Coroners Court
of Victoria

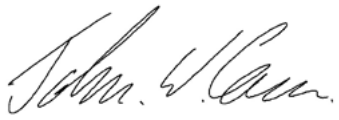
Annual Report

2022–2023

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 2023.



Judge John Cain, State Coroner
September 2023

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

September 2023

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

7480 new investigations opened

7620 investigations finalised

101.9% closure rate

TIMELINES

8.5 Average months to investigate

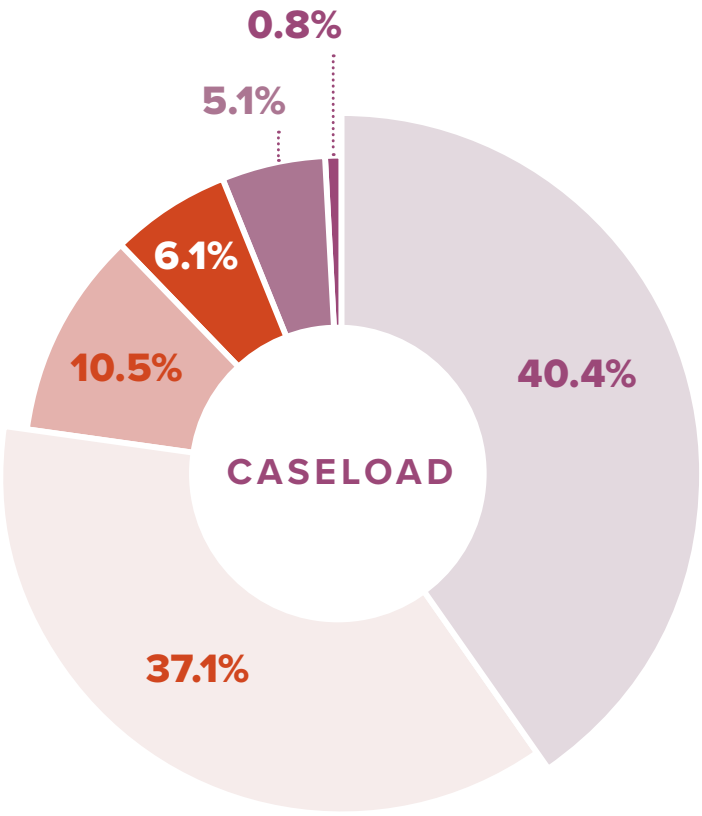
77.7% in <12 months

47.7% in <3 months

INQUESTS

82 inquests finalised

1.08% of investigations closed following inquest



RECOMMENDATIONS

221 recommendations made

147 accepted

7 not accepted

67 under consideration, awaiting response or overdue

DATA & DOCUMENTS

5891 requests for documents

37 requests from organisations for coronial data

42 research requests granted

Contents

The year in review

From the State Coroner

Judge John Cain

I am pleased to report that 2022–23 has been another successful year for the Court. Our coroners and staff have settled into the 'new normal' of hybrid work and our modernisation and reform agenda – which commenced in 2020 – has continued to develop. In overview, our achievements have been many – continuous enhancements were made to our digital case management system, work commenced on the new Aboriginal Passings Database, a Multifaith and Multicultural Advisory Committee was established, and new health and wellbeing initiatives were provided to coroners and staff.

These enhancements to Court processes are critical as the workload of the jurisdiction continues to increase. In 2022–23, 7480 new investigations were opened – compared to 7202 last year – and 7620 investigations were completed. These figures represent a monumental effort from coroners and staff while demonstrating the new digital uplift of the Court's systems and processes are highly effective.

We have continued to publish regular reports containing data from the Victorian Suicide Register (VSR) and the Victorian Overdose Death Register (VODR) during 2022–23. These reports are integral to the overarching discussion around preventable deaths in Victoria, ensuring that accurate data is available to facilitate open and transparent conversations about topics that still carry some stigma in our society. These reports also contribute to policy development regarding death prevention and assist in the design of effective prevention programs in the community.

Understanding how different groups in our community experience public health issues is also important. In 2022–23, the Court released two new reports to help support targeted government and community-based initiatives. The first was the inaugural *Coroners Court of Victoria – Suicide among LGBTIQ+ people* report published in October 2022. The second report was the first edition of the *Fatal overdose among Aboriginal and Torres Strait Islander people Victoria, 2018—2021* report released in February 2023.

Access to this information is imperative to establish a broader understanding of the diversity and complexity of community needs in Victoria and how best to respond. The Court will continue to build our capacity to deliver this information with the development of the Aboriginal Passings Database which aims to build a body of evidence around issues, themes and factors that might contribute to the passings of Aboriginal and Torres Strait Islander people in Victoria – particularly evidence informed by an Indigenous cultural lens.

In 2022–23, we published the fifth edition of our *Recommendations Report* – a publication containing all recommendations made by coroners and the responses received from a range of organisations and departments. This series of reports serves as an excellent record of the work of the Court and highlights the role and responsibility of all responding entities in reducing deaths in the State.

During 2022–23, we welcomed Coroner Paul Lawrie to the Court. Coroner Lawrie brings extensive experience to his role – having appeared in many coronial inquests for interested parties and as counsel assisting – and has proven an excellent addition to the coronial team. Additionally, we farewelled Coroner Darren Bracken in February 2023 after five years as a coroner. I'd like to thank Coroner Bracken for his contribution to the Court and dedication to the public health and safety of the Victorian community.

I would like to take the opportunity to thank our colleagues at the Victorian Institute of Forensic Medicine (VIFM) – the partnership between the Court and VIFM is of outstanding benefit to the Victorian coronial jurisdiction. I welcome Professor Noel Woodford's ongoing support and collaboration in further developing and streamlining opportunities to improve the quality of our investigations.

Finally, thanks to all the coroners and staff for their efforts in keeping the Court operating to such high standards. Our team continues to exceed expectations with an outstanding level of professionalism and care. Carolyn Gale, our CEO and her executive team have once again displayed strong leadership and made significant contributions to the jurisdiction. I consider myself to be very fortunate to work with such exceptional people.

From the CEO

Carolyn Gale

2022–23 has been another year of change and growth at the Court, and I deeply appreciate the performance of our coroners and staff over the year. Despite ongoing challenges, both locally and globally, the people behind the coronial process have once again stepped up to the plate and served the Victorian community with an astounding level of compassion, care and professionalism.

This year, we have continued to work on our reform and modernisation agenda based on our 2020–2024 strategic directions plan. Based on four pillars, the plan outlines improvements aimed at coroners and staff and the Victorian community. The pillars articulate our goals of reducing preventable deaths though independent investigations, enhancing efficiency through the adoption of new technologies, improving care for families throughout the coronial process, and supporting our workforce to develop and thrive.

Under the plan in 2022–23, we have focused on enhancing efficiency at the Court through technological upgrades at the coronial facility in Southbank – we completed an overhaul of the security systems and accomplished further enhancements to our digital records management system. In line with the objective to improve support for families, we have developed new initiatives to better meet the diverse cultural needs of the Victorian community and, to assist staff to develop and thrive, we have put in place greater support measures via new health and wellbeing programs.

Our achievements have been significant this year. We have commenced implementation of the new Aboriginal Passings Database, introduced a Multifaith and Multicultural Advisory Committee at the Court, and established new measures to protect coroners and staff under the *Reducing the Risk of Vicarious Trauma* project. We have also worked to strengthen our relationships with other organisations engaged in death prevention including Victoria Police, the Office of the Commissioner for LGBTIQ+ Communities and the Department of Health.

Additionally, the Court has remained a committed and active participant in the Aboriginal Justice Forum this year, maintaining a line of communication with the co-chairs of the Aboriginal Justice Caucus. Upon request in August 2022, we provided submissions to the Disability Royal Commission regarding deaths in custody where the deceased had a disability. Submissions were also made to the Inspector-General for Emergency Management's review of Victoria's water safety arrangements, and we provided data on overdose deaths for the Department of Health's review of the North Richmond supervised injecting room.

We could not have achieved so much in 2022–23 without our incredible coroners and staff. As always, they have approached their work with a level of dedication and professionalism this year that is beyond compare. It is not easy to work in this jurisdiction and I am inspired by the compassion and care demonstrated by everyone at the Court year on year. I will also take the opportunity to express my thanks to our partner agencies – VIFM and Victoria Police, without whom we could not perform our investigative role. Finally, special thanks to the State Coroner, Judge John Cain for his strong dedication to leadership and for his continuing drive to modernise the Court to keep up with the needs of the 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 2022–23 reporting period, the Coroners Court of Victoria welcomed Coroner Paul Lawrie in August 2022 and farewelled Coroner Darren Bracken in February 2023.

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, the Aboriginal Justice Forum, and the Council of Chief Coroners.

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.

Deputy State Coroner Hawkins is a member of the Coroners Pathologists Advisory Group, 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, the Aboriginal Initiatives Committee, Indigenous Inquests Advisory Group and the Asia Pacific Coroners Society.

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 and is a member of the Judicial College of Victoria Judicial Conduct and Ethics Steering 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 Antoniadis Spanos – BA LLB

Coroner Spanos graduated from the University of Melbourne in 1981 and was employed as an articled clerk/litigation lawyer in private practice until 1984. She then worked for 10 years with the Commonwealth *Director of Public Prosecutions*, primarily in trials and appeals. As senior assistant director, Her Honour headed first the major fraud and then one of the general prosecutions branches.

Coroner Spanos was appointed a Victorian Magistrate in 1994 and worked in the Broadmeadows region, Melbourne Magistrates' Court, the Children's Court and the Heidelberg region. From 2005, Coroner Spanos has worked exclusively as a coroner.

From 2005 to 2013, she was a member of the Victorian Child Death Review Committee and is currently a member of the Court and VIFM's Coroners and Pathologists Advisory Group, the Asia Pacific Coroners Society and the Hellenic Australian Lawyers Association.

Coroner Darren Bracken – LLB(Hons)

After more than 20 years as a barrister in Australia and overseas, Coroner Bracken was appointed a coroner in February 2018 and remained with the Court until February 2023. 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 Corner 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 master 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 and went on to mentor six readers and two Aboriginal lawyers over the next 23 years. He appeared in all courts in a variety of matters, including professional negligence, personal injury, administrative law, as well as human rights and confiscation proceedings. He has also appeared in a range of other matters, including royal commissions, 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 in 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 regulatory practice and representing the State's response for the Royal Commissions 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 both private practice and 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 and then Monash Health.

Prior to her coronial appointment, Coroner Lorenz held the position of Chief Executive Officer 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 through 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 (VSGO), 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 the 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 WA, Counsel Assisting at the Coroners 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 Coroners Education Committee and the Missing Persons Working Group.

Coroner Paul Lawrie – LLB

Coroner Lawrie was appointed in August 2022. Prior to his appointment, His Honour practised as a barrister for 23 years, also serving on the Victorian Bar Ethics Committee and mentoring six readers. His practice at the Bar involved criminal defence and prosecution matters, as well as personal injuries cases.

Coroner Lawrie regularly appeared in coronial inquests since 2000, acting for family members, Victoria Police and most recently as counsel assisting.

Prior to commencing at the Bar, Coroner Lawrie was a solicitor and articled clerk at Clayton Utz from 1997 to 1999. He was previously a member of Victoria Police, working as a general duties officer from 1986 to 1990 and then as a prosecutor and instructor from 1990 to 1997. His Honour holds a Bachelor of Laws from Deakin University.

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

Reportable 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, the cause of death and the circumstances in which a death or a fire occurred.

From **page 19**

Reducing preventable deaths

A coroner may also make recommendations or comment on matters connected to the death, including issues relating to public health and safety or the administration of justice.

From **page 24**

Promoting public health and safety

The Court regularly reports on data 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.

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 Victorian 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 testing 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 coroners' 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, or determine criminal guilt or civil liability.

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

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

Strategic Goals

The Coroners Court Strategic Directions 2020—2024 present the Court's vision, goals and priorities for a period of four years. The plan aims to facilitate an increased use of technology to improve efficiencies in Court processes; enhance engagement with families and friends experiencing loss; 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 the growing demand for coronial services, this plan has been informed by recent public enquiries into mental health, aged care and disability.

The Court has been implementing operational changes to meet these aims since 2020, including improvements in staff wellbeing programs, stronger support for culturally diverse communities in Victoria and ongoing efforts to produce reliable, publicly available data to support policy development, advocacy and prevention initiatives.

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 2022–2023

Implementation of the Aboriginal Passings Database

The Court maintains a range of specialist mortality datasets used to inform coroners' investigations and help identify death prevention opportunities. These include a general surveillance dataset of all deaths investigated by Victorian coroners, as well as specific datasets covering suicides, overdose deaths and homicides.

In 2021, the Court resolved to implement a new, enhanced dataset to capture data relating to passings of Aboriginal and Torres Strait Islander people. The Aboriginal Passings Database aims to build a body of evidence around issues, themes and factors that might contribute to the passings of Aboriginal and Torres Strait Islander people in Victoria – particularly evidence informed by an Indigenous cultural lens.

During 2022–23, a stakeholder consultation process was carried out and the technical build was completed. Coding is expected to commence in the latter part of 2023.

This data will be utilised for a range of purposes including:

- improving Victorian coroners' investigations into passings of Aboriginal and Torres Strait Islander people
- assisting Aboriginal and Torres Strait Islander people to advocate for measures to improve health and wellbeing in their communities
- further strengthening the cultural competence in the Court
- reducing the burden of preventable passings among Aboriginal and Torres Strait Islander people in Victoria.

The Aboriginal Passings Database comprises information on all Aboriginal and Torres Strait Islander passings reported to Victorian coroners for investigation. Its data fields capture information in domains relevant across a number of contexts including: the fatal incident; cultural, health, and psychosocial issues; service engagement; and other social determinants. The data fields were developed through an intensive process of consultation and pilot coding to ensure they meet the needs of coroners investigating passings and Aboriginal and Torres Strait Islander communities who may use the data to inform prevention initiatives and advocacy.

Establishing the Coroners Court of Victoria Multifaith and Multicultural Advisory Committee

In 2021, the Coronial Council identified a need to increase understanding between the Court and diverse communities in Victoria to ensure that cultural needs pertaining to death are integrated into the coronial process. In response, the Coroners Court of Victoria Multifaith and Multicultural Committee (the committee) has been established.

The committee was established at the Court and a Multifaith and Multicultural Senior Advisor was appointed in January 2023. The committee includes 17 members comprised of 11 community and faith spokespeople, along with representatives from the Court and PCSU. The aims of the committee include both demystifying coronial and forensic processes to faith leaders and their communities and keeping employees of the Court and VIFM informed about diverse cultural practices regarding the care of deceased loved ones.

To date, the committee has organised two information sessions for Court and VIFM staff. The first session, held in February 2023, included presentations from Islamic, Jewish, Hindu and Sikh spokespeople. The second, held in June 2023, featured representatives from the Buddhist, Jain, Coptic Christian and Bahá'í faiths.

Under this program, Deputy State Coroner Hawkins visited the Afri-Aus Care community centre in May 2023 to talk to the *Ubuntu Empowering Mothers Project* group about the role of the Court and the coronial process. This visit was the first in a planned series of events where coroners will engage directly with culturally diverse community groups to discuss the role of the Court.

Reducing the Risk of Vicarious Trauma project

The Court recognises that there are health and wellbeing risks in the work undertaken by staff – including accessing potentially distressing or graphic material and information which may, if left unchecked, create an exposure risk to vicarious trauma or cause psychological harm. While the Court is unable to completely eliminate exposure to potentially distressing material given the nature of the jurisdiction, systems can be adapted to reduce this exposure.

Over several years, significant investment has been made in people and wellbeing resources including health and safety governance, an established risk management program that includes psychosocial risk, and a dedicated suite of proactive wellbeing programs and resources.

In light of the Court's commitment to continuous improvement, a *Reducing Exposure Risk Working Group* (including specialist psychological representation) was established to identify further practical measures to enhance the management of exposure risk. Following extensive consideration, the working group delivered a suite of recommendations endorsed by the Court's Health and Wellbeing Committee and approved by the Court executive team.

Throughout 2022–23, considerable focus was given to developing initiatives that deliver on each recommendation. Key achievements to date include:

- A case classification system flagging potentially distressing content (low, moderate, and high) allowing staff greater control over what they view and providing them an opportunity to implement safe work practices prior to viewing.
- The development of an exposure points map across the coronial investigation lifecycle. The map details the different exposures that may occur and acts as a vicarious trauma risk assessment tool to ensure that appropriate controls are in place.
- The finalisation of individual control guidelines promoting healthy work practices that aid in effectively managing exposure risk. This is accompanied by systemic control guidelines outlining the system controls in place to reduce/limit exposure.
- The development of a vicarious trauma education series for staff to be incorporated into the Court's induction program. The series includes eLearns, podcasts and supporting resources to orientate new starters to safely work within a coronial environment. Official launch of the induction series will occur in 2023–24.
- Design of a wellbeing assessment tool, that include flags for vicarious trauma, to assist in the early recognition of change that may be related to exposure. This tool is currently being finalised for implementation in 2023–24.

Technology upgrades at the Court

In 2022–23, the Court successfully rolled out a suite of security and information technology upgrades to the Southbank coronial facility in partnership with VIFM. The upgrades were significant and included enhancements to CCTV cameras, duress response equipment, and courtroom infrastructure. Each of these upgrades will meet the complex and unique requirements of both the Court and VIFM into the future.

Since moving towards a paperless working environment in 2020–21, the Court has been making continuous improvements to its digital file management system. These enhancements are aimed at both improving internal efficiencies and facilitating better access to information for external stakeholders engaged with the Court – such as families and media. Changes made in 2022–23 include built-in direct integration with NCIS, improved communication with stakeholders submitting information relating to open investigations to the Court, stronger identification for National Disability Insurance Agency funded cases and enhanced internal reporting.

Building stronger relationships with external stakeholders

Victoria Police Family Violence Command and CCOV Information Sharing Day

In March 2023, the Court and Victoria Police held the first *Victoria Police Family Violence Command and CCOV Information Sharing Day*. Police records are frequently part of the coronial process – in a range of formats and types. This event aimed to provide a better understanding of Victoria Police processes and records to Court staff to support coronial investigations.

Held at VIFM, the event was open to all coroners and staff and provided overviews of: Victoria Police responses to family violence; the practicalities of responding to family violence following the reforms of the Royal Commission into Family Violence; training and procedures members are required to comply with when responding to family violence; and live demonstrations of police case management systems, referral procedures and protocols.

Opened by Assistant Commissioner of Victoria Police Lauren Callaway and State Coroner Judge Cain, the event was well attended by Court and VIFM staff.

New data report focusing on suicides in LGBTIQ+ communities

In October 2022, the Court published a new data report containing suicide data for LGBTIQ+ communities in Victoria from 2012 to 2021 to better understand suicide in these groups. The report was developed in consultation with the Office of the Commissioner for LGBTIQ+ Communities, the Victorian Department of Health and Switchboard Victoria following requests for data to help identify prevention opportunities for this cohort.

Historically, the Court has been cautious about publishing data focused on LGBTIQ+ communities due to challenges in identifying and collating relevant cases. Incomplete data may offer limited insights and hinder prevention efforts. This report represents a first step towards open dialogue with relevant organisations to improve data collection and mortality outcomes for LGBTIQ+ communities.

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	2021–22 actual	2022–23 estimates	2022–23 actual
QUANTITY				
Average cost per case	$	3987	3944	4123
The variance between the estimate and full-year result is due to a higher number of large-scale inquests requiring additional support.				
Case clearance	%	104.8	100	101.9
A total number of 7620 coronial investigations were finalised against 7480 new coronial investigations opened in 2022–23.				
QUALITY				
Court file integrity: availability, accuracy and completeness	%	90	90	97.9
The result reflects the Court's use of an electronic file management system which has streamlined and automated case management controls and processes.				
TIMELINESS				
On-time case processing: matters resolved or otherwise finalised within established timeframes	%	76.7	80	77.7
Of the 7620 matters closed, 5920 were closed within 12 months or less.				

1. Investigations into deaths and fires

Certain deaths and fires require independent investigation by the Court. 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 2022–23, the Court commenced 7480 investigations, 278 more than in 2021–22, and finalised 7620. The resulting closure rate for this period is 101.9 per cent.

Table 2: Investigations opened and finalised

	2018–19	2019–20	2020–21	2021–22	2022–23
Number of investigations commenced	6791	7304	7054	7202	7480
Number of investigations finalised	6010	6841	6591	7543	7620
Closure rate	88.5%	93.7%	93.4%	104.7%	101.9%

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 2022–23 was 8.5 months with 47.7 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

	2018–19	2019–20	2020–21	2021–22	2022–23
0–12 months	4978	5637	5288	5782	5920
12–24 months	785	846	886	1068	963
>24 months	247	358	417	693	737

Table 4: Average duration of cases before they are closed

	2018–19	2019–20	2020–21	2021–22	2022–23
Duration (days)	213.3	213.4	232.2	255.3	259.9

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 of the deceased 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 several expert witnesses, they can be invited to meet 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 2022–23, 82 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. During the reporting period, 89 inquests were held at the Court.

Table 5: Cases closed with inquests

	2018–19	2019–20	2020–21	2021–22	2022–23
Number of cases closed with an inquest	59	58	60	78	82
Percentage of cases closed with an inquest	1%	0.85%	0.73%	1.01%	1.08%

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

Coronial investigation highlights the dangers of gaming disorders following the death of a 13-year-old boy

In the early hours of 25 October 2019, OC, a 13-year-old boy, died at the Royal Children's Hospital after his mother found him unresponsive at home the evening prior.

Before his death, OC had shown a keen interest in video games. In the 12 months preceding his death, he became increasingly obsessed with gaming and his behaviour was at times irrational and aggressive. OC was resistant to assistance from his parents and reluctant to engage with mental health professionals. Unsure where to seek assistance, OC's parents attempted to restrict his access to gaming devices. This led to an escalation in his behavioural issues, including verbal and physical abuse. In the weeks before he died, OC was also involved in physical altercations with other students, which resulted in two short suspensions from school.

On 24 October 2019, OC was under a week-long technology ban due to a school suspension when his father arrived home and found OC in his bedroom playing on his computer. A confrontation ensued during which OC exhibited physical and verbal aggression towards members of his family.

Later that evening, OC's mother found him unresponsive and called emergency services. OC was airlifted to the Royal Children's Hospital but he could not be revived and died in the early hours of the next morning.

The coronial investigation focused on whether OC's gaming addiction could be considered a mental disorder. The coroner also sought information on available supports for gamers like OC and their families.

To assist the investigation, an expert report was obtained from a senior research fellow and clinical psychologist along with statements from the Office of the eSafety Commissioner and the Australian Psychological Society.

According to the World Health Organization (WHO), gaming disorder is characterised by a pattern of persistent or recurrent gaming behaviour in which gaming takes increasing priority over interests and daily activities. The condition includes marked distress or significant impairment in personal, familial, social, and other important areas of life. The coroner noted that while the WHO recognises the condition, the *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* – the primary diagnostic tool used by mental health professionals in Australia – does not include gaming disorder.

Such disorders often appear in high school, usually affecting males who play role-playing games and who spend time at home alone. People with a gaming disorder may also experience social phobia, disruptive behaviours, mood, anxiety and personality disorders. The coroner concluded that OC's behaviours suggested he met the threshold for gaming disorder.

The coroner found that the current understanding, diagnosis, prevention and treatment of gaming disorders is neither extensive nor rigorous. Scant material is available online – with most resources falling under the umbrella of general mental health support, addiction and gambling. The coroner found that compared to other countries with specialised gaming disorder services, information and support for those dealing with gaming addiction is minimal in Australia.

The coroner identified a need to increase the commitment to researching the prevalence and incidence of gaming disorders. Accordingly, Her Honour recommended that the Office of the eSafety Commissioner:

- Raise awareness in adolescents and young adults of the risks of gaming on their psychological wellbeing and promote the inclusion of information about gaming and psychological wellbeing in school-based digital health programs.
- Develop and promote evidence-based research about gaming that establishes the incidence and prevalence of psychological harms to adolescents and young adults from online gaming.

In response, the Office of the eSafety Commissioner advised it is implementing changes to its content to include safety messaging, along with proactive strategies, in its parent and carer webinars, as well as in its professional learning resources for educators and mental health practitioners working in school environments. A webinar aimed at parents and carers to assist them in recognising the warning signs of problematic gaming and when and how to seek help is also in development. Online gaming will be a subject of discussion by the Online Safety Youth Advisory Council – a group that meets quarterly to discuss and explore key online safety issues impacting young people aged between 13 and 24.

The eSafety Commissioner indicated its commitment to reviewing all gaming information available on its website to reflect both the benefits and potential risks of gaming to mental health and wellbeing, and available supports. The eSafety Commissioner also agreed to assist clinical research bodies in researching gaming disorders and promoting the results to parents and young people.

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, such as 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 2.1 per cent of findings in 2022–23. This figure was calculated excluding natural cause findings and cases where a coroner determined the death was not reportable.

The number of recommendations made increased in 2022–23 from 199 to 221. 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.

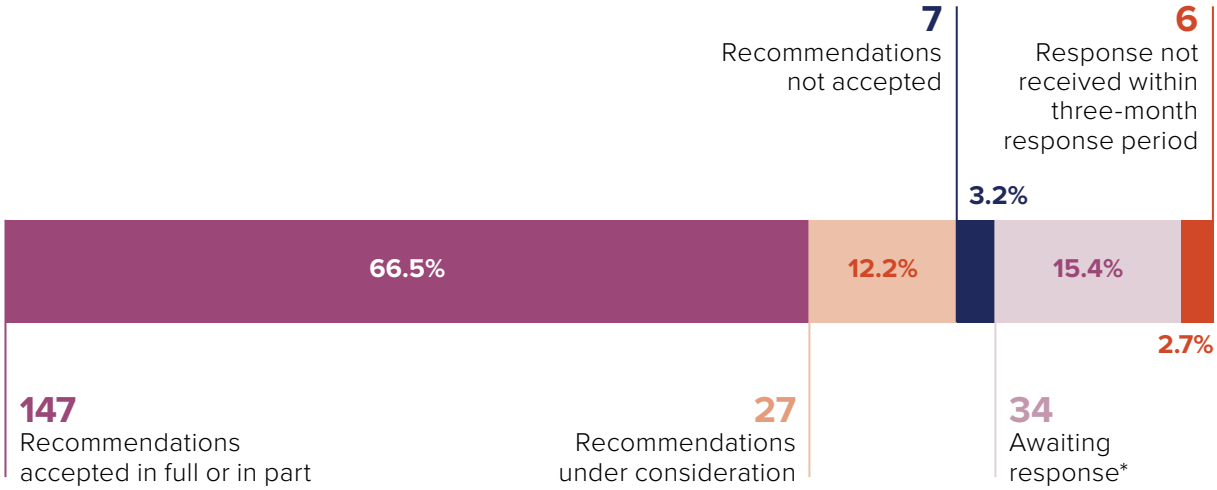
Any agency or person who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken.

In the past year, 147 of the 221 recommendations made by coroners were accepted in full or part for implementation and 27 recommendations are under consideration. Seven recommendations were not accepted, and in six instances a response was not received within the required time frame.

Table 6: Recommendations made in closed investigations

	2018–19	2019–20	2020–21	2021–22	2022–23
Number of investigations closed with recommendations	69	78	93	81	95
Number of recommendations made	154	166	204	199	221

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 by developing a better understanding of the circumstances in which deaths occur in Victoria, so that new prevention opportunities can be identified

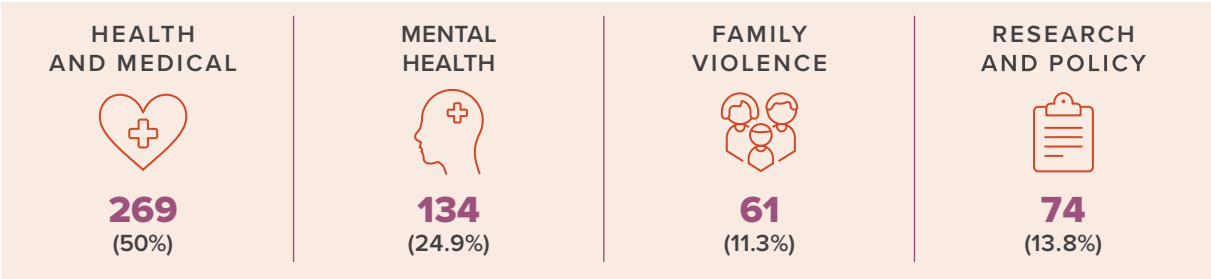
Throughout the 2022–23 reporting period, coroners made 538 referrals to the CPU about deaths under investigation. The advice coroners sought input on, included:

- 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 of similar deaths occurring in the 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 2022–23, coroners made referrals into four expert streams within CPU:

- **Health and medical:** for deaths where coroners required clinical advice on the level of healthcare provided to the deceased and whether this might have contributed to the death.
- **Mental health:** to advise coroners on the clinical appropriateness of mental health treatment provided (or not provided) in the lead-up to deaths of people experiencing mental ill health. The mental health team also incorporates a disability case investigation function examining deaths of people engaged in disability services.
- **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 2022–23



In addition to the above, the Health and Medical Investigations Team (HMIT) undertook 316 initial screening reviews of cases to assist coroners to determine whether the health and medical care in deaths required further investigation.

Paediatric placement program

Under this program, a senior paediatric trainee is based at the Court two days per week in the HMIT. In this 12-month role, the trainee works under the supervision of a consultant paediatrician, providing clinical advice to coroners and assistance with case reviews of relevant deaths under investigation.

During 2022–23, the Court engaged two senior paediatric trainees. The first commenced a placement with the Court in February 2022 and the second, a full-time employee of Monash health who works in the delivery of clinical paediatric care, joined the Court in February 2023.

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2022–23 the Court engaged 69 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 due to this re-classification process.

In 2022–23, causes of death reported to the Court were generally consistent with previous years – 40.4 per cent were natural causes, 37.1 per cent were accidental (due to unintentional falls, road accidents, drowning and similar), and 10.5 per cent were suicides.

Table 7: Cases reported to the Court in 2022–23

Cause of death	Frequency	Percentage
Natural causes	**3019**	**40.4**
Unintentional	**2771**	**37.1**
• Falls	1899	25.4
• Poisoning	356	4.8
• Transport	302	4.0
• Drowning	49	0.7
• Other	165	2.2
Suicide	**784**	**10.5**
• Hanging	414	5.5
• Poisoning	123	1.6
• Firearm	35	0.5
• Rail	28	0.4
• Jump from height	27	0.4
• Other	157	2.1
Assault	**60**	**0.8**
Complications of medical or surgical care	**384**	**5.1**
Other*	**168**	**2.2**
Not reportable	**174**	**2.3**
Still enquiring	**120**	**1.6**

* '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 reduction in Victorian overdose deaths during 2022–23 from 529 in 2021–22 to 514. The 2022–23 overdose deaths data is still preliminary and is likely to be revised as investigations progress. Early analysis suggests the decrease 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 a 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	Number of deaths
2018–19	540
2019–20	543
2020–21	498
2021–22	529
2022–23	514

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 2022–23, suicides comprised 10.5 per cent of all deaths reported to the Court. The number of reported suicides in 2022-23 was 784, a notable increase from 701 in financial year 2021-22. Suicides were particularly elevated in the period between October 2022 and May 2023. The reasons for the increase are not immediately apparent from inspection of the data, as there were no standout groups (defined by sex, age group or geographical region of residence) to which the increase was restricted.

Table 9: Annual reports of suicide

Financial year	Number of deaths
2018–19	723
2019–20	704
2020–21	685
2021–22	701
2022–23	784

Victorian Homicide Register

The Court created the Victorian Homicide Register (VHR) to track and analyse homicides across the State 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 legislated function of the Court that conducts in-depth reviews, identifies risks, contributory factors and trends 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 a project officer. Their work is informed by both individual investigations and the Victorian Homicide Register (VHR), which is a key data source informing systemic analysis and recommendations.

The Court has a strong commitment to the reduction of family violence related deaths. The VSRFVD works with the sector to share information on systemic issues to strengthen responses for those living with family violence. In partnership with academics and groups such as the Australian Domestic and Family Violence Death Review Network, the VSRFVD contributes to the evidence base for prevention of family violence deaths.

Homicide incidents in 2022–23

There were 38 probable homicide incidents in Victoria reported to the Court in 2022–23. This was a decrease from 51 homicide incidents in the previous year (**Table 10**). However, the data must be interpreted with caution because it excludes suspected homicide incidents where there was insufficient evidence at the date of data extraction (24 July 2023) to classify them with confidence. As criminal and coronial investigations progress and new evidence becomes available, the homicide numbers reported by the Court are likely to change.

Approximately a quarter of homicide incidents during 2022–23 (26.3 per cent) were identified as occurring between people who had an intimate or familial relationship. Please note, detailed data is not provided with respect to homicide offenders as the criminal proceedings for many homicides that occurred in 2022–23 remain ongoing at the time of publication.

Table 10: Homicides incidents by year – July 2018 to June 2023

Type of homicide incident	2018–19	2019–20	2020–21	2021–22	2022–23
Intimate or familial relationship	15	20	23	16	10
No intimate or familial relationship	32	41	31	26	18
Unknown	2	5	2	9	10

Most of the 38 probable homicide incidents in 2022–23 resulted in the death of one homicide victim (92.1 per cent) (Table 12).

Homicides by relationship

The 38 probable homicide incidents resulted in the deaths of 41 homicide victims.

Where an intimate or familial relationship was identified between the homicide offender and homicide victim in the 2022–23 data, the relationship most frequently was either child-parent (the offender was the child of the victim, four deaths) and current or former intimate partner relationships (four deaths). Parent-child homicides (the offender was the parent of the child) were least frequent (one death) alongside other intimate or familial relationships (one death).

Table 11: Homicide Victims by relationship to offenders – July 2018 to June 2023

	2018–19	2019–20	2020–21	2021–22	2022–23
Intimate partner	12	13	11	9	4
Child-parent*	1	0	4	3	4
Parent-child#	1	5	5	6	1
Other intimate or familial	1	3	5	1	1
Not intimate or familial	34	43	33	27	21
Unknown	2	5	2	9	10

* Child-parent indicates relationship only, and that the offender was the child of the victim. It does not indicate age (that is, the child who was the offender may be an adult).

#Parent-child indicates relationship only, and that the offender was the parent of the victim. It does not indicate age (that is, the child victim may be an adult).

Table 12: Homicide incidents by number of deaths – July 2018 to June 2023

Number of deaths from incident	2018–19	2019–20	2020–21	2021–22	2022–23
Single	44	60	51	46	35
Multiple*	5	6	5	5	3

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

Homicide victims by sex

In 2022–23, female homicide victims were most often killed in intimate or familial contexts (71.4 per cent), whereas males were most frequently homicide victims in situations where there was no intimate or familial relationship (55.9 per cent). This finding was consistent with preceding years of data (Table 13).

Table 13: Homicide victims by sex – July 2018 to June 2023

Sex of homicide victim	Type of homicide	2018–19	2019–20	2020–21	2021–22	2022–23
Male	Intimate relationship	2	3	3	2	1
	Familial relationship	1	5	6	3	4
	No intimate or familial relationship	27	39	29	27	19
	Unknown	1	4	2	9	10
Female	Intimate relationship	10	10	8	7	3
	Familial relationship	2	3	8	7	2
	No intimate or familial relationship	7	4	4	0	2
	Unknown	1	1	0	0	0

Recommendations in family violence investigations 2022–23

A total of nine recommendations were made across five family violence related closed coronial investigations in 2022–23.

Eight of the recommendations were directed towards regulation, training or registration standards of private clinicians such as general practitioners and psychologists. One was directed towards the New South Wales Police Force and Victoria Police jointly – this related to the management of warrants (including interstate warrants) to ensure that they are executed in a more timely manner.

External engagement

Networks

The Court continued to be an active member of the Australian Domestic and Family Violence Death Review Network (the Network) in 2022–23. The Network consists of representatives from family violence death review mechanisms in states and territories throughout Australia.

This year, the Network continued its collaboration with Australia's National Research Organisation for Women's Safety Limited (ANROWS) by exploring opportunities to develop a national minimum data set for filicides.

Case study 2

Coroner refers matter to the Director of Public Prosecutions following an investigation into the death of a 29-year-old woman.

On 17 January 2015, 29-year-old MY was found deceased at the Docklands apartment she shared with her husband PS – a respiratory and sleep physician.

Born and raised in Japan, MY met PS when he was visiting Japan in 2006. They commenced a relationship in 2010 and moved to Australia in the same year. The couple briefly stayed in New South Wales before moving to Victoria and getting married in 2011. Prior to her death, MY worked for PS as his business manager.

On 16 January 2015 MY and PS went out for dinner and drinks with friends, returning home just after 1.00am the following morning. In a statement provided to the Coroner's Investigator, PS stated that at approximately 4.00am on 17 January 2015 MY had a seizure and began vomiting. While attempting to resuscitate her, PS formed the belief that there was a blockage in her throat and consequently attempted to perform a cricothyroidotomy on her using a kitchen knife and pen.

The procedure was unsuccessful and PS contacted emergency services at 7.38am on 17 January 2015. Ambulance Victoria paramedics arrived at 7.49am and observed MY lying on the floor in the lounge area where PS appeared to be attempting cardiopulmonary resuscitation (CPR). MY was declared deceased at the scene by the attending paramedics. Her temperature was taken and noted to be 33.2 degrees, suggesting that she had been deceased 'for a considerable amount of time.'

Cocaine was located inside a bloodstained hand vacuum in the apartment and a bloodstained towel, syringes and plastic bags containing cocaine were found under some clothes inside the washing machine.

MY's cause of death was found to be cocaine toxicity, however the pathologist noted that there was no evidence of chronic injection drug use. PS was examined by a forensic physician who noted bruised veins on the inner aspect of both of his elbows, indicative of recent intravenous access with needles.

Evidence presented during the coronial investigation suggested that PS perpetrated family violence towards MY during their relationship, including alleged physical, emotional and psychological abuse, and coercive and controlling behaviour. MY told friends that PS had kicked her out of their house on several occasions late at night, punched her in the jaw, slapped her, pushed her over and hit her, sent her abusive messages and, on one occasion, had allegedly injected her with cocaine against her wishes.

Despite a thorough and comprehensive criminal investigation into the circumstances of MY's death, no person or persons have been charged with an indictable offence in relation to her death at the time of publication. Available evidence indicates that the police investigation only considered PS's connection to the cocaine overdose and not his significant delay in contacting emergency services.

An emergency specialist provided evidence to the investigating coroner that even in a stressful situation, which required a doctor to attempt resuscitation upon his own wife in a domestic setting, he would expect an ambulance to be called almost immediately, not several hours after the crisis. The expert considered it reasonable, given PS's medical training and concern for aspiration of vomitus, to undertake actions to attempt to clear the airway before calling an ambulance – the expert suggested these actions can be performed rapidly and abandoned quickly if not successful, leading to only a very short delay before seeking emergency assistance.

After a careful review of the available evidence, the coroner formed the belief, to the coronial standard, that an indictable offence may have been committed in the circumstances of MY's death. Due to the delays in seeking medical assistance and PS's duty of care to MY upon discovering her in a state requiring urgent medical assistance, His Honour formed the view that the circumstances may indicate negligent manslaughter. His Honour then made a formal referral to the Director of Public Prosecutions (DPP) that an indictable offence may have been committed in connection with MY's death. The coroner also provided a copy of his findings to the Australian Health Practitioner Regulation Agency (AHPRA).

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

During 2022–23 the Court contributed to two published journal articles in conjunction with practitioners and academics from multiple countries with an interest in suicide prevention.

The first was an examination of suicides during the first 9 to 15 months after the onset of the COVID-19 pandemic, in which the Court's Victorian Suicide Register (VSR) data was pooled with suicide data from 33 countries. The study, published in *The Lancet*, found that there was generally no change in suicide rates during the pandemic, though a small number of regions and countries did experience either increases or decreases.

The second involved a comparison of five major real-time suicide surveillance systems around the world, including the VSR. The paper (published in *Archives of Suicide Research*) identified the commonalities and differences between the systems and made recommendations on the best practice features a successful suicide surveillance system might require.

In addition to these internationally focused studies, the Court collaborated with researchers from the University of Melbourne on two published studies examining suicide in a specifically Victorian context. One study, published in the *Australian and New Zealand Journal of Psychiatry*, used linked data to identify risk profiles for suicide among young women who were admitted to hospital for self-harm. The other study, published in *Social Psychiatry and Psychiatric Epidemiology*, showed how rail suicides decreased at and around the sites of level crossing removals across Metropolitan Melbourne.

Finally, the Court collaborated with researchers from Queensland and Tasmania to examine the differences between Australian Bureau of Statistics (ABS) and state-based suicide register counts of suicides in Australia. The study (published in the *Australian and New Zealand Journal of Public Health)* found that over time ABS and state-based suicide register counts of suicides tended to converge despite having different case definitions and coding practices.

Supporting research

During 2022–23 reporting period, the Court's Research Committee met on eight occasions to assess 25 new applications for access to coronial data, as well as 21 applications to amend previously approved research projects.

Of these applications, 42 were ultimately approved. The approval process in some cases required correspondence with the applicants and changes to research design to address coronial concerns. Two applications were endorsed after revisions, one application was withdrawn during the consultation process, and 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:

- The characteristics of deaths involving methamphetamine
- Unexplained cardiac death
- Skeletal blunt trauma in motor vehicle collisions.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2022–23 the Court responded to 37 requests from external organisations for data and other assistance, including:

- Victorian Alcohol and Drug Association
- Inspector-General for Emergency Management
- Victoria Police
- Department of Transport and Planning.

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 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 2022–23 the Court received 5891 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports, evidence tendered during hearings or unpublished findings.

Table 14: Requests for coronial documents

	2018–19	2019–20	2020–21	2021–22	2022–23
Form 45 requests	5741	4600	5588	6144	5891

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 to those who need it.

Alongside the Coroners Aboriginal Engagement Unit (CAEU), the Family Liaison Officers (FLOs) provide critical support to families and friends affected a death, explaining the coronial processes and findings. The teams work closely with a broad range of 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 2022–23 coroners delivered 10 presentations to stakeholders. These formal and informal presentations to key stakeholders and at 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.

Additionally, the FLOs delivered 9 presentations focused on explaining the coronial process and the Court's family support program, which is administered by the FLOs and the CAEU. These in person and online presentations are aimed at community bereavement providers to assist them in caring for families experiencing loss. Attendees are mostly comprised of counsellors and bereavement support workers. During 2022–23, participating organisations included The Royal Children's Hospital, Coroners Court New South Wales, Traffic Accident Commission, Support After Suicide and Red Nose Australia.

During 2022–23 Court leaders also presented to multifaith leaders on the operation of the Court and to the expert panel convened by the Coronial Council to guide their work into reportable deaths of older Victorians.

Hospitals and health practitioners

The Coroners Prevention Unit (CPU) Health and Medical Investigations Team (HMIT), in collaboration with the coroners and VIFM, presented to hospital staff on coronial death investigations associated with health care in two rounds – one in August 2022 and the second in November 2022. During 2022–23 the online education sessions comprised a coroner, a forensic pathologist, and staff from HMIT with relevant clinical expertise.

In August 2022 a presentation was delivered to Western Health's and Royal Melbourne Hospital's intensive care units (ICU), and in November 2022 a session was held for staff from Royal Women's Hospital, Mercy Health, Monash Health, Royal Children's Hospital (RCH), Neonatal Intensive Care Unit (NICU) and Paediatric Infant Perinatal Emergency Retrieval (PIPER). Approximately 100 people attended each session.

Sessions covered a range of topics including the role of the coroner, elements of forensic pathology involved in the investigative process, case studies, how a coronial investigation is conducted, and the role of the HMIT within the CPU.

These education sessions provide an opportunity for the Court to demystify the investigative process. Feedback demonstrates that these sessions are extremely well received and provide opportunities to facilitate contact between the Court and practicing clinicians.

Law Week, May 2023

For Victorian Law Week this year, the Court, in conjunction with VIFM, held a mock inquest exploring the forensic investigation methods and coronial processes utilised in cases involving unidentified human remains.

The event, titled *Unidentified remains: A mock inquest*, addressed topics including the role of DNA testing, the processes initiated when a homicide is suspected, and the investigative procedures used by coroners to establish whether a death was accidental, or a crime may have been committed.

The event highlighted the range of professionals involved in a coronial investigation including police, forensic pathologists and anthropologists. It sold out, with approximately 60 people in attendance and feedback was overwhelmingly positive.

Case Study 3

Coroner recommends stronger safety precautions for LPG plumbing systems on recreational vessels

On 22 March 2020, GFE vanished during a sea voyage from St Kilda Marina to Gladesville Bridge marina in Drummoyne, New South Wales in his yacht. He was last seen by witnesses aboard the vessel in the morning of 19 March 2020, motoring out of Refuge Cove on the eastern side of Wilsons Promontory National Park.

GFE was an experienced and safety-conscious sailor, and had purchased the yacht, a 10.95m Radford aluminium sailing vessel, on 1 February 2020. Before buying it, GFE had the yacht examined by a marine surveyor who reported no structural issues and noted it had been 'well equipped with electrical and plumbing systems with no major faults'. Prior to departure GFE ensured there were sufficient provisions aboard the yacht, including a hand-held VHF radio, a satellite phone, an emergency position indicating radio beacon (EPIRB), two lifejackets, five lifelines, fully charged batteries, and additional diesel for the motor.

GFE had no recorded history of mental health concerns. His only notable health issue was hypertension, which was managed by medication.

On 20 March 2020 GFE phoned his wife and told her in a panicked tone that he had been 'hijacked by African pirates' who could 'shapeshift'. Water Police subsequently contacted GFE, who told police he was okay and the 'Africans were already on board when [he] met them in Melbourne', and that he had an electrical failure and was drifting in the ocean without an engine, radio or GPS tracker. Police told GFE they would attend his position to assist, but he refused to answer further questions and terminated the call. No further contact was made with the yacht and its last known position was near the coast off the Cape Conran/Pearl Point area.

Police arrived at Cape Conran around 11.00pm that day and began to search the area by radar and FLIR (thermal imaging using infrared). At 5.30am on 22 March 2020, police were informed that an aircraft had sighted a vessel fitting the description of GFE's yacht drifting around 8 nautical miles southeast of Cape Howe. Arriving on the scene at 7.15am, they boarded the vessel and found no one on board. Officers located GFE's wallet and described the level of safety equipment on board the yacht as exceptional. The yacht's extensive circuit breaker panel was in a switched-off position at the time, but in operable in condition. Police also noted that the toilet was not connected and several rail wires on the port side of the vessel were open, indicating that GFE may have attempted ablutions over the side as a result.

Despite extensive search operations over the following days, GFE was never located, and the investigating coroner concluded that he is most likely deceased.

Upon mechanical inspection of the yacht, several modifications to the original design were uncovered – including a liquid petroleum gas (LPG) tank fitted to the stern. The modified plumbing diverted the LPG to a ball valve that directed the flow to either a barbeque on the stern or the stove in the interior galley. Police tested the LPG bottle by sealing the vessel in a watertight state for three hours with the LPG bottle open. Atmospheric testing of the tiller compartment found it had filled with sufficient LPG to combust, as well as 157ppm of carbon monoxide.

As a result of the atmospheric testing, Police concluded that:

- the LPG system was leaking in the tiller room, resulting in the vessel being susceptible to gas ingress into the accommodation area
- it was likely that LPG filled the accommodation area whilst GFE was using or had the LPG bottle on.

Energy Safe Victoria conducted further testing of the LPG system and found the gas fitting failed to hold pressure due to a fracture in the body of the ball valve. They opined that the lack of proper seals surrounding the partitions allowed leaking LPG to migrate through the service ducts into the sleeping quarters and engine compartment with the potential to displace oxygen inside the sleeping quarters of the vessel.

His Honour concluded that GFE died on or around 20 March 2020, approximately 8 nautical miles east of Cape Howe, likely having fallen overboard. His Honour found that it was reasonable to conclude that GFE was suffering from a hypoxic episode caused by a combination of sleep deprivation due to prevailing rough conditions and the slow LPG leak seeping into the sleeping quarters at the time he spoke to his wife and police on 20 March 2020.

His Honour recommended that Marine Safety Victoria and the Department of Transport develop legislation mandating that:

- solo operators in enclosed and coastal Victorian waters must wear a personal flotation device (PFD) Type 1 with an attached registered EPIRB
- any recreational vessel with an LPG system on board in an enclosed area must have an operable gas detecting system.

The Department of Transport considered the current requirements prescribed in the Marine Safety Regulations 2012 to be proportionate and appropriate, and so did not agree that legislation was required to mandate the wearing of EPIRBs or personal locator beacons (PLBs) in the specified circumstances.

Transport Safety Victoria committed to continuing to educate solo boaters about the risks of boating alone and encourage them to carry additional means of raising the alarm, including carrying an EPIRB or PLB, particularly on solo trips, and to providing communications about the importance of ensuring good ventilation in enclosed spaces on vessels and ongoing inspections of gas installations.

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.

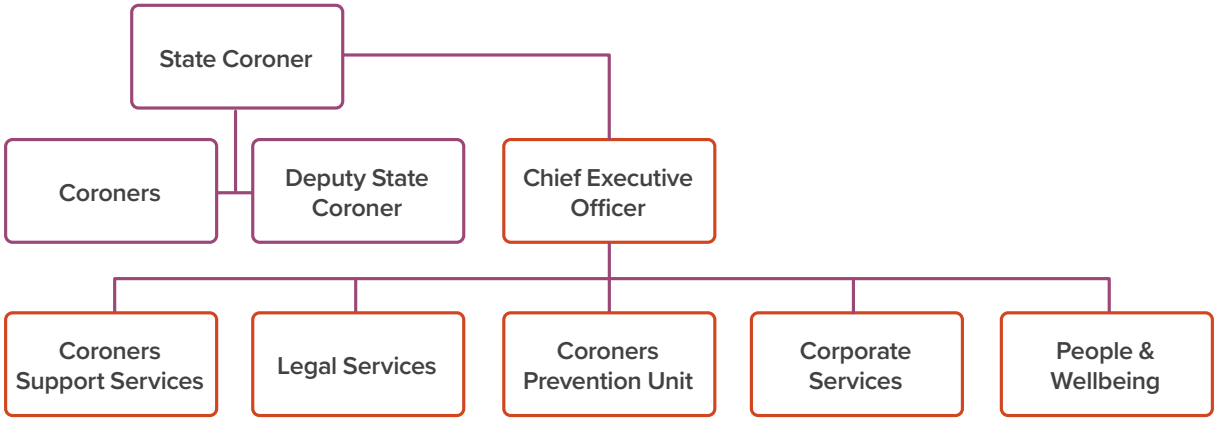
The Court sits within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its staff.

Organisational structure

The Court employs 126 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 2023, the Court had 126 staff members (109.3 full-time equivalent (FTE)), not including coroners. This includes 100 permanent staff, 25 per cent of which were employed on a part-time basis.

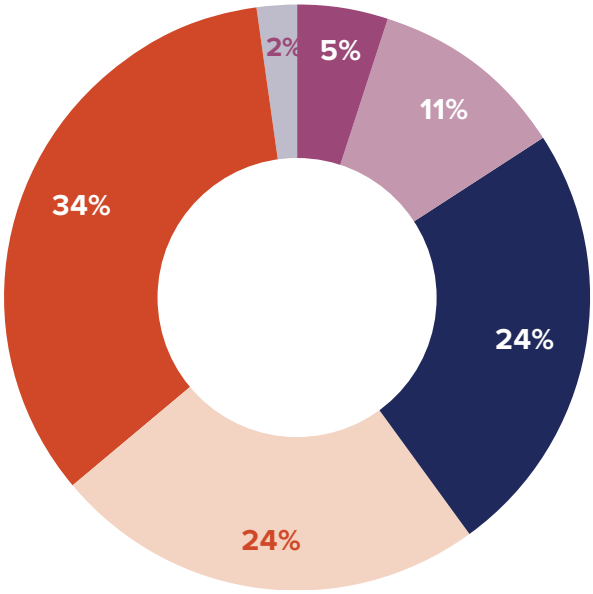
Table 15: Workplace profile as at 30 June 2023

	June 2023					
	ALL EMPLOYEES		ONGOING		FIXED TERM/CASUAL	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
Male	24	20.3	18	4	1	1
Female	102	89	57	21	16	8
Total	126	109.3	75	25	17	9

	ALL EMPLOYEES		ONGOING		FIXED TERM/CASUAL	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
VPS2	14	11.2	6	3	3	2
VPS3	35	33.4	22	2	10	1
VPS4	38	33.3	22	10	3	3
VPS5	17	15.4	12	4	0	1
VPS6	13	12.6	11	1	1	0
STS/7	8	2.4	1	5	0	2
Executive	1	1	1	0	0	0
Total	**126**	**109.3**	**75**	**25**	**17**	**9**

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

Figure 3: Divisional headcount at 30 June 2023



Division	Number FTE	Number Headcount
Office of CEO*	6	6
Corporate Services	12.2	14
Legal Services	26.2	28
Coroners Prevention Unit	26.1	35
Coroners Support Services	36.8	41
People and Wellbeing	2	2
Total	**109.3**	**126**

* The Office of the CEO includes staff supporting the CEO who are 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 one senior, internal committee – the Coroners Court Executive Committee. The committee oversees critical business functions, provides a clear decision-making framework, and ensures 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.

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.

Coronial Council of Victoria

Established under the Coroners Act to provide advice to the Attorney-General about matters of importance to the jurisdiction in Victoria, the Coronial Council of Victoria (the Council) was the first body of its kind in Australia and is independent of both the Court and the Victorian Government.

Under the Coroners Act, there are three statutory members: the State Coroner, the Director of the Victorian Institute of Forensic Medicine and the Chief Commissioner of Police. An additional five to seven members are appointed on recommendation by the Attorney-General.

Currently the Council includes members with expertise in policy development, law, psychiatry, grief and bereavement, paediatric medicine, gender and diversity, epidemiology, and emergency medicine.

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.

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 2022–23 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 2022–23 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.

The Court also worked in close partnership with 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 2022–23, the Court participated in internal audits at a CSV-wide level regarding:

- Information technology governance
- Physical security
- Investment management
- Delegations of authority
- Privacy.

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 Court staff who support them. A continued focus of 2022–23 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 that coroners and staff are exposed to. In response, it focuses on creating an environment with effective and safe systems of work, a strong and collegiate culture, and effective monitoring of health, safety and wellbeing.

During 2022–23 the following programs and initiatives were delivered or commenced:

- The commencement of regular group supervision sessions for staff working within the family violence area. These sessions provide staff with an opportunity to share experiences and identify factors that have the potential to impact on their wellbeing. Staff are encouraged to engage in reflective practice, and devise strategies that can be implemented to foster positive mental health.
- Implementation of a Peer Support Program designed to help create a safe and supportive workplace in which colleagues look out for each other. The program offers an additional avenue of wellbeing support and referral to staff that is provided by a trained group of Peer Supporters.
- Development of a vicarious trauma induction series for staff to be incorporated into the Court's induction program. The series includes eLearns, podcasts and supporting resources to orientate new starters to safely work within a coronial environment. Official launch of the induction series will occur in 2023–24.
- Implementation of the Reducing Exposure Risk Working Group recommendations that identified further opportunities to reduce inadvertent exposure to traumatic or distressing material. This included the:
  - introduction of a case classification system that flags potentially distressing content
  - development of an exposure points map, to be used as a risk audit tool detailing exposure by position to coronial material and interactions
  - development of individual and systemic control guidelines to minimise the risk of vicarious trauma.
- A range of health and wellbeing program offerings continued to be available including health checks, flu vaccinations, access to the Headspace app, Dogs@Work program, mindfulness and resilience programs and fitness initiatives.

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

In 2022–23, the Court focused on initiatives to continually attract and retain a diverse and high performing workforce. These included:

- A review of the supervision framework to ensure its continued effectiveness and usability to support managers in having regular one-to-one and supervision discussions with their staff – including supporting work performance and workload, professional development opportunities, and proactive wellbeing support.
- Reestablishment of a staff-led social club to facilitate engagement as staff commenced a hybrid working model. This connection has been strengthened by team-led events to support various charities and causes.
- The formation of a Court Diversity and Inclusion Committee to help foster a fair, inclusive, and safe environment so the Court work environment better reflects the community it serves.
- The Court recognises that internships provide a valuable pathway for law students seeking professional experience in a legal environment. In 2022–23, the Court partnered with several universities to provide law students an opportunity to gain hands-on experience working with coroners and solicitors.

  These internships provide students with an opportunity to gain practical experience in a collaborative and supportive legal practice setting, develop their understanding of coronial law and engage with other disciplines including forensic pathology.

  In 2022, Court and VIFM staff presented to students participating in the Victorian Bar Student Engagement Committee's shadowing program which gives students exposure to the work of barristers and courts who might not otherwise have had the opportunity. This includes students from culturally diverse backgrounds, First Nations people and people with disabilities.

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 Purposeful Leaders Speaker series was commenced to supplement the 12-month Purposeful Leadership Program conducted in the previous year.

The following sessions were held in 2022–23:

- Fatigue antidote for leaders
- Coaching and developing others
- Innovative problem solving.

Flexibility

To help employees balance the demands of work and personal commitments and to position the Court as an employer of choice, 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.

Glossary

BP3	Victorian Budget Papers Number 3
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
DPP	Director of Public Prosecutions
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
VHF Radio	Very high frequency radio
EPIRB	Emergency position-indicating radio beacon
FLIR	Forward looking infrared (imaging technology)
LPG	Liquid petroleum gas
ppm	Parts per million
PLB	Personal locator beacon
CPR	cardiopulmonary resuscitation
HMIT	Health and Medical Investigations Team

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 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 and circumstances that make it appropriate to do so. If a coroner determines not to set aside a finding or findings and therefore not 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 2022–23, the following appeals were finalised:

- Kontis & Anor v Coroners Court of Victoria (S ECI 2022 00252) – Judicial review pursuant to Order 56 of the Supreme Court (General Civil Procedure) Rules 2015 – Judgement issued on 1 August 2022 – Appeal dismissed.
- Mortimer v Coroners Court of Victoria & Ors (S ECI 2021 03907) – Judicial review pursuant to Order 56 of the Supreme Court (General Civil Procedure) Rules 2015 – Judgement issued on 9 August 2022 – Appeal dismissed.
- Hii v Coroners Court of Victoria (S ECI 2021 004042) – Appeal against Findings of a coroner – Judgement issued 13 October 2022 – Appeal dismissed.
- Farrar v Coroners Court of Victoria (S EAPCI 2022 0005) – Appeal of the decision of Justice O'Meara of the Supreme Court of Victoria in Farrar v Coroners Court of Victoria [2021] VSC 842 – Judgement issued on 11 November 2022 – Appeal dismissed.
- Kontis & Anor v Coroners Court of Victoria (S EAPCI 2022 0078) – Appeal of the decision of Justice O'Meara of the Supreme Court in Kontis & Anor V Coroners Court of Victoria [2022] VSC 422 – Judgment issued on 12 December 2022 – Appeal dismissed.
- Vallianos v Coroners Court of Victoria & Ors (S ECI 2022 05128) – Appeal against decision to release body – Judgement issued 14 February 2023 – Appeal dismissed.
- Diamond v Coroners Court of Victoria (SECI 2022 05001) – Appeal against decision not to hold an inquest – Orders made 5 June 2023 – Appeal allowed and matter remitted by consent.

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