LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 22 August 2005

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Witnesses

Mr D. Kaufmann;
Mrs M. Kaufmann; and
Mr D. Taylor, community development officer, Springvale Monash Legal Service.
The CHAIR — Welcome. We have had the opportunity of talking to you in a more informal way and we look forward to hearing your evidence.

Mr KAUFMANN — We thank you for your time today and ask for your understanding that our submission has been put before you at such a late date. Our mentally ill son, Mark, was killed by a police shooting in January 2002. We have just finished the coronial process, with the findings made on 4 August. It is picking ourselves up from that system that has caused the delay in getting the submission in.

It was our belief that a coronial inquiry takes place to find out how a death occurred and to find the cause of death so that further deaths may be prevented. If that was the objective of the inquest, it certainly has not worked for us. We find ourselves now with more questions than answers — more than we ever had before.

Firstly, on the issue of timing: three and a half years from the happening to a result. It takes far too long from the time a person dies until the completion of the brief ready to go before the coroner. In our case, the preparation of the brief took two and a half years. This strikes us as odd, when during the inquest it took all of 1 hour to go and get an additional statement from one of the witnesses, when it was the reputation of the police that was under threat.

The allocated time for the hearing was too short. Getting legal representation and the coroner organised for extra days if the proceedings are not finished in the allocated time is not easy. Therefore, the proceedings were spread over a long time — about five weeks — and this added to the distress of the family. Once the inquest was finished it took too long to bring down the findings. It took seven and a half months for our findings to come down. While it is in the interests of the family and society that the coroner does a thorough job, again it adds to the distress of the family and leaves their lives in limbo. Also we noticed in the press that deaths which happened much later than Mark’s had an inquest before ours.

The witnesses and materials also have a greater chance of being unavailable, or witnesses of even dying. In our case, when we asked for a statement from the crime scene photographer, which had not been included in the brief, we were told that he could not be found. Further death from police mistakes could have been prevented with timely change and implementation of recommendations. There were four shootings of mentally ill people alone until the inquest was finished, and in the seven and a half months until the findings were handed down there were two more police shootings.

We asked whether these deaths could have been prevented had Mark’s inquest been held earlier. We believe there should be a consecutive order of investigation, inquest and findings. Commonsense dictates that it would be more efficient to finish one case before the next is started. It would be fairer. When our solicitor inquired on our behalf when we could expect the findings — we had been given a timeframe and were well past it — the explanation was that ‘The coroner has to deal with some high-profile cases at the moment’.

Needless to say, we found that extremely offensive to say the least which begs the question, why are not all deaths treated equally? In a consecutive order everybody would know where they stand. There is less likelihood of added frustration, bitterness and cynicism for family and public, and the court retains credibility.

Mrs KAUFMANN — I now turn to the investigation and the chief investigator. The shooting death of a person should automatically be considered suspicious, no matter who did it. In a police shooting, police investigating police gives a perception of a conflict of interest. However, the police always investigate their own, and this can cause real or perceived problems.

During the inquest when we questioned the way the investigation had been done, the coroner declared himself to be the chief investigator, therefore cutting short any complaints against the homicide squad. In our case, after consultation with those present, the coroner decided on the night of the shooting that the shooting itself was considered justifiable. That conclusion set the framework for all that followed.
In our experience there are legitimate questions to be asked about the way the investigation was conducted prior to the inquest. It is very pertinent to ask whether Mark’s death would have been investigated differently or more thoroughly had the investigation been conducted by anyone totally independent of the police, and if the shooting had been done by anyone but the police. It is cold comfort that the coroner declared himself responsible at a time when it was too late to change the investigation preceding the inquest. In our view the investigation, which took two and a half years to complete, was no more than a collation of statements because it proceeded on the premise that the shooting was justifiable. Therefore we are adamant that police should not investigate police.

In his findings the coroner appeared to recognise the weakness of the system in this regard and made a separate recommendation, finding that it could be of benefit if a lawyer was present from the beginning. However, we think that if the lawyer is not totally independent, then the perception of conflict of interest remains. An independent investigator would be of great benefit not only to the investigation but also to the public perception created.

One strong perception remained throughout the inquest: there were rules for the police and there were rules for the general public, and that is sad to say. This perception only adds to the grief of the family and a feeling of dissatisfaction with the whole process. Police investigations following a police shooting, such as from the ethical standards department, are not for public view. We ask: why not? What is the secret? In contrast, every detail of the dead person’s history can be examined. There is no limit to what is known about the deceased person.

But as in our case, there is no knowledge of the people responsible for our son’s death. They were and are still shrouded in a protective cloth of secrecy which gives a total appearance of no public accountability by the organisation involved. Government organisations such as the police or the health department should have the same public accountability imposed on them as the ordinary man and woman on the street who pay their salaries.

At an inquest relevant information is provided to the coroner by all parties connected with the event and the investigation. If a member of the public or the police have relevant information about a death, they must provide it to the coroner. Is the penalty for not providing information the same for the public and the police? It appears not. Why not? What does that infer? In our case, if Mark had been shot by a member of the public, would the primary assumption of a justifiable shooting been more thorough? A second ripple effect of the assumption of justifiable shooting was that the doctor performing the autopsy did not consider certain procedures necessary.

Mr KAUFMANN — I turn to privilege against self incrimination. We note that the coroner has the power to order a witness to answer questions. However, the coroner’s power to summons and order a witness under oath is enormously diluted by the right to silence. Not having the person who shot Mark even publicly questioned had a huge effect on the family. It gives the perception that the witness is not accountable. It also gives a perception of bias and protection of main wrongdoers. It also gives the perception of lack of truth and meaning of the coronial process. It is nonsensical that the cause of our child’s death cannot be tested or properly inquired into during the very process for that purpose. A possible solution would be to do away with that privilege, as has happened in other Australian states.

I want to talk about an inquisitorial versus an adversarial system. It is our understanding that the coronial system is meant to be an inquisitorial system. However, it was plainly visible from the moment we entered the court that it was going to be adversarial, and that was exactly what it turned out to be. There were three separate legal teams defending the actions of various police parties. There was a separate legal team for mental health. Although the families have a right to represent themselves, where would we be without representation? We felt that the battery of barristers, trained in the adversarial system, went against the spirit of an inquiry — the inquisitorial system — and just reinforced the functioning of an adversarial system. It was clear that the barristers were defending their client’s actions or inactions rather than trying to get to the truth.

Other submissions from outside parties which came before the coroner were not admitted because the parties submitting them were not party to the proceedings. In our opinion, in an inquisitorial system where the aim is to find the truth and to better the systems, this extra material would have been an educational extra to help generate solutions to systemic problems. The coroner’s quote that, ‘I usually give the family the last word’ when taken up by us to address the various issues in writing in a totally non-legal manner ended up generating additional legal wrangling as the other sides must have felt in some way threatened by our last word. Therefore the impression of being exposed to a very adversarial system only deepened.
Mrs KAUFMANN — On the evidence taken or admitted: we note that a coroner is not bound by the rules of evidence. The coroner voiced restrictions to himself in that he was only going to consider the evidence put before him, not any unexplored options. From the beginning there was only one scenario of the shooting considered. With considerable pushing we were allowed to bring an alternative scenario to be considered. Evidence to back up this scenario was provided.

Both scenarios had their problems but in the end only the two scenarios were considered by the coroner. However, he really could have come up with his own likely scenario or other, or gathering of evidence. We felt that in a truly inquisitorial system the coroner — once he admitted that the shooting could have happened another way — could have ordered thought about other ways that the shooting could have happened. However, that does not occur. It should not be up to the family to feel that they have to point out different scenarios if the one investigated is inconclusive.

Enforceability of recommendations: had recommendations in previous inquests been heeded by the organisations involved — that is, the police — Mark might still be alive. Therefore we feel that recommendations should be enforceable, in particular those recommendations pertaining to government bodies. There is no point inquiring into a problem, discovering areas in need of fixing and then working out recommendations to address the problem if the pertinent parties are at liberty to ignore or dilute the recommendations.

Implementation of recommendations pertaining to government bodies should be overseen by an independent body. There should be a time frame for implementation of the recommendations and both persons or bodies concerned after that time frame should show cause why the recommendations have not been implemented. There should be accountability for not meeting that time frame. The government has an obligation to the people to change things for the better if fault has been found to exist in its functions.

Public accountability: in conclusion we observe that there is a common thread running through the above submission, a lack of public accountability. We and the public will not be advised as to the accountability of those persons and organisations involved in Mark’s death. We believe that we and the public should be informed. There is no mechanism to inform us of any progress or lack thereof in the implementation of any recommendations. There is no public accountability for any non-enforcement. Nothing has frustrated or enraged us more than the fact that there is no enforceability.

Speaking here to you today, believe me, is not easy. It will not bring our son back. Let us not make this an even bigger exercise in frustration. With mere understanding and compassion and words of approval, let us see changes. We seek changes to systems we feel have let our son down and ultimately were responsible for his death. Nothing is more frustrating than to see that at the end of the day no person, no system is accountable for the death of our son.

The CHAIR — Thank you very much for your submission and the very clear presentation you have given us. It was very succinct. I would like to go to one question about the investigation where you said that you felt the investigation was not independent because it was police investigating police. Could we tease that out a little bit because obviously the coroner was conducting an investigation but relying on presumably reports and evidence from police. How could that investigation been made more independent from your point of view?

Mr KAUFMANN — I think the coroner covers it in his recommendation. He suggests a lawyer, possibly from the Director of Public Prosecutions attend, as does he, at the event and perhaps point out from a lawyer’s point of view — ‘It could be this, it could be that, maybe you are a bit blinkered here’.

We would like to take that one step further and say that the lawyers from the DPP or OPP or whatever they call themselves are in fact in a working relationship with the police on a day-to-day basis, and so to give the perception, if not the fact of further independence, then perhaps an outside investigator/lawyer, not associated in any way with the police or the police enforcement, might be an even more emphatic way of having that accountability. On the night the coroner comes, the homicide squad comes, they all have a look and have a chat amongst themselves and they more or less figure it out on the spot — in Mark’s case they believed they had. These guys have been working together for umpteen years.

Mrs KAUFMANN — That was something the coroner pointed out to us and I am not kidding you, it was said in the court, ‘I have worked with so and so — the chief investigator of the homicide squad for 30 years, I have known him for 30 years, so therefore why should there be something wrong here’.
Mr KAUFMANN — He was not about to be critical because he had absolute faith in him. People make mistakes, people have different view points and different scenarios are open to different minds.

The CHAIR — You mentioned that you felt as if the coroner’s mind as to what had happened was made up very much on the night of the shooting.

Mrs KAUFMANN — He admitted that.

Mr KAUFMANN — He admitted it.

The CHAIR — What did he say?

Mr KAUFMANN — When we started questioning his chief investigator, he said, ‘Excuse me, hang on — that was me’.

Mrs KAUFMANN — That, ‘That was my decision — —

Mr KAUFMANN — That, ‘that was my decision not to look any further than the two problems as I perceived it on the night, one being communications, and the other being systems tactics’. Those were the two things that they put their heads together and came up with on the night and when we asked whether anyone had thought perhaps that the policeman involved may have made a mistake. No, no-one thought of that. Good on him, he has integrity, he put his hand up and said he had blown it.

Mrs KAUFMANN — But that does not solve the problem.

Mr KAUFMANN — That was in hindsight but it did not solve the problem. Hence his recommendation 9, if you want to look at it. Everyone is very open about it, there was no cover up or anything. People have their different points of view, as a coroner he has one point of view, police have their point of view and there are other points of view.

Mrs KAUFMANN — We were quite happy to accept the point of view that they had until we read the brief which we saw two and a half years after Mark was shot. When we started reading the brief we said, ‘Hang on, this does not add up, that does not add up, what is going on here, why is this so?’ There were so many questions and inconsistencies that we asked — wasn’t there any other way? It took considerable pushing, as I said, for the other way that we considered to be accepted, but it was accepted.

Mr KAUFMANN — It was accepted as a possibility.

Mrs KAUFMANN — It was accepted as a possibility, but that does not mean there could not have been any other alternative scenarios. The problem was it all happened between two people, one of whom is now dead.

The CHAIR — Do you feel it took too long for your scenario to be considered and even then it was not considered adequately in the court?

Mr KAUFMANN — First of all I do not think it was up to us to say that things could have happened differently.

Mrs KAUFMANN — That is correct.

Mr KAUFMANN — That should be plainly obvious to anyone.

Mrs KAUFMANN — That could have been something that the investigators, the homicide squad, could have addressed. They could have looked at the facts as we did and said, ‘Hang on, that is maybe not quite so clear-cut’. But that did not happen.

Mr KAUFMANN — It is also a matter that the main player, the only surviving witness, could not be questioned, which to me is farcical. He makes a statement but then you cannot question it. You cannot say, ‘Why do you say this, why do you say that?’. What from the outset makes him any different to Joe Blow Public? Someone has drawn a gun and killed someone and claimed self defence — okay, but it was taken on faith because he was a policeman on duty whereas with anyone else, that would be questioned.
The CHAIR — But he claimed the privilege against self-incrimination under the act, didn’t he?

Mrs KAUFMANN — Of course.

Mr TAYLOR — Victoria and Tasmania as I understand are the only two states which still hold self-incrimination in coronal processes. I think the other states have dropped it and when we, and my students, spoke with Graeme Johnstone he actually identified the case which had been a chase across from Albury to Wodonga and so Victorian and New South Wales police were included in that. The New South Wales police happily got up on the stand and presented their information whilst the Victorian police claimed self-incrimination, so they were not cross-examined.

The CHAIR — In practical terms if someone is going to refuse to testify, how would the coronial process deal with that putting aside claiming the privilege?

Mr KAUFMANN — In a normal court of law a judge can draw an inference from that.

Mrs KAUFMANN — But not in an inquest.

Mr KAUFMANN — But not in an inquest. In a normal court of law a judge can say, ‘If you will not get up and defend your statement, then perhaps I put less weight on your statement than others’. That does not happen in the coronial system. The coroner made no bones of the fact that it was ‘unhelpful’, as he put it, that this witness refused to testify, as did another police witness. There were two.

The CHAIR — In making the system sort of inquisitorial or reinforcing its inquisitorial nature, not being adversarial, what sort of changes do you think should be made to make sure it does not become too adversarial but becomes more of an inquisitorial system?

Mr KAUFMANN — That is a tough one.

Mrs KAUFMANN — I guess one way you could go — it may not be feasible — is you could possibly say, ‘We have specially trained lawyers that only deal with inquests with the inquisitorial system that we have in our adversarial system’. The way it works at the moment, we re-emphasise, is that it really is adversarial. And that is so contrary to what was set up to be. Apart from that fact, it is intimidating to people. I pointed out the cost. You go up against these barristers — do you want to go up as Mrs Jo Blow, and do what?

Mr KAUFMANN — There is a point that no charges arise out of the coronial system, so why does any interested party in fact need legal representation? If no charges are going to flow, then why do they have to watch every word and every nuance and argue about every sentence?

Mr DALLA-RIVA — I think the previous evidence from other witnesses was not about criminal charges but more so about medical negligence, therefore it becomes an issue of risk liability on particular hospitals and organisations. I am just giving you what other evidence has been given today. There are those particular issues that have been brought up that are similar but separate to what you are saying.

Mr KAUFMANN — Point taken, but not in our case.

Mrs KAUFMANN — But it also points towards organisations, does it not?

Mr DALLA-RIVA — Yes, exactly.

Mrs KAUFMANN — We are back to organisations.

Mr DALLA-RIVA — It is about avoiding the words ‘prosecution’ or ‘financial risk’.

Mrs KAUFMANN — Avoiding responsibility for something that has happened.

Mr DALLA-RIVA — Avoiding blame.

Mrs KAUFMANN — Avoiding blame, and you only do that in an adversarial system. If you want to find out why X, Y or Z has happened, you go about finding out.
Mr DALLA-RIVA — What was your perception of the court process physically? How did you feel walking into the court? I always find it interesting if it is a Coroners Court.

Mrs KAUFMANN — You mean when you see a line of barristers?

Mr DALLA-RIVA — Yes.

Mrs KAUFMANN — How would you feel? I do not know whether they have experienced it.

Mr DALLA-RIVA — That is why I am asking.

Mrs KAUFMANN — It is intimidating.

Mr KAUFMANN — If there are seven barristers and then there is little old you, you are just hoping that your barrister can read your mind.

Mrs KAUFMANN — And you see that these are all on one side and you are here. That is intimidating — actually, it is disheartening.

Mr KAUFMANN — Because you know all of these guys are there to defend a particular point of interest. He is there to defend the police force, and he is there to defend the policeman who did the shooting, and he is there to defend the guy who was in charge, and he is there to defend the health — or she is there; there are a couple of shes, I beg your pardon, Ladies. It is like the hexagon with everyone putting knives into the middle, and you hope you are not in the middle.

Mrs KAUFMANN — This sounds really silly, but if they had nothing to hide then why bring up these big guns, all these legal things? One wonders.

Mr MAUGHAN — If you could recommend the ideal system, what would you recommend?

Mrs KAUFMANN — I would recommend that they stay away from adversarial, definitely.

Mr MAUGHAN — Should barristers be allowed?

Mr KAUFMANN — There are plenty of people who do not have a voice who cannot — —

Mrs KAUFMANN — Speak for themselves easily.

Mr KAUFMANN — Speak for themselves, incisive — —

Mrs KAUFMANN — And especially at the grieving point.

Mr KAUFMANN — You are not thinking too clearly at that stage.

Mrs KAUFMANN — You are talking about families who have just gone through hell. To actually be confronted with this and to get up there and actually talk coherently, that is quite an ask. I think in a way legal representation is required because of that fact.

Mr TAYLOR — If an organisation such as Leo Cussen was to organise some sort of training for solicitors who want to specialise in coronial cases, that could be an ideal solution. It would be a different way of approaching it. They would look at the more European inquisitorial system rather than what we have with the generic court system being adversarial.

The CHAIR — Do you think it would be useful if there were trained specialist advocates for families and next of kin appearing before the Coroners Court?

Mrs KAUFMANN — Yes.

The CHAIR — Is that an option, because obviously legal representation gets incredibly expensive. We know that legal representation today is mainly confined to people in the greatest need who are on serious criminal charges, and there is no legal aid available virtually for civil proceedings. So in dealing with the coronial process
obviously you have to be able to afford a barrister, and that is for some people prohibitive. I know we have had families here today who have spent a lot of money on that process and still felt very dissatisfied with it.

I am just wondering whether we should have someone like an advocate, someone who could be there to assist someone who is family or next of kin in the process. Would that be helpful? They might be legally trained or they might be someone who is just experienced with that kind of process.

Mr MAUGHAN — Or a pool of advocates provided by the court, and you take your chances.

Mrs KAUFMANN — I think that is a good idea.

Mr MAUGHAN — Maybe one would appear for the health system and maybe another for the family.

Mrs KAUFMANN — Sad to say, there seems to be enough work. If we had a pool of advocates like that, there seems to be plenty of work for them. That is maybe a way to go.

Mr KAUFMANN — By the same token you have coroners who are not judges, because they have a different function. So by the same token you can have advocates who are not barristers who would have a slightly different function to work within the coronial system.

Mrs KAUFMANN — It needs to be accessible to everybody.

Mr KAUFMANN — If it has integrity, as do the coroners, then it will work.

Mrs KAUFMANN — As we said, we had no choice in the matter. We had to go to court, okay? So if you are actually forced to go to a court system that then also costs you money on top of already having lost your relative. How frustrating, disheartening and unfair is that?

Mr TAYLOR — The benefits of a sound and transparent coronial system are significant compared to, for instance, legal aid assistance in a Magistrates Court matter. You are looking at systemic benefit to the community versus what are often punitive measures towards a single individual. When you look at the Magistrates or County courts the government should certainly consider funding for some sort of advocate for the families there. Ignoring the immediate effects, the long-term benefit to the community of sound representation to the families is immense. That is quite clearly demonstrated by the six deaths in the last 18 months proceeding Mark’s in January 2002.

Mr DALLA-RIVA — That is an interesting point that I am trying to come to grips with after today’s hearings. We would have individual cases being presented from a coroner on particular issues or on a particular incident or a particular death. I am just concerned, for example, there was evidence given about the Attorney-General doing an investigation, he reports, provides recommendations that go to Parliament, but they may be across a variety of different areas. The theme still runs central. They are not one particular incident, but there are cases where they do one particular incident.

They talk about the system and the way the process is reviewed to avoid it occurring again. I am trying to work out in my mind, and it is obviously something we will discuss in committee later on, how you have one incident that provides recommendations. If we are to look at providing recommendations that are to be reported to Parliament, then a subsequent review of the application, I am concerned that we may have a particular incident where there are recommendations made by a coroner, then to Parliament, then to public scrutiny — that may have slight differences to another incident which will again recommendations which will go to Parliament.

I am worried that in one, two or three years we might have single incidences that actually go to Parliament that recommend a variety of recommendations that do not necessarily mix. I am just wondering — and this obviously is something I am keen to look at — about what was raised before in terms of aged care, in mental health and now in police shootings. Do you see there would be some concern with that sort of process, taking out a single incident and relying on recommendations to Parliament on a single incident as proposed there? And if not, why not?

Mr KAUFMANN — No. If not, why not? Because I think the coroner is intelligent enough to know that if what they recommend is going to be enforced, they are going to be very careful how they would frame that recommendation. It only has to be, as you say, proved to be counterproductive in another case for it to bounce back on them. It is like any law you make, be it pool fences — whatever. You can say, ‘That family, they are Olympic swimmers. We will not apply that law to them because it is nonsensical. Why bother?’ If there is an obvious need.
or a systemic failure, if the coroner knows that his recommendation is going to be enforced, that it goes to whoever it is that formulates the wording of that into law, I cannot believe that those two steps cannot filter out anything nonsensical.

Mrs KAUFMANN — Your committee is set up by Parliament and it has a function for something specifically. Why can there not be something set up to function specifically to follow up recommendations from the coroner? How frustrating must it also be for the coroners to see these things happen and re-happen? They should have already stopped because they have recommended that police should step back and wait their time, not rush in, grab their guns and shoot. Why are those recommendations not listened to?

Mr KAUFMANN — In Graeme Johnstone’s case if I can be a bit familiar, he has a thing for tasers and he has been recommending them for the last five years. He could have seen and he foresaw that in Mark’s case it would have been a useful thing to have, so he expressed frustration at the time when he was interviewing some SOGs — that is, special operations group people — that, ‘Here I am, five years down the line, saying the same thing’. Why have the system if it cannot be enforced?

Mr TAYLOR — You can see a pattern forming in the recommendations.

The CHAIR — It is a difficult issue with enforcement sometimes. I can readily agree that there must be a requirement to respond to a coroner’s recommendations even if a department says it has looked at it and it does not think it is feasible or practical or there are some problems with it and it prefers to do this or whatever.

The difficulty with specific enforcement is, for example, the issue of tasers. Yes, the coroner has referred to them in a number of reports, but the police have to go through a whole process in Victoria to test them. There was some controversy around their introduction. Some people have questioned it, whether or not in themselves they are going to create some harm, so obviously there is a whole set of testing that has to be gone through before you can use them.

In that sense it cannot be strictly enforced. You cannot have the coroner saying one day, ‘Let us have tasers’ and then several weeks later it happens, because obviously there is a whole other set of things that have to be considered by people responsible for the introduction of these things before it can happen.

Mr KAUFMANN — But to stick with tasers, as an example — I do not agree with tasers, by the way — it mentions in our findings ‘sergeants and above’ so you are not saying, ‘There you are, Force, strap your tasers on and go for it’. Because he knows that the recommendations have some weight, he tempers the recommendation to a practicality. First SOGs, then sergeants and above, then eventually we will get to it. But it is not done without thinking, so if they know the recommendations are going to be enforced, that much more thought should go into it.

Mr DALLA-RIVA — I note the police giving evidence in coronial settings has also made recommendations. He has looked at 33AA, the comparison with New South Wales and the police giving evidence and recommending that we review it. It is quite interesting. He has suggested that there may be an opportunity for us to consider whether police or others give incriminating evidence, which is similar to 33AA, which is what you raised before. It is quite interesting to go through the findings.

Mr KAUFMANN — I do not know whether this is in the findings, but during the course of the proceedings he made it very clear that he objected to the fact that people could claim.

The CHAIR — Sure. He has also commented on it in his submission to us, which we have not yet heard formally, but he has written something.

Mrs KAUFMANN — As to the recommendations generally, when we say ‘make a time frame’, maybe there could be a time frame of not implementation but actually to show that you have actually considered and — when I say show, I mean publicly show — show that you have considered, not have some internal review or whatever it is, that you have taken steps towards — —

The CHAIR — And you have responded.

Mrs KAUFMANN — Yes, that you have responded in a positive way. Otherwise, what is it for? Put yourself into the situation of a family that has just lost someone. Why put ourselves through this anyway? This is a joke, because it is a hardship reading through every detail in a coronial inquest, but if at the end of the day you
know that, ‘Such-and-such happened, that is why your son is dead’, then all right. I knew three and a half years ago that the death should have been avoidable. There was no need for anyone to plough through 11 days of evidence for that. But if something else comes out of it, if systems can change, then yes, it is worth while doing.

The CHAIR — I thank you for your submission. It is very clear and as you were going through it, it seemed to me that you were making about 11 recommendations. You were making the comment that the coronial process takes far too long and it needs to be shorter and more efficient; that the allocated time for the hearing was too short; it took too long for the findings to be made; the act needs a time frame which defines what ‘timely’ means so that all of this can happen in a timely way; and that there needs to be a consecutive order of inquest and findings, with all deaths being treated equally, not just high-profile ones being dealt with in the first instance.

Mrs KAUFMANN — Do you agree with that one?

The CHAIR — We will go away and consider the implications of that recommendation — that all shootings of a person should be automatically considered suspicious, no matter who did it; that the investigations need to be independent, not to have just police investigating police but a separate and independent investigating officer. You said ‘a lawyer from the DPP’ but it could be someone else attending the event in the first instance; that penalties for not providing information to the Coroner’s Court should be looked at.

For witnesses, you said the privilege against self-incrimination should be removed; that the coronial system should be inquisitorial and not adversarial, and that we may need to look at specially trained lawyers or advocates who can deal with these inquests; that the way in which and the type of evidence admitted to the Coroner’s Court should be reconsidered — in other words, the rules of evidence and how matters are considered — I think that ties back to the inquisitorial as against the adversarial kind of system; that the recommendations should be enforceable, particularly those pertaining to government bodies; that there should be a time frame for implementation; they should show cause why recommendations have not been implemented if they have not been implemented; and finally, that families should be informed of the progress in implementing those recommendations.

They seem to me to be the key things coming out of your submission. I thank you; it was a very comprehensive one. We appreciate the time you have taken to present it to us today. We know it is not easy to do it, and we will certainly take on board all those things you have given us in your written submission and in your evidence today.

That brings to a conclusion our evidence today. Today has been primarily devoted to hearing from the families, and I want to thank on behalf of the committee all those families and next of kin who have presented today. We know it has not been easy for many of you, and we appreciate the courage and your willingness to come and talk with us frankly about how the system has affected you. There will also be other days of public hearings when the coroner and other bodies will come and give evidence to the committee. They will be notified through the newspapers and on our web site, and you are welcome to attend those hearings and hear the other evidence that other bodies are going to give to us. Thank you very much.

Committee adjourned.