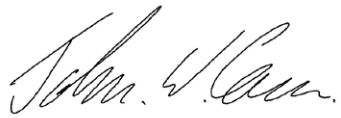
Coroners Court of Victoria

Annual Report

2024–2025

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 2025.



Judge John Cain, State Coroner

Warning

Aboriginal and Torres Strait Islander people are respectfully warned that the following report includes information associated with deceased persons from events that have occurred on Aboriginal land in Victoria.

Acknowledgement

The Coroners Court of Victoria acknowledges the Traditional Owners and continuing custodians of the land on which it is located, the Wurundjeri Woi Wurrung peoples of the Kulin Nation. Furthermore, the Court respectfully acknowledges all Traditional Owners across Victoria and pays respect to all Elders both past and present.

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65 Kavanagh Street Southbank VIC 3006
October 2025

We value your feedback

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

Please send your feedback to
mediaenquiries@courts.vic.gov.au

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www.coronerscourt.vic.gov.au

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Contents

At a glance

INVESTIGATIONS

7585 new investigations opened

7290 investigations finalised

96.1% closure rate

TIMELINES

8 Average months to investigate

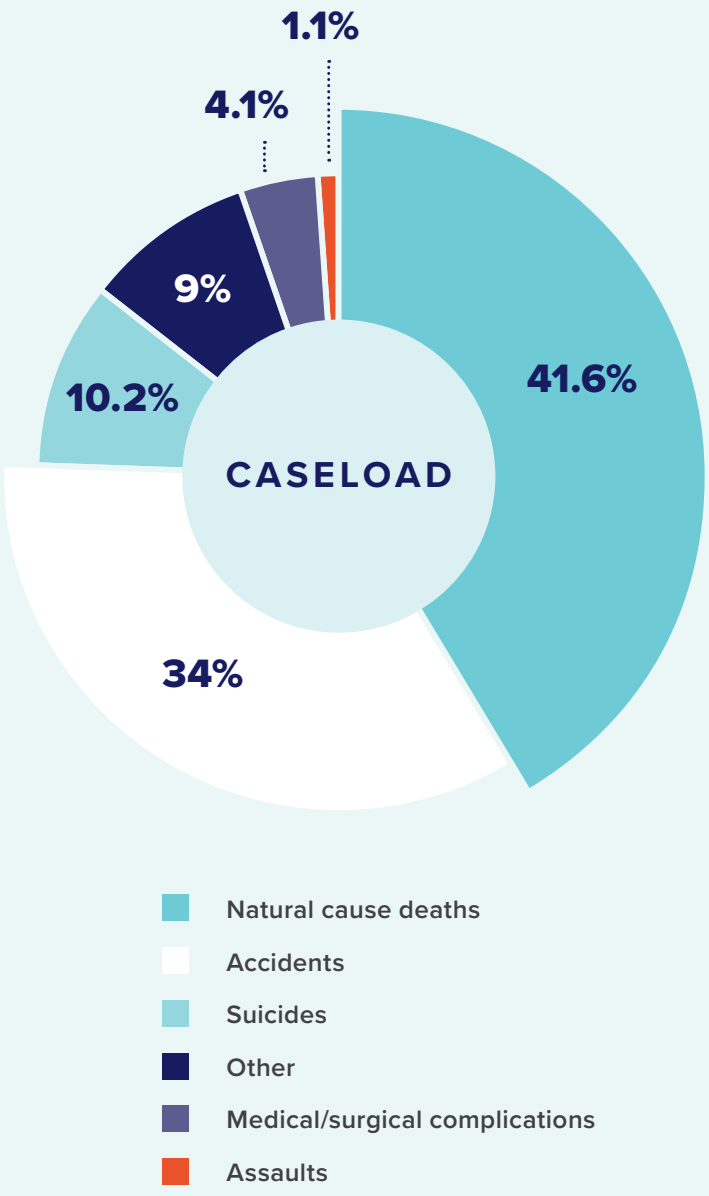
79.1% in <12 months

51% in <3 months

INQUESTS

58 inquests finalised

0.8% of investigations closed following inquest



RECOMMENDATIONS

292 recommendations made

179 accepted in full or in part

16 not accepted

97 under consideration, awaiting response or overdue

DATA & DOCUMENTS

6633 requests for documents

30 requests from organisations for coronial data

39 research requests granted

The year in review

From the State Coroner

Judge John Cain

Serving as the Victorian State Coroner from 2019 to 2025 has been a great honour – both for the opportunity to contribute directly to the health and safety of the community and due to the extraordinary people I've had the chance to work alongside every day.

During my time as State Coroner, the achievements of the Court have been many, and I have had the privilege of overseeing a range of initiatives aimed at modernising the jurisdiction and better supporting families going through the coronial process.

In 2024–25, we saw a small increase in workload, with 7585 new investigations opened, compared to 7413 last year. Over 2024–25, we finalised 7290 investigations and made 292 recommendations over 112 matters – a testament to the efficiency and dedication of our coroners and staff.

The Court often meets families at one of the worst times in their lives and ensuring that we support them is of critical importance. To this end, we have focused on several enhancements to our services over the last five years. These include expanding the Family Liaison team – a group of committed staff who provide front-line support to bereaved family members. We established the Yirramboi Murrup Unit – an Aboriginal-staffed unit dedicated to helping First Nations families engaged with the Court. We also created the Multifaith and Multicultural Advisory Committee in acknowledgement of the diverse needs of Victorian families. The committee has been instrumental in facilitating a program of face-to-face meetings between community and faith leaders and the Court, helping coroners and staff build knowledge of the cultural nuances surrounding death rituals for different community groups, and providing a greater understanding of the inner workings of the Court to communities in return.

Modernising the Court's technology to better meet the needs of the community has been a priority during my term as State Coroner. Accordingly, a range of technological upgrades have been made at the Court, including the transition to a paperless working environment and the implementation of a digital case management system. These upgrades have helped facilitate hybrid working arrangements for our staff, increased efficiencies to assist with our growing caseload, and provided data insights that will shape Court operations for years to come. Most recently, we have begun to explore the potential utility of artificial intelligence (AI) to help reduce staff exposure to vicariously traumatic material and improve efficiency.

The Court's prevention mandate cannot be achieved without timely access to information. The Court now publishes several, regular data reports intended to facilitate open and safe conversations about challenging topics including suicide and drug overdose. Drawing from the Victorian Suicide Register and the Victorian Overdose Death Register, we have published a monthly data update on suicides in Victoria since 2020 along with an annual Victorian Overdose Report, commencing in 2021. Making this data publicly available is crucial at every level – from grass-roots community work all the way up to government policy decision making.

To deepen our understanding of suicide data, the Court partnered with the Melbourne School of Population and Global Health at the University of Melbourne in 2024 to carry out new research into Victoria's suicide rate – to identify potential trends and inform public health responses. This research, which is in the early stages, is the first of its kind to be conducted in Victoria and aims to develop new statistical-based tools and methods to identify and interpret trends in the state's suicide data.

It is vital that different perspectives and experiences are considered in our work. First Nations people are overrepresented in our data, and it can be challenging for these groups to access timely and accurate data to help address this imbalance. In response to this need, we began publishing dedicated reports on suicides and overdoses within the Aboriginal and Torres Strait Islander communities, starting in 2020 and 2023 respectively. The Court has also implemented a dedicated Aboriginal Passings Database to collate reliable evidence around the issues, themes and factors that might contribute to Aboriginal passings, and to inform and address systemic issues to reduce preventable passings.

As my term comes to an end, we also farewelled Coroner Katherine Lorenz, who was a coroner from 2020 to 2024, and Coroner John Olle who served as a coroner from 2008 to 2025. Their contributions to the jurisdiction are innumerable and both will very much be missed. Coroner Dimitra Dubrow was welcomed to the Court in September 2024 and her extensive experience in medical and personal injury investigations is of great benefit to the Court.

Of course, the work of the Court cannot be achieved alone. I would like to take the opportunity to thank our colleagues at Victoria Police and those at the Victorian Institute of Forensic Medicine (VIFM) for their ongoing support and assistance. VIFM is a world leader in forensic medicine and the strong partnership between it and the Court is invaluable.

Thank you to all my fellow coroners and Court staff for their ongoing dedication to preventing deaths in the community. The people who work at the Court show an extraordinary resilience and desire to improve outcomes for the people of Victoria. They have continued to exceed expectations in their compassionate approach to the work of the Court. Carolyn Gale, our CEO and her executive team have provided strong leadership during my time as State Coroner, and I consider myself very fortunate to have had this experience alongside the exceptional people at the Court.

Finally, I extend my congratulations to Judge Liberty Sanger on her appointment as State Coroner and wish her every success as she brings her own vision, expertise and leadership to the role.

From the CEO

Carolyn Gale

It has been another great year at the Court and, once again, the coroners and Court staff have demonstrated an unwavering commitment to improving the health and safety of the Victorian community. Despite the challenges inherent to working in the coronial jurisdiction, the people of the Court continue to meet the needs of the community with a very high level of professionalism.

During 2024–25, a new strategic plan came into effect at the Court. The plan, which will take us through to 2026, comprises four pillars and centres on the themes of investigation, prevention and care. Under the pillars, we are developing modern, informed approaches to the daily work of the Court and utilising our data and other insights more broadly to help reduce preventable deaths in the state. We are maintaining our focus on finding new ways to support people going through the coronial process and prioritising the wellbeing of our coroners and staff to support them in the work they do for the benefit of all Victorians.

Our achievements this year have focused on supporting the needs of the Victorian community. For First Nations families engaging with the Court, we produced a new brochure tailored specifically for the community and initiated a new cultural awareness training program designed and delivered in-house to coroners and staff by the Court's Yirramboi Murrup Unit. The work of the Multifaith and Multicultural Advisory Committee has continued into 2024–25, with community visits and information sessions provided to a range of community and faith groups over the year. The program has matured since its inception in 2023, and new resources in this area are planned for the coming year. We have also commenced work on new website resources for families attending hearings at the Court along with a practical referral tool designed to assist court users in accessing legal advice and representation in coronial matters.

In light of these achievements and Court performance this year, I offer my thanks to all the coroners and staff – I am always impressed by the dedication, care and sensitivity they apply to the vital work of the Court. I also extend my thanks to our colleagues at the Victorian Institute of Forensic Medicine and Victoria Police. The coronial process is complex, and it would not be possible to investigate every reportable death in Victoria with the rigour and attention to detail required without the expertise provided by our partner organisations

Finally, it has been an honour to work with Judge John Cain, who is coming to the end of his term as State Coroner. As head of the jurisdiction, Judge Cain has provided effective leadership through some testing times, including weathering the COVID-19 pandemic and subsequent alterations to the way we work. During his time, he has overseen a wealth of positive changes at the Court, the impact of which will be felt for years to come. I wish him all the best for his next chapter and look forward to working closely with his successor.

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 2024–25 period, the Court farewelled Coroner Katherine Lorenz in August 2024, and Coroner John Olle in June 2025, and welcomed Coroner Dimitra Dubrow in September 2024.

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 and completed 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 1991–2002. Between 2002–2006, 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 Paresa Antoniadis Spanos – BA LLB

Paresa Spanos was appointed a magistrate in 1994 and has worked exclusively as a coroner since 2005. She was appointed Deputy State Coroner in October 2023.

Deputy State Coroner Spanos graduated from the University of Melbourne in 1981 with Bachelor of Laws and Bachelor of Arts degrees. Her Honour began her legal career as an articled clerk/litigation lawyer in private practice before joining the Commonwealth Director of Public Prosecutions, Melbourne Office, in 1984. Her Honour worked at the Commonwealth DPP for 10 years, initially as a legal officer in the trials and appeal section and, from 1989, as senior assistant director, first in the major fraud branch and then in general prosecutions.

As a magistrate, Deputy State Coroner Spanos worked across all jurisdictions – civil, criminal, family violence and the Victims of Crime Assistance Tribunal sitting first at (the old) Melbourne Magistrates' Court before working in the Broadmeadows, Melbourne and Heidelberg regions, as well as completing several tours of duty in the Children's Court of Victoria.

Deputy State Coroner Spanos was the Children's Courts representative on the Victorian Child Death Review Committee from 2005–2013; a member of the steering group involved in the Ernst & Young review of the Coroners Court in 2012, which led to the current structure and staffing of the Court; a member of the organising committee of the Asia Pacific Coroners Society annual conference held in Melbourne in 2014 and currently involved in the planning of the conference to be held in Melbourne in October 2025; a member of the CCOV's Research Committee from 2012–2022; the Court's representative on the Victims of Crime Consultative Committee from 2020–2023; and a member and current chair of the Coroners and Pathologists Advisory Group, part of the CCOV/VIFM collaboration.

Coroner Audrey Jamieson – BA LLB Grad Dip Bioethics

Coroner Audrey Jamieson was appointed a magistrate in December 2004 and has worked exclusively as a coroner since June 2005. Coroner Jamieson started her career as a nurse before obtaining Bachelor of Laws and Bachelor of Arts degrees from Monash University. She completed 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 is also a member of VIFM's Ethics Committee, appointed by the VIFM Council as the Court's representative, assisting in the ethical assessment of research applications. She also chairs the Coroners Education Committee.

Coroner John Olle – LLB BEc

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

Coroner Olle is a member of the Asia Pacific Coroners Society, and the Suicide Prevention and Response Victorian Secretaries' Board Subcommittee.

Coroner Simon McGregor – BA LLB

Coroner McGregor was appointed in September 2018. After being admitted to practice in 1994, His Honour was called to the Victorian Bar in 1997. As a barrister, he both practised and published in administrative and human rights law, health and regulatory law, inquests, commissions, proceeds of crime and other investigation spaces.

Coroner McGregor guest lectures in death investigation, public health law and forensic evidence at Monash University. He is also the Managing Coroner for the Court's Direct Pro Bono Referral Scheme, and a member of its Research and Aboriginal Initiatives Committees.

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 and later completed a postgraduate diploma in forensic science from La Trobe University.

As a solicitor she held roles at organisations including the Royal Commission into Aboriginal Deaths in Custody, Victoria Legal Aid and Women's Legal Service Victoria. While working in government, she managed the Coronial System Reform Project, overseeing the development and passage of the Coroners Act 2008, which established the Coroners 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 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 Commission into Victoria's Mental Health System and Aged Care. Admitted to legal practice in 1994, Coroner Peterson has had a broad regulatory, administrative law and inquiries practice in private practice as well as a government lawyer representing government, 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 and 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 though the crisis.

Coroner Kate Despot – BA LLB

Coroner Kate Despot was appointed a coroner in December 2020 and commenced this role in February 2021. 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.

Coroner David Ryan – BA LLB (Hons)

Coroner David Ryan was appointed a coroner in 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 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, and practised as a barrister prior to her appointment, having signed the Victorian Bar roll in 2016. Coroner Fitzgerald has extensive experience in criminal and coronial cases. Her Honour began her career as a solicitor at the New South Wales Office of the Director of Public Prosecutions and was subsequently a State Prosecutor at the Office of the Director of Public Prosecutions for Western Australia, 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, and appeared as counsel assisting and represented interested parties in coronial inquests. Coroner Fitzgerald is a member of the Coroner's Education Committee and the Coroners and Pathologists Advisory Group.

Coroner Paul Lawrie – LLB

Coroner Lawrie was appointed in August 2022. For the prior 23 years he practised as a barrister, also serving on the Victorian Bar Ethics Committee and mentoring six readers. His practice at the Bar has involved criminal defence and prosecution matters, as well as personal injury cases. Coroner Lawrie regularly appeared in coronial inquests from 2000, acting for family members, Victoria Police and as counsel assisting.

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

Coroner Ingrid Giles – BA LLB LLM (Human Rights Law)

Coroner Giles was appointed in July 2023, having initially joined the Court in 2020 as Senior Legal Counsel. In this role, she appeared as counsel assisting in complex coronial matters, with a focus on Aboriginal passings, and appeared/instructed in multiple appeal cases in the Supreme Court and Court of Appeal.

Prior to joining the Coroners Court, Coroner Giles held roles as a lawyer at the Law and Advocacy Centre for Women from 2018–2020, as well as in the Appeals Chamber and Trial Divisions of the International Criminal Court, The Hague, from 2013–2018. Prior to this, her Honour held legal and policy roles in NGOs and government both in Australia and overseas and completed a Master of Laws (Human Rights Law) at London School of Economics and Political Science.

Coroner Giles is a member of several internal and external committees at the Court, including the Victorian Judicial Officers' Aboriginal Cultural Awareness Committee, Aboriginal Initiatives Committee, Indigenous Inquests Advisory Group, Court User Group, Bench Book Committee and chairs the Working Group on the definition of persons 'in care'. She is also a member of the Court Services Victoria Pride Network, Australia and New Zealand Society of International Law, and Asia Pacific Coroners Society.

Coroner Dimitra Dubrow - BA(Hons) LLB (Hons)

Coroner Dubrow was appointed in September 2024. Prior to her appointment, Coroner Dubrow was a principal lawyer and head of Maurice Blackburn's national medical negligence and dust diseases practices. She was also a Law Institute of Victoria accredited personal injury specialist with 25 years of experience in the areas of medical negligence law, coronial law and personal injury.

Coroner Dubrow was a member of the Law Institute's Public Liability & Medical Negligence Committee, including serving as chair between 2014 and 2018, the Litigation Executive Committee and the CCOV User Group representing the Australian Medical Association/Law Institute of Victoria/Victorian Bar Medico-Legal Standing Committee.

About the Coroners Court

Our role

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

Independently investigating deaths and fires

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

At the conclusion of an investigation, the coroner will make findings about the identity of a deceased person, the cause of death and, in many instances, the circumstances in which a death or a fire occurred.

From **page 21**

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 25**

Promoting public health and safety

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

From **page 36**

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 Police Coronial Support Unit (PCSU).

Among many important roles, VIFM supports coroners by:

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

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

Our place in Victoria's court system

The 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 a hearing in a courtroom; rather, a 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 Plan 2024–2026

Investigation, Prevention and Care

Investigation, Prevention and Care outlines the future of a modern, innovative and caring Coroners Court – supporting critical health and safety outcomes for the Victorian community.

This strategic plan aligns with the Court's ongoing aims to implement modern and informed approaches to the way work is done, innovating with new technology, and designing improvements for families and stakeholders.

Built on four pillars, the strategic plan prioritises reducing preventable deaths by: sharing knowledge and insights, delivering further operational efficiencies, better supporting grieving families, and empowering coroners and staff to undertake the confronting work they do every day.

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

1. Seeking the truth with independent, modern and informed approaches:

- Refine our approach to prioritising cases and how we deploy our resources.
- Unlock the potential of our digital platforms and processes.
- Identify and activate opportunities for more efficient ways of working.
- Elevate data, knowledge and intelligence to inform and shape our investigations.

2. Reducing preventable deaths through our published findings and recommendations, data and insights:

- Create and leverage portfolios of coronial expertise to efficiently strengthen coronial decision making.
- Discover new ways to share our information and insights to provide timely impact.
- Develop and strengthen partnerships with organisations that contribute to and benefit from our insights.
- Amplify our contribution to public purpose research, policy and service development.

3. Supporting families with respect and dignity throughout the coronial process:

- Deepen our understanding of the family experience and provide support in a trauma-informed way.
- Enhance our coordination and responses for a more seamless experience for families, friends and communities.
- Develop more tailored support services according to individual needs, including First Nations, LGBTIQ+ and culturally and linguistically diverse families.
- Strengthen linkages to external agencies and programs to support families beyond the coronial process.

4. Empowering our people to work with purpose and reach their potential:

- Protect the health, safety and wellbeing of our people with support tailored to our unique work environment.
- Establish strength-based capability and career development approaches within and through our organisation.
- Design and embed flexible working arrangements to support agile, productive and fulfilled workplace.
- Nurture and sustain an outstanding organisational culture that champions care, diversity and integrity.

Achievements 2024–25

Building cultural awareness and competency at the Court

In 2024–25, the Court continued building initiatives to better support diverse communities in Victoria through the development of new resources and the delivery of information sessions about the work of the Court. There has also been a focus on increasing awareness of beliefs and practices around death and dying for different cultural and faith groups among coroners and staff.

Improved support for First Nations people engaging with the Court

During 2024–25, the previously named Coroners Aboriginal Engagement Unit was re-named the Yirramboi Murrup Unit (YMU) – meaning "tomorrow's spirit" in the Boonwurrung language.

A new program of in-house Aboriginal Cultural Awareness Training, which includes specific Sorry Business cultural protocols, was designed, developed and delivered by the YMU to coroners and Court and VIFM staff. A new brochure was also finalised and made available to First Nations families going through the coronial process. The new brochure contains information specifically tailored for the Aboriginal community dealing with Sorry Business. This resource was developed in close consultation with the YMU and is part of a broader aim to provide a culturally safer environment for First Nations families engaging with the Court. The Court has also ensured that cultural warnings are incorporated in all documents including material relating to Aboriginal passings, to respect and acknowledge cultural sensitivities throughout its proceedings.

Following a stakeholder consultation process in 2023, the Court implemented the Aboriginal Passings Database – an enhanced dataset aimed at capturing data relating to passings of Aboriginal and Torres Strait Islander people in Victoria. In late 2023, the Court engaged its first Aboriginal Project Officer to code information about passings into, and to maintain the Aboriginal Passings Database. In 2024–25, data coding was completed for all closed investigations into passings for the period 2019 to present.

The Multifaith and Multicultural Advisory Committee in 2024–25

The Multifaith and Multicultural Advisory Committee (MAC) has overseen a number of community visits in 2024–25. Work has also been initiated to create new resources to increase understanding between the Court and diverse communities regarding relevant cultural and faith practices, and the coronial process.

In 2024–25, information sessions delivered by coroners and staff from the Court, Victoria Police and VIFM have taken place with a range of communities including: the Pasifika community which involved representatives from Fiji, Papua New Guinea, New Zealand, Samoa, Tonga and other pacific nations; the Jewish community, organised in conjunction with Melbourne Chevra Kadisha and Chevra Hatzolah Melbourne; and the Chinese community assisted by the Chinese Community Council of Australia, Victoria Chapter. A visit to the Melbourne Shwetambar Jain Sangh Temple under construction in Moorabbin was organised by the MAC, and a presentation about the coronial process was delivered to the Monash University Chaplaincy Service.

The creation of new resources for building mutual awareness and understanding between coroners, multifaith and multicultural communities and Court staff is currently underway. This body of work focuses on how cultural and faith practices and beliefs intersect with the coronial process and how these practices and beliefs may be accommodated within the coronial process.

Established in January 2023, the MAC comprises 17 members including 11 community spokespeople along with representatives from the Court, VIFM and the Police Coronial Support Unit (PCSU).

Developing new resources for people engaging with the Court

In 2024–25, The Court developed the *Legal Resources for Families and Witnesses* document, a practical referral tool designed to assist court users in accessing legal advice and representation in coronial matters. This initiative comprises part of a broader effort to enhance accessibility and support for families, alongside other targeted resources and support provided by the YMU and family liaison officers (FLO).

In response to feedback received from families going through the coronial process, the FLO team commenced work on redesigning website content to assist friends and family attending court for hearings. Once completed, the new material will include a virtual tour of the Court and easily accessible information on what to expect when attending a hearing. This project builds on recently completed work including the redevelopment of information about external support services and resources available to people experiencing loss and the *Information for Witnesses, Family and Friends Attending Hearings at the Coroners Court of Victoria: Impact of Exposure to Trauma & Self Care* resource developed in 2023–24.

Engaging with stakeholders and supporting career development

In 2024–25, 11 law students completed placements at the Court, from institutions including the University of Melbourne, Monash University, Leo Cussen, and the College of Law. Collectively, students completed more than 150 placement days, gaining hands-on experience and contributing meaningfully to the work of the Court, while developing their legal knowledge and understanding of the coronial jurisdiction.

Additionally, as part of the VicBar Shadowing Program, coroners, legal services staff, and forensic pathologists from VIFM delivered information sessions to approximately 80 law students across two dedicated events. These sessions offered students valuable insights into the workings of the Court, helping them to understand coronial processes and promote career pathways in the field of coronial law. Legal services staff also presented an information session to the Office of the Public Advocate (OPA), offering a detailed overview of the coronial process. This engagement aimed to strengthen inter-agency understanding and collaboration, and support OPA staff in navigating the coronial system.

In 2024–25, the Court partnered with both Barwon Health and Western Health to commence a Sabbatical Placement Program with the Coroners Prevention Unit (CPU). The placement provided participating doctors an opportunity to analyse coronial case material with the aim of improving patient care, directly aligning with the prevention mandate of the Court.

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	2023–24 actual	2024–25 estimates	2024–25 actual
Quantity				
Average cost per case	$	4697	3998	4508
The variance between the 2024–25 estimate and actual is due to the Court's budget allocation being confirmed after the target was set.				
Case clearance	%	96.4	100	96.1
A total number of 7290 investigations were finalised against 7585 new coronial investigations opened in 2024–25.				
Quality				
Court file integrity: availability, accuracy and completeness	%	91	90	95.5
The result reflects the Court's use of an electronic file management system which has streamlined and automated case management controls and processes.				
Timeliness				
Ontime case processing: matters resolved or otherwise finalised within established timeframes	%	82	80	79.1
Of the 7290 matters closed, 5769 were closed within 12 months or less.				

Case study

Coroner calls for strengthened aviation safety regulations and oversight following fatal light aircraft crash.

On 18 September 2022, MF, aged 42, died in a light sports aeroplane crash in remote Victoria. MF was the pilot and sole occupant of the aircraft on a planned flight from Mt Beauty, Victoria, to Wollongong, New South Wales.

The inquest examined the circumstances and immediate causes of the crash, as well as MF's training and certification, and the investigative roles of aviation authorities.

The coroner concluded that the immediate cause of the crash was MF losing control of the aircraft after flying into cloud and becoming spatially disoriented when he lost outside visual references. The risk of icing also contributed, degrading the aircraft's aerodynamic performance.

The coroner found that MF had insufficient training and invalid endorsements, and his Recreational Pilot's Certificate (RPC) had been improperly issued by Recreational Aviation Australia (RAAus). The coroner found that MF had insufficient flying hours, and his previous paragliding experience should not have counted as recognised flight time for a 3-axis powered aeroplane. Further, it was found that MF's cross-country, passenger, and human factors endorsements were improperly issued, lacking the necessary qualifications or supporting material.

The coroner found that RAAus, the self-administering aviation organisation overseeing MF's licence and aircraft, engaged in a "deliberate strategy to hide key issues" from the Court at inquest. An officer of RAAus denied that there were any concerns about the RPC's validity despite internal RAAus communications contradicting her testimony and indicating serious internal concerns about the RPC's validity. The coroner referred RAAus's conduct to the Victorian Director of Public Prosecutions and ordered RAAus to pay one-third of the legal expenses of the senior next of kin.

The coroner made five key recommendations aimed at bolstering aviation safety and regulatory accountability – including that:

- the Civil Aviation Safety Authority (CASA) review RAAus' conduct during the investigation and inquest
- CASA facilitate amendments to RAAus' Flight Operations Manual to clarify 'recognised flight time' for different aircraft types
- CASA facilitate amendments to RAAus' Flight Operations Manual to include consistent definitions of 'aeroplane' and 'aircraft'
- RAAus develop standardised training records for its flight instructors to permit detailed auditing of pilot training
- Australian Transport Safety Bureau to investigate all fatal accidents involving RAAus registered aircraft.

The first four of the five recommendations have been accepted in full, and work is underway to implement the recommendations.

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.

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 2024–25, the Court commenced more investigations than it finalised, resulting in a 96.1 per cent closure rate for investigations into deaths and fires. This is consistent with last year's closure rate of 96.4 per cent.

Table 2: Investigations opened and finalised

	2020–21	2021–22	2022–23	2023–24	2024–25
Number of investigations commenced	7053	7200	7480	7413	7585
Number of investigations finalised	6591	7543	7620	7147	7290
Closure rate	94%	93.4%	104.8%	96.4%	96.1%

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 2024–25 was eight months with 51 per cent of all investigations 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

	2020–21	2021–22	2022–23	2023–24	2024–25
0–12 months	5288	5782	5920	5845	5769
12–24 months	886	1068	963	725	940
>24 months	417	693	737	577	581

Table 4: Average duration of cases before they are closed

	2020–21	2021–22	2022–23	2023–24	2024–25
Duration (days)	232.2	255.3	259.9	247.2	237.8

Inquests

An inquest is a public hearing into a death or fire. It is an inquisitorial rather than an adversarial process, meaning that the coroner does not make findings of guilt or apportion blame. Instead, the coroner aims to discover the circumstances of the death.

Only a small proportion of investigations require an inquest. An inquest must be 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). The coroner may also hold an inquest into any death they are investigating if the circumstances surrounding the death or fire are unclear, or if there are broader issues of public health and safety that need to be examined by way of public hearing.

Whenever possible, the Court uses its powers to obtain statements and other evidence, and 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, or reduce its length and complexity.

The Court utilises available tools to help reduce the duration of inquests along with corresponding costs for families, witnesses, and the Court – for example enabling witnesses from interstate or overseas to give evidence via video conferencing technology. In cases where evidence is required from a number of expert witnesses, they can be invited to come together and consider a series of questions formulated by the coroner to collectively reach consensus in areas of common agreement and disagreement, rather than giving evidence individually. The Court also obtains statements of agreed facts from parties where appropriate to reduce the need to hear evidence about those facts.

Of the cases finalised in 2024–25, 58 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, 53 inquests were held at the Court.

Table 5: **Cases closed with inquests**

	2020–21	2021–22	2022–23	2023–24	2024–25
Number of cases closed with an inquest	60	78	82	80	58
Percentage of cases closed with an inquest	0.73%	1.01%	1.08%	1.11%	0.8%

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

Recommendations made for enhanced support for transgender and gender diverse people after suicide cluster inquest.

A cluster inquest was held to examine the deaths of five young women from the transgender and gender diverse (TGD) community who suicided between September 2020 and May 2021. The deceased shared backgrounds of complex mental health challenges, social isolation amplified by COVID-19 lockdowns, and external stressors, including, in some cases, family rejection of their gender identity. Three of the five deceased, who were known to each other and whose deaths formed a 'cluster within the cluster', died by way of sodium nitrite toxicity.

The investigating coroner examined broader systemic issues impacting TGD people and their experience in accessing health and other services, in order to identify opportunities to improve public health and safety and prevent future deaths.

The coroner heard evidence that TGD individuals face disproportionately high rates of distress, mental ill health, and suicidality compared to the general population. The coroner emphasised that TGD identity itself does not cause mental ill health; rather, these issues are linked to extrinsic factors such as discrimination, violence, social exclusion, and family rejection.

The coroner heard that delayed access to culturally appropriate gender-affirming care increases suicidality, and reinforced access to healthcare as a fundamental human right, emphasising that there should be "no wrong door" for TGD people seeking gender-affirming care.

The coroner made ten recommendations across five separate findings to:

- restrict the online sale and distribution of sodium nitrite in Australia
- improve data collection in relation to TGD people, including to accurately capture gender identity in the report of death to the coroner
- increase resourcing for publicly funded gender-affirming care, and culturally appropriate wellbeing supports for TGD people and their families
- develop a statewide framework for provision of culturally appropriate care to TGD people in public hospitals and health services
- provide TGD awareness training for key healthcare professionals, coroners and court staff.

Specific to the death of one woman, who had been located deceased after an extended missing person search, the coroner recommended that:

- Victoria Police make several improvements to its missing persons processes and procedures, including in relation to those relating to TGD community members
- Victoria Police, under the guidance of experts from TGD community, make LGBTIQA+ awareness training mandatory for all police members and staff
- the Attorney General consider reformulating the definition of 'senior next of kin' in the *Coroners Act 2008* to reduce the hurdles and distress it can create for the loved ones of LGBTIQA+ Victorians who die in reportable circumstances while still allowing for the senior next of kin to be identified quickly and with certainty.

Nine of the recommendations have been supported in full or in principle, with one under consideration.

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 2.5 per cent of findings in 2024–25. This figure was calculated excluding natural cause findings and cases where a coroner determined the death was not reportable.

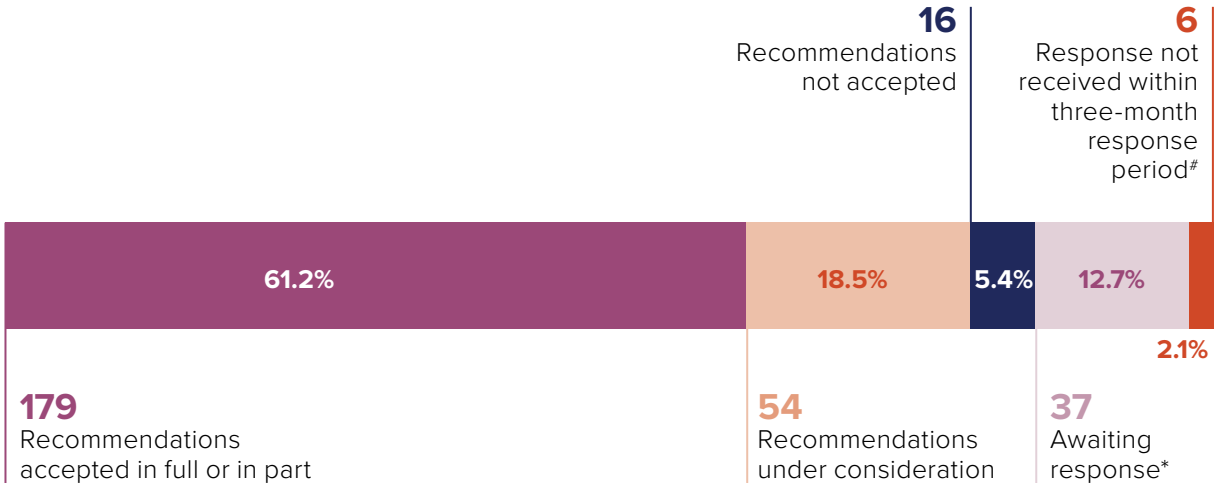
The number of recommendations increased in 2024–25 from 187 to 292. It should be noted that the number of recommendations made each year is dependent on the matters before the coroners and associated opportunities for prevention. The Court's focus is on providing robust, evidence-based investigations to help protect the Victorian community against preventable deaths.

In the past year, 179 of the 292 recommendations made by coroners were accepted in full or in part for implementation and 54 recommendations are under consideration. There were 16 recommendations that were not accepted, and six instances where responses were not received within the required time frame.

Table 6: **Recommendations made in closed investigations**

	2020–21	2021–22	2022–23	2023–24	2024–25
Number of investigations closed with recommendations	93	81	95	77	112
Number of recommendations made	204	199	221	187	292

Figure 1: **Responses to recommendations from closed investigations**



* 'Awaiting' includes those not yet required to respond at the time the data was extracted.

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.

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 Coroners Prevention Unit (CPU) was established within the Court's administrative arm to assist coroners in identifying opportunities to strengthen public health and safety through well-researched, evidence-based recommendations. It is the only multidisciplinary team of its kind in Australia, comprising specialist staff who work to identify any potential failures and other factors that contributed to the incident. Coroners can refer matters to the CPU at any point during an investigation.

Additionally, the CPU undertakes both individual and collaborative research projects to support coronial investigations, underpinning a better understanding of preventable deaths in Victoria.

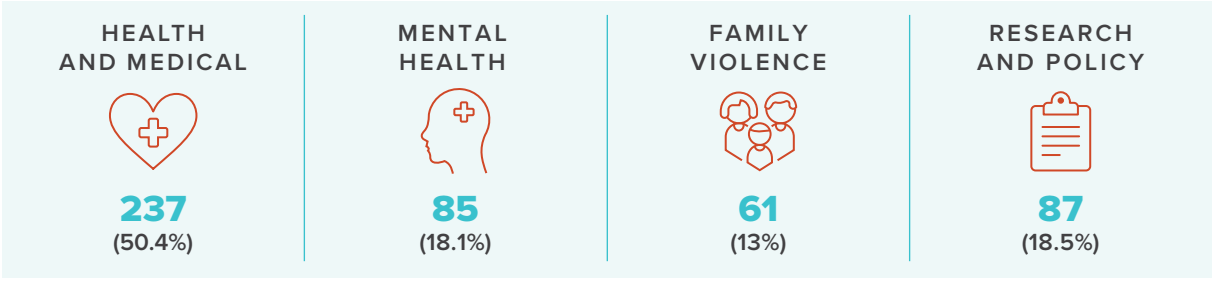
Throughout 2024–25, coroners made 470 referrals to the CPU about deaths under investigation. The advice coroners sought input on, included:

- 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 proven or are suspected to reduce the risk that similar deaths will occur in future
- regulations, standards, codes of practice or guidelines that might be relevant to the circumstances in which the death occurred
- insights gleaned from previous coronial investigations into similar deaths, including past recommendations
- feasible, evidence-based recommendations for prevention opportunities which the coroner can consider in finalising the investigation.

During 2024–25, coroners made referrals into four expert streams within CPU:

- **Health and medical:** for deaths where coroners required clinical advice on the healthcare provided (or not provided) to the deceased and whether this might have contributed to the death.
- **Mental health:** 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 with 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 2024–25



Paediatric placement program

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

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2024–25, the Court engaged 52 external experts. 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 in the Coroners Court of Victoria Death Surveillance Database. Monitoring all reportable deaths in a systemic way provides benefits for coroners. It provides a unique insight into emerging trends in certain kinds of deaths while assisting the development of coronial recommendations that reduce the incidences of similar deaths in the future.

The preliminary analysis of causes of death is reported annually. This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs slightly from previous annual reports because of this re-classification process.

In 2024–25, causes of death reported to the Court were consistent with previous years – 41.6 per cent of deaths reported to the Court were caused by natural causes, 34 per cent were accidental (due to falls, road accidents, drowning and similar), and 10.2 per cent were suicides.

Table 7: Cases reported to the Court in 2024–25

Cause of death	Frequency	Percentage
Natural causes	3154	41.6
Unintentional	2580	34.0
Falls	1669	22.0
Poisoning	377	5.0
Transport	311	4.1
Drowning	40	0.5
Other	183	2.4
Suicide	773	10.2
Hanging	383	5.0
Poisoning	133	1.8
Firearm	33	0.4
Rail	36	0.5
Jump from height	43	0.6
Other	145	1.9
Assault	81	1.1
Complications of medical or surgical care	310	4.1
Other*	211	2.8
Not reportable	254	3.3
Still enquiring	222	2.9

* ‘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 notable reduction in Victorian overdose deaths during 2024–25, with 507 overdose deaths occurring compared to 619 in 2023–24.

However, when considered over the five-year time period (**Table 8**), the number of overdose deaths in 2024–25 could be regarded as a return to the longer-term average number after an unusual spike in overdose deaths in 2023–24.

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

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

Table 8: **Overdose deaths reported**

Financial year	2020–21	2021–22	2022–23	2023–24	2024–25
Number of deaths	498	540	501	619	507

Victorian Suicide Register

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

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

In 2024–25, suicides comprised 10.2 per cent of all deaths reported to the Court. The number of reported suicides decreased to 769, from 820 in the previous reporting period.

Table 9: **Annual reports of suicide**

Financial year	2020–21	2021–22	2022–23	2023–24	2024–25
Number of deaths	655	692	786	820	769

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, 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 (the portal), which is maintained by the Crime Statistics Agency. The 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 comprises staff from across the Court, including a manager, senior solicitor, case investigators, a family liason officer (FLO), the Yirramboi Murrup Unit (YMU) registrar and project officer.

The VSRFVD can review family violence related deaths in the following categories:

- Homicides
- Suicides (of family violence victims or perpetrators)
- Bystander deaths
- Third party deaths
- Other family violence related deaths as directed by the coroner.

Two Victorian Systemic Review of Family Violence Deaths reports have been published, analysing common factors in family violence deaths between 2000 and 2010, and 2011 and 2015 respectively.

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

Homicide incidents in 2024–25

There were 68 probable homicide incidents in Victoria that were reported to the Court in 2024–25. This is an increase from 53 homicide incidents in the previous year (**Table 10**). Just over one quarter of these incidents (26.5 per cent) were identified as family violence related

The data for this reporting period was extracted from the VHR on 30 July 2025 and includes all homicides reported to the Court between 1 July 2024 and 30 June 2025. This reference period is based on the date the homicide incident occurred and includes data relating to open and closed coronial investigations and is subject to change as new information becomes available during the investigation process.

Detailed data is not provided with respect to homicide offenders, as the criminal proceedings for many homicides that occurred in 2024–25 remain ongoing at the time of this report.

Table 10: Homicides incidents by year

Type of homicide	2020–21	2021–22	2022–23	2023–24	2024–25
Family violence related	24	17	13	20	18
Not family violence related	32	29	25	25	34
Unknown	0	2	2	8	16

Homicides by relationship

In 2024–25, the 68 identified probable homicide incidents resulted in the deaths of 69 homicide victims.

Of the 19 homicide deaths where a familial relationship was identified between the homicide offender and the homicide victim, 42.1 per cent involved a child-parent relationship. This was followed by 31.6 per cent in intimate partner relationships, and other intimate or familial relationships comprised 21 per cent of the 19 deaths (**Table 11**).

Table 11: Homicide Victims by relationship to offenders

	2020–21	2021–22	2022–23	2023–24	2024–25
Intimate partner	11	8	6	13	6
Child-parent*	4	3	4	4	8
Parent-child#	6	7	1	1	1
Other intimate or familial	5	1	1	4	4
Not intimate or familial	34	31	29	25	34
Unknown	0	2	2	8	16

* 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).

Most of the family violence incidents in 2024–25 resulted in the death of one homicide victim (94 per cent) (**Table 12**).

Table 12: Homicide incidents by number of deaths

Number of deaths from incident	2020–21	2021–22	2022–23	2023–24	2024–25
Single	51	43	37	45	64
Multiple*	5	5	3	8	4

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

Homicide victims by sex

In 2024–25, 46.2 per cent of female deaths by homicide occurred in a family violence context. Males were more often homicide victims in non-family violence related homicides (51.8 per cent). This was consistent with data across the preceding five years (**Table 13**).

Notably, in 2024–25, the increase in child-parent homicide (**Table 11**) resulted in an increased number of males killed in family violence related homicides – in 87.5 per cent of child-parent homicides, the victims were male. Of the intimate partner homicides, 83.3 per cent of the victims were female.

Table 13: Homicide victims by sex

Sex of homicide victim	Type of homicide	2020–21	2021–22	2022–23	2023–24	2024–25
Male	Family violence related	10	6	6	8	13
	Not family violence related	30	29	27	22	29
	Unknown	0	2	2	8	14
Female	Family violence related	16	13	6	14	6
	Not family violence related	4	2	2	3	5
	Unknown	0	0	0	0	2

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

Recommendations in family violence investigations 2024–25

A total of 81 recommendations were made across 24 family violence-related closed coronial investigations in 2024–25.

These recommendations were most commonly directed to Victoria Police, Department of Families Fairness and Housing (DFFH) and Family Safety Victoria (FSV), the Department of Premier and Cabinet (DPC) and the Department of Justice and Community Safety (DJCS).

Common themes in the recommendations made in 2024–25 included:

- public education campaigns, related to risks of coercive control in intimate partner relationships, and enhancing understanding of elder abuse
- legislative mechanisms, including establishment of adult safeguarding legislation, and review of the *Serious Offenders Act 2018*
- expanding multi-disciplinary models where specialist family violence practitioners respond to family violence alongside Victoria Police
- resourcing for primary prevention work in Victoria
- investment in crisis accommodation and public housing to meet projected demands, including for victim survivors and perpetrators of family violence, who leave or are removed from their home
- ensuring victims of family violence are notified of court outcomes, particularly where an offender is considered high risk
- enhancements to information sharing infrastructure and guidelines within and across services
- implementation of a strategy for reducing sexual violence
- addressing misidentification of the predominant aggressor
- recovery programs for those who experience family violence, including tailored programs for young people, and also children bereaved by homicide.

In November 2024, findings from a cluster inquest held into the deaths of four children known to Child Protection were handed down. The finding highlighted the need to address workforce shortages, enhance professional development and streamline policies and tools for practitioners. It also supported recommendation one of the Yoorrook for Justice Report into Victoria's Child Protection and Criminal Justice Systems.

External engagement

Networks

The Court continued to be an active member of the Australian Domestic and Family Violence Death Review Network (the Network) this year. 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 (ANROWS) and commenced planning for the next national data report on family violence related deaths.

Case study

Stronger identification processes and support for people experiencing elder abuse recommended.

On 10 January 2023, SP was 68 years old when he was found deceased by police at his home, after his daughter called for a welfare check. SP died from head injuries inflicted by his adult son SO. At the time of his death, SP lived with SO who was 43 years old.

Up until the fatal incident, there was no reported family violence involving SO with any party, including his father. However, numerous people were aware of a significant history of unreported family violence by SO against his parents and evidence indicated that SP spent many years attempting to manage SO's behaviour and violence to keep himself and his late wife safe.

While SP's friends and family made various suggestions over time about reporting SO's violence, physically defending himself or moving away from SO, SP repeatedly declined. There was no evidence to suggest that SP was aware of, or ever attempted to engage additional supports for himself, such as contacting The Orange Door, Senior Rights Victoria, Better Place Australia or a service such as Mind Australia that offers support for carers of people experiencing mental illness. Shortly before the fatal incident, SP disclosed that he thought his son might "do me in".

The coroner noted that SP's case is one of several cases being investigated by the Court in which an adult child with undiagnosed or untreated mental health issues has assaulted and killed an older or elderly parent.

Recommendations included that:

- the Victorian Government implement the recommendation from Mind Australia in its submission to the Royal Commission into Victoria's Mental Health System by developing mechanisms that assist in identifying 'hidden' mental health carers and families that do not rely on self-identification. This could be through GPs, community health centres, My Aged Care, primary health networks, schools and other educational settings and workplaces.
- the Victorian Government implement the submission by Seniors Rights Victoria and the Council on the Aging to the Inquiry into Capturing Data on Family Violence Perpetrators, namely, to raise awareness through targeted campaigns and greater investment in community education to educate older people about the various forms of elder abuse and the importance of seeking help, providing clear information on where and how to get assistance to empower them to report abuse, thus improving data collection and enabling timely intervention.
- the Victorian Government fund pilot programs of integrated response models of care specifically for both victim survivors and perpetrators of elder abuse, given the barriers to engaging with support for this type of family violence.

The recommendations are currently under consideration by the Department of Health (DoH) and the Department of Families, Fairness and Housing (DFFH).

Case study

Coroner calls for systemic overhaul in family violence responses.

ND, a 49-year-old Aboriginal woman, was murdered on 4 February 2020 by her former partner, who had an extensive history of family violence and intervention order breaches.

ND and her former partner had extensive contact with various services over many years, including Victoria Police, Child Protection, Department of Justice and Community Safety (DJCS), specialist family violence services including The Orange Door, and housing services. The inquest heard evidence of the many barriers Aboriginal women face in engaging with family violence support systems. Despite these difficulties, ND consistently tried to keep herself and her children safe by engaging with authorities, relocating, and seeking intervention orders.

The inquest uncovered profound systemic failures and fragmentation in the multi-agency family violence response system. Critically, ND was not notified of her former partner's release from custody, a significant safety oversight.

The coroner found the Victoria Police Family Violence Investigation Unit (FVIU) engaged only in passive monitoring of the high-risk perpetrator and did not proactively engage with ND. The coroner also found there was an absence of clear leadership or a central contact person or agency for coordinated oversight of family violence cases, leading to diffused responsibility where "family violence becomes everyone's responsibility and no-one's responsibility". The inquest also highlighted the invisibility of ND's children as victims and the lack of comprehensive, culturally appropriate support for them, despite their direct exposure to severe violence.

The coroner issued 11 recommendations to government entities to enhance the safety of victim-survivors and improve accountability for perpetrators, including for government to:

- enhance the Central Information Point or seamless data flow with child protection practitioners
- mandate timely victim notification of court outcomes and offender release for high-risk cases
- identify a central leadership role for coordinated oversight of family violence cases,
- pilot embedded family violence practitioners in FVIUs and evaluate the effectiveness of FVIUs
- improve access for uniform police members responding to family violence incidents to priority target management and risk data for high-risk family violence offenders
- fast-track Community Corrections Order breach procedures and implement Digital Corrections warrants to enable processing without reliance on mail services
- expand the *Serious Offenders Act 2018* to include high-risk family violence offenders.

Of the 11 recommendations made, three have been accepted or accepted in principle, five remain under consideration, and three recommendations have not been accepted.

3. Promoting public health and safety

The Court is committed to ensuring coronial data and findings are shared to increase 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.

Supporting research at the Court

During 2024–25, the Court's Research Committee met on eight occasions to assess 26 new applications for access to coronial data, as well as 14 applications to amend previously approved research projects.

Of these applications, 39 were ultimately approved. The approval process in some cases required correspondence with the applicants and changes to research design to address coronial concerns. One application was not endorsed.

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

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

- deaths among people with diabetes
- farm-related fatalities
- fatal one-punch assaults.

Access and education

The Court is regularly approached to provide external organisations with coronial data for the purposes of death prevention. In 2024–25, the Court responded to 30 requests from external organisations for data and other assistance, including:

- Safer Care Victoria
- Royal Children's Hospital
- Fire Rescue Victoria
- Thirrili.

Contributing to national data collection

To support and inform research and prevention efforts on a national scale, the Court codes all closed investigation files for contribution to the National Coronial Information System (NCIS). This database contains information on reportable and reviewable deaths and all identified factors determined to have contributed to the death.

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

Requests for documents

In 2024–25 the Court received 6633 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports or unpublished findings.

Table 14: Requests for coronial documents

	2020–21	2021–22	2022–23	2023–24	2024–25
Form 45 requests	5588	6144	5891	6299	6633

Information and support

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

Family liaison officers (FLO) provide critical support to families and friends affected by loss, explaining coronial processes and findings. This team also works closely with Court staff, liaising with families on sensitive matters.

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

Stakeholder education and engagement

During 2024–25, coroners delivered six 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, students, community members and legal practitioners.

Law Week, May 2025

For Law Week this year, the Court delivered a panel presentation to a gallery of more than 50 attendees. The expert panel, consisting of members from across the Victorian Institute of Forensic Medicine (VIFM) and the Court, worked their way through a mock coronial investigation into the fictional 'Picnic at Hanging Rock' missing person's case. The panel demonstrated how the coroners and Court staff, VIFM staff, and Victoria Police work together to progress coronial investigations and achieve meaningful change.

While a cause of death remained as elusive as the missing students, a very thorough investigation and inquest resulted in impactful (hypothetical) recommendations to the Department of Education and Parks Victoria regarding the supervision of students on school excursions, and the demarcation of hiking trails at Hanging Rock.

Case Study

Coroner highlights dangers of e-scooters and calls for improved community education about safe riding.

ML was 73 years of age when he died on 21 December 2023 at Royal Melbourne Hospital due to a head injury sustained in an e-scooter accident. ML was an experienced, safety-conscious rider who often wore a helmet and enjoyed riding his electric scooters and bikes on various trails.

The coronial investigation found that on the day of the incident, ML was riding his e-scooter on a non-shared footpath, a location where e-scooters are not permitted. Crucially, ML had open toed footwear on and was not wearing a helmet or any other protective gear. He was also attempting to carry unwieldy PVC piping and wooden batons perpendicularly against his handlebars with his left hand, which caused him to wobble. He lost control of the e-scooter, veered into a grassy drainage culvert and was ejected, landing head-first on the bitumen road surface. The e-scooter was found to have no mechanical fault.

The coroner observed that some e-scooter riders were not complying with the prescribed conditions for their safe use, which undermined an otherwise efficient way to better utilise our existing road and shared path networks. To prevent similar deaths, the coroner recommended that the Transport Accident Commission (TAC) consult with the Department of Transport and Planning (DTP) on how best to improve community education about the conditions and requirements for the safe riding of e-scooters.

In its response, the TAC confirmed it had run two public education campaigns in relation to e-scooter safety in recent months.

In October 2024, a simplified campaign was launched covering new rules like mandatory helmet use, no riding on footpaths and no doubling up. A follow-up campaign, “If you think e-scooters are a toy, think again,” launched in December 2024 and was designed in collaboration with Victoria Police, DTP, hospitals and health professionals and aimed at improving the community’s understanding of key road safety laws relating to e-scooter use.

The TAC is evaluating these campaigns through its public education evaluation program and intends to re-run the campaign in its 2025–26 annual advertising plan to maintain focus on e-scooter safety.

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.

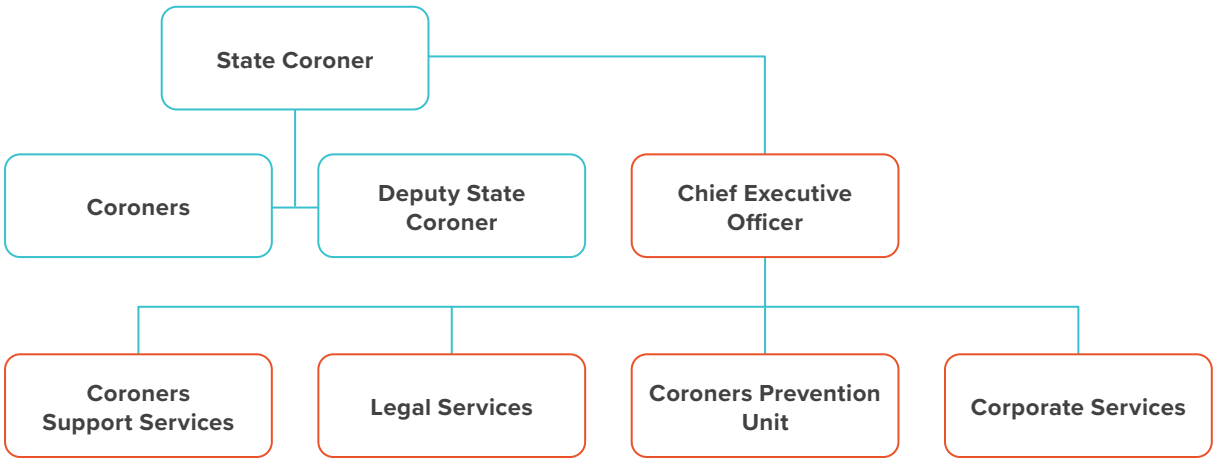
The Court sits within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's Chief Executive Officer (CEO) and its staff.

Organisational structure

The Court employs 117 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 four 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 (FLO), 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 a range of 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, procurement, information technology, media and communications, policy, and risk and audit functions.

Organisation chart



Workplace profile

At 30 June 2025, the Court had 117 staff members (104.1 full time equivalent (FTE), not including coroners. This includes 108 permanent staff, 25 per cent of which were employed on a part-time basis.

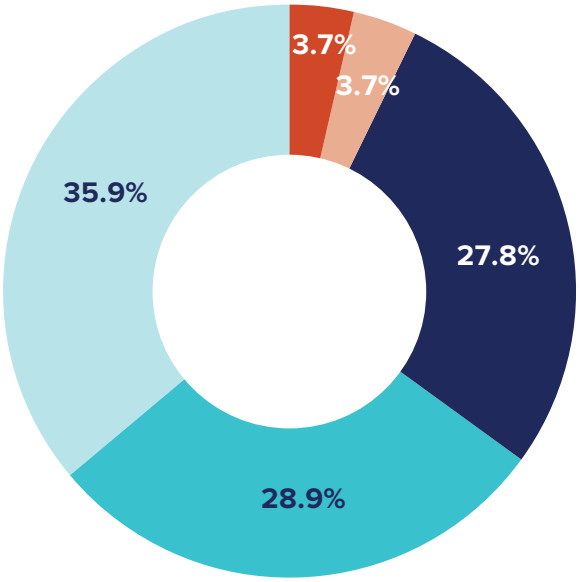
Table 15: Workplace profile as at 30 June 2023

	June 2025					
	All employees		Ongoing		Fixed term/casual	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
Male	27	23.3	20	5	1	1
Female	90	80.9	61	22	5	2
Total	**117**	**104.2**	**81**	**27**	**6**	**3**

	All employees		Ongoing		Fixed term/casual	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
VPS2	12	9.8	6	4	1	1
VPS3	34	33	27	2	5	0
VPS4	35	31.7	25	9	0	1
VPS5	17	15.7	12	4	0	1
VPS6	10	10	10	0	0	0
STS/7	8	3	0	8	0	0
Executive	1	1	1	0	0	0
Total	**117**	**104.2**	**81**	**27**	**6**	**3**

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

Figure 3: Divisional headcount at 30 June 2025



Division	Number FTE	Number Headcount
Office of CEO*	3.8	4
Corporate Services	3.8	4
Legal Services	29	30
Coroners Prevention Unit	30.1	38
Coroners Support Services	37.5	41
Total	**104.2**	**117**

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

Governance and accountability

Various internal and external governance processes guide the Court's conduct, actions and decisions. The Coroners Court Executive 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 four business units, as well as the Director of Strategic Programs. The committee meets fortnightly and is accountable for:

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

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

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 2024–25 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 2024–25 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.

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

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.

Coronial Council of Victoria

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

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

The State Coroner is a member of the Coronial Council.

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.

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 2024–25, the Court participated in internal audits at a CSV-wide level regarding:

- Integrity, fraud and corruption
- Cyber-security
- Standing Directions
- Contract Management.

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 Court comprises a highly skilled workforce which includes coroners and Court staff. In 2024–25, the Court continues to prioritise workforce initiatives, focused on reinforcing a culture characterised by safety, respect and care. Building on previous work, a range of programs and activities were implemented to support employee engagement, enhance performance, and maintain a workplace environment aligned with the delivery of high-quality services to the Victorian community.

Health and wellbeing

The Court recognises the ongoing impact of exposure to sensitive and often graphic material inherent to the jurisdiction. In response, the Court maintains a sustained focus on supporting the health and wellbeing of our people through the provision of safe systems of work, a collegiate and supportive culture, and structured monitoring of health, safety and wellbeing. This commitment continues to inform the design and delivery of workplace initiatives.

During 2024–25, the following programs and activities were in place at the Court:

- In 2024–25, the Health and Wellbeing Committee continued to champion safety and wellbeing initiatives at the Court. Established under the *Occupational Health and Safety Act 2004* – with identified Designated Work Groups and Health and Safety Representatives – membership of the committee includes coroners and staff members to ensure a collaborative approach is taken to safety and wellbeing matters at the Court. The committee led the review of a psychosocial risk register to strengthen controls and support the ongoing monitoring of psychosocial safety in 2024–25.
- Reflective practice programs continue to be offered to all employees who are exposed to coronial information. Expert providers have been engaged by the Court to deliver these programs to coroners and staff, including psychologists and other professionals who understand the unique needs of employees exposed to vicariously traumatic material.
- The Court maintains a range of health and wellbeing initiatives available to coroners and staff, including general health checks, flu vaccinations, access to the Headspace app, a peer support program, wellbeing support services (including a wellbeing assessment tool), webinars, and the Dogs@Work program.

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

In 2024–25, the Court worked to embed initiatives aimed at attracting, supporting, and retaining a diverse and high-performing workforce. Key initiatives included:

- **Supervision framework:** the supervision framework provides employees with leadership support, wellbeing, professional development, and effective day-to-day guidance.
- **Flexible working:** the Court continued to strengthen hybrid work practices over 2024–25 to support employee flexibility, meet service delivery requirements, and promote a positive workplace culture that enables improved work-life balance.
- **Leadership development:** a continuation of the leadership roundtable series, this program supports the development of leadership capability across the Court. These sessions provided a platform for leaders to share insights, discuss emerging issues, and strengthen collaborative leadership practices.
- **Sabbatical Placement Program for Doctors:** the Court partnered with both Barwon Health and Western Health to commence a Sabbatical Placement Program hosted by the CPU. Doctors employed by Barwon and Western Health as medical specialists are entitled to undertake sabbatical leave placements at external organisations. The placement with CPU provides an opportunity for sabbatical doctors to analyse cases with the aim of improving patient care, which directly aligns with the prevention mandate of the Court.
- **Legal student placement program:** The Court hosted 11 students who completed more than 150 placement days, gaining hands-on experience while developing their legal knowledge and understanding of the coronial jurisdiction. The program also provides the existing legal services employees a chance to develop their mentoring and leadership skills.

Performance and development

Performance and development planning at the Court is guided by the Victorian State Government's annual Performance Development Plan (PDP) cycle. This framework supports structured goal setting, ongoing performance support, and annual review for progression. All employees have an individual PDP that outlines clear objectives, expectations, and development opportunities, enabling staff to understand their contributions at both individual and team levels.

Court employees have access to a range of learning and development opportunities designed to build capability and support professional growth. These include structured on-the-job learning through the supervision framework, as well as formal development programs delivered by the Court and through CSV. Learning activities are aligned with individual performance development plans and the Court's strategic priorities, ensuring our people are equipped to contribute effectively to the work of the Court and deliver meaningful outcomes for the Victorian community.

A performance and development goal library has been developed for each business area of the Court. The goal library aligns operational and strategic priorities with employee goals, ensuring greater connection between our people and the work of the Court.

Glossary

BP3	Victorian Budget Papers Number 3
CASA	Civil Aviation Safety Authority
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
DFFH	Department of Families Fairness and Housing
DoH	Department of Health
DJCS	Department of Justice and Community Safety
DPC	Department of Premier and Cabinet
DPP	Director of Public Prosecutions
DTP	Department of Transport and Planning
FLO	Family Liaison Officer
FSV	Family Safety Victoria
FTE	Full time equivalent
FVIO	Family violence intervention order
FVIU	Victoria Police Family Violence Investigation Unit
MAC	Multifaith and Multicultural Advisory Committee
NCIS	National Coronial Information System
PCSU	Police Coronial Support Unit
RAAus	Recreational Aviation Australia
RPC	Recreational Pilot's Certificate
STS	Senior Technical Specialists
The Coroners Act	Coroners Act 2008
TAC	Transport Accident Commission
TGD	Transgender and gender diverse
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
VSR	Victorian Suicide Register
VSRFVD	Victorian Systemic Review of Family Violence Deaths
YMU	Yirramboi Murrup Unit

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 available, making it appropriate to do so. If a coroner determines not to set aside a finding or findings and re-open an investigation, the person may appeal to the Supreme Court within 90 days of the coroner's decision.

Appeals

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

In appeals, the Court's role is usually limited to assisting the Supreme Court in relation to the applicable law, questions of jurisdiction and power, as well as the practices and procedures of the Court that are relevant to the appeal. It does not make any submissions on the merits of an appeal, consistent with the principles set out in *R v Australian Broadcasting Tribunal; Ex parte Hardiman* (1980) 144 CLR 13 (the Hardiman principle). The Court will provide the Supreme Court with information or documents that may assist the Court in determining the appeal. This may include provision of an affidavit recounting salient aspects of the procedural history of the coronial investigation and exhibiting relevant documents held by the Court, including documentary material that was before the investigating coroner at the time of making their decision.

In 2024–25, the following appeals were finalised:

- *Spencer v Coroners Court of Victoria* [2024] VSC 757 – Appeal against findings of a coroner – Judgment issued on 6 December 2024 – Appeal dismissed. There is a pending appeal against this judgment.
- *Helmer v The Coroners Court of Victoria* [2025] VSC 235 – Application seeking judicial review of coroner's conduct of investigation – Judgment issued 2 May 2025 – Application dismissed.
- *Hii v Coroners Court of Victoria* [2025] VSC 279 – Appeal against refusal to re-open investigation – Judgment issued on 19 May 2025 – Appeal dismissed.

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

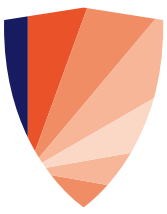
Complaints about the conduct or capacity of Victorian judicial officers or members of the Victorian Civil and Administrative Tribunal (VCAT) may be made to the Judicial Commission of Victoria. The Commission is established under the *Judicial Commission of Victoria Act 2016*. The Commission cannot investigate 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