to his own death by diving from the pole. After the death only three of the immigration detainees who witnessed the events were interviewed. It was a full five weeks before police returned to the immigration detention centre to interview other detainee witnesses. In the interim five weeks up to 17 eye witnesses, some of them key eye witnesses, were either removed from the detention centre to other states or removed from the country, and their evidence was not captured at all or was captured in only a very perfunctory way.

The video footage that ACM was taking of the whole day’s events — and it would have captured the actual act of the leap — was not collected from ACM for 14 days by the police. It was actually held by the officer who was in charge of the overall events, and he was playing basketball in front of Villiami while Villiami was in a very distressed state. Only seconds of that is captured, and the final moment is not captured, or at least was not made available to the police, so that failure to collect that evidence is quite critical. It is key forensic and other evidence.

ACM conducted its own internal investigation. Its officers interviewed on tape three key witnesses, including the detainee they were using to try to negotiate the situation down. The evidence interviews, which were contemporaneous, were not made available to the court, and ACM’s lawyers said they no longer existed.

Many of the witnesses were asylum seekers who were later given temporary protection visas. They were very, very fearful of giving evidence, potentially against the Department of Immigration, which was making or had the power to make determinations about their refugee status and their lives per se. Many of those asylum seekers and refugees had also seen or experienced people dying in prisons, people being killed in prisons, and one of their fears that I was aware of is that they were afraid that the body would just be taken from the scene and there would be no investigation of the death, because that was what they were routinely used to and had seen and experienced, as well as their own experiences of extreme persecution in their lives. Although some witnesses were called, there was significant evidence withheld because of those fears.

That highlights the importance of being pre-emptively focused on what kind of investigation needed to take place in such a challenging setting, in a new setting, and what kind of evidence needed to be obtained and how quickly. It also foreshadowed the issue of opening the inquest very quickly after the death in order to capture the evidence of some people who the Department could remove to other states and remove completely out of the jurisdiction, and that capacity to be reflexive and responsive was very important to the integrity and effectiveness and accountability of the investigation. It also highlights the need to potentially involve expert investigators with expertise in these sorts of situations. I raise that just as a case example because the possibility of deaths in new scenarios, whether they are in the course of intelligence interrogations or anti-terrorist operations, as we have seen with the death in custody of Mr de Menezes, of deaths in a whole range of forms of detention that the commonwealth is now instituting and wanting the state to institute, like preventive detention regimes, is very much on the cards.

The court and people like us need to be involved in developing the investigatory infrastructure and standards to respond to deaths whenever and wherever they occur in very challenging situations; in situations where an interrogation may be occurring and no-one is able to say it is occurring, or someone is shot and killed pre-emptively and, as occurred in the United Kingdom, the Independent Police Complaints Authority was prevented for two and half days from beginning its investigation. As you know, those first two to three days is critical in capturing evidence in a death-in-custody situation or in any death.

We think the standards and the agreements must be profoundly informed by Royal Commission into Aboriginal Deaths in Custody standards, by previous coroner’s recommendations and the applicable human rights law that applies to everyone who has a right to life. We all have a right to life and the human rights law around an inquest and the right to life in comparable jurisdictions like England and Ireland have had an enormous impact on the standards and the conduct of inquests in the UK, and that is something we need to look at. We all have a right to protection from the arbitrary denial of life and the right to effective investigations when a life is taken by the state or in state custody. So the cases of Amin, Middleton and Sacker and the European case law is really instructive because it sets the four standards for post-death investigations which are independence, effectiveness, promptness and transparency, including family involvement. So all of those issues need to be enshrined in guidelines or in legislation and not just for the sake of consistency, but also additional agreements need to be set up to respond to the individual circumstances of different death scenarios.
Ms SPENCER — Just briefly, because I am mindful of the time, I will touch on the quite straightforward issue of family support and representation. From the perspective of community legal centres in our work with families we feel that five areas need to be covered for families to feel that they are supported through the process.

Firstly, that the right people are involved. We have to look at the definition of ‘family’ and who has sufficient interest to be involved, particularly where there are psychiatric issues and incarceration where there might often by family breakdown, and there may be other supports for that person who are not necessarily traditional family members. Also in that respect having the right people at the table means that we need to look at issues of public interest standing and intervenor status. Numerous organisations work in a range of areas that have expertise and knowledge that can be brought to the table. If our ultimate goal is to prevent deaths, then their expertise is crucial in bringing out the issues in the coroner’s inquest and asking the right questions and raising the knowledge that they have, and bringing that to the table. So the first point is having the right people at the table at the coronial inquest process.

Once those people are there, particularly family members who are not professionals, the next key point is access and information — that is, having access to the process and knowing what is going on, so being invited to meetings and all that very basic logistical stuff and having information available. I understand it can be quite shocking for families to have various pieces of information available to them and there might be some reticence in providing such information. However, in our experience it is crucial that the family has the choice to know what has gone on, and that they are empowered to make decisions about what information they get and when. It is absolutely the worst thing for a family, because they want to know what is going on. It is very important for the grieving process to feel there may be some information they are not getting or they cannot access for whatever reason. So it is very important that all information is available to the family and then that the interested person has the choice on what information they have.

Obviously such information should be provided in a supportive setting, which leads on to my next point about support services. It is important that the role of support services are legislatively enshrined and appropriately funded. Obviously it is crucial that the family feel they have the capacity to participate in the process. If they are feeling too distressed or traumatised by the process, that undermines their ability to participate and ultimately undermines the process and the findings.

Fourth, legal representation is absolutely crucial. We have seen over and over again the quality of investigations, inquests and findings being raised by the involvement of appropriate legal representation asking the right questions, digging a little further and raising the right issues. It is abhorrent that at the moment we have a situation where we have to rely upon pro bono — that is, the charity of the legal profession. There are some amazing counsel who give their time for free or for pitiful legal aid rates, and it is just not appropriate that we have a system where people are dying at the hands of the state and then it relies upon the charity of others to ask the crucial questions that need to be asked. It is also not appropriate that we go on relying upon the goodwill and enthusiasm of the community legal sector to pick up where the state has left off in not providing adequate legal representation through legal aid. So the key here is to ensure that there is a legislative requirement for adequate legal representation, which is backed up through an amendment to the legal aid guidelines and by appropriate funding being made available.

Last but not least, there should be involvement of the family or interested parties in the follow-up and report back. As mentioned by Hugh, the families are very keenly aware when they walk out of the coronial inquest that that should not be the end of it. They are interested in knowing what happens with the recommendations, and so there should be some formal way of them reporting back. If it is not a public hearing, some letters should be written and provided to them on a regular basis — say, six-monthly intervals — to update them on what is happening with the implementation. It is very important for them to feel that the life lost of their loved one is not a waste. That is all I have to say about supportive families. I might now open it up to questions.

The CHAIR — Thank you for your submission. There are lots of points you have raised. Perhaps we could start with the issue of investigation standards. In his submission the coroner indicated that, whilst there are a number of standards in four or five areas, including forms and so on that have been developed, he would be concerned about having detailed investigation standards in all areas because each case is individual and has its own unique circumstances, and therefore you need to allow the investigator to have the flexibility to properly investigate, unconstrained by particular requirements. He was concerned about that being a dumbing-down or that it might produce a lowest common denominator result, I think was what he said. Can you comment on other jurisdictions and their standards, how they worked and what your response is to that view?
Mr SINGH — I think we should aim for a highest common denominator standard — not one that micromanages an investigation but one standard that sets the required standards for knowing what to look for and what the issues are from previous inquests. You might have 10 deaths in custodies and have 8 different investigators looking at it, and you will have 8 different types investigations that may not really go the systemic issues that are shared by all 8 of them. When I am talking about standards, I am not talking about micromanaging issues, I am saying that these are the issues that have occurred in previous deaths — these are the documents, these are the witnesses, this is the electronic information and so on — and have a process and a protocol to ensure that that standard is captured.

Responding to the individual issues is really essential, but no standard should or can really circumscribe that. But I am just talking about setting a standard, because my experience with all the different states is that there is very little consistency in investigations, and there are very few standards or guidance that guide investigations. There is usually a police standing order, but that does not speak to the complexity of individual deaths and the investigation into — —

The CHAIR — Do you know of jurisdictions where standards have worked well in your opinion?

Mr SINGH — It is really the absence of standards that is a concern. In the Queensland model, looking at the death in custody at Palm Island, there are a whole lot of issues to do with the police investigating a death in police custody, which can really mitigate against the effectiveness of standards. That is about the independence of the investigation. I think it is something that along with the evolution of the jurisdiction needs to be seriously looked at — not to hamper the work, but to enhance it to a standard that provides consistency. Because you are also looking at the disparities between inquests that are undertaken in the country and inquests undertaken in the city, and that disparity is sometimes very large. The setting of standards and guidelines should introduce that level of consistency. It also provides an audit framework and looks at managing risks like occurred in the Villiami Tanginoa inquest, particularly when you are walking into settings where there has not been an investigation before. It is really a pre-emptive process as well as a proactive process that needs to occur.

The CHAIR — Pauline, you raised the issue of legal representation. One of the issues that affects us a little bit is the whole nature of coronial court processes. We have had differing evidence and views: families who feel that often there are too many lawyers in the court, that they get in the way of getting at the truth of what actually happened; others who have said, ‘They were all represented by lawyers and I was not’. You seem to be implying a major shift in the provision of legal aid in Victoria in terms of what we have understood about when and in what circumstances legal aid has been proposed. What is your view about this balance within what is essentially meant to be an inquisitorial process which often becomes adversarial? Does the federation have any views about that?

Ms SPENCER — Certainly. Having been across the bar table from eight different legal representatives in the Port Phillip inquest for six weeks where you are representing the family and every other state body is well represented with Queen’s Counsel and so on, I can see how it is crucial that there is a quality of representation. It is important because unless we are looking at maybe throwing out all the lawyers, and that would be maybe an interesting thing to look at, I do not necessarily think that that is helpful.

The CHAIR — Are there some circumstances where you would throw them all out? Maybe not the Port Phillip situation, but what about other situations?

Ms SPENCER — Maybe the better idea is to be looking at who is practising in the jurisdiction and maybe we need to be looking at coronial specialists and having people who are appropriately trained to work in the jurisdiction who understand the nature of the jurisdiction, that it is an inquisitorial process.

In various inquests the coroners need to be quite forthright with the parties and set the scene and the temperature, I suppose, of the way that the parties are going to conduct themselves, and that requires the coroner to be quite forthright. Maybe that needs something so the nature of the process needs to be enshrined in the legislation, so that the ultimate purpose is an inquisitorial one and it sets that sort of environment. The families that we have worked with need representation to be able to put forward their questions. To not have that available puts the whole process at a severe disadvantage, because you end up having, literally in the Port Phillip private prison inquest, every other party looking to hide the truth or to minimise their contribution and only one party funded or not funded to ask the hard questions there. The disparity is quite significant.
I think we need to look at not only legal aid being available for representation, but also the rate of legal aid that is available. You cannot have $600 a day when you have the state government lawyers who are being paid whatever. It is just the disparity there. It is not going to allow for the hard questions to be put, and it makes it a very difficult process. If you are going to invest money in the coronial process, which is what you are doing, you are investing public funds to have a good coronial process to get to the bottom of what has gone on, to have everyone adequately represented is very much part of that process; otherwise ultimately that prior investment is a little wasted. I think having the representation there for the family — families may choose not to be represented, and that is fine; they may choose not to be involved — and making sure that if there is no family involvement, at least there is some public interest involvement of some sort, so that you are weighing up who is at the table and who is advocating what interest.

Mr LUPTON — Could you expand a little bit on what you mean by public interest involvement and how you would see that sort of criteria being met?

Ms SPENCER — I look at it from a very practical point of view. I think there is a range of organisations who work day to day in the jurisdictions and often see what is going on in the jurisdictions. Say, for example, thinking back to the Kew cottages fire inquest, Villamanta Legal Service had a wealth of knowledge of intellectual disability that they were able to bring to the table and to assist the coroner in looking at what was a very difficult area, so looking at those organisations who have knowledge and expertise that they can bring to the table to raise the level of knowledge and to feed into the questions that the coroner might be thinking of, so that you marry that expertise in coronial processes with the expertise of what is happening on the ground. The organisations that are working on the ground in these areas have a lot of information and knowledge about the systemic issues that often underpin the deaths and also in the follow-ups then are often involved in key players having those recommendations implemented — to have them involved all the way through so that you are getting recommendations that are solid and that are going to be able to be acted upon is very important.

Mr SINGH — The test for standing under the act is not a public interest test. It is a sufficient interest test. In New South Wales it is sufficient interest in the subject matter, so my research has been that it is the state coroner who has determined the interested parties like the Victorian Council of Civil Liberties or the federation or Villamanta. It has been an interpretation of the sufficient interest to encapsulate the unique perspectives, experiences and contributions that parties can make to an inquest. It is either a matter that the sufficient interest test is interpreted liberally under the standing rules, or that a public interest test be added to the test for standing, so they are the two mechanisms by which additional parties may become involved. The coroner can also determine to what extent a party is involved. Are they limited to final submissions? Are they limited to cross-examination, cross-examination by leave? But I think it is an important issue to address in terms of maximising the effectiveness of the jurisdiction.

Mr HILTON — I want to follow up something that both you and Ms Spencer referred to, that if we had not had legal representation for the family in the Whyte case, the findings would have been rather different, or the outcome would have been rather different. My understanding is that the coroner also has some opportunity to question witnesses to determine the truth. Are you saying that in your experience the coroner would not have been able to do that, or what conclusion are you drawing there?

Mr de KRETSER — The coroner was assisted by counsel from the Office of Public Prosecutions, and my understanding of counsel’s role is that it is an independent facilitator in the investigation, so that particular counsel, Chris Ryan, led off the cross-examination of the key witnesses, but well before that the police officer assisting and the Office of Public Prosecutions had prepared statements and a list of witnesses. We reviewed those statements and witnesses and asked the coroner — we felt that the coroner had not included critical witnesses — and they proved to be critical witnesses. Key forensic evidence would not have come out at the hearing which placed Mr Whyte relative to the shooter if we had not been involved in the inquest and had not requested those witnesses. The critical piece of cross-examination in the inquest was of the prison officer’s partner, and that was extracted by counsel assisting the Whyte family. We also requested a lot of material which the coroner had not asked Corrections Victoria to provide in relation to training and policies, so — —

Mr HILTON — Can I just interrupt there? Are you drawing the conclusion that without adequate representation of the family’s interests, the findings of the inquests and coronial processes are suspect?
Mr de KRETSER — Yes, because their independence is critical. Sorry, I guess counsel assisting the coroner is independent, as they are there to facilitate a process, but the interest of the family is specific to the issues confronting the family and is often opposite to that of the persons who might be implicated in or having contributed to the death, and it is adequate representation of those interests that brings out the truth or that ensures a thorough investigation that canvasses all of the relevant issues. I can definitely say in this particular case it would not have been as thorough and as important an inquest with the same findings if the family had not been properly represented by counsel. We got senior counsel in that case who originally agreed to appear pro bono. We fought incredibly hard. I had to write eight letters to legal aid to convince them that there was public interest in this particular family being represented, and in the end they got the legal aid rate, which I think is about $600 a day compared to the normal QC rate, which is somewhere between $3000 and $10 000 a day; whereas Corrections Victoria and the prison officer were both represented by senior counsel. The hospital was also represented by senior counsel.

The CHAIR — I wonder if you have any comments on the coroner’s submission where he indicated that perhaps we need to look at abrogating the principle against self-incrimination in relation to coronial inquests, obviously with the proviso that that evidence cannot be used in any subsequent proceedings. Do you have any comments on that in order to get at the truth, in order to at least require people to answer questions or at least not to be able to avoid answering questions on the basis that it may incriminate them?

Mr LUPTON — You can choose to remain silent.

The CHAIR — You have a right to remain silent.

Ms SPENCER — It is not something we have specifically addressed, but we would be happy to provide further submissions if that would be helpful.

Mr SINGH — I have had experience with the issue in New South Wales in the police killing of James Hallinan and the death in custody of Thomas Hickey, Jr. In both those cases, although the coronial certificate option was available to the state coroner, he excused the officer from giving evidence in the Thomas Hickey matter. He excused him for two reasons. One, he stated that anything that Officer Hollingsworth had to say was not believable anyway, and the other issue was that Officer Hollingsworth may have faced internal disciplinary proceedings which had not been those that has been used since or before.

Even in New South Wales it is extremely problematic. But I think it is fair to say that the conduct of that issue has really impacted on confidence in the system in New South Wales, particularly around those two deaths; and it has impacted on confidence and integrity issues in inquests in Victoria and has been the subject of coronial recommendations. In almost every police death in custody I have been involved in it is a big issue, because it relates to and links with the issue of police investigation of police homicides. There is also the issue of the fundamental right to silence, and Magistrate Heffey has addressed that. It is something we need to give more thought to, but it is a really fraught issue and goes to the issue of integrity.

The CHAIR — Can I thank you for coming along today and for giving us your views and the additional case study material. It has been very helpful and informative for us in terms of our considerations. Thanks for coming.

Witnesses withdrew.