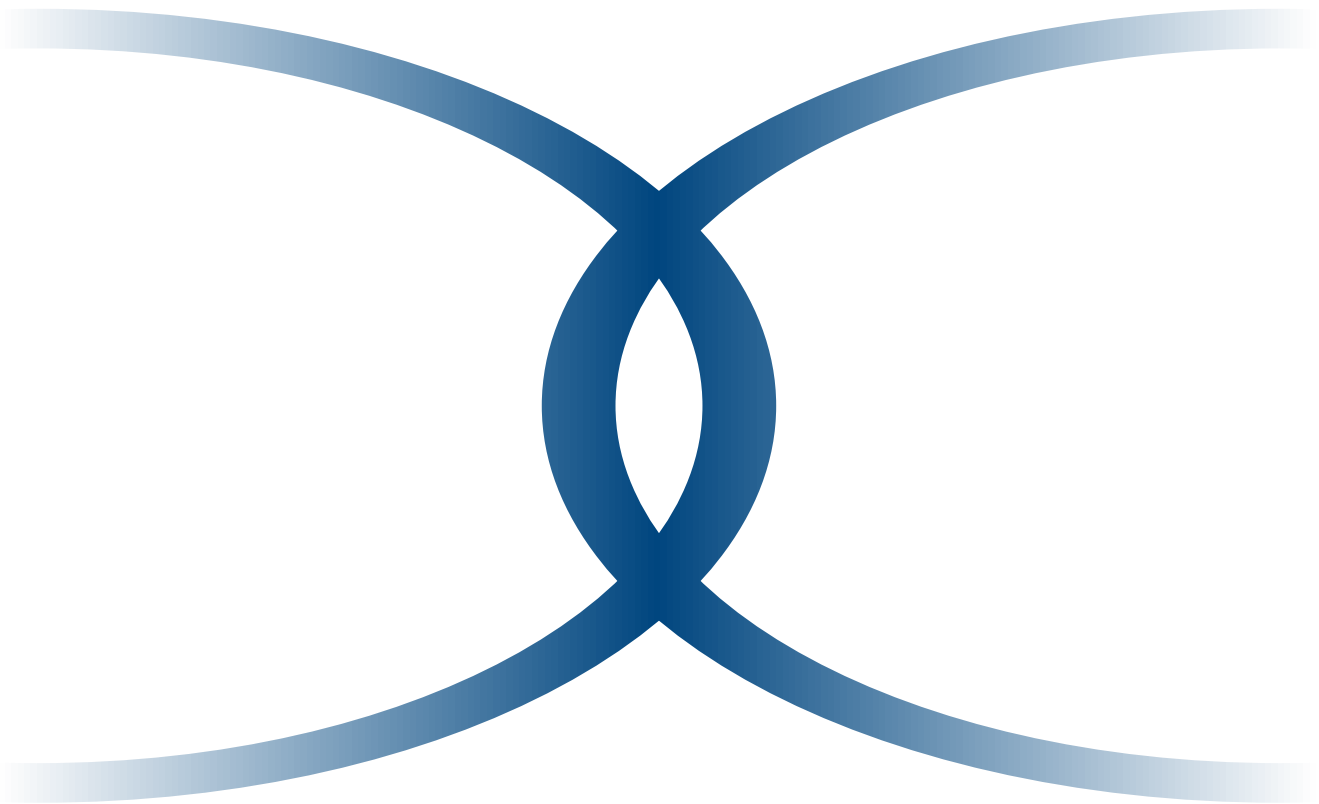


Coroners Court of Victoria

2011–2012 ANNUAL REPORT





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Coroners Court of Victoria

18 February 2013

The Honourable Robert Clark MP
121 Exhibition Street
Melbourne 3000

Dear Attorney-General,

I am pleased to present the 2011-12 Annual Report of the Coroners Court of Victoria.

This report sets out the court's functions, duties, performance and operations during the year under review from 1 July 2011 to 30 June 2012. This report relates to the reporting period when the court was lead by former State Coroner Judge Jennifer Coate and former CEO Judy Leitch.

I am advised by Judge Coate that the contents of the report are accurate for the reporting period.

Yours sincerely

A handwritten signature in black ink, appearing to read 'I. Gray', with a long, sweeping underline.

Judge Ian Gray
State Coroner



Report from the State Coroner

I am pleased to present the third Coroners Court of Victoria Annual Report.

The pace, complexity and number of developments in and around the court's operation has not slowed in this reporting year. The contents of this Annual Report underscore a number of those areas of development and change in our on-going efforts to provide the people of Victoria with the best modern coronial system we can with the resources provided to us by the State.

In the wake of the introduction of the *Coroners Act 2008*, we continue to strive to develop and refine our processes to fulfil our statutory obligations and serve our community. Our challenges remain significant and complex. A number of areas of public endeavour are being called upon to work with reduced resources. The Coroners Court of Victoria has been no exception.

Despite this, the court has managed to complete a number of initiatives it was hoping to achieve as outlined in last year's Annual Report.

To assist the work of our coroners in the regions, acknowledging the special difficulties of coronial work in regional Victoria, with the cooperation of the Chief Magistrate, we have set up the anticipated regional roving coroner program. This program makes available an experienced sessional coroner to assist with complex medical investigations, investigations where there is a potential conflict or where an inquest is likely to take more than three sitting days.

Courtview, the much awaited new electronic case management software program for the court was finally launched successfully in April 2012. It was very resource intensive for both staff and coroners and remains so as at the time of reporting. But it brings with it many positives. For the first time in its history, the court has a consistent state wide electronic case management system. It provides the capacity to provide instant access to any coronial file held by the court. It also allows for management overview reporting of numbers and types of cases that has had to be performed manually up until Courtview.

The court was also pleased to be able to deliver the Legal Practitioners Practice Handbook at the end of 2011. The Practice Handbook was made possible by a grant from the Victoria Law Foundation.

The much sought after In-House Solicitors team was set up in July 2011 and has proved its value in so many ways in its first 12 months. The two lawyers, Jacqui Hawkins and Sarah Gebert, as Principal and Senior In-House Solicitor, have not only saved thousands of dollars in external legal fees, but provided invaluable guidance and knowledge to the work of the court.

Tragically, the need for the Family Violence Death Review process commenced inside the court in 2009, remains as pressing today as it was when it commenced. During the 2011-2012 reporting period there were 66 suspected homicides reported to the court. Of that number, preliminary investigations indicate 20 of those deaths appear to have occurred within a context of family violence. Despite no on-going funding being provided for the program, the court has strived to continue doing its best to produce in depth analysis and review of each of these deaths to learn whatever is possible from these tragedies and give this information back to the family, community and service system.

Our thanks again to the Judicial College of Victoria in its support of the court, providing regular on-going professional development for coroners state-wide.

Our thanks to the members of the Victorian Institute of Forensic Medicine, the police in the Police Coronial Support Unit and to all of those members of Victoria police who provide investigative support to our court.

The volunteers of Court Network continue to provide support to families who attend the court.

I wish to record my deepest respect and gratitude to our staff who deserve both acknowledgment and thanks for the difficult work they are required to do.

I also wish to record my sincere thanks to our CEO Judy Leitch, who has been dedicated to continuous improvement in the administration of the court over the reporting period.

Finally, my respect and gratitude to all of my coronial colleagues who continue to give dedicated service as coroners to our community. My deepest thanks to Deputy State Coroner Iain West, who provides unflagging support and guidance both to me and the court generally.

State Coroner
Judge Jennifer Coate



Report from the CEO

This is the court's third Annual Report since its establishment as a specialist inquisitorial court on 1 November 2009 under the *Coroners Act 2008*.

During the current reporting period, the court has strived to ensure that improvements made to its operations are aligned to the needs of the community, implemented in accordance with its legislative obligations, and deliver value to the Victorian Government and the community. In particular, our focus has been on providing a better service to those who find themselves involved in the jurisdiction as a result of the death of a loved one.

As noted in last year's Annual Report, KPMG was engaged to undertake a post-implementation review following the introduction of the new legislation and associated reform. During the reporting period, KPMG completed phase two of this review.

KPMG found that the court's cost per case finalised compares favourably with other coronial jurisdictions and that the court delivers more services for this cost than other jurisdictions. KPMG noted that their benchmarking activities and analysis of the court's major cost categories suggest that its recurring budget deficits reflect an inadequate funding base rather than any deficiencies in financial management. In terms of the court's operations, KPMG highlighted opportunities to improve the internal efficiency of the court by up to ten percent through improving the management of caseloads.

The court has made considerable efforts to implement the key recommendations made by KPMG. In February 2012, the court introduced a new triage system to expedite investigations into deaths found to be the result of natural causes. This system endeavours to ensure that families are not exposed unnecessarily to distressing and prolonged coronial investigations when the circumstances of natural cause deaths do not involve broader issues of public health and safety or the administration of justice.

In July 2011, the court began a pilot In-House Solicitor Service to assist coroners conducting particular investigations, such as investigations involving deaths of persons in police custody or during police pursuits. Previously this work was outsourced at a considerable cost to the court. The new service has greatly assisted coroners with the efficient management of key cases, has enabled the court to develop and retain a high level of expert legal knowledge specific to the coronial jurisdiction, and has significantly reduced the court's legal costs.

Early in the reporting period, following extensive consultation with KPMG and senior officers of the Department of Justice, the court prepared a proposal for a comprehensive organisational redesign. The redesign was aimed at addressing issues raised by KPMG and included a new organisational structure, the introduction of pro-active case management processes, the redistribution of some internal resources, a carefully planned process to reduce net staffing numbers, the reduction in contractor expenses, and an expansion of the new In-House Solicitor Service.

However, in December 2011, before this proposal could be formally submitted to the Department of Justice for approval, the Victorian Government's Sustainable Government Initiative (SGI) was implemented across the public sector, immediately placing very different priorities onto the court. The focus of the court since then has been to minimise the impact of staffing and revenue losses associated with the SGI in order to ensure continuity of its front-line service delivery. The court's average staffing level during the reporting year was 71.0 equivalent full-time positions (FTE), down from an average of 78.4 FTE in 2010-11. Due to the further loss of fixed term positions on 30 June 2012, the court's actual staffing complement as at 1 July 2012 was down to 65.7 FTE. This represents a staffing loss of approximately 16 percent.

Unfortunately, as a result, the court has had to reduce the delivery of some important services, such as its counselling service, community education program and its provision of coronial data to key external agencies. In addition, the court's ability to manage its caseload has been impacted, as indicated by the drop in its case clearance rate from 115 percent in 2010-11 to 98 percent in 2011-12.

Despite these difficulties, I continue to be impressed by the compassion, sensitivity and professionalism our staff demonstrate in their daily contact with grieving families. The manner in which they conduct themselves is reflected in a significant increase in compliments received by the court during the reporting period. I would like to thank them for their ongoing commitment to the court and to the Victorian community. I would also like to thank the State Coroner, Judge Jennifer Coate, for her support, wise counsel and leadership during what has been a very challenging year.

Chief Executive Officer
Judy Leitch

Coroners Court of Victoria

The Coroners Court of Victoria

The Coroners Court of Victoria was established on 1 November 2009 when new legislation, the *Coroners Act 2008* (the new Act), came into effect following the passage of the Coroners Bill 2008 through the Parliament of Victoria in December 2008. The implementation of the new Act represented the most significant reform of the Victorian coronial jurisdiction in 25 years.

Under the new Act, the former State Coroner's Office was re-established as the Coroners Court of Victoria. The *Coroners Act 2008* sets out as one of its purposes the establishment of the Coroners Court of Victoria as a specialist inquisitorial court.

Strengthening the prevention function of the court is a defining feature of the new Act. The prevention function refers to the capacity of the jurisdiction to contribute to public health and safety through coroners' findings, and the development of comments and recommendations that are targeted at the reduction of preventable deaths and fires. Significantly, under the new Act, coroners have the power to make recommendations to any Minister, public statutory authority or entity relating to issues of public health and safety and the administration of justice. From 1 November 2009 any public statutory body or entity receiving a recommendation contained in a coroner's finding must respond in writing within three months stating what action, if any, will or has been taken to address the recommendation.

Unless a coroner orders otherwise, all inquest findings, coronial recommendations and responses to recommendations are published on the court website.

Preamble to the *Coroners Act 2008*

The *Coroners Act 2008* preamble is the foundation upon which the court operates. It clearly defines the role and importance of the coronial system within Victorian society by stating the jurisdiction involves:

The independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.

Objectives of the *Coroners Act 2008*

Whilst the preamble defines the foundation of the court, the objectives give guidance in the administration and interpretation of the Act. The objectives seek to ensure that the coronial system where possible:

- avoids unnecessary duplication of inquiries and investigations to expedite the investigation of deaths and fires
- acknowledges the distress of families and their need for support following a death
- acknowledges the effect of unnecessarily lengthy or protracted investigations
- acknowledges and respects that different cultures have different beliefs and practices surrounding death
- acknowledges the need for families to be informed about the coronial process and the progress of an investigation
- acknowledges the need to balance the public interest in protecting a person's information and the public interest in the legitimate use of the information
- acknowledges the desirability of promoting public health and safety and the administration of justice
- promotes a fairer and more efficient coronial system

Jurisdiction

The Coroners Court of Victoria has jurisdiction under the *Coroners Act 2008* to investigate reportable and reviewable deaths and fires, as defined respectively in sections 4 and 5 of the Act.

Part 5 of the Act also gives coroners the power to hold inquests, which are public court hearings, in some investigations.

Inquests are held both in the Coroners Court of Victoria in Melbourne and in regional Magistrates' Courts, where magistrates also function as coroners.

The map below indicates the location of courts where inquests may be held.



Reportable deaths

Coroners are required to investigate all reportable deaths. There does not have to be anything suspicious about a death for the death to be reported to the coroner. Many investigations conducted by coroners result in the coroner finding that although the person died unexpectedly, the death was otherwise as a result of natural causes.

During the reporting period, there were 4726 deaths reported to the coroner.

Section 4 of the Act states a death is considered reportable if:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death; and
- the death appears to have been unexpected, unnatural, or violent or to have resulted, directly or indirectly, from an accident or injury; or
- the death occurred during a medical procedure, or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur; or
- the identity of the person was not known; or
- a medical practitioner has not signed, and is not likely to sign, a death certificate certifying the cause of death; or
- a death has occurred at a place outside Victoria, and the cause of death is not certified and is unlikely to be certified; or
- the person immediately before their death was a person placed in 'custody or care'; or
- the death is of a person who immediately before their death, was a patient within the meaning of the *Mental Health Act 1986*; or
- the person was under the control or custody of the Secretary to the Department of Justice or a member of the police force; or
- the person was subject to a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

Reviewable deaths

Coroners must also investigate a category of deaths called 'reviewable deaths'.

Section 5 of the Act defines a reviewable death as being the death of a second or subsequent child of a parent, with some exceptions. A child is anyone under the age of 18 years, the child will have died in Victoria, or the cause of death occurred in Victoria, or the child lived in Victoria but died elsewhere.

Importantly the *Coroners Act 2008* has changed the definition of reviewable deaths to exclude stillborn children and children who lived their entire lives in hospital, unless otherwise determined by a coroner.

During the reporting period there were five* reviewable deaths reported to the court.

Fires

Coroners can also investigate a fire or fires, regardless of whether or not a death has occurred. Section 30 of the Act states that a coroner must investigate a fire after receiving a request to investigate from the Country Fire Authority or Metropolitan Fire and Emergency Services Board, unless the coroner determines the investigation is not in the public interest.

A coroner conducting an inquest into a fire must make a finding stating, if possible, the cause and origin of the fire and circumstances in which it occurred.

During the reporting period, there were 28 fires with death reported to the court. There was one fire without death reported.

* figure excludes reviewable deaths that were also deemed reportable deaths

Structure and organisation of the Coroners Court of Victoria

The court is comprised of one part-time coroner and nine full-time coroners, including the State Coroner and the Deputy State Coroner. In Melbourne, the court is staffed by in-house solicitors, court registrars, counsellors, researchers and case investigators, and administrative staff. Staff are grouped into specialist teams to assist coroners with particular aspects of their investigations. The administration of the court is led by the CEO.

Across the five court regions of Victoria, regional magistrates are assigned as coroners and perform coronial duties and functions.

The Coroners

State Coroner

Judge Jennifer Coate

Deputy State Coroner

Mr Iain West

Metropolitan Coroners

Dr Jane Hendtlass

Ms Audrey Jamieson

Mr John Olle

Ms Kim Parkinson

Ms Paresa Spanos

Ms Heather Spooner

Mr Peter White

Regional Coroners

Ms Jacinta Heffey (based in Melbourne)

Most magistrates in regional Victoria have also been appointed as coroners and will usually perform the functions of a coroner when necessary in the region.

Court Administration

Chief Executive Officer

Judy Leitch

Initial Investigations Unit

Manager: vacant*

Registry

Principal Registrar: Margaret Craddock

Coroners Prevention Unit

Manager: Samantha Hauge

Family and Community Support Services

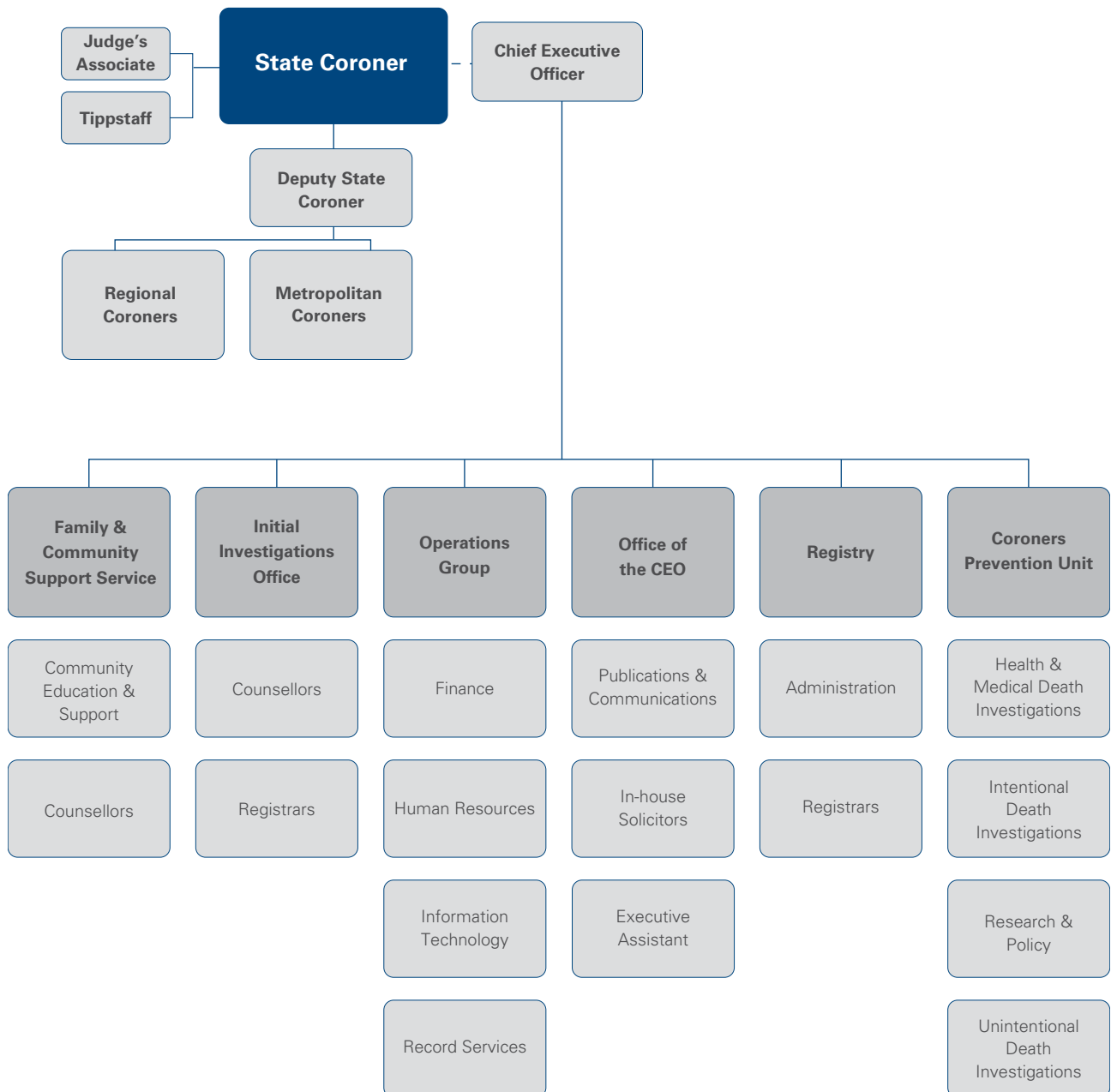
Manager: vacant*

Operations Group

Manager: vacant*

* These management positions became vacant during the reporting period and, as they are not exempt from the Sustainable Government Initiative staffing cuts, have not been able to be filled as at 30 June 2012.

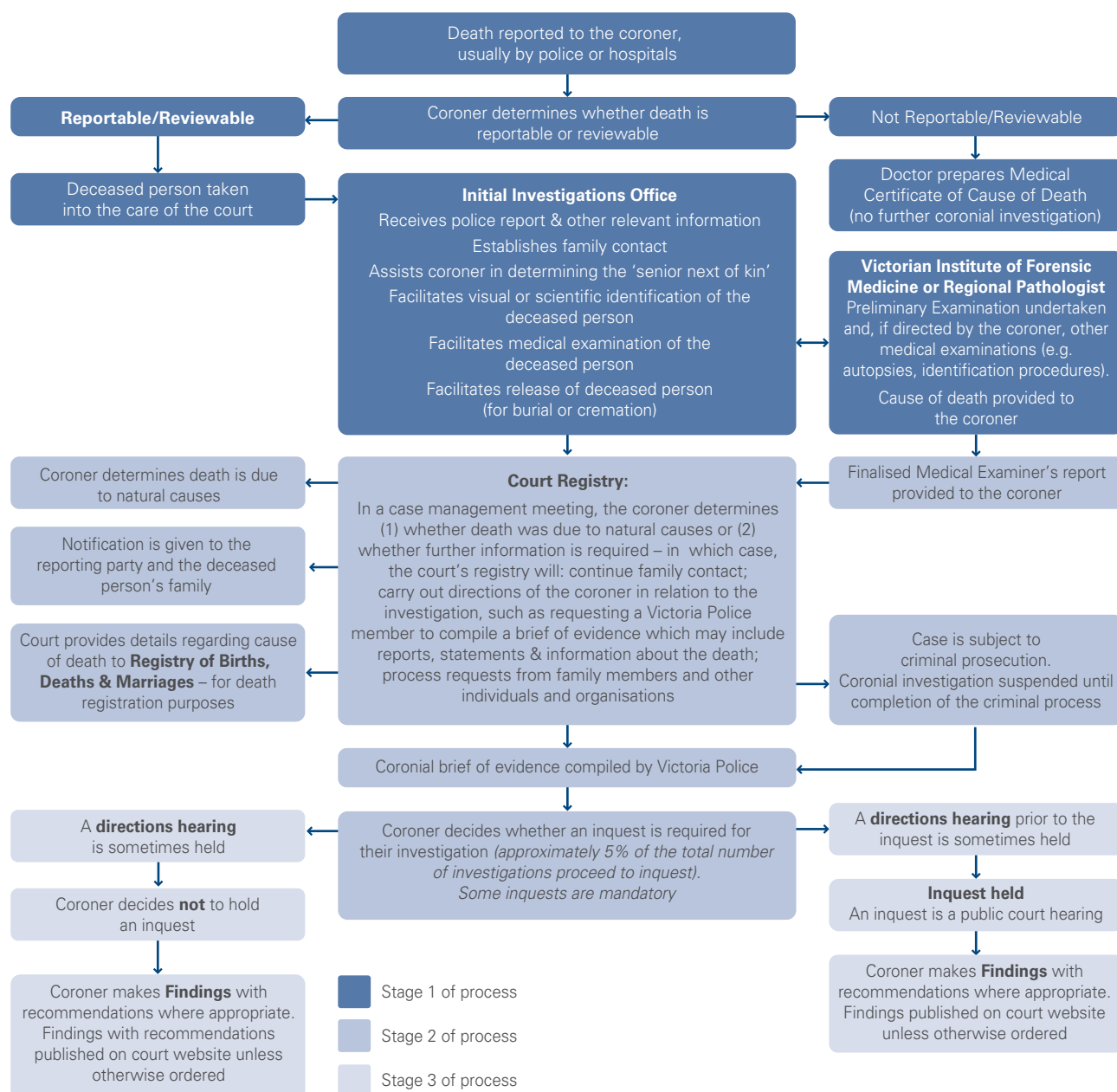
Organisational Chart



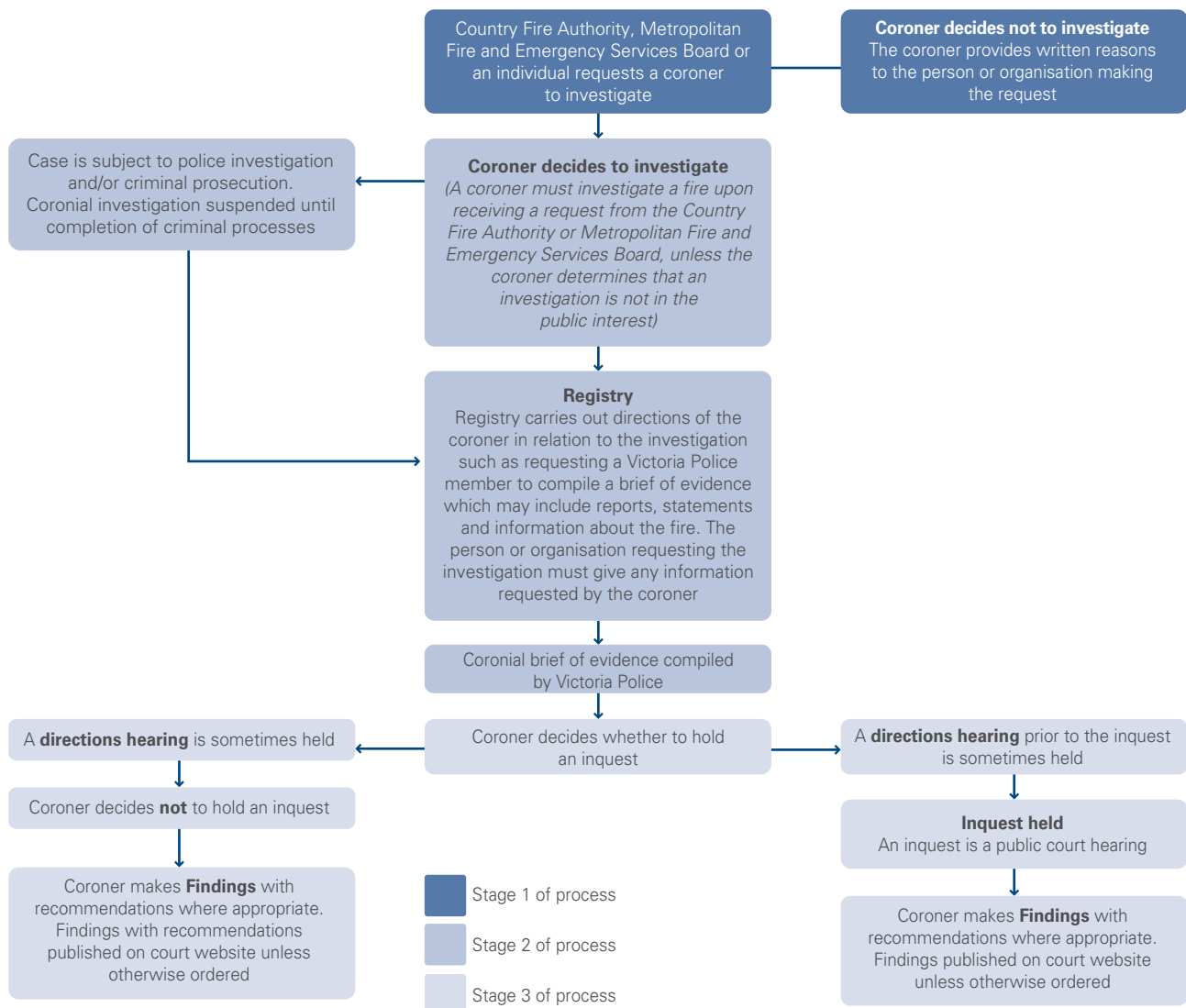
Coronial processes

Every death and fire reported to the court is unique and requires an individual investigative approach.

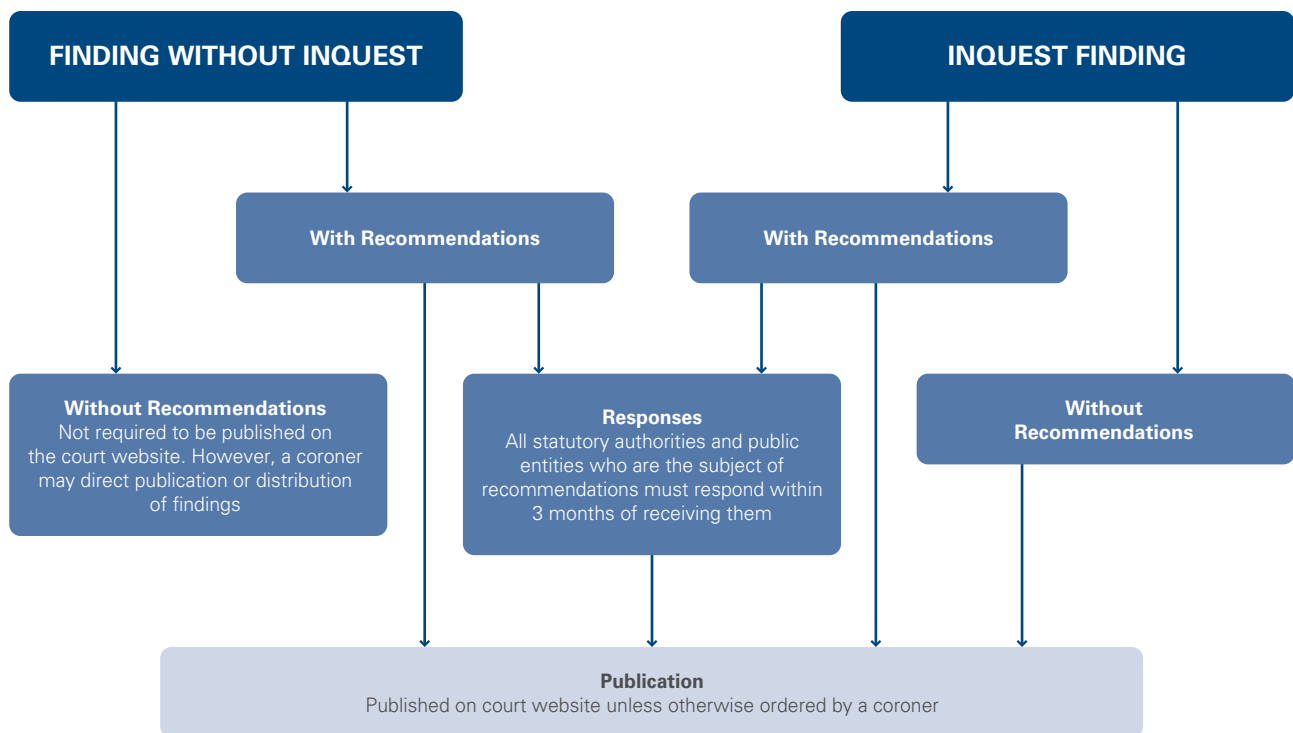
In order to achieve this, the court has established a number of processes allowing different areas within the court and services provided to the court to work together to investigate deaths and fires throughout each stage of the coronial process, as follows:



The coronial process – when fire without death occurs



Publication of findings, recommendations and responses (Sections 72 & 73)



Highlights and initiatives

Site redevelopment

The redevelopment of the State Coronial Services Centre in Kavanagh Street Southbank continued throughout the reporting period following the commencement of the main building works in January 2011.

The works are part of a staged redevelopment plan that will result in:

- the addition of a second storey to the existing building to create more room for coroners and coronial staff
- an expansion of the existing two courtrooms
- the building of a small third courtroom for directions hearings and summary inquests
- a complete redevelopment of the Initial Investigations Office to create an improved area for families attending to identify and spend time with their deceased loved ones
- extensive upgrading of the coronial mortuary and other facilities of the Victorian Institute of Forensic Medicine; and
- new facilities for the Police Coronial Support Unit.

While these works are being undertaken, most court staff and the Police Coronial Support Unit are temporarily accommodated at 222 Exhibition Street in facilities previously occupied by the Victorian Bushfires Royal Commission. However, the Initial Investigations Office and the Victorian Institute of Forensic Medicine will remain on site throughout the duration of the project.

The redevelopment remains a crucial project to ensure the court can continue to cater for advancements in post-mortem forensic pathology, expected future increases in the number of deaths requiring investigation and higher degrees of complexity required to carry out those investigations and the increased focus on the prevention role of the coroner.

The project is scheduled for completion in December 2013 with all staff expected to return to the site from Exhibition Street in early 2014.

Options for future-proofing

In the 2010-11 Annual Report, the court raised concerns that the long lead-time for the redevelopment project and the building design may result in little or no capacity for future growth of the court.

As a result of the court raising these concerns, the Department of Justice is currently investigating options for expanding the footprint of the new facility in order to address this concern.

Impact on families

As with any on-site redevelopment, there have been both planned and unplanned disruptions to operations, including noise and vibration, temporary loss of essential services and loss of car parking. Although these disruptions have been difficult for staff working on the site, every attempt has been made to minimise the impact on grieving families attending the Initial Investigations Office.

However, the impact on families is expected to be more significant when the Initial Investigations Office is relocated into temporary accommodation on the site in early 2012-13 while works are undertaken to redevelop the office. The temporary location will be less accessible for families and other court stakeholders, such as funeral directors, as it will be upstairs and no longer adjacent to the mortuary. There will also be very limited parking available for families during this time.

Every effort is being made to ensure that the impact of these issues are managed to minimise any detriment to services.



Victorian Coronial Council

The Victorian Coronial Council was established under the *Coroners Act 2008* and is the first of its kind in Australia.

The council provides advice and recommendations to the Attorney-General regarding matters of importance to the coronial system, matters relating to the preventative role of the court, the way in which the coronial system engages with families and respects the cultural diversity of the community, as well as any other matters referred to it by the Attorney-General.

The council consists of three statutory and seven non-statutory members.

Statutory members include:

- State Coroner Judge Jennifer Coate
- Victorian Institute of Forensic Medicine Director Professor Stephen Cordner
- Victoria Police Chief Commissioner Ken Lay

Non-statutory members include:

- Judge James Duggan (Chairperson)
- Mr Stephen Dimopoulos
- Dr Ian Freckelton SC
- Mr Chris Hall
- Professor Katherine McGrath
- Dr Sally Wilkins
- Dr Rob Roseby

While expected on its establishment to meet three to four times per year, the Council actually met on nine occasions during the 2011-12 financial year due to the workload the Council set for itself.

The Council received two references from the Attorney-General during the 2010-11 financial year, both of which were completed during the current reporting period. The first reference was a request to examine measures that might be adopted to assist those affected by coronial investigations in the course of their employment. The Council produced a final report to the Attorney-General on this reference in October 2011.

The second reference was a request to advise whether asbestos-related deaths should be investigated by the coronial jurisdiction. The Council provided a response to this reference in January 2012. It is expected that the Attorney-General will make both reports publicly available shortly.

The Council also considered other issues during the current reporting period, including the development of its website, access to legal representation for families in the coronial system and the difficulties associated with funding pressures placed on the Coroners Court as a result of recent reforms.

In May 2012, the Attorney-General agreed to make a formal reference to the Council to provide advice on the reporting of suicide and the coronial jurisdiction, and work has commenced on this reference. The Council considers itself well-placed to consider the complex and sensitive issues around suicide reporting and, as the Council is the only body of its kind in Australia, it can take a leading role in coronial reform matters.

The court considers the work of the council to be of considerable benefit to the operation of the coronial system in Victoria and appreciates the valuable work it undertakes.



Legal Practitioners Practice Handbook

In December 2011, Attorney-General the Honourable Robert Clark and the State Coroner officially launched *The Coroners Court of Victoria Practice Handbook*.

The launch, at the court's Exhibition Street facility, was attended by more than 80 people from the legal profession.

The handbook, made possible by a 2009-10 grant from the Victorian Law Foundation, recognises the unique nature of the Victorian coronial jurisdiction. It provides a tool for members of the legal profession to assist in the effective representation of clients by providing information about the jurisdiction, court practices and procedures, and the rights of bereaved family members and interested parties.

An electronic copy of the handbook is also available on the court's website.

CourtView

In late April 2012, following a long period of intensive preparation, CourtView was successfully launched in the Victorian coronial jurisdiction. CourtView is an integrated courts technology system used by courts in the United States and adapted to integrate data from all Victorian courts within a single electronic case management system.

The implementation of CourtView has enabled the court to introduce consistent case management processes across the State, which was previously not possible. It has also provided the court with the capacity to interrogate and report on its own data, which was also previously not possible.

As with the implementation of many major IT projects, the launch of CourtView was challenging. The extensive preparation period drew significantly on the resources of coroners and staff, as well as key court stakeholders, in particular the Victorian Institute of Forensic Medicine (VIFM). Despite an extended period of design modifications and user acceptance testing, unexpected issues inevitably arose, many of which related to the electronic interface that allows the exchange of data between the court and VIFM. Unfortunately, until these issues are resolved the court will need to utilise 'work-arounds' to maintain the continuity of its work, and these work-arounds will have a significant impact on the overall efficiency of the court.



In-house solicitor service

The Police Coronial Support Unit (PCSU) provides assistance to coroners in a significant number of coronial investigations that proceed to inquest.

However, in any coronial investigation where the conduct of police will or may come under scrutiny, the coroner will not seek the assistance of PCSU to avoid any possible conflict of interest. Such matters include where a death has occurred in police presence, or as a result of a police shooting or pursuit or while the person was in police custody, or was being taken into police custody. Historically the assistance needed by coroners during the course of these investigations and inquests has been outsourced to external law firms, including the Victoria Government Solicitors Office.

In response to rapidly escalating legal costs, the Department of Justice approved a pilot program to employ two in-house solicitors. In July 2011, the court welcomed Jacqui Hawkins and Sarah Gebert as Principal and Senior In-House Solicitors respectively to the court.

Since the pilot program began, no external law firm has been engaged for new investigations to assist coroners. Further, three large investigations that had been outsourced were returned in-house. During the past financial year, the In-House Solicitor Service has set up the new system for operating the service and have appeared in:

- six inquests as Counsel Assisting the Coroner
- 35 directions hearings as Counsel Assisting the Coroner
- 30 inquests as the Instructing Solicitor
- 5 Supreme Court appeal matters
- provided 76 separate complex legal briefings to coroners across the state
- participated in ongoing professional development for coroners.

In addition, the In-House Solicitor Service has assisted with the preparation of a range of other complex legal documents, liaised extensively with the legal profession, hospitals, police and families and given guidance to court staff on a range of legal issues. In particular, the service has assisted in the implementation of a new practice direction relating to deaths in police presence or custody. The practice direction requires that a directions hearing be held within 28-days of the death being reported to the court. The hearing determines who the investigating police member will and the status and nature of the police investigation.

Records of the In-House Solicitor Service's 'billable hours' indicate the court would have incurred a cost in excess of \$1.1 million had these services been outsourced. Of this \$1.1 million, \$783,000 would have been required to be outsourced to the Victorian Government Solicitors Office or other external legal firms because of conflict of interest issues.

Although some work that was committed prior to July 2011 was undertaken by external legal firms during the reporting period, the court expects it will continue to see a reduction in external legal costs in the subsequent reporting period.

The In-House Solicitor Service has greatly assisted coroners in their investigations and afforded the court a greater capacity to provide and retain a high level of expert legal knowledge specific to the coronial jurisdiction.

This service is of immense value to all court stakeholders, but in particular, to families who are often required to attend and participate in coronial inquests without the benefit of their own legal representation.



Roving regional coroner

In regional Victoria, 20 magistrates also hold the office of coroner, conducting about 1200 coronial investigations each year.

In order to further support the work of regional magistrates, Sessional Acting Magistrate Jacinta Heffey was made available in August 2011 to exclusively perform coronial work for regional Victoria on a part-time basis.

Magistrate Heffey assists regional coroners with complex medical investigations, inquests likely to involve in excess of three sitting days, and matters where there may be a conflict of interest between the regional magistrate and interested parties.

Magistrate Heffey is based at the Coroners Court of Victoria in Melbourne but travels to regional courts to conduct most of her proceedings. This enables families, witnesses and interested parties to attend coronial inquests in their local area without the burden of having to travel to proceedings held in Melbourne.

Magistrate Heffey has had 30 regional coronial investigations allocated to her in the 2011-12 financial year.

Natural cause triage system

In February 2012, the court implemented a new triage system to expedite investigations into deaths found to be the result of natural causes.

In some situations, a medical investigator may conduct an examination of a deceased person whose death is reported to the court, and provide a report to the coroner that includes an opinion that the death was the result of natural causes.

A coroner may then determine that, other than the fact that the death was unexpected, it is not otherwise reportable under the *Coroners Act 2008* and further investigation is not necessary.

To ensure these investigations are finalised in a timely manner, the court introduced a natural cause triage system, which involves the family being notified in writing that the cause of death was a result of natural causes and that the coroner does not intend to investigate further. Families are given an opportunity to raise any concerns they may have in relation to the death of their loved one with the coroner. Where no concerns are raised by families, the system aims to finalise these investigations as soon as practical.

The natural cause triage system will ensure families are not exposed unnecessarily to distressing and prolonged coronial investigations when the circumstances of those deaths do not involve broader issues of public health and safety or the administration of justice.

Coronial investigations

Coronial findings

A coroner investigating a reportable death under section 67 of the *Coroners Act 2008* (the Act) must find, if possible:

- the identity of the deceased
- the cause of the death; and
- the circumstances of the death in some cases.

A coroner investigating a fire under section 68 of the Act must find, if possible:

- the cause and origin of the fire; and
- the circumstances in which the fire occurred.

Coroners delivered 4620 findings in the 2011-12 financial year. For a full breakdown of findings figures see page 54.

Coronial recommendations

In addition to the findings that a coroner must make under the Act, an important purpose of a coronial investigation is to contribute to public health and safety through recommendations aimed at the reduction of preventable deaths and fires.

A coroner can make more than one recommendation in a finding.

In the last financial year 78 coronial findings contained recommendations. For a full breakdown of recommendation statistics see page 55.

Investigations of significant public interest

In the reporting period, coroners continued their investigations into a number of deaths and fires of significant public interest.

Such investigations provide a unique opportunity to influence public health and safety development in this State. Some of the investigations the court had underway in the reporting period included:

Black Saturday Bushfire deaths

Victoria Police have now provided a number of the coronial briefs of evidence relating to the Black Saturday fires as outlined below. Some matters remain the subject of ongoing criminal prosecution. In those cases, the coronial investigations remain suspended until the court proceedings are complete. This ensures the coronial investigations do not interfere with the administration of justice.

Beechworth/Mudgegonga fires

Findings into the deaths of a man and a woman, and a finding into the Beechworth fire itself, were completed and finalised in the reporting period. The investigations were finalised by way of a finding without inquest.

Bendigo/Maiden Gully fires

The criminal charges against two juvenile boys in relation to these fires were discontinued by the Director of Public Prosecutions in 2011. Victoria Police have provided the briefs of evidence in relation to these fires and the State Coroner is currently reviewing the information in order to determine the direction of the coronial investigation. One man died in the Bendigo/Maiden Gully fires.

Churchill fires

A 41-year-old man was convicted of arson related offences in relation to these fires. An appeal has been lodged by the Director of Public Prosecutions against the convicted man's sentence. The coronial investigation into these fires is suspended until the criminal process has concluded. Eleven people died in the Churchill fires.

Kilmore East fires

Victoria Police have provided the briefs of evidence in relation to these fires and the State Coroner is currently reviewing the information in order to determine the direction of the coronial investigation. There were 119 people who died in the Kilmore East fires.

Murrindindi fires

Victoria Police advised the court in June 2011 that they were no longer pursuing a criminal investigation into the cause of the Murrindindi fires and subsequently provided the briefs of evidence to the court in late June 2012. The court will now begin the process of making contact with the families of the 40 people who died in these fires, to seek their views as to whether they wish for an inquest to be held.

Level crossing deaths

The investigations into the deaths of 29 people who died in collisions between trains and vehicles at level crossings across continued during the reporting period.

To date the investigations into these deaths have focused on two main areas of inquiry including the emergency response, and road and rail infrastructure issues.

Kerang

The inquest into the 11 Kerang Level Crossing deaths concluded during the financial year following a further 27 days of hearings. The coroner expects to be in a position to begin preparing her written finding within the next financial year.

Tyabb

A four-day inquest was held in May 2012 into the death of a 32-year-old woman who died when her vehicle was struck by a Connex diesel locomotive in Tyabb in January 2008. The coroner is expected to deliver her finding within the next financial year.

Edithvale

A two-day inquest was held in January and February 2012 into the death of a 24-year-old man who died when his car was struck by a Connex train at a level crossing in Edithvale in July 2009. The coroner is expected to deliver her written finding within the next financial year.

Trawalla

Investigations into the deaths of a man and woman, who were occupants of a VicRail sprinter train that collided with a semi-trailer at Trawalla in April 2006, were adjourned following two directions hearings in October 2011.

The coroner was advised during the second directions hearing that the circumstances of those deaths are now the subject of civil action proceedings in the Supreme Court. The coronial investigation into those deaths will resume when the civil proceedings are complete.

Youth suicides

Investigations into a cluster of youth suicides continued in the reporting year, with the Coroners Prevention Unit continuing its extensive research regarding potential systemic issues unique to youth suicides.

The unit is examining existing research into factors such as contagion and social stressors as well as reviewing existing youth specific policies and clinical guidelines.

The research will continue throughout the next financial year.

Gastric-banding surgery deaths

The investigation into the deaths of three people following lap-band surgery continued during the 2011-12 reporting period. A four-day inquest was held into the death of a 61-year-old woman in October 2011 with the coroner examining issues relating to:

- the appropriate use of laparoscopic gastric-banding surgery
- communication of test results
- accreditation of laparoscopic gastric-banding surgeons
- accreditation of private hospitals to perform laparoscopic gastric-banding surgery; and
- appropriate guidelines for obesity recognition training.

The coroner is expected to be in a position to begin preparing her written finding within the next financial year.

The investigation into the death of a second person was adjourned during the 2010-11 reporting period following the commencement of civil action proceedings in the Supreme Court. The coronial investigation into this death will resume following the completion of the civil proceedings.

The investigation into the death of a third person, a 45-year-old was adjourned in March 2012 following an appeal to the Supreme Court. The coronial investigation into this death will resume following the completion of the Supreme Court appeal.

Quad bikes

During the 2011-12 reporting period, six quad bike related deaths were reported to the court. Research by the Coroners Prevention Unit has indicated that quad bikes are now recognised as the leading cause of farm-related fatalities in Australia.

The coronial investigation into these deaths will focus on a number of relevant quad bike safety initiatives and developments that have occurred since a previous coronial inquest into a number of quad bike deaths was finalised in 2009.

Anaphylaxis management

The investigation into the death of a 13-year-old boy who died from anaphylaxis after ingesting a beef satay ration pack whilst on a school army cadet camp was concluded during the reporting period.

The coronial inquest focussed on the role of the secondary school in the management of students with severe food allergies attending school camps.

In a finding delivered on 1 June 2012, the coroner found that despite the body of information on allergies and anaphylaxis available at the time, the secondary school had failed to comprehend the seriousness of peanut allergy.

The coroner also found that the death could have been prevented had the school exercised reasonable care and attention to the obtaining and distribution of the cadet camp ration packs in light of the medical information that was known to them.

The coroner recommended that:

- the Department of Education and Early Childhood Development (DEECD) review the 2006 Anaphylaxis Guidelines for Victorian Government Schools
- that the DEECD provide specific guidance to schools with respect to purchasing spare adrenaline auto-injection devices for first aid kits
- that the Minister for Education introduce a requirement that all schools complete an annual risk management checklist to ensure compliance with legislative requirements; and
- that the secondary college revise their student action management plan to incorporate strategies to prevent allergen exposure.

Responses to the recommendations are due in the 2012-13 financial year.

Fitness to drive

Two coronial investigations were conducted during the 2011-12 financial year examining the relationship between fatal motor vehicle crashes and driver medical conditions.

In December 2011, a coroner handed down her inquest finding from the investigation into the death of a 26-year-old woman pedestrian who was struck by an errant vehicle in Melbourne's central business district. The collision was caused by the driver experiencing an episode of paroxysmal rapid ventricular tachycardia, which led to loss of consciousness. The driver had experienced dizziness in the weeks leading up to the collision. The coroner examined issues regarding how the driver was able to be licensed to drive a motor vehicle in spite of his underlying medical condition.

The coroner's finding emphasised that the gate-keepers of the driver medical review system were usually the drivers themselves, and that the system largely relied on the knowledge, capacity and integrity of individual drivers.

The coroner made comments in her finding that encouraged VicRoads to take a more proactive approach to enhancing road safety in relation to the medical fitness of drivers.

The 2011-12 financial year also saw the continued investigation into the circumstances surrounding the death of an 84-year-old woman who died of injuries sustained when her car travelled through an intersection against a red light.

The coroner's investigation is examining the role of general practitioners in discussing and advising their patients on fitness to drive issues. Advice has been sought from the Royal Australian College of General Practitioners and the Australian Medical Association and the investigation will continue in the 2012-13 financial year.

Recreational vessel safety

In the 2011-12 financial year, coroners have investigated a number of drowning deaths involving the occupants of recreational water vessels.

Five human-powered (i.e. canoe or kayak) vessel occupants have died in drowning incidents since January 2011, including two kayakers who drowned in Port Phillip Bay in November 2011.

Extensive coronial investigations are already underway for the earlier 2009 deaths of two fishermen who drowned when their vessel sank in Port Phillip Bay.

Neither man was wearing a personal floatation device, or had an effective means of communication available to raise the alarm and verify their location.

Research to date into the circumstances of a number of these deaths has indicated that there may be a common theme emerging for the need to carry additional safety equipment beyond the minimum required under the marine safety legislation.

These ongoing investigations are in addition to a finding delivered in April 2012 into the drowning death of a 74-year-old man whose home-made pontoon boat overturned in waters near Reef Island in Western Port Bay.

The coroner investigating the death found that once overturned, the boat was unable to be righted and recommended that Transport Safety Victoria:

- continue to advise operators of human-powered vessels to go beyond the minimum safety equipment requirements and carry additional equipment including a more effective Type 1 personal flotation device (PFD) and an Emergency Position Indicating Radio Beacon (EPIRB)
- consider notification and advice to boating enthusiasts who construct their own vessel of the regulatory requirements for seaworthiness and safety equipment.

Failure to report reportable deaths to a coroner

An investigation into the death of a 30-year-old man who died from complications related to a drug overdose sparked a broader investigation into issues of the under reporting of deaths to the Coroners Court of Victoria.

The unnatural circumstances of the man's death constituted a reportable death under Section 4 of the *Coroners Act 2008*. The man was also on a Community Treatment Order at the time of his death, meaning his death was arguably reportable under section 4(2)(d) of the Act as a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986*.

The death was not reported to the court by a doctor or any other hospital staff member. The death eventually came to the attention of the court following a notification by the Registrar of Births Deaths and Marriages who identified that the death should have been reported.

An inquest held into the death in May 2012 examined whether doctors fully understand their legal obligation to report certain deaths to the court and whether they understand how to write an adequate death certificate.

In the 2011-12 financial year, the court received 680 reports of death from the Registrar of Births Deaths and Marriages that the Registrar considered should have been reported to the court for investigation.

The coroner expects to be in position to prepare her finding within the 2012-13 reporting period.

Psychiatric care

A coroner made a series of recommendations aimed at improving the supervision of vulnerable psychiatric patients and the design of their inpatient units following an investigation into the death of a 28-year-old man. The man committed suicide whilst receiving treatment at a regional psychiatric facility in 2009.

An inquest held in February 2012 examined issues relating to:

- the adequacy of risk assessments for patients at the Adult Acute Unit
- the presence of ligature points in the Adult Acute Unit
- the adequacy of monitoring of patients during admission to the Adult Acute Unit

The coroner found that the death was preventable and that a combination of hanging points in the patient's room and a failure to properly supervise him provided the means and opportunity for the man to cause his death.

The coroner made several recommendations to the Department of Health (DOH) and the Office of the Chief Psychiatrist including:

- that DOH produce guidelines to assist health services to design inpatient units that maximise adequate patient observation and to mitigate risks associated with hanging points
- that DOH implement Recommendation 7 made in the report titled "*Chief Psychiatrist's investigation of inpatient deaths 2008-2010*", which recommended that the DOH and health services ensure there are clear and consistent processes and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented
- in addition to the above recommendation, that DOH processes and the documentation of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a nurse's responsibility to conduct observations as clinically indicated

- that DOH develop Risk Assessment and Risk Management Guidelines specific to inpatient/bed-based Adult Acute Units. The assessment and guidelines should reflect the evidence-base and be inclusive of the range of vulnerabilities and risk exposures present in the adult acute inpatient setting
- that Recommendation 15 made in the report titled "*Chief Psychiatrist's investigation of inpatient deaths 2008-2010*" be implemented, that is the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system.

Dog Attack

A coroner investigating the death of a 3-year-old girl who died from a dog attack in her family home in August 2011 held her first court proceeding during the reporting period. The dog belonged to a neighbour and escaped from its yard before entering the 3-year-old's home. The dog attacked several people inside the house before fatally attacking the little girl.

A directions hearing on 15 March 2012 allowed the coroner to set the scope and issues to be heard at inquest, including whether a failure to properly register and contain a restricted breed dog contributed to her death.

An inquest into the death will be held in August 2012.

Ladder deaths

An inquest held in October and November of 2011 highlighted workplace issues surrounding fatal falls from ladders.

The inquest investigated the circumstances surrounding the death of a 56-year-old plumber who died after falling from a ladder at a South Melbourne worksite in March 2009 whilst installing air conditioning ducting.

The coroner made recommendations including:

- that the Victorian Workcover Authority and/or its agency WorkSafe Victoria should immediately advise building and construction contractors to cease using A-frame ladders for the installation of air conditioning ducting and utilise methods of installation that provide a stable work platform from which the work may be performed
- that the Victorian Workcover Authority and/or its agency WorkSafe Victoria publish a safety alert to this effect
- that the Victorian Workcover Authority and/or its agency WorkSafe Victoria abolish the distinction between working at height above or below two metres in its publications of guidelines for industry in relation to falls protection
- that the Victorian Workcover Authority and/or its agency WorkSafe Victoria restate in its publications the risk of death and serious injuries from any fall from height, and that working with ladders is a particular risk.

There have been a further two deaths resulting from falls from ladders since this inquest was held and the circumstances surrounding those deaths continue to be investigated.

Power tools

An inquest into the death of an 82-year-old man, who accidentally electrocuted himself while attempting to fix metal straps to a fence post, identified issues surrounding the safe use of power tools.

It appeared the man had repaired the drill during its operating life, but that poor repairs made it effectively 'live' at three points.

The coroner made a recommendation in her finding that Energy Safe Victoria take appropriate steps to publicise the risk of home maintenance tools and, in particular, the need for regular testing of such devices.

Powerboard fires

In February 2012, a coroner held her first court proceeding into two separate electrical fires.

The directions hearing touched upon a fire that burnt down a restaurant in Lygon Street, Melbourne in August 2009, while the second fire involved the death of a 12-year-old Cranbourne boy who died after a blaze broke out in the family home in December 2009.

The coroner is investigating whether overloaded and/or poorly designed powerboards had caused both fires.

A second directions hearing was held into the fires in March 2012, and the inquest is expected to begin in August 2012.

Co-sleeping

In November 2011, a coroner held an inquest into the deaths of four infants who had died in co-sleeping settings. Co-sleeping refers to the practice of an infant sharing a sleeping surface with another sleeping person.

During the inquest, the coroner released a detailed study on sleep-related deaths and the role of co-sleeping in Victoria.

The study, undertaken by the Coroners Prevention Unit, examined the deaths of 72 infants reported to the court between 2008 to 2010 where:

- the infant was aged between seven days and 12 months; and
- the infant died in a sleeping context; and
- where the medical cause of the death was unexplained.

Of those, 33 occurred whilst the infant was sharing a sleeping surface with another sleeping person.

The coroner requested the study be undertaken after becoming aware of an increase in the number of infants who have died in co-sleeping settings – from 7 deaths in 2008 to 15 deaths in 2010.

The issues examined by the coroner during the inquest included:

- the frequency and nature of co-sleeping deaths in Victoria
- the forensic medical evidence related to sleep-related infant deaths and the role of co-sleeping in connection to those deaths
- a review of the evidence surrounding both the risks and benefits associated with co-sleeping; and
- a review of the messaging and dissemination of health information to parents and carers about co-sleeping.

The coroner is expected to hand down his finding in July 2012.

Home births

In the 2011-12 financial year, coroners investigated three deaths of babies following attempted home births.

The first investigation considered the circumstances surrounding the death of an 8-day old baby boy who died from hypoxic brain injuries from an attempted breech home birth.

In her investigation the coroner considered:

- the antenatal care provided to the mother by the hospital
- the reversion of the mother's care from ambulance paramedics to the midwife
- the midwifery care provided to the mother before and during the labour by the midwife
- the post-birth care of the infant by the hospital.

Following an extensive investigation, the coroner found that the death was preventable and that the care provided to the mother by the midwife had contributed to the infant's death.

A directions hearing into the death of a baby boy who died following an attempted home birth in Clayton in December 2010 was also held during the reporting period. It is understood the infant's mother had received advice from hospital staff that she should not attempt a natural home birth after her previous two pregnancies resulted in deliveries by caesarean-section. The woman attempted to birth at home with the assistance of a midwife but was transported to hospital after it became apparent that mother and baby were in difficulty. The infant died shortly after delivery.

An inquest into this death will be held early in the next financial year.

A directions hearing is also expected to be held into the death of a 2-day-old baby boy following an attempted home birth in Bendigo in October 2010.

Police pursuits

During the 2011-12 financial year, nine fatal collisions were reported to the court in circumstances where the deceased person was a driver or occupant of a car that was being actively pursued, or had been recently pursued by police immediately before the collision occurred.

Deaths in police custody or whilst police are attempting to take a person into custody require mandatory inquests under the *Coroners Act 2008*, unless a person has been charged with an indictable offence in connection to the death.

Fatal collisions involving police pursuits during the 2011-12 financial year included:

- **11 July 2011** – The death of a 30-year-old man who was the driver of a vehicle that collided with a tree off the Wangaratta-Glenrowan Rd in Wangaratta South. Investigations into this death are continuing
- **4 December 2011** – The death of a 17-year-old girl who was a passenger in a car that lost control and crashed off the Murray-Valley Highway in Bandianna, near Albury. A directions hearing was held into this death on 15 December 2011. The circumstances of this death are currently the subject of ongoing police criminal investigations and the coronial investigation has been suspended until these investigations, including any subsequent criminal proceedings, are complete
- **17 December 2011** – The death of a 19-year-old man who was the driver of a car that lost control on Racecourse Road, Cobram. A directions hearing was held into this death on 23 January 2012 and investigations are continuing
- **10 January 2012** – The death of a 19-year-old man who was a passenger in a car that lost control and collided with a guardrail on Stud Road, Dandenong. A directions hearing was held into this death on 25 January 2012. This death is the subject of criminal proceedings in another jurisdiction and further coronial investigations have been suspended until those criminal proceedings matters are complete
- **21 January 2012** – The death of a 42-year-old man who was the driver of a vehicle that collided with another car whilst driving down the wrong side of the Princes Freeway in Morwell. The 26-year-old driver of the vehicle he struck also died as a result of the collision. A directions hearing was held into both of these deaths on 1 March 2012 and investigations are continuing

- **26 January 2012** – The death of a 27-year-old man who was the driver of a car that struck a power pole in Hoddle Street, Collingwood. A directions hearing was held into this death on 16 February 2012 and investigations are continuing
- **30 April 2012** – The death of a 32-year-old man who was the driver of a motorcycle that collided with a sign on Blackburn Road, Mount Waverley. A directions hearing was held into this death on 29 May 2012 and investigations are continuing
- **3 June 2012** – The death of a 24-year-old man who was the driver of a car that lost control and crashed off the Bendigo-Maryborough Rd near the Bradford Road intersection in Shelbourne East. A directions hearing was held into this death on 26 June 2012 and investigations are continuing.

Pain management toxicity deaths

The investigation into the deaths of up to 12 people from drug toxicity relating to the management of chronic pain continued during the reporting period, with two inquests held by the court.

The first inquest held between January and March 2012 focused on the death of a 31-year-old woman who died from a combination of injuries she sustained during a fall in the shower and the medication she was given to manage her injury pain.

The second inquest, held in June 2012, focused on the death of a 45-year-old woman who died from an accidental overdose of pethidine medication she was prescribed to manage her pain from a recent surgery.

The coroner expects to be in a position to begin preparing her written inquest findings within the next financial year. In addition to these inquests, a number of the other drug toxicity and chronic pain management death investigations were finalised with findings without inquests.

The coroner will draw upon the information in those findings to assist her to develop comments and/or recommendations in her written inquest findings where there are common themes relevant to the circumstances in each of the deaths.

Family violence deaths

During the 2011-12 reporting period there were 66 suspected homicides reported to the court.

Preliminary investigations conducted within the reporting period by coroners into the circumstances of those deaths indicate 20 of those deaths appeared to have occurred within a context of family violence and a further 20 require additional investigation to provide more information about those involved in the deaths.

Apparent family violence related deaths reported to the court during the reporting period included:

Intimate partner deaths

1 July 2011 – A 48-year-old Donvale woman was found deceased in her home by neighbours with head trauma. Her ex-husband was subsequently charged with murder in connection to her death.

18 October 2011 – A 60-year-old Rye woman was found deceased in her home. Her male partner was subsequently charged with murder in connection to her death.

1 November 2011 – A 55-year-old Mulgrave woman died after sustaining gunshot wounds whilst standing in her driveway. Her ex-husband was subsequently charged with murder in connection to her death.

16 December 2011 – A 47-year-old Ashwood woman was found deceased in her home. Her husband was subsequently charged with murder in connection to her death.

26 December 2011 – A 55-year-old Bendigo man died after sustaining stab wound injuries. His female partner was subsequently charged with murder in connection to his death.

26 March 2012 – A 58-year-old Craigieburn man died after sustaining stab wound injuries. His female partner was subsequently charged with murder in connection to his death.

Child deaths

24 October 2011 – A 3-month-old infant boy died from injuries suspected to be non-accidental in nature while in the care of his parents. A criminal investigation remains ongoing into the circumstances of the death.

5 November 2011 – A 10-month-old infant girl died after being left in a hot car in the driveway of her Glenroy home by her mother. The infant's mother was subsequently charged with manslaughter in connection to the death.

26 April 2011 – An 8-week-old infant girl died from injuries deemed to be non-accidental in nature. The baby's mother was subsequently charged with murder in connection to the death.

Suspected other family violence related deaths

3 October 2011 – A 34-year-old Brooklyn man died from head injuries and his body was found in an industrial area in Brooklyn after police and fire fighters attended a report of a fire. The man's business partner was subsequently charged with murder in connection to the death. It is alleged the business partner suspected the man of having a relationship with his wife.

12 December 2011 – A 53-year-old woman died from injuries she sustained from multiple stab wounds. A female relative was subsequently charged with murder in connection to her death.

16 December 2011 – A Vermont South couple, a 58-year-old woman and a 65-year-old-man, died from injuries they sustained from multiple stab wounds. A male relative was subsequently charged with murder in connection to their deaths.

4 May 2012 – A 21-year-old Bundoora woman died from head injuries. The woman's mother-in-law was subsequently charged with murder in connection to her death.

Suspected homicide/suicides

1 May 2012 – A 36-year-old Glen Waverley man is suspected of taking his own life after killing his 35-year-old wife and two children, a boy aged five and a girl aged three.

1 June 2012 – A 37-year-old Clayton South woman is suspected of taking her own life after killing her two children, both boys, aged nine and five.

11 June 2012 – A 29-year-old Blackburn North woman is suspected of taking her own life after killing her partner, a 37-year-old man.

For further information on the Victorian Systemic Review of Family Violence Deaths and the work undertaken to assist coroners investigating these types of deaths see page 46.

Application to reopen investigation into the death of Jennifer Tanner

During the 2011-12 financial year, the court continued to receive information and material relating to three separate applications to set aside a previous finding and reopen the investigation into the deaths of Jennifer Tanner and Adele Bailey.

Jennifer Tanner died on 14 November 1984 at a property called 'Springvale' in Bonnie Doon, from injuries she sustained from two gun shot wounds to the head.

There have been two previous inquests into her death.

The first inquest, held on 11 December 1985, returned an open finding. In December 1996 the Supreme Court of Victoria ruled on an application made under the then *Coroners Act 1985* and made orders that the original finding be quashed and a new inquest held.

A second inquest was held by former State Coroner Graeme Johnstone over a series of sitting days between October 1997 and September 1998, and a new finding was handed down.

Between December 2009 and February 2010, the court received three separate applications to set aside the second finding of the former State Coroner and reopen the investigation into Jennifer Tanner's death.

In August 2011, current State Coroner Jennifer Coate made a ruling with respect to the application to reopen the investigation into the death of Adele Bailey, stating she was not satisfied based on the material submitted that there were new facts and circumstances connected to the death that would allow for the investigation to be reopened.

Under section 77 (3) of the *Coroners Act 2008*, a coroner may only reopen an investigation if he or she is satisfied that there are new facts and circumstances and that is appropriate to do so. The State Coroner anticipates holding a directions hearing in August 2012 to hear further submissions in relation to the remaining two applications.



Euthanasia investigations

In the 2011-12 financial year, the court undertook a number of investigations relating to the separate suicide deaths of people suffering from chronic or terminal illnesses, including:

- the death of an 89-year-old man
- the death of an 88-year-old woman
- the death of an 86-year-old woman
- the death of an 82-year-old woman
- the death of a 67-year-old woman
- the death of a 58-year-old man.

Investigations into the circumstances of the deaths have indicated there are a number of commonalities between the deaths including:

- the person was suffering from a chronic or terminal illness at the time of their death
- there was significant evidence of advance planning for the death
- three of the deaths involved the use of pentobarbitone, a known euthanasia drug
- the person's family, friends and/or doctor was aware of euthanasia plans in a general sense.

The investigations into these deaths will continue in the 2012-13 reporting period.

Take-away methadone deaths

During the reporting period, the court received an increasing number of deaths reported from acute methadone toxicity where the source of the methadone was a 'take-away' dose dispensed by pharmacists after being prescribed by doctors for the treatment of drug addiction.

In 2011 there were 72 deaths of this type reported to the court, an increase from 52 deaths in 2010. This represents a 35 per cent increase in a 12-month period.

Investigations into these deaths will continue during the 2012-13 financial year with a number of matters proceeding to inquest.

Issues likely to be examined by coroners include:

- risk management assessments undertaken by doctors and pharmacists when prescribing and dispensing take-away doses of methadone
- co-prescription of take-away methadone with other drugs
- current standards, policies, legislation and practices surrounding the prescribing and dispensing of take-away methadone.

Antibiotic complications

A coroner recommended improvements for prescribing strong antibiotics following an inquest into the May 2008 death of a 90-year-old woman.

She was admitted to a major hospital for surgery for a fractured elbow and pelvis following a fall but the surgery was postponed after she exhibited symptoms of a urinary tract infection. She was prescribed Gentamicin, a potent and potentially nephrotoxic antibiotic, to treat the infection and underwent surgery at a later date. However, after surgery, her health continued to decline and an investigation revealed she had died from renal failure secondary to Gentamicin for the treatment of urinary tract infection. The woman had compromised liver function and her body was unable to cope with the strength of antibiotic prescribed to her. Doctors incorrectly attributed the continual decline of her health to her age and a range of other underlying medical conditions, rather than the antibiotic.

The inquest highlighted the importance of clinicians taking the time to check the correct doses of Gentamicin and the need for accurate, standard and readily accessible information about Gentamicin to ensure effective prescribing and patient safety.

Developments in public health and safety

Elevating work platforms

In March 2012 a coroner delivered a finding without inquest following an investigation into the 2008 death of a 70-year-old painter who died from injuries he sustained when he was crushed between the work platform of a hired scissor lift he was operating, and a factory ceiling. The investigation identified operator error as the cause of the incident, although the coroner noted that the man had never acquired formal training in the use of the mobile elevating work platform. The investigation revealed that operators of similar work platforms had also died in comparable circumstances both in Victoria, interstate and abroad.

The coroner recommended that:

- Safe Work Australia expand the national standard for licensing persons performing high-risk work to include scissor lifts
- Elevating Work Platform Association of Australia emphasise the importance of plant-specific training to plant hirers
- WorkSafe Victoria conduct an education campaign to ensure that employers seek training for their employees.

WorkSafe Victoria subsequently advised the court in a response to the coroner's recommendations that an education campaign would be conducted to highlight the importance of adequate training, and would be directed at construction, maintenance and service industries.

Safe Work Australia also advised the court in its response that the coroner's recommendation would be considered as part of a broader legislative review, which will include the effectiveness of licensing and the classes of high risk work.

Fire safety messaging

An inquest into the death of a four-year-old Hampton boy who suffered extensive and fatal burn injuries after playing with matches in the family garage with his brother in April 2007 has highlighted the need for renewed fire safety messaging.

In delivering her finding in April 2012, the coroner made two recommendations including:

- that fire and child safety authorities give consideration to a public campaign reminding parents and householders of the need to review the safety of their household if young children are likely to attend the premises; and
- that fire and child safety authorities give consideration to a public campaign reminding parents and householders that matches and other fire lighting implements should be stored safely and out of the reach of young children.

The Office of the Child Safety Commissioner supported the recommendations made by the coroner and stated that it would be interested in leading or working on a collaborative project with relevant stakeholders to develop and implement a community education strategy designed to reduce the incidents of children being burnt as a result of playing with matches.

International visitors and road safety

The death of two international tourists in a fatal traffic collision highlighted the need for improved safety information for visitors intending to drive in Victoria.

The January 2010 death of a 62-year-old man and a 34-year-old woman occurred as they travelled along the Great Ocean Road in a hired passenger van with GPS navigation.

After several days of extensive driving, the GPS guided the vehicle onto a smaller network of roads for the shortest possible route to their designation.

It appears the driver lost his concentration and overcorrected the vehicle, causing it to roll several times. Of the seven occupants inside the van, two died and several others were injured.

Following an investigation into the circumstances of the deaths, the coroner made a number of recommendations to State and Commonwealth agencies regarding the availability and distribution of safety information to international visitors to Victoria.

The recommendations were accepted and resulted in the distribution of safety information, including indicative travel times between destinations, to international visitors arriving at Melbourne Airport.

Tourism Victoria also accepted the coroner's recommendations to establish a range of safety arrangements for international visitors to Victoria, including:

- the development of a comprehensive safety strategy for international visitors to Victoria, including an "all-hazards" approach, encompassing that of road safety
- Tourism Victoria, in conjunction with the fire service agencies and the Transport Accident Commission to produce a State map detailing key bushfire and road safety messages
- Tourism Victoria to recommend to the Australian Standing Committee on Tourism that the National Visitor Safety Program Working Group be reconvened to ensure visitor safety remains a priority for all jurisdictions.

Car door hazards for cyclists

A coronial investigation into the death of a 20-year-old cyclist resulted in a VicRoads safety campaign to educate car users to consider bike riders more carefully on Victorian roads.

The one-day inquest investigated the circumstances of a cyclist who was fatally injured after he struck an open car door and fell into the path of an oncoming truck.

This was the first reported cyclist "dooring" fatality in Victoria. The investigation found that the frequency of door collisions was increasing, with most incidents occurring in inner metropolitan areas. In her finding the coroner recommended that VicRoads:

- work closely with local governments to promote the reconfiguration of bicycle and parking lanes. One suggested means of achieving this was through the provision of guidance material to assist local governments in the identification of specific sites where such reconfiguration would be appropriate
- implement a communication campaign to educate motorists of the need to thoroughly check before opening their car door, and to increase awareness among cyclists of the need to remain vigilant when riding past parked cars.

In response to these recommendations, VicRoads advised that the next series of Cycle Notes (information bulletins on design standards for cycling infrastructure) will be based on treatments that provide cyclists with increased separation from motor vehicles.

VicRoads also developed a communication campaign for all road users regarding cyclists. One of its key messages was to educate motorists to look out for cyclists before opening their car door, and for cyclists to be aware of this risk. VicRoads is also working with the Road Safety Action Group Inner Melbourne to begin a targeted campaign aimed at drivers and cyclists that addresses the risks associated with open car doors.

The coronial investigation led to a greater awareness of the hazard that open vehicle doors can present to cyclists. The Road Safety Amendment (Car Doors) Bill 2012 was introduced into the Legislative Council in February 2012, proposing to increase the penalties associated with causing a hazard by opening a door of a vehicle. The Bill is currently under review by the Economic and Infrastructure Legislation Committee.

Heathmere Bus Crash

In the 2010-11 Annual Report the court reported on the investigation into the deaths of three people including a 20-year-old man, a seven-month pregnant 19-year old woman and her two-year-old daughter after a V/Line coach they were travelling in rolled over on the Princes Highway in April 2009. An inquest was held to investigate the contributing factors to the rollover and subsequent fatalities. Both adult passengers who died were found to have not worn their available seatbelt, while there was no suitable child restraint available for the two year old victim. The coroner determined that had all three passengers been properly restrained, the deaths may have been prevented.

The coroner subsequently made a number of recommendations for improving bus passenger compliance with seatbelt wearing requirements, monitoring such compliance, providing child restraints on coaches, and reviewing the road maintenance system with respect to road surfaces to ensure a best practice approach.

In response to these recommendations, VicRoads advised that it was reviewing its policies and processes for managing roadways with poor surfaces to develop a best practice system to minimise the risk of crashes, including in response to extreme weather events.

Transport Safety Victoria also advised that a workshop was held with key stakeholders to discuss the implementation of the coroner's recommendations. In addition, Transport Safety Victoria engaged a consultant to undertake a cost-benefit analysis for the provision of child restraints on long distance coaches. Transport Safety Victoria is now seeking submissions from key stakeholders before making a mandatory transport safety decision.

Prescription shopping

In August 2011, an inquest was held into the death of a 24-year-old Essendon man who died from the toxic effects of prescribed morphine and diazepam. The coronial investigation found that he had visited 19 different doctors and 32 different pharmacies in the three years leading up to his death.

The circumstances surrounding this death highlighted significant issues regarding the practice of prescription shopping, also referred to as “doctor shopping”.

Prescription shopping occurs when a person deliberately visits numerous doctors in order to obtain multiple prescriptions and frequents several different pharmacies in order to have those prescriptions filled. In most cases, the prescribing doctors and pharmacists are unaware of the person’s prescription shopping activities.

At the time the inquest was held, the court was investigating a further six apparent prescription shopping related deaths.

The investigating coroner requested the assistance of the Coroners Prevention Unit to consult widely with Victorian and Commonwealth government departments, peak medical bodies, the drug and alcohol sector, and other public health organisations with the intention of:

- outlining current prescription monitoring practices in Victoria
- examining existing shortcomings in existing monitoring practices and the way in which they are unable to identify and assist prescription shoppers
- discussing potential options for addressing these issues including a ‘real-time’ prescription monitoring program for Victoria; and
- proposing a draft recommendation and inviting interested parties to make submissions.

Following the inquest, the coroner made four recommendations to the Victorian Department of Health supporting a “real time” prescription monitoring system.

In its response to the court, the Victorian Department of Health indicated that it is now working in conjunction with the Commonwealth Department of Health and Ageing to deliver real-time prescription monitoring.

In the last decade, Victorian coroners have made seven previous recommendations calling for the introduction of a real-time prescription monitoring program to help prevent deaths from the abuse of prescribed medications.



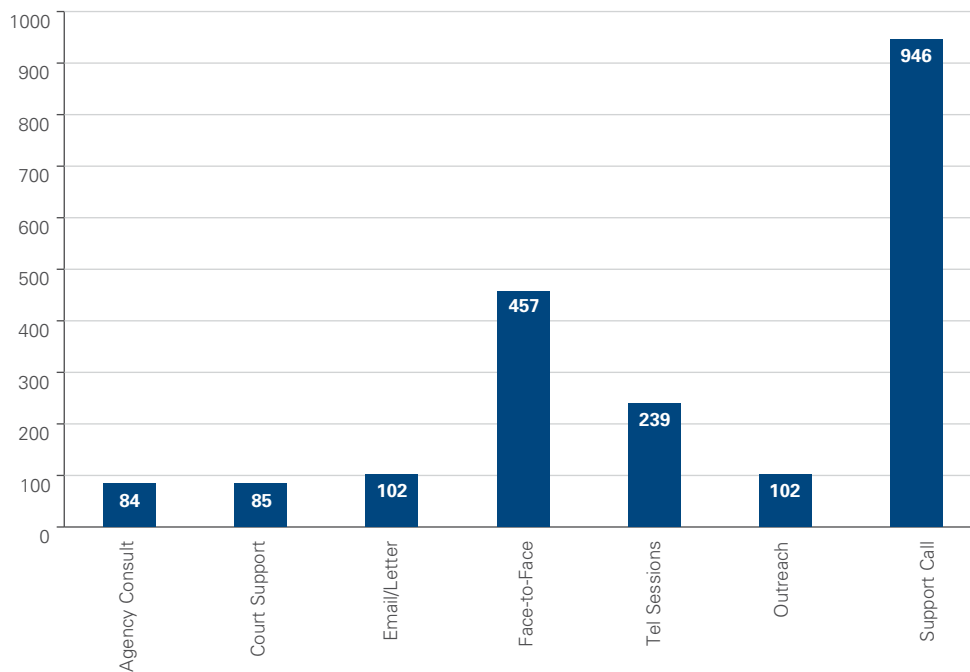
Engaging the community

Supporting bereaved families

In the 2011-12 reporting period the court's Family Community Support Service undertook significant counselling contacts to assist families and friends whose loved ones' death was being investigated by the court.

Counselling sessions 1 July 2011 – 30 June 2012 (Total number of sessions 1923*)

Session type: July 2011 – June 2012



* compared with 1370 for the 2010-11 reporting period

Community education

During the reporting period the Family Community Support Service (FCSS) continued its program aimed at educating students, social workers and medical and health professionals about the coronial jurisdiction.

In the period from September 2009, when statistics for the FCSS community education sessions were first recorded, to the end of the 2011-12 reporting year, the number of attendees increased by 284 per cent.

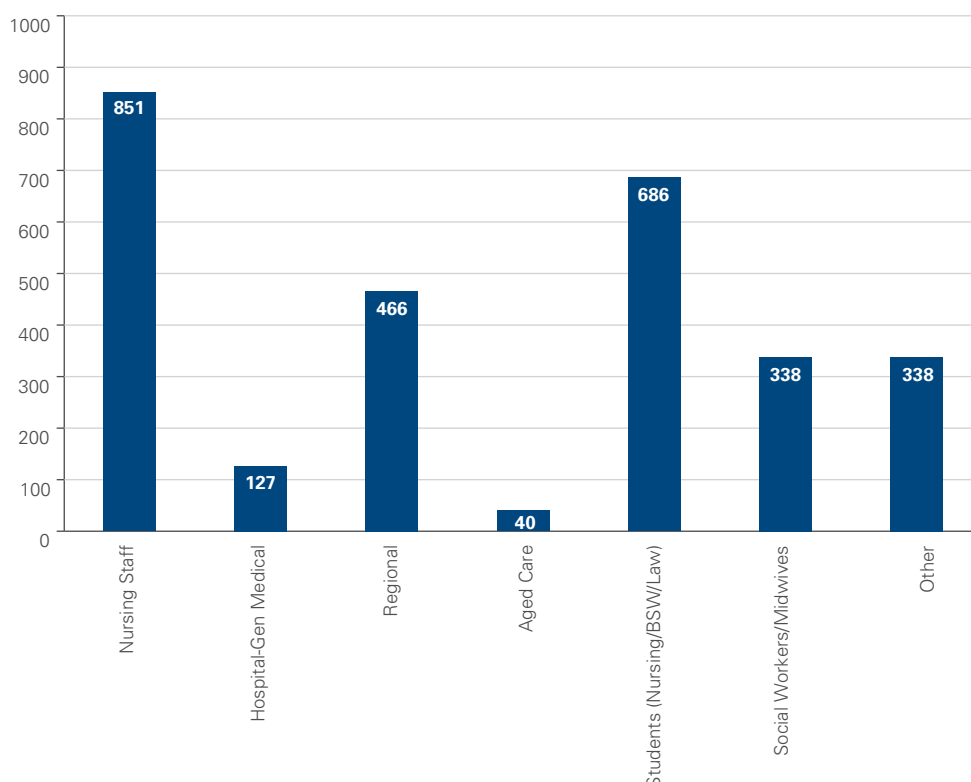
These education sessions, particularly in the wake of legislative reform, are critical to creating an ongoing understanding of the coronial jurisdiction and generating greater awareness of the legal obligations required of some professionals to report deaths to the court.

In the 2011-12 reporting period, 680 deaths were referred to the court by the Registrar of Births, Deaths and Marriages that the Registrar considered should have been reported by other parties such as doctors or nursing staff. These figures indicate that there is a significant lack of awareness as to what constitutes a reportable death under the Act, and the legal obligations of some professionals to report such deaths to the court. The community education sessions sought to address such knowledge gaps and ensure that all deaths defined as reportable are reported.

Unfortunately, the impact of the Sustainable Government Initiative has resulted in the FCSS having to completely suspend all community education sessions for the 2012-13 financial year.

Education sessions attendance (Total 2846 attendees*)

Community Education 2011 – June 2012 (by groups) Total: 2846 attendees



* Hospital General Medical includes doctors, nurses, other clinicians, quality & risk management officers, legal officers and senior hospital administrators

• Students include social work, psychology, nursing, health, medical and law students not yet graduated

• Regional includes education sessions delivered outside metropolitan Melbourne

• Aged Care includes aged care facilities and hospital-based outreach aged carers

Coroner presentations and committee membership

In addition to their work investigating deaths and fires, the coroners, in their role as judicial officers, made significant contributions to the community through conference presentations, membership of various committees and councils, assisting with the delivery of professional development programs by the Judicial College of Victoria, and mentoring law students and graduates. During the reporting period coroners participated in a wide range of activities, including those listed below.

Presentations at 27 conferences and other forums including:

- Judicial College of Victoria – Coroners Intensive
- Australian Medical Association Medico Legal Seminar
- Donate Life Network Meeting
- Parliamentary Road Safety Committee Inquiry into Motorcycle Safety
- Asia Pacific Coroners Conference
- State Conference of Court Network
- Legislative Council Committee Public Hearing on Organ Donation
- Exercise Hades – Emergency Services Exercise
- National Mental Health Commission Roundtable
- Royal Australasian College of Medical Administrators Webinars
- Senior Professional Women Seminar
- Coroners Court of Victoria Information Day ‘Coroner’s Role when Investigating Medical Deaths’
- Ramsay Health Post Anaesthetic Care Unit Conference
- AUSMED Conference ‘Nursing and the Law’
- Scientific Meeting for Emergency Medicine hypothetical scenario
- Coroners Court of Victoria education session ‘Aged and Palliative Care – The Role of the Coroner’
- Monash University Forensic Medicine Law Course

- School of Nursing – LaTrobe University
- Melbourne University – Law Masters
- Judge and Chair of Judging group for Victorian Healthcare Awards
- Palliative Care Certificate Course
- Victorian Association of Drink Driving services AGM
- Burke & Wills Mock Inquest
- Psychiatric Essentials lecture for Australian Medical Association
- Judicial College of Victoria Twilight Sessions
- Victoria Police Training for Regional Coroner’s Assistants

Membership of committees and councils, including:

- Coroners Education Steering Committee
- State Coronial Services Centre Redevelopment Steering Committee
- Courts Executive Services Steering Committee
- Victorian Institute of Forensic Medicine Council
- Australian Domestic and Family Violence Death Review Network
- Coronial Council
- National Coroners Information System Committee
- Victorian Institute of Forensic Medicine Ethics Committee
- Magistrates’ Professional Development Committee
- Transport Safety Implementation Group
- Australian Coronial Heads of Jurisdiction Committee
- Coroners Court of Victoria Research Committee
- Director on the Board of Family Life
- Donor Tissue Bank of Victoria
- Board of In-house Health Legal Counsels

Coroners professional education

In partnership with the Judicial College of Victoria, the court has continued its commitment to offering ongoing training, education and access to resources for coroners. Significant highlights of the reporting period include:

- a series of twilight education seminars accessible to regional coroners via video conferencing facilities
- key involvement of regional coroners in the organisation and presentation of twilight seminars
- an intensive workshop on Writing Coronial Findings to assist coroners in writing clear, concise and reasoned findings and recommendations
- a two-day intensive workshop as an ongoing professional development to coroners state wide
- publication and maintenance of a Coroners Bench Book to help coroners stay up-to-date with the latest developments in Australian coronial law
- monthly circulation of Coroners Prevention Unit research.

Coroners Prevention Unit presentations

Further to the court's contribution to reducing, preventable deaths and promoting public health and safety, the Coroners Prevention Unit participated in a range presentations and other community engagements including:

- Australasian College of Emergency Medicine – hypothetical: end of life in the Emergency Department
- St Vincents Hospital – intern medical education regarding reportable deaths
- Peninsula Health – Coroners process
- Health Legal Counsels Meeting – reportable deaths and death certificates
- Metropolitan Fire Brigade Products Forum – fire crews dealing with dangerous goods
- Asia-Pacific Coroners Society Conference, Queensland – Domestic and Family Violence Death Reviews: The Australian Context
- Annual General Meeting of the Mallee Sexual Assault Unit and the Mallee Domestic Violence Services, Mildura – The Victorian Systemic Review of Family Violence Deaths
- Northern Territory Domestic and Family Forum – Domestic and family violence death reviews in Australia
- 2012 International Conference on Law and Society, Hawaii – Domestic/family violence death reviews: An international comparative analysis of current models
- Hosting visit for the Northern Ireland Law Commissioner
- Attendance at the Interfaith Dinner at the Melbourne Magistrates' Court
- Radio 3AW medical segment – Coroners process



Website

Improvements to the court website continued during the reporting period. A new section called Family Violence Investigations allows findings related to family violence deaths to be singled out.

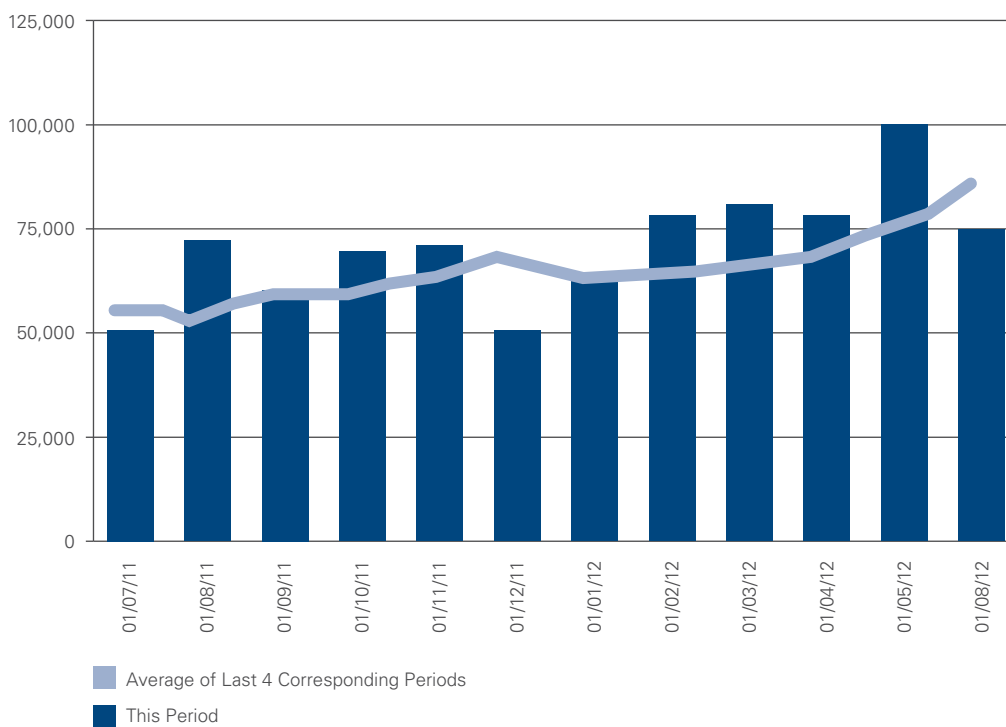
During the reporting period, 237 new findings and 30 new rulings were uploaded onto the court website.

The court has also continued work on a Virtual Tour of the Coroners Court of Victoria and expects this project to be completed within the next financial year.

Visits to court website

The below table indicates the number of visits (906,648) to pages on the court website during the reporting period. This is an increase of 43 per cent from visits to pages in the 2010-11 reporting period (631,987).

By month



* data collected by Neilson Net Ratings Statistics

Publications

During the reporting period, the court continued to provide access to information about the coronial process through the distribution of court publications.

The court disseminated 10,722 copies of its publications (compared with 8,448 in 2010-11) following requests from hospitals, police, courts, community workers, social workers and funeral directors. These distributions were in addition to publications normally provided by the court to families engaged in the coronial process, and to attendees of the court's Community Education sessions.

The table below provides a breakdown of different publications disseminated by the court during the reporting period.

PUBLICATION TITLE	NUMBER OF PUBLICATIONS SENT
<i>Access to Documents</i>	211
<i>The Coroners Process – Information for families and friends</i>	3142
<i>Family & Community Support Service</i>	3138
<i>What do I do now?</i>	3610
<i>Information for Health Professionals</i>	584
<i>Reporting Deaths (A4 sign for hospitals)</i>	21
<i>Legal Practitioners Handbook</i>	196
Total	10,902

List of publications

Important information about the coronial process is contained in nine publications and two booklets including:

- **Family and Community Support Services** – a brochure that details support and counselling services provided by the court
- **What do I do now?** – a brochure that provides information about what occurs when a death is first reported to the court, including the identification process and information about medical examinations required by the court
- **Inquest** – a brochure sent to families following a determination by a coroner that the investigation into their loved one's death will proceed to an inquest. This brochure outlines the purpose of an inquest and what families can expect to happen during an inquest.
- **Findings** – a brochure sent to families when a coroner is preparing to hand down a finding. The brochure contains information about what a coroner must include in a finding, the difference between a finding with inquest and a finding without inquest, as well as a person's right to object to a finding
- **Reviewable deaths** – a brochure containing information for families who have experienced the loss of a child where that death has been identified as a reviewable death that must be examined by a coroner
- **Disaster Victim Identification** – a brochure explaining the different phases involved in identifying persons who have died in circumstances where normal identification procedures (such as visual identifications) cannot be utilised
- **Coroners Prevention Unit** – a brochure providing information about the role and function of various research teams within the unit
- **Access to Documents** – a brochure advising the public and interested parties on how to gain access to coronial documents
- **Information for Health Professionals** – a publication with detailed information regarding the reporting obligations relevant to the health profession following the implementation of the *Coroners Act 2008*
- **Coroners Process – Information for Family and Friends** – a 58 page booklet providing detailed information about the coronial process from the time a death is first reported to the court to the time a coroner makes a finding
- **Coroners Court of Victoria – Legal Practitioners Handbook** – an 80 page publication that serves as a guide for legal practitioners operating within the coronial jurisdiction.

Research and prevention

The Coroners Prevention Unit (CPU) is a specialist service for coroners to strengthen the prevention role of the jurisdiction and provide coroners with assistance in investigations where improving public health and safety may be a consideration.

The CPU comprises case research investigators who gather and provide expert information on particular types of deaths including:

- Unintentional deaths – such as drownings, fires, electrocutions, transport-related fatalities and industrial fatalities
- Intentional deaths – such as suicides, homicides and mental health related deaths
- Health and medical related deaths – such as deaths occurring during or following a medical procedure where the death is, or may be, related to the procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur.

Since its establishment in October 2009, the CPU has contributed to 1106 coronial investigations. The demand for the services it provides is demonstrated by figures that indicate:

- between 2009 and 2010, there was a 377% increase in the number of referrals to the CPU for assistance
- between 2010 and 2011, there was a further 145% increase of referrals to the CPU for assistance
- as of 30 June 2012, the CPU has received 1106 requests for assistance since its commencement with 858 of those being completed and 248 either currently underway or awaiting further information.

The table below indicates the number of research and prevention referrals, projects and investigations completed and/or undertaken within the financial year.

CORONERS PREVENTION UNIT DATA	2009/10	2010/11	2011/12
Total referrals received by Coroners Prevention Unit	101	489	527
Referrals from metropolitan coroners	91	390	429
Referrals from regional coroners	3	61	55
Referrals from external agencies	7	17	29
Referrals from other business units within the court	~	21	14
Total referrals completed	76	265	372
Total referrals underway with expected completion in the next financial year	29	235	155

Research and Policy

The CPU also undertake specific and targeted projects; develops policies; capture, codes and analyse data; record and monitor coroners' recommendations and responses.

The Coroners Prevention Unit also completed a number of referrals received from external agencies during the reporting period including creating reports for several agencies including:

- Barrier Breakers Inc
- Country Fire Authority
- Australian Centre for Agricultural Health & Safety (University of Sydney)
- Life Saving Victoria
- Parliamentary Committee for Road Safety
- Victorian Department of Health
- Mental Health, Drugs and Regions Division, Department of Health
- Office of the Chief Psychiatrist
- Rail, Rail, Train, Bus Union – Locomotive Division
- Taxi Industry Inquiry
- Victoria Police
- VicRoads
- Victorian Attorney-General
- Victorian Drug and Alcohol Association
- Wesley Life Force
- Yarra Trams

Much of the information requested by external agencies relies on information that is coded by Coroners Prevention Unit staff after careful review and classification of the circumstances surrounding the death or fire reported to the court.

As a result of staff shortages due to the Sustainable Government Initiative, the CPU is now in the position where it must decline almost all external requests for information as its reduced resources mean it is working at full capacity just responding to requests from coroners in support of their investigations.

Coroners Prevention Unit investigations for coroners

The list below demonstrates the range and extent of investigations the unit has been requested to provide assistance with during the 2010-2011 reporting period.

Building and construction – touching upon issues relating to building approval processes and fatal falls through roofing material

Drowning – touching upon issues relating to children and backyard pools and spas, drowning in inland waterways, alcohol related drowning incidents, and incidents involving recreational water vessels

Fires – touching upon issues relating to power board safety, overloaded fuses, residential fires originating in bedrooms from electric blankets and smoke alarm installation

Product safety – touching upon issues relating to nursery furniture, appropriate child restraints and DIY activities on cars and the use of car jacks

Recreation – touching upon issues relating to paragliding safety, power boat racing, recreational go-karting safety, snow skiing and rockfishing

Transport – touching upon issues relating to fatalities involving buses, cyclists, motorcyclists, driver fatigue, quad bike safety, tractor roll-overs and fork lift related deaths

Work related – touching upon issues relating to ladder falls, tree-felling, construction collapse, helicopter wirestrike and hay baler deaths

Alcohol & drugs / poisoning – touching upon issues relating to prescription shopping, carbon monoxide poisoning, 'take-away' methadone deaths and combined drug toxicity

Suicide – touching upon issues such as jump from height, rail deaths, deaths occurring in psychiatric facilities and recent police contact prior to suicide

Legal intervention – touching upon issues relating to police deaths in custody and police pursuit deaths

Mental health review – touching upon issues relating to mental health inpatient supervision, complexities for treating dual diagnosis patients, aged psychiatry and absconding from voluntary and involuntary treatment facilities

Medical investigations – touching upon issues relating to septic shock, respiratory failure, asthma, pregnancy, births, blood loss, aspiration pneumonia, closed head injuries, infections, accidental falls and heart disease

Other – Autism and absconding, dog bites, unsupervised hunting deaths, nursing home deaths

Coroners Prevention Unit Collaborative Projects

In addition to completing internal and external investigative referrals, the CPU also undertook a number of collaborative research projects during the reporting period. Examples of such projects include:

Deakin University

Deakin University and the Coroners Prevention Unit have established a collaborative relationship with the primary aim of contributing to the reduction of preventable deaths and the promotion of public health and safety. Discussions with Faculty Heads is about to commence to identify areas of research that will primarily focus on patient safety, injury prevention and mental health.

The University of Melbourne

In 2009, the Coroners Court of Victoria and the University of Melbourne School of Population Health were awarded an Australian Research Council Linkage Grant for a three-year study titled: *Learning from preventable deaths: a prospective evaluation of the impact of coroners' recommendations in Victoria*. The primary aim of the three-year study is to evaluate the impact of legislative reforms requiring statutory authorities and entities to respond to coroners' recommendations.

Statutory authorities and entities that have responded to coroners' recommendations under the *Coroners Act 2008* have begun participating in the project via the completion of an electronic survey and face-to-face interviews. Data collection will continue into the 2012-13 period and preliminary results are due to be reported to the project's Advisory Group in early 2013.

Life Saving Victoria

In response to concerns that the true nature and extent of alcohol involvement among drowning deaths in Victoria was unknown, the CPU collaborated with Life Saving Victoria to examine unintentional drowning deaths over a nine-year period. Preliminary results of the study were released in November 2011. The study findings revealed that alcohol was present in 23% of all drowning deaths. Among those deaths where alcohol was present:

- 82% of the victims were male
- the greatest proportion of deaths occurred in those aged 35-44 years
- the deceased was most commonly swimming at the time of the incident
- deaths most often occurred in inland waterways, particularly rivers.

The study results will assist coroners and life saving agencies in better understanding the nature of the problem, and will provide an evidence base for the development of targeted prevention strategies for Victoria.

Prevention representations

The CPU also has representatives on the following boards and committees:

- Australian Injury Prevention Network – membership
- Deakin University – several CPU team members have visitor status with the University, some hold Clinical Lecturing positions and one is a Senior Clinical Lecturer. These positions are held in the School of Nursing, School of Medicine and School of Psychology.
- National Committee for Standardised Reporting of Suicide (convened by Suicide Prevention Australia) – membership
- Victorian Driveway Safety Working Committee – membership up until 18 April 2012
- Victoria Police Road Fatality Review Panel – observer status
- Department of Justice Family Violence Steering Committee – membership.

Victorian Systemic Review of Family Violence Deaths

Each year in Victoria, more than 40 per cent of all deaths attributed to homicide involve intimate partners and other family members. Many of these deaths feature a clearly documented history of family violence that precedes the fatal event. The Victorian Systemic Review of Family Violence Deaths (VSRFVD) was established to assist with the coronial investigation into the incidents. The VSRFVD has a prevention focus that is directed toward strengthening the response to family violence across the state.

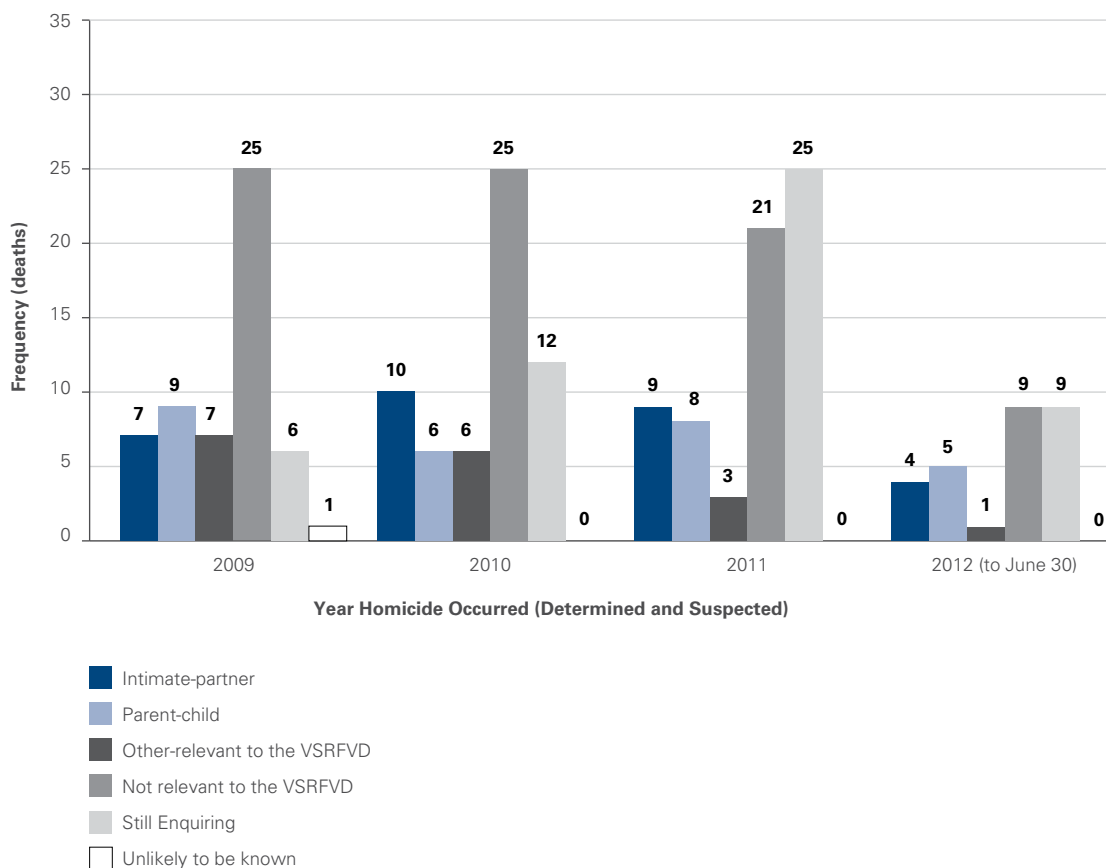
The figure below shows the preliminary classification of determined and suspected homicides reported to the court from 1 January 2009 to 30 June 2012. As at 18 September 2012, 75 (36.1%) of these 208 deaths, were classified as having an apparent relevance to the VSRFVD.

Of these:

- 30 were intimate partner homicides (40.0%);
- 28 were parent-child homicides (includes homicide of parents by children) (37.3%); and
- 17 were deaths that involved other familial relationships and/or occurred in a context of family violence (i.e. involving a bystander to family violence); (22.7%)

There were 80 determined and suspected homicides identified as not relevant to the VSRFVD, with 52 deaths requiring additional information for classification purposes.

This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs from the previous report (2010-2011) because of this re-classification process.



During the 2011-12 financial year, the VSRFVD provided 12 case review reports to coroners to assist with their investigation of family violence-related deaths. This involved the analysis of 18 deaths spanning from 2006 to 2011 involving infants, children, adults and older persons. Eight investigations of deaths of relevance to the VSRFVD proceeded to inquest during the reporting period. Relevant case findings are now centrally located on the court website, enabling public and professional access to this important information.

Two major presentations examining the contribution of family and domestic violence deaths reviews in Australian and international jurisdictions were provided to external audiences in May and June 2012. Members of the Coroners Prevention Unit attended the *Northern Territory Domestic and Family Forum* in Alice Springs and the *Law and Society Conference* in Hawaii, to describe how family violence prevention can be enhanced through the death review process (funding to attend these forums was provided from external sources).

In order to improve knowledge of service contact points for victims and perpetrators of family violence related-deaths, the Coroners Prevention Unit has recently embarked on a collaborative project with RMIT University. This will involve a retrospective analysis of intimate partner homicide deaths from 2000-2008, in order to map the history of service involvement and possible points of intervention. The project will also identify intimate partner homicides in which family violence was previously recorded, against those involving no known history of violence.

Intimate partner homicide – case example

The VSRFVD assisted the coroner with the investigation of an intimate partner homicide incident that occurred in 2008. This involved the death of a 45-year-old man who died from a single penetrating stab wound sustained during a family violence incident involving his female partner.

As part of the VSRFVD, a detailed case-review was prepared for the coroner. This included a chronology of events; the identification of relevant risk and contributory factors; and mapping important service contacts with the health-care and justice systems. At inquest, evidence was provided by an Applicant Support Worker from the Magistrates Court of Victoria.

The coroner made a detailed finding that highlighted areas for improvement within the justice system. Victoria Police agreed to make recommended updates to the Victoria Police Manual in order to clarify member responsibility in the area of family violence risk assessment and ensure referrals are made to relevant support agencies. Recommendations directed to the Department of Justice to extend the applicant support worker program to each Magistrates' Court in the state was not implemented due to resource constraints.

International collaborations

The VSRFVD and Associate Professor Myrna Dawson, University of Guelph, have engaged in a collaborative project to examine family violence death review processes around the world. Professor Dawson is a Canadian academic and a founding member of the Ontario Domestic Violence Death Review. This research will compare existing fatality reviews within international jurisdictions to highlight core functions and objectives, and identify key elements of best practice in this area.

Australia Domestic and Family Violence Death Review Network

The VSRFVD is a member of the Australia Domestic and Family Violence Death Review Network. In November 2011, the Network gave a joint presentation to the Asia Pacific Coroners Conference in Queensland. This provided information about the establishment and operations of domestic and family violence death reviews currently in operation in coronial jurisdictions throughout Australia.

Court administration

Compliments and complaints register

During the 2011-12 financial year, the court began utilising its new Relativity database to register feedback received by the court.

Relativity is a web-based information database that has been modified to include a register that records feedback from families and external stakeholders, as well as incidents that impact on service delivery.

In the 2011-2012 reporting period the court received:

- 99 compliments
- 45 complaints*
- 21 service delivery issues*

* complaints and service delivery issue figures capture reports of gaps or failures in processes and includes reports and complaints about services outsourced by the court as part of the coronial process, such as work undertaken by funeral directors, police and the Victorian Institute of Forensic Medicine

Coronial reform post-implementation review

During the reporting period, KPMG was engaged to complete phase two of a post-implementation review.

This review was undertaken following major reform within the Victorian coronial jurisdiction following the introduction of the *Coroners Act 2008* on 1 November 2009. The new Act established the court as an inquisitorial court separate from the Magistrates' Court, and introduced a raft of changes to the way the work of the court was administered.

Phase two of the post-implementation review specifically involved:

- a cost and activity analysis and benchmarking for the purposes of cost base assessment
- a detailed analysis of workflow and business processes throughout the court, and
- the establishment of a performance measurement and monitoring framework consistent with the International Framework for Courts Excellence.

Some of KPMG's key findings included:

- Despite having a persistent structural deficit, the court's cost per finalisation compares favourably with comparator jurisdictions and it delivers more services than other coronial jurisdictions, with no other jurisdictions operating a 24-hour Initial Investigations Office, a Family and Community Support Service and a Coroners Prevention Unit
- The cost of transporting deceased persons for coronial investigations has escalated to approximately 18 per cent of total expenditure for the court due to the closure of regional forensic pathology services and lack of a competitive market
- While the court has a number of opportunities to improve its financial performance and move to a balanced budget, the benchmarking analysis and the analysis of major cost categories suggest that the court's recurring budget deficits reflect an inadequate funding base rather than any deficiencies in financial management
- Opportunities exist to improve the efficiency of the court by introducing a suite of changes centred on proactive end-to-end case management, case triaging, a reduction in duplication, and better quality control
- The organisational structure and working practices are not well aligned with the statutory responsibilities assigned under the *Coroners Act 2008*
- Developing formal service level agreements with the Victorian Institute of Forensic Medicine and Victoria Police would ensure that the manifestation of legislative responsibilities in day-to-day practice are documented and understood by all parties, and that performance requirements are understood and measured.

KPMG has made a number of recommendations in relation to these findings that are currently being assessed by the court and the Department of Justice.

Deceased transportation services

Under the *Coroners Act 2008*, a deceased person whose death is reportable is taken into the care of the coroner while medical examinations are undertaken as part of the investigation into the death.

The court is therefore charged with the responsibility of removing and transferring deceased persons from the place of death (where that death occurs anywhere in the State) to a coronial mortuary, and engages external contractors, usually private funeral directors, to provide this service. There are currently 36 separate contractors (one metropolitan and 35 regional) providing this service.

As reported in the 2010-11 Annual Report, the cost of deceased persons transportation continues to have a significant impact on the court's operating budget.

In February 2011, the court sought tenders for a new contract for the removal and transfer of deceased persons under a prime service provider model, however, no successful applicant was identified during the tender process. In January 2012, contracts with current deceased transfer contractors were extended for a further 12-month period, starting on 1 March 2012 and concluding on 28 February 2013, with two optional six-month extension periods.

The Department of Justice's Major Procurement Program Office is continuing to work with the court to examine service delivery options beyond the contract extension period.

Transcripts

In the 2010-11 financial year, the court reported significant delays in receiving transcripts of court hearings from the Victorian Government Recording Services (VGRS) and indicated it was working with VGRS to improve the situation.

In the 2011-12 financial year, the court is pleased to report a considerable improvement in the receipt of transcripts for court hearings and sincerely extends its appreciation to VGRS staff who have consistently worked with the court to reinforce and further refine service delivery parameters.

Discussions between VGRS and the court established an acceptable transcript receipt turnaround to be 14 business days. The court is pleased to report this objective has been met, with 265 transcripts received by the court during the reporting period in an average turnaround time of 8-10 business days. The shortest turnaround period for transcripts was two days and the longest period was 141 days.

Records management

The court receives many requests for access to information and documents contained within coronial files. As such, the court has a Records Management team to track, coordinate and manage these requests, including liaising with the Public Records Office of Victoria.

During the reporting period, the court received an estimated 2800 requests for access to coronial documents. Of these, 1000 were requests from external agencies and 1800 were requests initiated by court staff.

In addition to actioning these records requests, throughout the reporting period Records Management undertook the significant task of electronically scanning 18,000 court files from records dating from 2008 to the first half of 2011.

Many of these electronic records will be uploaded into the new CourtView system within the next financial year, enabling more efficient access to coronial information for court staff.

It is anticipated that such access will notably decrease costs incurred by the court in having to recall, store and courier hard copy files to and from the court.

Finances

Overview

In the 2010-11 Annual Report, the court highlighted a number of cost pressures that placed considerable burden on its operating budget.

During the current reporting period the Department of Justice allocated additional funding of \$1.283 million to the court to cover the escalating costs of the retrieval and transportation deceased persons. However, many of the other cost pressures facing the court continued during the reporting period and remained unresolved at the end of the period.

Early in the reporting period, following receipt of the preliminary findings from stage two of the KPMG post-implementation review referred to on page 48, and after extensive consultation with KPMG and with senior officers in the Department of Justice, the court prepared a draft proposal for a comprehensive organisational re-design.

This proposal was aimed at addressing many of the issues raised in the KPMG review, as well as the implementation of significant cost reduction strategies. It included a new organisational structure to better support the court's work, the introduction of more efficient case management processes, the redistribution of some internal resources, a carefully planned process to reduce net staffing numbers, a reduction in contractor expenses, and the ongoing in-sourcing of legal assistance for coroners.

However, in December 2011, before this proposal could be formally submitted to the Department of Justice for approval, the Sustainable Government Initiative (SGI) was implemented, which immediately placed very different priorities onto the court. While the court's redesign proposal has since been adapted to take the SGI into account and has been presented to the Department for consideration, it has not been approved or implemented. The focus of the court since December 2011 has been to minimise the impact of staffing losses associated with the SGI in order to ensure continuity of its front-line service delivery.

The average full time equivalent table on this page outlines the court's staffing as at 30 June 2012 indicates the impact of the SGI on the court. Unfortunately, as noted elsewhere in this report, as a result of staffing cuts the court has had to reduce the delivery of some key services deemed to be important but not critical, such as its counselling service, its community education program and its provision of coronial data to key external stakeholders. In addition, as noted in the following section under the heading 'Statistics and reports – operational', the court's ability to manage its heavy workload has been impacted, as indicated by the drop in its case clearance rate from 115 percent in 2010-11 to 98 per cent in 2011-12.

The issue of appropriate resourcing for the court following the implementation of major reform in recent years, involving a significant increase in workload, remains a major challenge for the court and for the Department of Justice, and it is hoped that this matter can be addressed during the upcoming reporting period.

Average full time equivalent as at June 30 2012

	SPECIAL APPROPRIATION	BASE BUDGET	ERC FUNDED	BUSHFIRE FUNDED	APPROVED – NOT FUNDED*	TOTAL
Judicial Officers	9.5	-	-	-	-	9.5
Ongoing staff	-	24	10.0	-	17.8	51.8
Fixed-term staff	-	2.0	-	7.0	0.7	9.7
Total Average FTE	9.5	26	10.0	7.0	18.5	71.0

* compared with a total staffing of 78.4 average full-time equivalent as 30 June 2011



Court's financial position

At the close of the reporting period, the court was provided with a summary of its financial position by the Department of Justice. This summary concluded that the court recorded a deficit of \$1.248 million. More than half of this deficit is attributed to costs incurred by the court for external legal counsel, and medical and expert opinion expenses.

The court now understands that the notional amount budgeted by the Department for these expenses was just \$121,200. This figure was reached without reference to the actual cost of these services to the court demonstrated over a number of years. In this reporting year, the actual cost to the court for these services was \$970,347, resulting in the court recording an \$849,147 deficit. This method of budget allocation will continue to result in a "deficit" being recorded as during the past three financial years, these costs to the court have not been below \$600,000.

Other items that contributed to the court's General Appropriations deficit included the cost of reimbursing lay witness who incurred loss of earnings or other expenses as a result of being required to attend court to give evidence during an inquest. The notional amount budgeted by the Department to this court, which held 148 inquests in the financial year was \$4900. The actual cost to the court's budget for this reimbursement of witnesses was \$36, 200, resulting in the court recording a deficit of \$31, 300.

The annual budget afforded to the court by the Department and the method of striking the budget, requires serious examination. The court requires a realistic budget that reflects both its past and predicted expenditures if it is to continue to provide the Victorian community with the services required of this unique inquisitorial jurisdiction.

Financial Statement

Comprehensive operating statement for the financial year 2011- 2012

	NOTES	2008-09	2009-10	2010-11	2011-12
Income from transactions					
Output Appropriation*		8,188,700	8,469,100	8,731,700	10,087,600
Special Appropriation**		2,222,000	2,320,000	2,427,000	3,182,600
Other income		-	-	(317)	
Total Income		10,410,700	10,789,100	11,158,383	13,270,200
Expenses from transactions					
Employee benefits	Note 1	5,395,337	6,907,580	7,948,768	8,597,502
Depreciation and Amortisation		410,219	418,255	421,405	93,465
Interest expense		2,167	3,504	2,974	2,722
Grants and other transfers	Note 2	-	27,572	32,610	34,114
Supplies and Services	Note 3	2,215,838	1,977,645	3,262,224	3,839,448
Deceased removal and transfers	Note 4	1,737,021	1,441,018	2,080,571	1,932,225
Total Expense from transactions		9,760,583	10,775,574	13,748,552	14,499,476
Net result from transactions (net operating balance)		650,117	13,526	(2,590,169)	(1,229,276)
Other economic flows					
Other gains (losses) from other economic flows	Note 5	(5,444)	(550)	(760)	(19,307)
Total other economic flows included in net result		(5,444)	(550)	(760)	(19,307)
Net Result***		644,673	12,976	(2,590,929)	(1,248,583)

* The court received an additional \$1.283 million to assist with deceased persons transport costs. Extra funding was also allocated for rent and indexation related to the Southbank redevelopment.

** Special appropriations related to some coroners was previously allocated to the Magistrates' Court and is now allocated to the Coroners Court of Victoria.

*** At the close of the reporting period, the court requested the Department of Justice conduct a review of its financial statements. This review showed that funds previously recorded against the court as a deficit were allocated incorrectly. The court has addressed these in the 2011-12 reporting period, and as a result the deficit shown against the court is less than previously reported.

Note 1 – Employee benefits

See Average fulltime equivalent table on page 50.

Note 2 – Grants and other transfers

Grant Payment to the University of Melbourne working collaboratively with CPU on a project partially funded by the Australian Research Council (ARC): "Learning from Preventable Deaths: A prospective evaluation of reforms to Coroner's recommendations powers in Australia".

Note 3 – Supplies and Services

	2008-09	2009-10	2010-11	2011-12
Contractors and consultants	209,557	676,447	838,662	865,186
Legal Professional Services	660,112	583,567	1,225,705	941,878
Medical Professional Services	37,249	78,212	149,983	28,469
Information Technology	93,239	148,121	163,409	97,819
Printing and Stationery	335,123	143,420	201,418	166,479
Postage and Communication	137,823	105,424	165,976	172, 865
Travel and Personal Expenses	63,926	70,046	51,015	44,400
Staff Training and Development	25,132	57,989	47,384	33,662
Witness Expense	19,460	42,782	36,492	36,199
Other Operating Expense	634,216	71,637	382,180	1,452,491
Total Supplies and Services	2,215,838	1,977,645	3,262,224	3,839,448

Note 4 – Removal and Transfer of deceased persons from place of death to coronial mortuary

	2008-09	2009-10	2010-11	2011-12
Metropolitan areas	644,704	385,683	749,851	687,597
Regional areas	1,092,317	1,055,335	1,330,720	1,244,628
	1,737,021	1,441,018	2,080,571	1,932,225

Note 5 – Other gains(losses) from other economic flows

Net gain/(loss) from the revaluation of long service leave liability due to changes in assumptions.

Statistics and reports – operational

Case initiations and closures

	2008-09	2009-10	2010-11	2011-12
Cases Opened	6341	5311	4857	5029
Cases Closed	4728	5573	5586	4949**
Case clearance rate (cases opened/cases closed)	75%	105%	115%	98%*
Number of cases referred to the court by the Registry of Births, Deaths and Marriages	787	742	657	680

* The court's clearance rate has dropped below 100% as a result of staffing reductions associated with the SGI. The clearance rate is an indicator of the court's operational efficiency and its backlog. If a court has a rate of 100 per cent it indicates it is breaking even in terms of managing its workload. If the finalisation rate is greater than 100 per cent it means the court is managing its existing workload and addressing its backlog. If the finalisation rate is less than 100 per cent, it means the court is getting behind in its workload and adding to its backlog.

** Of the total cases closed, 329 did not result in a formal finding being made by a coroner, although often still required a considerable level of investigation by the court. These include deaths where a coroner made a determination that the death was not reportable and subsequently discontinued the investigation under Section 16 of the Act. The figure also includes remains found to be non-human and reviewable death investigations that have already been completed.

Case progress

From the date of initiation to the end of the financial year

	2008-09	2009-10	2010-11	2011-12
0-12 months	4034	3001	2263	2908
12-24 months	1254	1558	850	845*
> 24 months	340	1027	1396	1203*
Total number of lodgements pending	5628	5586	4509	4956

* 192 of the cases aged 12 months and greater in 2011-12 cannot be actioned as they are currently the subject of police criminal investigations or court proceedings in other jurisdictions. As such, the coronial investigations are suspended until the police investigation and/or other court proceedings are complete. The figure for cases that cannot be actioned due to involvement with other jurisdictions is likely to be much higher than reported in this note, however these cases were not able to be identified during the initial implementation of CourtView. This has since been rectified and the court anticipates being able to report this number more accurately within the next financial year.

Objections to autopsy

	2009-10	2010-11	2011-12
Objections upheld	285	61	45*
Objections refused	84	70	51*
Objections withdrawn	41	16	18*
Total number of objections	410**	147	114*

* These figures do not include all objections to autopsy in regional Victoria

** Total figures in the 2009-10 reporting period include 282 objections made under the previous *Coroners Act 1985*

Findings

FINDINGS INTO DEATH WITH INQUEST	FINDING INTO FIRES WITH INQUEST	FINDING INTO DEATH WITHOUT INQUEST	FINDING INTO FIRES WITHOUT INQUEST	TOTAL
182	0	4437*	1	4620

* Finding into Death Without Inquest includes 2089 Form 3 natural causes deaths.

Coronial recommendations

Total recommendations

Of the 4620 findings made by coroners during the reporting period, 78 contained recommendations. A coroner can make more than one recommendation in a single finding. The table below indicates the total number of recommendations made by coroners during the reporting period.

	RECOMMENDATIONS FROM FINDINGS HANDED DOWN UNDER THE CORONERS ACT 1985		RECOMMENDATIONS FROM FINDINGS HANDED DOWN UNDER THE CORONERS ACT 2008		TOTAL NUMBER OF COMBINED METRO AND REGIONAL RECOMMENDATIONS
	METRO	REGION	METRO	REGION	
Total number of recommendations made 2009-10	91	17	46	5	159
Total number of recommendations made 2010-11	8	-	100	36	144
Total number of recommendations made 2011-12	-	-	179	38	217

Responses to recommendations

The table below indicates the number of responses to recommendations received by the court during the reporting period.

	RECOMMENDATIONS CONTAINED IN FINDINGS HANDED DOWN UNDER THE CORONERS ACT 1985	RECOMMENDATIONS CONTAINED IN FINDINGS HANDED DOWN UNDER THE CORONERS ACT 2008	TOTAL NUMBER OF RESPONSES RECEIVED
Responses to recommendations received	-	90*	90*

* Some responses received relate to recommendations made during the 2010-11 reporting period. Also, the figures do not include required responses to recommendations made during the 2011-12 reporting period that were not due within the same reporting period

Court locations

CORONERS COURT OF VICTORIA

Level 11, 222 Exhibition Street
MELBOURNE
Ph 1300 309 519
Fax 1300 546 989

ARARAT LAW COURT

Cnr. Barkly & Ingor Streets
PO Box 86
ARARAT 3377
Ph 5352 1081
Fax 5352 5172

BAIRNSDALE LAW COURT

Nicholson Street
PO Box 367
BAIRNSDALE 3875
Ph 5152 9222
Fax 5152 9299

BALLARAT LAW COURT

100 Grenville Street South
PO Box 604
BALLARAT 3350
Ph 5336 6200
Fax 5336 6213

BENDIGO LAW COURT

71 Pall Mall, PO Box 930
BENDIGO 3550
Ph 5440 4140
Fax Office 5440 4173
Court Coordinator:
Ph 5440 4110

CASTLEMAINE LAW COURT

Lyttleton Street
PO Box 92
CASTLEMAINE 3450
Ph 5472 1081
Fax 5470 5616

ECHUCA LAW COURT

Heygarth Street
PO Box 76
ECHUCA 3564
Ph 5480 5800
Fax 5480 5801

GEELONG LAW COURT

Railway Terrace
PO Box 428
GEELONG 3220
Ph 5225 3333
Fax 5225 3392

HAMILTON LAW COURT

Martin Street
PO Box 422
HAMILTON 3300
Ph 5572 2288
Fax 5572 1653

HORSHAM LAW COURT

Roberts Avenue
PO Box 111
HORSHAM 3400
Ph 5362 4444
Fax 5362 4454

KERANG LAW COURT

Victoria Street
PO Box 77
KERANG 3579
Ph 5452 1050
Fax 5452 1673

KYNETON LAW COURT

Hutton Street
PO Box 20
KYNETON 3444
Ph 5422 1832
Fax 5422 3634

LATROBE VALLEY LAW COURT

134 Commercial Road
PO Box 687
MORWELL 3840
Ph 5116 5222
Fax 5116 5200
Court Coordinator:
Ph 5116 5223

MARYBOROUGH LAW COURT

Clarendon Street
PO Box 45
MARYBOROUGH 3465
Ph 5461 1046
Fax 5461 4014

MILDURA LAW COURT

Deakin Avenue
PO Box 5014
MILDURA 3500
Ph 5021 6000
Fax 5021 6010

PORTLAND LAW COURT

67 Cliff Street
PO Box 374
PORTLAND 3305
Ph 5523 1321
Fax 5523 6143

SALE LAW COURT

Foster Street
(Princes Highway)
PO Box 351
SALE 3850
Ph 5144 2888
Fax 5144 7954

SHEPPARTON LAW COURT

High Street
PO Box 607
SHEPPARTON 3630
Ph 5821 4633
Fax 5821 2374

STAWELL LAW COURT

Patrick Street
PO Box 179
STAWELL 3380
Ph 5358 1087

ST ARNAUD LAW COURT

Napier Street
ST ARNAUD
(C/- PO Box 17)
St Arnaud 3478)
Ph 5495 1092

SWAN HILL LAW COURT

Curlewis Street
PO Box 512
SWAN HILL 3585
Ph 5032 0800
Fax 5032 0888

WANGARATTA LAW COURT

Faithfull Street
PO Box 504
WANGARATTA 3677
Ph 5721 0900
Fax 5721 5483

WARRNAMBOOL LAW COURT

218 Koroit Street
PO Box 244
WARRNAMBOOL 3280
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CORONERS COURT OF VICTORIA

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