Coroners Court
of Victoria

Annual Report

2017–2018

CORONERS COURT
OF VICTORIA

Acknowledgement
The Coroners Court of Victoria is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture and Elders both past and present.

Dear Attorney-General

In accordance with section 102 of the *Coroners Act 2008*, I am pleased to present the Coroners Court of Victoria's Annual Report for the year ended 30 June 2018.

IAIN WEST,
Acting State Coroner
September 2018

Contents

The year in review 6

The Coroners 9

About the Coroners Court 12

Strategic Plan 2016–19 13

1. Investigations into deaths and fires 14

Challenges and achievements 14

Closure rates 15

Timely investigations 18

Inquests 19

Findings 19

2. Reducing preventable deaths 22

Challenges and achievements 22

Making recommendations 23

Monitoring trends 26

Victorian Overdose Death Register 26

Victorian Suicide Register 27

Victorian Homicide Register 27

Family Violence Death Review 27

3. Promoting public health and safety 30

Challenges and achievements 30

Drug overdose deaths 30

Access and education 31

Stakeholder engagement 32

Corporate governance 34

Organisational structure 34

Minimising risk 36

Workplace profile 37

Providing a safe and healthy workplace 38

Applications and appeals 39

Feedback 40

Access to information and documents 40

At a glance

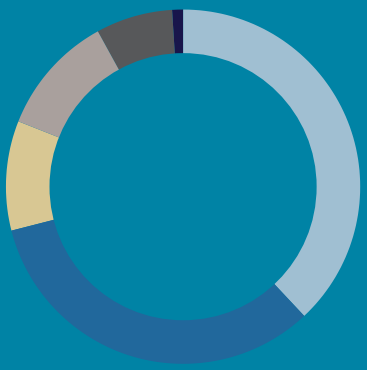
Investigations

6642 New investigations opened

6500 Investigations finalised

97.9% Closure rate

Caseload



- Natural cause deaths (38.2%)
- Accidents (33.1%)
- Suicides (10.4%)
- Other (10.4%)
- Medical/surgical complications (6.9%)
- Homicides (1%)

Timelines

11.8 Average months to investigate

85.4% in <12 months

47.4% in <3 months

Recommendations

108 Recommendations made

49.1% Accepted

1.9% Not accepted

49% Awaiting response or under consideration

Inquests

49 Inquests held

Represents **0.7%** of investigations

Data and documents

5237 Requests for documents

24 Request from organisations for coronial data

45 Research requests granted

About this report

The Coroners Court of Victoria's Annual Report 2017–18 is a comprehensive report of investigations into reportable deaths and fires, the services we provide to families who have lost loved ones, as well as to the wider Victorian community.

This report analyses our operational environment and performance, and is a key document providing accountability to important stakeholders – namely, Victorian families, the Parliament of Victoria, the Coronial Council of Victoria, reporting bodies and other organisations that support or use our services.

How to read this report

The first three sections of this report align with the three main roles of the Coroners Court of Victoria (the Court), namely:

1. **Investigations into deaths and fires**
2. **Reducing preventable deaths**
3. **Promoting public health and safety.**

Each section describes and analyses our performance and achievements, and the challenges faced throughout the reporting period.

Please note:
Wherever possible, the Court openly and transparently shares coronial information. However, there are some activities that cannot be reported on publicly, such as active investigations.

All case studies are from investigations closed by the Court in the past year. They have been de-identified out of respect for the families.

Some content in this report may be distressing to some readers. A list of helpful contacts and support services is available at **www.coronerscourt.vic.gov.au**

Glossary

BP3	Budget Paper 3
CEO	Chief Executive Officer
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
DEDJTR	Department of Economic Development, Jobs, Transport and Resources
DHHS	Department of Health and Human Services
DPP	Director of Public Prosecutions
FLO	Family Liason Officer
FTE	Full-time equivalent
NCIS	National Coronial Information System
PCSU	Police Coronial Support Unit
VAGO	Victorian Auditor-General's Office
VCAT	Victorian Civil and Administrative Tribunal
VIFM	Victorian Institute of Forensic Medicine
VODR	Victorian Overdose Death Register
VPS	Victorian Public Sector
VSRFVD	Victorian Systemic Review of Family Violence Deaths

The year in review

From the State Coroner

I am pleased to report that 2017–18 has been another year of excellence and outstanding achievement at the Court.

During the reporting period, the Coroners conducted thousands of investigations and made 108 evidence-based recommendations; turning insights gained from the investigation of preventable deaths into meaningful contributions to key policies on issues ranging from drug-related deaths and suicide prevention to road safety.

Every death investigation is unique and the Court has established a number of processes to ensure that the coronial system operates efficiently, while each case is dealt with fairly. Throughout the reporting year, the Court has strengthened our existing practices, and embraced new challenges and initiatives, to deliver on our steadfast commitment to the families and communities we serve.

Efficiencies and innovation

The death of a family member is a difficult and painful experience. To support families during their time of loss, we have continued to focus on reducing delays at all stages of the coronial process and delivering timely findings.

The Court's investigation closure rate has remained steady with the Court finalising 6500 cases during the reporting period. The efficiency of our processes was also demonstrated by the increase in cases with shorter investigation timeframes. Eighty-five per cent of investigations are closed within 12 months, and over 47 per cent in less than three months. This is not always an easy task, with many investigations needing to appear before a court in another jurisdiction before a Coroner can hand down a finding.

We have also made a significant difference for families who experience the death in hospital of an elderly relative from a fall resulting in a fractured neck of femur. Collaborating with our colleagues at the Victorian Institute of Forensic Medicine (VIFM), we have implemented a new process whereby the deceased can be released directly to a funeral home, rather than being taken into the care of the Court and undergoing unnecessary medical examinations. Such improvements help us better meet the needs of grieving families, both now and into the future, as we address the implications of Victoria's aging population.

Working with stakeholders

The work of the Court is highly collaborative, and our achievements during the 2017–18 period owe a great deal to the strong relationships we have built with our partners and stakeholders.

The support provided by VIFM and Victoria Police is integral to the Court's work. These organisations play a vital role in providing scientific and medical advice and reports that enable Coroners to conduct their investigation in the most informed and efficient manner possible. Additionally, I'd like to thank VIFM and Victoria Police for the significant role they play in liaising with families throughout the coronial process.

I'd like to further acknowledge all of the Court Network volunteers, who provide ongoing compassion and dedicated assistance to families and witnesses navigating court proceedings, often for the first time.

Staff wellbeing

The nature of the Court's work, and distressing circumstances surrounding some reportable deaths, can have an impact on staff. It has never been more important for us to focus our organisational commitment on supporting their emotional wellbeing. All staff have access to important resources, including our Employee Assistance Program, peer support programs, dedicated quiet spaces for reflection and staff debriefings led by qualified psychologists. The Court will continue to ensure that we foster a culture of inclusion and collaboration.

Thanks

I'd like to welcome Coroner Darren Bracken to the Court, and extend my deepest thanks to all of the Coroners for their expertise, professionalism and above all, the commitment they bring to their roles. Their ability to influence health and safety practices, public policy and community education, arises from the fact that each investigation is thorough, with all comments and recommendations being evidence-based.

I extend my sincere thanks and congratulations to all staff. The dedication and generosity they bring to their work, and to the community we serve, are interwoven into the spirit of the Court. Every day, they build relationships of trust and respect with families and stakeholders through the provision of expert advice and clear, considerate communication.

Equally important has been the leadership of the Court's CEO Samantha Hauge. My sincere gratitude to Samantha for her support and dedication since I joined the Court. And finally, I would like to thank Acting CEO Tim Greene. Tim's knowledge and enthusiasm are contributing greatly to the effectiveness of the Court. Together with his senior managers and staff, he is positioning the Court to meet key challenges for the future.

Future focus

I am incredibly privileged and excited to present the achievements of the Court in this report. Looking forward, the Court will continue to be a strong leader in coronial process; reviewing and refining our strategic plan to create a court of excellence, where the quality and integrity of the coronial system is maintained and consistently meets the changing demands of the Victorian community. The Court will also continue to work with other jurisdictions, both nationally and internationally, to ensure that our findings and data can be used for the greatest benefit. By contributing to global knowledge sharing, we can also analyse national and international trends for the benefit of the Victorian community.

Judge Sara Hinchey
State Coroner

The wellbeing of the Victorian community is the foundation of the coronial process. Through sensitive, courteous and thorough investigations we are able to help families understand what has happened to their loved ones, and continue our dedication to strengthening public health and safety.

The year in review

From the CEO

I have been struck by the hard work and dedication of all staff. Everyone works tirelessly with the value of serving the Victorian community and the families who have lost their loved ones.

I joined the Coroners Court at the end of February this year. Since I arrived at the Court, I have been struck by the hard work and dedication of all staff. Everyone works tirelessly with the value of serving the Victorian community and the families who have lost their loved ones.

Feedback is essential in every aspect of the Court's work and it is valued as an opportunity to review our activities and processes. It is also delightful to receive compliments as this reminds all staff of the value of their efforts. This is illustrated in the following letter:

'I just wanted to thank and commend your staff for the care, professionalism and respect they demonstrated in their work, following the passing of my father.

I'm not sure if you ever hear from those who have dealings with the Court, but I found all my contact with your staff reassuringly professional and respectful.

This information provided at all times was very helpful and clear.

For such difficult work, I want to thank you and your staff for making this process a little easier at such a sad time.'

A cornerstone of the coronial process is helping families and friends understand what has happened to their loved ones. Central to this is our work on improving investigation processes and closure times, so as to minimise the time families and friends wait for findings into their loved one's death.

The Court is focused on building our capacity to investigate high-profile and complex cases, including the Bourke Street tragedy and Essendon DFO plane crash. Such incidents require significant resources to ensure thorough and timely investigations, for the benefit of those directly impacted and the broader community. As such, the Court appointed an additional Coroner and supporting staff.

The Coroners Court prides itself on being an open and accessible environment for the public. However, a prudent examination of what that means in today's world reveals the need to balance this openness with appropriate security measures for staff and members of the public attending the Court. For this purpose, a review of Court security was undertaken, which resulted in the appointment of full-time Court Security Officers and an upgrade to staff identification cards. The need for improved security arrangements will see further changes to the Court's process over time.

The Victorian community is diverse and we must make sure that the Court is accessible to everyone we serve. To this end, the Court works closely with the Koori community, publishing information brochures and formally engaging Koori Elders in Court to assist community members to navigate the coronial process. We also provide support to families from a range of language backgrounds though our interpreter services.

For anyone who through circumstance, comes into contact with the Court, it can be a very unfamiliar and confronting experience. We are striving to educate the broader community and help them understand what we do. To assist in this process we have engaged in a series of educative and information programs for the public, including a mock inquest for Law Week (a collaboration with VIFM), regular appearances by the State Coroner on talk-back radio and newspaper articles about the Court and the 11 Coroners that are fundamental to our operation.

As Acting CEO I am very keen to make sure that all practices of the Court are progressively reviewed and are efficient and meet corporate best practice. This includes identifying and gathering data to guide our continuous improvement program and associated resources.

The Court is committed to continuous improvement. Over the next year, we will seek new opportunities to educate the community on the work of the Court and ensure efficient allocation of resourcing, including funding for the transport of deceased persons.

I would like to acknowledge:

The State Coroner, Her Honour Judge Hinchey and all the Coroners with a welcome to His Honour Coroner Bracken. My thanks also go to our hard-working Court staff and colleagues, who made me feel welcome. I commend them for their professionalism and dedication to the Court. In addition, the good work of the Court would not be possible without the ongoing support and assistance from Court Services Victoria's (CSV) Jurisdiction Services, VIFM, Victoria Police and the Court Network.

Tim Greene
Acting Chief Executive Officer'

The Coroners

Led by the State Coroner Judge Sara Hinchey, the Court has 11 Coroners.

Coroners are independent judicial officers. In Victoria, all Coroners are Magistrates or can be directly appointed under the *Coroners Act 2008* (the Coroners Act). To be directly appointed they must be an Australian lawyer who has been practising for at least five years. Appointed for five-year terms, the State Coroner must be a Judge of the County Court and the Deputy State Coroner must be a Magistrate.

State Coroner Judge Sara Hinchey

BSc LLB

Prior to her appointment as a County Court Judge in May 2015, Her Honour had extensive experience as a barrister, appearing in numerous high-profile inquests, as well as maintaining a broad-ranging practice including commercial law, occupational health and safety, corporate crime, professional negligence and professional disciplinary matters. Her inquisitorial experience included briefs in relation to the royal commissions into *Institutional Responses to Child Sexual Abuse* and the 2009 *Victorian Bushfires*. Throughout her career, Her Honour regularly appeared in the higher courts of Australia including the Federal and High Courts.

Her Honour is Chair of the Victorian Systemic Review into Family Violence Deaths, and a member of the Victorian Coronial Council, the Asia Pacific Coroners Society, the National Coronial Information System Board of Management, the Board of the Judicial Commission, the Board of the Judicial College of Victoria, the Interim Board of the Law Library of Victoria, the State Disaster Victim Identification Committee and the Council of Chief Coroners. She is also a member of the CSV Courts Council, the Coroners' Education Committee, the VIFM Council and the Health and Legal Counsel Forum.

Deputy State Coroner Iain West

B Juris LLB

Deputy State Coroner Iain West was admitted to practise in 1975. He was a barrister for 11 years before being appointed a Magistrate in 1985. He was appointed the Deputy State Coroner in 1993.

Coroner West is a member of the Coroners and Pathologists Advisory Group and the State Disaster Victim Identification Committee. His Honour may also attend meetings on behalf of the State Coroner.

Coroner Phillip Byrne

LLB

Coroner Phillip Byrne was appointed a Magistrate in 1982 and has more than 30 years' experience as a Coroner. He joined the Magistrates' Court in 1961, working as a Clerk of the Courts for 20 years, supporting the day-to-day operations of metropolitan and regional courts. He obtained his Bachelor of Laws from Melbourne University during this time, and following his appointment as a Magistrate spent 19 years as a Co-ordinating Magistrate for the Wimmera Mallee region, headquartered in Bendigo.

Coroner Byrne retired in 2000 but returned to work as a Coroner from 2003 to 2006. He has been a reserve Coroner since 2013.

The Coroners (continued)

Coroner Rosemary Carlin

LLB(Hons) BSc

Coroner Rosemary Carlin commenced her legal career as a solicitor for the Commonwealth Director of Public Prosecutions (DPP). In 1991 she became a barrister and for the next 16 years prosecuted criminal trials, holding the positions of Crown Prosecutor for Victoria, Senior Crown Prosecutor for the Northern Territory and In-house Counsel for the Commonwealth DPP. In 2007 she was appointed a Magistrate and in 2014 began working exclusively as a Coroner.

Coroner Carlin is a member of the Donor Tissue Bank of Victoria Committee, Victims of Crime Consultative Committee and the Asia Pacific Coroners Society.

Coroner Jacqui Hawkins

BA(Hons) LLB

Coroner Jacqui Hawkins was appointed as a Coroner in January 2014. Prior to her appointment, she was the Court's Senior Legal Counsel and established the In-house Legal Service. Coroner Hawkins was previously a Partner at Landers & Rogers in the Workplace Relations and Safety Group. She specialised in occupational health and safety and was the partner responsible for the Specialist Inquest Panel on the Victorian Government Legal Panel.

Coroner Hawkins is a member of the Asia Pacific Coroners Society, and the Courts Council Information Technology Portfolio Committee.

Coroner Audrey Jamieson

BA LLB Grad Dip Bioethics

Coroner Audrey Jamieson was appointed a Magistrate in December 2004 and has been a Coroner since June 2005. Coroner Jamieson started her career as a nurse before obtaining arts and law degrees from Monash University. She did her Articles of Clerkship at Holding Redlich Lawyers before moving to Maurice Blackburn Lawyers in 1992 where she became Partner and an accredited specialist in personal injury litigation with the Law Institute of Victoria.

Coroner Jamieson is a member of the Court's Research Committee, the Judicial Advisory Group on Family Violence, the Chief Magistrate's Family Violence Taskforce and the Asia Pacific Coroners Society. Coroner Jamieson also sits on VIFM's Ethics Committee as the Court's representative; assisting in the assessment of research applications.

Coroner John Olle

LLB BEc

Coroner John Olle was appointed as a Coroner in September 2008. Having started out as a solicitor with McCarthy & Co in Rye on the Mornington Peninsula, he signed the Bar Roll just three years into his legal career in 1983. As a barrister of more than 25 years' experience, Coroner Olle appeared mostly in civil matters and criminal defence trials in the County Court jurisdiction, as well as before inquests at the Coroners Court of Victoria.

Coroner Olle is a member of the Court's Occupational Health and Safety Committee, and is also a member of the Asia Pacific Coroners Society.

Coroner Paresa Spanos

BA LLB

Coroner Paresa Spanos was appointed a Magistrate in 1994 and has worked exclusively as a Coroner since 2005. Coroner Spanos graduated from the University of Melbourne in 1981 and was employed as an articled clerk/litigation lawyer in private practice. She worked for 10 years with the Commonwealth Director of Public Prosecutions, primarily in trials and appeals. As Senior Assistant Director, Her Honour headed the major fraud and general prosecutions branches.

Coroner Spanos is the Court's Judicial Member of the Courts Council Human Resources Portfolio Committee and is a member of the Court and VIFM's Coroners and Pathologists Advisory Group and of Hellenic Australian Lawyers. She was also a member of the Victorian Child Death Review Committee from 2005 to 2013.

Coroner Peter White

LLB LLM

Coroner Peter White was appointed as a Coroner in March 2007. After starting his career in Melbourne, Coroner White moved to Papua New Guinea in 1973 to work as a government lawyer, Crown Prosecutor and parliamentary advisor. Following the country's independence, Coroner White was appointed legal counsel to the Ombudsman Commission and later as a regional senior Magistrate. In 1983, Coroner White took up an appointment as a Magistrate in Hong Kong, where he was later appointed as a Coroner.

Coroner White is a member of the Judicial College of Victoria's Judicial Officers' Aboriginal Cultural Awareness Committee

Coroner Caitlin English

BA(Hons) LLB MPP

Coroner Caitlin English was appointed a Magistrate in June 2000, working as a Coroner since 2014. Prior to this, she worked as a solicitor at Minter Ellison, Victoria Legal Aid and the Public Interest Law Clearinghouse. She completed a Churchill Fellowship in 1999 and has presided in all jurisdictions of the Magistrates' Court, including six years at Broadmeadows Magistrates' Court where she sat in the Koori Court. She was on the editorial committee of the Magistrate's Bench Book for 12 years.

Coroner English is Chair of the Coroners Education Committee and a member of the Court Council Court's Koori Portfolio Committee and the Magistrates' Court Judicial Well-being Committee.

Coroner Darren Bracken

LLB

Coroner Darren Bracken was appointed as a Coroner in February 2018. After spending more than 20 years as a barrister in Australia and overseas, regularly appearing before the Supreme and County Courts as a prosecutor for the Director of Public Prosecutions. He has also appeared before the Federal Court of Australia and the High Court in addition to a number of appearances before the Coroners Court and the *2009 Bushfire Royal Commission*.

Coroner Bracken is a member of the Coroners' Education Committee and is the Legal Vice President of the Medico-Legal Society of Victoria.

About the Coroners Court

Our roles

Independently investigating deaths and fires
Certain deaths and fires are reported to the Court for independent investigation. Coronial investigations seek to establish the facts – when, where, how and why the death or fire happened.

From page 14.

Reducing preventable deaths
Wherever possible, a Coroner will suggest ways to prevent similar deaths or fires by making well-informed and practical recommendations based on the evidence before them.

From page 22.

Promoting public health and safety
The Court regularly reports on data and trends regarding preventable deaths in Victoria to help inform public health responses.

From page 30.

The Court's functions, powers and obligations are detailed in the *Coroners Act 2008* (The Coroners Act).

Our values

Integrity
We show integrity by consistently applying ethical and principled behaviour which reflects trust and honesty.

Collaboration
We show collaboration by working together with our stakeholders to achieve better results for the community.

Accountability
We commit to the actions we take to achieve the best possible outcome for the Coroners Court of Victoria.

Respect
We show respect by considering others and treating them with dignity, empathy, sensitivity, and courtesy.

Excellent service
We strive to do our best to deliver quality service, focusing on improving the way we work within the Court, to provide excellent services to the Victorian community.

Our history

Victoria's first Coroner was appointed in 1841, 30 years before Melbourne established a morgue in 1871. It was not until 1888 that the first permanent Coroners' courthouse was constructed and in 1988, the Court moved to the purpose-built Coronial Services Centre in Southbank.

The Court as it is today was established on 1 November 2009 when the *Coroners Act 2008* came into effect. This was the most significant reform of the Victorian coronial jurisdiction in 25 years and replaced the former State Coroner's Office.

Coronial services in Victoria

Victoria's Coroners are supported by coronial services delivered by a number of different organisations including VIFM and the Police Coronial Support Unit (PCSU).

To streamline coronial investigations, we are all co-located at the State Coronial Services Centre, Southbank.

Among many important roles, VIFM supports Coroners by:

- receiving notifications of reportable deaths
- taking deceased persons into the care of the Court and managing the mortuary
- undertaking medical examinations, autopsies and toxicology scans as directed by a Coroner
- providing expert reports on the cause of death for the investigating Coroner.

PCSU also supports Coroners by helping Victoria Police members compile a thorough coronial brief, as well as appearing as the Coroner's Assistant at some inquests.

Our place in Victoria's court system

The Court is part of CSV, a statutory body established in July 2014 to strengthen the independence of Victorian courts and tribunals and place court administration into the hands of an entity directed by the judiciary. CSV provides and supports some administrative and corporate functions and the Court is responsible for establishing how the judicial business is managed in accordance with law. The State Coroner, as Head of Jurisdiction, directs the administrative support provided by CSV jurisdiction-based staff under the management of the Court CEO. As a distinct entity, the Court is accountable to Parliament through CSV.

The Court operates differently to other courts. Unlike other courts which are adversarial in nature, we have an inquisitorial jurisdiction. This means the Court actively investigates the matters before us. Additionally, while all cases that come before the Court are thoroughly investigated, the vast majority of matters do not proceed to a hearing in a courtroom. Rather, a finding is made 'in chambers'.

Strategic Plan 2016–2019

The Court's Strategic Plan details how we work to achieve our vision.

Feeding into our business planning cycle and budget process, the Strategic Plan 2016–19 ensures we put in place the processes, resources and technology to realise three strategic directions:

1. **Engaging our community and stakeholders**
2. **Investing in our people**
3. **Achieving our priorities**

1. Engaging our community and stakeholders

The Court will deliver the highest-quality services for our stakeholders and the community. Our focus is to provide a better service to those who find themselves involved with the Court as a result of the death of a loved one. We aim to deal with the community with sensitivity and professionalism.

Key focus areas

- Service ethos: Provide professional coronial services.
- Community and professional education: Improve the understanding of the role of the Court and of court practices in order to set realistic expectations.
- Maintaining strong partnerships: Work together with partner organisations to ensure the best outcomes for the Victorian community.

2. Investing in our people

The most important resources of the Court are our people – the Coroners and the Court's staff who support them. In delivering a professional service, the Court promotes a culture of excellence in line with our values, by engaging staff through consultation and professional development.

Key focus areas

- Workforce planning: Provide a highly skilled and multidisciplinary team that meets current and future needs.
- Staff health, safety and wellbeing: Create a high-performance culture within a productive and rewarding workplace.

3. Achieving our priorities

Following a period of significant change, the Court has implemented a new operating model and continues to monitor operational performance to ensure that we remain responsive to the needs of the community.

Key focus areas

- International Framework of Court Excellence: Sustain the efficient and effective performance of the Court.
- Legislation and internal business systems review: Review and recommend amendments to relevant legislation and develop the Court's internal business systems to deliver coronial services that meet the future requirements of the Victorian community.
- Performance measures and management capability: Improve transparency and accountability through the development of performance measures and management capability.
- Court efficiency and sustainability: Promote a more sustainable Court through efficient procurement practices and the implementation of a cost recovery model to self-fund promotion of public safety in the area of preventable deaths.
- Information technology: Implement changes to technology that the Court has local control over.

Output performance

The Court's output performance measures outlined in the Victorian Budget Papers (BP3), are detailed below.

Table 1: Output performance measures

Major outputs/deliverables	Unit of measure	2016–17 actual	2017–18 estimates	2017–18 actual
Quantity				
Average cost per case	$	3015	3379	3376
The average cost per case is marginally lower than the target				
Case clearance	%	100.6	100	97.9
Finalisation of investigations remains steady, with an increase in overall number of cases closed. The slight reduction in case clearance rate resulted from a 6 per cent increase in the number of new investigations initiated (page 15).				
Quality				
Court file integrity: availability, accuracy and completeness	%	89.9	90	87.6
File integrity continued to be maintained to a high standard. The Court continued to work towards streamlining and strengthening processes with improved staff training and digital tracking.				
Timelines				
On time case processing – matters resolved or otherwise finalised within established timeframes.	%	80.3	80	85.4
Due to ongoing streamlining of processes, the proportion of investigations finalised within 12 months continues to increase (page 18).				

1. Investigations into deaths and fires

The Court independently investigates certain deaths and fires to determine their causes, reduce preventable incidents and promote public health and safety. This chapter provides an overview of these investigations, including the Coroners' caseload, how investigations were managed and their outcomes.

Challenges and achievements

Education and support

The Court is committed to ensuring the needs of families and friends who have lost loved ones are considered and that their wellbeing is cared for. The Court undertook a number of initiatives in 2017–18 to support affected families and enhance community understanding of the coronial process as follows:

- Family Liaison Officers (FLO) provided critical support to families and friends affected by loss, explaining coronial processes and findings. The FLO team worked closely with Court staff, liaising with families on sensitive matters.
- The Court continued to work with Court Network volunteers in their provision of support to people involved in the coronial process.
- As part of an ongoing program to help the community understand the coronial process, the Court is developing a proactive community education program to address a range of common misconceptions about the Victorian coronial system. Key areas of focus are medical examinations, the intersection of coronial and criminal investigations, investigation timeframes and the proportion of investigations that go to inquest.

Clarity and efficiency

Helping families and friends to understand what has happened to their loved ones is the cornerstone of the coronial process. The Court continued to improve processes for assisting families to obtain the documentation associated with a death. Whether families are seeking to better understand the cause of death or to finalise the estate of the deceased, timeliness is paramount at this sensitive time.

To this end, the Court worked to improved procedures for handling queries about death certificates with the Registry of Births, Death and Marriages to assist families who are in the process of arranging funerals or finalising insurance, financial and other matters.

In May 2018, the Court commenced a review of our correspondence to families to ensure the style and tone of all communication was accessible and sensitive. This project will be expanded in 2018–19 to include a new suite of letter templates in plain English that provide clear, professional and easily understood information about coronial processes and services.

Reducing timeframes

The Court always seeks to strike balance between thorough investigation and minimising the time families who have lost loved ones are engaged in the coronial process. The Court is continually working to reduce the duration of investigations through a focus on efficient investigations (page 18) and by streamlining internal processes.

This process has resulted in 85 per cent of investigations being closed within 12 months, and over 47 per cent in fewer than three months. One factor influencing this outcome is the high proportion of natural cause deaths reported to the Court, that, due to administrative improvements, can generally be finalised swiftly.

Improving statewide transport

The 2017–18 period saw continuing improvements in service delivery for the transport of deceased persons to the Coronial Services Centre in Southbank for identification and medical examination. These improvements stem from the establishment of new contractual arrangements in late 2016, which allow for greater oversight of contractor performance and include clearly defined service standards.

Under the new arrangements, St John Ambulance (Victoria) is responsible for all metropolitan transfers and statewide repatriation. Regional Victoria is covered by 22 contracts extending across almost 80 per cent of regional Victoria.

In addition to service improvements, the new contracts have seen the average price per transfer in metropolitan areas decrease from $475 to $418 – a reduction of 12 per cent. As the transport of deceased persons has historically comprised more than 30 per cent of the Court's budget, this represents a significant reduction in total expenditure.

Table 2: Transfer and repatriation costs

	2013–14	2014–15	2015–16	2016–17	2017–18
Metropolitan areas	$1,121,753	$1,730,220	$1,997,002	$1,841,651	$1,779,087
Regional areas	$1,534,920	$2,135,959	$2,264,647	$2,429,582	$2,367,355
Total	**$2,656,673**	**$3,866,179**	**$4,261,649**	**$4,271,233**	**$4,146,442**

Closure rates

Closure rates for investigations into deaths and fires remained steady at 97.9 per cent in 2017–18. This slight reduction in case clearance rate resulted from a 6 per cent increase in the number of new investigations initiated. Case closure requires the determination, where possible, of the exact circumstances surrounding a death. This includes the identity of the person who has died, the cause of the death or fire and how it occurred.

Many cases are the subject of ongoing criminal investigations or court proceedings in other jurisdictions. As a result, the number of pending cases also remained steady at 3938 cases.

Table 3: Investigations opened and finalised

	2013–14	2014–15	2015–16	2016–17	2017–18
Number of investigations commenced	6343	6336	6305	6248	6642
Number of investigations finalised	7623	6884	6596	6285	6500
Closure rate	120.2%	108.6%	104.6%	100.6%	97.9%

Types of investigations

By law, certain types of deaths must be investigated by a Coroner. They include:

Among the 6500 cases closed in the 2017–18 financial year, 99.1 per cent were closed following a coronial investigation. Administrative case closures (which do not require coronial investigation and include preliminary enquiries and incorrectly initiated cases) made up most of the remainder.

CASE STUDY

Mandatory reporting of medically unfit drivers

A Victorian health practitioner has no legal obligation to notify VicRoads regarding a patient who, because of illness, presents a danger to the public when he or she drives a motor vehicle. Over the past decade several Coroners have investigated fatal motor vehicle collisions involving medically unfit drivers, and have recommended that VicRoads introduce such a legal obligation.

VicRoads has repeatedly declined to do so. Most recently, two Coroners examined the need for mandatory reporting of medically unfit drivers across three published findings.

The first finding was in the death of **Mr H**, an 87-year-old man who was driving with his wife when the car veered off the road, collided with a tree and rolled; he sustained fatal injuries in this collision. The investigating Coroner established that the collision was most likely caused by a sudden cardiac ischaemic event. Mr H had a history of significant cardiac disease and general poor health. His general practitioner told him he was not fit to drive but did not report him to VicRoads. The Coroner commented:

Mr H's death and the danger caused to the wider community by impaired drivers continuing to operate motor vehicles, serve as a compelling indication that VicRoads' existing policy measures and intransigence on this issue are inadequate.

The second finding was in the death of **Mrs E**, an 85-year-old woman who was a passenger in a car driven by her husband when he drove through a T-intersection at speed without braking or swerving and collided with a tree. The investigating Coroner found that Mrs E had experienced progressive cognitive decline for approximately seven years. Neither her general practitioner nor her psychiatrist ever reported her declining cognitive function to VicRoads.

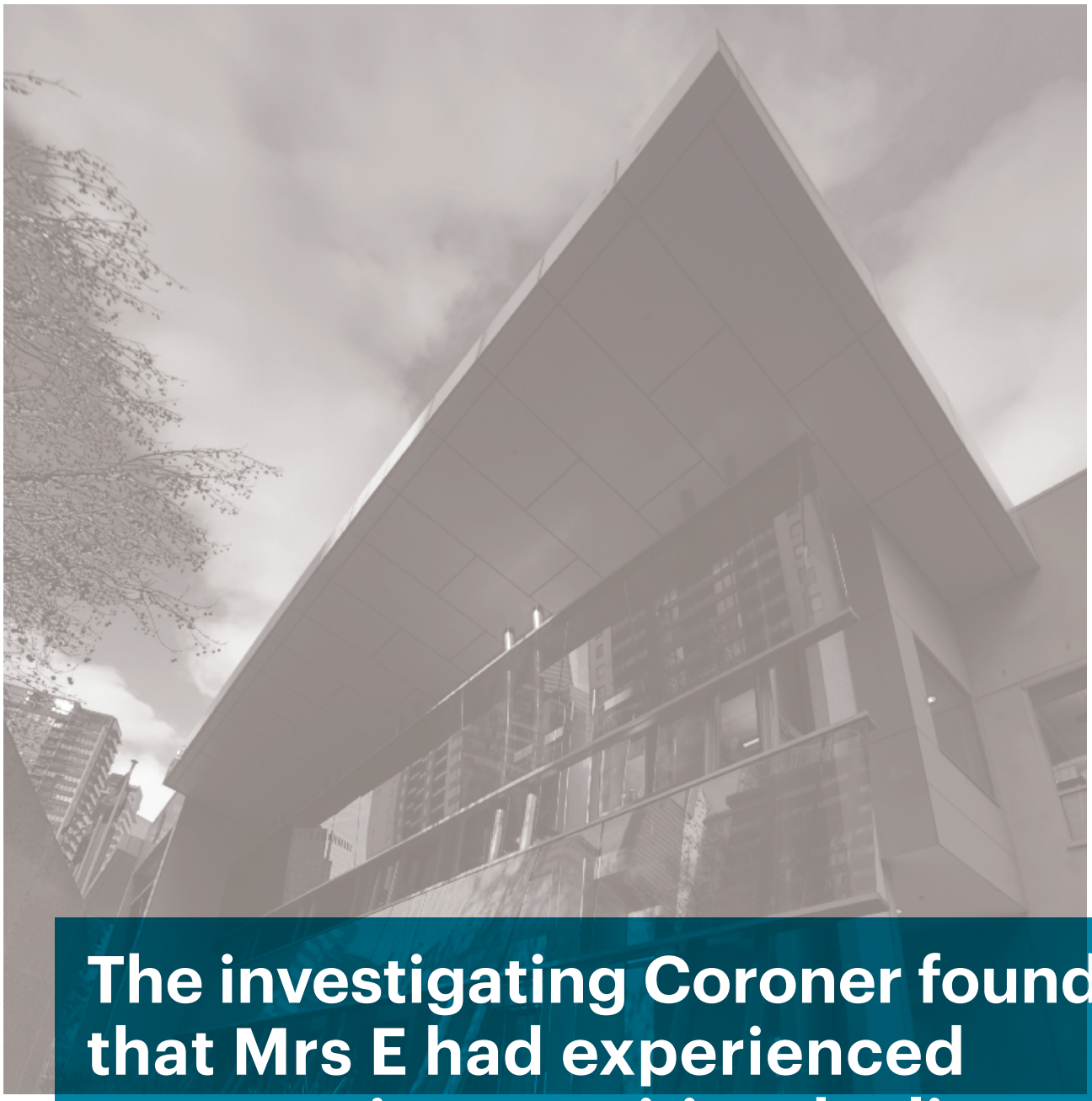
The Coroner concluded:

The circumstances of Mrs E's death reflect that in the absence of a mandatory reporting system for the medical profession, a significant opportunity is lost to protect drivers and other road users.

The third finding was in the death of 68-year-old **Mr F**, who was riding a motorcycle when a car turned directly into his path of travel. The investigating Coroner noted the possibility that the car driver's impaired vision – as documented by two medical practitioners – may have contributed to his not seeing the oncoming motorcycle.

All three findings included variations of the same recommendation: that VicRoads and the Department of Economic Development, Jobs, Transport and Resources (DEDJTR) develop a legislative framework requiring mandatory reporting to VicRoads when a medical practitioner determines a person may not be medically fit to drive.

In their responses to these recommendations, VicRoads and DEDJTR did not implement mandatory reporting but identified opportunities to improve the existing voluntary reporting systems including research and health practitioner education and continued monitoring of fitness to drive, addressing all age cohorts, to ensure that the Victorian Government is provided with appropriate and timely advice and policy options to address this important challenge.



The investigating Coroner found that Mrs E had experienced progressive cognitive decline for approximately seven years. Neither her general practitioner nor her psychiatrist ever reported her declining cognitive function to VicRoads.

1. Investigations into deaths and fires (continued)

Timely investigations

The duration of death and fire investigations can vary widely, with each case requiring an individual approach. A number of factors contribute to the duration of a case, including the complexity of the matter and whether an inquest will be held. In some cases, investigations by other authorities need to take place before a coronial investigation can be finalised. These investigations may result in other court proceedings, including criminal proceedings, which will also have an impact on the duration of a coronial investigation.

The average duration of investigations closed in 2017–18, was 11.8 months. A large proportion of investigations (47.4 per cent or 3082 cases) were finalised within three months. These cases were largely comprised of natural cause deaths determined by the Coroners as requiring no further investigation. The number of cases open for 24 months or more reduced by approximately 34 per cent on 2016–17 figures.

Table 4: Duration of closed investigations

	2013–14	2014–15	2015–16	2016–17	2017–18
0–12 months	5369	5667	5289	5047	5526
12–24 months	1210	730	785	855	722
>24 months	1044	487	522	383	252
Total	**7623**	**6884**	**6596**	**6285**	**6500**

Reducing open cases

Timely resolution of cases is a key indicator of the Court's commitment to meeting the needs of the community. In 2017–18, there was a continued decline in the number of cases that have been open for longer than 24 months. Whereas five years ago the Court had 2254 open investigations older than 12 months, by 30 June 2018 there were only 974. Many of the remaining open investigations are the subject of ongoing criminal investigations or court proceedings in other jurisdictions and therefore cannot be finalised by the Court.

Table 5: Average duration of open cases before the Court at 30 June

	2013–14	2014–15	2015–16	2016–17	2017–18
Duration (days)	417.2	403.5	364.2	333.1	359

Inquests

Inquests are required for a small proportion of investigations, including most deaths in custody and homicides in which no one has been charged with an indictable offence in relation to the death. Coroners hold inquests only when necessary as the process of preparing, scheduling and holding an inquest can extend the duration of an investigation, and cause unnecessary costs to parties, including families.

Table 6: Inquests held

	2013–14	2014–15	2015–16	2016–17	2017–18
Number of metropolitan inquests held	191	170	122	72	43
Number of regional inquests held	25	26	9	11	6
Percentage of closed investigations with inquest*	2.8%	2.8%	2.0%	1.3%	0.7%

* Not all investigations for which inquests were held were closed in the same financial year.

In order to reduce the time in which families and friends who have lost loved ones are involved in the coronial process, the Court uses directions and mention hearings to reduce the need for inquests whenever possible. Scoping issues in a case at an earlier stage increases opportunities to obtain relevant evidence without the need for an inquest, further reducing the requirement. As a result of these efforts, the number of inquests held has been steadily decreasing, with 0.7 per cent of investigations closed requiring inquests in 2017–18.

Where inquests are required, the Court has instituted a number of initiatives to reduce their duration. These include hearing expert evidence concurrently and allowing more witnesses to give evidence by video conference from interstate or overseas. This saves time and expense in rescheduling hearings to allow witnesses to attend in person.

Findings

For a majority of coronial investigations, a Coroner will hand down a finding. These findings may be made with or without an inquest. In 2017–18, most of the Coroners' findings (99.2 per cent) were made 'in chambers' rather than in the courtroom.

Findings must be published in the following circumstances:

- when an inquest was held
- when recommendations are made
- following an investigation into the death of a person in custody and care, where the death was found to be due to natural causes.

A Coroner may also direct that a finding be published if they consider that it is in the public interest to do so.

In all four deaths, the responses to recommendations that the Court has received to date have been positive...

CASE STUDY

Access to means of suicide in inpatient mental health services

Most patients are admitted to mental health inpatient units because they are experiencing acute exacerbations of their mental illness, often involving threatened or actual self-harm including suicidal behaviour. Ensuring patient safety is crucial while clinicians work to treat the mental illness, and four recent coronial findings have explored the tragic consequences of lapses in safety measures:

Ms P, a 29-year-old woman who suicided by hanging while an inpatient in Ward E of Casey Hospital. Ms P used a door handle as the ligature point for her suicide. The investigating Coroner found that the design and placement of the door handle were contributing factors in Ms P's death, and recommended that the Department of Health and Human Services work with Area Mental Health Services to develop more effective ligature audit tools.

Ms G, a 59-year-old woman who suicided by hanging while an inpatient at the Albert Road Clinic. She used a dressing-gown cord as the ligature and the ligature point was the top edge of a closed door. The investigating Coroner noted that there was no 'compelling reason' why a psychiatric inpatient should have access to ligatures such as dressing-gown cords, belts, or shoelaces, and recommended that the Albert Road Clinic draft a policy for removing potential ligatures from inpatients.

Ms E, a 39-year-old woman who suicided by incised injury to the wrist while an inpatient at Latrobe Regional Hospital's Flynn Ward. The investigating Coroner found that on the balance of probabilities, the razor Ms E used to inflict this injury had been secreted in a Kindle brought into Flynn Ward, and had been missed during a search of her property upon admission. The investigating Coroner recommended that the Chief Psychiatrist issue a revised guideline regarding searches of compulsory inpatients, informed by the circumstances of Ms E's death.

Mr H, a 62-year-old man who suicided by hanging in Ward 2B of Frankston Hospital. Mr H used a belt as the ligature, which he had been permitted to bring onto the ward, and the ligature point was the door between his toilet and bedroom. The investigating Coroner recommended that the Chief Psychiatrist review policies on bringing personal items into psychiatric wards, and that Peninsula Health create a new audit team responsible for ligature point risk management.

In all four deaths, the responses to recommendations that the Court has received to date have been positive, with organisations demonstrating a genuine willingness to address inpatient safety risks.

2. Reducing preventable deaths

The wellbeing of the Victorian community is at the centre of the work undertaken by the Court. When conducting an investigation, a Coroner will always consider if there are opportunities to prevent similar deaths or fires by making comments or recommendations to improve public health and safety. This chapter explains how recommendations are formed and responded to, and the Court's role in reviewing family violence deaths.

Challenges and achievements

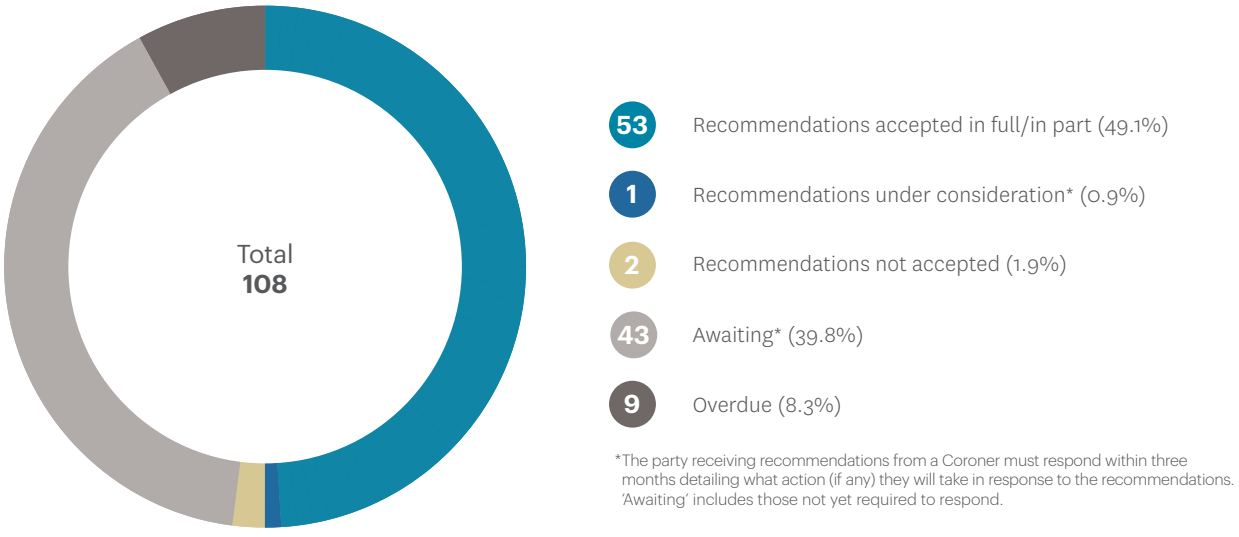
Strengthening public health and safety

The Court strives to develop coronial recommendations that will inform social policies aimed at reducing the number of preventable deaths and strengthening public health and safety responses. Recommendations are rigorously prepared to ensure they are informed by and based on the evidence before the Court. Their presentation is carefully considered to maximise the likelihood of their acceptance and implementation.

The Court draws on a range of resources when developing coronial recommendations. The Coroners Prevention Unit (CPU) was established to assist Coroners to identify opportunities to strengthen public health and safety through the formulation of feasible, evidence-based recommendations. The only multidisciplinary team of its kind in Australia, the CPU supports the Coroners in developing coronial recommendations that are well received and practical to implement.

This thorough, considered approach has delivered notable results, with 53 recommendations made in the past year accepted in full or part for implementation, and one further recommendation under consideration. In many cases in which recommendations were not accepted, the organisation in question had already taken steps to improve their processes and procedures in the wake of a preventable death.

Figure 1: Responses to recommendations from closed investigations



*The party receiving recommendations from a Coroner must respond within three months detailing what action (if any) they will take in response to the recommendations. 'Awaiting' includes those not yet required to respond.

Making recommendations

While every death and fire reported to the Court requires an individual investigative approach, each investigation considers whether the death could have been prevented, with a mind to preventing similar deaths in the future. Where such measures are identified, Coroners can make recommendations to any minister, public statutory authority or entity. These may include any matter connected with a death, including recommendations relating to public health and safety or the administration of justice. A Coroner may also report to the Attorney-General in relation to a death they have investigated.

Coroners made recommendations in 1.4 per cent of findings made under section 67 of the *Coroners Act 2008* in 2017–18. This figure excludes natural cause deaths, deaths where a Coroner discontinued the investigation and administrative closures.

While there were fewer recommendations over the past year, it should be noted that this figure is entirely dependent on the matters before the Court and associated opportunities for prevention. As always, the Court focused on providing robust and informed recommendations in order to increase the likelihood of a recommendation being accepted and implemented.

Table 7: Recommendations made in closed investigations

	2013–14	2014–15	2015–16	2016–17	2017–18
Number of investigations closed with recommendations	101	111	105	65	48
Number of recommendations made	306	305	296	127	108

Consultation

The CPU played a key role in supporting Coroners develop recommendations over the 2017–18 year, with Coroners making 670 referrals to the CPU regarding deaths under investigation. Typically, Coroners requested advice on:

- the circumstances in which the death occurred, including factors that may have contributed to the outcome
- the frequency of previous and subsequent similar deaths in Victoria, and common risk factors
- previous interventions that have been proven or are suspected to reduce the incidence of future similar deaths
- regulations, standards, codes of practice or guidelines that might be relevant to reduce similar deaths
- previous coronial recommendations and other feasible, evidence-based recommendations to reduce similar deaths.

Figure 2: Theme of referrals

Health and medical
387 (57.8%)

Mental health
161 (24.0%)

Family violence
40 (6.0%)

General referrals
82 (12.2%)

CPU case investigators worked across four streams:

Health and medical: focusing on deaths where Coroners required clinical advice on healthcare provided (or not provided) to the deceased and whether this might have contributed to the death.

Mental health: examining deaths of people with suspected or diagnosed mental illness and the treatment provided (or not provided) in the lead-up to their deaths.

Family violence: examining deaths that occurred in a context of family violence as defined by the *Family Violence Protection Act 2008* (page 27).

General: providing non-clinical advice to Coroners on deaths such as drug overdoses and motor vehicle accidents.

The CPU employs five doctors, each with different specialities. It also has an ongoing relationship with Monash Children's Hospital, engaging a paediatric registrar who is undertaking advanced clinical training. The paediatric registrar provides clinical advice to Coroners and assists with case reviews of deaths under investigation. Additionally, the paediatric registrar undertakes a research project that will benefit both the Court and Monash Children's Hospital. The 2017 research project examined suicide among adolescents aged 10 to 19 years.

CASE STUDY

Communication of medical results between clinicians and the patient

The investigation exposed a significant disconnect between the expectations in communication of results by the reporting radiologist and the referring doctor who ordered the PET scan. The reporting radiologist considered the results abnormal but not uncommon, whereas the referring doctor considered the results unexpected and significantly abnormal.

Mr M was 58 years old and an overseas resident working in the country. He was staying alone at a local hotel and his family were overseas. He was diagnosed at the local hospital with extensive Hodgkin's lymphoma. Treatment involved several cycles of chemotherapy at multiple hospitals.

A positron emission tomography (PET) scan in Melbourne suggested that Mr M may be suffering from toxic effects of his chemotherapy. Despite this, two days later Mr M received another dose of chemotherapy. This occurred because the specialist who had ordered the scan was unaware of the PET scan results, as was the treating team administering the chemotherapy. Mr M called the specialist to report feeling unwell and was told to go to hospital. The next morning he was found deceased in his hotel room.

The investigating Coroner identified the difficulties that may be encountered in patient management where differing components of care are delivered by individuals and institutions geographically separated from each other and between which there is no established professional relationship. The Coroner focused particularly on appropriate communication of results that are significant for the individual patient and unexpected to the referrer.

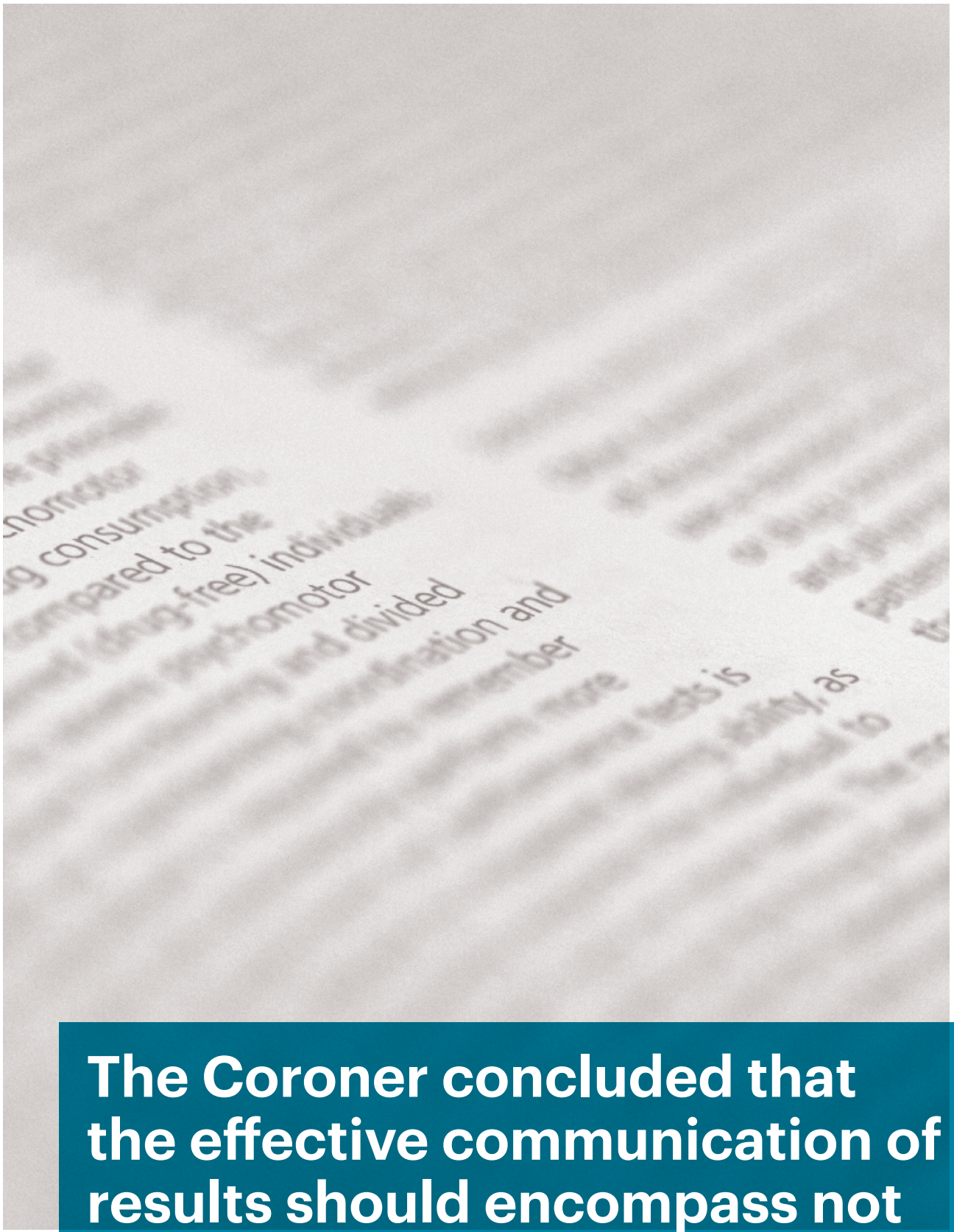
The investigation exposed a significant disconnect between the expectations in communication of results by the reporting radiologist and the referring doctor who ordered the PET scan. The reporting radiologist considered the results abnormal but not uncommon, whereas the referring doctor considered the results unexpected and significantly abnormal.

The Coroner concluded that the effective communication of results should encompass not only method of delivery, but also the circumstances of the review of the results. Rather than results being reviewed in an ad hoc way, such as the end of a busy day when comprehension and decision-making may be compromised by fatigue, results should be reviewed at a time and in a manner conducive to thoughtful analysis and appropriate response.

While acknowledging the complexity of communication, the Coroner found that the treating clinicians owed a duty of care to both communicate with each other and Mr M when the abnormal results were known. Her first recommendation was:

That the Royal Australian and New Zealand College of Radiologists, the Australian Association of Nuclear Medicine Specialists and the Royal Australasian College of Physicians collaborate to develop a set of Standards dedicated to systems for the communication of imaging results. The Standards should be as explicit as possible in setting out the roles and responsibilities of diagnostician and referring doctor and the required manner of communication in different situations consistent with the conclusions and comments in this case.

Responses to the Coroner's recommendations were not due to be provided to the Court at the time of publication.



The Coroner concluded that the effective communication of results should encompass not only method of delivery, but also the circumstances of the review of the results.

2. Reducing preventable deaths (continued)

Monitoring trends

The Court maintains a comprehensive and detailed set of records on reportable deaths in Victoria. This information provides a unique insight on emerging trends and patterns in causes of death, driving the development of coronial recommendations to reduce the incidence of similar deaths in the future.

The preliminary analysis of causes of death set out in this chapter is indicative only and is subject to review as Coroners progress their investigations and more information becomes available. A more comprehensive review will be conducted at a later stage.

Causes of death reported to the Court in 2017–18 were consistent with the caseload in previous years. Just over 38 per cent of cases reported to the Court were deaths caused by natural causes, 33.1 per cent were accidental (due to falls, road accidents, drowning and similar), and 10.4 per cent were suicides.

Table 8: Cases reported to the Court in 2017–18

Deceased intent / mechanism of death	Number	Percentage
Deaths from natural causes	**2536**	**38.2**
Unintentional	**2198**	**33.1**
Falls	1436	21.6
Poisoning	334	5.0
Transport	287	4.3
Drowning	31	0.5
Other	110	1.7
Intentional self-harm (suicide)	**688**	**10.4**
Hanging	351	5.3
Poisoning	141	2.1
Firearm	27	0.4
Rail	42	0.6
Jump from height	32	0.5
Other	95	1.4
Assault	67	**1.0**
Complications of medical and surgical care	**460**	**6.9**
Other*	**289**	**3.4**
Non-reportable deaths	**300**	**4.5**
Still enquiring	**171**	**2.6**
Total	**6642**	**100.0**

* 'Other' comprises of 115 (1.7 per cent) deaths from undetermined intent, 104 (1.6 per cent) other reportable deaths, 2 (0.03 per cent) legal intervention cases and 1 (0.015 per cent) fire without death.

Victorian Overdose Death Register

The Victorian Overdose Death Register (VODR), established by the Court in 2009, records detailed information regarding illegal and pharmaceutical drug deaths in Victoria. Further information on deaths of this nature in 2017 is provided on page 30.

The number of deaths due to drug overdose continued to rise in Victoria over the reporting period. A review of the intentional and unintentional poisoning deaths detailed in Table 8, and deaths from undetermined intent, identified all overdose deaths involving pharmaceuticals, illegal drugs and/or alcohol during the 2017–18 financial year. The data, presented in Table 9, shows that 512 overdose deaths occurred in Victoria in 2017–18, a 6.7 per cent increase compared to the previous reporting period.

The VODR is a dynamic database and is subject to change as coronial investigations are finalised and causes of deaths are determined.

Table 9: Drug overdose investigations reported

	2013–14	2014–15	2015–16	2016–17	2017–18
Number of deaths	390	396	473	480	512

Victorian Suicide Register

The Victorian Suicide Register was established by the Court in 2000 and contains detailed information relating to suicides that have occurred in Victoria since that time.

The primary purpose of the register is to assist Coroners in conducting investigations. However, it also serves as a resource for government and community organisations developing suicide prevention policy and initiatives, and for academic research.

The number of suicides over the past five years has gradually risen, with suicides comprising 10.4 per cent of all deaths reported to the Court in 2017–18. As further investigations are closed and Coroners confirm causes of death, these figures may change; however, the overall trend of an increase in numbers of suicides over the past five years is expected to remain consistent.

Table 10: Annual reports of suicide

	2013–14	2014–15	2015–16	2016–17	2017–18
Number of deaths	609	626	646	672	688

In 2017–18 the CPU responded to requests from a range of external organisations for coronial material regarding suicide deaths. The requests varied widely in scope, and included:

- a profile of suicides among Aboriginal and Torres Strait Islander people in Victoria, to assist the Department of Health and Human Services in preparation for its Statewide Stakeholders Forum on Preventing Suicide in Aboriginal Communities
- a detailed analysis of suicides occurring across the Victorian rail network, for the Transport and Mental Health Ministerial Roundtable
- data to assist various organisations (including Victoria Police, Primary Health Networks and local councils) to understand the frequency, nature and geographic distribution of Victorian suicides and fatal overdoses.

On 6 February 2018, a Memorandum of Understanding was signed to formalise information sharing about suicides between the Court and DHHS. With funding from DHHS, CPU has provided extensive data on suicides across Victoria, to assist DHHS with its suicide prevention initiatives including planning and implementation of the place-based suicide prevention trials. The CPU is currently working with DHHS and its other partners on data linkage projects to understand how people who suicide engaged with public mental health services, and is assisting the Chief Psychiatrist to identify people at risk of suicide among clients of public mental health services.

Victorian Homicide Register

The Victorian Homicide Register was established by the Court in 2000 and contains detailed information relating to all Victorian homicides reported to the Court since that time. It captures a broad range of data including: socio-demographic characteristics; location information; presence and nature of physical and mental illness; service contact; and in cases of family violence, information on the presence and nature of the violence.

The register indicates there were 57 homicides in Victoria in 2017–18, a decrease from 64 in the previous year (Table 11). This is the lowest number of homicides in the past five years and continues the trend of an overall reduction in homicides over the past three years.

The State Coroner initially takes carriage of all homicides and family violence matters. This ensures consistency and transparency in the handling of investigations and liaison with Victoria Police. Once underway, homicides which are not family violence-related, may be allocated to another Coroner for completion.

Family Violence Death Reviews

Victoria's Coroners have long been engaged in efforts to understand why family violence-related deaths occur and how they may be prevented. In 2009 the Court established the Victorian Systemic Review of Family Violence Deaths (VSRFVD). To further strengthen the response to family violence across the state, the Court has a dedicated team that conducts in-depth reviews of deaths suspected to have resulted from family violence which meet certain inclusion criteria.

2. Reducing preventable deaths (continued)

Family Violence Death Reviews (continued)

In November 2017, the Court updated the inclusion criteria for VSRFVD cases to include cases where:

- the deceased and offender were or had previously been in an intimate or familial relationship as defined by the FVPA or in a family-like relationship, such as kinship relationships as defined by the Victorian Indigenous Family Violence Taskforce (2003) or
- the death occurred during an episode of family violence or
- there was an identifiable history of family violence proximate to or causal to the death.

This enabled the inclusion of cases that had previously fallen outside of the scope of the VSRFVD, such as:

- deaths arising from bystander or police intervention in family violence incidents
- third parties killed in furtherance of family violence; for example, when a family violence perpetrator kills a new partner or family member of the family violence victim
- familial homicides where there is no otherwise identifiable history of family violence prior to the fatal incident
- suicides of family violence victims and perpetrators in certain circumstances.

These new criteria have led to an increase in the number of cases referred to the VSRFVD for investigation and consultation.

In the past financial year, 40 cases were referred to the VSRFVD CPU team for consultation and investigation. Of these, nine referrals were finalised by case review reports, five referrals were completed via consultation, and one referral was discontinued. At the end of the financial year 25 investigations remained ongoing within the CPU team.

In the past financial year, coronial proceedings were finalised in six family violence cases that were included within the VSRFVD. This includes referrals to the VSRFVD that were made in prior financial years.

Support for the operation of the Victorian Systemic Review of Family Violence Deaths

In March 2016, the Royal Commission into Family Violence recommended the Victorian Government establish a legislative basis for the Court's VSRFVD and provide adequate funding to enable the Court to perform this function, with these recommendations to be implemented within 12 months.

Subsequently, the Coroners Act was amended to establish a legislative basis for the VSRFVD, with the amended legislation commencing on 16 December 2017. The amended Coroners Act establishes the VSRFVD as a unit headed by the State Coroner of Victoria, specifies the VSRFVD's objectives and functions, enables the Court to include information relating to family or domestic violence intervention orders in its findings, recommendations and reports, and requires the Court to report on the operation of the VSRFVD in its Annual Report.

Increased resourcing

The 2017–18 State Budget provided $1.9 million over four years to allow the Court to expand the family violence team and strengthen the review of family violence-related deaths.

The VSRFVD team is now led by a new Manager, with a dedicated Family Violence Legal Officer, Family Violence Registrar and Family Violence Family Liaison Officer, in addition to the existing Family Violence Project Officer and two Family Violence Case Investigator positions.

Homicides by relationship

During the reporting period, 30 per cent of homicides occurred between family members or partners. Many of these deaths occurred in the context of family violence.

Of the murders that were identified as familial homicides in 2017–18, the majority (76.5 per cent) occurred between current or former intimate partners. This data is consistent with previous year-on-year figures.

The remaining familial homicides from 2017–18, were either parent–child or occurred between parties in 'other intimate or familial relationships' such as between siblings or extended family members (including in-laws).

Table 11: Homicides by relationship

	2013–14	2014–15	2015–16	2016–17	2017–18	Total
Intimate partner	15	9	15	14	13	66
Parent–child	8	7	11	7	3	36
Other intimate or familial (including kinship)	5	6	7	2	1	21
Not intimate or familial	34	32	36	31	25	158
Still inquiring	3	6	5	10	15	39
Total	**65**	**60**	**74**	**64**	**57**	**320**

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 slightly from the 2016–17 Annual Report because of this re-classification process.

Contributing to national data on intimate partner homicides

The Court is a founding and active member of the Australian Domestic and Family Violence Death Review Network (the Network). The Network represents a unique collaboration between domestic and family violence death review mechanisms operating across Australia.

The Network was established in 2011 to:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence-related deaths
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths
- identify, collect, analyse and report data on domestic and family violence-related deaths
- analyse and compare domestic and family violence-related deaths, findings and recommendations.

In May 2018, the Network released its inaugural *Australian Domestic and Family Violence Death Review Network – National Data Report 2018* which provided findings with respect to all intimate partner homicides that occurred across Australia, in a context of family violence, between 2010 and 2014. Data in this report revealed that:

- between 2010 and 2014 there were 152 intimate partner homicides in Australia, which followed an identifiable history of domestic violence
- almost 80 per cent of these homicides involved a male killing his current or former female partner, and approximately 20 per cent involved a female killing her current or former male partner
- the vast majority of males who killed a female partner had been the primary domestic violence abuser against that female prior to the homicide
- approximately a third of males killed a former female partner (36.4 per cent) and almost half of those homicides of former female partners occurred within three months of the relationship ending
- almost a quarter of males (24 per cent) who killed their current or former female partner were named as respondents in domestic violence orders protecting the female homicide victim at the time of her death
- of the females that killed a male intimate partner, most killed a male they were currently in a relationship with (82.1 per cent)
- the majority of females (60.7 per cent) that killed a current or former male intimate partner were the primary domestic violence victim in the relationship.

Of the 152 homicides examined, there were at least 107 children under the age of 18 who survived the intimate partner homicide involving one or both of their parents.

Table 12 shows a comparison of the national data from the inaugural data report with the equivalent Victorian data.

Table 12: Comparison of national and Victorian data 2010–2014

	National	Victoria
Intimate partner violence (IPV) homicides*	152	26
Male-perpetrated IPV homicides against females	121	20
Female-perpetrated IPV homicides against males	28	6
Same-sex IPV homicides	3	1

*Intimate partner violence homicides are defined as homicides between current or former intimate partners where there was an identifiable history of family violence prior to the homicide.

State bodies

As an important party in implementing recommendations from the Royal Commission into Family Violence, the Court was represented by Coroner Audrey Jamieson on the:

- Judicial Advisory Group on Family Violence, which was established by the Courts Council in 2016 to provide advice to CSV's governing body on the implementation of the Royal Commission recommendations from a Victorian court-system-wide perspective
- Chief Magistrate's Family Violence Task Force which provides a direct link to the Victorian Government for critical, strategic, and cross-sectoral advice concerning issues related to the broad intersection of justice and family violence, arising from the Royal Commission.

3. Promoting public health and safety

The Court is strongly committed to educating the community on coronial matters. Access to court documents and data is encouraged in the hope the Court's findings will contribute to improving public health and safety. This chapter outlines some of the research being undertaken by and with the Court, and the demand for Court's services and information.

Challenges and achievements

Supporting research

Each year the Court's Research Committee receives and assesses applications for access to coronial data for research purposes. The Committee meets eight times per year to review research and its resource implications for the Court, and consider its impact on affected families and other loved ones of deceased people. It then advises the State Coroner about the appropriateness of applications. The State Coroner considers the committee's advice together with the application, to determine whether to endorse the research.

In 2017–18, 48 applications were assessed, covering a broad range of topics, including:

- child deaths
- suicide and borderline personality disorder
- deaths while diving
- deaths during and following bariatric surgery
- deaths in residential fires
- deaths involving prescribed medications.

Fostering cultural inclusion and respect

The implementation of the Court's Koori Inclusion Plan continued in 2017–18 and included the distribution of a brochure to Victoria's Koori community. The brochure contains information about the coronial process, including why a Coroner may be notified of a death, why medical examinations and autopsies may be needed and when a funeral can be arranged.

Another key element of the plan, which was developed in consultation with the Koori community, involves the formal engagement of Koori Elders in the Court. This initiative is designed to reduce perceptions of cultural alienation and foster greater participation by the Koori community in the coronial process.

Drug overdose deaths

Each year the Court reviews data from the VODR to ascertain the number of Victorian overdose deaths that occurred in the previous calendar year and conduct comparative analysis with past annual data to identify trends.

The Court's analysis shows that in the calendar year 2017, the number of people who died in Victoria from overdose rose to 523, though this may rise as cause of death is confirmed through finalised coronial investigations. This is consistent with long-term trends that have seen the number of drug overdose deaths in Victoria steadily increasing since the early 2000s.

Over the past five calendar years, pharmaceutical drugs were the most frequent contributing drug type, playing a role in 79.6 per cent of all overdose deaths during the period. Illegal drugs contributed in 48.7 per cent of overdose deaths, and alcohol contributed in 25.5 per cent of the deaths. These three proportions sum to greater than 100 per cent because the majority of Victorian overdose deaths involve multiple drugs in combination with one another rather than a single drug; between 2013 and 2017 on average 72 per cent of overdose deaths each year were the result of mixed drug toxicity.

Table 13: Victorian overdose deaths by calendar year

	2013	2014	2015	2016	2017
Involved pharmaceutical drugs	312	316	356	381	414
Involved illegal drugs	163	164	227	263	271
Involved alcohol	95	94	106	124	151
Total number	**380**	**387**	**454**	**492**	**523**

Contributing to drug harm reduction

In the 2017–18 financial year, the Court continued its longstanding focus on reducing drug-related harms including those associated with pharmaceutical drugs in particular. Activities included the following:

- In July 2017, the State Coroner delivered a finding where the deceased died from combined toxic effects of drugs including benzodiazepines he had obtained from multiple prescribing medical practitioners. In the finding, Judge Hinchey reinforced the urgent need for DHHS to implement a real-time prescription monitoring program to reduce the risk of further such deaths.
- In October 2017, Coroners Prevention Unit Senior Case Investigator presented at the Turning Point Symposium and Oration held at the State Library of Victoria. The presentation addressed anticipated benefits and challenges of implementing Victoria's real-time prescription monitoring system.
- In November 2017, the Deputy State Coroner delivered a finding following the inquest into a death where the individual died after a fall in a residential aged care facility. One focus of the investigation was the link between the fall and administration of drugs including oxazepam. The Deputy State Coroner ultimately found that the oxazepam medication regime contributed to the death and made a number of recommendations regarding clinical governance of prescribing in these settings.
- In February 2018, Court staff in collaboration with experts from Turning Point published the results of a study in the *International Journal of Drug Policy* on witnesses to fatal pharmaceutical opioid-involved drug overdoses in Victoria. The study found that in 21 per cent of these overdose deaths, a person was present who witnessed signs and symptoms of overdose before death and could potentially have intervened. The study findings supported the need for overdose education delivery to partners and family members of people who use pharmaceutical opioids.

Access and education

The Court often assists external organisations who request data for purposes of death prevention. Over the past year, the Court responded to 24 requests for data and other assistance from external organisations, including:

- the Victorian Commission for Gambling and Liquor Regulation, to assist its Sixth Review of the Casino Operator and Licence
- VicRoads, to collate more specific and detailed information on jumping suicides from Victorian road bridges and overpasses
- the New Zealand State Coroner, to assist the Coroner's response to the Mental Health and Addiction Inquiry
- Victoria Police, to assist them in understanding and quantifying overdose deaths that occur at music festivals.

Knowledge sharing

The Court is increasingly working with other jurisdictions to ensure our findings and data can be used to the greatest benefit. To help inform research and prevention efforts on a national scale, the Court codes all closed investigation files for contribution to the National Coronial Information System (NCIS). This database contains information on the deceased and all identified factors contributing to their death. The NCIS provides the Court with access to detailed statistics from Australia and New Zealand.

The Court has allocated a dedicated resource to work with NCIS to ensure files are coded accurately and quickly. The Court is steadily reducing the number of closed cases which require coding. In 2017–18, 5525 closed cases were entered on NCIS. Quality audits conducted by NCIS show Victoria is consistently achieving a lower error rate than national averages.

Requests for documentation

Each year, the Court receives a high volume of requests for access to information and documents contained in the coronial files, such as medical examination reports, toxicology reports or unpublished findings. Applications, known as a Form 45, continue to grow, with the number of requests received by the Court having increased by 47 per cent in the past five years (Table 14).

Table 14: Requests for coronial documents

	2013–14	2014–15	2015–16	2016–17	2017–18
Form 45 requests from external parties	3553	4327	4668	5063	5237

3. Promoting public health and safety (continued)

Access and education (continued)

Information and support

The Court is continually striving for better ways to support families and friends who have lost loved ones. In the days and months following a death, clear, easy-to-understand information about the coronial process is imperative.

Traditionally, families and other stakeholders have been encouraged to call the Court to obtain information. However, people are increasingly utilising the Court's website to access information, with more than 176,000 users visiting the site each year. To improve the quality of information available to the Victorian community, the Court is developing a suite of user-friendly online content, forms and instructions. This information will be made available with the launch of the Court's new website in 2018–19.

To meet the needs of Victorians from culturally and linguistically diverse backgrounds, the Court's main family brochure *What do I do now?* is available in 15 languages. Translation and interpretation services are also available for families and friends requiring the service during their interactions with the Court.

Stakeholder engagement

Hospitals and health practitioners are key stakeholders in the coronial process. The Court holds quarterly information sessions at the State Coronial Services Centre to explain the circumstances in which they are obligated to report medical deaths, and what they are required to report. These information sessions are further supported by targeted resources published by the Court.

Coroners and Court staff regularly present to key stakeholders and at industry events to improve community and stakeholder understanding of the coronial process. Key industry stakeholders include Victoria Police, clinicians and allied health professionals, radiologists, medical students and legal practitioners. Over the past year, Coroners presented at a total of 20 events. Court staff presented at a further five events on topics such as overdose from illegal and pharmaceutical drugs, and coronial recommendations.

As part of the Victorian Law Foundation's 2018 Law Week, the Court held a mock inquest to provide an educational and entertaining insight into the coronial system. Court and VIFM staff worked together to produce the mock inquest and over 150 people attended.

Supporting innovative research

The Court will continue to build our collaborative relationships with academic institutions and health organisations in 2018–19 to further promote public health and safety in the Victorian community. A central goal is to further develop research ties with VIFM, to draw upon the expertise of its staff and share knowledge and skills in death investigation. The Court is also engaging with Deakin University researchers to generate new insights into Victorians who suicide in rural and regional areas of Victoria, and with experts from St Vincent's Hospital to understand suicide in a context of physical ill health.

CASE STUDY

Pharmacist responsibility to dispense drugs safely

While in recent years the steady rise in deaths involving prescribed drugs has focused attention on doctors' prescribing practices, far less consideration has been given to the role that pharmacists play in ensuring safe and clinically appropriate access to medications. Two recent Victorian coronial findings have highlighted pharmacists' responsibilities in this respect.

The first finding was in the death of 79-year-old **Mrs Y**, who was wrongly dispensed the drug rosuvastatin rather than simvastatin at a pharmacy. This dispensing error coincided with the onset of a deterioration in her health culminating in death. The investigating Coroner considered at length the forensic evidence regarding whether the rosuvastatin could be related to Mrs Y's deterioration and concluded that it was a contributing factor along with several other factors. The Coroner further noted that the dispensing error was queried at the time by Mrs Y's husband, but he was assured by a staff member that the script was accurately dispensed. The Coroner made two recommendations:

1. *In the interests of contributing to a reduction of preventable deaths, I recommend that the Epping Plaza Chemmart institute a policy whereby, when issues that concern dispensed medication are raised by a customer, the concern is referred to the pharmacist for review.*
2. *I further recommend that the National Council of the Pharmacy Guild of Australia review the circumstances of Mrs Y's death, for the purposes of education, awareness and the creation of robust dispensing policies and guidelines.*

The second finding was delivered following an inquest in the death of 77-year-old **Mr G**, whose general practitioner prescribed methotrexate to treat his recalcitrant psoriasis, but provided clinically inappropriate dosing instructions (that tablets were to be taken daily rather than weekly). The general practitioner also did not conduct relevant tests before commencing the treatment. When Mr G subsequently presented the script for dispensing, the pharmacist was concerned about the dosing and contacted the general practitioner for clarification. Despite the pharmacist indicating the dose was possibly lethal, the general practitioner confirmed the prescription as written. Ultimately, the pharmacist determined to dispense the prescription. Mr G's health deteriorated over the next few days and he was admitted to hospital but died from complications of methotrexate toxicity in combination with his pre-existing illness.

The investigating Coroner considered a range of issues emerging from the circumstances of Mr G's death. With respect to the pharmacist, the Coroner noted that she:

[…] knew she had the option of not dispensing the medication, but for some reason she was not prepared to do it. She explained that she believed the doctor–patient relationship was stronger than the relationship between pharmacist and patient. She also believed there was a power imbalance between doctor and pharmacist, but agreed that she was an experienced pharmacist dealing with a GP who was quietly spoken and polite.

However, the Coroner further noted that regardless, the pharmacist should not have dispensed the methotrexate given her concerns:

The fundamental obligation of a pharmacist is to take reasonable steps to ensure that the dispensing of a medicine in accordance with a prescription is consistent with the safety of the patient. The pharmacist is required to exercise an independent judgement about the safety of the medicine and to contact the prescriber in case of doubt.

The Coroner made a number of recommendations in the death. With respect to pharmacist prescribing responsibilities, she recommended:

That the Pharmacy Board of Australia and the Pharmaceutical Society of Australia consult with each other and any other professional body they deem relevant, as to what, if any, further guidance and support should be provided to pharmacists to enable and empower them to discharge their duty of care to patients in situations where they have a concern as to the safety and appropriateness of prescribed medication.

The Coroner further noted that the dispensing error was queried at the time by Mrs Y's husband, but he was assured by a staff member that the script was accurately dispensed.

Corporate governance

To deliver the best possible services to Victorian families, the Court works closely with other courts and organisations. A strong culture of collaboration enables the Court to meet our obligations while making by making good decisions for the benefit of the community. This chapter outlines the Court's structure, committees and workforce, and processes for complaints, appeals and accessing information.

The Court sits within the governance structure of CSV, an independent statutory body. As a member of the Courts Council, the State Coroner directs the strategic and operational performance of the Court and its staff. The Court is accountable to the community through the Parliament of Victoria.

Organisational structure

More than 70 staff support the Coroners in their independent investigations and manage the administration of the Court. The organisation comprises four divisions, each of which is led by a manager:

Coroners Support Services closely manages case files, providing support to families and liaising with other parties. This division includes Court administration, family liaison officers and registrars.

Corporate Services supports the efficient operation of the Court through governance, records management, finance and procurement, information technology, media and communications, policy, risk and audit and human resources functions.

Legal Services assists Coroners with their investigations by analysing evidence, preparing draft findings, preparing matters for inquest and appearing as counsel to assist the Coroner at inquests.

Coroners Prevention Unit works closely with the Coroners to help them identify and research matters that may lead to recommendations being made to prevent similar deaths.

Coroners' group

All Coroners meet regularly discuss issues that arise in their daily practices and to receive an update from the State Coroner as to her upcoming or recently completed activities. Quarterly meetings of the Council of Coroners (introduced in April 2018) provide a forum for formal, business reporting by the Operational Executive back to Coroners in relation to the operations of the Court. This meeting examines themes and issues identified within the business units of the Court, makes high-level decisions in relation to the operations of the Court and sets the strategic direction going forward. The Coroners also attend an annual two-day professional development seminar.

Operational Executive Committee

The Operational Executive Committee comprises the CEO, the heads of the Court's four business units and the Executive Officer to the State Coroner. It meets fortnightly to discuss:

- day-to-day operations
- progress on major projects
- efficient management of Court resources
- strategic direction of the Court.

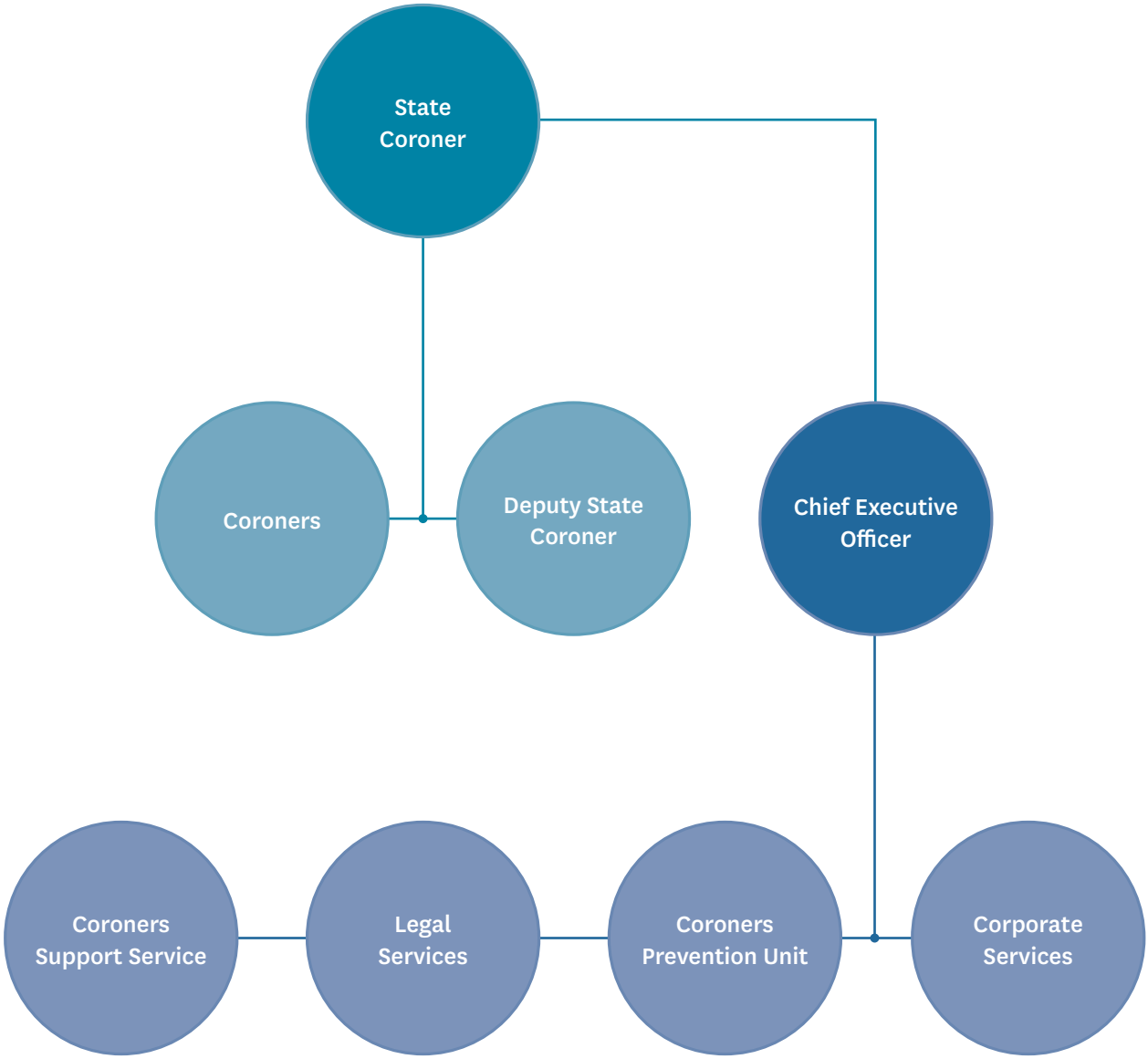
CSV representation

Like other courts, the Court is bound by CSV policies and procedures to ensure the overarching strategy for Victoria's judicial system is advanced. Many of the administrative functions are provided or supported by CSV Jurisdiction Services in order to streamline service delivery to the community.

As Head of the Coronial Jurisdiction, the State Coroner is a member of the Courts Council, CSV's governing body. Coroners represent the Court on several standing committees established by the Courts Council:

- Strategic Planning, Infrastructure and Services Portfolio Committee
- Finance Portfolio Committee
- Human Resources Portfolio Committee
- Information Technology Portfolio Committee
- Courts' Koori Portfolio Committee.

Figure 3: Organisational chart



Corporate governance (continued)

Organisational structure (continued)

VIFM representation

Important aspects of the state's coronial services are provided by VIFM. The Court is represented in several key VIFM bodies.

VIFM Council

VIFM Council is the institute's governing body, taking a strategic and stewardship role in leading VIFM in accordance with the responsibilities set out in the *Public Administration Act 2004*. The State Coroner is a member of the VIFM Council.

Coroners and Pathologists Working Group

Two Coroners and senior staff from both the Court and VIFM meet quarterly to provide expert advice on operational and other issues. The working group is chaired alternately by the Deputy State Coroner and the Deputy Director of VIFM Forensic Services. It provides guidance to two Coroners Court and VIFM joint committees:

Steering Committee
This committee provides strategic leadership and oversight of death investigation matters, resolution of operational issues and emergency management for the State Coronial Services Centre. It also responsible for overseeing joint protocols and the memorandum of understanding between the two organisations. The committee meets quarterly and is alternately chaired by the State Coroner and the Director of VIFM.

Joint Operations Committee
This committee works to maintain and strengthen the working relationship between the two organisations. It seeks to continuously improve the quality and efficiency of the death investigation services provided by the Court and VIFM to families of the deceased, the justice system and the broader Victorian community. Comprised of senior staff from both organisations, it is alternately chaired by the Court's CEO and VIFM's Chief Operating Officer.

Coronial Council of Victoria

The first body of its kind in Australia, the Council was established under the *Coroners Act 2008* to provide advice to the Attorney-General regarding matters of importance to the coronial system in Victoria. Independent of both the Court and the Victorian Government, the Council acts in a way that:

- does not impinge on the independence of Coroners' professional tasks
- strengthens collaboration between agencies across the service system
- focuses on advice to enhance services to families and friends who have lost loved ones
- promotes the prevention role of the Coroners
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The State Coroner is a member of the Council.

Minimising risk

Risk management is integral to all aspects of decision-making, planning and service delivery at the Court.

The Court complies with CSV practices, policies and procedures to ensure both risks and resources are managed responsibly. In the past year the Court has continued to review business continuity and risk management planning to align with CSV's Risk Management Framework and the Victorian Government Risk Management Framework. Updates to the Court's risk management plan, register and profiles have driven operational improvements to the way the Court identifies, manages and treats risk.

Planning for interruptions

The Court undertook a major review of our Business Continuity Plan to align with CSV's newly implemented framework with a focus on ensuring the Court is adequately prepared to minimise the impact and duration of any disruption. All business areas contributed to the process, which included a series of business impact analysis workshops, a review of key stakeholders and the development of additional tools to assist the business continuity management team to manage a disruption.

Audits

The Court works collaboratively with CSV in the implementation of the CSV Annual Audit Plan, which reviews the Court's operational, administrative and financial performance and decisions.

In the past year, audits were conducted into procurement and budgeting processes. No Court-specific recommendations were made. However, the Court did improve its internal procurement processes, particularly in relation to the management of the transport of deceased persons (page 14).

External audits
External audits of the Court's administrative functions are occasionally undertaken by the Victorian Auditor-General's Office (VAGO). The Court's finances, along with all other jurisdictions', are included in VAGO's annual audit of CSV's finances, which are reported in full in the CSV Annual Report.

Workplace profile

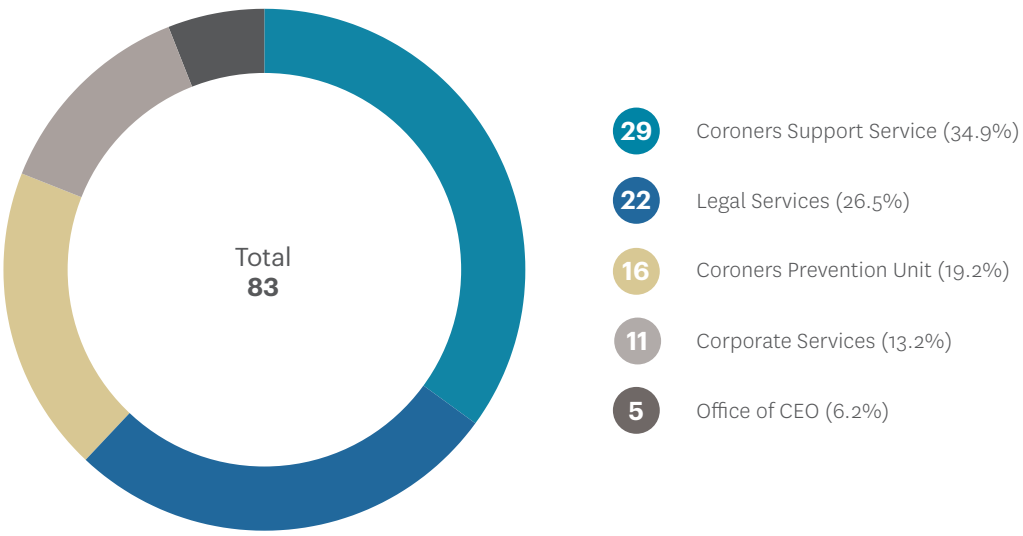
The following table discloses the head count and full-time equivalent (FTE) of all public service employees of the Court in the last full pay period in June 2018. All employees have been correctly classified in this workforce data collection.

Table 15: Workplace profile as at 30 June 2018

	All employees		Ongoing		Fixed term/casual	
	Head count	FTE	Head count		Head count	
	83	72.2	Full-time	Part-time	Full-time	Part-time
Gender						
Male	16	15.4	4	1	11	-
Female	67	56.8	21	17	22	7
Total	83	72.2	25	18	33	7
VPS Grade						
VPS2	18	15	5	5	7	1
VPS3	17	15.3	9	3	3	2
VPS4	30	24.6	4	7	15	4
VPS5	9	8.3	3	3	3	0
VPS6	7	7	4	0	3	0
STS/VPS7	1	1	-	-	1	-
Executive	1	1	0	0	1	-
Total	**83**	**72.2**	**25**	**18**	**33**	**7**

At 30 June 2018, the Court had 83 staff members (72.2FTE), not including Coroners. This includes 43 permanent staff, 41.9 per cent of whom were employed on a part-time basis.

Figure 4: Divisional headcount at 30 June 2018



Corporate governance (continued)

Providing a safe and healthy workplace

The provision of a safe and healthy workplace is one of the Court's key strategic objectives. The Court seeks to provide and maintain a healthy, safe working environment for all staff and visitors in accordance with the *Occupational Health and Safety Act 2004* and associated regulations. The Court has recently implemented a number of important initiatives to better support the social cohesion of the Court.

Maintaining a rewarding culture underpinned by a clear framework of values allows the Court to achieve excellent results in what can be a challenging area of work. Complying with CSV policies and practices, the Court promotes public sector professionalism and provides for fair treatment, career opportunities and the early resolution of workplace issues.

Recruitment

The Court works in partnership with the CSV executive and leadership teams to build and maintain the capacity of our workforce at each stage of the workforce lifecycle, from planning and engagement through to rewarding, retaining and transitioning staff. In-house human relations staff lead and contribute to a range of workplace initiatives to support a skilled workforce and fair and equitable recruitment process. This process is designed to ensure applicants are equally assessed and evaluated on the basis of the key selection criteria and other accountabilities, without discrimination.

In 2017–18, the Court began to refine its induction program for new staff and the review and development of clear, accurate position descriptions. This allowed the Court to offer development opportunities through secondments to other business units, higher duties and project-based positions. It recognised the Court's top talent and provided pathways for employees to build careers in CSV and the wider Victorian public sector.

Flexibility

The Court encourages flexible working arrangements to help employees balance the demands of work and personal commitments. Court employees have reasonable access to a range of leave options, flexible work hours, job-share arrangements, study leave and options to work from home.

The Court has taken all practical measures to comply with the *Carers Recognition Act 2012*. This includes ensuring, through the staff induction program and available leave options, that all staff understand the principles of the Act.

Debriefing

In 2017, the Court introduced the Wellbeing Debriefing Program, which provides support mechanisms and enhances the existing capacity of staff to manage the daily stressors, which arise in this unique workplace. Court staff are regularly exposed to traumatic cases and material and engage with distressed family and friends who have lost loved ones. As part of the program, it is now mandatory for all staff to attend two compulsory debriefing sessions with an experienced psychologist, with the option for a further two sessions if required.

Activities and initiatives

The Court offered a range of activities and initiatives aimed to ensuring the continued health and wellbeing of staff in 2017–18. These included:

- an Employee Assistance Program, which provides online resources, counselling and coaching to assist in dealing with general wellbeing, and work and life issues
- a 'quiet room' where staff can take time out from their desk
- ergonomic assessments
- desks that can be raised to allow staff to stand
- flu vaccinations.

The Court also works with VIFM on the joint Health and Wellbeing Committee and participates in inter-organisational projects, such as the annual Step Challenge.

Participation

The Court continues to work on building a culture of participation and collaboration, which is exemplified in a number of cross-organisational initiatives aimed at encouraging health and wellbeing and supporting the community.

The Green Team

The Green Team develops and implements initiatives that encourage staff to consider how they can make a positive contribution to the environment. Consisting of staff from the Court, VIFM and PCSU, the team ran several projects over the past year, including:

- recycling programs for coffee pods, batteries, polystyrene, plastic film and medical consumables
- an edible garden and composting bins
- clothing collection drives for various charities, such as Fitted for Work, Wear for Success and Lort Smith Animal Hospital.

The Green Team also contributed funds to non-profit micro-financing company Kiva.org, which lends money to low-income entrepreneurs.

Performance and development

Performance and development planning allows managers and staff to understand how their individual and team outputs contribute to the Court's Strategic Plan (page 13) and identify areas for further learning and development. All employees have an individual Performance Development Plan, which aims to support their ongoing performance and development by documenting clear goals, expectations and development opportunities.

The Learning and Development Program supports management and staff to build staff capability and develop new skills. It provides targeted training and development to enhance employees' knowledge and capacity to deliver on the Court's strategic objectives. This year, several training programs were implemented, including training on developing cultural intelligence.

Applications and appeals

Application to reconsider an order for autopsy

Autopsies are required for fewer than half of all deaths reported to the Court. When ordered by a Coroner, autopsies are conducted by a forensic pathologist practising at VIFM, to help determine the exact cause of death.

If a Coroner orders that an autopsy be performed in a particular case, an application can be made on cultural, religious or other grounds, for a Coroner to reconsider their decision.

If a Coroner affirms their original decision, a person may appeal that decision to the Supreme Court.

Application to hold an inquest

A person may apply to the investigating Coroner to hold an inquest as part of their investigation into a death or fire.

If a Coroner determines not to hold an inquest, the person who requested the inquest may appeal a Coroner's decision to the Supreme Court.

Application to re-open an investigation

A person may apply to the Court to set aside a finding or findings of a Coroner and re-open an investigation. However, a Coroner can only re-open an investigation if they are satisfied there are new facts and circumstances and it is appropriate to do so.

A Coroner's determination not to set aside a finding or findings and re-open an investigation may be appealed to the Supreme Court within three months of the Coroner's decision.

Appeals against the finding(s) of a Coroner

A person with a sufficient interest in an investigation may appeal to the Supreme Court against the finding(s) of a Coroner.

Supreme Court appeals

In 2017–18, four appeals were finalised.

They included the following:

Glascott v Coroners Court of Victoria [2017] VSC 328
Mr Glascott appealed the decision of the former State Coroner to refuse to re-open the investigation into the death of a solicitor he had been convicted of murdering in 2008. The State Coroner had refused Mr Glascott's application under section 77 of the *Coroners Act 2008*, noting that he had exhausted his appeal options through the criminal justice process. Justice Ginnane dismissed the appeal having found no error of law or matters relating to the interests of justice, which would allow the appeal.

Coulston v State Coroner of Victoria [2018] VSC 103
Mr Coulston sought leave to appeal the determination of the State Coroner to refuse to re-open an inquest into the deaths of three individuals Mr Coulston had been convicted of murdering in 1995. Mr Coulston made an application pursuant to section 77 of the *Coroners Act 2008* to have the matter re-opened and the State Coroner determined that while there were new facts and circumstances presented, it was not appropriate to re-open the matter.

Justice Garde was not satisfied that the grant of leave to bring the appeal was desirable in the interests of justice and Mr Coulston's case before the Supreme Court was essentially the same case as was made to the State Coroner. In reviewing the determination Justice Garde found the reasons for the State Coroner's refusal to re-open highly persuasive and dismissed the appeal, finding it to have no merit.

Spear v Hallenstein [2018] VSC 169
Ms Spear made application for orders under section 59 of the *Coroners Act 1985* (to re-open an inquest) and Justice Niall determined that the Supreme Court did not have jurisdiction to hear and determine the application.

Smith v Coroners Court of Victoria [2018] VSC 307
A Coroner determined to release a body to the estranged wife of a deceased person, who was the senior next of kin according to the *Coroners Act 2008*. This determination was challenged by the deceased's mother (and step-father) in the Supreme Court. Justice Richards decided that there was no error of law and in doing so, noted that there is no discretion permitting a coroner to release a deceased person outside the senior next of kin hierarchy set out in the *Coroners Act 2008* (mandatory hierarchy).

Corporate governance (continued)

Feedback

The Court welcomes feedback and considers it an important resource for improving services and the experience of those involved in the coronial process. While feedback is predominantly positive, complaints regarding service provision, the conduct of Coroners and the Court's processes or procedures do occur.

Complaints and information relating to them are confidential. The Court receives and manages complaints in accordance with the *Privacy and Data Protection Act 2014*.

The Court has no jurisdiction to address complaints about the merits of a finding or other matters that are outside of the Court's responsibilities, such as Victorian Government policy, legislation or legal representation.

How to provide feedback

Compliments and complaints can be addressed to:

Coroners Court of Victoria

Attention: Feedback and Complaints Officer

65 Kavanagh Street

Southbank VIC 3006

New Judicial Commission

From 1 July 2017, complaints about the conduct or capacity of Victorian judicial officers or members of the Victorian Civil and Administrative Tribunal (VCAT) may be made to the Judicial Commission of Victoria. The Commission is an independent organisation established under the *Judicial Commission of Victoria Act 2016*.

The Commission cannot investigate the correctness of a decision made by a judicial officer or VCAT member. Nor can it investigate complaints about federal courts or tribunals, such as the Family Court and Administrative Appeals Tribunal, nor can it investigate complaints about court or VCAT staff.

A member of the public or the legal profession can make a complaint by completing the online complaint form. The Law Institute of Victoria and the Victorian Bar can also refer complaints on behalf of their members without disclosing the identity of the complainant.

For more information:

Judicial Commission of Victoria
GPO Box 4305
Melbourne VIC 3001

enquiries@judicialcommission.vic.gov.au
www.judicialcommission.vic.gov.au

(03) 9605 2420

Access to information and documents

Freedom of information

The *Freedom of Information Act 1982* does not apply to documents held by courts in respect of their judicial functions.

Applications for documents relating to court administration may be made to CSV, or through **www.foi.vic.gov.au**.

How to access Court documents

Families, interested parties and other parties involved in a coronial investigation may request access to Court documents such as:

- the medical examination report
- toxicology report
- the coronial brief
- witness statements
- exhibits and transcripts from an inquest
- coronial findings (that are not already publicly available).

Media, researchers and members of the community may also request copies of Court documents. Access will be granted if the investigating Coroner is satisfied that the application meets the criteria under the *Coroners Act 2008*.

To request access to coronial documents, please download the application, known as Form 45: Access to coronial documents including transcripts, from **www.coronerscourt.vic.gov.au**

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