



# Coroners Court of Victoria

## 2009–10 annual report

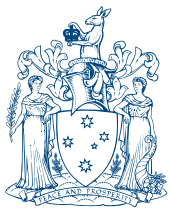




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## Coroners Court of Victoria

10 September 2010

The Honourable Rob Hulls  
Attorney-General  
1 Treasury Place  
Melbourne 3000

Dear Attorney General,

In accordance with the requirements under Section 102 of the *Coroners Act 2008*, I am pleased to present the inaugural annual report of the Coroners Court of Victoria. The report sets out the court's functions, duties, performance and operations during the year under review from 1 July 2009 to 30 June 2010.

Yours sincerely

A handwritten signature in black ink, appearing to be 'J. Coate', written over a horizontal line.

Judge Jennifer Coate  
State Coroner



## Report from the State Coroner

I am pleased to have the opportunity to provide the inaugural annual report on the operation of the Coroners Court of Victoria pursuant to the new *Coroners Act 2008*.

This report sets out a brief background to the former State Coroners Office, the development of the new *Coroners Act 2008*, the structure and organisation of the new Coroners Court and the range and depth of activities that have been undertaken during the reporting period.

The report also provides an opportunity to assist the community to better understand the purpose and work of their court.

The new Coroners Court of Victoria was established on 1 November 2009 by operation of the *Coroners Act 2008*.

Prior to the new Act, the work of the State Coroner's Office was reported upon in one or two pages of the Annual Report of the Magistrate's Court of Victoria. Whilst this reporting mechanism made sense, given that the work of the coroner was largely being performed by magistrates, given the number of jurisdictions covered by the Magistrate's Court, it did not provide the opportunity to report on the extensive activities of this jurisdiction.

I take this opportunity in this first Annual Report to pay tribute to the two previous State Coroners, His Honour Mr Hal Hallenstein and His Honour Mr Graeme Johnstone. Both men brought passion and dedication to the Office and both have left a considerable legacy of practice wisdom upon which the jurisdiction has been able to grow and develop in their wake.

I took up appointment as the State Coroner in November 2007. The redevelopment of the jurisdiction was underway and the *Coroners Act 2008* was gaining shape. The new Act received Royal Assent on 11 December 2008 although it was planned not to become operational until 1 November 2009, to allow the necessary time for preparation for implementation.

The developing of the new Act has been an enormous amount of work which has been achieved by a combination of the Department of Justice Legal and Policy team at the Courts and Tribunals Unit and in particular Stephen Lodge, Sarah Gebert and Janti Lakusa and our own Martin Botros and Dheepna Benoit.

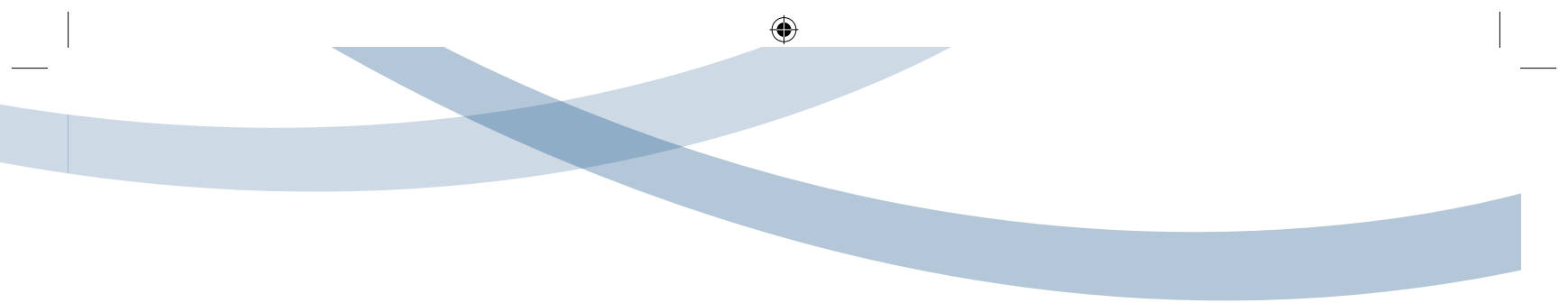
The redevelopment of the jurisdiction has included a new and expanded family contact service to provide counselling and support to those affected by deaths reported to the coroner. It has also included the new Coroners Prevention Unit established towards the end of 2008 to assist and support the coroners in their investigations and prevention role. It has also included a program of on-going professional development state-wide for coroner's registrars and coroners. The Judicial College of Victoria has been very active in its support of the court. It has almost completed the writing of an on-line Coroner's Bench Book, together with the implementation of a range of other professional development programs including both full day and residential programs for coroners across the state.

At the end of 2008, given the amount of change being undertaken, we were aware that 2009 would be a very challenging year.

We had a new Act requiring the development of court rules, forms, new procedures, a modernising and up-dating of our web-site, massive changes to our outdated IT systems, staff and coroner training across the state together with training and information packages to a large array of user groups to prepare for November 1. We were also facing a temporary re-location of the State Coroner's Office to enable a significant building redevelopment of the Coronial Services Centre at Southbank. We had commenced an administrative review of the structure of and intersection between each of the agencies co-located at Southbank, being the Victorian Institute of Forensic Medicine and Victoria Police performing work on behalf of the coroner.

It was in this context, that we experienced the period of extreme heat at the end of January and beginning of February 2009, which resulted in a significant increase in the number of deaths reported to the coroner.

On the 7 February 2009, the catastrophic events of Black Saturday sent our State into shock, creating unprecedented demand on our office and those that work with us.



As the full horror of what happened on that day unfolded publicly in the days and weeks after that, we looked to each other for comfort and reassurance on a human level but also for strength and professionalism to do the grim work the grief stricken families and our community needed us to do in the wake of this catastrophe.

During the months that followed, we experienced the extraordinary generosity of families who had lost loved ones in circumstances other than the fires, expressing reluctance to disturb us or add to our burden as they saw it, despite their own losses.

Our staff cut holidays short to return to work and returned from courts to which they had transferred. Staff worked hours beyond expectations keeping the daily operations going including our receptionists and counsellors who kept our reception and counselling lines open until 9pm each night of the week trying to help and support those that needed it.

Magistrates across Victoria assisted generously with our daily work and offers of assistance came in from coroners around the nation and from New Zealand.

We were overwhelmed with offers of assistance from senior staff inside the Department of Justice who helped us gather and do what we needed. Mr John Griffin, the Executive Director of Courts provided his personal staff for some weeks to assist us.

There were hundreds of members of Victoria Police who performed our work in dozens of locations across the state as well as inside the Coronial Services Centre at Southbank. There were police who came from all over Australia and New Zealand trained in the work necessary to be performed during that period. Similarly, the Victorian Institute of Forensic Medicine provided outstanding scientific expertise and knowledge to both the police and the coroners during that time and were assisted by scientific experts who came from around the nation and New Zealand.

There is still much to be said and written and thought about in the wake of Black Saturday in our State. In the meantime though, I can only express my deepest gratitude to all of those for their contribution during this harrowing and tragic time.

My thanks also to Professor Stephen Cordner and the members of the Victorian Institute of Forensic Medicine without whom we could not perform our work and to the police in our Police Coronial Support Unit and to all of those members of Victoria Police who provide investigative support to us.

I would like to take this opportunity to acknowledge our staff generally. Many of them are required to deal so directly with the distressed families who come into our jurisdiction. It can be such difficult work, which they endeavour to perform with both compassion and professionalism.

I wish to record my gratitude to our CEO Judy Leitch who has lead the administration of the court with distinction.

I also wish to acknowledge the Deputy State Coroner Iain West who has given so many years of dedicated service as a coroner and is rightly much respected and admired both inside and outside our court, and whose assistance and support has been invaluable to me.

As coroners, we work daily in the face of huge sadness, tragedy and loss. We work under the strain of ever growing case loads. We have and will continue to search for answers for bereaved families needing to understand what has happened. We have and will continue to search for ways to reduce the number of preventable deaths and fires in our community and improve systems of public health and safety by using the powers vested in us and the resources made available to us.

**State Coroner**  
**Judge Jennifer Coate**

# Report from the CEO

It is with pleasure that I report on the administration of the Coroners Court of Victoria, which as noted in the State Coroner's report, was established on 1 November 2009. This is the court's first Annual Report. It is an important document that ensures accountability of the court to the Victorian Parliament, to those Victorian families who through tragedy and loss find themselves involved in our jurisdiction, and to the general public.

The establishment of this court as a specialist inquisitorial court is the culmination of a period of major reform of the former State Coroner's Office driven by a review of the *Coroners Act 1985* by the Victorian Parliament Law Reform Committee, which reported to Parliament in September 2006. The establishment of the court is also a foundational milestone underpinning ongoing reform of the coronial system in this State.

The reform has been particularly focussed on strengthening the role of the coroner in reducing preventable death and on better meeting the needs of grieving families whose deceased loved ones come into the care of the court.

In terms of court administration, the ongoing reform also aims to address some significant business risks. These administrative reforms include putting into place mechanisms to optimise the performance of our service providers, replacing the court's obsolete information technology system so that for the first time the court can gain control of its own data, and improving the court's business infrastructure, in particular its emergency response capability and its capacity to respond to unexpected surges in demand.

Implementing the reforms has been challenging, particularly as other extraordinary demands have confronted the court at the same time, such as the Black Saturday bushfires, and the need to temporarily relocate the court to enable the redevelopment of our Southbank site. However, court staff have demonstrated a remarkable ability to rise to the challenge and have also demonstrated an ongoing and steadfast commitment to the families and communities we serve.

Given the significance of the reform process, it is appropriate and now timely to plan a review of the reforms implemented to date. Such a review will be undertaken in the upcoming year and will assess the impact and outcomes of the reform process, with the aim of ensuring that the way we are now undertaking our work is as efficient and effective as possible.

This report provides an overview of the activities undertaken in this jurisdiction during 2009–2010, a watershed year in terms of the reform process. It has been a pleasure to be responsible for the administration of the court during this period and I am hopeful that our services will continue to improve as we review the changes we have made.

I would like to thank our staff sincerely for the extraordinary effort they have made during the period, and for the professionalism and compassion they offer the distressed families we work with. I would also like to thank State Coroner Judge Jennifer Coate for her wise leadership of our court, and Mr John Griffin for the support he has provided as the Executive Director of Courts.

**Chief Executive Officer**  
**Judy Leitch**



# Background

## The State Coroner's Office

The State Coroner's Office of Victoria was established by the *Coroners Act 1985*, as was the Victorian Institute of Forensic Medicine. The 1985 legislation came out of a general review of the Coroner's Service in Victoria in the early 1980s, which was conducted by retired Supreme Court Judge, the Honourable Justice John Norris QC. The co-location of the State Coroner's Office and the Victorian Institute of Forensic Medicine in a purpose built facility at Southbank was also a recommendation of the review.

## Development of the *Coroners Act 2008*

In May 2004, the Victorian Attorney-General, the Honourable Rob Hulls, announced a review of the *Coroners Act 1985*. The stated purpose of the review was to improve the capacity of the State Coroner's Office to contribute to accident prevention and safety strategies and to meet the needs of family members involved in the coronial process.

In December 2004, the Attorney-General referred terms of reference to a Victorian Parliament Law Reform Committee (VPLRC) to review the *Coroners Act 1985*. Following a 21-month inquiry, which included a public consultation process, the VPLRC published its final report in 2006. The report made 138 recommendations for legislative, procedural and system reform aimed at modernising the jurisdiction.

The next stage of the reform process began with the formation of a Government appointed steering committee to respond formally to the VPLRC report. Members of the steering committee included representatives from the State Coroner's Office, the Victorian Institute of Forensic Medicine, Victoria Police, the Department of Justice, the Registry of Births, Deaths and Marriages, the Department of Premier and Cabinet, the Department of Treasury and Finance and the Department of Human Services. In addition to reviewing the VPLRC report and responding to its recommendations, the steering committee also oversaw the rewriting of the *Coroners Act 1985*.

In 2008, the Government introduced the Coroners Bill 2008 into the Parliament of Victoria which received Royal Assent on 11 December 2008. It is now referred to as the *Coroners Act 2008* (the new Act) and came into effect on 1 November 2009.

## 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 new 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.

## The Coroners Court of Victoria

The implementation of the new Act represents the most significant reform of the Victorian coronial jurisdiction in 25 years.

Under the new Act, the 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 was also 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.

# 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 new Act.

Section 52 of the new Act also gives coroners the authority 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 magistrate's courts, where magistrates also function as coroners.

The below map indicates locations 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 5293 deaths reported to the coroner.

Section 4 of the new 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 new 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 new Act 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 six 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 new 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 the circumstances in which it occurred.

During the reporting period, six fires without death were reported to the court.

## Structure and organisation of the Coroners Court of Victoria

The court is comprised of nine full time coroners including the State Coroner and the Deputy State Coroner. In Melbourne, the court is staffed by registrars, counsellors, researchers, case investigators and administrative staff. The administration of the court is led by the CEO.

Across the five court regions of Victoria, regional magistrates assigned as coroners 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*

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.

## **Office of the Chief Executive Officer**

### *CEO*

Judy Leitch

### *Initial Investigations Office*

Manager: Jenny Hoar

### *Registry*

Principal Registrar: Gayle Chirgwin

### *Coroners Prevention Unit*

Manager: Samantha Hauge

### *Family and Community Support Services*

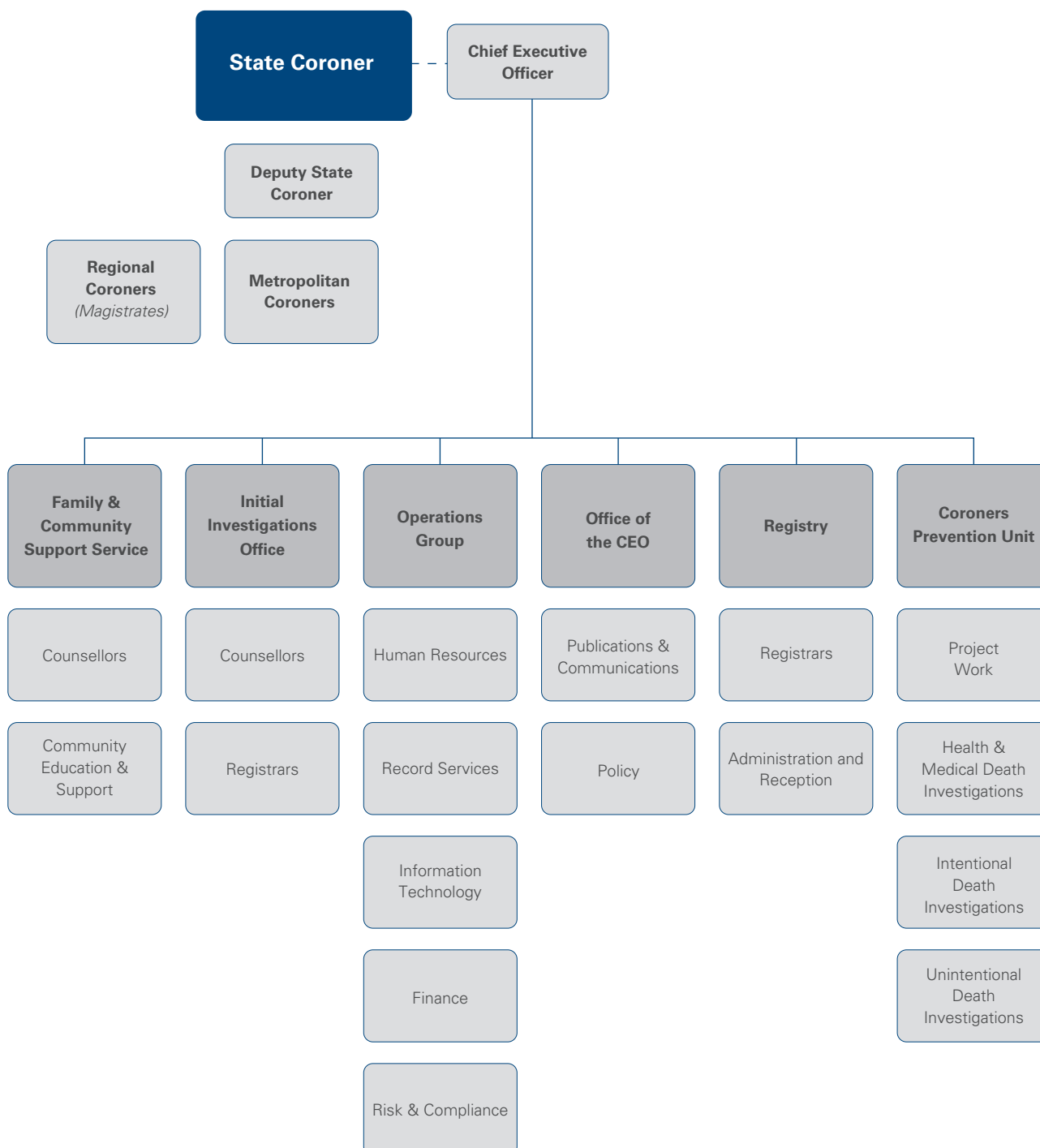
Manager: Michelle Skinner

### *Operations Group*

Manager: Therese Goodman



## Organisational chart

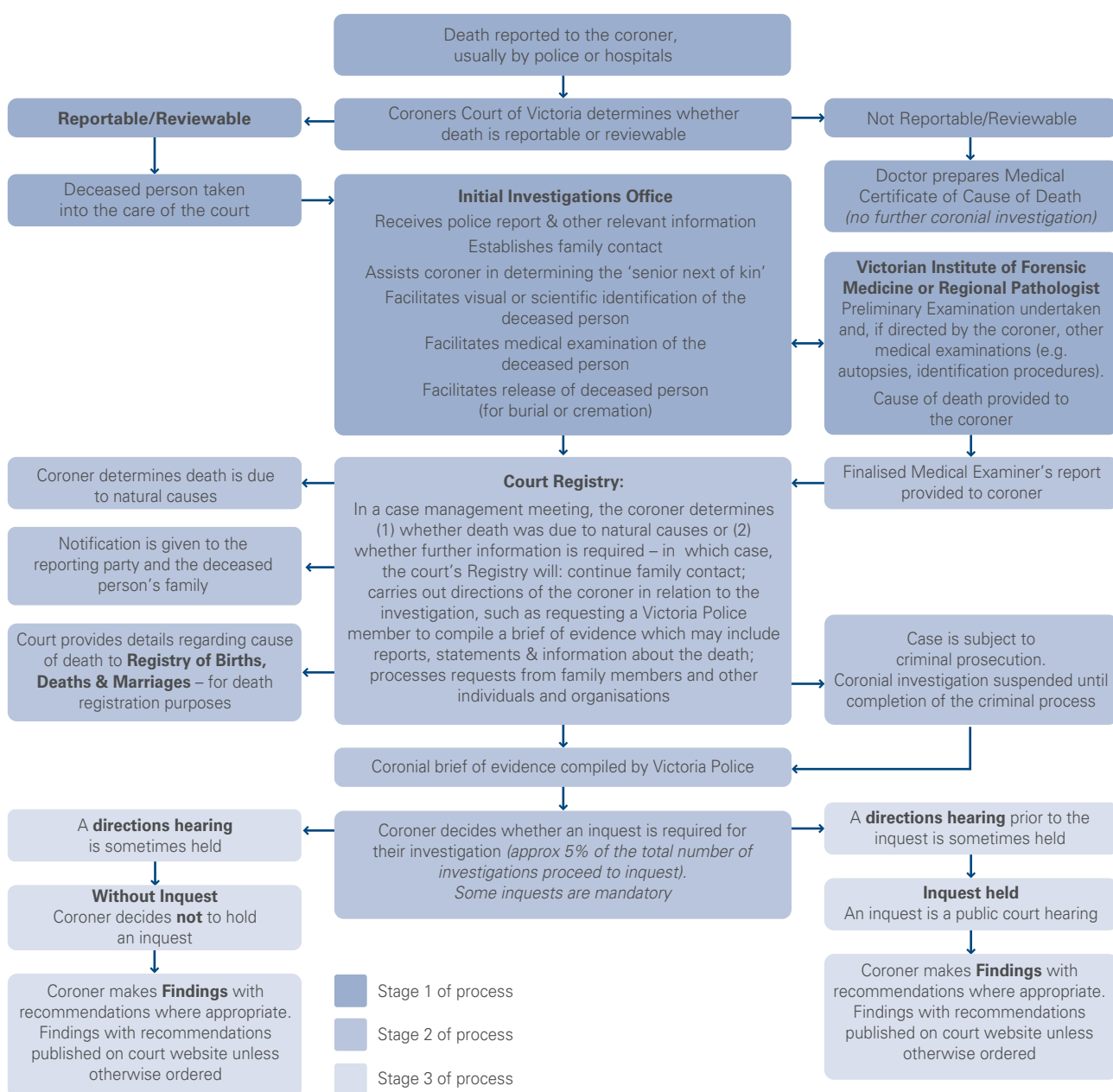


# Coronial processes

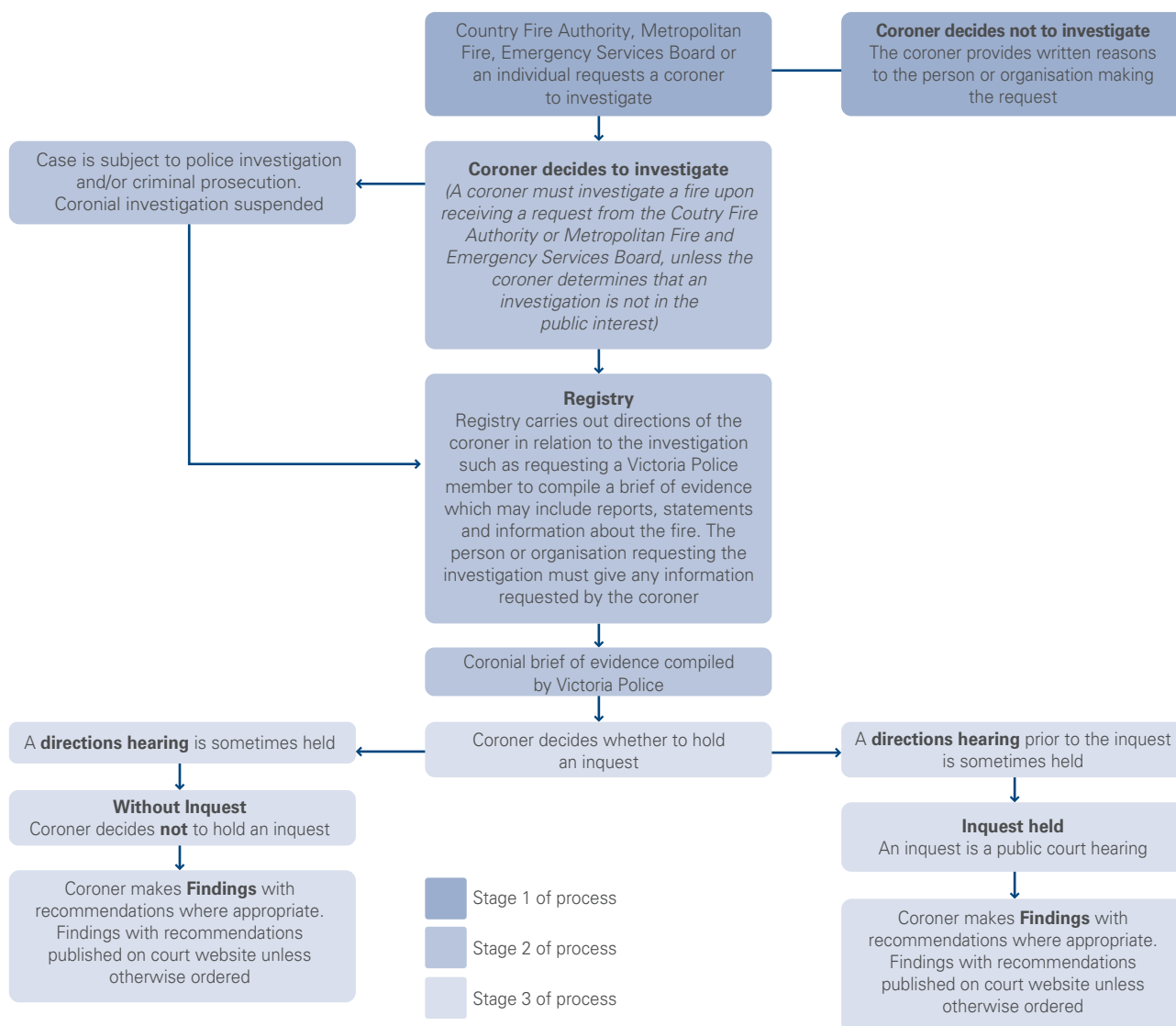
Every death and fire reported to the court is unique and requires an individual investigative approach.

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 death occurs

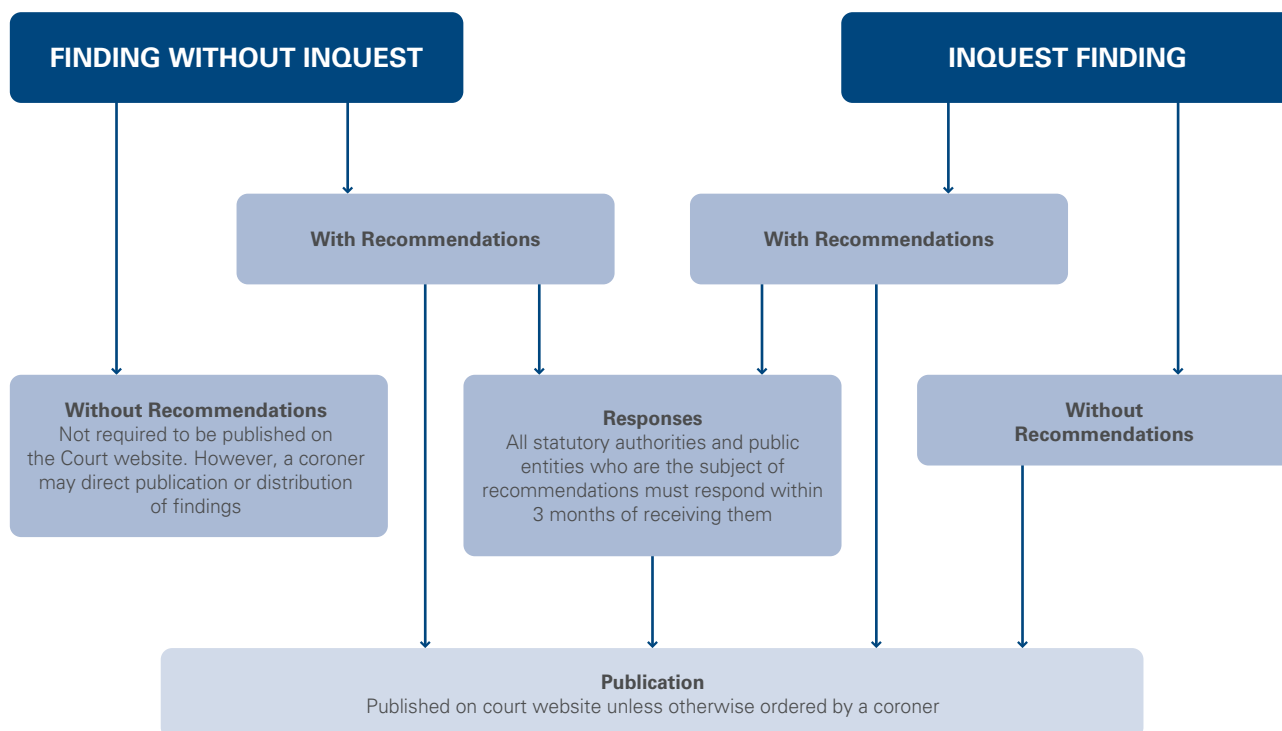


## The coronial process – when fire without death occurs





## Publication of findings, recommendations and responses (Ss. 72 & 73)



# A time of change

## Site redevelopment

The Coronial Services Centre of Victoria in Kavanagh Street Southbank was first opened on 26 July, 1988. It was created in recognition of the need to situate appropriate mortuary and medical examination facilities close to the coroners responsible for investigating deaths.

Significant changes during the past 22 years including advancements in post-mortem forensic pathology, increasing numbers of deaths being reported to the court and an expansion of staff needed to investigate those deaths, has necessitated a redevelopment of the existing site.

The State Government allocated funds in both the 2006–2007 and 2007–2008 budgets for a major redevelopment of the Coronial Services Centre.

The site will undergo substantial alterations during the next four years including;

- adding a second storey to the coroners' precinct creating more room for coroners and coronial staff
- expanding the two existing courtrooms
- building a new directions hearing room
- redeveloping the Initial Investigations Office to create an improved area for families visiting their deceased loved ones, and
- upgrading and expanding the mortuary and other facilities of the Victorian Institute of Forensic Medicine.

Work at the Southbank premises is expected to begin early in the 2010–2011 financial year.

## Relocation

In order to facilitate the redevelopment of the Southbank premises, all metropolitan coroners and most of the court staff were relocated to 436 Lonsdale Street in August 2009.

The move to Lonsdale Street has proven to be difficult with no dedicated courtrooms available to the court resulting in the majority of inquests heard during 2009–2010 being held in courtrooms of the Magistrates' Court or County Court. In addition, there is limited space available for office staff and court files and no appropriate counselling or public facilities. We anticipate being re-located to the more appropriate facility of the former Bushfire Royal Commission at 222 Exhibition Street in the second half of 2010.

## Victorian Coronial Council

The Victorian Coronial Council (VCC) was established under the new Act and is the first of its kind in Australia. The council will provide 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 families, 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 Simon Overland.

### Non-statutory members include:

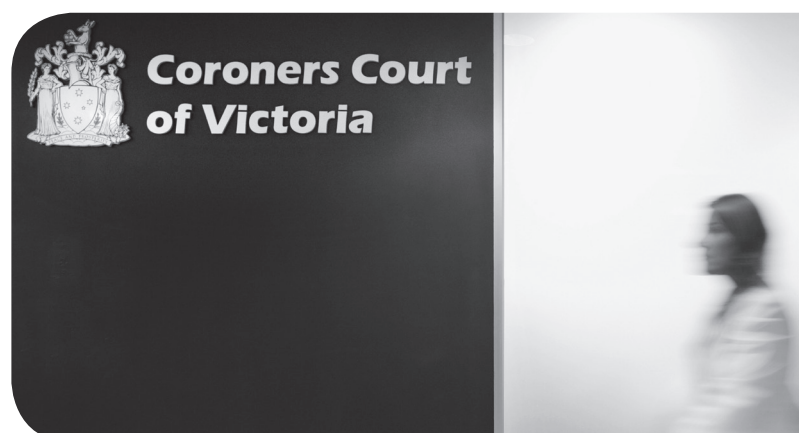
- Judge James Duggan, (Chairperson)
- Mr Stephen Dimopoulos
- Dr Ian Freckelton SC
- Mr Chris Hall
- Professor Katherine McGrath
- Dr Sally Wilkins
- Dr Rob Roseby.

The council met for the first time in April 2010 and is expected to meet three to four times a year.

It is anticipated that in future the council could provide advice regarding:

- the identification of themes, trends and patterns that may be emerging – including regional issues
- legislative issues
- proposed law reform activities.

The council has no supervisory role of the court, its operations or its decision making.



## Highlights and initiatives

### Launching the Coroners Court of Victoria

The inaugural sitting of the Coroners Court of Victoria marked a significant turning point in the history of Victorian coronial reform.

On Wednesday 4 November 2009, the State Coroner and all metropolitan coroners were ceremonially sworn in by County Court Chief Judge Michael Rozenes at the Melbourne County Court.

The court was addressed by Attorney-General the Honourable Rob Hulls, Michael Colbran QC Chairman Bar Council of Victoria and Danny Barlow President of the Law Institute of Victoria.

The event provided an important opportunity to acknowledge the beginning of the new court and promote the new Act and the changes within the jurisdiction to the wider public.

### Regional registrars' conference

As part of the implementation of the new Act, the court hosted a regional registrars' conference in October 2009. The event aimed to provide education and training for regional registrars to assist them with the implementation of the new Act and to ensure the development of a more consistent coronial service across the State.

### Coroners Bench Book

During the reporting period, the Judicial College of Victoria, in conjunction with the court, produced a Coroners Bench Book that has been published electronically on the Judicial Officers Information Network (JOIN). The bench book provides an important online resource for coroners and coronial registrars. It contains commentary on the new Act and includes references to relevant rules, regulations, practices and procedures.

The Bench Book will be progressively expanded throughout the next reporting period.

It is an invaluable tool to coroners and registrars across the state.



## Legal Practitioners Practice Handbook

The Coroners Court of Victoria Practice Handbook project was funded by the Victoria Law Foundation. It aims to assist legal practitioners unfamiliar with the coronial jurisdiction.

It introduces changes to the jurisdiction following the introduction of the new Act and details court practices, procedures and the rights of bereaved family members and interested parties.

A key consideration of the project was to assist in making the jurisdiction as accessible as possible by equipping the legal profession with the necessary knowledge to work in the jurisdiction and to promote confidence in the administration of justice.

The handbook recognises the unique nature of this jurisdiction and provides a tool for the legal profession to assist in the effective representation of their clients.

The project has incorporated the contributions from a steering committee comprising of members from:

- Judicial College of Victoria
- The Victorian Bar
- Human Rights Law Resource Centre
- Victorian Aboriginal Legal Service
- Epworth HealthCare
- Law Institute of Victoria
- Victoria Legal Aid
- Federation of Community Legal Centres
- Department of Justice
- Latrobe University.

The Coroners Court of Victoria Practice Handbook is expected to be completed early in the 2010–2011 financial year.

## CourtView

In January 2010 the court was granted approval by the Department of Justice to become the second Victorian court to move across to the new CourtView electronic case management system.

CourtView is designed to integrate data from all Victorian courts to create a single, consistent, and highly functional case management system.

CourtView will address a number of issues and risks that the court is exposed to with its existing data management system, Suncor.

The raft of administrative changes required following the introduction of the new Act, coupled with its age and the rigidity of its functionality, has resulted in Suncor becoming increasingly obsolete and unable to assist with the management of coronial cases.

Until CourtView goes live, the court has had to implement a series of 'work-arounds' to maintain the continuity of its work. These manual systems are cumbersome and time consuming and introduce unnecessary risk in the management of critical court information.

The new CourtView system will enable the court to dispose of these stopgap measures and to efficiently manage court data.

A significant benefit of CourtView is that accurate and timely data about deaths and fires reported to court can also be extracted and collated with minimal difficulty.

It is anticipated that CourtView will go live for the court in early 2011.

## Coroners Prevention Unit database

In the reporting year, the Coroners Prevention Unit (CPU) designed and implemented a database to code and classify all deaths reported to the court. This coding is done in accordance with Chapter 20 of the International Statistical Classification of Diseases and Related Health Problems – 10<sup>th</sup> Revision (ICD-10). The system comprises both daily prospective surveillance data and retrospective data back to 1 January 2000, ensuring the CPU has access to up-to-date information on both current and completed investigations.

The data contained within the surveillance system assists the CPU to:

- identify new and recurring trends in reportable deaths (e.g. drug-related deaths, intentional self harm, heat-related, infectious disease outbreaks)
- inform CPU data requests, requests for information and case reviews for coroners
- prepare timely quarterly reports for the court on the frequency and nature of deaths reported across Victoria and their current status;
- efficiently respond to data requests from authorised external agencies as required; and
- have available a complete and up-to-date data set of deaths and fires reported to the coroner.

## Coroners Research Information System for Prevention

The CPU has also developed an electronic data storage and retrieval system for information and research material generated for coroners' death investigations. Called the Coroners Research Information System for Prevention (CRISP), the information management system manages research information gathered and generated during investigations into preventable deaths, injury prevention and public health and safety. It is anticipated that CRISP will become an important resource that coroners can draw upon in the future when developing their recommendations and to inform their investigations generally. Previously no central database existed that allowed coroners to share their research materials into particular deaths or injury prevention.



# Coronial Investigations

## Coronial Findings

**A coroner investigating a reportable death must find (s.67), if possible**

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

**A coroner investigating a fire must find (s.68), if possible**

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

The table indicates the number of findings made with and without inquest.

TYPE OF FINDING	FINDINGS MADE 2008–2009	FINDINGS MADE 2009–2010
Inquest Finding	224	196
Finding without inquest	3738	5135
<b>Total numbers of findings</b>	<b>3962</b>	<b>5331</b>

## Coronial Recommendations

Aside from the findings that a coroner must make under the new 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. The table below indicates the total number of recommendations contained within the 49 coronial findings with recommendations handed down in the reporting period.

### Total recommendations 2009–2010

There were a total of six sets of recommendations requiring a response under the *Coroners Act 2008* in the reporting period. A response was received for each recommendation.

	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	91	17	46	5	<b>159</b>



## **‘Cluster’ investigations**

S. 54 of the new Act makes explicit the coroner’s power to hold an inquest into two or more deaths or fires. Given the new statutory emphasis on using the coroner’s investigation to contribute to the reduction in the number of preventable deaths and fires, coroners have embarked upon a number of ‘cluster’ investigations.

In 2010–2011 the court will continue to undertake those cluster investigations that have already commenced and are expected to be of high public interest. Such investigations provide a unique opportunity to influence public health and safety outcomes in relation to deaths and fires occurring in similar circumstances. At a glance these will include, but are not limited to, the following investigations:

### **February 2009 bushfire deaths**

Following the completion of the work of the Victorian Bushfire Royal Commission on 31 July 2010 the court expects to receive a significant amount of material relating to the Black Saturday bushfires and the 173 people who lost their lives in the fires.

The State Coroner will review this material and make a decision about the manner in which the coronial investigation into the deaths and fires should proceed. The State Coroner will take into account the material already presented at the Bushfire Royal Commission, any ongoing criminal prosecutions relating to the fires and the concerns of the families whose loved ones died.

### **Level crossing deaths**

On 15 October 2009, the first of several direction hearings were held into the deaths of 29 people who died in collisions between trains and vehicles at level crossings across Victoria. This ongoing investigation will examine factors that may influence the frequency and characteristics of level crossing fatalities, and will encompass three main areas of inquiry: rail and road infrastructure issues, heavy vehicle combinations, and human factors. The first inquest, relating to the Kerang level crossing deaths will begin in January 2011.

### **Deaths at aged care facility**

The inquest into the deaths of four aged care residents at an aged care facility will continue during the 2010–2011 reporting period. This inquest is examining whether the deaths were related to an outbreak of gastroenteritis at the facility in April 2007 and possible related health and safety issues.

### **Co-sleeping deaths**

Investigations will continue into the deaths of 15 infants who died in suspected co-sleeping settings with adults. The deaths occurred between 2008 and 2010.

## **Youth suicides**

Investigation will continue into a cluster of youth suicides. This investigation will examine the circumstances surrounding the deaths of up to 10 teenagers in Victoria between 2008 and 2010.

### **Tipper truck deaths**

An investigation into the deaths of three people following tipper truck contacts with overhead powerlines will continue in the 2010–2011 reporting period. These deaths occurred between 2006 and 2010. A directions hearing relating to the investigation is expected to be held in August 2010.

### **Psychiatric patients deaths in regional Victoria**

The investigation into the death of five patients following their release from a regional Victorian psychiatric facility between 2008 and 2010 will continue during the 2010–2011 reporting period.

### **Rock fishing deaths**

An investigation will continue into the deaths of three people swept off rocks whilst rock fishing in Victoria in 2009. The investigation will examine prevention and education issues surrounding rock fishing safety measures in Victoria.

### **Lap-band surgery deaths**

The investigation into the deaths of two people following lap-band surgery will continue in the 2010–2011 reporting period. The investigation will consider 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 recognition of obesity training.

### **Immigrant drowning deaths**

An investigation will continue into the separate drowning deaths of two men from 2008 to 2009 following their recent immigration to Australia. The investigation will consider the level of education provided to immigrants regarding safe swimming and Victoria waterways.

### **Psychiatric asphyxiation deaths**

An investigation will continue into the separate deaths of two men in psychiatric facilities in 2008 and 2009. An inquest into the deaths will begin in January 2011 and will examine whether the men died of asphyxiation following physical restraint by security staff.

### **Pain management toxicity deaths**

An investigation into the deaths of up to 10 people from drug toxicity relating to the management of chronic pain will continue in the 2010–2011 reporting period. The deaths occurred between 2005 and 2010.



# Engaging the community

## Initial family contact – regional expansion

The Initial Investigations Office (IIO) is the first point of contact for families after a death is reported to the court. The IIO performs a significant and critical role for families during a distressing and difficult time. It is a 24 hour, seven days a week service, with counselling support available for much of that time. Until recently the initial family contact support was not uniformly available in regional Victoria.

During the reporting period the IIO expanded its initial family contact program to include families in regional Victoria. This capability was developed and implemented by the IIO within the present staffing structure and has resulted in increased support to families in regional areas.

Regional families are now able to receive early contact from IIO staff outside the boundaries of normal business hours and on weekends. At the conclusion of the initial family contact, the IIO is able to provide regional coroners and registrars with highly relevant information such as family preferences regarding autopsy, any issues or concerns families may wish to have investigated, clarification as to senior next of kin and any competing family interests.

The early provision of this information enables regional coroners to be better informed during the preliminary examination phase of the investigation.

## Beyond Black Saturday

A challenging aspect of the work undertaken by the court during the past financial year is the continued support provided to members of the community affected by the Black Saturday bushfires. The devastation that occurred during the 7 February 2009 bushfires drew on the extraordinary capacity of many Victorians including the court's Family and Community Support Service (FCSS).

In the reporting year, the FCSS has continued to support bereaved family members and to provide information about the status of the coronial investigations. The FCSS has also worked closely with the Victorian Bushfire Royal Commission, the Victorian Bushfire Reconstruction and Recovery Authority, and the Departments of Health and Human Services to assist with the recovery of many affected communities.

## Expanding regional support services

During the reporting period, FCSS also began expanding and improving the court's commitment to bereaved families and communities in outer metropolitan Melbourne and regional Victoria. The team began the process of forming stronger links with counselling services in these areas, including the provision of ongoing education and secondary consultation to those services. Discussions were held throughout regional Victoria to examine the current availability of grief support provided by qualified counsellors and to ascertain the need for their further education and increased frequency of communication with FCSS staff.

In some cases, education sessions have been provided with further sessions scheduled to take place during the next reporting period.

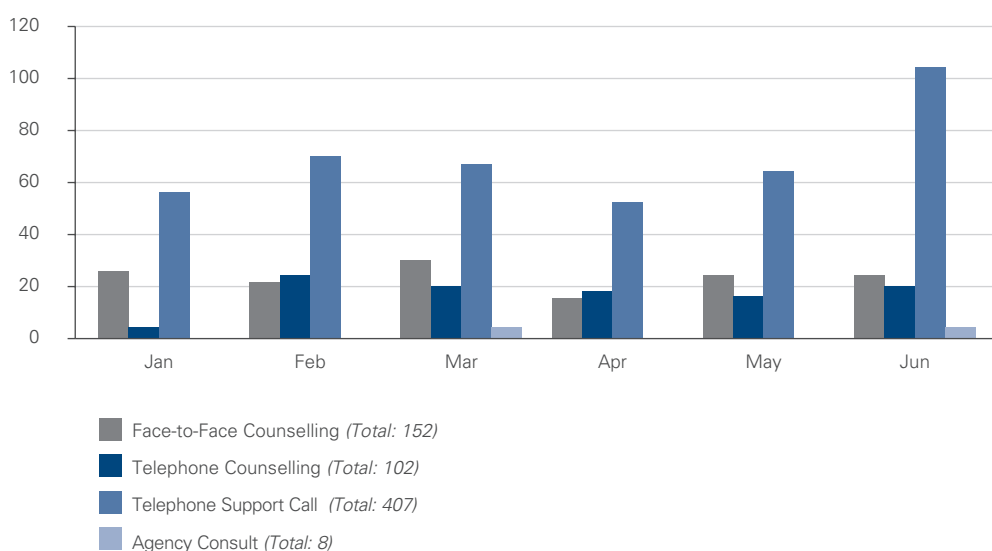
### WHILST STILL IN ITS INFANCY, FROM NOVEMBER 2009 TO JUNE 2010, DISCUSSIONS AND MEETINGS HAVE BEEN HELD WITH:

<b>Ballarat</b>	<i>Centacare</i> – Diocese includes Hamilton, Horsham, Bacchus Marsh, Warnambool, Swan Hill
<b>Bendigo</b>	<i>Centacare</i> – Diocese includes the Bendigo & Loddon Valley region of Shepparton, Wangaratta, Wodonga, Cobram, Echuca, Wedderburn, Corryong
<b>Geelong</b>	<i>Centacare</i>
<b>Morwell</b>	<i>Anglicare Gippsland</i>
<b>Mildura</b>	<i>Sunraysia Community Health Services</i> – region includes Ouyen, Robinvale and south to Swan Hill
<b>Narre Warren</b>	<i>Windemere Child &amp; Family Services</i> – outer Melbourne metropolitan locations in City of Casey, Greater Dandenong and South-Eastern suburbs.
<b>Ringwood</b>	<i>Eastern Access Community Health (EACH)</i> – outer eastern metropolitan region, including City of Knox, Maroondah and Yarra Ranges.
<b>Shepparton</b>	<i>Goulburn Valley Community Health Centre</i>
<b>Wangaratta</b>	<i>Ovens &amp; King Community Health</i> – covering the Ovens Valley/Hume region including Kyabram, Shepparton, Mansfield, Myrtleford, Wodonga, Corowa, Yarrawonga, Cobram

## Supporting bereaved families

FCSS also created a database in January 2010 to capture the number and type of counselling contacts undertaken directly with bereaved families as well as indirectly via secondary consultation with other agencies. The below graph provides a snapshot of the support provided by FCSS from the time the database was created to the end of the reporting period.

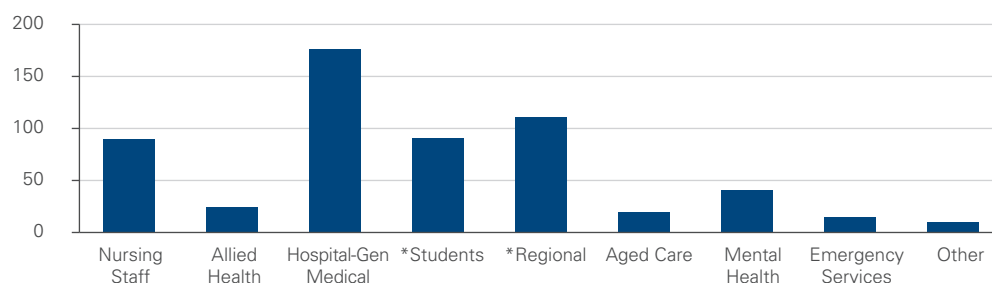
**Counselling Sessions Jan–June 2010 (Total 669)**



## Community education

During the reporting period, FCSS continued its program aimed at educating students, social workers and medical and health professionals about the coronial jurisdiction. In the January – June 2010 period, staff from FCSS provided education sessions to 565 attendees (21 sessions).

**CCOV Education Sessions Group attendance across 21 sessions, Jan–Jun 2010**



\* The students category includes social work, psychology, nursing, health, medical and law students not yet graduated

\* The regional category includes all education sessions delivered outside metropolitan Melbourne.

## 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 some 55 activities, as outlined below.

### **Presentations at 11 conferences including:**

- the Australian Institute of Judicial Administration conference on Therapeutic Jurisprudence
- the Law Institute of Victoria's conference
- the Asia Pacific Coroners conference
- the Australian Nurses Federation Div2 conference.

### **Membership of 14 committees and councils, including:**

- the State Disaster Victim Identification Committee
- the Victorian Institute of Forensic Medicine Council
- the Victorian Institute of Forensic Medicine Human Research Ethics Committee
- the Donor Tissue Bank of Victoria Board
- the Victorian Child Death Review Committee
- the Transport Safety Group
- the Victorian Coronial Council.

### **Some 30 other activities, including:**

- presentations to the Melbourne Law School
- presentations to the Office of the Chief Psychiatrist,
- presentations to the Victoria Police Traffic Management Course
- presentations to various hospitals
- the mentoring of law students and graduates from various tertiary education institutions.

## Coroners professional education

In partnership with the Judicial College of Victoria, the court has continued to support its commitment to ongoing training and education for coroners. Key highlights during the reporting period include:

- a two-day intensive training program prior to the introduction of the new Act
- monthly twilight education seminars that are accessible to regional coroners via video conferencing facilities
- the introduction of an orientation program for newly appointed coroners
- judgement writing workshops to assist coroners in writing rulings, findings and recommendations
- a three-day intensive training program following the implementation of the new Act addressing the challenges of working within the jurisdiction.

## Law Week 2010 media event

Law Week 2010 provided a unique opportunity to host a media event aimed at demystifying the coronial process by explaining to media what occurs when a death is first reported to the court, the procedures required for various medical examinations including realistic time frames, and the legislative framework and decision making process coroners employ when determining whether an investigation ought to proceed to inquest.

The event was attended by 22 journalists and began with a tour of the Victorian Institute of Forensic Medicine, followed by a discussion panel. The group was taken through a fictional scenario involving a multi-victim road fatality with each panellist explaining their role within the coronial process.

It is hoped this educational event will increase the frequency and accuracy of reporting surrounding coronial issues and therefore better inform the wider public of the role and purpose of the court.

## Website

A significant redevelopment of the court website was required in order to comply with the new Act. The visual aspects of the site were completely redesigned to reflect the change from the previous State Coroner's Office to the new identity of the Coroners Court of Victoria.

All content within the site was re-written and the menu buttons redesigned to include a section for coroners' findings and responses to recommendations.

The court also added a section for case rulings to allow greater public accessibility to the decisions made by coroners during the course of an investigation. Included are rulings on the status of interested parties and suppression orders.

The redesign of the court's website has been an important step in renegotiating the way the court keeps the wider community informed about the work in this jurisdiction.

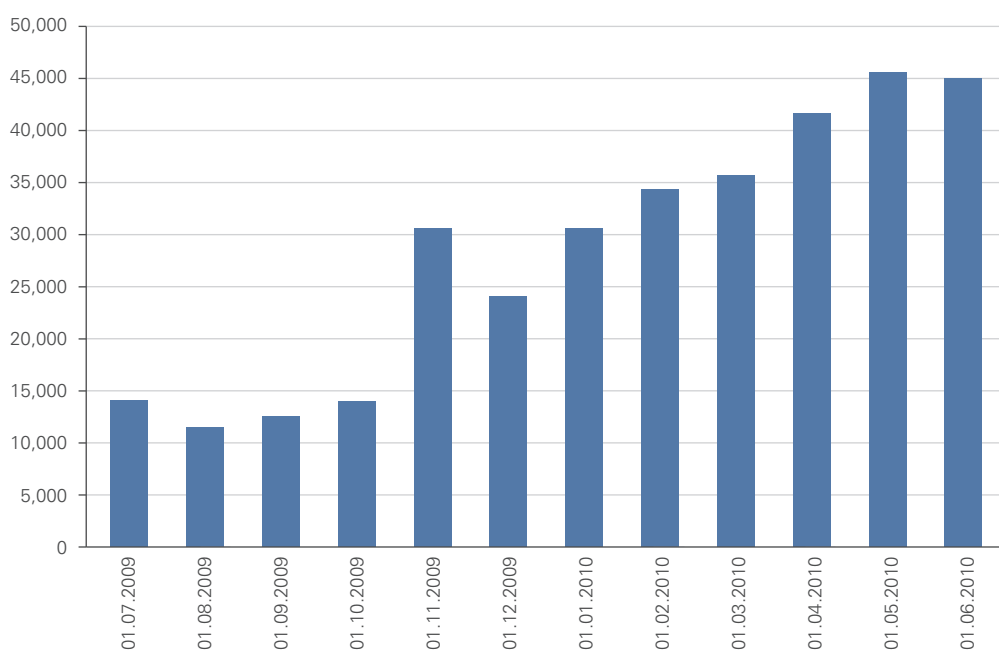
More information than has ever previously been available can now be accessed online. This development is particularly positive for people from regional Victoria whose death of a loved one is reported to the court.

In the reporting period 68 findings with recommendations and six responses to recommendations were published on the court website.

The below table indicates the number of visits (338,370) to the court's website during the reporting period.

\* data collated from Nielsen NetRatings Statistics.

### Visits to court website



## Publications

During the reporting period the court expanded its range of publications from four previous publications to nine brochures and a booklet including:

- **What do I do now?** – a new brochure replacing the previous 'First 48-hours' brochure providing greater detail about what occurs when a death is first reported to the court including the identification process and medical examinations required by the court
- **Family and Community Support Services** – a new brochure detailing the support and counselling services provided by the court
- **Inquest** – a new brochure sent to families when a coroner determines the investigation into their loved one's death will go to inquest.
- **Findings** – a new 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 appeal a finding
- **Reviewable deaths** – a new brochure containing information for families who have experienced the loss of a child and the death has been identified as reviewable
- **Disaster Victim Identification** – a new general brochure replacing the previous information produced by the court following the February 2009 bushfire, explaining the Disaster Victim Identification process
- **Coroners Prevention Unit** – a new brochure providing information about the role and function of the unit

- **Access to documents** – a new brochure advising the public and interested parties on how to gain access to coronial documents
- **Information for Health Professionals** – a new publication with detailed information regarding the new reporting obligations relevant to the health profession following the implementation of the new Act
- **Coroners Process Information for Family and Friends** – a new booklet replacing the previous process booklet. This book has been expanded from 26 to 58 pages and covers in thorough detail the coronial process in accordance with the changes under the new Act.

In the reporting year the court also began the process of having the 'What do I do now?' brochure translated into 15 different languages including Arabic, Cambodian, Chinese Simplified, Croatian, Greek, Hindi, Italian, Macedonian, Polish, Russian, Serbian, Somali, Spanish, Turkish and Vietnamese.

Once translated, the brochure will be available on the website creating greater access to the court for people of non-English speaking backgrounds engaged in the coronial jurisdiction.

Importantly this information will also be available to provide assistance to families from overseas whose death of a loved one has occurred in this State.



# Research and prevention

The Coroners Prevention Unit (CPU) is a specialist service for coroners created in 2008 to strengthen the prevention role of the jurisdiction and provide coroners with assistance in an investigation where improving public health and safety may be a consideration.

The table indicates the number of research and prevention referrals, projects and investigations completed and/or undertaken by the CPU in the reporting year.

CPU referrals, projects and investigations 2009–2010

DATA	TOTAL
<b>Collaborative research projects with external parties</b>	<b>4</b>
<b>Total referrals received by CPU 2009–2010</b>	<b>101</b>
Referrals by metro coroners	91
Referrals by regional coroners	3
Referrals by external agencies	7
<b>CPU referrals completed in 2009–2010</b>	<b>76</b>
CPU referrals completed with reports	58
<b>CPU reports underway (work beginning in 2009–2010 with an expected completion in 2010-2011)</b>	<b>29</b>



## CPU Investigations

The list below demonstrates the range and extent of the investigation types in which the CPU has been requested to provide assistance to coroners during 2009–2010.

- Asbestos reported deaths 2006–2008
- Asthma and asthma plans
- Absconding from an aged care facility
- Aged psychiatry unit inpatient seclusion
- Anaphylaxis management requirements in Victorian children's services and schools
- Bicyclist safety and awareness
- Coroner-determined and suspected suicides in Victoria 1 January 2007 to 23 February 2010
- Co-sleeping / bed-sharing: deaths of infants
- Deaths following butane inhalation
- Deaths of inpatients at psychiatric units following physical restraint
- Deaths related to riding BMX bicycles on dedicated BMX parks
- Department of Human Services client care management and fall protection devices (in care death of disabled person)
- Do-It-Yourself injuries in Victoria
- Drowning deaths in Victoria inland waterways associated with alcohol consumption
- Drowning of young people recently emigrated to Australia
- Drug-related deaths of female prisoners in Victoria, 2000–2010
- Energy Safe Victoria – powerline contact incidents
- Fall from height during Do-It-Yourself activity
- Family violence suicide
- Family violence homicide
- Family violence homicide-suicide
- General overview of reported deaths in persons aged between 0 and 18 years
- Ignition of flammable materials at home during Do-It-Yourself activities
- Injury involving manual wheelchair falls
- Intentional self harm following counselling retreat; regulatory context for counsellors and psychotherapists
- Investigation of police related deaths national data 2000–2010
- Jump from height intentional self-harm
- Late detection of cancer in prisoners
- Marine vessel explosion with fatalities
- Nitrocellulose safety management plan
- Off-road motorcycling injuries among persons aged <18 years
- Quad bike rollovers
- Recreational vessel drowning in Victoria: personal flotation devices as a drowning prevention measure
- Review of mental health treatment and police response
- Scissor lift tip-over following application of external force
- Stevedoring safety during cargo unloading operations
- Structural fires attributed to electrical equipment: power boards
- Suicide – carbon monoxide (car exhaust) poisoning
- Suicide following Crisis Assessment and Treatment Team (CATT) contact prior to release from police custody, Victoria 2004–2009
- Suicide following discharge from a psychiatric inpatient facility, 2005–2010
- Suicides involving plastic bags in a custodial setting, Victoria 2000–2010
- Tipper trailer electrocutions
- Vapour explosion following an attempt to cut a metal drum.



## Victoria Systemic Review of Family Violence Deaths

In 2008, the Victorian Attorney-General the Honourable Rob Hulls announced the Systemic Review of Family Violence Deaths (SRFVD). The SRFVD was established on the premise that family violence deaths are preventable, and that improving systemic responses to this issue is a fundamental step toward achieving this goal.

The first of its kind in Australia, the SRFVD provides a unique opportunity to examine family violence deaths reported to the court. The central aim of the SRFVD is to inform interventions that help protect children and adults from family violence by considering the context in which deaths occur. The SRFVD seeks to identify and examine risk factors that may have contributed to the deaths and considers systemic interventions to reduce these in the future. All deaths referred to the court from 1 January 2009 are subject to review where the victim-offender relationship meets the definition of a family member in the *Family Violence Protection Act 2008* (Vic).

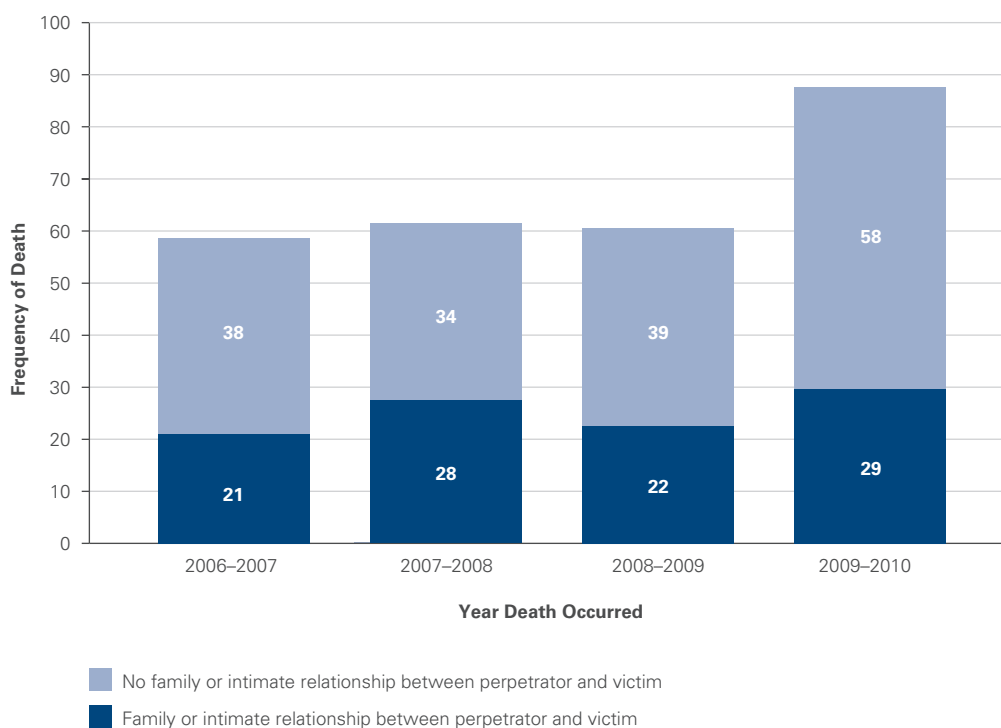
The SRFVD is led by the State Coroner and positioned within the CPU. Consultative support is provided by the SRFVD Reference Group. Featuring 38 representatives from across government and the community sector, the reference group formally meets up to three times a year to provide support and guidance to the review on a range of policy and practice issues.

A number of key implementation activities were initiated by the CPU to support the work of the SRFVD during the reporting period. These included:

- a surveillance process for early identification of reportable deaths where family violence issues were present;
- facilitating discussion and information exchange between the court and relevant parties; and
- a data set of family violence-related deaths aligned to the commencement of the integrated family violence service reform in July 2006.

The table below shows the number of suspected homicides reported to the coroner by financial year. Deaths where there was evidence that the victim-offender relationship met the definition of a family member are distinguished in dark blue in the table below and comprise between 33% and 45% of homicides in Victoria. It should be noted that deaths still under investigation by the coroner have been included in these statistics and it is possible the numbers reported will change following the completion of the coroner's investigation.

**Total number of suspected homicides reported to the coroner by financial year, Victoria 2006–2007 to 2009–2010**





## CPU collaborative projects

The CPU also undertook a number of collaborative research based projects including jump from height suicides, a review of the impact of coroners recommendations and two projects focusing on heat related deaths.

### Jump from height suicides

The jump from height suicides investigation is a research project undertaken by the CPU in partnership with the Australian Institute of Suicide Research and Prevention at Griffith University in Queensland. The project will examine jump from height suicides in Victoria since January 1990.

The project will also review whether those who jump at the State's most frequented suicide jumping locations can be distinguished from those who jump at other types of locations.

The research will be used to evaluate whether specific groups of people are more likely to use, or be at risk of, jumping from such locations.

It will also assess whether suicide barriers are an effective suicide prevention measure.

Finally, the research material will be used to determine whether there is a reduction in deaths of this type following the erection of suicide barriers and whether there is a post-intervention shift of jump from height suicides to other locations.

## Australian Research Council grant

In the reporting period the School of Population Health at the University of Melbourne, in partnership with the CPU, successfully applied for and received a substantial grant from the Australian Research Council to undertake a review of the impact of reform regarding coronial recommendations following the implementation of the new Act.

This four year project will examine the frequency and form of coroners' recommendations and assess the impact of those recommendations on public health and safety. The specific research objectives are:

- to determine the reform's effect on the frequency of coroners' recommendations;
- to determine the reform's effect on the form and nature of coroners' recommendations;
- to examine and describe changes made within respondent entities in response to recommendations;
- to describe the form and nature of entities' written responses; and
- to assess the attitudes of key staff in respondent entities to the quality of recommendations.

## Extreme heat related deaths

Victoria experienced an unprecedented extreme heat event over five days in late January 2009. Between 27–31 January, maximum temperatures across the state were up to 15°C above normal average temperatures. Three days were above 43°C in Melbourne, and corresponding night-time temperatures offered little relief.

The event had a major impact on communities, infrastructure and the service delivery capabilities of the court, ambulance service and hospitals. Deaths reported to the court during this time were 77% higher than for the same period in the previous year, with the most significant increase in deaths of people aged 65 years and over.

The Coroners Prevention Unit provided data to the Chief Health Officer of Victoria (CHO) to assist in the assessment of health impacts from the event. Coronial information was collated by the CHO with inputs from Ambulance Victoria, Victoria's hospital system and the Registry of Births, Deaths and Marriages. The CHO concluded that there were 374 deaths above the average expected for that time period. The CPU has continued working with the CHO by providing weekly reports to the Heat Health Impact Surveillance System which was implemented for the 2009–2010 summer period.

During the reporting year, a detailed systematic review of the deaths reported during the heat event and the following week was undertaken by the CPU and the results presented to coroners. The review examined the individual circumstances of each death, including the post-mortem and coronial findings. This information was then compared with historical averages to determine the number of additional (or excess) deaths that were reported during and following the heat event.

Extreme heat events are a well-recognised risk factor for increased rates of illness and death. However, the measurement of heat-related deaths is difficult as the majority occur due to an exacerbation of pre-existing chronic illness.

With no established pathological criteria for determining heat-related deaths in Australia, the contribution of heat to most deaths can only be inferred by the circumstances recorded for the case, and consideration at autopsy of the prevailing environmental conditions at the time of death.

As coroners rely on evidence provided by police and forensic science experts to assist in the determination of the cause of death, the CPU established a project in partnership with Victoria Police and Victorian Institute of Forensic Medicine to provide an evidence based collaborative approach to the classification and reporting of potentially heat-related deaths during extreme heat events. This project has standardised the range of information collected at the death scene. This will increase the capacity of pathologists to consider heat as contributing to the cause of death, and will assist coroners in determining heat-involvement in a death as well as potential preventative measures which can be undertaken to reduce heat-related deaths in the future.

# Court administration

## Administrative review

Two key organisations provide the court with specialist investigative services, the Institute of Forensic Medicine (VIFM) and the Police Coronial Support Unit, both of which are located at the Coronial Services Centre in Southbank. As part of the administrative reforms being undertaken by the court, a review has been undertaken in collaboration with VIFM and Victoria Police, aimed at improving the way in which the court works with these organisations. This review was completed in December 2009 and the recommendations accepted. The recommendations related mainly to the need for improved role clarity between the court, VIFM and Victoria Police and the need for administrative protocols to be developed to better manage the interface between the court, the VIFM and Victoria Police. Work is currently underway to implement the recommendations.

## Compliments and complaints register

In early 2010, the court embarked on a project to electronically collect, monitor and report compliments and complaints received by the court.

The project involved the creation of an incident register to record feedback from external stakeholders as well as incidents that impacted on service delivery.

Previously complaints were manually recorded and stored in various locations preventing the court from gaining a holistic view of the types of issues impacting upon service delivery.

Importantly the register now records positive feedback and will allow the court to establish an incident history that can be drawn upon to inform and improve its business practices in the future.

## Summer 2009–2010 bushfire preparedness

The court created an Interim Emergency Response Plan for the 2009–2010 bushfire season specifically tailored to capture key planning requirements in the event of an extended period of extreme hot weather or a bushfire resulting in multiple fatalities.

The plan defined a number of practices which could be adopted and used by the court in the event of an emergency, including:

- receiving email notifications and bushfire situational reports from the Department of Human Services, and heat-health alerts from the Chief Health Officer, Department of Health.
- developing or refining linkages with various parts of the Department of Justice
- assessing and managing the risk to court staff who may be asked to travel to, or through a bushfire prone area, on a Code Red (Catastrophic) day.



## Disaster Victim Identification Manual 2010

Following the February 2009 bushfires, Disaster Victim Identification (DVI) processes facilitated the identification of the majority of people (169 of 173) who died in the fires. This work took three months to complete, which was both extraordinary and exemplary considering both the enormity and complexity of this tragic event.

DVI is a specialised area of emergency response, involving the location, retrieval and identification of deceased persons and remains using forensic science methods. Victoria Police undertake this function on behalf of the State Coroner with specialist assistance from the Victorian Institute of Forensic Medicine.

At the time of the bushfires, the court and emergency response agencies were operating from the Victorian DVI Manual, the first edition of which was published in 2005 following Australia's experiences in the Bali terrorist bombings.

A key priority for the court and other agencies involved in DVI post the February 2009 bushfires was to debrief on all phases of the DVI process.

Recommendations arising from the debrief have now been translated into the revised Victorian DVI Manual 2010, scheduled for consideration by the State DVI Committee in August 2010.

The Victorian DVI Manual outlines the roles and responsibilities of each agency involved in a response to a multi-fatality incident requiring the use of DVI.

## Multi-victim Fatality Response Plan

Not all multi-fatality incidents requiring investigation by the court involve a DVI process. However, their impact on the court's resources and business practices can be just as significant and challenging.

The court experienced this first hand when it received a sudden increase in the number of reportable deaths during and following the January 2009 heatwave event.

In this situation the identification process was relatively straightforward as DVI was not required, however the impact on the mortuary and the capacity of the court to receive deceased persons into its care was significantly impacted.

In recognition of these types of events, the court began preparing a Multi-victim Fatality Response Plan 2010, which covers in more detail its operational response arrangements following an event involving multiple fatalities.

The plan's development is being informed by a coronial advisory committee, chaired by the State Coroner and including representation from Magistrate Ron Saines, Regional Coordinating Magistrate, Barwon South-West Region.

## Business continuity preparation

The court's Operations Group worked diligently throughout the reporting period to develop a business continuity plan that describes the critical objectives of the court and how these may continue to be achieved in the event of a significant business interruption.

The court, in conjunction with the Victoria Police and the Victorian Institute of Forensic Medicine (VIFM), undertook a training seminar considering a range of possible disruption scenarios that could affect business continuity within the coronial jurisdiction. This process was conducted by a consultant appointed by the Department of Justice. A significant risk identified by the consultant was the lack of alternative mortuary and scientific laboratory facilities should the Southbank premises become compromised.

The Operations Group has since established a series of controls and risk mitigation strategies to reduce the impact of a disruption.

The court will continue working with Victoria Police and VIFM towards addressing infrastructure vulnerabilities throughout the next reporting period.

## Registry family letters

A key aspect of the Registry case management system was the development of a suite of template letters streamlining communication with families and investigation bodies.

The letters provide consistent terminology and plain language to ensure families are best able to understand various stages within the coronial process.

Registry also identified key points within every investigation where sending information to family members was both appropriate and necessary in order to inform them about status of the investigation into their loved one's death. Registrars regularly provide updates to families over the phone to reinforce and/or clarify the information provided in the court's letters.

The letter templates were also provided to all regional registrars following the introduction of the new Act, creating greater uniformity regarding the type of information provided by regional and metropolitan registrars within the coronial jurisdiction.

## Supporting regional registrars

The Magistrates' Court of Victoria provides registrars at 22 locations across the State who manage regional coronial cases.

In the past various factors including a lack of business support frameworks (such as access to a shared database) have impacted upon the court's efforts to provide a consistent State-wide coronial registry service.

The court Registry has recognised this shortfall and developed an operations manual that identifies and describes all coronial processes throughout an investigation to assist and guide regional registrars within the coronial jurisdiction.

Registry also created a Regional Contact Team that provides additional support by operating as a centralised point of contact that provides advice and assists regional registrars as required.

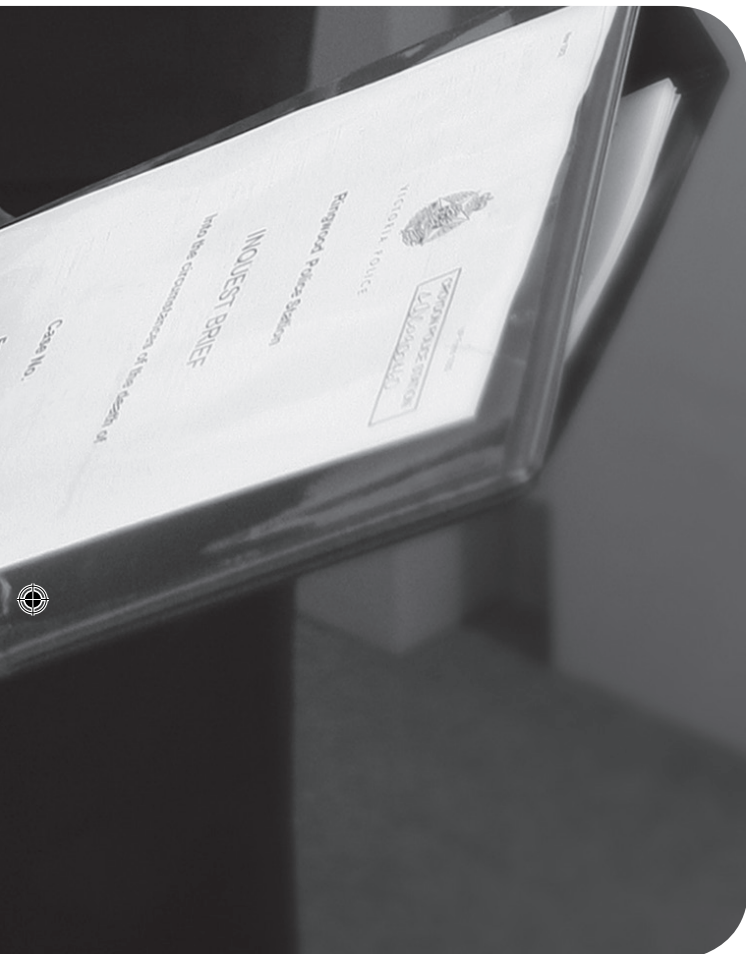
## Coronial reform post-implementation review

During the reporting period the court planned a review into the impact of the extensive reform that has recently been undertaken within the jurisdiction. The ultimate aim of the review is to optimise the operating efficiency of the court's service delivery model and to ensure that its resources are appropriately allocated in order to ensure the sustainability of the court into the future.









# Finances

## Overview

As the court heads towards the 2010–2011 financial year and beyond, there remain a number of external factors that will continue to place significant pressure on the court's existing resources. These factors include:

- Decreasing pathology services in regional Victoria causing increasing costs of transferring deceased people to and from Melbourne
- increasing funeral director costs
- increasing costs associated with complex coronial investigations
- the need to build capacity to respond to sudden surges in demand
- hospitals opting to reduce autopsy and mortuary capacities when they undergo redevelopment resulting in reduced contingency capacity during surges in demand
- the cost of relocating court staff while the Kavanagh Street site is undergoing redevelopment.

The challenge for the court is to ensure that future budgetary allocations both recognise and address these emerging cost pressures.

## Financial statement

Comprehensive Operating Statement for the financial year ended 30 June 2010

	NOTES	2008–2009	2009–2010
<b>Income from transactions</b>			
Output Appropriation		8,469,100	8,188,700
Special Appropriation		1,570,498	1,673,555
<b>Total Income</b>		<b>10,039,598</b>	<b>9,862,255</b>
<b>Expenses from transactions</b>			
Employee benefits	Note 1	6,907,580	5,395,337
Depreciation and Amortisation		418,255	410,219
Interest expense		3,504	2,167
Grants and other transfers	Note 2	27,572	–
Supplies and Services	Note 3	1,977,645	2,215,838
Deceased removal and transfers	Note 4	1,441,018	1,737,021
<b>Total Expense from transactions</b>		<b>10,775,574</b>	<b>9,760,583</b>
<b>Net result from transactions (net operating balance)</b>		<b>(735,976)</b>	<b>101,672</b>
<b>Other economic flows</b>			
Other gains(losses) from other economic flows	Note 5	(550)	(5,444)
<b>Total other economic flows included in net result</b>		<b>(550)</b>	<b>(5,444)</b>
<b>Net Result</b>		<b>(736,525)</b>	<b>96,229</b>



**Note 1 – Average Full Time Equivalent as at 30 June 2010**

	SPECIAL APPROPRIATION	BASE BUDGET	ERC FUNDED	BUSHFIRE	APPROVED NOT FUNDED	TOTAL FTE
Judicial Officers	5.00*					<b>5.00</b>
On-going staff		28.02	11.79		19.22	<b>59.03</b>
Fixed-Term staff				6.92	3.17	<b>10.09</b>
<b>Total Average FTE</b>	<b>5.00</b>	<b>28.02</b>	<b>11.79</b>	<b>6.92</b>	<b>22.39</b>	<b>74.12</b>

\* Currently only five full time coroner positions are funded within the court's budget.

**Note 2 – Grant payment to the University of Melbourne working collaboratively with CPU on project partially funded by the Australian Research Council (ARC): "Learning from Preventable Deaths: A prospective evaluation of reforms to Coroners' recommendation powers in Victoria."**

**Note 3 – Supplies & Services**

	2008–2009	2009–2010
Contractors & Consultants	676,447	209,557
Legal Professional Services	583,567	660,112
Medical Professional Services	78,212	37,249
Information Technology	148,121	93,239
Printing & Stationery	143,420	335,123
Postage & Communication	105,424	137,823
Travel & Personal Expenses	70,046	63,926
Staff Training & Development	57,989	25,132
Witness Expenses	42,782	19,460
Other Operating Expenses*	71,637	634,216
<b>Total Supplies &amp; Services</b>	<b>1,977,645</b>	<b>2,215,838</b>

\* Storage costs of \$402,707 were incurred in 2009–2010 as part of the relocation to Lonsdale Street.

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

	2008–2009	2009–2010
Metropolitan Areas	385,683	644,704
Regional Areas	1,055,335	1,092,317
	<b>1,441,018</b>	<b>1,737,021</b>

\* Higher costs in 2008–09 due to heat related deaths and the February 2009 Bushfire.

**Note 5 – Net gain/(loss) from revaluation of long service leave liability due to changes in bond rates.**

# Statistics and reports – operational

## Case initiations and closures

	2008–2009	2009–2010
Cases opened	6341*	5305
Cases closed	4728*	5573
Case clearance rate (cases opened/cases closed)	75%*	105%
Number of cases referred to the court by the Registry of Births Deaths and Marriages	787	742

\* Due to a counting error in the data provided to the court, the actual number of cases opened and closed during 2008–2009 is different from the numbers of cases reported in the Report of Government Services 2010. The error has been corrected in this report.

The decrease in the number of cases opened during 2009–2010 compared with 2008–2009 can be largely explained by the following factors:

- The unprecedented surges in demand during the heatwave and bushfires in early 2009
- A significant reduction in the number of natural causes deaths reported to the court since the implementation of the new Act compared with the number usually reported during the same period. It is likely that this is attributable to the intensive internal and external education program provided by the court prior to 1 November 2009. This education program was targeted particularly at medical practitioners and hospitals and aimed to ensure a sound understanding of what constitutes a reportable death under the new Act.

## Case progress

From date of initiation to end of financial year

	2008–2009	2009–2010
0–6 months	— **	1857
6–12 months	4034**	1144
12–24 months	1254	1558*
> 24 months	340	1027*
<b>Total number of lodgements pending</b>	<b>5628</b>	<b>5586</b>

\* 784 of the cases aged 12 months and greater in 2009–2010 cannot be actioned as they are currently the subject of police criminal investigations or court proceedings in other jurisdictions. As such, the coronial investigation is suspended until the police investigations and/or other court proceedings are complete. This includes the 173 Black Saturday Bushfire deaths.

The *Coroners Act 2008* has only been in force for seven months of the current reporting period, and as such, the full impact of the coronial reform is yet to be realised in the lodgements pending figures.

\*\*The court's data program did not support a breakdown of case progress between 0–6 months and 6–12 months in the 2008–2009 financial year. Hence, the figure for 6–12 months in the 2008–2009 period also includes the figures for case progress from 0–6 months. This was addressed in the 2009–2010 reporting period.

## Objections to autopsy

### Autopsy objections 2009–2010

	<i>CORONERS ACT 1985</i> (1 JULY 2009–30 OCTOBER 2009)	<i>CORONERS ACT 2008</i> (1 NOV 2009–30 JUNE 2010)	TOTAL
Objections upheld	226	59	<b>285*</b>
Objections refused	29	55	<b>84*</b>
Objections withdrawn	27	14	<b>41*</b>
<b>Total number of objections</b>	<b>282</b>	<b>128</b>	<b>410*</b>

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

# Court locations

## CORONERS COURT OF VICTORIA

436 Lonsdale Street  
MELBOURNE  
Ph 1300 309 519  
Fax 1300546 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

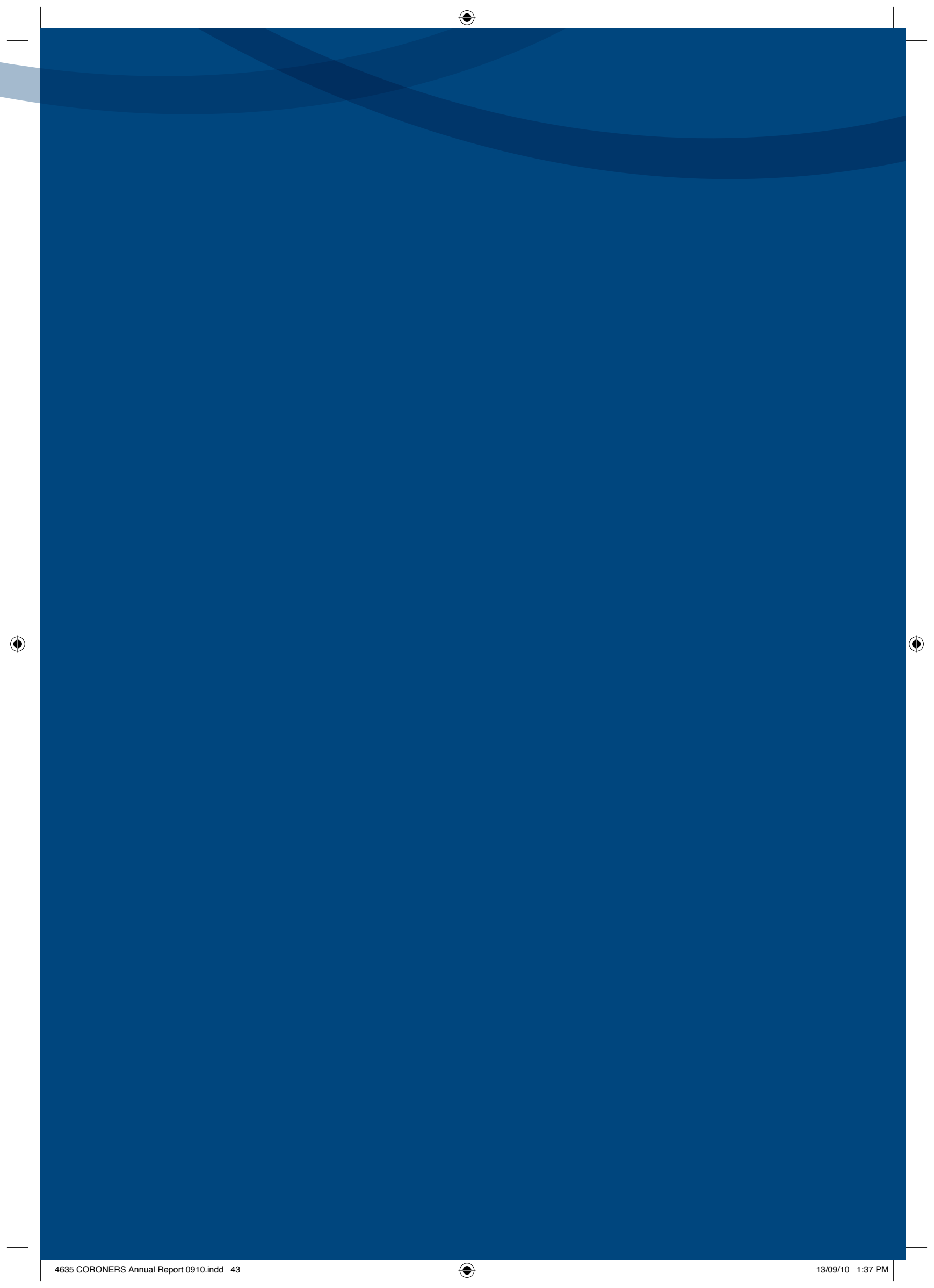
Curlewis Street  
PO Box 512  
SWAN HILL 3585  
Ph 5032 0800  
Fax 5032 0888

## 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  
Ph 5564 1111  
Fax 5564 1100



**CORONERS COURT OF VICTORIA**

57–83 Kavanagh Street, Southbank 3006 | Ph: 1800 309 519 | [www.coronerscourt.vic.gov.au](http://www.coronerscourt.vic.gov.au)

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