Coroners Court of Victoria

2010-2011 Annual Report

Contents

Coroners Court of Victoria

31 October 2011

The Honourable Robert Clark MP
Attorney-General
1 Treasury Place
Melbourne 3000

Dear Attorney-General

In accordance with the requirements under Section 102 of the *Coroners Act 2008,* I am pleased to present the 2010-11 annual report of the Coroners Court of Victoria.

The report sets out the court's functions, duties, performance and operations during the year under review from 1 July 2010 to 30 June 2011.

Yours sincerely

Judge Jennifer Coate
State Coroner

Report from the State Coroner

I am pleased to present the second Annual Report of the Coroners Court of Victoria. This report is the first report on a full 12-month period of the court's operation.

Our first report set out some of the complexities of the development required by the court in the first reporting year in the context of significant legislative and structural change to the court's operation. The pace and complexity of developments in and around the court's operation have not slowed in this reporting year. The contents of this report underscore a number of those areas of development and change in our ongoing efforts to provide the people of Victoria with the best modern coronial system we can with the resources provided to us by the State. In the wake of the introduction of the *Coroners Act 2008,* we continue to strive to develop and refine our processes to fulfil our statutory obligations and serve our community

The capacity of the work of the court to have a significant impact on public health and safety and the administration of justice is readily apparent in the section of this report which extracts some investigations of significant public interest. The public interest in the work of the court generally is demonstrated by the increase in the number of "hits" on the court's website. Access to the court's website has doubled from our first reporting year to our second. The resources required to maintain an up to date website appear to be justified by these figures.

I wish to make special mention of the work of the magistrates in our regional areas. As our work becomes more demanding and complex, magistrates in regional locations are required to fit their coronial work around all of their other multi-jurisdictional court duties. During the reporting period, considerable concern has been expressed by regional magistrates as to the pressures of their coronial work. Whilst all of the full-time coroners at Melbourne do their best to support our regional colleagues, their concerns have been acknowledged. To this end, we entered into discussions with the Chief Magistrate in an endeavour to address the concerns of regional coroners. We anticipate that, with the willing cooperation of the Chief Magistrate, we will be in a position to provide a regional roving coroner in the next reporting year, to enable the much-needed support to be provided to regional coroners.

The number of deaths reported has dropped in this reporting period. Whilst still being examined carefully, this may be a response to the legislative aim to strive to avoid cases from entering the system that did not require a coronial investigation. In the meantime, for a range of reasons, our work has become more demanding and more complex.

Our court could simply not do the work that it does without considerable input from a range of agencies and bodies that support us.

We have been, and continue to be, supported and assisted by the Courts and Tribunal staff of the Department of Justice led by Dr Graham Hill. The Judicial College of Victoria continues to be active in its support of the court providing ongoing professional development for coroners statewide. With the college's support we now have an electronic bench book which is regularly updated. We have continued to provide ongoing bi-monthly seminars to coroners on topics of interest by way of statewide video conferencing link. With the support of the college we conducted a two-day residential program for coroners. The college also provided another full day writing course specifically for writing coronial findings.

My thanks to Professor Stephen Cordner and the members of the Victorian Institute of Forensic Medicine, without whom we could not perform our work, to the police in our Police Coronial Support Unit and to all of those members of Victoria Police who provide investigative support to our court and to the volunteers of Court Network who continue to provide support to families who attend the court.

I wish to record my gratitude to our staff who deserve both acknowledgment and thanks for the difficult work they are required to do.

I also wish to record my sincere thanks to our CEO Judy Leitch who has been dedicated to continuous improvement in the administration of the court over the reporting period.

Finally, my respect and gratitude to all of my coronial colleagues who continue to give dedicated service as coroners to our community. My special thanks to Deputy State Coroner Iain West, who provides invaluable support and guidance both to myself and the court generally.

State Coroner
Judge Jennifer Coate

Report from the CEO

It is with pleasure that I report on the administration of the Coroners Court of Victoria for the financial year 2010-11. This is the court's second annual report since its establishment on 1 November 2009 under the *Coroners Act 2008,* and the first report covering a full 12-month period. It provides an opportunity for the court to demonstrate its accountability to the Victorian Parliament, to the Victorian public and, perhaps most importantly, to those Victorian families who through the loss of loved ones find themselves involved in our jurisdiction.

The court has continued to review and consolidate the many changes made within the jurisdiction as part of the major reform process undertaken during recent years. With the assistance of KPMG, stage one of a three-part post-implementation review was undertaken during the period. This review highlighted the many notable achievements delivered by the court during a period of significant upheaval. However, in terms of the administration of the coronial process, the review also identified that further work is required in order to optimise the court's performance and deliver best practice against the International Framework for Court Excellence.

As noted on page 47 of this report, the court's case clearance rate improved significantly for the third year in a row, from 75% in 2008-09 to 105% in 2009-10 to 115% in 2010-11. However, despite this improvement, the number of open cases outstanding at the end of the period remains high, having decreased from 5628 in 2008-09 to 5586 in 2009-10 to 4509 in 2010-11. This is at least partly because the complexity and length of inquests has increased as a result of the new emphasis on the role of the coroner in reducing preventable deaths that was introduced in the *Coroners Act 2008.* With each full-time coroner carrying a caseload of between 300 and 600 cases at any one time, clearing the court's backlog has proven more difficult than expected.

While focussing on continually improving its performance, during the reporting period the court also faced some significant challenges. These included the second temporary relocation of most of its staff while the redevelopment of its Southbank site commenced, and ongoing preparation for the implementation of CourtView, the whole of courts electronic case management system. In addition, work was undertaken to analyse and address some cost escalations that are beyond the control of the court, including a significant increase in the cost of transporting deceased persons into the care of the court for medical examination.

Work was also undertaken to identify the cause of an unexpected and continued decline in the number of deaths reported to the coroner following the implementation of the *Coroners Act 2008* in November 2009, from a peak of 6341 in 2008-09 during the year of the heatwave and bushfires, to 5305 in 2009-10 and 4857 in 2010-11.

Although the work performed by those who work in this jurisdiction is confronting and at times very difficult, our staff have continued to demonstrate high levels of professionalism, supporting grieving families with compassion and sensitivity. I would like to thank them sincerely for this. I would also like to thank Judge Coate for her support, wise counsel and leadership.

Chief Executive Officer
Judy Leitch

Coroners Court of Victoria

The Coroners Court of Victoria

The Coroners Court of Victoria was established on 1 November 2009 when new legislation, the *Coroners Act 2008* (the Act), came into effect following the passage of the Coroners Bill 2008 through the Parliament of Victoria in December 2008. The implementation of the Act represented the most significant reform of the Victorian coronial jurisdiction in 25 years.

Under the Act, the former State Coroner's Office was re-established as the Coroners Court of Victoria. The *Coroners Act 2008* sets out as one of its purposes the establishment of the Coroners Court of Victoria as a specialist inquisitorial court.

Strengthening the prevention function of the court is a defining feature of the Act. The prevention function refers to the capacity of the jurisdiction to contribute to public health and safety through coroners' investigations, findings and the development of comments and recommendations that are targeted at the reduction of preventable deaths and fires. Significantly, under the Act, coroners have the power to make recommendations to any Minister, public statutory authority or entity relating to issues of public health and safety and the administration of justice. From 1 November 2009 any public statutory body or entity receiving a recommendation contained in a coroner's finding must respond in writing within three months stating what action, if any, will or has been taken to address the recommendation.

Unless a coroner orders otherwise, all inquest findings, coronial recommendations and responses to recommendations are published on the court website.

Preamble to the *Coroners Act 2008*

The *Coroners Act 2008* preamble is the foundation upon which the court operates. It clearly defines the role and importance of the coronial system within Victorian society by stating the jurisdiction involves:

> The independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires, and to contribute to the reduction of the number of preventable deaths and fires, and the promotion of public health and safety, and the administration of justice.

Objectives of the *Coroners Act 2008*

Whilst the preamble defines the foundation of the court, the objectives give guidance in the administration and interpretation of the Act. The objectives seek to ensure that the coronial system where possible:

- avoids unnecessary duplication of inquiries and investigations to expedite the investigation of deaths and fires
- acknowledges the distress of families and their need for support following a death
- acknowledges the effect of unnecessarily lengthy or protracted investigations
- acknowledges and respects that different cultures have different beliefs and practices surrounding death
- acknowledges the need for families to be informed about the coronial process and the progress of an investigation
- acknowledges the need to balance the public interest in protecting a person's information and the public interest in the legitimate use of the information
- acknowledges the desirability of promoting public health and safety and the administration of justice
- promotes a fairer and more efficient coronial system.

Jurisdiction

The Coroners Court of Victoria has jurisdiction under the *Coroners Act 2008* to investigate reportable and reviewable deaths and fires, as defined respectively in Sections 4 and 5 of the Act.

Part 5 of the Act also gives coroners the power to hold inquests, which are public court hearings, in some investigations.

Inquests are held both in the Coroners Court of Victoria in Melbourne and in regional magistrates' courts, where magistrates also function as coroners.

The below map indicates the location of courts where inquests may be held.

Reportable deaths

Coroners are required to investigate all reportable deaths. There does not have to be anything suspicious about a death for the death to be reported to the coroner. Many investigations conducted by coroners result in the coroner finding that although the person died unexpectedly, the death was otherwise as a result of natural causes.

During the reporting period there were 4857 deaths reported to the coroner.

Section 4 of the Act states a death is considered reportable if:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death; and
- the death appears to have been unexpected, unnatural, violent or to have resulted, directly or indirectly, from an accident or injury; or
- the death occurred during a medical procedure, or following a medical procedure, where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur; or
- the identity of the person was not known; or
- a medical practitioner has not signed, and is not likely to sign, a death certificate certifying the cause of death; or
- a death has occurred at a place outside Victoria, and the cause of death is not certified and is unlikely to be certified; or
- the person immediately before their death was a person placed in 'custody or care'; or
- the death is of a person who immediately before their death, was a patient within the meaning of the Mental Health Act 1986; or
- the person was under the control or custody of the Secretary to the Department of Justice or a member of the police force; or
- the person was subject to a non-custodial supervision order under Section 26 of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.

Reviewable deaths

Coroners must also investigate a category of deaths called 'reviewable deaths'.

Section 5 of the Act defines a reviewable death as being the death of a second or subsequent child of a parent, with some exceptions. A child is anyone under the age of 18 years, the child will have died in Victoria, or the cause of death occurred in Victoria, or the child lived in Victoria but died elsewhere.

Importantly the *Coroners Act 2008* has changed the definition of reviewable deaths to exclude stillborn children and children who lived their entire lives in hospital, unless otherwise determined by a coroner.

During the reporting period there were three reviewable deaths reported to the court that were otherwise not reportable, and a further three deaths reported that were both reviewable and reportable.

Fires

Coroners can also investigate a fire or fires, regardless of whether or not a death has occurred. Section 30 of the Act states that a coroner must investigate a fire after receiving a request to investigate from the Country Fire Authority or Metropolitan Fire and Emergency Services Board, unless the coroner determines the investigation is not in the public interest.

A coroner conducting an inquest into a fire must make a finding stating, if possible, the cause and origin of the fire and the circumstances in which it occurred.

During the reporting period, there were 14 fires with death reported to the court.

There were no fires without death reported.

Structure and organisation of the Coroners Court of Victoria

The court is comprised of nine full-time coroners including the State Coroner and the Deputy State Coroner. In Melbourne, the court is staffed mainly by court registrars, counsellors, researchers and case investigators, and administrative staff. Staff are grouped into specialist teams to assist coroners with particular aspects of their investigations. The administration of the court is led by the CEO.

Across the five court regions of Victoria, regional magistrates are assigned as coroners and perform coronial duties and functions.

The Coroners

State Coroner
Judge Jennifer Coate

Deputy State Coroner
Mr Iain West

Metropolitan Coroners
Dr Jane Hendtlass
Ms Audrey Jamieson
Mr John Olle
Ms Kim Parkinson
Ms Paresa Spanos
Ms Heather Spooner
Mr Peter White

Regional Coroners
Most magistrates in regional Victoria have also been appointed as coroners and will usually perform the functions of a coroner when necessary in the region.

Court Administration

Chief Executive Officer
Judy Leitch

Initial Investigations Office
Manager: Jenny Hoar

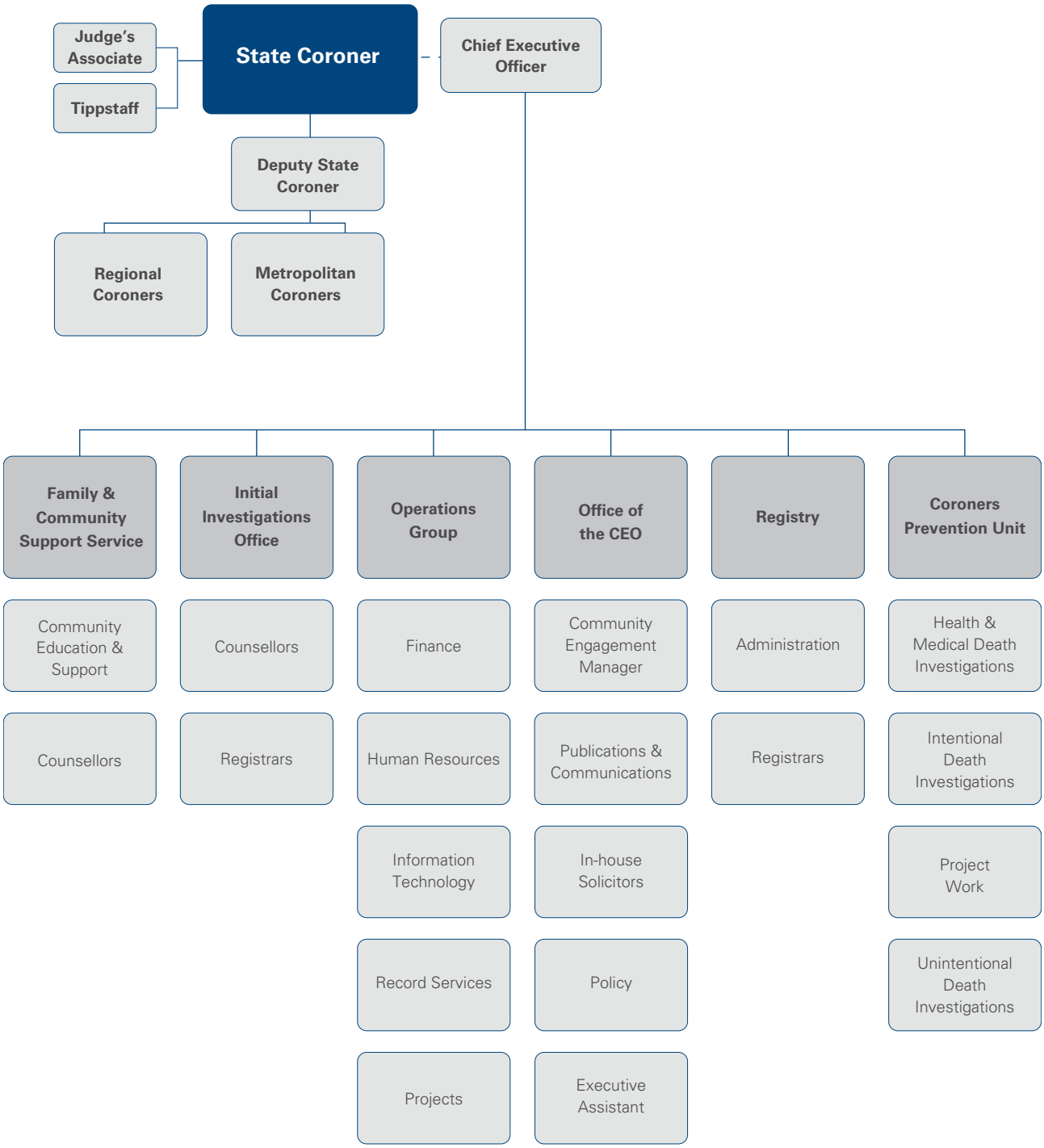
Registry
Principal Registrar: Gayle Chirgwin

Coroners Prevention Unit
Manager: Samantha Hauge

Family and Community Support Service
Manager: Carolyn Gillespie

Operations Group
Manager: Therese Goodman

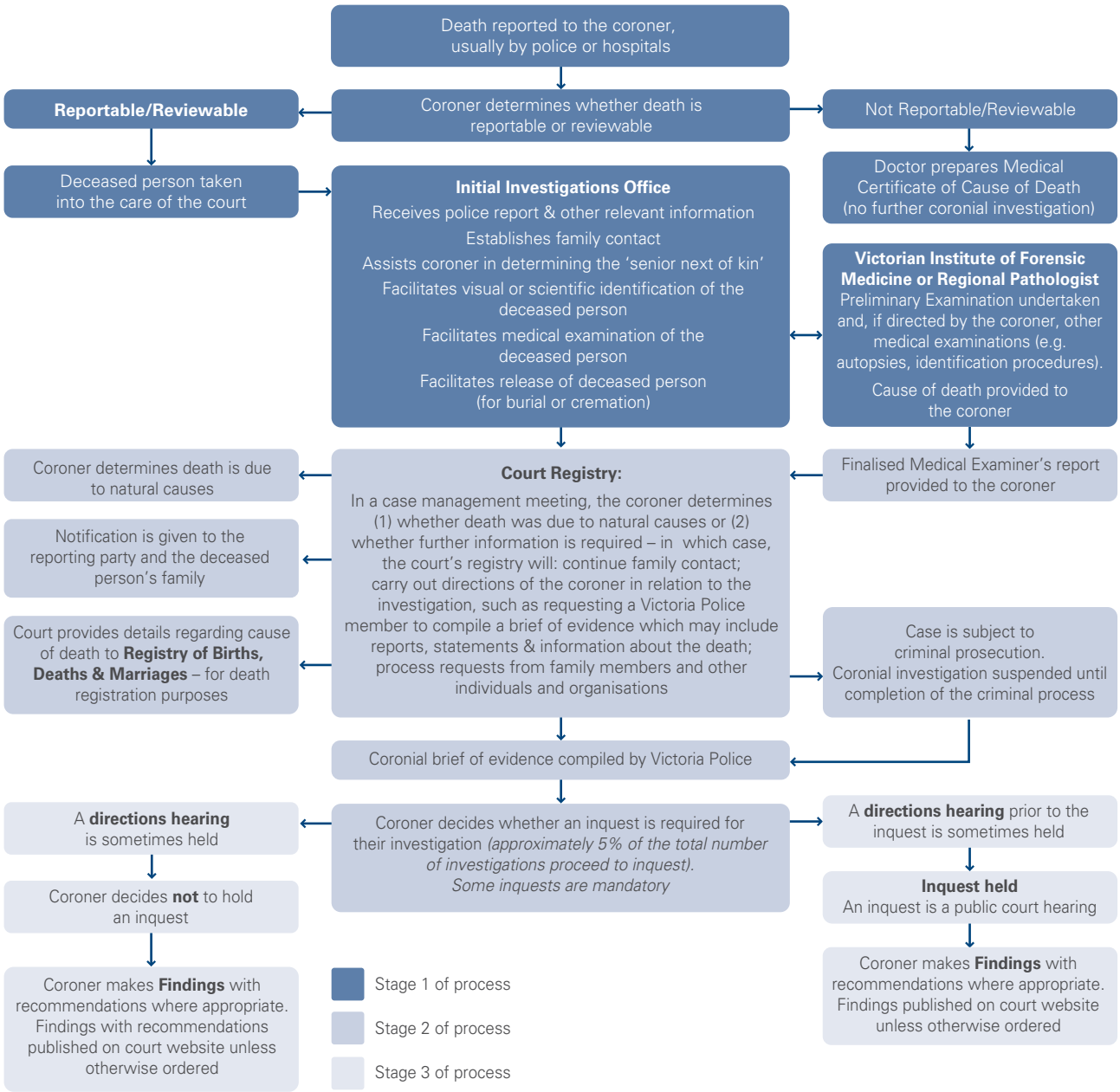
Organisational Chart



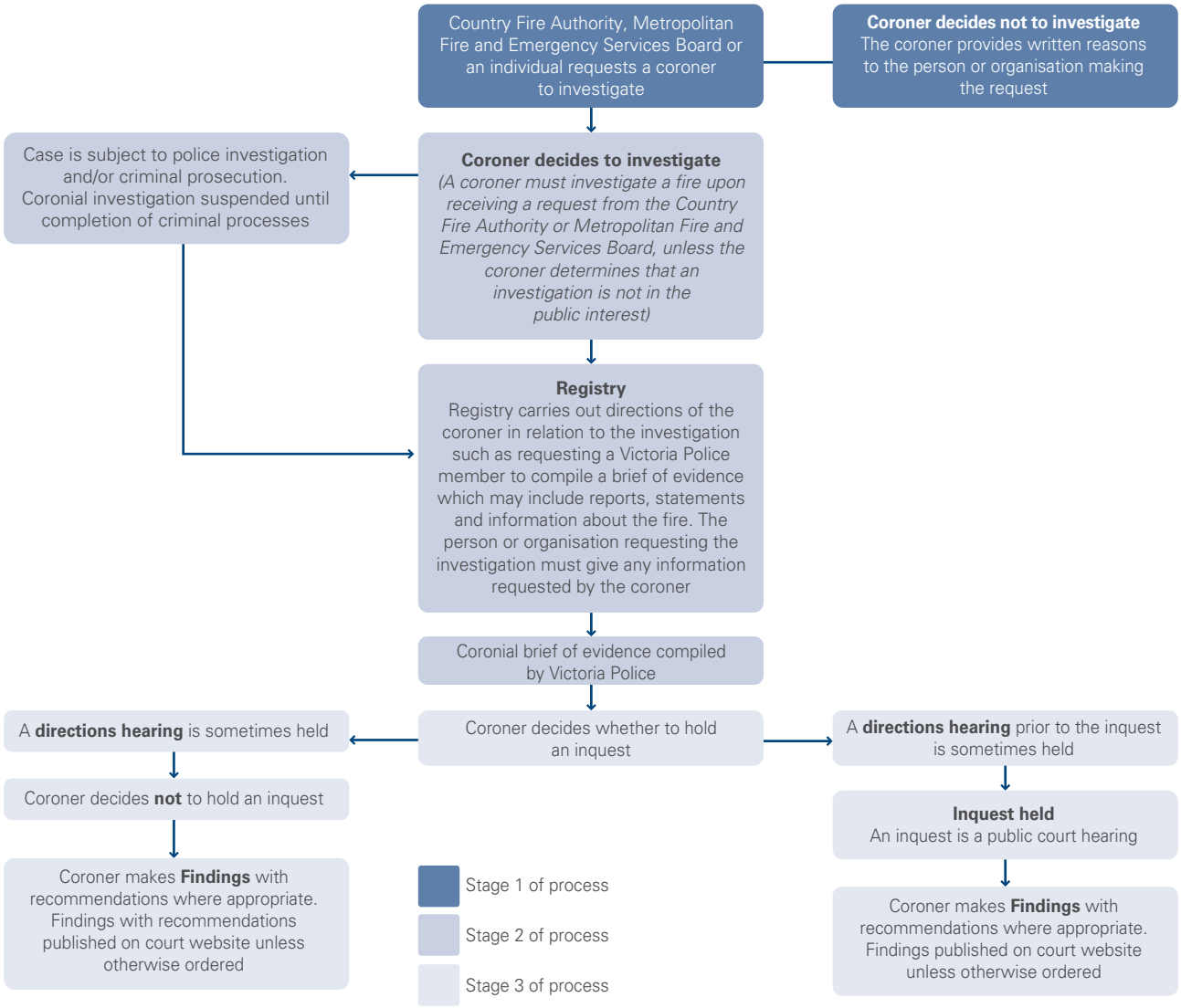
Coronial processes

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

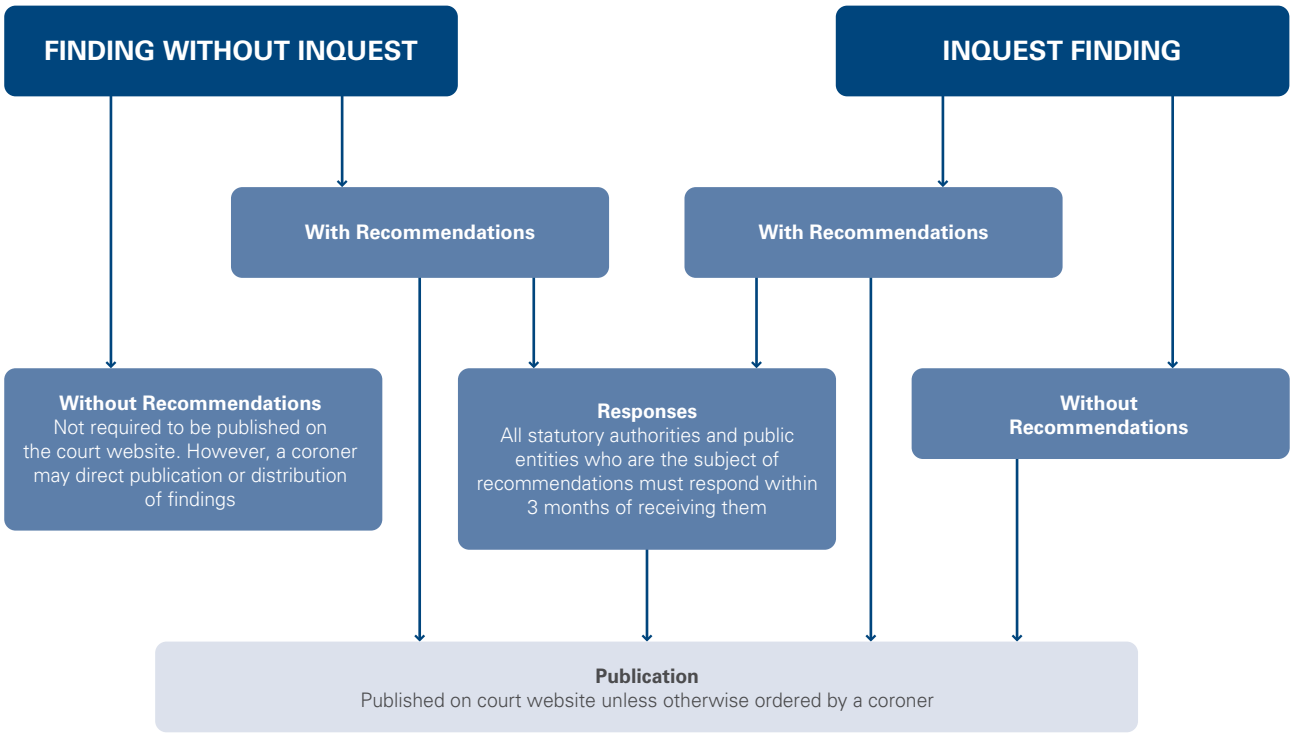
In order to achieve this, the court has established a number of processes allowing different areas within the court and services provided to the court to work together to investigate deaths and fires throughout each stage of the coronial process, as follows:



The coronial process – when fire without death occurs



Publication of findings, recommendations and responses (Sections 72 & 73)



Highlights and initiatives

Site redevelopment

Redevelopment of the 23-year-old Coronial Services Centre of Victoria site in Kavanagh Street, Southbank, continued during the reporting year.

Unfortunately, the project was delayed for some months following ground testing and soil remediation works before any construction works could begin.

Following the temporary relocation of the coroners and most court staff to Level 1, 436 Lonsdale Street in August 2009, early works were commissioned to reconfigure the existing building to enable the Victorian Institute of Forensic Medicine to continue operating at the Southbank site during the life of the redevelopment project. The early works were completed in mid-December 2010, with the main building works beginning in January 2011.

The main building works are aimed at decommissioning, demolishing, building and handing back the Coronial Services Centre in four separate parts.

Although capacity to complete its normal functions is reduced, this staged plan allows the centre to operate its core business and provides the coroners with the appropriate medical and scientific services they require.

The works are part of a four-year redevelopment plan that will result in:

- the addition of a second storey to the existing building to create more room for coroners and coronial staff
- an expansion of the existing two courtrooms and the building of a new directions hearing room
- a complete redevelopment of the Initial Investigations Office to create an improved area for families coming to spend time with their deceased loved ones; and
- extensive upgrading of the mortuary and other facilities of the Victorian Institute of Forensic Medicine and the Police Coronial Support Unit.

The court is not expected to be able to return to the site until late 2013 or early 2014, however the Initial Investigations Office, along with the Victorian Institute of Forensic Medicine, will remain onsite throughout the redevelopment.

Impact on families

The redevelopment remains a crucial project to ensure the court can continue to cater for advancements in post-mortem forensic pathology, expected future increases in the number of deaths requiring investigation and higher degrees of complexity required to carry out those investigations.

However, the court is acutely aware that the redevelopment works will have a significant impact in the short-term on families coming to the Initial Investigations Office following the death of a loved one.

Where possible, the court is attempting to minimise those impacts by trying to ensure some car parking remains available for families and that major works, particularly those that are noise intensive, are avoided at sensitive times when families are present.

Impact on the jurisdiction

The complexity of this project, the lengthy planning processes required and the unexpected delay caused by the requirement to undertake significant soil remediation works has extended the expected duration of the project significantly. This has caused increasing concern for the court in that while the current redevelopment will be a vast improvement on the existing facility, it has no capacity to allow for future growth of the court. There is a genuine possibility that by the time the redevelopment has been completed, the accommodation will be inadequate to enable the jurisdiction to conduct its business in an efficient manner. This may impact on the court's ability to manage backlogs, for example if it has no capacity in which to hold more inquests due to insufficient courtrooms.

Data collected by the court shows that the average number of courtrooms required for each sitting day has increased from 1.7 per day in 2009-10 to 2.4 per day in 2010-11.

This increase in demand has resulted in the court currently having no courtroom availability for inquests scheduled longer than one week until 2012.

Second relocation

Due to the court not having direct access to courtrooms at Level 1, 436 Lonsdale Street, the court underwent a second temporary relocation in December 2010, taking over the premises vacated by Victorian Bushfires Royal Commission at 222 Exhibition Street.

Whilst the move itself resulted in some short disruptions to workflows, the new facility has proved to be a good fit for the court, which now has the ability to run three courtrooms continuously.

Victorian Coronial Council

The Victorian Coronial Council was established under the *Coroners Act 2008* and is the first of its kind in Australia.

The council provides advice and recommendations to the Attorney-General regarding matters of importance to the coronial system, matters relating to the preventative role of the court, the way in which the coronial system engages with families and respects the cultural diversity of the community, as well as any other matters referred to it by the Attorney-General.

The council consists of three statutory and seven non-statutory members.

Statutory members include:

- State Coroner Judge Jennifer Coate
- Victorian Institute of Forensic Medicine Director Professor Stephen Cordner
- Victoria Police Chief Commissioner.

Non-statutory members include:

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

Photograph by Janti Lakusa

While expected on its establishment to meet three to four times per year, the council actually met on ten occasions during the 2010-11 financial year due to the workload the council set for itself.

The council received two references from the Attorney-General.

The first reference was a request to examine measures that might be adopted to assist those affected by coronial investigations in the course of their employment. The council received feedback from respondents including medical and emergency service personnel, corrections staff and transport workers. The council also contacted other coronial jurisdictions nationally and internationally in a bid to examine how they provide assistance to people affected by the coronial jurisdiction. The council expects to produce a final report to the Attorney-General on this reference by the end of October 2011.

The second reference was a request to advise whether asbestos-related deaths should be investigated by the coronial jurisdiction. The council expects to provide a response to this reference by February 2012.

The council also considered other issues, including the redevelopment of the Coronial Services Centre of Victoria site in Southbank and difficulties associated with the accurate reporting of suicide deaths.

The court considers the work of the council to be of considerable benefit to the operation of the coronial system in Victoria and appreciates the valuable work it undertakes.

Legal Practitioners Practice Handbook

The court received funding from the Victorian Law Foundation in the 2009-10 financial year to create The Coroners Court of Victoria Practice Handbook.

Content and layout design of the handbook, which aims to assist legal practitioners unfamiliar with the coronial jurisdiction, has been completed and the handbook is expected to be launched in the first half of the 2011-12 financial year.

The handbook recognises the unique nature of this jurisdiction and provides a tool for the legal profession to assist in the effective representation of their clients by providing information about the jurisdiction, court practices and procedures, and the rights of bereaved family members and interested parties.

CourtView

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

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

CourtView will enable the court to operate a statewide electronic case management system, which the current computer system is unable to provide. The current system is more than 20-years-old and is only able to service the Melbourne registry of the court, further, the current system falls significantly short of what is required by the court to manage its caseload and "count" significant aspects of the work it does. For example, complex and time consuming activities undertaken by coroners are unable to be 'counted', such as:

- reconsideration of coroners' directions regarding autopsies
- applications to hold inquests
- applications to reopen cases
- applications for access to documents.

It was anticipated the court would 'go live' with the new system in early 2011.

However, a number of necessary customisations to CourtView were required to accommodate the unique business requirements of this jurisdiction, particularly in relation to the development of an electronic interface between the court and the Victoria Institute of Forensic Medicine which conducts forensic medical examinations on behalf of the court. These customisations and other unexpected factors have resulted in ongoing delays to the implementation of CourtView.

Unfortunately these delays have resulted in the court having to persist with a series of 'work-arounds' to maintain the continuity of its work until CourtView is implemented. Despite the frustration arising from these delays, coroners and court staff began receiving training in the operation of CourtView in June 2011 and the court expects it will be in a position to 'go-live' during the 2011-12 financial year.

In-house solicitor service

The Police Coronial Support Unit (PCSU) currently provides assistance to coroners in a significant number of inquests. PCSU also provides assistance to coroners by liaising with investigating members who are conducting investigations on behalf of a coroner. However, in any coronial investigation where the conduct of police will or may come under scrutiny, the coroner will not seek the assistance of PCSU to avoid any possible conflict of interest. In these circumstances the services of independent lawyers are required to assist the coroner. This also happens in some highly technical or complex investigations. Given the increasing complexity of coronial cases, and the rising costs of legal assistance, the costs of obtaining the necessary independent legal assistance for coronial investigations and inquests has increased significantly, from $583K in the 2009-10 reporting period to $1.225M in the 2010-11 reporting period.

In a bid to reduce these rising costs the court advertised in March 2011 for the positions of Principal In-House Solicitor and Senior In-House Solicitor to assist with the development of an in-house legal service for the court. The service will be responsible for providing assistance with investigations, managing investigation files, preparing matters for inquest and appearing as counsel to assist in inquests.

It is anticipated that the development of an in-house solicitor service will not only result in the building and retaining of expert legal knowledge within the court, but also result in a significant reduction in the rising costs of providing the necessary assistance to coroners in those cases where the PCSU is unable to do so.

Coronial investigations

Coronial findings

A coroner investigating a reportable death under Section 67 of the Act must find, if possible:

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

A coroner investigating a fire under Section 68 of the Act must find, if possible:

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

Coroners delivered 5194 findings in the 2010-11 financial year. For a full breakdown of findings figures see page 48.

Coronial recommendations

In addition to the findings that a coroner must make under the Act, an important purpose of a coronial investigation is to contribute to public health and safety through recommendations aimed at the reduction of preventable deaths and fires.

A coroner can make more than one recommendation in a finding.

In the last financial year 53 coronial findings contained recommendations. For a full breakdown of recommendation figures see page 48.

Investigations of significant public interest

In the reporting period, coroners continued their investigations into a number of deaths and fires of significant public interest.

Such investigations provide a unique opportunity to influence public health and safety development in this State. Some of the investigations the court has underway in the reporting period included:

Black Saturday Bushfire deaths

The court had expected to receive the briefs of evidence in relation to the 173 Black Saturday bushfire deaths from Victoria Police in April 2011. This date has been revised by Victoria Police, and the court now expects to receive the majority of the material in late July 2011. Further to this was the recent shift in the focus of the investigation into the cause of the Murrindindi fire in which 39 people died. Victoria Police advised the court in June 2011 that although initially thought to be suspicious, the cause of the Murrindindi fire is no longer thought to have resulted from criminal actions. This will substantially increase the level of work required to be undertaken by the court as the cause of this fire was not investigated by the Victorian Bushfires Royal Commission in 2010 due to criminal investigations being undertaken at the time. Victoria Police has advised they should be in a position to provide the briefs of evidence for the Murrindindi fire by late August 2011.

Heathmere bus crash

The investigation into a fatal bus rollover at Heathmere in April 2009 was finalised at inquest during the reporting period.

The coroner examined the deaths of three people including a 20-year-old Heywood man, a seven-month pregnant 19-year-old Mount Gambier woman and her two-year-old daughter after the V/Line coach they were travelling in rolled over on the Princes Highway.

During the inquest the coroner examined several issues including:

- the condition of the roadway
- the condition of the bus
- driver behaviour
- apparent failure of passengers to comply with seatbelt legislation; and
- measures to improve seatbelt wearing compliance.

The inquest process included:

- one direction hearing
- nine days of inquest, including handing down of the finding
- 3299 pages of transcript
- 35-page finding, with;
- nine recommendations.

The coroner found that the road surface contributed to the coach rolling over and that the three passengers may have survived and their deaths been prevented had they been properly restrained.

In particular, the coroner identified a lack of regulation regarding child restraints in buses and made a specific recommendation that Transport Safety Victoria introduce a requirement that child restraints be made available on all buses operating in Victoria that are subject to Australian Design Rule 68/00.

The court expects to receive responses to the recommendations early in the next financial year.

Level crossing deaths

The investigations into the deaths of 29 people who died in collisions between trains and vehicles at level crossings across Victoria continued in the reporting period, with the inquest into the Kerang Level Crossing deaths commencing in January 2011.

This collision, between a truck and V/Line passenger train at Kerang, claimed the lives of 11 people in June 2007.

To date the inquest has focused on two main areas of inquiry including the emergency response, and road and rail infrastructure issues.

The inquest process has been extensive including:

- a directions hearing
- six days of inquest
- oral evidence from 20 witnesses
- 105 exhibits
- 2167 pages of transcript
- 23,814 pages of materials in the inquest brief.

The inquest into the Kerang Level Crossing deaths is expected to continue in July 2011.

Co-sleeping deaths

Investigations into the deaths of up to 33 infants who died in co-sleeping settings with adults have continued in the reporting period.

To assist the coroner undertaking these investigations, the Coroners Prevention Unit undertook extensive research into potential risk factors associated with co-sleeping and infant mortality. The deaths being examined by the court occurred between 2008 and 2011.

The court expects to be in a position to conduct a directions hearing to further assist in defining the scope of an inquest within the next financial year.

Deaths at aged care facility

The inquest into the deaths of four aged care residents at an aged care facility continued during the 2010-11 reporting period. The inquest examined whether the deaths were related to an outbreak of gastroenteritis at the facility in April 2007 and any subsequent related health and safety issues.

The investigation conducted by the State Coroner into these deaths has been extensive and includes:

- a directions hearing
- 13 days of inquest beginning in March 2011
- oral evidence from 20 witnesses
- 71 exhibits
- 1518 pages of transcript.

This is in addition to the investigations undertaken in the 2009-10 reporting period which included:

- two mention hearings
- two directions hearings
- five days of inquest hearing
- 854 pages of transcript.

The court received final written submissions from the interested parties in April 2011.

Youth suicides

Investigations into a cluster of youth suicides continued in the reporting year, with the Coroners Prevention Unit undertaking extensive research regarding potential systemic issues unique to youth suicides. The deaths being investigated occurred between 2008 and 2010.

The court anticipates it will be in a position to conduct a directions hearing to further assist in defining the scope of any potential inquests within the next financial year.

Tipper truck deaths

The continued investigation into the deaths of three men following tipper truck contacts with overhead powerlines resulted in the holding of a cluster inquest during the 2010-11 reporting period. The deaths occurred between January and April 2006.

The inquest into these deaths commenced on 1 May 2011 and identified a number of commonalities between each of the deaths, including that they all involved:

- the bulk ordering of either lime or fertiliser to rural properties or farms
- the order was to be delivered by a tipper truck
- all the deliveries had a dumping site that required the tipper truck to be in close proximity to power lines (Swer Line)
- each of the incidents resulted in the death of a person due to the tipper trailer contacting overhead transmission lines on the farming properties
- apparently all parties were aware of the power lines
- a spotter was not used at any of the sites
- the drivers were not familiar with the properties that they were attending.

The inquest process included:

- one directions hearing
- four days of inquest, including final submissions
- oral evidence from 26 witnesses
- 53 exhibits tendered; and
- 485 pages of transcript.

The coroner expects to be in a position to begin preparing her written finding within the next financial year.

Bariatric (lap-band and stomach reduction) surgery deaths

The investigation into the deaths of two people following bariatric surgery continued during the 2010-11 reporting period. Inquests into these deaths are scheduled to begin early in the next reporting year and are expected to examine a number of issues including:

- the appropriate use of laparoscopic bariatric surgery
- communication of test results
- accreditation of laparoscopic surgeons
- accreditation of private hospitals to perform laparoscopic surgery; and
- appropriate guidelines for recognition of obesity training.

Immigrant drowning deaths

The investigation into the separate drowning deaths of two people in 2008 and 2009 following their recent immigration to Australia continued during the reporting period, with an inquest held into these deaths in November 2010.

The inquest included:

- a directions hearing
- three days of inquest hearing
- oral evidence from nine witnesses
- 13 exhibits tendered.

The inquest considered issues regarding the level of information provided to immigrants regarding safe swimming and Victoria waterways. The coroner expects to be in a position to begin preparing a finding following receipt of the transcript within the next financial year.

Donor recipient deaths

The investigation into the deaths of three donor transplant recipients continued during the 2010-11 reporting period. These deaths occurred within a seven-day period in January 2007 and subsequent investigations indicated that the common thread in these deaths was that each of the three deceased had received an organ from an organ donor who had died in December 2006.

A series of blood samples were taken by the Victorian Institute of Forensic Medicine and sent to the US, where the Arenavirus was detected as being common in all four of the deceased. The Arenavirus has been identified only relatively recently and little is known about its epidemiology. It was identified in two separate clusters of deaths in the US in 2003 and 2005 and these were also transplant related cases.

Issues that were considered during the inquest into these deaths included:

- procedures for screening donors and transplant recipients
- communications between the various hospitals when the recipients started becoming unwell
- quality of information obtained from donor families about the health of a donor prior to removal of organs taking place.

The inquest included:

- two directions hearings
- five days of inquests
- oral evidence from 15 witnesses
- 33 exhibits tendered; and
- 991 pages of transcript.

The coroner expects to be in a position to begin preparing her written finding within the next financial year.

Psychiatric asphyxiation deaths

The investigation into the separate deaths of two men in psychiatric facilities in 2007 continued during the reporting period. The investigation examined whether the two men died from positional asphyxiation following restraint by facility staff.

The inquest into one of these deaths commenced on 31 January 2011 and has included:

- 11 days of inquest
- oral evidence from 16 witnesses
- 46 exhibits tendered to the court; and
- 791 pages of transcript.

The inquest into the other death began on 11 April 2011 and has included:

- 10 days of inquest
- oral evidence from 12 witnesses
- 51 exhibits tendered; and
- 697 pages of transcript.

The coroner expects to receive final submissions for both inquests early within the next reporting period.

Pain management deaths

The investigation into the deaths of up to 12 people from drug toxicity relating to the management of chronic pain continued during the reporting period. This investigation has focused on deaths that occurred during 2006 and 2010. A directions hearing into one of the deaths was held in September 2010. The investigation will continue throughout the next reporting period.

Re-opening of coronial investigation

The investigation into the September 1976 death of Colac man Hugh Wilson continued during the reporting period. Mr Wilson was struck by a motor vehicle whilst walking on the Colac-Gellibrand Road in Barongarook and an inquest into his death was held on 25 February 1977. It was determined the cause of his death was consistent with injuries sustained from the impact of a motor vehicle.

In late August 2006, the Victoria Police Ethical Standards Department (ESD) received information that a police car from Colac may have been involved in the death and a new investigation into Mr Wilson's death began. Based on their enquiries, Victoria Police made an application in July 2007 to the Supreme Court requesting that the previous coronial finding into Mr Wilson's death be set aside and the investigation re-opened. This application was granted.

A new brief of evidence was prepared for the court and an inquest conducted including:

- two directions hearings
- three days of inquest hearings
- oral evidence from 18 witnesses
- 52 exhibits tendered
- 376 pages of transcript.

The coroner has adjourned the inquest with further hearing dates listed for July and December 2011.

Police shooting of a young person

The inquest into the death of 15-year-old Tyler Cassidy was one of the most high-profile investigations conducted by the court during the reporting period. Tyler was shot dead by police at a Northcote skate park on 11 December 2008 and remains the youngest person killed by police in Australia.

The investigation conducted by State Coroner Judge Jennifer Coate into his death has been extensive and includes:

- five directions hearings
- 36 days of inquest hearings, including final submissions
- 124 exhibits tendered
- 3693 pages of materials within the brief of evidence
- 81 witnesses called to give evidence; and
- almost 4500 pages of transcript.

There were eight interested parties represented by legal counsel including:

- Counsel Assisting the Coroner
- the Cassidy family
- Austin Health
- Human Rights Law Resource Centre
- Victoria Legal Aid
- Emergency Services Telecommunications Authority (ESTA)
- Chief Commissioner of Police
- the four police members involved in the incident.

In total, the bar table comprised nine senior counsel, four junior counsel and eight instructing solicitors. In addition to these members of the bar table, the State Coroner also received representations from Mr Pappas on behalf of a female witness and Dr Collins on behalf of the Australian Broadcasting Corporation.

There were several published rulings in the course of the inquest.

The State Coroner expects to be in a position to hand down her finding within the next reporting period.

Family violence deaths

The investigations into the deaths of a 23-month-old toddler and her 26-year-old father continued during the reporting period. A joint inquest was held into these deaths with a focus on examining early intervention opportunities for children and families at risk of abuse. The toddler died following injuries sustained at her home in 2009. She was airlifted to the Royal Children's Hospital, but died several days later. Police had charged her father with assault offences in relation to her injuries, however, he took his own life prior to her death.

The inquest included:

- a directions hearing
- nine days of inquest, including submissions
- oral evidence from 22 witnesses
- 68 exhibits
- 1155 pages of transcript.

The coroner expects to hand down the finding early within the next financial year.

Unidentified remains

During the reporting period the court examined more than 15 cases of unidentified human remains against missing person reports.

These cases formed part of a series of investigations carried out by the former Victoria Police Belier Taskforce. The taskforce was created in January 2007 in a bid to reconcile 600 long-term missing person reports, some dating back to the 1950s, against unidentified human remains.

A coroner held a number of summary inquests and was able to identify the human remains in many cases including:

- Geoffery Bragge – missing since 1971
- William Dixon – missing since 1964
- Roy McLennan – missing since 1972
- Melva Staff – missing since 1981
- Edward Reade – missing 1958
- Charles Dobbyn – missing since 1982
- Cindy Ward – missing since 1986.

Application to re-open investigation into police deaths

In May 2010 the court received two applications to set aside the previous coronial findings and re-open the investigations into the deaths of Victoria Police members Constable Steve Tynan and Probationary Constable Damian Eyre, who were shot dead in Walsh Street in 1988.

The State Coroner began the extensive process of considering the applications during the reporting period. The original investigation produced :

- 3809 pages of transcripts from the original Magistrates' Court committal hearing into the deaths
- 2792 pages of transcript from the Supreme Court trial into the deaths
- the materials contained in the original briefs of evidence for the criminal proceedings relating to the four persons charged in connection to the deaths
- the exhibits tendered at the Supreme Court trial
- the original briefs of evidence compiled for the coronial investigations into the deaths
- the Record of Investigations (chambers findings) into the deaths made by former State Coroner Graeme Johnstone.

All this information must be taken into account to determine if there are any new facts and circumstances that would allow the investigation to be re-opened. Under Section 77 (3) of the Act a coroner may only re-open an investigation if he or she is satisfied that there are new facts and circumstances and that it is appropriate to do so. The State Coroner anticipates she will be in a position to make a ruling on the applications within the next reporting period.

Developments in public health and safety

Ambulance to carry blood products

A recommendation contained in the finding into the death of Cobram mother Veronica Campbell has resulted in the Department of Health and Ambulance Victoria agreeing to implement a new system to improve urgent access to blood products across Victoria.

Veronica died from a ruptured ectopic pregnancy in 2008 and Coroner Stella Stuthridge held an inquest into her death in Shepparton in April 2010. Coroner Stuthridge recommended that Ambulance Victoria and the Victorian Government develop a viable method of providing blood products in emergencies in rural communities.

In late 2010, Ambulance Victoria installed refrigeration units in Mobile Intensive Care Ambulance Single Responder Units, which can be used for short-term periods to transport blood and blood supplies from a major hospital to a rural hospital upon request from a medical practitioner. It is anticipated that this initiative will broaden the statewide base for improved, rapid availability of blood and blood products to ensure there are appropriate mechanisms in place to support rural communities in emergencies. Further, in April 2011 Ambulance Victoria made arrangements with the Royal Melbourne Hospital to begin carrying blood and blood products on ambulance aircraft to incident scenes.

Brodie's Law

On 5 April 2011 Attorney-General Robert Clark introduced the new *Crimes Amendment (Bullying) Bill* into the Victorian Parliament.

Dubbed 'Brodie's Law', the bill was drafted after the tragic death of 19-year-old Brodie Panlock in 2006. She took her own life after being bullied and victimised by colleagues at a Hawthorn café where she worked.

Coroner Peter White conducted an inquest into Brodie's death in October 2007 and January 2008 and heard evidence that during the course of her employment Brodie was verbally abused, spat on, had beer poured over her head and fish oil poured into her bag. When she first attempted suicide, she was ridiculed for failing, then offered rat poison. In his finding Coroner White recommended WorkSafe investigate the named parties further and take such action as it deemed appropriate. The Hawthorn café owner, manager, chef and waiter were all charged and convicted of workplace offences, but not criminal offences, and were collectively fined $337,000.

Following this outcome, the State Government decided the established method for taking legal action against bullying through the *Occupational Health and Safety Act 2004* was not sufficient for bullying that was as serious as the type suffered by Brodie.

The Bill aims to ensure that bullying behaviour can be effectively prosecuted by expanding the previous stalking provisions in the Crimes Act by making it clear that

- threatening or abusive words or acts may form part of the course of conduct for bullying
- the term 'course of conduct' is expanded to include any behaviour that could reasonably be expected to cause a person to physically harm themselves
- provides that harm includes psychological harm that could cause a person to engage in suicidal thoughts.

Rock fishing safety

A public safety campaign targeting culturally and linguistically diverse communities about the dangers of rock fishing is underway following a finding by Coroner Heather Spooner in April 2011.

A cluster inquest into the deaths of three men in 2009 resulted in the reactivation of the Rock Fishing Safety Management Group. Chaired by Coroner Spooner and involving representatives from the Coroners Prevention Unit, Fisheries Victoria, Parks Victoria, VRFish, Australian Sportfishing Association, Multicultural Commission and Lifesaving Victoria, the group developed a Rock Fishing Safety Management Plan to assist in preventing rock fishing fatalities.

Research undertaken by the Coroners Prevention Unit showed:

- most rock fishing deaths involved people from culturally and linguistically diverse backgrounds
- that there was a notable absence of any safety equipment used by rock fishers
- there were difficulties in contacting and directing emergency service personnel to precise rescue locations.

The plan recommended key strategies to address known risk factors including:

- that wearing of personal floatation devices be promoted to recreational fishers
- that education safety campaigns specifically target culturally and linguistically diverse communities
- that land managers, including Parks Victoria and local councils, consider appropriate signage at rock fishing locations
- that coastal municipalities adopt updated location markers
- that angel rings continue to be made available at known rock fishing sites, and;
- a new safety initiative of "000" alarms with webcams be trialled at two rock fishing sites.

It is anticipated that the Victorian plan will also assist the New South Wales coronial jurisdiction in their investigations into a spate of rock fishing deaths which occurred between 2009 and 2011.

Flammable lacquer dangers

When a firefighter became critically injured whilst responding to an emergency call at a Yarraville furniture manufacturing factory Japanese Screens and Interiors in October 2007, it was clear a broader examination of public health and safety issues was required.

The firefighter sustained serious injuries after becoming caught in an explosion of nitrocellulose lacquer overspray in the factory. The substance, which was being used as a spray paint lacquer over Japanese rice paper screens, is highly flammable and can ignite spontaneously and without warning.

Shortly after the incident the Victorian firefighters union made an application to the court requesting a coroner hold an inquest into the circumstances surrounding the fire. Under the Section 31 of the Act, a coroner may investigate a fire after receiving a request to do so, regardless of whether a person has died or not.

Coroner Heather Spooner began investigating the incident and convened a series of Safety Management Meetings, attended by the Metropolitan Fire Brigade (MFB), Country Fire Authority (CFA), WorkSafe Victoria, the Furniture Industry Association of Australia and the Office of the Emergency Services Commissioner, following discussions from a directions hearing in September 2009.

With the assistance of the Coroners Prevention Unit, the working group developed a Safety Management Plan for Nitrocellulose Lacquer in Victoria, which outlined a multi-agency approach to managing risks to operational firefighters, and ensuring that nitrocellulose lacquer users are meeting their obligations under occupational health and safety legislation.

The inquest began in April 2010 and Coroner Spooner heard evidence that the use of nitrocellulose lacquer in small-scale industrial premises presented a real and ongoing threat to operating firefighters.

She found poor housekeeping and maintenance led to a dangerous accumulation of lacquer overspray and nitrocellulose dust which provided the perfect conditions for the heat build up and the exothermic chemical reaction and spontaneous combustion to occur, which resulted in the serious injury to the attending firefighter.

Coroner Spooner recommended in her finding that the plan be formally adopted to prevent similar fires from occurring in the future. The plan has since been incorporated into a Memorandum of Understanding between WorkSafe Victoria, the CFA and MFB, and is currently being implemented. WorkSafe Victoria has worked with suppliers of nitrocellulose lacquer to identify end-users of the products. This end-user list has been incorporated into MFB and CFA operational planning. Fire agencies and WorkSafe have also been working together to visit industries using the product to raise awareness of safety issues, and to ensure that they are using the product safely.

This approach to managing nitrocellulose lacquer safety is the first of its kind in Australia, and MFB have been promoting this process through national emergency management and fire-fighting forums.

Off-road transport

The summary inquest into the death of a 14-year-old Gisborne South boy who died following an off-road motorcycle collision in 2009 has led to the Department of Health committing to making injury prevention a key priority within the next financial year.

The move followed a Coroners Prevention Unit review of the deaths of 20 children riding off-road transport vehicles between 2000 and 2009 as part of the summary inquest into the death.

The review identified that the burden of injury from off-road transport is alarmingly high and increasing each year.

A Monash University study of emergency department presentations identified that between 2002-03 and 2004-05, there was an average rate of one hospital admission per day of a child who had been riding off-road on a motorcycle, and a similar rate of emergency department presentations.

The review also identified that there was no lead agency with responsibility for dealing with off-road transport injury, impeding prevention efforts.

In handing down his finding in March 2011 Coroner John Olle recommended that the Department of Health establish a Victorian Injury Prevention Strategy and place off-road motorcycling safety as a priority. He further recommended that targeted awareness campaigns be made in an effort to educate parents and carers.

In its response to the coronial recommendations, the Department of Health stated it was:

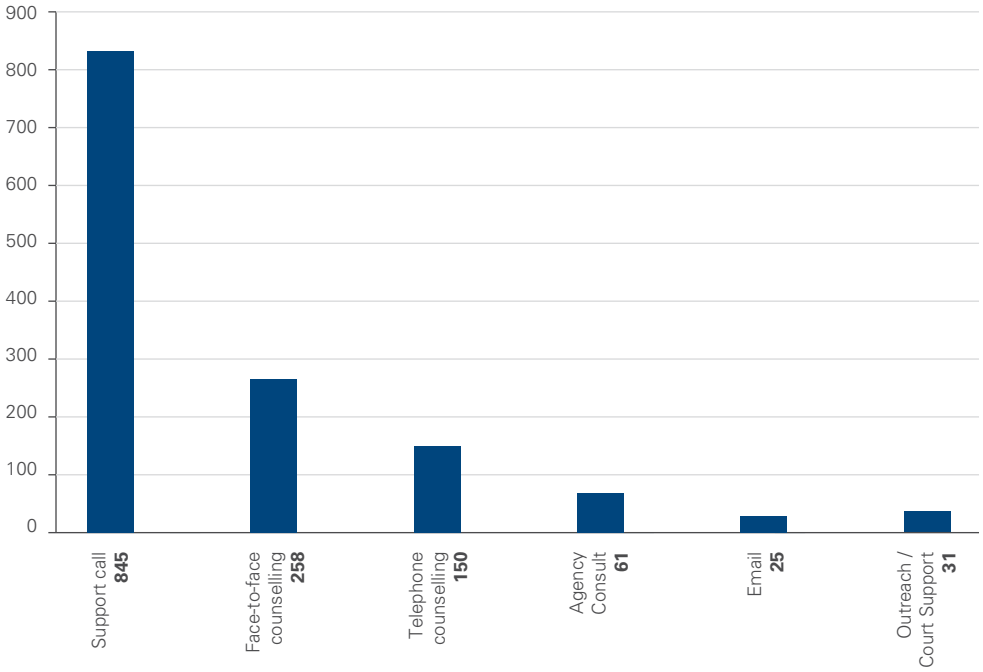
> "...committed to developing a state-wide Injury Prevention Plan over the next 12 months, in collaboration with other government departments, statutory bodies and community agencies. The Plan will establish shared priorities for prevention investment across government."

Engaging the community

Supporting bereaved families

In the 2010-11 reporting period the court's Family and Community Support Service undertook significant counselling contacts to assist families and friends whose loved one's death was being investigated by the court.

Counselling sessions 1 July 2010 – 30 June 2011 (total number of sessions 1370*)

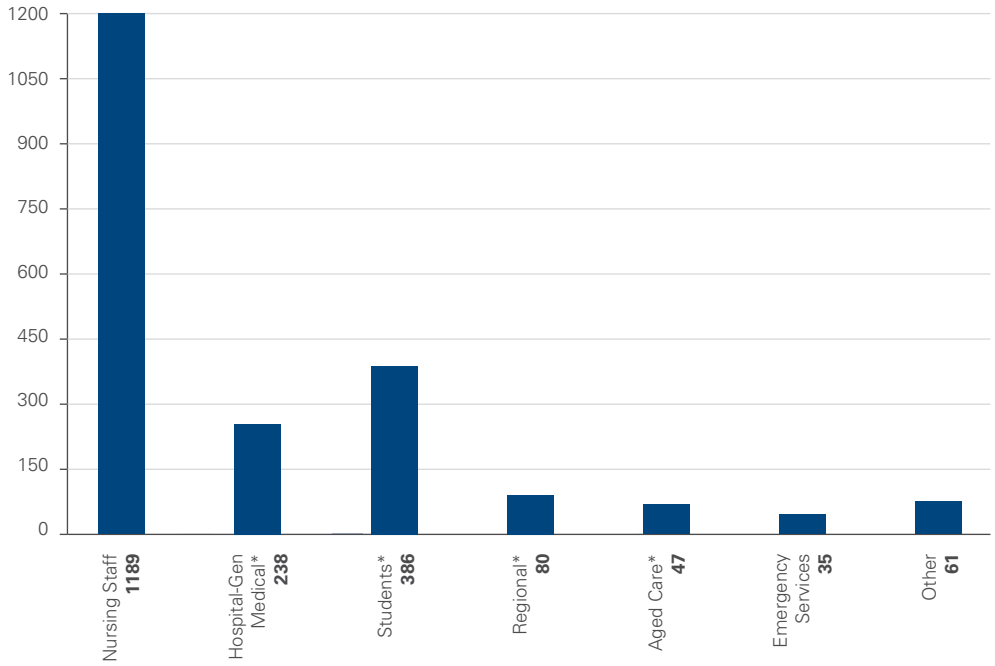


* compared with a total of 669 for the six-month period from January – June 2010

Community education

During the reporting period the Family and Community Support Service continued its program aimed at educating students, social workers and medical and health professionals about the coronial jurisdiction.

Attendance across 40 education sessions (total of 2036 attendees†)



† compared with 21 sessions and a total of 565 attendees in the six-month period from January - June 2010

* Hospital General Medical includes doctors, clinicians, social workers, quality & risk, senior hospital staff and nurses

* Students include social work, psychology, nursing, health, medical and law students not yet graduated

* Regional includes education sessions delivered outside metropolitan Melbourne

* Aged Care includes aged care facilities and hospital-based outreach aged carers

Coroner presentations and committee membership

In addition to their work investigating deaths and fires, the coroners, in their role as judicial officers, made significant contributions to the community through conference presentations, membership of various committees and councils, assisting with the delivery of professional development programs by the Judicial College of Victoria, and mentoring law students and graduates. During the reporting period coroners participated in a wide range of activities, including those listed below.

Presentations and attendances at conferences and other forums including:

- Judicial College of Victoria Twilight Sessions (monthly)
- International Association of Women Judges Conference Seoul
- Health and Medical Investigation Team Open Days
- Australian Medical Association Seminar – Death Certificates and the Coroners Court of Victoria
- Victoria Police Coroners Assistants Course
- Suicide Conference
- Asia Pacific Coroners Conference
- Industrial Deaths Support and Advocacy (including memorial service)
- Leadership Victoria – 2011 Williamson Community Leadership Program
- Office of Police Integrity Forum
- Homicide Squad Training Day
- Law Week Presentations
- Palliative Care Nurse conference
- Mock Inquests for the Royal Society of Victoria
- Moot Courts for Universities
- Presentations for New Zealand Law Commissioner
- Presentations to visiting Thai Delegations
- Session chairs for Judicial College of Victoria Intensive Conference (and participation in the two-day conference)
- Operational Safety Tactics Training - Training modules for Victoria Police on mental health issues
- Nursing and law conferences
- Department of Health and Aged Care – Health Service Executive Forum Panel Discussions
- Coroners judgement writing day provided by Judicial College of Victoria
- Belier presentations to interstate coroners (NSW & QLD) for cold case task forces
- Forensic Law Seminars at Victorian Institute of Forensic Medicine.

Membership of many committees and councils, including:

- Coronial Council of Victoria
- National Coroners Information System Committee
- State Disaster Victim Identification Committee
- State Coronial Services Centre Redevelopment Project Control Group
- Coronial Heads of Jurisdiction Committee
- Victorian Institute of Forensic Medicine Council
- Courts Executive Service Steering Committee
- Donor Tissue Bank Of Victoria
- Victorian Child Death Review Committee
- Heavy Vehicle Transport Safety Group
- Judging for Public Health Care Awards
- Births Deaths and Marriages Committee
- Coroners Education Project Judicial Steering Committee
- Coroners Court of Victoria Research Committee
- VIFM Human Research Ethics Committee
- Victoria Police Expert Mental Health Advisory Panel
- Nurses Board of Victoria History Project Steering Committee
- Magistrates' Court of Victoria Professional Development Committee
- Magistrates' Court Professional Development - Sub-committee for the development of mentoring programs.

Coroners professional education

In partnership with the Judicial College of Victoria, the court has continued its commitment to offering ongoing training, education and access to resources for coroners. Significant highlights of the reporting period include:

- a series of twilight education seminars accessible to regional coroners via video conferencing facilities
- key involvement of regional coroners in the organisation and presentation of twilight seminars
- an intensive workshop on Writing Coronial Findings to assist coroners in writing clear, concise and reasoned findings and recommendations
- a two-day intensive workshop designed to further develop and explore coroners' understanding of the operation of the *Coroners Act 2008* and refine their case management skills
- publication and maintenance of a Coroners Bench Book to help coroners stay up-to-date with the latest developments in Australian coronial law.

Law Week 2011

In May 2011 the court hosted three events as part of Law Week in a bid to educate the Victorian community about the coronial jurisdiction and the role of the coroner.

The first event titled "The Coronial Investigation" and chaired by Coroner Paresa Spanos comprised a panel of experts from the Coroners Court, scientific staff from the Victorian Institute of Forensic Medicine and a member of the Police Coronial Support Unit. The session guided the attendees through a hypothetical coronial investigation from the time the death was reported through to the inquest.

The second event, titled "The Role of the Coroner", chaired by Coroner Peter White, featured a panel of court staff who described their respective roles in assisting a coroner in an investigation.

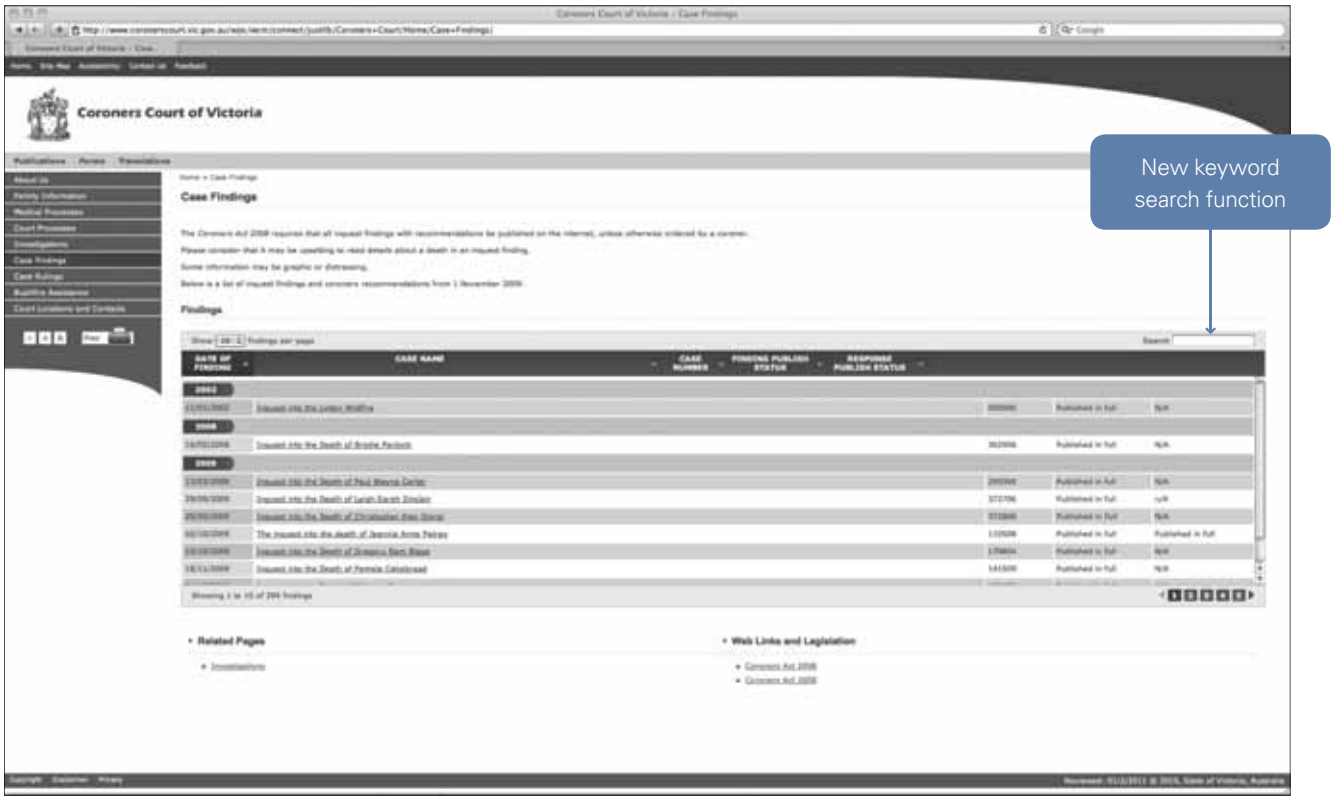
On the final day of Law Week, court staff manned an information desk as part of 'Courts Open Day' and Coroner Spanos presented the third session on "The Role of the Coroner" in reducing preventable deaths and fires across Victoria.

The three sessions were attended by a cross section of the community including a member of parliament, representatives from government departments, legal professionals, students, and the general public – totalling in excess of 120 attendees.

Website

Improvements to the court website continued during the reporting period. New fields were added to 170 existing findings pages on the site to help users better search and locate relevant coronial findings. By using an added findings search box, users can now search for keywords or categories such as drownings, homicides and fatalities to locate relevant findings by topic.

The search function was also improved to allow users to search for findings by case number, name of the deceased, date of finding and response status.

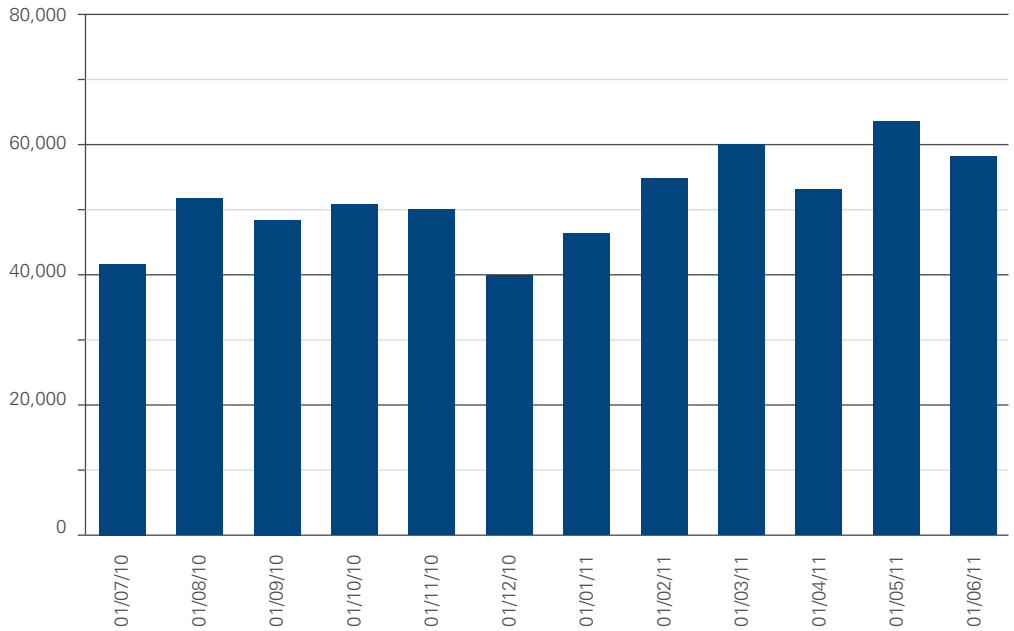


During the reporting period, 166 new findings and 17 new rulings were uploaded onto the court website.

Visits to court website

The below table indicates the number of visits (631,987) to pages on the court website during the reporting period. This is almost double the number of visits to pages in the 2009-10 reporting period (338,370).

By month



* data collated from Nielson NetRatings Statistics

Publications

During the reporting period, the court continued to provide access to information about the coronial process through the distribution of court publications.

The court disseminated 8448 copies of its publications following requests from hospitals, police, courts, community workers, social workers and funeral service companies. These distributions were in addition to publications normally provided by the court to families engaged in the coronial process. Of the publications provided, 63% were sent to organisations in metropolitan Melbourne and 37% to organisations in regional Victoria.

The table below provides a breakdown of different publications disseminated by the court during the reporting period.

PUBLICATION TITLE	NUMBER OF PUBLICATIONS SENT
Access to Documents	842
The Coroners Process – Information for families and friends	3006
What do I do now?	2411
Information for Health Professionals	287
Reporting Deaths (A4 sign for hospitals)	88
Total	**8448**

List of publications

Important information about the coronial process is contained in nine publications and one booklet including:

- **Family and Community Support Service** – a brochure that details support and counselling services provided by the court
- **What do I do now?** – a brochure that provides detail about what occurs when a death is first reported to the court including the identification process and information about medical examinations required by the court
- **Inquest** – a brochure sent to families following a determination by a coroner that the investigation into their loved one's death will proceed to an inquest. This brochure outlines the purpose of an inquest and what families can expect to happen during an inquest
- **Findings** – a brochure sent to families when a coroner is preparing to hand down a finding. The brochure contains information about what a coroner must include in a finding, the difference between a finding with inquest and a finding without inquest, as well as a person's right to object to a finding
- **Reviewable deaths** – a brochure containing information for families who have experienced the loss of a child where the death has been identified as a reviewable death that must be examined by a coroner
- **Disaster Victim Identification** – a brochure explaining the different phases involved in identifying persons who have died in circumstances where normal identification procedures (such as visual identification) cannot be utilised
- **Coroners Prevention Unit** – a brochure providing information about the role and function of various research teams within the unit
- **Access to Documents** – a brochure advising the public and interested parties on how to gain access to coronial documents
- **Information for Health Professionals** – a publication with detailed information regarding the reporting obligations relevant to the health profession following the implementation of the *Coroners Act 2008*
- **Coroners Process - Information for Family and Friends** – a 58 page booklet providing detailed information about the coronial process from the time a death is first reported to the court to the time a coroner makes a finding.

During the reporting period the court also completed translations of the *'What do I do Now?'* brochure into 15 different languages. The translated documents are now available on the court website.

Research and prevention

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

The table below indicates the number of research and prevention referrals, projects and investigations completed and/or undertaken within the reporting period.

CORONERS PREVENTION UNIT DATA	2009/2010	2010/2011
Total referrals received by Coroners Prevention Unit	101	489
Referrals from metropolitan coroners	91	390
Referrals from regional coroners	3	61
Referrals from external agencies	7	17
Referrals from other business units within the court	~	21
Total referrals completed	**76**	**265**
Total referrals underway with expected completion in the next financial year	**29**	**235**

The Coroners Prevention Unit completed 10 of the 17 referrals received from external agencies during the reporting period, including creating reports for several agencies such as:

- Corrections Victoria
- Life Saving Victoria
- Parliament of Victoria Drugs and Crime Prevention Committee
- The Office of the Child Safety Commissioner
- Victorian Department of Health - Mental Health, Drugs and Regions Division
- Victoria Police
- Victorian Auditor-General's Office
- Victorian Department of Transport
- Wesley Life Force
- Yarra Trams.

Coroners Prevention Unit investigations undertaken for coroners

The list below demonstrates the range and extent of investigations the unit has been requested to provide assistance with during the 2010-11 reporting period.

- Tasers and Victoria Police - legal intervention (police shooting)
- Aged care facilities - absconding controls and extreme heat events
- Emergency services information for international visitors
- Deaths highlighting risks associated with extreme weather events in Victoria
- Drug-related deaths among female prisoners in Victoria, 2000-2010
- Heavy vehicle modifications, roadworthiness and the impact on road safety
- Victorian and interstate coronial findings concerning police cordon and containment of armed suspects
- Deaths involving Oxycodone in Victoria, 2000-2009
- Failures in medical care for a mentally and physically ill older male who suicided
- V/Line passenger coach roll-over, Heathmere, 16 April 2009
- Discharge planning and crisis assessment of patients with a chronic mental illness
- Review of Ballarat Psychiatric Service Acute Mental Health Unit deaths between September 2008 and 2010
- Access to secure extended care inpatient beds for psychiatric patients
- Transfer requirements and public bed access of a recommended patient under Mental Health Act 1986 (Vic)
- Suicide among school-aged youths Victoria, 2000-2010

- Treatment responses to persons with complex mental and other health problems
- Over prescribing of Aminoglycoside (Gentamicin) antibiotic
- Unstable angina, previous CAGs and an angiogram procedure
- Hypersensitivity to the anti convulsant medicine Phenytoin
- Licensing and training of crowd controllers in Victoria
- International visitors and driver safety on Australian roads
- Victorian workplace fatalities working alone and machinery hazards
- Electrical work near live overhead power lines
- Deaths involving Dothiepin in Victoria, 2000-2009
- Prescription shopping and real-time prescription monitoring
- Motorcycle riders fatalities occurring whilst travelling in groups
- Fitness to drive poly-substance abuse and psychiatric illness
- Total knee replacement with post operative multi-system organ failure from ischemic heart disease
- Mobile elevating work platforms: operator training for safe use
- Neonatal death, delay in second stage
- Combined drug toxicity and multiple prescriptions 'Doctor Shopping'
- Cardiac arrest and administration of Amiodarone
- Perforation of the sigmoid colon
- Deaths in a Corrections Victoria Context, 2000-2010 - Part A Deaths in custody / Part B: Deaths not in custody
- Excited delirium as a medical cause of death: concepts and controversies
- Review of Victorian Christmas holiday road toll (1999-2010)
- Trail bike rider safety in Victoria
- Rear overhang limits for light vehicles and trailers
- Victorian deaths in automobile impacts where installed airbags did not deploy, 2000-2010
- Jumping suicides at the West Gate Bridge following temporary barrier installation, May 2009-February 2011
- Acute myocardial infarction following cardiac valve replacement surgery
- Cerebral infarction complicating intracerebral haemorrhage
- Three-tiered ranking of Victorian local government areas by suicide rate
- Sepsis in the setting of management of an infected prosthesis
- Cyclist safety on Heidelberg Road - Hoddle Street overpass
- Rock fishing safety management plan
- Strategies to prevent deaths from butane inhalation
- Victorian deaths of people prescribed duloxetine, March 2008 - February 2011
- Victorian deaths involving Methadone, 2000-2010
- Victorian deaths resulting from assaults by crowd controllers, 2000-2010
- Motorcyclist deaths at official riding venues in Victoria
- Cases closed as unidentified skeletal remains 2007-2009
- Identification of filicide deaths 2010-11
- Victorian deaths in which methylamphetamine was present, 2008-2010
- Child deaths in driveways 2000-2011
- Principles for safe physical restraint of inpatients in adult psychiatric units
- Tractor-related deaths in the Latrobe Valley Court region, Victoria: 2000-2011
- Complications of acute aortic dissection in a man with ischemic heart disease
- Investigation into a cyclist death: similar deaths in Victoria and Australia
- Deaths from Pentobarbitone Toxicity, Victoria 2000-2010
- Briefing material: Protecting Victoria's Vulnerable Children Inquiry
- VicRoads data summary: cyclist collisions with vehicle doors
- Deaths by drowning associated with operation of vessels on Victorian waters (1 December 2005 - 1 December 2010)
- Victoria Police - Summary of deaths reported to Coroners Court of Victoria in 2010.

Coroners Prevention Unit collaborative projects

In addition to completing internal and external research referrals, the Coroners Prevention Unit also undertook nine collaborative research projects during the reporting period. Agencies involved in the collaborative projects included:

- Australian Institute for Suicide Research and Prevention
- Kidsafe Victoria
- Life Saving Victoria
- Melbourne University – School of Population Health
- Monash University Accident Research Centre – Victorian Injury Surveillance Unit
- Monash University – Faculty of Arts
- Monash University – Faculty of Medicine, Nursing and Health Sciences
- The Office of the Child Safety Commissioner
- Victoria Police.

Highlights from some of these projects are outlined below:

The University of Melbourne

In 2009 the Coroners Court of Victoria and the University of Melbourne School of Population Health were awarded an Australian Research Council Linkage Grant for a three-year study titled: *Learning from preventable deaths: a prospective evaluation of the impact of coroners' recommendations in Victoria.* The primary aim of the three-year study is to evaluate the impact of legislative reforms requiring statutory authorities and entities to respond to coroners' recommendations.

During the 2010-11 reporting period, ethics approval was sought and granted from the University of Melbourne Human Research Ethics Committee, the Department of Justice Human Research Ethics Committee and Victoria Police Human Research Ethics Committee.

Key achievements of the projects to date are the development and piloting of an interview instrument and the development of an online survey. All organisations who have responded to a coroner's recommendation since the *Coroners Act 2008* came into force will shortly be invited to participate in the survey and some will also participate in face-to-face interviews.

Australian Institute of Suicide Research and Prevention

The Coroners Prevention Unit and the Australian Institute of Suicide Research and Prevention have engaged in a collaborative research project on jumping suicide in Victoria. The aim of the study is to improve current understandings of populations at-risk for this highly lethal suicide method and to inform the development of suicide prevention interventions.

Deakin University

Deakin University and the Coroners Court of Victoria (via the Coroners Prevention Unit) have recently signed a Memorandum of Understanding with the stated intention of establishing a collaborative relationship with the primary aim of contributing to the reduction of the number of preventable deaths and the promotion of public health and safety.

The overarching objectives are to enhance the research capacity of both organisations and facilitate the development of joint research programs. The areas of research will primarily focus on patient safety, injury prevention and mental health.

Life Saving Victoria

The true extent of alcohol involvement among drowning deaths in Victoria, and those at risk is unknown. This lack of knowledge is a significant impediment to drowning prevention efforts. To address this issue, the Coroners Prevention Unit is collaborating with Life Saving Victoria in a research project examining alcohol-related drowning deaths over a 10-year period. This study will assist both coroners and life saving agencies in better understanding the association between alcohol consumption and drowning risk, and will provide an evidence base for the development of targeted prevention strategies for Victoria.

Victorian Systemic Review of Family Violence Deaths

The Victorian Systemic Review of Family Violence Deaths was established in 2009 to inform interventions that protect children and adults from family violence by considering the context in which these deaths occur.

During 2010-11 reporting period, reviews of family violence-related deaths continued with nine case review reports completed. Of these, one was completed as an inquest finding in April 2011. A number of other deaths are currently being heard at inquest.

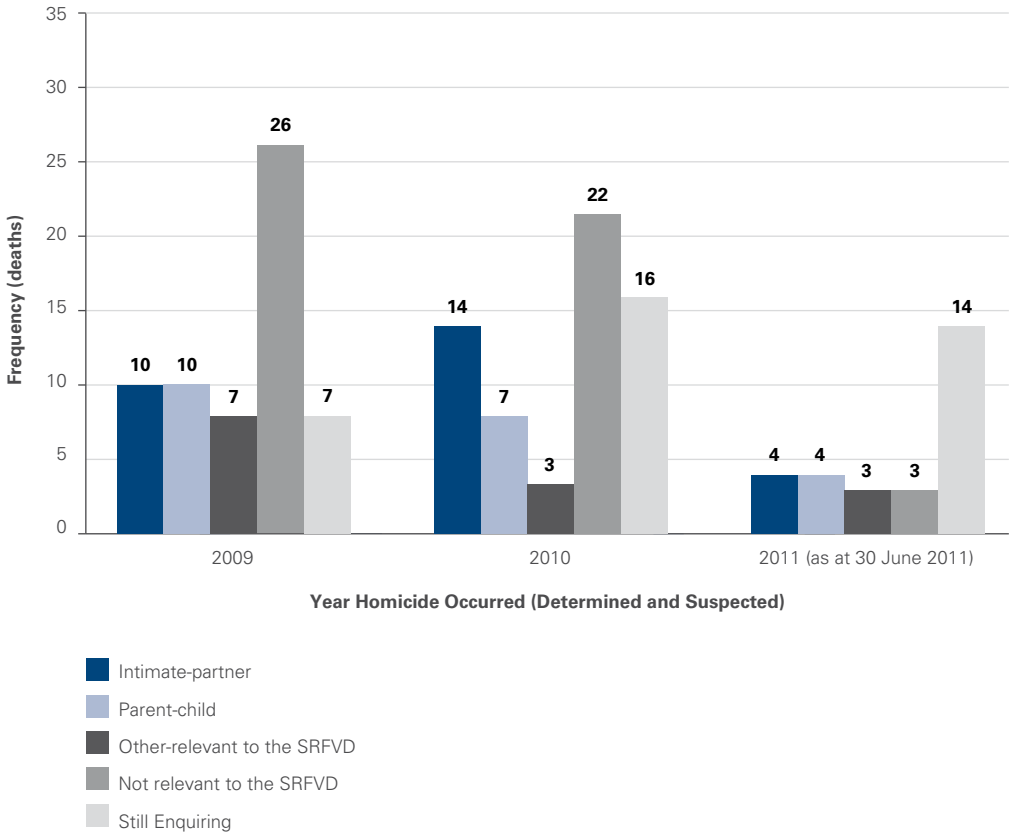
The review has continued to monitor homicides in Victoria to determine those that occurred in the context of family violence.

The table below shows that for the period 1 January 2009 to 30 June 2011, there were 150 suspected homicides in Victoria and of these, 62 (41.3%) have been identified as relevant to the review.

The review further determined that:

- intimate partner homicides occurred most frequently (45.2%)
- followed by parent-child homicides (33.8%), and;
- 13 homicides (21%) involved other familial relationships or occurred in a context of family violence (i.e. involving a bystander to family violence).

For 37 (24.7%) of the homicide incidents identified, further information is required to establish if the death is relevant to the review. This data includes open criminal and coronial investigations and is therefore subject to change as further information becomes available to the court.



* Figure 1: Categorisation of homicides by relevance to the SRFVD, Victoria 1 Jan 2009 – 30 June 2011

Prevention representations

The Coroners Prevention Unit also has representations in the following boards and committees:

- Australian Injury Prevention Network – membership
- Deakin University – several Coroners Prevention Unit members now have visitor status with the University, a couple have Clinical Lecturing positions and one is a Senior Clinical Lecturer. These positions are held in the School of Nursing, School of Medicine and School of Psychology.
- National Committee for Standardised Reporting of Suicide (convened by Suicide Prevention Australia) - membership
- Victorian Driveway Safety Working Committee – membership
- Victoria Police Road Fatality Review Panel – observer status
- Family Violence Interdepartmental Committee – observer status
- Department of Justice Family Violence Steering Committee - membership.

Driveway deaths working group

In April 2011, the Coroners Prevention Unit joined forces with Victoria Police and other agencies to promote driveway safety messages following a review of driveway deaths over the last 11 years.

A working group was established to explore a range of strategies aimed at increasing public awareness of driveway safety for Victorians.

The working group comprises:

- the Coroners Court of Victoria
- Victoria Police
- the Office of the Child Safety Commissioner
- Kidsafe Victoria
- VicRoads
- Transport Accident Commission
- Royal Children's Hospital; and
- the Department of Health.

Tragically, the review showed that 13 children had lost their lives in driveway-related fatalities in the period between January 2000 to April 2011 and that toddlers accounted for almost 70% of all fatal driveway incidents involving children.

Court Administration

Compliments and complaints register

During the previous reporting period the court embarked on a project to electronically collect, monitor and report compliments and complaints received by the court. The project involved the creation of an incident register to record feedback from families and external stakeholders as well as incidents that impact on service delivery.

In the 2010-11 reporting period the court received:

- 64 compliments
- 39 complaints
- 31 service delivery issues.*

* service delivery issues capture reports of gaps or failures in service delivery processes and includes reports about services outsourced by the court as part of the coronial process, such as work undertaken by funeral directors and the Victorian Institute of Forensic Medicine

Coronial reform post-implementation review

During the previous reporting period, the court began a review into the impact of the extensive reform undertaken within the jurisdiction as part of the implementation of the *Coroners Act 2008*.

In the 2010-11 reporting period the court began preparing for phase two of the review which included engaging consultants KPMG to undertake detailed investigations into the court's operations by:

- reviewing workflow processes and allocations to help identify areas where processes can be streamlined and/or double-handling reduced
- identifying performance benchmarks across all levels of the organisation that are achievable and realistic
- developing key performance indicators to help the court recognise what is needed in order to reach those performance benchmarks
- reviewing the roles and responsibilities assigned to each area of the court to establish if any adjustments are required
- analysing the underlying cost structure of the court to determine the most appropriate allocation of current resources and to assess the cost base in relation to the outputs expected of the court
- assisting the court to align its operations with the International Framework for Courts Excellence.

This phase is expected to begin October 2011.

Relationship review

In June 2011, the Attorney-General the Honourable Robert Clark MP requested that the State Services Authority conduct a review of the relationship between the court and the Victorian Institute of Forensic Medicine. The request was made following a recommendation made by the Victorian Ombudsman in his report to Parliament *"Investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee" in May 2011.*

The Ombudsman recommended in his report that the Attorney-General: *Consider reviewing the relationship between the Institute and the Victorian Coroner to ensure that the statutory functions of the State Coroner are supported and not impeded.*

The State Services Authority is expected to deliver its findings and recommendations to the Attorney-General in October 2011.

Deceased transportation services

Under the *Coroners Act 2008,* a deceased person whose death is reportable is taken into the care of the coroner while medical examinations are undertaken as part of the investigation into the death.

The court is therefore charged with the responsibility of removing and transferring deceased persons from the place of death where that death occurs anywhere in the State to a coronial mortuary. The court engages external contractors, usually private funeral directors, to provide this service. There are currently 36 separate contractors (one metropolitan and 35 regional) providing this service.

The cost of deceased persons transportation has continued to rise from $561K in 2004-05 to $2.081M in 2010-11 due to a combination of:

- a lack of interest in undertaking coronial transfers
- a lack of market competition within the funeral director industry driving up prices
- the complexity of the service requirements (delivery to nominated mortuaries within a specified timeframe); and
- increases in the distances now being required for delivery to a coronial mortuary (the result of declining regional pathology services requiring more transfers to Melbourne)
- absorbing the cost of returning deceased persons to regional locations (until two years ago these were included as part of private funeral arrangements fees paid by families).

In a bid to address these growing costs and improve the transportation service, the court undertook a market review during the reporting period in preparation for renewing existing contracts within the bounds of probity. The research resulted in the development of a prime service provider model that would have the capacity to deliver a consistent service across the State.

Tenders for the prime service provider model opened in February 2011 and closed in March 2011. The results of the tender applications are expected to be announced early within the next reporting year.

Transcripts

Delays in receiving transcripts of court hearings from the Victorian Government Recording Services (VGRS) has been identified as a serious impediment to the court's ongoing efforts to reduce waiting periods between the last day of an inquest and the handing down of the coroner's finding.

From March to June 2011 the court began monitoring the timeframes from when a matter was heard in court to when the court received a copy of that written transcript.

A review of 38 matters during this period identified that the court waited an average of 89 days to receive a copy of a transcript. The shortest turnaround period for transcripts was eight days and the longest period was 593 days.

Such delays have a significant impact on the court's efficiency including:

- creating added stress to families who are waiting for the investigation into their loved one's death to be finalised by the completion of the finding
- increased workload on the court's registry and counselling teams who provide ongoing support to families during this waiting period
- increased workload for coroners who must schedule significant periods of time in chambers in order to read the transcript to re-familiarise themselves with the evidence.

The court will attempt to address these issues with VGRS in the next reporting period.

Relativity

Relativity is a new internally accessible web-based data management system created and installed to house all data not contained within the new CourtView system. For example, it will house counselling notes created by the Family and Community Support Service team, along with requests made to the Records and Media teams.

The Coroners Prevention Unit (CPU) has four distinct, but connected, modules within the Relativity database:

- CPU Database
- Recommendations and Response Logging
- Coroners Research Information System for Prevention (CRISP)
- CPU Work Logging.

The data contained within each module is linked using the court reference number, allowing the team to access connected information on each coroners case or topic.

Coroners Prevention Unit database

This database contains unit record information on all case numbers generated by the court from 1 January 2000 to present, housed in an analysis ready form. Each unit record contains a set of pre-defined codes that were assigned by the unit using information from various sources, including the paper court record and the local case management system. This includes first making a decision as to whether the case is a reportable death, reportable fire or reviewable death (in accordance with the *Coroners Act 2008* Sections 4, 5 and 30). Once the unit assigns a case as a reportable death, they further classify it using broad categories of death. This coding is done in accordance with Chapter 20 of the International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10).

The codes assigned by the unit at the notification stage continue to be reviewed as further information becomes available through the course of the coroners' investigations. The CPU then applies final coding once the coronial investigation has been completed and a finding delivered.

The unit use this information to inform topic-related investigations they are conducting on behalf of the coroner to support their case investigations.

Recommendation and response logging

Under Section 72 of the *Coroners Act 2008,* the coroner has new powers in relation to recommendations. Any recommendation made to a public statutory authority or entity must be responded to in writing within three months from the date of receipt of that recommendation. Any response received must be published on court website, unless otherwise ordered by a coroner.

One of the roles of the Coroners Prevention Unit is to log all of these recommendations and responses and ensure all responses are published on the website in a timely manner. The Relativity database provides a mechanism to manage this process efficiently, by allowing all relevant data to be logged and reported.

CRISP

The Coroners Prevention Unit has developed the Coroners Research Information System for Prevention (CRISP); an electronic data storage and retrieval system, for information and research material generated for coroners' death investigations. The information management system manages research information gathered and generated during the investigations into preventable deaths, injury prevention and public health and safety. This data is housed within the Relativity database and is easily searchable enabling the team to have access to all data previously gathered and referenced on a particular topic.

Records management

The court receives many requests for access to information and documents contained within coronial files. As such the court has a records management team to track, coordinate and manage these requests, including liaising with the Public Records Office of Victoria.

During the reporting period the court received 1412 requests for access to coronial documents.

Finances

Overview

The Coroners Court of Victoria has undergone significant and continuous reform over the last five years, since the Victorian Parliamentary Law Reform Committee reported to Parliament in September 2006 on its review of the *Coroners Act 1985.*

During this period, the court has received some additional funding from the Victorian Government to assist with the implementation of the reforms, however, the court continues to experience significant cost pressures, including the escalation of costs associated with operating its core business, some of which are beyond the control of the court. Such pressures continue to impact on the court's ability to provide an efficient and modern service for Victorian families whose death of a loved one is investigated by the court.

Legal costs

One cost pressure experienced by the court was the cost of obtaining expertise from external lawyers, which increased from $583K in 2009-10 to $1.225M in 2010-11.

As noted on page 17 of this report, it is hoped that the establishment of an in-house legal service will significantly reduce this cost.

Deceased transportations costs

The cost of transporting deceased persons has significantly increased during the past six financial years. Total costs increased from $561K in 2004–05 to $2.081M in 2010–11. This represents a 270% increase, which is of great concern to the court and places a significant burden on the court's operating budget. Other notable points include:

- Metropolitan deceased person transportation costs have fluctuated, peaking in demand during the 2008-09 heatwave and bushfires, and increasing from $256K in 2004–05 to $760K in 2010-11. This represents a 197% increase during the past six years
- Regional deceased person transportation costs have increased from $207K in 2004–05 to $887K* in 2010-11, representing a 329% increase during the past six years
- Regional deceased person transportation costs accounted for 71% of the total deceased person transportation costs paid by the court from 2007-2010 – despite comprising only 20% all deceased person transfers.**
- The number of deceased person transportations has decreased from 5286 in 2009 to 4325 in 2010, yet the cost of the contracts have increased from $1.44M in 2009-10 to $2.081M in 2010-11.

* Figures do not include the costs of returning deceased persons.

** This figure can be explained by the long distances often required for regional deceased person transfers removals. It is also noted that metropolitan deceased person transfer returns are not paid for by the court but the cost of deceased person transfer returns to regional areas are paid for by the court.

The causes for these recent cost increases include:

- The court did not receive a single tender when the Melbourne metropolitan contract was advertised in December 2009 resulting in an urgent contract extension negotiation with the current service provider. The contract extension resulted in a 150% price increase for the provision of contracted services in the Melbourne metropolitan areas
- Increases in service demand as noted
- Lack of competitive procurement processes, resulting in a lack of market tension and ability for current contractors to increase prices without scrutiny.

Costs associated with the Victorian Systemic Review of Family Violence Deaths

The Victorian Systemic Review into Family Violence Deaths has earned an international reputation for its innovative approach to investigating deaths associated with family violence, its examination of risk factors that may have contributed to the deaths, and its formulation of systemic interventions to protect vulnerable children and adults from family violence.

However, after being established and funded in 2009, in 2010-11 the court has not been provided with funds to maintain the service. Given the importance of the work of this specialised team and support they are able to provide to the coronial investigations, the court has continued to operate the program throughout the reporting period without the funding it had anticipated. The cost to the court was $250K.

Indirect redevelopment costs

The costs associated with the court maintaining its business operations over two locations during the period of redevelopment of its Southbank site continues to be a burden on the operation budget of the court. The added cost to operations includes:

- costs associated with running separate administration and mail systems
- increased courier costs to transfer records and information including medical records and coronial files between the two locations
- cost of lost productivity due to coroners and staff having to commute back and forth between the two locations for pathology and duty meetings.

The estimated costs of this dislocation during the reporting period was $483K.

Costs associated with CourtView

During the reporting period the court dedicated significant resources to the CourtView project. Direct project-related costs required to be absorbed by the court included:

- $104K for a business analyst to assist in the data conversion and extraction from the existing Suncor system to the CourtView product
- $93K for a business analyst to undertake configuration of the court business processes for CourtView purposes
- $40K for a project officer to prepare training manuals and deliver training.

Total estimated direct cost during the reporting period was $237K

Other resources required for the project that impacted directly on court productivity included:

- Significant front line staff resources to assist the ICMS project team to align coronial business processes with the CourtView product
- CEO and Principal Registrar participation in numerous steering committee and change control board meetings.

Bushfire IT costs

When the Victorian Bushfires Royal Commission was established to inquire into the Black Saturday fires a highly functional IT system was created enabling secure storage of the thousands of documents, statements, reports and images required to investigate those deaths and fires.

When the commission concluded its work following the handing down of its final report, the court inherited its IT system to enable access to those 103,000 documents for the purposes of the coronial investigations into the Black Saturday deaths and fires.

Unfortunately, the Department of Justice was unable to integrate the commission's IT environment with the court's current IT environment, and the court was effectively unable to access any of the commission's evidentiary materials. The only alternative available to the court to resolve this issue was to create a separate stand-alone IT network to house the commission's information in such a way that enabled the court to access this information. This system, called Relativity, is expected to be fully operational by late 2011.

However, the cost to the court during the reporting period to create this new stand-alone system and network and to transfer the data from the commission's IT system into it was an estimated $497K. Whilst the court received some preliminary funding to cover the cost of creating the new system, no funding has been provided for the ongoing maintenance and support of this network and system.

Additional positions required to deliver core business

The reforms undertaken at the Coroners Court of Victoria arising from the September 2006 Report to Parliament by the Victorian Parliamentary Law Reform Committee of its review into the *Coroners Act 1985* were extensive and have significantly changed the way the court undertakes its business. However, apart from additional funding being allocated for the redevelopment of the Coronial Services Centre, the establishment of the Coroners Prevention Unit, and the introduction of the new Act, the courts output appropriations have not changed. This means that the additional staffing required to undertake core business under a very different service delivery model, which emphasises the level and quality of support provided to grieving families, was approved and funded yearly by the Department of Justice without adjusting the court's recurrent operational budget. This has contributed significantly to the court's operational deficit. The table below outlines the court's staffing establishment, which includes 21.2 full-time equivalent positions that are approved but unfunded.

Average full-time equivalent as at 30 June 2010

	SPECIAL APPROPRIATION	BASE BUDGET	ERC FUNDED	BUSHFIRE FUNDED	APPROVED – NOT FUNDED*	TOTAL
Judicial Officers	9	-	-	-	-	9
Ongoing staff	-	29.4	11.6	-	19.9	60.9
Fixed-term staff	-	0.6	-	6.6	1.3	8.5
Total Average FTE	9	30	11.6	6.6	21.2	78.4

* Approved not funded through the court's recurrent operational budget.

Financial Statement

Comprehensive operating statement for the financial year 2010-11

	NOTES	2008-09	2009-10	2010-11
Income from transactions				
Output Appropriation		8,188,700	8,469,100	8,731,700
Special Appropriation		1,673,555	1,570,498	2,056,417
Other income		-	-	(317)
Total Income		**9,862,255**	**10,039,598**	**10,787,800**
Expenses from transactions				
Employee benefits	Note 1	5,395,337	6,907,580	7,948,768
Depreciation and Amortisation		410,219	418,255	421,405
Interest expense		2,167	3,504	2,974
Grants and other transfers	Note 2	-	27,572	32,610
Supplies and Services	Note 3	2,215,838	1,977,645	3,262,224
Deceased removal and transfers	Note 4	1,737,021	1,441,018	2,080,571
Total Expense from transactions		**9,760,583**	**10,775,574**	**13,748,552**
Net result from transactions (net operating balance)		**101,672**	**(735,976)**	**(2,960,752)**
Other economic flows				
Other gains (losses) from other economic flows	Note 5	(5,444)	(550)	(760)
Total other economic flows included in net result		**(5,444)**	(550)	(760)
Net Result		**96,229**	**(736,525)**	**(2,961,512)**

Note 1 – Employee benefits

See Average full-time equivalent table on page 44.

Note 2 - Grants and other transfers

Grant Payment to the University of Melbourne working collaboratively with CPU on a project partially funded by the Australian Research Council (ARC): "Learning from Preventable Deaths: A prospective evaluation of reforms to Coroner's recommendations powers in Australia".

Note 3 - Supplies and Services

	2008-09	2009-10	2010-11
Contractors and consultants	209,557	676,447	838,662
Legal Professional Services	660,112	583,567	1,225,705
Medical Professional Services	37,249	78,212	149,983
Information Technology	93,239	148,121	163,409
Printing and Stationery	335,123	143,420	201,418
Postage and Communication	137,823	105,424	165,976
Travel and Personal Expenses	63,926	70,046	51,015
Staff Training and Development	25,132	57,989	47,384
Witness Expense	19,460	42,782	36,492
Other Operating Expense	634,216	71,637	382,180
Total Supplies and Services	**2,215,838**	**1,977,645**	**3,262,224**

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

	2008-09	2009-10	2010-11
Metropolitan areas	644,704	385,683	749,851
Regional areas	1,092,317	1,055,335	1,330,720
	1,737,021	**1,441,018**	**2,080,571**

Note 5 - Other gains(losses) from other economic flows

Net gain/(loss) from the revaluation of long service leave liability due to changes in assumptions.

Statistics and reports – operational

Case initiations and closures

	2008-09	2009-10	2010-11
Cases Opened	6341	5311*	4857
Cases Closed	4728	5573	5586
Case clearance rate (cases opened/cases closed)	75%	105%	115%
Number of cases referred to the court by the Registry of Births, Deaths and Marriages	787	742	657

* The figure for 2009-10 includes 5305 cases opened involving a death, plus an additional six cases opened involving fires without death.

The court is conducting examinations into the continued decline in the number of cases being reported. The last time the court had less than 5000 deaths reported to it was in 2006-07. Such a decline does not fit with projected expectations that both a growing and ageing population would result in more, not fewer, deaths being reported to the court.

Court data reveals that the decline in the number of deaths reported can be largely explained by a significant reduction in the reporting of natural causes deaths, that is deaths that should be reported because they are unexpected or unexplained but upon medical investigation the cause of death is determined to be natural.

Investigations are underway to determine whether Section 17 of the Act is possibly being misinterpreted. For example, the court is investigating whether some hospitals or doctors may be incorrectly assuming that if a death was unexpected, but most likely the result of natural causes, there is no requirement to report it. The court will consult with hospitals and doctors throughout the next reporting period to ensure that any unintentional under-reporting of reportable deaths is identified and addressed.

Case progress

From the date of initiation to the end of the financial year

	2008-09	2009-10	2010-11
0-12 months	4034	3001	2263
12-24 months	1254	1558	850*
> 24 months	340	1027	1396*
Total number of lodgements pending	**5628**	**5586**	**4509**

* 606 of the cases aged 12 months and greater in 2010-11 cannot be actioned as they are currently the subject of police criminal investigations or court proceedings in other jurisdictions. As such, the coronial investigation is suspended until the police investigation and/or other court proceedings are complete.

Objections to autopsy

	2009-10	2010-11
Objections upheld	285	61
Objections refused	84	70
Objections withdrawn	41	16
Total number of objections	410**	147

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

** Total figures in the 2009-10 reporting period include 282 objections made under the previous *Coroners Act 1985*

Findings

FINDINGS INTO DEATH WITH INQUEST	FINDING INTO FIRES WITH INQUEST	FINDING INTO DEATH WITHOUT INQUEST	FINDING INTO FIRES WITHOUT INQUEST	TOTAL
142	2	5050*	2	5194

* Finding into Death Without Inquest includes 1444 natural causes deaths.

Coronial recommendations

Total recommendations

Of the 5194 findings made by coroners during the reporting period, 53 contained recommendations. A coroner can make more than one recommendation in a single finding. The table below indicates the total number of recommendations made by coroners during the reporting period.

	RECOMMENDATIONS FROM FINDINGS HANDED DOWN UNDER THE CORONERS ACT 1985		RECOMMENDATIONS FROM FINDINGS HANDED DOWN UNDER THE CORONERS ACT 2008		TOTAL NUMBER OF COMBINED METRO AND REGIONAL RECOMMENDATIONS
	METRO	REGION	METRO	REGION	
Total number of recommendations made 2009-10	91	17	46	5	159
Total number of recommendations made 2010-11	8	-	100	36	144

Responses to recommendations

The below table indicates the number of responses to recommendations received by the court during the reporting period.

	RECOMMENDATIONS CONTAINED IN FINDINGS HANDED DOWN UNDER THE CORONERS ACT 1985	RECOMMENDATIONS CONTAINED IN FINDINGS HANDED DOWN UNDER THE CORONERS ACT 2008	TOTAL NUMBER OF RESPONSES RECEIVED
Responses to recommendations received	2	50	52

* Some responses received relate to recommendations made during the 2009-10 reporting period
* Figures do not include required responses to recommendations made during the 2010-11 reporting period that were not due within the same reporting period.

Court locations

CORONERS COURT OF VICTORIA
Level 11, 222 Exhibition Street
MELBOURNE
Ph 1300 309 519
Fax 1300 546 989

ARARAT LAW COURT
Cnr. Barkly & Ingor Streets
PO Box 86
ARARAT 3377
Ph 5352 1081
Fax 5352 5172

BAIRNSDALE LAW COURT
Nicholson Street
PO Box 367
BAIRNSDALE 3875
Ph 5152 9222
Fax 5152 9299

BALLARAT LAW COURT
100 Grenville Street South
PO Box 604
BALLARAT 3350
Ph 5336 6200
Fax 5336 6213

BENDIGO LAW COURT
71 Pall Mall, PO Box 930
BENDIGO 3550
Ph 5440 4140
Fax Office 5440 4173
Court Coordinator:
Ph 5440 4110

CASTLEMAINE LAW COURT
Lyttleton Street
PO Box 92
CASTLEMAINE 3450
Ph 5472 1081
Fax 5470 5616

ECHUCA LAW COURT
Heygarth Street
PO Box 76
ECHUCA 3564
Ph 5480 5800
Fax 5480 5801

GEELONG LAW COURT
Railway Terrace
PO Box 428
GEELONG 3220
Ph 5225 3333
Fax 5225 3392

HAMILTON LAW COURT
Martin Street
PO Box 422
HAMILTON 3300
Ph 5572 2288
Fax 5572 1653

HORSHAM LAW COURT
Roberts Avenue
PO Box 111
HORSHAM 3400
Ph 5362 4444
Fax 5362 4454

KERANG LAW COURT
Victoria Street
PO Box 77
KERANG 3579
Ph 5452 1050
Fax 5452 1673

KYNETON LAW COURT
Hutton Street
PO Box 20
KYNETON 3444
Ph 5422 1832
Fax 5422 3634

LATROBE VALLEY LAW COURT
134 Commercial Road
PO Box 687
MORWELL 3840
Ph 5116 5222
Fax 5116 5200
Court Coordinator:
Ph 5116 5223

MARYBOROUGH LAW COURT
Clarendon Street
PO Box 45
MARYBOROUGH 3465
Ph 5461 1046
Fax 5461 4014

MILDURA LAW COURT
Deakin Avenue
PO Box 5014
MILDURA 3500
Ph 5021 6000
Fax 5021 6010

PORTLAND LAW COURT
67 Cliff Street
PO Box 374
PORTLAND 3305
Ph 5523 1321
Fax 5523 6143

SALE LAW COURT
Foster Street
(Princes Highway)
PO Box 351
SALE 3850
Ph 5144 2888
Fax 5144 7954

SHEPPARTON LAW COURT
High Street
PO Box 607
SHEPPARTON 3630
Ph 5821 4633
Fax 5821 2374

STAWELL LAW COURT
Patrick Street
PO Box 179
STAWELL 3380
Ph 5358 1087

ST ARNAUD LAW COURT
Napier Street
ST ARNAUD
(C/- PO Box 17)
St Arnaud 3478)
Ph 5495 1092

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

WANGARATTA LAW COURT
Faithfull Street
PO Box 504
WANGARATTA 3677
Ph 5721 0900
Fax 5721 5483

WARRNAMBOOL LAW COURT
218 Koroit Street
PO Box 244
WARRNAMBOOL 3280
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