Coroners Court
of Victoria

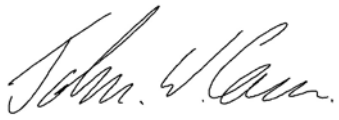
Annual Report

2021—2022

Coroners Court
of Victoria

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 2022.



Judge John Cain, State Coroner
November 2022

Acknowledgement

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

Published by the Coroners Court of Victoria

65 Kavanagh Street Southbank VIC 3006

November 2022

We value your feedback

We welcome feedback on our Annual Report, particularly about its readability and usefulness.

Please send your feedback to **mediaenquiries@coronerscourt.vic.gov.au**

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This document can also be found at **www.coronerscourt.vic.gov.au**

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At a glance

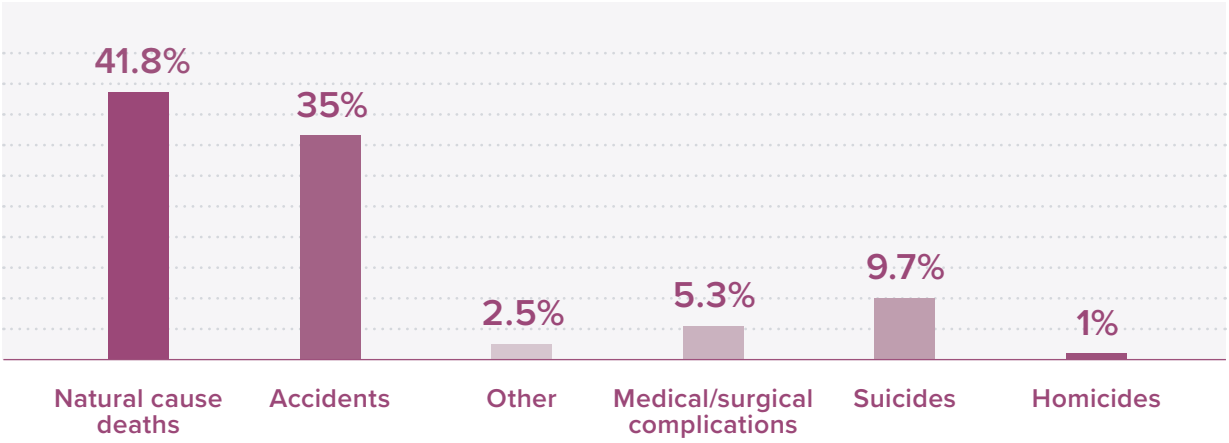
INVESTIGATIONS

7200 new investigations opened

7543 investigations finalised

104.8% closure rate

CASELOAD



TIMELINES

8.5
Average months to investigate

76.7% in <12 months

46.8% in <3 months

INQUESTS

78 inquests finalised

1.01% of investigations closed following inquest

RECOMMENDATIONS

199 recommendations made

102 accepted

12 not accepted

85 awaiting response or under consideration

DATA & DOCUMENTS

6144 requests for documents

36 requests from organisations for coronial data

44 research requests granted

Contents

The year in review

From the State Coroner

The recent work of the Coroners Court has been characterised by a second year of COVID-19 and the operating constraints arising from stay-at-home orders and other restrictions. Despite these challenges, the reform and modernisation agenda that commenced at the Court last year has continued. The highlights include further enhancements to our digital case management system, the consolidation of the Court working environment into a mix of in-person and online, and further work to assist families through the coronial process.

The number of reportable deaths increased this year, with 7200 cases being reported to the Court. Pleasingly, our finalisation rate also improved, and 7543 cases were closed during the year. With this outcome achieved while most staff were working from home for a large part of the year, it is clear our enhanced case management system is performing very well.

The COVID-19 restrictions also presented challenges for families interacting with the Court. Many family members were unable to see their loved one in the period prior to their passing, particularly if they were hospitalised or in a care facility, compounding their grief. Our family Liaison officers (FLOs) have continued to accommodate the emotional needs of these families while guiding them through the coronial process. The FLOs are a unique group of individuals who demonstrate exceptional empathy for the people in their care.

First Nations people are disproportionally represented in our work. The Court's Koori Engagement Unit (CKEU) provides significant support to families and communities from the first report of a passing through to the inquest hearing and delivery of the finding.

I commend both the FLOs and the CKEU for their dedication and commitment. Not only do they provide a critical, compassionate service for those whose loved ones come into the care of the Court, they are also invaluable in keeping coroners informed of family concerns.

In 2021–22, we have continued to publish regular data reports on suicide and overdose. These reports inform open safe and transparent conversations about these very important topics. The data also guides policy development and initiatives aimed at reducing deaths in Victoria.

Our Recommendations Report, first published in 2020, records all recommendations made by coroners and the responses made by departments and organisations. This report has greatly improved the transparency of entities' responses to recommendations and their role in implementing change to reduce the number of preventable deaths.

The data and information contained in these reports is managed by the Coroners Prevention Unit (CPU). Their work is vital to the Court's role in death prevention. CPU staff use their specialist knowledge to provide advice to coroners on a range of topics including medical and mental health issues, family violence, and matters of prevention policy throughout investigations.

This year we farewelled Deputy State Coroner Caitlin English who was appointed a judge of the County Court in April after eight years at the Coroners Court. During her time with us, Judge English made outstanding contributions in managing many complex and challenging cases. In her role as Deputy State Coroner, she provided much assistance to me and her colleagues. Our loss is nevertheless the County Court's gain, and we wish her well in her new role.

Coroner Jacqui Hawkins was appointed Deputy State coroner following Judge English's departure. Deputy State Coroner Hawkins seamlessly moved into the role and is an asset to me, the Court and the community.

In other departures, Coroner Phillip Byrne retired in April after a career spanning 61 years in courts. He commenced as clerk of courts, before becoming a Magistrate and, from 2014, he served as a coroner. Phil's contribution to the profession has been remarkable and it is highly unlikely that a commitment of over six decades to courts will be seen again in Victoria. I thank Phil for his extraordinary service and wish him the very best in a well-deserved retirement.

The Court also welcomed new coroners – Coroner David Ryan in July 2021 and Coroner Catherine Fitzgerald in April 2022. Both have outstanding credentials and substantial experience in the coronial jurisdiction.

The Court continues to work closely with the Victorian Institute of Forensic Medicine (VIFM). This partnership is a strength of the state's coronial system and Professor Noel Woodward's ongoing collaboration is highly appreciated. We continue to discuss innovation opportunities with VIFM to streamline the investigative process.

Finally, I would like to thank all the staff of the Court for their ongoing dedication. We have a wonderful team who continue to exceed expectations. The Court CEO, Carolyn Gale, and her executive team are a real strength and I acknowledge their significant contributions to the jurisdiction. I am very lucky to work with a great team of coroners, lawyers and registrars who are very supportive and collegiate – I thank them for their commitment and hard work.

From the CEO

Despite on-going global challenges, our staff have worked tirelessly to ensure the Court maintained exacting standards serving the community in death prevention throughout 2021–22.

The Court and our staff have successfully navigated the obstacles presented by the last few years – including extended periods working from home in response to the COVID-19 pandemic and a shift to hybrid work. To temper the effects of these changes, the Court has been engaged in a suite of digital upgrades to both modernise operations and facilitate our new hybrid work model. It is encouraging to see how these changes have become "business as usual" at the Court. While we expect hybrid working arrangements to continue into the future, it is great to see staff enjoying coming back into the Court and connecting with coroners and colleagues in person.

In 2021–2022 the Court continued to build on the priorities of the 2020–2024 strategic directions plan. The strategic plan focuses on four pillars; reducing preventable deaths though independent investigations, findings and recommendations, enhancing efficiency through the adoption of new technologies, improving support for families throughout the coronial process, and supporting our workforce to develop and thrive. Work has continued during the 2021–22 reporting period to meet these goals, including our continuous upgrades to digital services, and staff consultation on matters of wellbeing at the Court.

Under the plan, there have been many enhancements to the Court's procedures and policies including the continued publication of regular data reports that support prevention programs in the community, and the transition to a paperless office and hybrid working environment. Engagement with families has also shown consistent improvement as measured by the Court's on-going family survey that has been deployed since 2020.

In September 2021, the Court made its most significant step towards becoming a paperless court, with hard copy files for new matters ceasing production. From now on, files for new cases are initiated digitally and accessed through the Court's custom-built data base – Birrung. This shift has made it faster and easier for staff to access and collaborate on files both in the office and when working from home.

We are proud of our achievements in 2021–22 – including the implementation of a pilot program with WorkSafe Victoria to ensure a smoother transition between organisations when WorkSafe investigations into work-place deaths conclude and the coronial investigation begins. The Court also welcomed trainees to its workforce through the National Electrical and Communications Association (NECA) National Education and Careers program. Additionally, our Family Survey, established in 2020, has matured – providing us with excellent insights into our performance with families engaged with the coronial system.

Last, but definitely not least, I offer my sincere thanks to all the coroners and our staff for the dedication and exemplary professionalism with which they approach their work. I would also like to thank our partner agencies, the Victorian Institute of Forensic Medicine and Victoria Police for their on-going support – and of course, many thanks to Judge John Cain for his leadership and drive to ensure the Court continues to meet the needs of the Victorian community.

The Coroners

Coroners are independent judicial officers appointed by the Governor in Council at the recommendation of the Attorney-General. In Victoria, all coroners are either magistrates or directly appointed under the *Coroners Act 2008* (the Coroners Act). To be directly appointed, a coroner must be an Australian lawyer who has been practising for at least five years.

During the 2021–22 reporting period, the Coroners Court of Victoria farewelled Deputy State Coroner Caitlin English who has been appointed a judge of the County Court, and Coroner Philip Byrne who retired in early 2022. Former coroner Jacqui Hawkins was appointed a magistrate and Deputy State Coroner in April 2022. The Court also welcomed Coroner David Ryan in July 2021, and Coroner Catherine Fitzgerald in April 2022.

State Coroner, Judge John Cain – LLB BEc

John Cain was appointed State Coroner in October 2019, prior to which he was Victoria's Solicitor for Public Prosecution since November 2015.

Judge Cain completed a Bachelor of Economics and a Bachelor of Laws at Monash University before completing the Legal Professional Services Firm course at Harvard Business School in 2010.

His legal career began at Maurice Blackburn in 1982, where he was appointed a partner in 1987 and then managing partner from 1991 to 2002.

Between 2002 and 2006, Judge Cain was CEO of the Law Institute of Victoria and became the Victorian Government Solicitor in 2006 until 2011, after which he became managing partner at Herbert Geer (now Thomson Geer).

In his capacity as State Coroner, Judge Cain serves as a member of the Courts Council, the Coronial Council, the Asia Pacific Coroners Society, the National Coronial Information System (NCIS) 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 Victorian Disaster Victim Identification Committee, and the Aboriginal Justice Forum.

(Former) Deputy State Coroner Caitlin English – BA(Hons) LLB MPP

Coroner Caitlin English was appointed as Deputy State Coroner in April 2019 and remained in that role until April 2022. Her Honour served as Acting State Coroner prior to the appointment of Judge John Cain. Before becoming a coroner in 2014, Coroner English was a magistrate for more than 13 years, including six years at the Broadmeadows Magistrates' Court where she sat on the Koori Court and Children's Court. Her Honour started her career as a solicitor at Minter Ellison, followed by the Legal Aid Commission of Victoria (now Victoria Legal Aid) and the Public Interest Law Clearing House (now Justice Connect). In 1999 she completed a Churchill Fellowship, reporting on the delivery of *pro bono* legal services in the United States and England.

In her capacity as Acting State Coroner, Her Honour served as a member of the Courts Council, the Coronial Council, the Asia Pacific Coroners Society, the National Coronial Information System (NCIS) 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 Victorian Disaster Victim Identification Committee, and the Victorian Judicial Officer's Aboriginal Cultural Awareness Committee. She was also a chair of the Coroners Education Committee, the Coroners and Pathologists Advisory Group, the Court's Koori Committee and the Judicial College of Victoria's Wellbeing Committee.

Deputy State Coroner Jacqui Hawkins – BA(Hons) LLB

Deputy State Coroner Jacqui Hawkins was appointed a coroner in January 2014 and was appointed a magistrate and Deputy State Coroner in April 2022. Prior to her appointment, she was the Court's senior legal counsel and established the in-house legal service. Deputy State Coroner Hawkins was previously a partner at Lander & Rogers in their 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 Services Panel.

Coroner Hawkins is a member of the Coroners Pathologists Advisory Group, the Koori Initiatives Committee, the Coroners Education Committee, the Judicial College Judicial Wellbeing Steering Committee, the Judicial College Koori Steering Committee, the Judicial Officers' Aboriginal Cultural Awareness Committee, the Suicide Prevention and Response Secretaries Sub-Committee, the Aboriginal Justice Forum, and the Asia Pacific Coroners Society.

Coroner Phillip Byrne – LLB

Coroner Phillip Byrne became 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 courts for 20 years supporting the day-to-day operations of metropolitan and regional courts. He obtained his Bachelor of Laws from the University of Melbourne during this time and following his appointment as a magistrate spent 19 years in Bendigo as a co-ordinating magistrate for the Wimmera Mallee region.

Coroner Byrne retired in 2000 but returned to work as a coroner from 2003 to 2006. He served as a reserve coroner since 2013 until his retirement in early 2022.

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 laws 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 a 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, and the Asia Pacific Coroners Society. Coroner Jamieson also sits on VIFM's Ethics Committee as the Court's representative, assisting in the ethical assessment of research applications. She also chairs the Coroners Education Committee.

Coroner John Olle – LLB BEc

Coroner John Olle was appointed a coroner in September 2008. He commenced his legal career as a solicitor with McCarthy & Co in Rye. Three years later he joined the Victorian Bar, where he practiced as a barrister for 25 years. He appeared primarily in the criminal and coronial jurisdictions.

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

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, is a member of the Court and Victorian Institute of Forensic Medicine's (VIFM) Coroners and Pathologists Advisory Group and is a member of Hellenic Australian Lawyers. From 2005 to 2013 she was also a member of the Victorian Child Death Review Committee.

Coroner Darren Bracken – LLB(Hons)

Coroner Bracken was appointed a coroner in February 2018, after more than 20 years as a barrister in Australia and overseas. As a barrister, Coroner Bracken appeared in all Victorian jurisdictions, the Victorian Bushfires Royal Commission, the Federal and High Courts of Australia and in 2005 the United Nations Special Court for Sierra Leone. In 2014 Coroner Bracken was appointed as a Magistrate in the Republic of Nauru.

Coroner Bracken is a past president of the Medico-Legal Society of Victoria, a presenter at the Australasian College of Legal Medicine and is currently completing a masters' degree in bioethics.

Coroner Simon McGregor – BA LLB

Coroner McGregor was appointed a coroner in September 2018. After being admitted to practice in 1994, His Honour became a member of the Victorian Bar in 1997. As a barrister he appeared before the Court of Appeal and Supreme, County and Magistrates' Courts in a variety of matters, including professional negligence and personal injury law, human rights, discrimination and confiscation proceedings. He has also appeared in a range of other matters, including the Royal Commission into Institutional Responses to Child Sexual Abuse and as counsel assisting in several coronial inquests, including deaths in custody.

Coroner McGregor lectures in death investigation with VIFM and supervised the Monash University clinical placement program. He is also the Court's Managing Coroner for the Court's Direct *Pro Bono* Referral Scheme.

Coroner Sarah Gebert – LLB, BSc, PostGradDip (ForensicSc)

Coroner Gebert was appointed in June 2019, after serving for eight years as the Court's principal in-house solicitor; assisting with investigations, preparing matters for inquest and managing Supreme Court appeals. Her Honour obtained degrees in law and science from Monash University in 1988 and was admitted to practice as a barrister and solicitor in the same year.

As a solicitor she held roles including the Royal Commission into Aboriginal Deaths in Custody, Victoria Legal Aid and Women's Legal Service Victoria. From 2007 to 2011 she managed the Coronial System Reform Project, overseeing the development and passage of the Coroners Act, which established the Court as a specialist inquisitorial court. In addition, she worked on the establishment of the Neighbourhood Justice Centre, adult Koori Courts and the Children's Koori Court.

Coroner Gebert also holds a postgraduate diploma in forensic science from La Trobe University, which she completed in 2002.

Coroner Leveasque Peterson – BA LLB

Coroner Peterson was appointed a coroner in February 2020. Prior to her appointment, Her Honour served as the Assistant Victorian Government Solicitor for two years, supervising the regulatory practice and representing the State's response for the Royal Commission into Victoria's Mental Health System and Aged Care. Admitted to legal practice in 1994, Coroner Peterson has had a broad regulatory, administrative law and inquiries practice in private practice as well as a government lawyer representing governments, departments and statutory agencies.

During the 2009 Victorian Bushfires Royal Commission, Coroner Peterson represented 77 local councils and subsequently assisted in the local government response to recommendations made by the Royal Commission.

Coroner Katherine Lorenz – BA LLB (Hons)

Coroner Katherine Lorenz was appointed a coroner in December 2020. Coroner Lorenz began her career in 2002, completing her articles of clerkship at Mallesons Stephen Jaques (now King & Wood Mallesons), where she developed her practice in commercial litigation. In 2009, Her Honour held the position of special counsel at the Australian Wheat Board, followed by a period as special counsel at Clayton Utz specialising in complex commercial advisory and litigious matters. From here, Coroner Lorenz served as an Executive Director at The Royal Children's Hospital Melbourne and then Monash Health.

Prior to her coronial appointment, Coroner Lorenz held the position of CEO at the Victorian Bar from late 2018. She was responsible, during this time, for managing the organisation through the early stages of the COVID-19 pandemic, ensuring that its essential services could operate safely and effectively though the crisis.

Coroner Kate Despot – BA LLB

Coroner Kate Despot was appointed a coroner in December 2020 and commenced this role in February 2021. Since her admission to practice in 2003, Coroner Despot has worked primarily in the public sector focusing on criminal law and compliance and regulation.

During her career, Coroner Despot has worked with the Office of Public Prosecutions and served in senior leadership positions at the Victorian Building Authority and WorkSafe Victoria.

Her Honour most recently held the position of Executive Director of Legal and Governance and General Counsel at WorkSafe Victoria prior to her coronial appointment. Her honour has significant experience in overseeing occupational health and safety law in Victoria.

Coroner David Ryan – BA LLB (Hons)

Coroner David Ryan was appointed a coroner in late June 2021. Prior to this appointment, His Honour was a judicial registrar of the Federal Court of Australia and held several longstanding positions at the Victorian Government Solicitor's Office (VGSO), including in the role of managing principal solicitor. His work at VGSO focussed on government litigation including inquests.

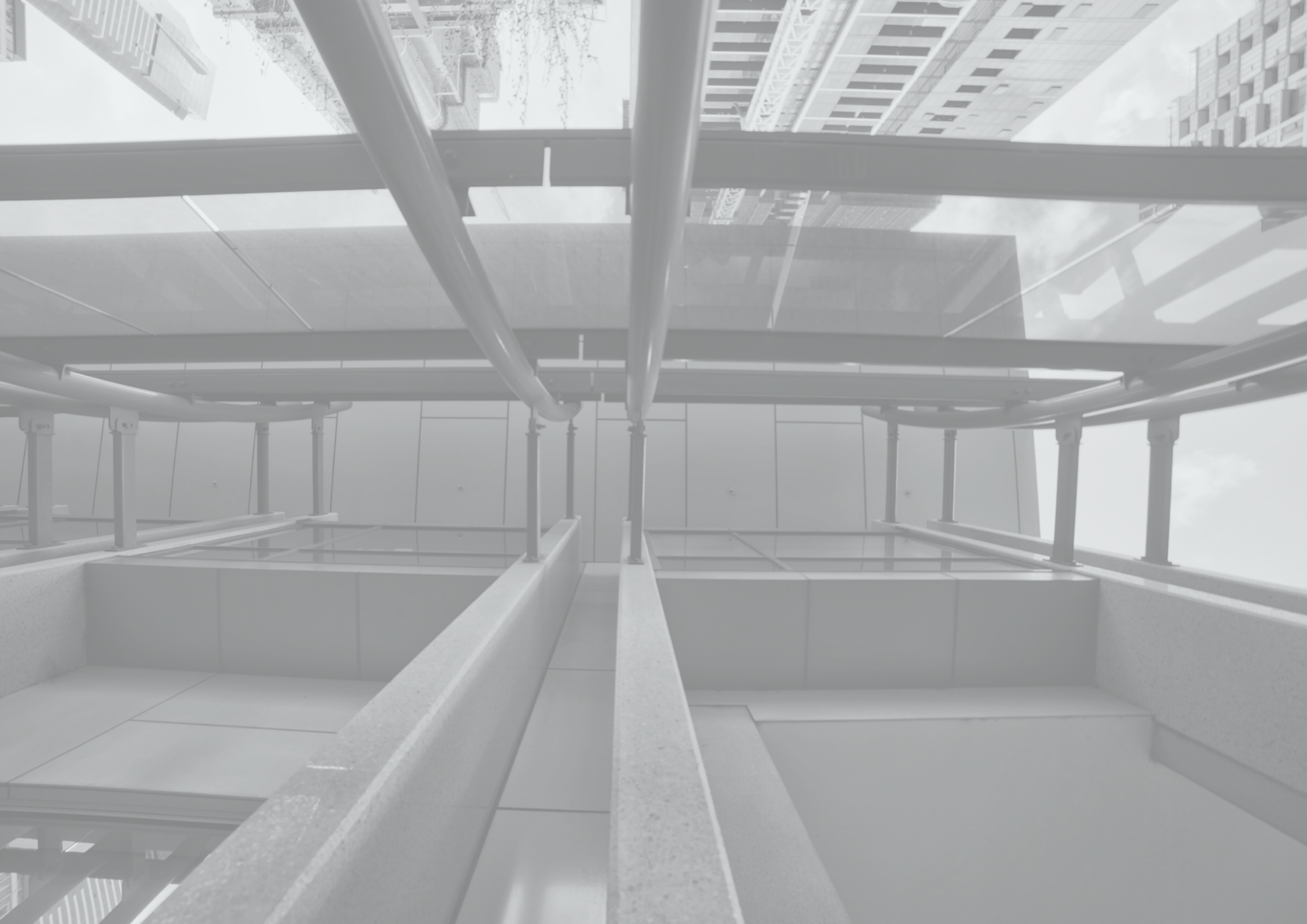
Coroner Catherine Fitzgerald – BA LLB (Hons)

Coroner Fitzgerald was appointed a coroner in April 2022. Her Honour was admitted to practice in 2004. Prior to her appointment she practised as a barrister, having signed the Victorian Bar roll in 2016. Coroner Fitzgerald has extensive experience in criminal law and coronial inquests.

Her Honour began her career as a solicitor at the NSW Office of the Director of Public Prosecutions. She was subsequently a State Prosecutor at the Office of the Director of Public Prosecutions for Western Australia, Counsel Assisting at the Coroner's Court of Western Australia and a Senior Federal Prosecutor for the Commonwealth Director of Public Prosecutions in Melbourne.

As a barrister, Coroner Fitzgerald appeared before the Supreme, County and Magistrates' Courts in a variety of criminal matters for both prosecution and defence. Her Honour appeared as counsel assisting and represented interested parties in numerous inquests.

Coroner Fitzgerald is a member of the Coroner's Education Committee and the Missing Persons Working Group.



About the Coroners Court

Our roles

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

Independently investigating deaths and fires

Unexpected deaths and fires are reported to the Court for independent investigation. Coronial investigations seek to establish certain facts, such as the identity of a deceased person and the cause of death, and the circumstances in which a death or a fire occurred.

From page 18

Reducing preventable deaths

A coroner may also comment on matters relating to public health and safety, or the administration of justice, or make recommendations directed at preventing similar deaths based on the evidence.

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 and safety responses.

From page 32

Our history

Victoria's first coroner was appointed in 1841, 30 years before Victoria established its first morgue in Melbourne. The first permanent coroners' courthouse was constructed in 1888 and 100 years later, 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 – replacing the former State Coroner's Office and establishing the Court as Victoria's first specialist inquisitorial court.

Our Values

Integrity and Independence

- We are open, transparent, honest and accountable
- We work to uphold public trust in the work of the Court

Responsiveness and Respect

- We are inclusive, empathetic and informative to the families and friends of those who have died

Excellence

- We deliver outcomes that are accurate and timely and contribute to reducing preventable death
- We embrace ways to learn and improve

Teamwork

- We are collegiate and supportive, learn from each other and welcome a diversity of skills and views

Human Rights

- We engage with the Charter of Human Rights and Responsibilities as a public authority and through our investigations

Coronial services in Victoria

Victoria's coroners are supported by several organisations to deliver coronial services, including the Victorian Institute of Forensic Medicine (VIFM) and the Police Coronial Support Unit (PCSU).

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 supports coroners by helping members of Victoria Police compile coronial briefs and serving as the coroner's assistant at some inquests. PCSU members also provide training to Victoria Police in relation to the coronial jurisdiction and assist police officers who take on the role of coroner's investigators.

Our place in Victoria's court system

The Coroners Court is part of Court Services Victoria (CSV), a statutory body established in July 2014 to protect and promote the independence of each of the courts and the judiciary.

The Court is responsible for judicial business in accordance with law, and CSV provides and supports administrative and corporate functions. The State Coroner, as head of jurisdiction, is supported by CSV jurisdiction-based staff under the management of the Court's Chief Executive Officer.

Unlike other courts which are adversarial in nature, the Coroners Court of Victoria is an inquisitorial jurisdiction where coroners actively investigate cases – the aim of the Court is to discover the circumstances that contributed to a death, not apportion blame.

Additionally, while all cases that come before the Court are thoroughly investigated, many matters do not proceed to a hearing in a courtroom; rather, a finding is made 'in chambers'.

Strategic goals

The Coroners Court Strategic Directions 2020–2024 present the Court's vision, goals and priorities. The plan has been developed to usher in an increased use of technology to improve efficiencies in Court processes; enhance engagement with families and friends; increase awareness about the role and processes of the Court; and strengthen support for coroners and staff as they undertake what can be very confronting work.

Achieving these goals is the shared commitment of all coroners and staff to the Victorian community. Developed in response to a growing demand (approximately 16 per cent increase in cases during the last five years) for coronial services due to population growth, this plan has been informed by recent public enquiries into mental health, aged care and disability.

The Court has started implementing operational changes to meet these aims, including improvements in IT capabilities, steps taken towards a paperless future, and increased transparency though new publicly available reports.

The Court's strategic goals and the planned outcomes under this plan are:

1. **Reducing preventable deaths through independent investigations, findings and recommendations**
   - Coronial investigations and recommendations contribute to improve community understanding of preventable deaths and how to reduce similar incidents, with a particular focus on suicide deaths.
   - Coronial investigations of like cases conducted together produce higher impact recommendations for prevention of systemic issues.
   - Coronial data is accessible and able to inform further development of prevention approaches in the community.
   - Coronial investigations and recommendations lead to sustainable change for the Victorian community.

2. **Enhancing the efficiency and timeliness of our work through adoption of new technologies**
   - A modern, efficient, digitally enabled court.
   - Average case investigation times are reduced.
   - Flexible working conditions for staff.
   - An environmentally sustainable Court.

3. **Improving support for families throughout the coronial process**
   - Families are confident in their engagement with the Court.
   - As far as possible the coronial process does not add to the trauma of families.
   - Families are well informed about the progress of their case.
   - Families are assisted to receive the support they need.

4. **Supporting our workforce to develop and thrive**
   - A safe workplace for coroners and staff.
   - The Court continues to attract the best and brightest talent.
   - Staff and coroners are supported to build their careers.
   - Coroners and staff feel empowered to raise issues that affect them.
   - Health and safety at the Court is everyone's responsibility.
   - Vicarious trauma is well understood and managed.

Achievements 2021–2022

WorkSafe Pilot Program

During the 2021–22 reporting period, the Court established a pilot program with WorkSafe Victoria (WorkSafe) to better support families where a WorkSafe investigation into a death takes place prior to a coronial investigation.

Under the pilot, a dedicated WorkSafe staff member, appointed to liaise directly with affected families, makes initial contact with each family and uses a trauma-informed framework to provide individualised support to them throughout the WorkSafe investigation.

When the WorkSafe investigation of a death concludes, the WorkSafe staff member provides a handover to the Court's WorkSafe Family Liaison Officer (FLO). The handover details the outcome of the WorkSafe investigation, family participation and other relevant information including family dynamics. The WorkSafe staff member also provides an overview of families' contact preferences and expectations to the investigating coroner for their consideration.

The level of engagement and regularity of contact with both the WorkSafe staff member and subsequently the FLO, is determined by the needs of the family. The Court and WorkSafe meet monthly to ensure that the Court is updated on WorkSafe investigations in a timely manner.

The aim of this process is for families to experience a smooth and cohesive transition from a WorkSafe investigation to an active coronial investigation. Feedback so far has been positive, and the Court will continue to monitor the performance of this program.

Coroners Court of Victoria Family Survey – update

To better understand the needs of families, the Court developed and implemented a family survey in 2020. The survey was designed to provide an evidence-based approach to identify systemic improvements for Court users.

Between its implementation in 2020 and June 2022, there were 2680 responses to the survey, representing a 93 per cent completion rate. The April to June 2022 quarter recorded 385 responses – the highest number received to date.

Feedback received via the survey has been overwhelmingly positive, with 96.4 per cent of respondents reporting satisfaction with the compassion and consideration offered to them by Court staff. Additionally, 95.2 per cent of respondents said Court staff demonstrated an understanding of how they felt while engaging with the coronial process. An analysis of the results indicates that families generally feel most positively towards interactions they have had with Court staff and are least satisfied with the timelines required for coronial investigations (approximately seven per cent of respondents).

Data from the family survey has been invaluable in improving Court services and will continue to be a feature of family engagement.

NECA Program at the Court

The Court, along with the Magistrates' Court of Victoria, participated in the National Electrical and Communications Association (NECA) National Education and Careers program in conjunction with the Victorian Apprenticeship Recovery Package – an initiative providing opportunities to young people within State Government departments.

The traineeship program offers people aged 15 to 24, who are completing an accredited traineeship in business, paid work experience for 12 months. The program aims to increase the participation of young people in the workforce and assist communities in building future skills and meeting employment needs.

Under the program, three trainees joined the Court – one was allocated to the Coroners Prevention Unit, another to the Coroners Support Services (CSS) team and the third worked across both the Legal Unit and CSS team. The program was successful and at the conclusion of year-long traineeships, all three trainees were offered on-going roles at the Court.

In February 2022, one of the trainees was awarded the Global Apprenticeship Network National Youth Initiative of the Year Award for her participation in the program. Court Services Victoria was also awarded Trainee Host of the Year for excellence in providing outstanding support and mentorship to trainees at the NECA Education and Careers Annual Awards on 18 March 2022.

Output performance

The Court's output performance measures are included in the Victorian Budget Papers (BP3), and detailed below:

Table 1: Performance against BP3 measures

Major outputs/deliverables	Unit of measure	2020–21 actual	2021–22 estimates	2021–22 actual
Quantity				
Average cost per case	$	4123	4267	3987
The variance between the estimate and full-year result is due to an increase in the number of cases finalised.				
Case clearance	%	93.4	100	104.8
A total number of 7543 coronial investigations were finalised against 7200 new coronial investigations opened in 2021–22.				
Quality				
Court file integrity: availability, accuracy and completeness.	%	N/A	90	90
In response to COVID-19, and a need to modernise its processes, the Coroners Court moved to an electronic case management system for court files and records. Paper files are no longer maintained for new matters, and electronic files are now business-as-usual at the court. The higher standard of file integrity result with this approach is reflected in current audits.				
Timeliness				
On-time case processing: matters resolved or otherwise finalised within established timeframes	%	79.6	80	76.7
Of the 7543 matters closed, 5786 were closed within 12 months or less.				

1. Investigations into deaths and fires

Certain deaths and fires require independent investigation by the Coroners Court of Victoria. Through their investigations, coroners seek to establish certain facts, such as the identity of a deceased person and their cause of death, and in many instances, the circumstances in which a death or a fire occurred.

These findings can inform public health and safety strategies to reduce preventable incidents. This chapter provides an overview of these investigations, their management and their outcomes.

Investigations

Types of investigations

Certain types of deaths are required by law to be investigated by a coroner. They include:

- unexpected, unnatural or violent deaths
- deaths resulting directly or indirectly from an accident or injury
- deaths during or after a medical procedure where a registered medical practitioner would not have reasonably expected the death
- deaths of people in custody or care
- cases where the identity of the person or their cause of death is not known
- deaths of children where the death is a second or subsequent child to have died of the same parent, unless the child has died in a hospital and always remained an in-patient, and the death is not otherwise reportable.

Coroners may also investigate fires, even where there is no loss of life, if they consider it to be in the public interest. Investigations into fires comprise a very small number of investigations.

Closure rate

In 2021–22, the Court commenced more investigations than it finalised, resulting in a 104.8 per cent closure rate for investigations into deaths and fires. This represents an increase from last year's closure rate of 93.4.

Table 2: Investigations opened and finalised

	2017–18	2018–19	2019–20	2020–21	2021–22
Number of investigations commenced	6642	6757	7323	7053	7200
Number of investigations finalised	6500	6010	6841	6591	7543
Closure rate	97.9%	89%	94%	93.4%	104.8%

Timeliness

Each death and fire investigation requires an individual approach, and the duration of each investigation varies. The complexity of the matter and whether an inquest will be held are two factors that contribute to the duration of a case.

In some cases, investigations by other authorities need to take place before a coronial investigation can be finalised. If the case is before another jurisdiction, such as in criminal and appeal proceedings, these matters must also be finalised prior to the completion of the coronial investigation. In most cases this will result in an increase in the time needed to finalise a coronial investigation.

The average duration of investigations closed in 2021–22 was 8.5 months with 46.8 per cent of these finalised within three months. In most of these cases, the coroner's investigation deemed them to be natural cause deaths.

Table 3: Duration of closed investigations

	2017–18	2018–19	2019–20	2020–21	2021–22
0–12 months	5526	4978	5637	5288	5782
12–24 months	722	785	846	886	1068
>24 months	252	247	358	417	693

Table 4: Average duration of cases before they are closed

	2017–18	2018–19	2019–20	2020–21	2021–22
Duration (days)	205.8	213.3	213.4	232.2	255.3

Inquests

An inquest is a public hearing into a death or fire. It is an inquisitorial rather than an adversarial process and the coroner does not make findings of guilt or apportion blame. Not all investigations result in an inquest.

Mandatory inquests are held for deaths that occur in custody or care (where the coroner considers the death was not due to natural causes) and homicides (where no person has been charged in relation to the death).

Whenever possible, the Court uses direction and mention hearings to reduce the need for inquests. This is done principally to reduce the time in which families and friends who have lost loved ones are involved in the coronial process. These hearings allow coroners to obtain relevant evidence and develop a scope of enquiry early in an investigation, which may reduce the need for an inquest.

The Court utilises several initiatives to help reduce the duration of inquests along with corresponding costs for families, witnesses, and the Court – for example allowing witnesses from interstate or overseas to give evidence via video conferencing technology. In cases where evidence is required from a number of expert witnesses, they can be invited to come together and consider a series of questions formulated by the coroner to collectively reach consensus in areas of common agreement and disagreement, rather than giving evidence individually.

Of the cases finalised in 2021–22, 78 were closed with an inquest. It should be noted that not all investigations closed with an inquest had their inquests held during this reporting period. Over the reporting period, 61 inquests were held at the Court.

Table 5: Cases closed with inquests

	2017–18	2018–19	2019–20	2020–21	2021–22
Number of cases closed with an inquest	49	59	58	60	78
Percentage of cases closed with an inquest	0.7%	1%	0.85%	0.73%	1.01%

Findings

At the end of their investigation, a coroner will hand down a finding. Findings can be made with or without an inquest.

A coroner investigating a reportable death must find, if possible:

- the identity of the person who died
- the cause of death
- the circumstances of the death.

A coroner investigating a fire must find, if possible:

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

In a finding a coroner may comment on any matter connected with the death or make recommendations on any matter connected with a death or fire, relating to public health and safety and the administration of justice.

The findings, comments and recommendations made following an inquest must be published online, unless the coroner otherwise directs

Findings following an investigation into the death of a person in custody or care, where the death was found to be due to natural causes, must also be published online.

If a public statutory authority or entity receives recommendations made by a coroner, they must provide a written response within three months to the coroner specifying a statement of action that has or will be taken in relation to the recommendation. This may include alternatives to or non-acceptance of the recommendation. The coroner must publish that response online.

In addition to making findings and recommendations, coroners may also comment on any matter connected with a death, including matters relating to public health and safety or the administration of justice.

Case study 1

The coroner calls for stronger residential inspection and maintenance rules following a fatal balcony collapse

Ms T and Ms K sustained fatal injuries when the timber balcony of a Doncaster East home where they were attending a Christmas party collapsed on 16 December 2017. Ms T died at the scene, while Ms K died at the Royal Melbourne Hospital a few hours later.

The coronial investigation focused on how the balcony, originally built in 1987, failed – if it was built to applicable industry standards or complied with the standards in place at the time of the collapse.

During the inquest, the coroner heard evidence from an independent engineering witness and technical experts from Manningham City Council and the Victorian Building Authority (VBA) regarding the original build and the regulatory standards for construction and maintenance.

In the finding, Her Honour concluded that one of the load beams was undersized at the time of construction and, combined with poor maintenance, provided inadequate support for the balcony. Her Honour also found that the balcony did not comply with the plans approved by Manningham City Council in 1986, nor did it meet relevant industry standards for 1987 or 2017.

In addition to the deaths of Ms T and Ms K, 34 people presented to Victorian emergency wards with injuries from balcony collapses during the period March 2004 to June 2019 – highlighting the need for increased awareness and safety measures.

To prevent similar deaths, the coroner recommended that the VBA:

1. promotes among registered builders and building surveyors a practice of ensuring that balconies associated with residential premises are subject to mandatory inspections at either the frame stage or at the final stage and that the inspection is specifically directed to the compliance of the balcony with currently applicable standards.
2. continues its efforts to improve public awareness of the need for regular inspections and competent maintenance of balconies, particularly where they are of timber construction or have timber structural members.
3. continues its efforts to develop a specific standard addressing the design and durability of exposed structures in response to the 2018 paper referred to it by the Chair of the Building Regulations Advisory Committee.
4. considers developing a system for:
    - the certification of newly constructed balconies as to their maximum distributed load capacity.
    - requiring an alert to all users of newly constructed balconies in the form of signage age to be permanently affixed to the balcony with an appropriately worded alert to owners and occupiers not to exceed that capacity and to be mindful of the need for regular inspection and competent maintenance.

The VBA has accepted recommendations one and two in full and rejected three and four – referring them to the Australian Building Codes Board (ABCB) and the Department of Environment, Land, Water and Planning (DELWP) respectively.

2. Reducing preventable deaths

Throughout their investigations, coroners consider all opportunities to provide comments and recommendations to prevent similar deaths or fires. This chapter explains how recommendations are formed and responded to, and the Court's role in reviewing family violence deaths.

Recommendations

Recommendations are made where, following an investigation into a reportable death or fire, a coroner has identified systemic issues or other learnings that can help prevent similar incidents occurring in the future. Coronial recommendations are rigorously prepared to ensure they are informed by and based on the evidence before the Court.

If a coroner determines that the care and circumstances relating to an incident were handled appropriately by the parties involved, or that existing failures have since been adequately addressed, or that no prevention opportunities can be identified relating to that death, recommendations will not be made.

Where prevention opportunities are identified, the coroner will direct recommendations to any relevant minister, public statutory authority, or entity. Any matter connected with a death may be included, for example 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 or fire they have investigated.

Coroners made recommendations in 1.8 per cent of findings in 2021–22. This figure was calculated excluding natural cause findings and cases where a coroner determined the death was not reportable.

The number of recommendations decreased in 2021–22 from 204 to 199. It should be noted that the number of recommendations made each year is dependent on the matters before the coroners and associated opportunities for prevention. The Court's focus is on providing robust, evidence-based investigations to help protect the Victorian community against preventable deaths.

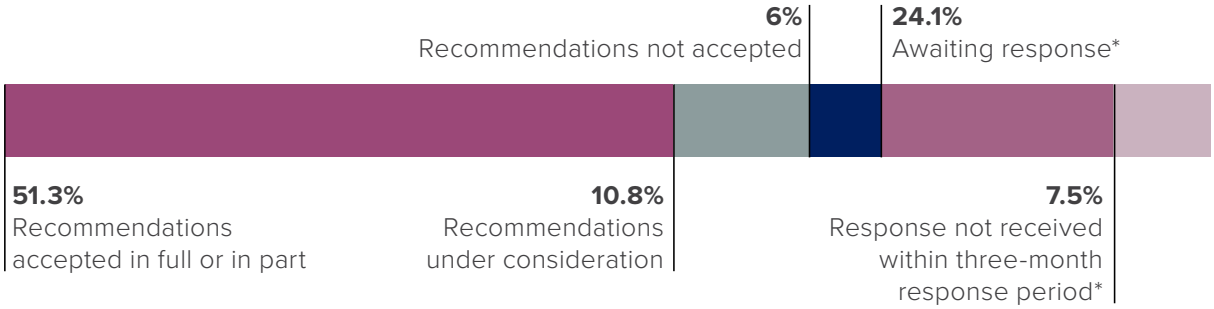
Any agency or person who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken.

In the past year, 102 of the 199 recommendations made by coroners were accepted in full or part for implementation and 22 recommendations are under consideration. There were 12 recommendations that were not accepted, and 15 instances where responses were not received within the required time frame.

Table 6: Recommendations made in closed investigations

	2017–18	2018–19	2019–20	2020–21	2021–22
Number of investigations closed with recommendations	48	69	78	93	81
Number of recommendations made	108	154	166	204	199

Figure 1: Responses to recommendations from closed investigations



The party receiving recommendations from the 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 at the time the data was extracted.

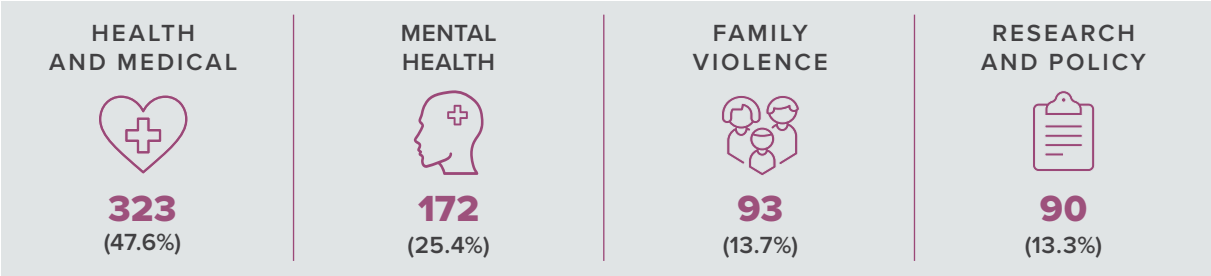
Expert advice

When developing coronial recommendations, coroners draw on a range of resources including the Coroners Prevention Unit (CPU), registrars, external agencies and independent experts.

Coroners Prevention Unit

- The CPU was established within the Court's administrative arm to assist coroners in identifying opportunities to strengthen public health and safety through well-researched, evidence-based recommendations. It is the only multidisciplinary team of its kind in Australia, comprising specialist staff who work to identify any potential failures and other factors that contributed to the incident.
- Coroners can refer matters to the CPU at any point during an investigation.
- Additionally, the CPU undertakes both individual and collaborative research projects to support coronial investigations, underpinning a better understanding of preventable deaths in Victoria.
- Throughout the 2021–22 reporting period, coroners made 678 referrals to the CPU about deaths under investigation. The advice coroners sought input on included:
  - the circumstances in which the death occurred, including factors that may have contributed to the fatal incident
  - the frequency of previous and subsequent similar deaths in Victoria, including recurring themes and shared features
  - interventions that have been proved or are suspected to reduce the risk that similar deaths will occur in future
  - regulations, standards, codes of practice or guidelines that might be relevant to the circumstances in which the death occurred
  - insights gleaned from previous coronial investigations into similar deaths, including past recommendations
  - feasible, evidence-based recommendations for prevention opportunities which the coroner can consider in finalising the investigation.
- During 2021–22, coroners made referrals into four expert streams within CPU:
  - **Health and medical:** for deaths where coroners required clinical advice on the healthcare provided (or not provided) to the deceased and whether this might have contributed to the death.
  - **Mental health:** for 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:** for deaths that occurred in a context of family violence. This includes homicides and suicides where there was a reported or unreported history of family violence as defined by the *Family Violence Protection Act 2008*.
  - **Research and Policy:** For cases where coroners are seeking data and public health insights to inform their investigations.

Figure 2: Theme of coroners' referrals for 2021–22



Paediatric placement program

The paediatric trainees are based at the Court for one day a week, providing clinical advice to coroners and assistance with case reviews of relevant deaths under investigation.

During this reporting period, the Court engaged two senior paediatric trainees. The first, from The Royal Children's Hospital Melbourne, was with the Court from July 2021 to February 2022. The second, most recently employed by Sydney Children's Hospital Network, commenced a placement with the Court in February 2021.

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2021–22, the Court engaged 44 external experts to supply reports and give testimony in inquests. External experts assist coroners to understand specific complex matters and are selected for their qualifications, training and specialist knowledge.

Trends and patterns

The Court has developed and maintains comprehensive records on reportable deaths in Victoria – the Victorian Surveillance Database. Monitoring all reportable deaths in a systemic way provides benefits for coroners. It provides a unique insight into emerging trends in certain kinds of deaths while assisting the development of coronial recommendations that reduce the incidences of similar deaths in the future.

The preliminary analysis of causes of death is reported annually. 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 previous annual reports because of this re-classification process.

In 2021–22, causes of death reported to the Court were consistent with previous years – 41.8 per cent of deaths reported to the Court were caused by natural causes, 35 per cent were accidental (due to falls, road accidents, drowning and similar), and 9.5 per cent were suicides.

Table 7: Cases reported to the Court in 2021–22

Cause of death	Number	Percentage
Natural causes	3006	41.8
Unintentional	2523	35.0
Falls	1610	22.3
Poisoning	400	5.6
Transport	299	4.2
Drowning	41	0.6
Other	173	2.3
Suicide	701	9.7
Hanging	367	5.1
Poisoning	117	1.6
Firearm	35	0.5
Rail	19	0.3
Jump from height	27	0.4
Other	136	1.8
Assault	72	1.0
Complications of medical or surgical care	378	5.3
Other*	184	2.5
Not reportable	156	2.2
Still enquiring	180	2.5

* 'Other' here includes other reportable deaths, legal intervention deaths and deaths from undetermined intent.

Victorian Overdose Death Register

The Victorian Overdose Death Register (VODR) was established by the Court in 2012 and provides detailed information for Victoria regarding overdose deaths involving pharmaceutical drugs, illegal drugs and/or alcohol.

There was a slight increase in Victorian overdose deaths during 2021–22 from 497 in 2020–21 to 525. The 2021–22 overdose deaths data is still preliminary and is likely to be revised as investigations progress. Early analysis suggests the increase is not driven by any specific issue, factor or population.

Frequencies reported from the VODR can change over time as coronial investigations progress and more information becomes available. For example, through the coroner's investigation, an overdose death initially characterised as involving one drug might be determined to have involved two other drugs, or a death initially thought to be unrelated to drug consumption might be found to be a fatal overdose.

Revisions in how drugs are grouped and categorised for analysis can also occur when the Court revises its approach to understanding and describing drug-related harms, usually in response to expert advice and feedback.

Table 8: Overdose deaths reported

Financial year	2017–18	2018–19	2019–20	2020–21	2021–22
Number of deaths	517	538	542	497	525

Victorian Suicide Register

Established by the Court in 2011, the Victorian Suicide Register contains detailed information relating to suicides that have occurred in Victoria since 2000.

The primary purpose of the register is to support coroners in conducting investigations and identifying evidence-based opportunities to reduce suicide. In addition, the register serves as an important resource for government and community organisations in the development of suicide prevention policy and initiatives, and for academic research.

In 2021–22, suicides comprised 9.7 per cent of all deaths reported to the Court. The number of reported suicides increased to 701, slightly more than the 685 in the previous reporting period.

Table 9: Annual reports of suicide

Financial year	2017–18	2018–19	2019–20	2020–21	2021–22
Number of deaths	671	723	704	685	701

Victorian Homicide Register

The Court created the Victorian Homicide Register (VHR) to track and analyse homicides across Victoria and identify themes for targeted prevention opportunities.

The database contains detailed information on all Victorian homicides reported to the coroner since 1 January 2000 including:

- socio-demographic characteristics
- location information
- presence and nature of physical and mental illness
- service contact in cases of family violence, and information on the presence and nature of the violence.

The VHR is a live database that includes open and closed criminal and coronial investigations. Data is subject to re-classification and updating as further information becomes available through the coronial investigation process.

The Victorian Family Violence Data Portal

The Court also contributes VHR data to the Victorian Family Violence Data Portal, which is maintained by the Crime Statistics Agency. The Victorian Family Violence Data Portal contains data from the VHR relating to homicides in Victoria from 1 June 2014 onwards and is updated annually.

Victorian Systemic Review of Family Violence Deaths

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) is a dedicated function at the Court that conducts in-depth reviews of deaths suspected to have resulted from family violence.

Led by the State Coroner, the VSRFVD consists of staff from across the Court, including a manager, senior solicitor, case investigators, family liaison officer, registrar and project officer.

The Victorian Homicide Register (VHR) serves as the key data source for the VSRFVD. There have been two published VSRFVD reports – analysing common factors in family violence deaths between 2000 and 2010, and 2011 and 2015 respectively.

The Court has a strong commitment to the reduction of family violence related deaths through the thorough investigation of such deaths and the sharing of information to assist the sector in strengthening responses to those living with family violence.

Homicide incidents in 2021–22

In the 2021–22 reporting period, there were 40 homicide incidents in Victoria that were reported to the Court. This is a decrease from 48 homicide incidents in the previous year (**Table 1**). Almost one third of these incidents (35 per cent) were identified as family violence related. The 40 identified homicide incidents resulted in the deaths of 45 homicide victims.

The data for this reporting period was extracted from the VHR on 4 July 2022 and includes all homicides reported to the Court between 1 July 2021 and 30 June 2022. This reference period is based on the date the homicide incident occurred. This data includes data relating to open and closed coronial investigations and, as such, it is subject to change as new information becomes available during the investigation process.

It is noted that detailed data is not provided with respect to homicide offenders, as the criminal proceedings for many homicides that occurred in 2021–22 remain ongoing at the time of this report.

Table 10: Homicides incidents by year – July 2016 to June 2021

Type of homicide	2017–18	2018–19	2019–20	2020–21	2021–22
Family violence related	21	16	20	20	14
Not family violence related	38	32	40	24	17
Unknown	0	3	3	4	9

Most (87.5 per cent) of the family violence incidents in 2021–22 resulted in the death of one homicide victim (**Table 12**).

Homicides by relationship

The 40 identified homicide incidents resulted in the deaths of 45 homicide victims.

Where a familial relationship was identified between the homicide offender and homicide victim, the relationship was most likely to be of a current or former intimate partner (18 per cent). This was followed by parent-child relationships (15 per cent) and other intimate or familial relationships (2 per cent) (**Table 11**).

Table 11: Homicide Victims by relationship to offenders – July 2016 to June 2021

	2017–18	2018–19	2019–20	2021–22	2021–22
Intimate partner	14	13	13	9	8
Parent-child	5	≤3	5	8	7
Other intimate or familial	≤3	≤3	3	5	≤3
Not intimate or familial	27	34	41	25	20
Unknown	0	3	3	4	9

Table 12: Homicides incidents by number of deaths – July 2016 to June 2021

Number of deaths from incident	2017–18	2018–19	2019–20	2020–21	2021–22
Single	96.6%	90.1%	92%	89.5%	87.5%
Multiple*	3.3%	9.8%	7.9%	10.4%	12.5%

*Multiple death incidents include incidents where there were multiple homicide victims and incidents in which the offender also died (for example homicide-suicides).

Homicide victims by sex

In 2021–22, females were more often the victim of family violence related homicides (75 per cent), whereas males were more often homicide victims in non-family violence related homicides (95 per cent). This was consistent with data across the preceding five years (**Table 13**).

Table 13: Homicide victims by sex – July 2016 to June 2021

Sex of homicide victim	Type of homicide	2017–18	2018–19	2019–20	2020–21	2021–22
Male	Family violence related	7	3	8	8	4
	Not family violence related	34	28	41	25	28
Female	Family violence related	14	13	13	14	12
	Not family violence related	4	9	3	4	1

*For the purposes of this table 'not family violence related' includes cases where the relationship between the homicide victim and homicide offender is unknown.

Recommendations in family violence investigations 2021–22

A total of 25 recommendations were made across 10 family violence-related closed coronial investigations in 2021–22.

These recommendations were most commonly directed to Victoria Police (eight), Corrections Victoria (six), the Department of Families, Fairness and Housing (four), and the Royal Australian College of General Practitioners (three).

The family violence related recommendations were targeted towards improving:

- the regulation of firearms
- police processes for serving family violence intervention orders on perpetrators
- case management of family violence perpetrators by Corrections Victoria
- the training and guidance provided to general practitioners in relation to family violence.

Coroners also recommended that Aboriginal Child Specialist Advice and Support Service programs receive appropriate funding, and that the state and federal government consider making counsellors and social workers subject to an accreditation scheme to ensure their practices are underpinned by appropriate standards, guidelines and educational frameworks.

External engagement

Networks

Having served as Chair in the last reporting period, the Court continued to be an active member of the Australian Domestic and Family Violence Death Review Network (the Network) in 2021–22. The Network consists of representatives from family violence death review mechanisms in states and territories throughout Australia.

This year the Network progressed its partnership with Australia's National Research Organisation for Women's Safety (ANROWS) to compile and publish national data on intimate partner homicides. A report summarising this data was launched at the ANROWS conference in February 2022 and subsequently published online.

Case study 2

The coroner calls for changes to firearm licensing requirements and education programs following a fatal family violence incident involving a "missing" firearm.

On 21 August 2017, Ms MB died due to a fatal gunshot wound inflicted by Mr CB, who then turned the firearm on himself. Ms MB and Mr CB had been in an intermittent relationship for six years and had been living together until approximately two months prior to the incident.

At the time of the incident, Mr CB had been seeing a mental health professional where he had expressed feelings of suicidal ideation and made comments about Ms MB not wanting to continue their relationship. The psychiatrist gave evidence that he was not aware of Mr CB's violent behaviour towards previous partners and did not have specialised training to recognise potential perpetrators of family violence.

The coronial investigation into these deaths revealed that Mr CB had separated from his wife in 2004 after she was granted a family violence order against him for his controlling and verbally abusive behaviour. Ms KC, a woman who was in a relationship with Mr CB at the same time as Ms MB, provided evidence that Mr CB also acted abusively towards her.

Following the family violence order in 2004, Mr CB's firearms licence was cancelled and his 15 registered firearms were confiscated. Evidence suggests that Mr CB circumvented this restriction by assisting his friends and associates to acquire the firearms so he could retain access to them.

In 2014, Victoria Police conducted a search of Mr CB's property having received information that he was illegally in possession of firearms. Six firearms were found during the search – four of which were registered to his friend, Mr SC. Further investigations showed that Mr SC had a total of eight firearms registered in his name. Six of the eight were accounted for and the missing pair had been previously owned by Mr CB. Mr SC advised police that he had loaned several firearms to Mr CB, including the two not found in the search. Mr CB subsequently denied being in possession of the missing guns – they were later found near the scene of the incident, one having been used to inflict the fatal injuries.

At the time of the fatal incident in 2017, of the 15 firearms originally seized from Mr CB in 2004, two were still in his possession, 11 were owned by his acquaintances and the remaining two were owned by unrelated parties.

The coroner identified that the ability for individuals who lose their firearms license to get friends or associates to lawfully acquire these firearms is a gap in the firearms regulation system.

His honour recommended that Victoria Police update policies and procedures relating to firearm registration and ownership:

- Improve information technology systems so all previous registered owners of a firearm are listed when searching the serial number.
- Strengthening checks to ensure that anyone involved in the process of registering a firearm is not a prohibited person (like Mr CB after a family violence order was made against him) – including witnesses on application forms and checking that listed addresses are not those of a prohibited person.
- Improve systems for identifying and investigating missing and unregistered firearms.
- Consider updating firearms safety courses for new licence holders and providing a written brochure about licence holders' responsibilities and highlighting common offences under the *Firearms Act 1996*.

His honour further recommended that the Victorian Attorney General consider requesting a review of the sentencing outcomes and practices under the *Firearms Act 1996*, and that the Royal Australian and New Zealand College of Psychiatrists (RANZCP) mandate that a minimum of four hours training in family violence (including identification, risk assessment and understanding of relevant frameworks) be undertaken by all Fellows every two years.

Victoria Police advised that it would be unable to implement changes to its information technology systems, strengthen procedures to prevent prohibited people from supporting applications for firearms licencing or checking that prohibited peoples' addresses are listed as storage locations for guns.

Victoria Police has committed to improving its investigation processes for missing registered firearms and will update its safety courses for new licence holders along with producing an information brochure advising of responsibilities for licence holders.

The Victorian Attorney-General advised that a study in 2019 had been completed by the Sentencing Advisory Council into firearm related offences. The Council's study re-affirmed the concerns raised by the coronial investigation about the links between firearms use, family violence and the inherent risks to the community.

RANZCP has committed to developing a continuing professional development program targeting family violence issues.

3. Promoting public health and safety

The Court is committed to ensuring coronial data and findings are shared to improve community awareness, and support the development of improved public health and safety knowledge and policies. This chapter outlines some of the research being undertaken by and with the Court, and the demand for the Court's services and information.

Research at the Court

In 2021–22 the Court continued to build relationships with researchers around Australia to develop new insights into preventable deaths. During this reporting period, the Court contributed to three published journal articles.

The Court collaborated with experts from St Vincent's Hospital Melbourne, the University of Melbourne, and the Monash University Department of Forensic Medicine to understand the impact of the COVID-19 pandemic on Victorian suicides. The study's findings, published in the *Australian and New Zealand Journal of Public Health*, showed how the pandemic and the measures taken to mitigate its spread could affect wellbeing, personal agency, and connectedness to others in the period proximal to suicide.

In a related study published in *Frontiers in Psychiatry*, the Court worked with the Magistrates Court of Tasmania – Coronial Division, University of Melbourne, and Australian Institute for Suicide Research and Prevention to examine whether the prevalence of known risk factors in suicides across three states changed following the onset of the COVID-19 pandemic. This was the first time data from Victorian, Tasmanian, and Queensland suicide registers was combined to examine a public health issue. It is hoped this work will serve as a model for further collaboration between jurisdictions.

Finally, the Court's well-established relationship with the National Centre for Farmer Health at Deakin University resulted in a study published in the *Australian Journal of Rural Health*. The study focused on physical ill health and how it acts as a stressor in rural suicides. The study highlighted several themes including the importance of contextually and culturally appropriate rural health services; and the need to respond to alcohol misuse as a coping strategy for physical ill health.

Supporting research

During 2021–22 reporting period, the Court's Research Committee met on eight occasions to assess 26 new applications for access to coronial data, as well as 19 applications to amend previously approved research projects.

Of these applications, 44 were ultimately approved. The approval process in some cases required correspondence with the applicants and changes to research design to address coronial concerns. One application was not endorsed.

In making its decisions, the committee considers the resource implications for the Court and the impact such access might have on families and friends of deceased people. The committee provides advice on the appropriateness of applications to the State Coroner, who determines whether the Court will endorse the research.

The applications assessed covered a broad range of topics, including:

- Work-related fatalities
- Serious injuries and fatalities among children in motor vehicle collisions
- Suicide among specific cohorts including construction workers, and current serving and former Australian Defence Force members
- Issues in medical settings such as human factors contributing to blood transfusion errors, and risks associated with the administration of contrast dyes in medical imaging
- Incidence, determinants and predictors of outcomes in traumatic brain injury.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2021–22, the Court responded to 36 requests from external organisations for data and other assistance, including:

- Victoria Police
- Victorian Department of Health
- Coroners Court of New South Wales
- Victorian Department of Transport.

Contributing to national data collection

To support and 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 reportable and reviewable deaths and all identified factors determined to have contributed to the death.

The NCIS provides access to detailed coronial information from Australia and New Zealand to those who need it.

Requests for documents

In 2021–22 the Court received 6144 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports or unpublished findings.

Table 14: Requests for coronial documents

	2017–18	2018–19	2019–20	2020–21	2021–22
Form 45 requests	5237	5741	4600	5588	6144

Information and support

In the days and months following the death of a loved one, it is important for friends and families to understand the coronial process. The Court is committed to providing support throughout this difficult time, in part by providing clear and readily understood information.

Family Liaison Officers provide critical support to families and friends affected by loss, explaining the coronial processes and findings. This team also works closely with Court staff, liaising with families on sensitive matters.

The Court also produces a range of communications resources containing information about the coronial process and available supports for people whose loved one's death is being investigated. These resources include a family brochure *What happens now?* and *The Coroners Process* booklet. Translation and interpretation services are also offered to families and friends for whom English is not their preferred language.

Stakeholder education and engagement

During 2021–22, coroners delivered nine presentations to stakeholders.

These formal and informal presentations to key stakeholders and industry events provide the community with information and insights into the coronial process. Stakeholders include Victoria Police, clinicians, allied health professionals, radiologists, medical students and legal practitioners.

Hospitals and health practitioners

The Coroners Prevention Unit (CPU) Health Team, in collaboration with the coroners and VIFM, presented to several hospital grand rounds on coronial death investigations associated with health care.

These education sessions provide an opportunity for the court to demystify the investigative process. Feedback demonstrates that these presentations are extremely well received and are a great opportunity to facilitate contact between the court and clinicians.

This year, presentations were held in September 2021 and March 2022. In September 2021, the Court delivered a presentation to 65 staff members from Monash Children's Hospital paediatric team. In March 2022 two sessions were held – one for 59 attendees from St Vincent's Hospital Melbourne and Eastern Health's geriatric teams, and another for 51 participants from The Royal Children's Hospital Melbourne emergency and paediatric intensive care unit teams.

Each session was conducted remotely and attended by medical specialists, registrars and residents, and a broad range of others including nursing staff, allied health representatives, and members of medico-legal teams.

Victorian Law Week, May 2022

This year, the Court held a joint event with the VIFM for Victorian Law Week 2022.

The event, entitled *Missing persons – how the forensic and coronial systems search for answers*, aimed to pull back the curtain on forensic identification methods and the role of the coronial process in identifying missing persons.

Held in front of a live audience, the event featured a panel discussion comprised of legal and forensic experts including State Coroner Judge Cain, Detective Inspector Andrew Stamper (Victoria Police), Dr Dadna Hartman (VIFM), Dr Jodie Leditschke (VIFM), and Professor Soren Blau (VIFM).

The panel discussed a range of topics ranging from how DNA can be used to identify remains, the role of the police, forensic pathologists and anthropologists, to the investigative procedures used by the coroner to piece together a missing person's last movements.

Tickets for the event sold out and feedback was overwhelmingly positive.

Case Study 3

Changes to inter-agency communication protocols during complex rescues following the deaths of two experienced surf life savers

Mr RP and Mr AP, both experienced surf life savers, died while attempting to rescue a tourist in dangerous waters.

On the morning of 21 April 2019, two tourists visited Sherbrook Beach, an area known for hazardous conditions. Emergency services were alerted when one of the tourists waded waist high into the water and was swept out to sea.

A multi-agency emergency response was activated involving Victoria Police, the State Emergency Service and the Country Fire Authority. Parks Victoria and the Port Campbell Life Saving Club were subsequently alerted informally as word of the emergency spread around town.

Mr Y, the Port Campbell Country Fire Association Captain and member of the Port Campbell Surf Lifesaving Club received alerts on his State Emergency Service and Country Fire Authority pagers. He made his way to the Life Saving Club where he met Mr RP and Mr AP, who were also members of other volunteer organisations. Together, they launched the *Pelican*, an offshore rescue boat owned and operated by the club to assist in the search.

While performing a manoeuvre in a large swell, the *Pelican* capsized, and all three men were ejected from the vessel. Mr RP and Mr AP subsequently drowned, and Mr Y suffered a fractured and dislocated pelvis. The missing tourist was later rescued by helicopter without significant injuries.

The investigating coroner was assisted by Life Saving Victoria's Critical Incident Review, which made 32 recommendations covering the following areas:

- training, qualifications, and compliance
- vessel licensing, audits, maintenance and trials
- safety aids/equipment for crew members
- the maintenance of a marine rescue service in the area and consideration of requirements for future responses
- operation procedures and interaction between agencies
- command hierarchy and information dissemination and information recording during rescues
- planning for future rescues.

Her Honour strongly supported all of the recommendations made in the Critical Incident Review report and recommended Life Saving Victoria take immediate action to implement each of them.

Part of the coronial investigation focussed on whether there was a clear delineation of roles in the circumstance that volunteers were members of multiple responding agencies.

The investigation revealed that Mr RP and Mr AP had been alerted to the rescue emergency either through the other volunteer agencies or by word of mouth, and subsequently self-deployed. The Victoria Police Rescue Co-ordination Centre, when coordinating maritime rescues, will conduct a risk assessment, consider who should respond, and formulate a plan to ensure the most efficient and safe response possible. In this case, the *Pelican* and its crew had deployed before the maritime co-ordinator had the chance to implement a plan.

The coroner was informed that changes had already taken place or were to be implemented so that the Rescue Co-ordination Centre will be contacted immediately for future marine search and rescue operations; enabling earlier interaction between responding agencies to ensure adequate risk assessment and formulation of a response plan.

To improve inter-agency communication, Emergency Management Victoria's Marine Search and Rescue office has also developed an Operational Communications Project Plan to support interagency operational channels for direct contact between responding search and rescue agencies and the Rescue Co-ordination Centre.

The coroner was also of the view that warning signs were inadequate in the area, particularly for the non-English speaking community. Given the area is a well-known tourist attraction, Her Honour recommended Parks Victoria work with Life Saving Victoria to develop adequate signage warning of risks – with consideration to size, location, audience, and languages other than English – along with unique emergency location markers.

Her Honour also recommended Parks Victoria consider providing rescue/flotation aids along non-patrolled areas of the Port Campbell coastline so that they can be deployed while awaiting Marine Search and Rescue services.

Parks Victoria did not accept the recommendations.

4. Corporate governance and support

The Court works closely with other jurisdictions and organisations to deliver the best possible services to Victorian families. By fostering a strong culture of collaboration, the Court can fulfil its functions while making good decisions for the benefit of the community. This chapter outlines the Court's structure, committees and workforce.

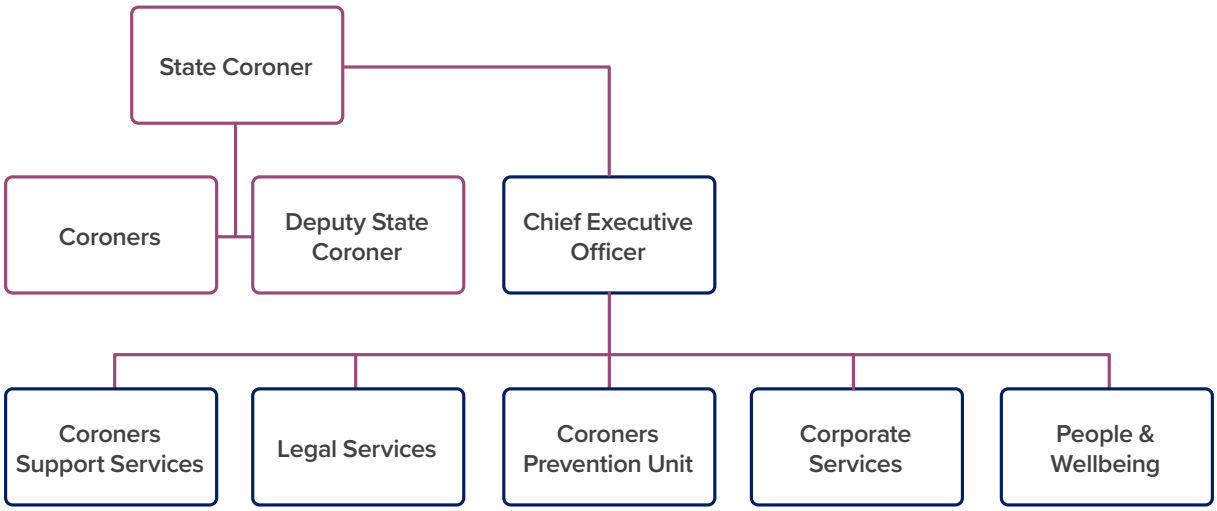
The Court sits within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its staff.

Organisational structure

The Court employs 112 staff to support the coroners in their independent investigations and manage the administration of the Court. The organisation comprises the Office of the Chief Executive Officer which includes a business transformation function, and five divisions – each led by a director.

- **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.
- **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 hearings. Legal Services also has carriage of Supreme Court appeal proceedings that may arise from coronial matters, and advises the Court and coroners on other legal and policy matters.
- **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.
- **Corporate Services** supports the efficient operation of the Court through governance, records management, finance and procurement, information technology, media and communications, policy, and risk and audit functions.
- **People and Wellbeing** supports the delivery of a range of human resource services through effective management of the Court's workforce, including workforce planning, attraction and retention, induction, performance management, health and wellbeing, learning and development, and workforce metrics and reporting.

Organisation chart



Workplace profile

At 30 June 2022, the Court had 112 staff members (97.3 full-time equivalent (FTE)), not including coroners. This includes 97 permanent staff, 26 per cent of which were employed on a part-time basis.

Table 15: Workplace profile as at 30 June 2022

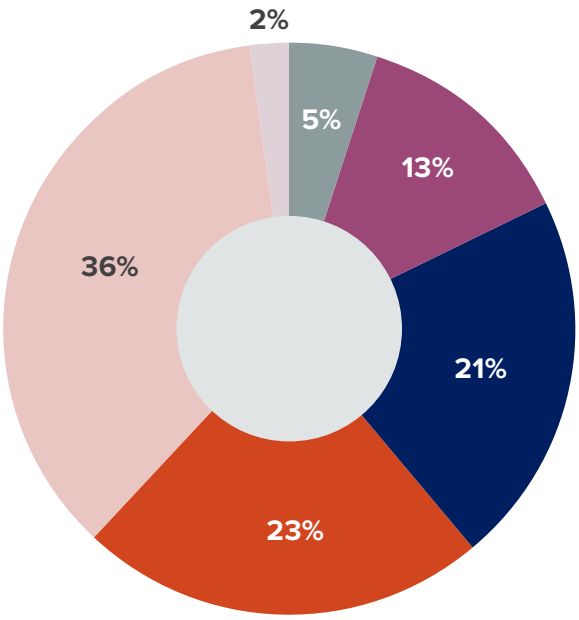
	June 2022					
	All employees		Ongoing		Fixed term/casual	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
Male	25	21.5	20	4	0	1
Female	87	75.8	51	22	8	6
Total	**112**	**97.3**	**71**	**26**	**8**	**7**

	All employees		Ongoing		Fixed term/casual	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
VPS2	15	12.8	8	3	3	1
VPS3	26	23.5	18	4	2	2
VPS4	38	33	22	10	2	4
VPS5	17	16.3	13	3	1	0
VPS6	10	9.6	9	1	0	0
STS/7	5	1.1	0	4	0	1
Executive	1	1	1	0	0	0
Total	**112**	**97.3**	**71**	**25**	**8**	**8**

Note: Victorian Public Service (VPS) and Senior Technical Specialists (STS)

Figure 3: Divisional headcount at 30 June 2022

Division	Number FTE	Number Headcount
Office of CEO*	4.9	5
Corporate Services	12.4	15
Legal Services	20.8	21
Coroners Prevention Unit	22	29
Coroners Support Services	35.2	40
People and Wellbeing	2	2
Total	97.3	112



* The Office of the CEO includes staff supporting the CEO and involved in delivering the strategic transformation agenda of the Court.

Governance and accountability

Various internal and external governance processes guide the Court's conduct, actions and decisions. The Court has two senior committees – the Council of Coroners and Coroners Court Executive Committee. These committees oversee critical business functions, provide a clear decision-making framework, and ensure the Court makes appropriate decisions in both day-to-day work and large-scale projects or procurements.

Coroners Court Executive Committee

The Coroners Court Executive Committee, headed by the CEO, comprises the directors of each of the Court's five business units, as well as the Director of Strategic Programs. The committee meets fortnightly and is accountable for:

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

The Coroners Court Executive Committee supports the Council of Coroners to make strategic decisions by providing timely information and advice on operational matters.

Courts Council

As head of the coronial jurisdiction, the State Coroner is a member of the Courts Council, CSV's governing body. Coroners represent the Coroners Court of Victoria 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.

CSV support

The Coroners Court of Victoria, like other courts, operates using CSV policies and procedures to ensure that the overarching strategy for Victoria's judicial system is advanced. Additionally, CSV jurisdiction services provide or support many of the Court's administrative functions to streamline service delivery to the community.

Joint VIFM and coroner governance committees

The VIFM Council

VIFM provides important aspects of the State's coronial services. To support collaboration the State Coroner represents the Court as a member of the VIFM Council. The 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*.

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 joint committees – the Joint VIFM and Coroners Court Steering Committee and the Joint Operations Committee.

Joint Operations Committee

This committee's focus is on strengthening and maintaining the working relationship between the Court and VIFM. It seeks to inform and enable regular improvements in 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 Victorian community. Senior staff from both organisations comprise the Joint Operations Committee and is alternately chaired by the Court's CEO and VIFM's Chief Operating Officer.

Coronial Council of Victoria

Established under the *Coroners Act 2008* to provide advice to the Attorney-General about matters of importance to the coronial system in Victoria, the Council was the first body of its kind in Australia. Independent of both the Court and the Victorian Government, the Council's function is to provide advice and make recommendations to the Attorney-General in respect of:

- issues of importance to the coronial system in Victoria
- matters relating to the preventative role played by the Court
- the way in which the coronial system engages with families and respects the cultural diversity of families
- any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

The State Coroner is a member of the Coronial Council.

Minimising risk

Risk management is integral to all aspects of the Court's decision-making, planning and service delivery. The Court ensures that risks and resources are managed responsibly and complies with all CSV practices, policies and procedures, as well as the Victorian Government Risk Management Framework.

In the 2021–22 reporting period, the Coroners Court Risk Management Committee actively reviewed all relevant risk registers and continued to identify emerging risks to build and refine the Court's risk profile.

Business continuity planning

During 2021–22 the Court reviewed its business continuity plan in line with CSV's Business Continuity Policy & Framework. The plan provides clear guidance on contingencies for maintaining essential business resources and services in the event of interruptions, including a detailed pandemic response plan which was enacted in response to COVID-19.

The Court also worked in close partnership with the VIFM to ensure joint business continuity and emergency management procedures continued to be well aligned.

Audits

The Court's operational, administrative, and financial performance and decisions are reviewed every year in the CSV Annual Audit Plan, which is undertaken in a collaboration between the Court and CSV.

In 2021–22, the Court participated in internal audits at a CSV-wide level regarding:

- core financial processes and controls
- the CSV risk management framework
- procurement compliance.

The Court's administrative functions are also subject to external audits by the Victorian Auditor-General's Office (VAGO).

The Court's finances, along with those of all other jurisdictions, are included in VAGO's annual audit of CSV's finances and are reported in full in the CSV Annual Report.

Providing an engaging, healthy and supportive workplace

The most important resources of the Court are our people – the coroners and the Court's staff who support them. A continued focus of 2021–22 has been on developing and implementing activities and initiatives designed to build an engaged, high performing, respectful, and safe work culture that delivers excellent services to the Victorian community.

Health and wellbeing

The Court is keenly aware of the sensitive and sometimes graphic nature of the material coroners that staff are exposed to and focusses its effort on ensuring effective and safe systems of work, a strong and collegiate culture, and effective monitoring of health, safety and wellbeing.

During 2021–22 the following programs and initiatives were delivered or commenced:

- Programs designed to create greater awareness for managers regarding their responsibility to provide a safe and healthy workplace including sessions on 'leading for positive mental health' and 'OHS duty of care obligations'.
- Workshops on 'understanding and managing exposure risk' to support staff with a focus on creating greater awareness of exposure risks, self-care strategies and available support mechanisms.
- Continued focus on active participation in the Court's Proactive Wellbeing Supervision Program to ensure staff have regular supervision with a qualified clinician.
- Endorsement of the Reducing Exposure Risk Working Group recommendations that identified further opportunities to reduce the inadvertent exposure to traumatic or distressing material. Implementation of these recommendations commenced in February 2022.

- Implementation of a dedicated health and wellbeing resources intranet hub and the offering of a wide variety of online wellness programs.
- Identified opportunities for coroners and Court staff to come together by providing forums on a range of topics, from mental health to men's and women's health.
- The introduction of the Dogs@Work Program as part of the transition back to the office routine to support a mentally healthy workplace.

The continued impact of COVID-19 resulted in the majority of the Court's workforce working remotely through to the gradual lifting of restrictions at the end of 2021/start of 2022. The Court continued its focus on supporting staff wellbeing, productivity, and engagement during this time, and worked collaboratively with the Court's Health and Wellbeing Committee to commence discussions on co-designing new (hybrid) ways of working.

Building and maintaining a work environment where our people can grow and thrive

In 2021–22, the Court focused on initiatives to continually attract and retain a diverse and high-performing workforce. These included:

- Embedding the Supervision Framework into day-to-day operations to support managers in having quality and regular one-to-one supervision discussions with their staff, including guidance on, and understanding of, their work, professional development opportunities and wellbeing support.
- The implementation of a new Capability Framework to establish a set of core capabilities to support the professional development of Court staff and to assist the Court in selecting best-fit candidates.

Performance and development

Management and staff planning in the areas of performance and development allows staff to understand their output, whether on an individual or team basis, and identifies areas for further learning and development. Every employee has an individual performance development plan to support their ongoing performance by documenting clear goals, expectations and development opportunities.

The Court's Learning and Development Program provides opportunities to build staff capability and develop new skills. It offers targeted training to enhance an employee's knowledge and capacity to fulfil their role and contribute to delivering the Court's strategic objectives. With a focus on strengthening leadership capability and building collegiality, a 12-month Purposeful Leadership Program commenced in July 2021. Court leaders were provided with – and shared insights into – such topics as:

- Authentic and resilient leadership
- Feedback culture and leader as coach
- Managing people through change.

Flexibility

To help employees balance the demands of work and personal commitments, the Court offers flexible working arrangements which employees are encouraged to access. These include reasonable access to a range of leave options, flexible work hours, job-share arrangements, study leave and hybrid work arrangements involving a mix of working in the office or at home. This has been particularly relevant during lockdown periods, where the Court's workforce has been supported to work effectively from home.

Glossary

BP3	Victorian Budget Papers Number 3
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
FTE	Full time equivalent
NCIS	National Coronial Information System
PCSU	Police Coronial Support Unit
STS	Senior Technical Specialists
The Coroners Act	*Coroners Act 2008*
VAGO	Victorian Auditor-General's Office
VCAT	Victorian Civil and Administrative Tribunal
VHR	Victorian Homicide Register
VIFM	Victorian Institute of Forensic Medicine
VODR	Victorian Overdose Death Register
VPS	Victorian Public Service
VSRFVD	Victorian Systemic Review of Family Violence Deaths

Appendices

Applications and appeals

Application to reconsider an order for autopsy

Autopsies are conducted to help determine the exact cause of death and, if required, will be ordered by a coroner and conducted by a forensic pathologist practising at VIFM.

Fewer than half of all deaths reported to the Court require an autopsy. A senior next of kin may ask a coroner to reconsider their decision for an autopsy on cultural, religious or other grounds. If a coroner affirms their original decision, a senior next of kin may appeal that decision to the Supreme Court within 48 hours.

Application to hold an inquest

A person may apply to an investigating coroner to hold an inquest as part of an 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 within three months.

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. It should be noted, however, that coroners can only re-open an investigation if they are satisfied there are new facts available and circumstances make it appropriate to do so. If a coroner determines not to set aside a finding or findings and re-open an investigation, the person may appeal to the Supreme Court within 90 days of the coroner's decision.

Appeals

Eligible parties may appeal to the Supreme Court against various decisions that coroners make, including a coroner's findings and other determinations including that a death is not a reportable death, decisions about autopsy, exhumations, release of the body, decisions not to hold an inquest, and refusals not to re-open a coronial investigation. Time limits apply to the making of appeals and vary depending on the ground of appeal. Judicial review may also be sought in relation to certain decisions made by a coroner.

In 2021–22, the following appeals were finalised:

- **Huang v Coroners Court of Victoria** (S ECI 2021 03592) – Appeal against determination that a death is not a reportable death – Judgement issued on 27 October 2021 – appeal dismissed.
- **Farrar v Coroners Court of Victoria** (S ECI 2021 03932) – Appeal against determination that a death is not a reportable death – Judgement issued on 17 December 2021 – appeal dismissed. Application for leave to appeal pending.
- **Trotta v The Coroners Court of Victoria & Anor** (S ECI 2021 00094) – Appeal against decision not to hold Inquest – appeal dismissed.
- **Dr Eljas Laufer v Coroners Court of Victoria** (S ECI 2022 00190) – Appeal against Findings (discontinued 14 April 2022)

Three further matters are currently on foot, either awaiting judgment or trial.

Feedback

The Court welcomes feedback and considers it important to 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.

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 matter that are outside of the Court's responsibilities, such as Victorian Government policy, legislation or legal representation.

Judicial Commission of Victoria

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 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 of Australia 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.

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 **https://ovic.vic.gov.au/.**

Coroners Court
of Victoria