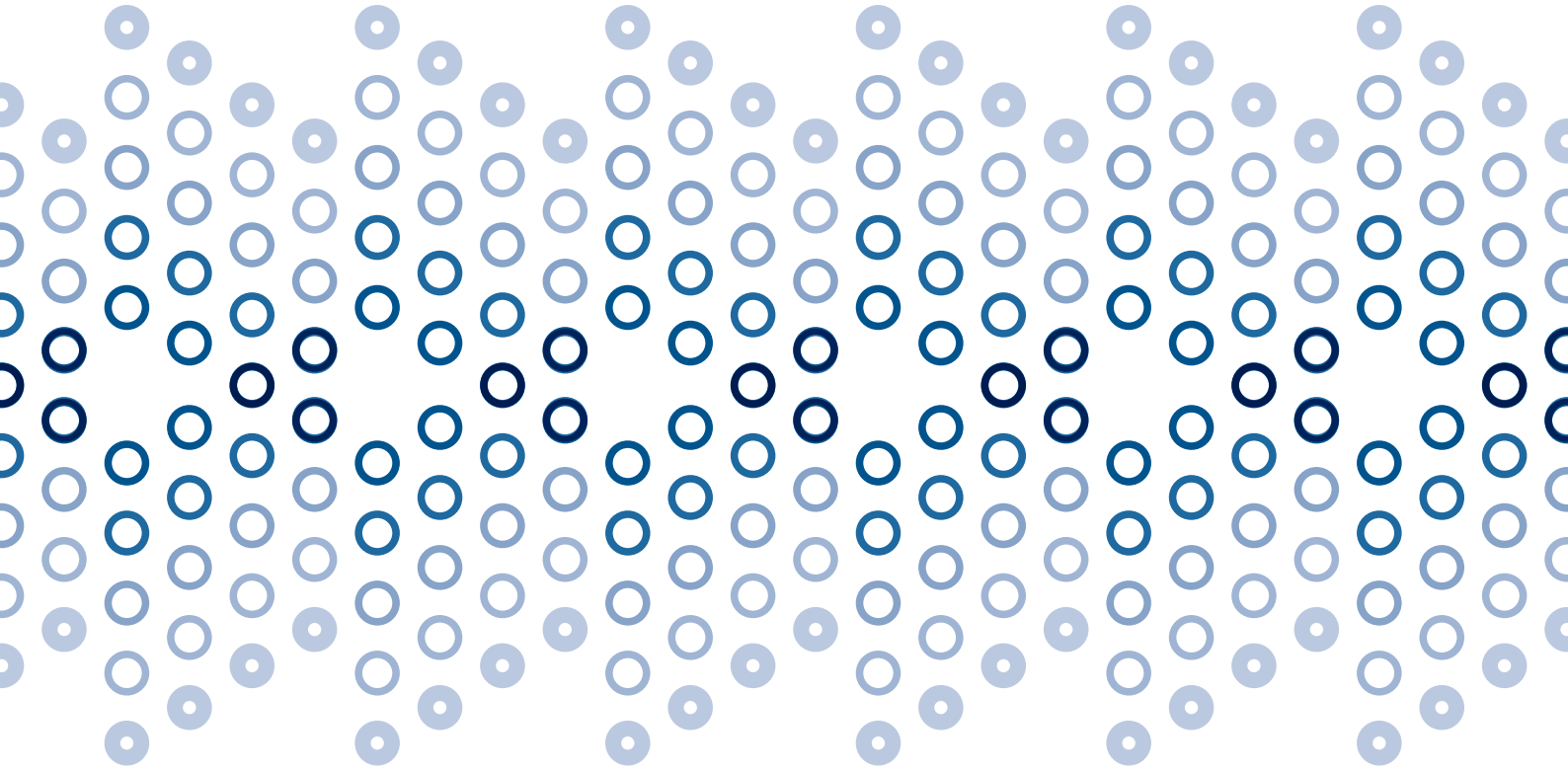
2013–14
Annual Report
Coroners
Court of Victoria



Coroners Court
of Victoria

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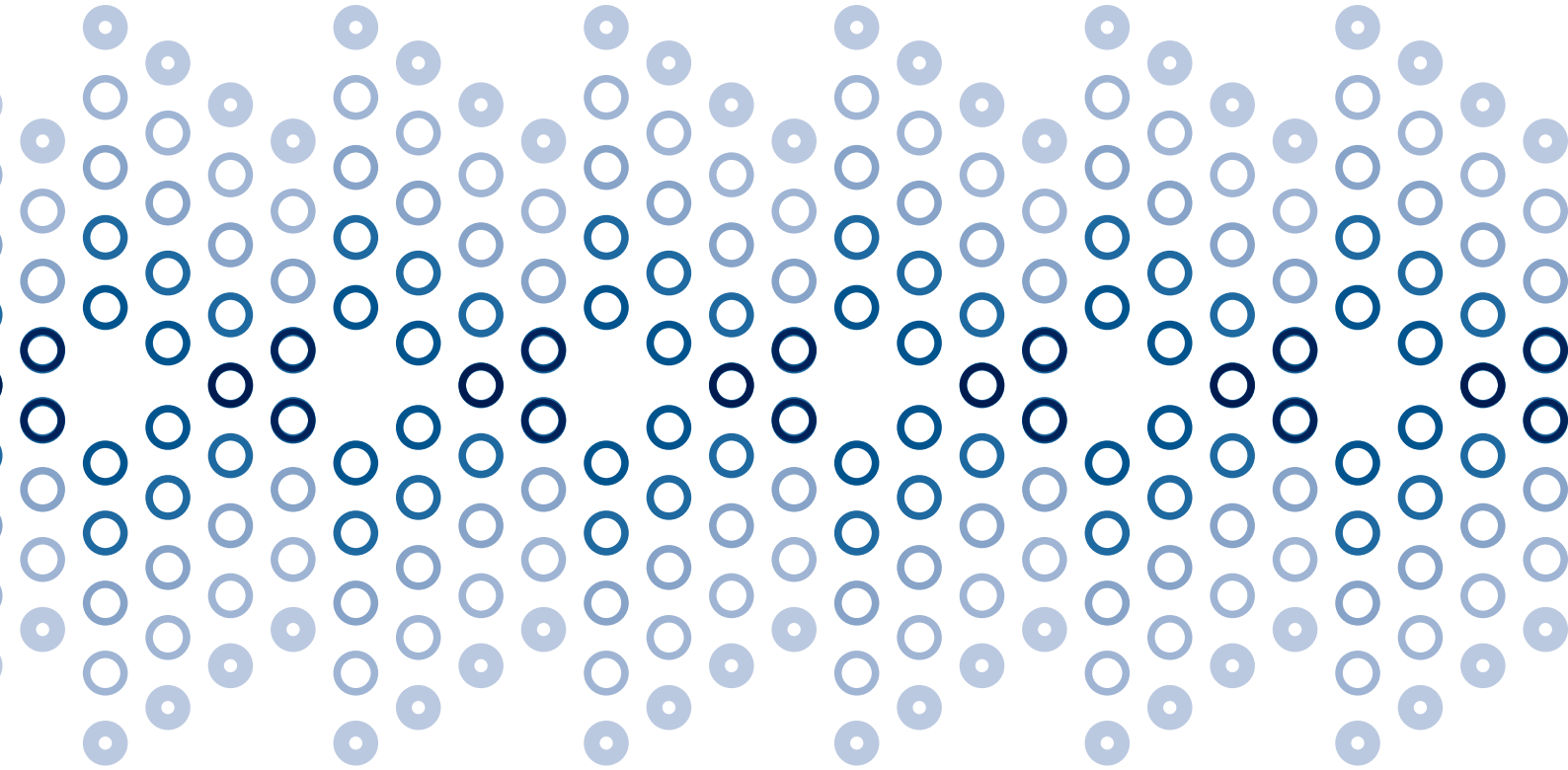


Coroners Court of Victoria

19 September 2014

The Honourable Robert Clark MP
121 Exhibition Street
Melbourne 3000

Dear Attorney-General

In accordance with the requirements under Section 102 of the *Coroners Act 2008*, I am pleased to present the 2013–14 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 2013 to 30 June 2014.

Yours sincerely

Judge Ian Gray
State Coroner

Report from the State Coroner

I am very pleased to present my second annual report on the operations of the Coroners Court of Victoria (the Court). By far the most important development in the last twelve months was the restructure of the Court and the commencement of the new operating model. The Chief Executive Officer has covered this in detail in her report and noted the significant improvement in the Court's performance. She also referred to the Court's success in bringing in a balanced budget. I am pleased with this outcome, but I sound a cautionary note: The Court's budget is tight and whilst remaining fully committed to efficiency and delay reduction, there will be challenges. These pressures arise from increasing numbers of reportable deaths requiring investigation.

Report on the work of the Coroners Prevention Unit (CPU) details the breakdown of the death types in respect of which the CPU has provided advice and assistance to coroners. The work of the CPU is of critical importance to the Court's ability to identify, research and articulate recommendations aimed at reducing preventable deaths in Victoria. In 2013–14, key areas of investigation again included deaths from prescription drug overdose and the potential benefits of real time prescription monitoring; and in respect of family violence deaths, a focus on risk assessment systems and the integration of responses across agencies to identify risk. These subjects will be again under consideration in the coming year in the context of a number of investigations and inquests. I note also the very important work being done on the continued development of the Victorian Suicide Register.

I record my gratitude to the Victorian Institute of Forensic Medicine, its outgoing Director, Professor Stephen Cordner and its incoming Director, Professor Noel Woodford, Manager of the Coronial Admissions and Enquiries Office, Dr Jodie Leditschke and staff who continue to provide outstanding forensic services for the Court and the community.

I extend my thanks to the Police Coronial Support Unit, members of Victoria Police who assist coroners in and out of Court on a daily basis.

I acknowledge the work of the volunteers of the Court Network who, year after year, provide support to so many families and witnesses who again find themselves at the Coroners Court.

I thank the Court's Chief Executive Officer, Samantha Hauge, for her strong support, for her leadership in the Court and for the many achievements she has made over the twelve months including the achievement of a balanced budget in difficult circumstances, the highly successful planning of the move back to Southbank and, above all, the implementation of the new operating model.

I thank all members of the Court staff – managers, administrators, registrars, solicitors and others who display a remarkable level of commitment, compassion and dedication in this Court. They work hard and exhibit great personal resilience in the face of difficult, stressful and sometimes traumatic circumstances. I also thank my Executive Assistant Nola Los, not only for supporting me, but for her work with all coroners. Last and certainly not least, I extend my thanks to my fellow coroners for their continued hard work, commitment, dedication and support.

Judge Ian Gray
State Coroner

Report from the Chief Executive Officer

It is with pleasure that I report on the administration of the Coroners Court of Victoria (the Court). Our Annual Report provides an opportunity for the Court to demonstrate accountability to the Victorian Parliament, public and importantly, those Victorian families who find themselves involved in our jurisdiction.

On 1 August 2013, we launched the new operating model for the Court. This was a culmination of a 12 month project that sought to identify process and organisational improvements to create a more efficient coronial system and pursue our strategic direction of moving towards a more modern, sustainable Court of Excellence. The main drivers for the project lay in the ongoing major operational, financial and caseload pressures in the Court. The new operating model provides increased support to coroners, better aligning the skills of staff with the core requirements set out in the *Coroners Act 2008*, and better integration of service delivery across the organisation and with the Victorian Institute of Forensic Medicine (VIFM).

A post-implemention review was recently conducted, and whilst not yet concluded, the results demonstrate the new model is meeting operational requirements and has seen a significant improvement in performance. I am delighted to report that in the 11 months since the implementation of the new model, there continues to be a notable increase in case finalisation and a concomitant decrease in the average age of cases under investigation.

Also of note during the reporting period is the Court's budget. For the past three years, the Court has recorded a significant deficit (ranging from 2.5 to 1.5 million). This year, I am pleased to report we have achieved an underspend in both our Annual Appropriations and Special Appropriations budgets. This is a significant achievement and we will continue to work hard to ensure this year's actual spend is again in line with our allocated budget.

On 1 July 2014, legal history will be made when all Courts and the Victorian Civil and Administrative Tribunal (VCAT) separate from the Department of Justice and form their own statutory authority; Court Services Victoria (CSV). This will be a tremendous achievement and, for the first time, will see the Courts and VCAT directly reporting to Parliament.

After five years, the redevelopment of the State Coronial Services Centre in Southbank is almost complete. Coroners, staff and the Police Coronial Support Unit will relocate back on 25 July 2014 to occupy a new purpose-built Coroners Court. Upon return, the Court will also be reunited with its close partner, the VIFM. The new state of the art facility will reunite the Justice and Forensic services, providing a more efficient coronial system ready to meet its current and future needs for the Victorian community.

This has been a very challenging year for our staff, particularly undergoing the operational review, and I thank them for their patience, contribution and professionalism during this time. The year's case finalisation rates reflect an outstanding achievement. Such a result cannot be achieved without dedication and hard work and I commend the efforts of staff; their willingness to adapt to the changed environment and the continual strive to provide improved service delivery. The ongoing compassion and care the staff provides to families is also a credit to their professionalism and dedication to the coronial jurisdiction. Finally, I would like to thank our State Coroner, Judge Ian Gray, for his encouragement, support and leadership.

Samantha Hauge
Chief Executive Officer

The Coroners Court of Victoria

The Coroners Court of Victoria was established on 1 November 2009 when new legislation, the *Coroners Act 2008* (Vic) (the Act), came into effect. The implementation of the Act represented the most significant reform of the Victorian coronial jurisdiction in 25 years. Under the new Act, the former State Coroner's Office was re-established as the Coroners Court of Victoria. The Act established the Coroners Court of Victoria as a specialist inquisitorial court.

The Court's statutory obligations are to find, where possible, identity, cause and circumstances of reportable deaths and fires. A defining feature of the Act is to strengthen the prevention function of the Court. The prevention function refers to the capacity of the jurisdiction to contribute to public health and safety through coroners' findings, and the development of comments and recommendations that are targeted at the reduction of preventable deaths and fires. Coroners maintained their discretion to make recommendations to any Minister, public statutory authority or entity relating to issues of public health and safety and the administration of justice. Under the Act, 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

The Jurisdiction of the Coroner

The Coroners Court of Victoria has jurisdiction under the *Coroners Act 2008* (Vic) 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. Inquests are held both at the Coroners Court of Victoria in Melbourne and in regional Magistrates' Courts. The map below 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 6,260 reportable deaths reported to the coroner, an increase of 1,357 reportable deaths in the previous reporting period.

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, or 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 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 seven* reviewable deaths reported to the Court, an increase of two reviewable deaths from the previous year.

** figure excludes reviewable deaths that were also deemed reportable deaths*

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 circumstances in which it occurred.

During the reporting period, there were 16 fires with death reported to the Court, a decrease of six fires with death recorded in the previous reporting period.

There were six fires without death reported, an increase of four in the previous reporting period.

Operational Structure of the Coroners Court of Victoria

The Court is comprised of nine full-time coroners and two reserve coroners, including the State Coroner and the Deputy State Coroner. In Melbourne, the Court is staffed by in-house solicitors, registrars, family liaison officers, 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, some regional Magistrates are assigned as coroners and perform coronial duties and functions. There have been some recent changes to regional coronial investigations within the reporting period and this is explored in further detail on page 16.

The Coroners

State Coroner
Judge Ian Gray

Deputy State Coroner
Mr Iain West

Coroners
Ms Audrey Jamieson
Ms Caitlin English (from March 2014)
Ms Heather Spooner (retired February 2014)
Ms Jacinta Heffey
Ms Jacqui Hawkins (from January 2014)
Dr Jane Hendtlass (to December 2013)
Mr John Olle
Ms Paresa Spanos
Mr Peter White
Mr Phil Byrne
Ms Rosemary Carlin (from March 2014)

Court Administration

Chief Executive Officer
Ms Samantha Hauge

Principal Registrar
Ms Margaret Craddock

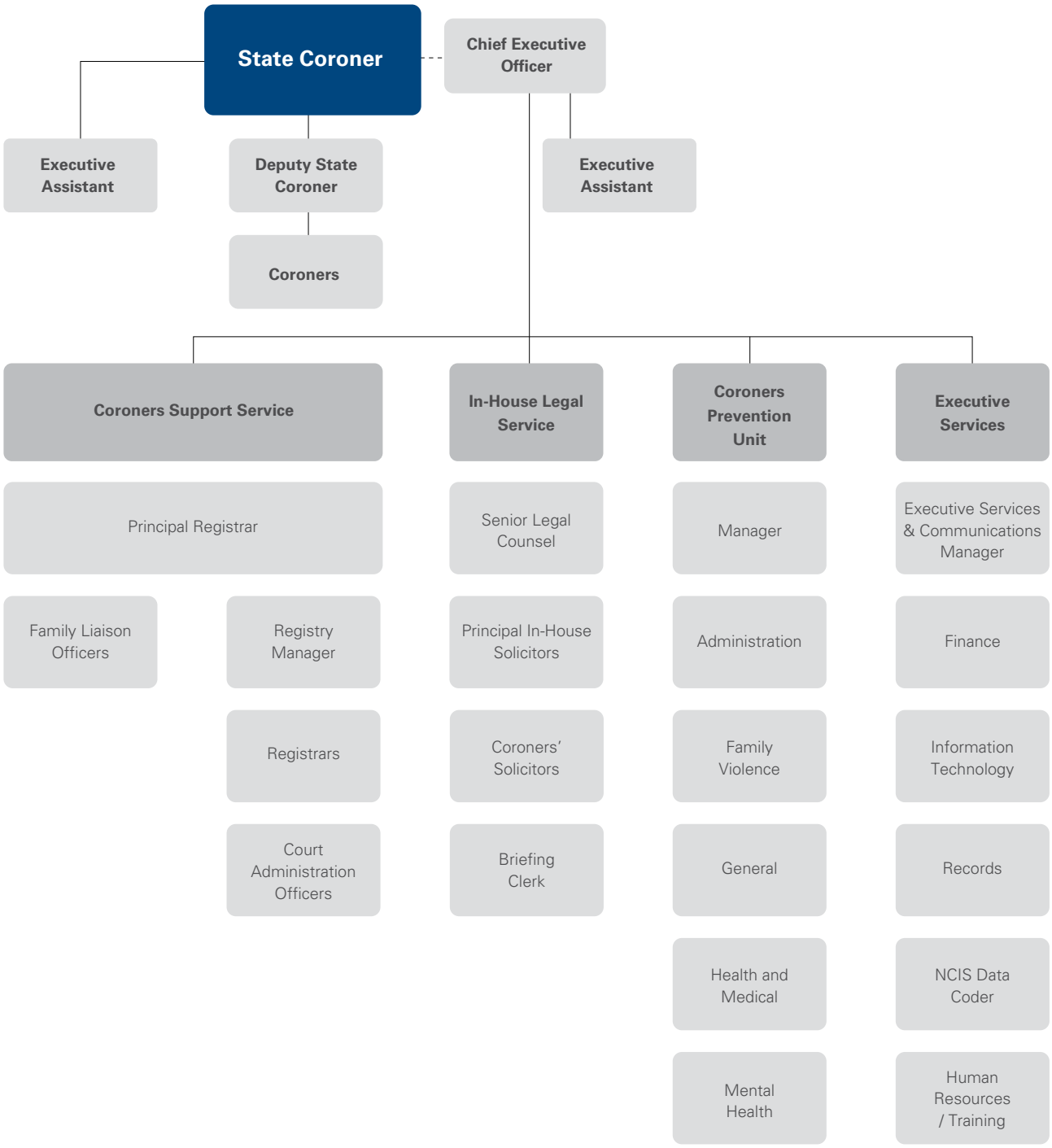
Executive Services Manager
Ms Sheree Argento

Coronial Liaison Manager
Ms Kellie King

Senior Legal Counsel
Ms Jodie Burns (from March 2014)

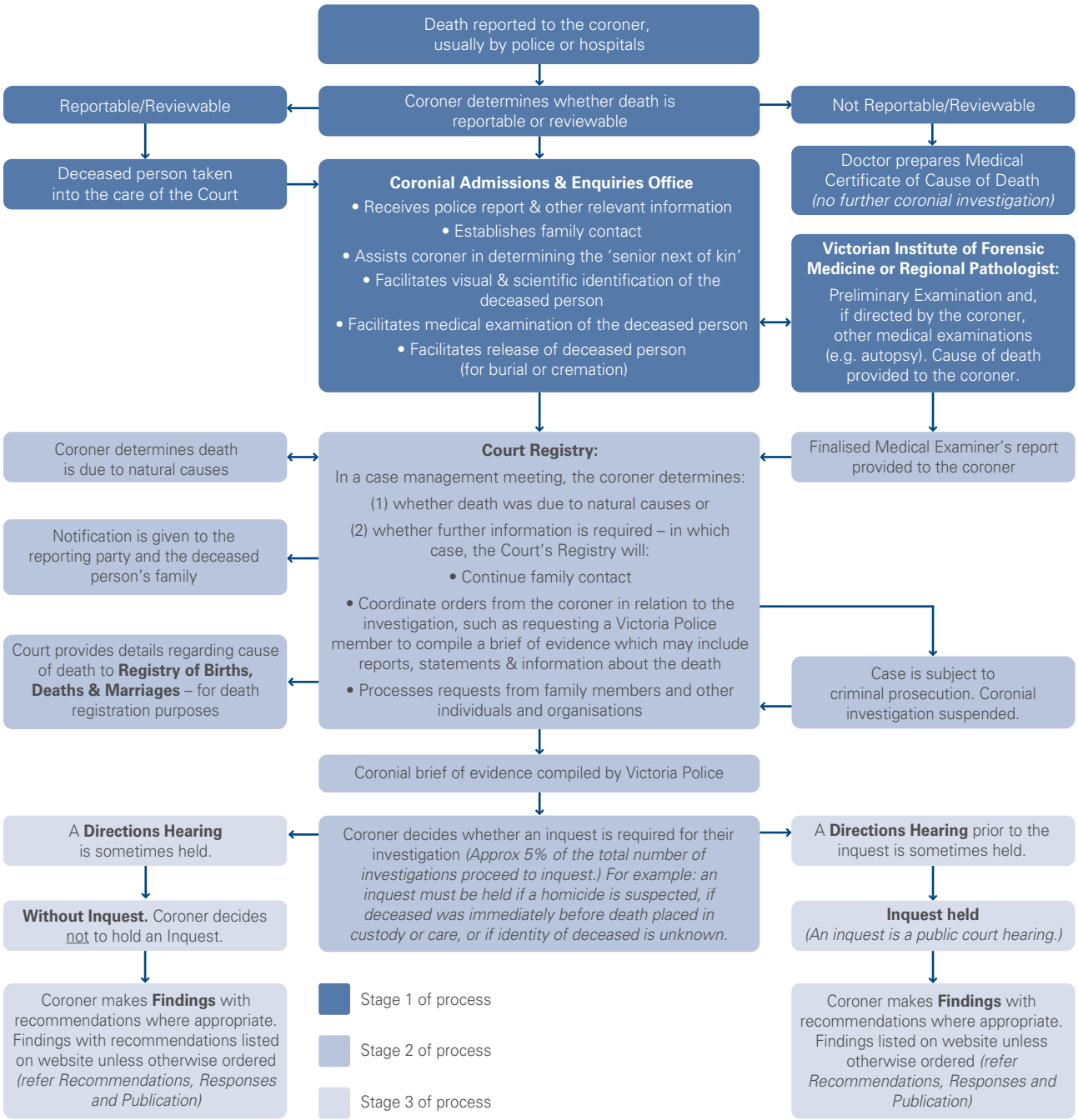
Coroners Prevention Unit Manager
Dr Lyndal Bugeja

Organisational Chart

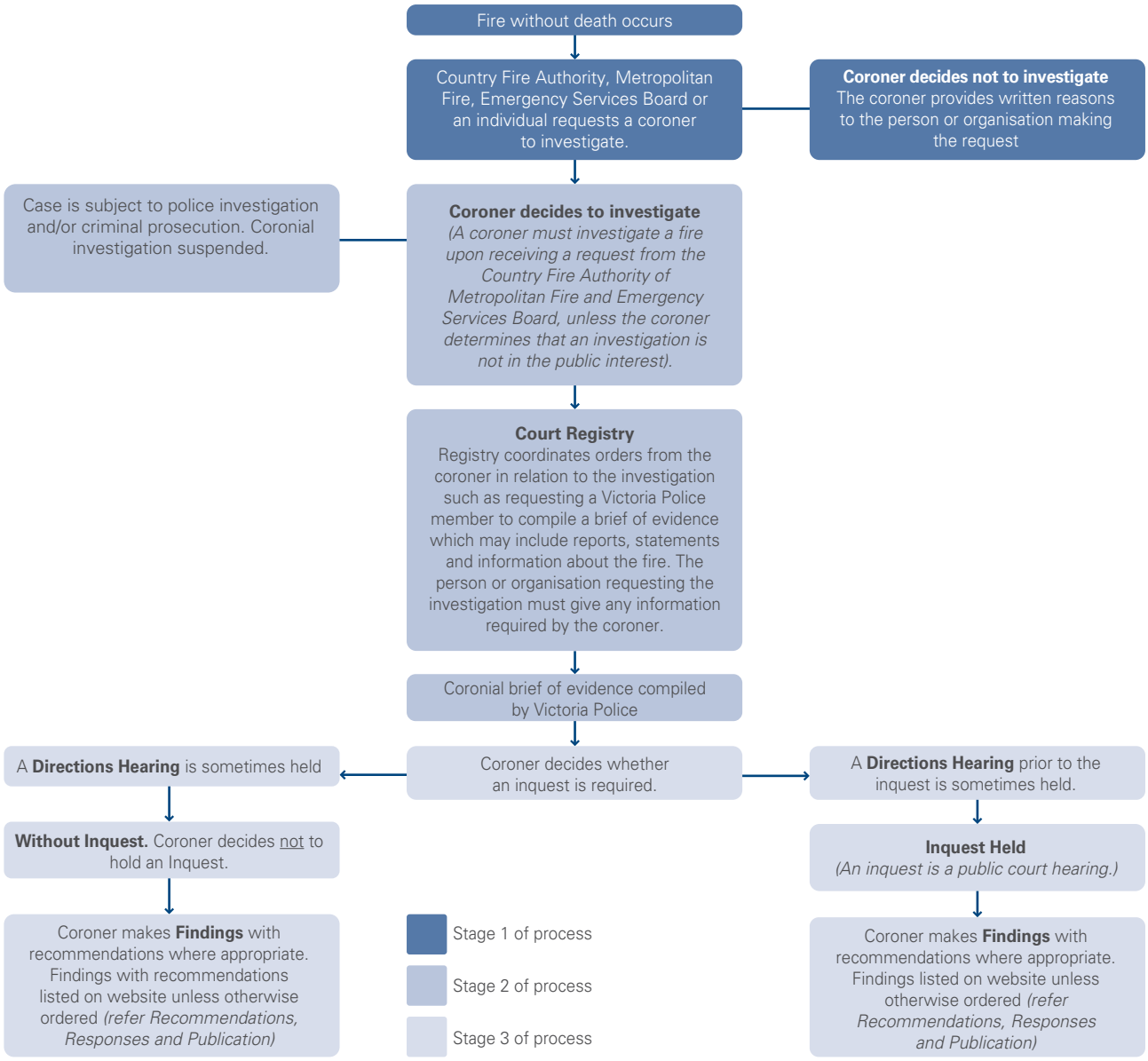


Coronial Processes

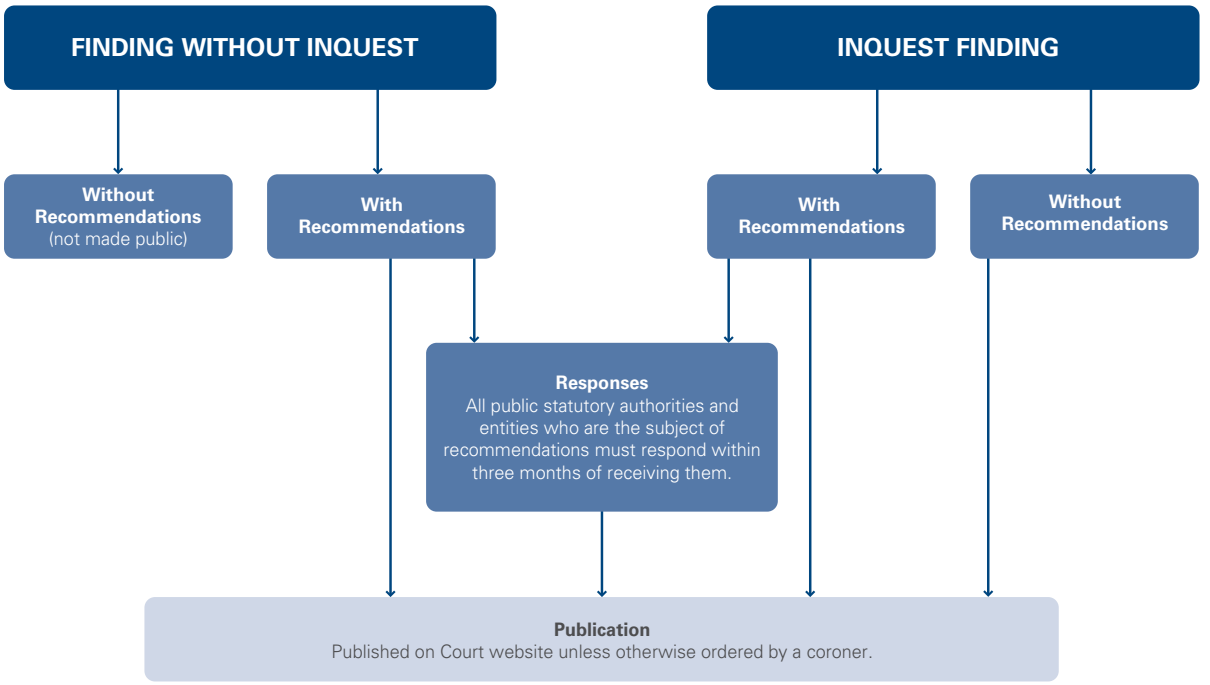
Every death and fire reported to the Court is unique and requires an individual investigative approach. To achieve this, the Court has established a number of processes allowing different areas within the Court and services provided to the Court to work together to investigate deaths and fires throughout 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)



Court Operations and Initiatives

Court Services Victoria

On 1 July 2014 legal history will be made when all Courts and VCAT separate from the Department of Justice and form their own statutory authority; Court Services Victoria (CSV). CSV will be truly independent from departmental or government control and will be accountable to the Victorian Parliament directly. CSV will provide a new court-focussed and court-administered body to provide enhanced services for the judiciary and court users.

Section 8 of the *Court Services Victoria Act 2014* states:

The function of Court Services Victoria is to provide, or arrange for the provision of, the administrative services and facilities necessary or desirable –

(a) to support the performance of the judicial, quasi-judicial and administrative functions of –
  (i) the Supreme Court; and
  (ii) the County Court; and
  (iii) the Magistrates' Court; and
  (iv) the Children's Court; and
  (v) the Coroners Court; and
  (vi) VCAT; and

(b) to enable the Judicial College of Victoria to perform its functions.

The Courts, VCAT and Judicial College of Victoria will remain as distinct entities. Each court will continue to have a Chief Executive Officer and will come together with the Chief Executive Officer of CSV to manage CSV as a whole. A Courts Council will govern CSV. The Council will be chaired by the Chief Justice of the Supreme Court of Victoria and will include the Head of Jurisdiction from each of the other Courts and Tribunals, as well as up to two co-opted non judicial members.

New Coroners Court Operating Model

In 2013-14, the Court implemented a new operating model. This followed the completion of an organisational review in April 2013. The purpose of the review and subsequent operating model restructure was to identify process and organisational improvements aimed at creating a sustainable and efficient coronial system. Two significant changes were implemented as part of the new operating model:

- expansion of the Court's in-house legal services to include a team of solicitors to assist the coroners.
- the transfer of the Initial Investigations Office to the Victorian Institute of Forensic Medicine to form the new Coronial Admissions and Enquiries Office.

The new operating model has enabled improvements in case disposition performance across the Court.

In 2013-14:

- the average frequency of all cases finalised has increased by 48%
- the average frequency of cases finalised by way of written findings without inquest and with circumstances increased by 102%
- the average frequency of cases finalised following a determination that the medical cause of the death was the result of natural causes increased by 71%
- the average frequency of cases finalised through findings without inquest and without circumstances increased by 37%
- the average age of a case from the date it was reported to the Court to the date it was finalised has decreased by 61 days.

These improvements demonstrate the overwhelming success of the new operating model which focuses on providing more timely outcomes for the Victorian community.

It should be noted that the comparison figures do not necessarily indicate an increase in any particular type of death. That is, the figures do not indicate, for example, that more people are dying from natural cause related deaths than in previous years. Rather the figures demonstrate the newly enhanced capacity of the Court to identify those particular matters which are less complex and streamline their case management to ensure that where possible, they are finalised in an efficient and timely manner.

The Court will continue to review and monitor its performance to ensure the gains and efficiencies created by the new operating model continue into the future.

Building Redevelopment

Redevelopment of the Court building at Kavanagh Street, Southbank continued during the reporting period with an end of July 2014 move date confirmed. Refurbishment of the existing courtrooms was ongoing while new offices, workstations and coroners' chambers underwent processes in preparation for the final fit-out. Practical completion of the Court's building occurred on 4 June 2014 with the Department of Justice taking possession of the building from John Holland.

The move from the Court's current Exhibition Street location, back to Southbank is highly anticipated by coroners and staff and will mark the completion of the five and half year project.

The project first began in January 2007 when the Department of Justice produced a feasibility study report in respect of upgrading the entire Coronial Services Centre site, including the Court building and the building and facilities occupied by the Victorian Institute of Forensic Medicine (VIFM). This was in response to a review, which indicated there were significant current and future limitations in the quality of services that could be provided to Victorians under the layout and condition of the previous existing buildings and facilities.

During the redevelopment process, VIFM staff and services remained onsite while the balance of court staff and services were relocated while construction was underway. The Court has been located at two different CBD premises during the redevelopment process, with the first being 436 Lonsdale Street until 2010, and then to 222 Exhibition Street, where it currently presides.

Roving Regional Coroner

Historically, some 20 regionally based Magistrates have also held the office of coroner, conducting approximately 1,200 coronial investigations annually. To support the work of regional Magistrates, Sessional Acting Magistrate Jacinta Heffey was made available in August 2011 to exclusively perform coronial work for regional Victoria on a part-time basis.

Magistrate Heffey is based at the Court in Melbourne but travels to regional courts to conduct most of her proceedings. This enables families, witnesses and interested parties to attend coronial inquests in their local area without the burden of having to travel to proceedings held in Melbourne.

Magistrate Heffey has assisted regional coroners with complex medical investigations, inquests likely to involve in excess of three sitting days, and matters where there may be a conflict of interest between the regional magistrate and interested parties.

In the reporting period Magistrate Heffey directed:

- ten inquests
- five direction hearings
- one mention hearing
- one summary inquest
- the delivery of five inquest findings

Since accepting the position of roving regional coroner in 2011, Magistrate Heffey has had 46 complex regional matters referred to her for investigation.

Developments in Regional Coronial Investigations

In May 2013, the Court announced that it intended to centralise all regional coronial investigations as of 1 January 2014. In order to assist with this process, all regional coronial investigations reported to the Court from 1 December 2013 have been centrally managed. This management refers to the administrative aspects of the investigation and does not mean that all inquests will be held in Melbourne. Coroners can and do still hold inquests in regional locations.

Regional coronial investigations that were already underway, or part heard, prior to 1 December 2013, have continued to be managed by regional registrars and finalised by a regional coroner. These regional coronial developments have not impacted on existing arrangements regarding the transfer of deceased persons to and from the Court for medical examinations.

The Court appointed one additional coroner during the reporting period to assist with the increased workload coming into Melbourne from the regions, bringing the total number of coroners from 9.5 in 2012–2013 to 10.5 in 2013–2014.

Victorian Coronial Council

The Coronial Council of Victoria was established under the *Coroners Act 2008* and commenced operating in 2010. The Council is independent of the Court and provides advice and recommendations to the Attorney-General regarding matters of importance to the coronial system in Victoria or that relate 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 at large; and other matters either of its own motion, or at the request of the Attorney-General. It is the only known body of its kind in the Australian coronial jurisdiction. The Coronial Council also tables its own annual report to Parliament.

Under section 111 of the *Coroners Act 2008*, the Council consists of three members *ex officio* and between five and seven members appointed by the Governor in Council on recommendation by the Attorney-General. Members are appointed for a renewable three year period under the *Appointment and Remuneration Guidelines for Victorian Government Bodies and Advisory Committees*.

** Note: not all members of the Coronial Council are present in the photograph*

Ex officio Members

His Honour Judge Ian L Gray
State Coroner

Professor Stephen Cordner AM
Director, Victorian Institute of Forensic Medicine

Deputy Commissioner Graham Ashton AM
representing the Chief Commissioner, Victoria Police

Appointed Members

Professor Katherine McGrath – Chair

Dr Ian Freckelton QC

Mr Christopher Hall

Dr Celia Kemp (from May 2014)
Dr Robert Roseby
Dr Sally Wilkins (to August 2013)
Professor Mark Stevenson (from May 2014)

The Council met five times during the reporting period.

Having been in operation for over three years, the Council took the opportunity to review its work practices. In doing so, it agreed to work against an annual plan, and develop a standardised approach to conducting its investigative reference work. The Council also reviewed its composition, resulting in the appointment of two further members who bring specialist medico-legal and road trauma knowledge.

During the reporting period, the Council progressed its investigation into suicide reporting in the coronial jurisdiction, through the engagement of a specialist researcher. Under the direction of the Chair, the researcher developed a consultation paper, which was circulated to identified stakeholders, including State and Chief Coroners. The consultation paper and responses formed the basis of the Council's submission to the Attorney-General in June 2014.

Suicide accounts for more deaths in Australia than transport crashes and homicides combined, and is the leading cause of death for people under the age of 34. While there remains diverse opinion on the issue, the Council proposed in its report legislative amendment in the Victorian jurisdiction to require coroners to make clear findings about the intention of people whose actions caused their own death. The Council also made recommendations to the State Coroner to clarify and assist coroners in making findings of intent in cases where the deceased caused their own death, and the use of standardised terminology to describe such cases. Finally, the Council supported the adoption of the National Police Form for the collection of consistent and detailed information related to such deaths.

The Council also concluded its examination of the issues surrounding legal representation at coronial inquests for families who are otherwise unrepresented. The Council determined that the number of cases in which such families faced large and well-resourced organisations was few and that the State Coroner should have a legislative basis for requiring that legal assistance be provided, on par with similar powers in other jurisdictions.

Finally, the Council commenced a new reference into the reporting of deaths in hospitals, and expects to provide advice and recommendations to the Attorney-General in 2015.

Court Network at the Coroners Court

Court Network was established in 1980, in a small court in the Melbourne suburb of Prahran when founder Carmel Benjamin AM saw a gap in the justice system for people who were coming to court without access to information or support. The service has grown significantly since then with volunteers based in 30 courts across Victoria. In 2006, the service expanded to Queensland in the Brisbane CBD courts and in 2010 to Cairns and Townsville.

Court Network is a unique court support service operating throughout Victoria and Queensland. They are a court based service explicitly and solely concerned with the needs of court users with information, support and referral services provided by over 400 trained volunteers. Court Networkers support family members and friends of the deceased person and attend the proceedings in the coronial jurisdiction and support around 1,842 court users per year.

Coroners and Coronial Investigations

Coronial Findings

In accordance with section 67 of the *Coroners Act 2008* (Vic), a coroner investigating a reportable death must find, if possible:

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

In accordance with section 68 of the *Coroners Act 2008* (Vic), a coroner investigating a fire must find, if possible:

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

Coroners delivered 4,259 findings in the 2013–14 financial year. For a full breakdown of findings figures see page 39.

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. Section 72 (2) of the Act allows coroners to make recommendations to any Minister, public statutory authority or entity on any matter connected to their investigation.

In the 2013–14 reporting period there were 90 coronial findings, which contained recommendations. For a full breakdown of recommendation statistics see page 40. Notable findings which contained recommendations made by coroners during the reporting period include: recreational boating; prescription drugs and homicide.

Recreational boating

In December 2013 a Coroner delivered a finding without inquest into the 2011 drowning death of a 31-year-old man at Gough's Bay, Lake Eildon.

The circumstances surrounding the death were that the man and two friends borrowed a three-man canoe and took it out onto the lake. None of the occupants were wearing personal flotation devices when about 150 metres from shore the vessel became unstable and all three men fell into the water. The 31-year-old man soon indicated he needed assistance and his friends told him to keep treading water and remove his clothing before they all began heading to shore. The vessel had filled with water and so provided no assistance.

The 31-year-old soon became distressed and began going under the water. At the time of the incident he was wearing heaving clothing including jeans, boots and a heavy jacket. Conditions on the lake were described by witnesses as poor with strong winds, choppy water conditions and fading daylight. An autopsy later revealed that the man had a BAC of 0.04%.

The coroner found the cause of death to be drowning and that the man's heavy clothing may have contributed to his death. She further found that the death could have been prevented had he been wearing a personal flotation device. The coroner stated that the death highlighted the importance of always wearing a personal flotation device until help arrives. She said it was apparent the man was aware of, and had adhered to, this safety requirement previously, but that he did not do so on the day of the incident because the device was wet from use the day before.

She further stated that data from Victoria, one of only two jurisdictions in the world to have legislation mandating the use of personal flotation devices, has shown they are an effective drowning prevention measure for recreational boating, but that despite these requirements drowning amongst occupants and operators of human powered vessels, such as canoes and kayaks, continues at an unacceptable frequency.

In handing down her finding the Coroner made two recommendations including that:

- Canoeing Victoria, the Victorian Canoe Association Inc and Victorian Sea Kayaking Club consider the distribution of the Australia New Zealand Safe Boating Education Group's Paddle Safe brochure to their members
- retailers of canoes and kayaks, in consultation with Maritime Safety, consider the distribution of the Australia New Zealand Safe Boating Education Group's Paddle Safe brochure to consumers at point of sale for both online and face-to-face transactions.

Prescription drugs

In February 2014 a coroner delivered her finding without inquest into the 2009 prescription drug related death of a 33-year-old man.

He had a past medical history that included anxiety, depression, migraine and chronic alcohol abuse. A relative conducting a welfare check discovered the man deceased in his own home and an autopsy revealed he had died from a drug overdose, namely oxycodone toxicity.

During the investigation, the coroner raised serious concerns regarding the prescribing practices of doctors who were treating the man for his migraines. In particular the coroner noted that one doctor, who had been prescribing oxycodone to the man intermittently in 2006 and 2007, had began prescribing far more regularly including a total of 22 prescriptions between April 2008 and the man's death in August 2009 and that the quantity of oxycodone given had also increased during that time. The same doctor also prescribed several other opioids in addition to oxycodone, including pethidine, morphine, dextropropoxyphene, codeine and tramadol – all recorded as being for the purpose of treating the man's migraines.

The investigation also revealed a number of other doctors who were also involved in the man's care and whom also provided opioids for the treatment of migraines. As such, the coroner found that when one reviewed the total number and type of drugs being prescribed by all doctors, it was apparent that the man had probably developed opioid dependence long before his death.

A review of clinical guidelines for using drugs to treat migraines identified two Australian guidelines and four international guidelines that addressed the use of drugs to treat acute migraine symptoms and for migraine prevention.

In summary they included:

- two guidelines which recommended that opioids should never be used to treat acute migraine symptoms
- two guidelines which recommended that opioids must be avoided to treat acute migraine symptoms
- two guidelines which recommended that opioids should only be used to treat acute migraine symptoms where other treatments have failed and/or where appropriate controls are in place to manage the significant risk of dependence, abuse and over sedation
- none of the guidelines recommended opioids for migraine prevention.

In handing down her finding, the coroner made three recommendations including:

- that Drugs and Poisons Regulation review all current valid permits nominating migraine (intermittent as otherwise) as the clinical diagnosis for prescribing a Schedule 8 opioid, and assess whether each permit was issued consistently with the expert advice. Drugs and Poisons Regulation should take appropriate steps to notify prescribers and if necessary cancel permits that were not issued for appropriate clinical diagnoses.
- Drugs and Poisons Regulation review its procedures to ensure any application nominating migraine (intermittent as otherwise) as the clinical diagnosis for prescribing a Schedule 8 opioid, is evaluated consistently with the expert advice.
- that the Victorian Department of Health consult with relevant peak medical bodies such as the Australian and New Zealand College of Anaesthetists' Faculty of Pain Medicine and the Royal Australasian College of Physicians' Australasian Chapter of Addiction Medicine to obtain expert advice on the clinical appropriateness of:
  - short-term opioid prescribing to treat migraine, and
  - long-term (greater than eight weeks) continuous opioid prescribing to treat migraine.

Homicide

In December 2013 a coroner delivered her inquest finding into the 2005 shooting death of a 32-year-old man. The man had a previous medical history including poly-substance abuse, hepatitis C, anxiety, peptic ulcer, asthma and attempted suicide. The man also had a criminal history spanning 20 years for drug and dishonesty offences and throughout his life had served four youth training centre sentences and 15 adult prison sentences.

The investigation revealed that on the day of his death, the man had attended at the address of friends and that they were using illegal drugs. At about 12pm there was a knock on the door and a friend and associate of the man walked in. These two persons were known to each other and had both served periods of imprisonment together in 1998. Witness accounts state that after the man knocked on the door and was let, he walked straight to the 32-year-old and shot him with a handgun.

The man then coerced the two other occupants, a man and a woman, to assist him to move the body into the bathroom and dismember it. The body was then driven away from the premises and has never been found.

In handing down her finding the coroner made a single recommendation that the Chief Commissioner of Police direct the Homicide Squad to review their investigation of the death of the 32-year-old man with a view to identifying who assisted in the disposal of his body and ascertaining its whereabouts.

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. Victorian coroners made a number of conference presentations, participated in various committees and councils, assisted with the delivery of professional development programs by the Judicial College of Victoria, and mentored law students and graduates.

Conference Presentations

- Asia Pacific Coroners Society Conference
- AUSMED Enrolled Nurses' 2014 Melbourne Conference
- Australia and New Zealand Anti Terrorist Exercise
- Australian Catholic University Graduation Keynote Speaker
- Australian Catholic University Undergraduate Law Students
- Australian College of Midwives Annual General Meeting
- Australian Society of Post Anaesthesia and Anaesthesia Nurses Conference
- Coroners Court of Victoria Health Information Day
- Interstate and Victorian Police re: Disaster Victim Identification
- Judicial College of Victoria – Coroners Intensive
- KidSafe *Closing the Gate of Pool Safety* Campaign Launch
- Law Institute of Victoria Symposium
- Law Week 2014
- Life Saving Victoria *Dangers of Rock Fishing* Launch
- Monash University Department of Forensic Medicine Short Course
- Monash University Law School
- Monash University White Ribbon Breakfast
- New Zealand Coroners Professional Development Seminar
- Sisters in Crime Panel
- St John of God Hospital Nursing Students
- University of Melbourne Juris Doctor Program
- University of Melbourne Masters of Law
- Victoria Police Homicide Squad Conference

In addition to the above listed conference presentations, the Court participated in a number of significant public events. The State Coroner opened an exhibition jointly hosted by the Law Foundation and the Supreme Court of Victoria marking the 30th Anniversary of the Ash Wednesday bush fires. The State Coroner also participated in a judicial panel titled *One Hit, One Punch* discussing the law, sentences and the consequences of one-punch assaults. The Court also prepared an exhibition on the 1970 West Gate Bridge collapse for Law Week 2014.

Committee and Council Memberships

- Asia-Pacific Coroners Society
- Australian Coronial Heads of Jurisdiction Committee
- Coroners Court of Victoria Research Committee
- Coronial Council
- Courts and Tribunal Services' Audit and Risk Committee
- National Coronial Information System Board of Management
- RMIT Juris Doctor Program Advisory Board
- Victorian Institute of Forensic Medicine Council
- Victorian Institute of Forensic Medicine Ethics Committee
- Victorian Law Foundation Ambassador
- Victorian Systemic Review of Family Violence Deaths Reference Group

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
- an intensive workshop on Writing Coronial Findings to assist coroners in writing clear, concise and reasoned findings and recommendations
- a two-day intensive workshop as an ongoing professional development to coroners state wide
- publication and maintenance of a Coroners Bench Book to help coroners stay up-to-date with the latest developments in Australian coronial law
- monthly circulation of Coroners Prevention Unit research.

Coroners Court of Victoria Research Committee

The Coroners Court of Victoria Research Committee was established in July 2011. The Committee meets monthly and is co-chaired by Coroners Spanos and Jamieson. Other Committee members include a representative from each of the business units. The Executive Assistant to the Court's Chief Executive Officer provides administrative support.

The Court regularly receives requests for access to the National Coronial Information System (NCIS) or to court files. This may include private, personal and sensitive information relating to the deceased as well as living persons. Access to this material for purposes of research is subject to approval by the State Coroner prior to submission to an ethics committee.

Having considered each application, the Committee provides recommendations to the State Coroner with respect to the appropriateness of each research proposal and impact on the resources of the Court. Since the Committee's establishment, it has considered approximately 75 applications for access to data, including 25 applications in the year 2013–2014.

Report of the Coroners Support Service

The Coroners Support Service comprises the Principal Registrar, Registry Manager, Registrars, Court Administration Officers and Family Liaison Officers.

Principal Registrar

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 transporting 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.

As reported in previous Annual Reports, the cost of deceased person's transportation has continued to have a significant impact on the Court's operating budget. To address this, the Transport of Deceased Persons Project was commenced. During the reporting period the Transport of Deceased Persons Project issued a Request for Tender. It is anticipated that the tender process will be completed during the next reporting period.

Compliments and Complaints

The Court records feedback from families and external stakeholders, as well as incidents that impact on service delivery. During the reporting period the Court received:

- 27 compliments
- 23 complaints*
- 16 service delivery issues*

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

Registry

Each registrar is allocated to a coroner and assists in the case management of the coronial files. Following the release of a deceased person from the Coronial Admissions and Enquiries office (CA&E) the coronial file is transferred to the registry and allocated to a registrar.

A primary part of the registrars role is to liaise with the senior next of kin, family members, interested parties, the Victorian Institute of Forensic Medicine, police, public, health service providers and many other departments and agencies.

The registrar's main function is to case manage and provide administrative support to the coroners. This may include seeking further statements on behalf of the coroner, organising expert medical opinions, liaising with external parties for information and coordinating court hearings, including inquests, direction hearings, mention hearings and the delivery of findings.

Providing information and updates to families through letters and phone calls is a crucial part of their every day work. Letters are sent to family members at key points during the coroner's investigation. These letters may provide updates regarding the cause of death, which often includes the medical examiners report, how the coroner intends to investigate the death of their loved one and to advise if any further medical investigations are required.

Court Administration Officers

The Court Administration Officers assist the coroner by undertaking general administration duties, maintaining various records and registers and bench clerking at court hearings. The receptionists are part of the administration team and are the first point of face-to-face contact with the public. They also assist in the management of incoming calls to the Court.

Family Liaison Officers

The Family Liaison Officers assist coroners with investigations where families and witnesses require additional support during the coronial process. This includes delivering sensitive information on behalf of the coroners and stakeholders, helping families understand information contained within a coronial brief of evidence and providing support during court proceedings when required.

Family Liaison Officers also assist families and witnesses by providing referral information and advice on external counselling and support agencies that can assist with their grief and loss experience.

Report of the In-House Legal Service

The Police Coronial Support Unit (PCSU) provides assistance to coroners in a significant number of coronial investigations that proceed to inquest. 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. Such matters include where a death has occurred in police presence, or as a result of a police shooting or pursuit or while the person was in custody, or was being taken into police custody. Historically the assistance needed by coroners during the course of these investigations and inquests was outsourced to external law firms, including the Victoria Government Solicitors Office.

The Court now has a dedicated In-House Legal Service (IHLS), which comprises two permanent full-time solicitors and one fixed term full-time solicitor. In the reporting period, the IHLS assumed the conduct of all potential conflict matters and assisted in:

- five inquests as counsel assisting a coroner
- 40 directions hearings, mentions etc… as counsel assisting a coroner
- 24 inquests as the instructing solicitor
- one Supreme Court appeal
- provided 59 separate complex legal briefings to coroners across the State
- participated in ongoing professional development for coroners and coroner's solicitors.

In addition, the IHLS assisted with the preparation of a range of other complex legal documents, liaised extensively with the legal profession, hospitals, Victoria Police, families and provided guidance to court staff on a range of legal issues.

The IHLS has greatly assisted coroners in their proceedings and afforded the Court a greater capacity to provide and retain a high level of expert legal knowledge specific to the coronial jurisdiction. This service is of immense value to all court stakeholders, but in particular, to families who are often required to attend and participate in coronial inquests without the benefit of their own legal representation.

The IHLS is also represented at the Judicial Education Committee, Coroners Court Research Committee and Coroners Court of Victoria and Victorian Institute of Forensic Medicine Joint Committee.

During the reporting period, the IHLS assisted the State Coroner to implement seven Practice Directions pursuant to section 107 of the *Coroners Act 2008*. Each Practice Direction has been implemented to ensure:

- the coronial system operates in a timely and efficient manner
- an appropriate allocation of the Court's resources, while taking into account the needs of other cases
- simplicity in procedure, fairness in administration and the elimination of unnecessary delay
- efficiencies in determining all the issues in each case
- the investigation of deaths and fires are expedited where possible
- clear communication and accurate and early disclosure of the issues to interested parties
- appropriate case management
- appropriate use of technology.


CORONERS COURT
OF VICTORIA
Courtrooms
Police Coronial Support Unit

The Practice Directions are as follows:

- Practice Direction 1 of 2014 – Access to documents provided to senior next of kin pursuant to section 115 of the *Coroners Act 2008* published on 9 April 2014.
- Practice Direction 2 of 2014 – Access to documents provided to parties other than the senior next of kin pursuant to section 115(2) of the *Coroners Act 2008* published on 9 April 2014.
- Practice Direction 3 of 2014 – Communications with the Court published on 9 April 2014.
- Practice Direction 4 of 2014 – Police contact deaths published on 9 April 2014.
- Practice Direction 5 of 2014 – Listings published on 9 April 2014.
- Practice Direction 6 of 2014 – Medical Records published on 9 April 2014.
- Practice Direction 7 of 2014 – Coronial briefs published on 24 June 2014.

The IHLS also assisted the State Coroner to develop a number of internal protocols, including guidelines for discretionary inquests, and participated in developing joint protocols between the Victorian Institute of Forensic Medicine and the Court to ensure efficiencies between each organisation.

Report of the Coroners Prevention Unit

The Coroners Prevention Unit (CPU) comprises a multi-disciplinary team of investigators that support coroners to fulfil their prevention mandate. The CPU assists coroners to identify opportunities for and strengthen public health and safety via the formulation of evidence-based and feasible recommendations.

CPU advice ranges from short consultations with coroners to in-depth reviews examining some or all of the following issues:

- the frequency of previous and subsequent similar deaths
- known or emerging risk factors
- evidence on efficacious interventions aimed at reducing future similar deaths and their applicability to Victoria
- regulations, standards, codes of practice or guidelines in place to mitigate risks
- previous recommendations made by coroners and / or further evidence-based and feasible recommendations.

Coroner Referral and Completion Statistics

Since the establishment of the CPU in October 2009, coroners have sought assistance for over 2,000 investigations and the CPU has provided approximately 1,850 separate pieces of advice to coroners. The annual frequency of advice sought and provided by stream of activity is shown in the Table below.

STREAM OF ACTIVITY	2009/10	2010/11	2011/12	2012/13	2013/14
Referrals Received					
Family Violence	7	23	14	15	6
General	73	123	141	110	107
Health and Medical	-	262	258	250	387
Mental Health	19	53	71	65	114
Other Business Units	1	11	18	18	26
External Agency	8	14	29	17	9
Total	**108**	**486**	**531**	**475**	**649**
Referrals Completed					
Family Violence	10	10	15	17	4
General	57	90	126	112	114
Health and Medical	-	121	267	299	358
Mental Health	3	23	63	66	93
Other Business Units	1	10	16	20	26
External Agency	5	10	33	18	11
Total	**76**	**264**	**520**	**532**	**606**

During the reporting period, coroners sought assistance on a range of deaths where prevention opportunities were identified. Examples included:

- appropriateness of health care treatment following medical intervention
- adequacy of follow up procedures of persons recently discharged from a mental health service
- feasibility of the introduction of prescription drug monitoring programs to reduce harms association with prescription drug misuse
- reducing opportunities for diversion of take-away methadone
- fitness to drive amongst persons with known medical conditions
- homicide between parties in an intimate or familial relationship

Developments in Public Health and Safety

Innovations in detection of aortic dissection

Following an inquest into the death of a 74 year old woman from aortic dissection (AD) after an emergency department (ED) attendance, the Coroner requested a Round Table meeting with emergency physicians (EPs) from Melbourne with a view to identifying system changes that could improve outcomes from the disease.

This novel initiative resulted in attendance at the Court by 17 emergency physicians, many of them Directors of Emergency Medicine from metropolitan Melbourne hospitals, to meet with the Coroner and representatives of the Court, including nurses and EPs from the CPU and representatives of the Police Coronial Support Unit.

The CPU had prepared a descriptive statistical overview and case summary report outlining the frequency of AD deaths reported to the Court from 2010 to 2012 where there had been contact with health services in the three months prior to death. This was circulated to the group prior to the meeting. Important clinical, system and cultural features of AD presentation and management were discussed, with a view to identifying strategies that might be useful in improving case detection and management, and hence outcomes.

A number of clinical and system issues around case detection were discussed and agreed. Key recommendations were that: EPs change the way that chest pain patients are discussed in EDs, with an emphasis on 'red flags' for AD being considered at the beginning of any discussion; and clinical pathways for chest pain management be modified to include consideration by senior medical staff of the possibility of AD at the beginning and end of the pathways.

Following the Round Table, one of the EPs from the CPU was invited to present on the topic at the Emergency Care Improvement and Innovation Clinical Network Annual Forum "Evidence into Action" in Melbourne in February 2014, indicating the level of engagement of the Department of Health in Victoria with this initiative. This innovative collaboration between the Court and EPs may serve as a model for future interactions between the Court and the medical profession.

Victorian Systemic Review of Family Violence Deaths

Each year in Victoria, approximately 40 per cent of all deaths attributed to homicide occur between parties in an intimate or familial relationship. In addition, many of these deaths occur in the context of family violence, for example a documented history of violence, and are therefore considered preventable. The Victorian Systemic Review of Family Violence Deaths (VSRFVD) was established in 2009 to assist with the coronial investigation into these incidents. The VSRFVD conducts in-depth reviews of deaths that meet the following criteria to contribute to strengthening the response to family violence across the state:

- the death resulted from the actions or inactions of another person
- the deceased and the offender were or had previously been:
  - in an intimate or familial relationship as defined by the *Family Violence Protection Act 2008* (Vic) or
  - family like relationship, in particular kinship relationship as defined by the Victorian Indigenous Family Violence Taskforce (2003) (Note: these are referred to as family homicides)
  - the death occurred in the context of family violence as defined by the *Family Violence Protection Act 2008* (Vic) (Note: these are referred to as family violence homicides)

Homicide in Victoria

Since the establishment of the VSRFVD, 315 have been identified as resulting from the actions or inactions of another person. The table below shows the preliminary classification of determined and suspected homicides reported to the Court from 1 January 2009 to 30 June 2014. Note that, 28 (8.9%) deaths require additional information for classification purposes.

Where the deceased-offender relationship was established (287, 91.1%), 133 (46.3%) were family homicides, that is occurred between parties in an intimate, familial or family like relationship. This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs from the previous report (2012–13) because of this re-classification process.

The annual frequency of family homicides ranged from 22 in 2009 to 27 in 2011. For the period 1 January to 30 June 2014, 14 family homicides have been identified.

Annual frequency of suspected homicides reported to the Court by relationship, Victoria 1 January 2009–30 June 2014

DECEASED-OFFENDER RELATIONSHIP	YEAR						TOTAL
	2009	2010	2011	2012	2013	2014 (TO JUNE 30)	
Intimate Partner	7	9	9	8	11	5	**49**
Parent-Child	9	7	9	8	9	6	**48**
Other Intimate or Familial (Including Kinship)	6	8	9	7	3	3	**36**
Not Intimate or Familial	31	27	30	22	26	18	**154**
Still Inquiring	-	4	5	3	6	6	**24**
Unknown	3	1	-	-	-	-	**4**
Total	**56**	**56**	**62**	**48**	**55**	**38**	**315**

Intimate Partner Homicides

Of the 133 family homicides, 49 (36.8%) occurred between intimate partners. Of these, 32 (65.3%) occurred between current partners, 16 (32.6%) between former partners and the remaining death the relationship status at the time of the incident was unknown.

Further examination of these 49 intimate partner homicides showed that 34 (69.4%) occurred in a family violence context. The majority of these deaths were of victims of family violence (24, 70.6%) over half of which were killed by their current partner (16, 66.7%).

Frequency of intimate partner homicides by relationship status and family violence role, Victoria 1 January 2009–30 June 2014

DECEASED'S FAMILY VIOLENCE ROLE	RELATIONSHIP STATUS			TOTAL
	CURRENT PARTNER	FORMER PARTNER	STILL INQUIRING	
Victim	16	8	-	**24**
Perpetrator	7	-	-	**7**
Victim and Perpetrator	1	-	-	**1**
Unknown	1	-	1	**2**
Total	**25**	**8**	**1**	**34**

An examination of the nature of violence identified showed that physical violence was most frequent, followed by emotional abuse. A combination of both physical and emotional abuse was identified in 18 (52.9%) of the 34 intimate partner homicides that occurred in a family violence context.

This scenario was exemplified in a recent finding by State Coroner Judge Ian Gray who identified that the offender "*had an established history of violence against women and that he was repeatedly abusive, violent, threatening and aggressive towards his wife …*" and that he "*could reasonably be described as a recidivist perpetrator of family violence*".

Frequency of intimate partner homicides by family violence role and nature of violence, Victoria 1 January 2009–30 June 2014

NATURE OF VIOLENCE	DECEASED'S FAMILY VIOLENCE ROLE			TOTAL
	PERPETRATOR	VICTIM	VICTIM / PERPETRATOR	
Physical	7	16	1	**24**
Sexual	2	3	-	**5**
Emotional	5	15	1	**21**
Psychological	5	8	1	**14**
Social	3	8	-	**11**
Economical	2	2	1	**5**

Parent-Child Homicides

Homicides amongst parents and children comprised a further 48 (36.1%) of the 133 family homicides between 2009 and 2014. Just over half of the homicides in this category were of parents killing their children (52.1%), the majority by fathers.

Frequency of parent-child homicides by offending party and relationship, Victoria 1 January 2009–30 June 2014

RELATIONSHIP TYPE	OFFENDING PARTY			TOTAL
	PARENT OFFENDER	CHILD OFFENDER	STILL INQUIRING	
Father-Daughter	8	1	-	**9**
Father-Son	8	12	-	**20**
Mother-Daughter	6	2	-	**8**
Mother-Son	3	6	-	**9**
Still Inquiring	-	1	1	**2**
Total	**25**	**22**	**1**	**48**

Other Intimate or Familial

The remaining 36 (27.1%) of the 133 family homicides occurred between parties in other intimate or familial relationships. The majority occurred between other family or kinship members, which includes:

- immediate family members, i.e. siblings (2, 5.6%)
- extended family members:
  - grandparents/grandchildren (2, 5.6%)
  - uncle-aunty/nephew-niece (4, 11.1%)
  - cousins (1, 2.8%)
  - in-laws (5, 13.9%)
- kinship relationships (2, 5.6%)

The other type of relationship in this category was sexual relationships (8, 22.2%) and relationship triangles, that is conflict between couples and either a new partner or ex partner (8, 22.2%). The remaining four (11.1%) deaths occurred in the context of other familial relationships, for example 'ex-boyfriend/ex girlfriend's father'. Within the 36 other intimate or familial homicides, eight (20.6%) were identified as taking place within the context of family violence.

Investigations and Recommendations

During the 2013–2014 reporting period, coroners completed investigations into three family violence homicide incidents: one intimate partner homicides and two parent-child homicides. From one of these investigations, recommendations were directed to the Department of Health. These were:

> *To improve the access to programs specific to improving mental health literacy for children, teenagers and young adults of parents with a mental illness, the Department of Health, Mental Health, Drugs and Regions review the scope of the FaPMI strategy rollout across all public mental health services and regions in Victoria, including:*
>
> – *Access by public mental heath service families to peer support programs such as CHAMPS and PATS, regardless of where they live in Victoria.*
> – *Access by families from other services that come into contact with families where a parent has a mental illness or significant mental health issue such as alcohol and drug services, family support services, child and youth services, community health, Child Protection, and schools.*

A response to these recommendations is still pending.

A number of comments were made in other investigations, which included:

- the need to evaluate the impact of Victoria Police's *Enhanced Family Violence Service Delivery 2011–2014* model to provide a more effective response to recidivist offenders and high risk victims.
- the need to overcome the unresolved issue of non-compliance with court directed referrals to behaviour change programs to address alcohol misuse connected to the perpetration of family violence.

Victorian Suicide Register

Suicide is a leading cause of death in Australia and, in recognition of this, coroners frequently request assistance from the CPU on areas of potential prevention intervention. To achieve this required a more detailed understanding of the range of stressors a person may be experiencing and the type of service contact made proximate to death. In response, the CPU adopted the concept of a suicide register, first developed in Queensland over a decade ago.

The Victorian Suicide Register (VSR) was developed in consultation with mental health practitioners, epidemiologists and suicidologists and comprises a combination of coded and free text data fields on socio-demographics, known stressors, proximate service contact, evidence of help seeking and evidence of intent. The VSR was extensively piloted, has a quality program, data dictionary and coder training program.

A collaborative research project with the University of Melbourne funded by the *beyondblue* Victorian Centre of Excellence in anxiety and depression continued in this reporting period. The study aims to examine health service and pathway to health service contacts amongst persons who suicided in Victoria during 2009 and 2010. Ethics approval was obtained from the Justice Human Research Ethics Committee and coding of all suspected suicides was completed. The data analysis will be conducted during the next reporting period, the results of which will be communicated to coroners, health and other services to assist them to identify, respond and assist members of the community that may be contemplating suicide.

An evaluation of the VSR continued during the reporting period. The evaluation was funded by the National Health and Medical Research Council (NHMRC) in partnership with the University of Melbourne, Monash University Injury Research Institute and Lifeline Foundation for Suicide Prevention.

Learning from Preventable Deaths

During the reporting period, a collaborative research project with the University of Melbourne was completed, part of which examined the perceptions of organisations directed coroners' recommendations. The results show that recommendations that were formulated with the assistance of the CPU were more likely to be viewed by the organisations to which they were directed as useful and appropriate than recommendations without CPU involvement.

Education and Training

Health and Medical Information Days

The CPU hosted two half-day information programs for health and medical staff during the 2013–2014 financial years. On each occasion, the presenters included a coroner, Victorian Institute of Forensic Medicine forensic pathologist, a representative of CPU and the Police Coronial Support Unit (PCSU). The focus was on clinical case studies, which highlight the coronial process and common themes in health and medical related deaths. Approximately 50 health professionals attended each program, primarily from hospitals across greater metropolitan Melbourne and regional Victoria. The overall feedback from participants was positive with participants enjoying the opportunity to discuss issues relating to reporting health and medical related deaths, the investigation process and timely feedback to clinicians.

Undergraduate Internships

The CPU hosted 17 undergraduate and post-graduate students during the reporting period from a range of Victorian tertiary institutions, which included:

- RMIT's Criminal Justice Administration degree.
- Deakin University's Faculty of Science, Engineering and Build Environment third year Practical Training Program.
- Melbourne Law School's Juris Doctor program.
- Holmesglen's Bachelor of Justice.

In addition, members of the CPU commenced / continued co-supervision of students undertaking research projects for Honours in Criminal Justice Administration and Doctor of Philosophy degrees.

Representations

- Violence Against Women and Children Interdepartmental Committee.
- Victorian Pharmaceuticals Misuse Summit Advisory Group.
- Road Fatalities Review Panel (observer).

Presentations

Dwyer, J. Drug overdose deaths in inner North West Melbourne. Yarra Drugs and Health Forum and Inner North West Melbourne Medicare Local forum on pharmaceutical misuse. 24 September 2013.

Hyland, M. Suicide deaths, other mental illness related coronial themes and CCOV activities. Clinical Directors Peer Support. 11 October 2013.

Dwyer, J. Benzodiazepine contribution in Victorian overdose deaths. Reconnexion. 29 October 2013.

Publications

Bugeja L, Butler A, Buxton E, Ehrat H, Hayes M, McIntyre S-J, Walsh C. The implementation of domestic violence death reviews in Australia. Homicide Studies. Published online 12 July 2013.

Neate SL, Bugeja L, Jelinek GA, Spooner HM, Ding L, Ranson DL. Non-reporting of reportable deaths to the coroner: when in doubt, report. Medical Journal of Australia. 199(6), 402–405, 2013.

Bugeja L, Dawson M, McIntyre S-J, Walsh C. Domestic/family violence death reviews: An international comparison. Trauma, Violence, & Abuse. Published online 31 December 2013.

Neate SL, Bugeja L, Jelinek GA. Doctors, death certificates and reporting to coroners – room for improvement. Medical Journal of Australia. 200(5), 263, 2014.

Bugeja L, Cassell E, Brodie LR, Walter SJ. Effectiveness of the 2005 compulsory personal flotation device (PFD) wearing regulations in reducing drowning deaths among recreational boaters in Victoria, Australia. Injury Prevention. Published online 23 June 2014.

Report of the Executive Services

Communications and Publications

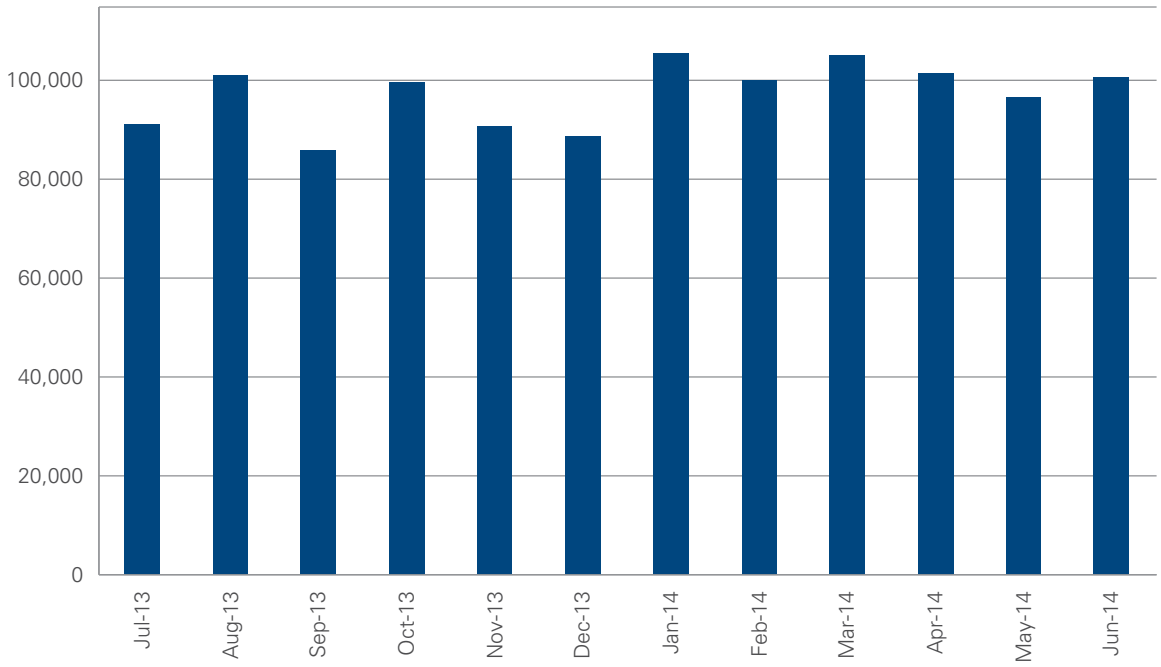
During the reporting period, the Court updated and uploaded information about the coronial process on to the Court's website. The updated publications *The Coroners Process – Information for families and friends* and *What do I do now?* were also printed. The Court distributed 1,462 copies of *The Coroners Process – Information for families and friends* and 1,333 copies of *What do I do now?* to hospitals, police, courts, community workers, social workers and funeral directors. These distributions were in addition to publications normally provided by the Court to families engaged in the coronial process and persons attending the Court's public information sessions.

The Court's website continued to be relied upon as an information repository to make information available to families, the community and key stakeholders. During the reporting period, 245 new findings and 83 new rulings were uploaded onto the Court website. In addition, there was a significant increase in the frequency of visits to the Court's website. The table below indicates the number of visits (1,168,242) to pages on the Court website during the reporting period. This is an increase of 223,947 visits from the 2012–2013 reporting period (944,295).

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 an estimated 2,231 requests for access to coronial documents. Of these, 811 were requests from external agencies and 1,420 were requests initiated by Court staff.



** data collated from Google Analytics*

Human Resources

Average full time equivalent as at June 30 2014

	SPECIAL APPROPRIATION	BASE BUDGET	OTHER FUNDED	TOTAL
Judicial Officers	9.5	-	-	**9.5**
Ongoing Staff	-	49.4	-	**49.4**
Fixed-Term Staff	-	2.6	2.0	**4.6**
Total Average FTE	**9.5**	**52**	**2.0**	**63.5**

**compared with a total staffing of 61.6 average full-time equivalent as 30 June 2013*

Financial Statement

In the reporting period 2013–14, the Court managed its expenses within the allocated budget after three financial years with repeated over spending. This followed from a comprehensive budget review to identify cost drivers and the management of fund allocation to these areas, while maintaining the ability to provide effective coronial services to the Victorian community.

An initiative implemented to ensure expenses remained within budgeted limits was a change to the Court's monthly financial reporting system to a more process oriented and transparent system. This facilitated immediate corrective action against over spending. Further this reporting system identified process owners for each area and which allowed for continuous improvement opportunities.

As a result of the Court's new operating model, expenditure on external legal professional services was reduced by 30% compared to last financial year 2013–14. Further, the Court significantly reduced (67%) expenditure on contract labour compared to last financial year 2013–14 following the implementation of the new operating model. The Court remains committed to further improvements in this area in the next reporting period.

Comprehensive operating statement for the financial year 2013–2014

	NOTES	2009–10	2010–11	2011–12	2012–13	2013–14
INCOME FROM TRANSACTIONS						
Output Appropriation		8,469,100	8,731,700	10,087,600	9,998,190	11,252,900
Special Appropriation		2,320,000	2,427,000	3,182,600	2,895,706	3,479,417
Other Income		-	(317)		315	-
Total Income		**10,789,100**	**11,158,383**	**13,270,200**	**12,894,247**	**14,732,317**
EXPENSES FROM TRANSACTIONS						
Employee Benefits	NOTE 1	6,907,580	7,948,768	8,597,502	8,269,596	8,090,138
Depreciation and Amortisation		418,255	421,405	93,465	86,527	84,905
Interest Expense		3,504	2,974	2,722	1,559	1,493
Grants and Other Transfers	NOTE 2	27,572	32,610	34,114	1,317	-
Supplies and Services	NOTE 3	1,977,645	3,262,224	3,839,448	3,458,268	3,040,797
Deceased Removal and Transfers	NOTE 4	1,441,018	2,080,571	1,932,225	2,584,540	2,656,673
Total Expense from Transactions		**10,775,574**	**13,748,552**	**14,499,476**	**14,401,780**	**13,948,481**
Net result from transactions (net operating balance)		**13,526**	**(2,590,169)**	**(1,229,276)**	**(1,507,533)**	**783,836**
OTHER ECONOMIC FLOWS						
Other gains(losses) from other economic flows	NOTE 5	(550)	(760)	(19,307)	(6,896)	- 6,372
Total other economic flows included in net result		**(550)**	**(760)**	**(19,307)**	**(6,896)**	**- 6,372**
Net Result		**12,976**	**(2,590,929)**	**(1,248,583)**	**(1,514,429)**	**790,208**

Note 1 – Employee benefits

See average full time equivalent table on page 36.

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 Coroners' recommendations powers in Australia".

Note 3 – Supplies and services

	2009–10	2010–11	2011–12	2012–13	2013–14
Contractors and Consultants	676,447	838,662	865,186	529,427	180,319
Legal Professional Services	583,567	1,225,705	941,878	766,365	530,257
Medical Professional Services	78,212	149,983	28,469	258,296	165,691
Information Technology	148,121	163,409	97,819	98,737	87,237
Printing and Stationary	143,420	201,418	166,479	117,121	92,540
Postage and Communication	105,424	165,976	172,865	111,913	117,185
Travel and Personal Expenses	70,046	51,015	44,400	23,801	30,357
Staff Training and Development	57,989	47,384	33,662	11,386	29,436
Witness Expense	42,782	36,492	36,199	39,571	34,717
Other Operating Expense	71,637	382,180	1,452,491	1,501,605	1,773,057
Total Supplies and Services	**1,977,645**	**3,262,224**	**3,839,448**	**3,458,268**	**3,040,798**

Note 4 – Removal and transfer of deceased persons from place of death to coronial mortuary

	2009–10	2010–11	2011–12	2012–13	2013–14
Metropolitan areas	385,683	749,851	687,597	935,892	1,121,753
Regional areas	1,055,335	1,330,720	1,244,628	1,648,649	1,534,920
Total	**1,441,018**	**2,080,571**	**1,932,225**	**2,584,540**	**2,656,673**

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.

Operational Statistics

Case initiations and closures

	2009–10	2010–11	2011–12	2012–13	2013–14
Cases Opened	5,311	4,857	5,029	5,934	6,267
Cases Closed	5,573	5,586	4,949	5,342	7,270
Case clearance rate (cases opened / cases closed)	105%	115%	98%	93%	116%
Cases referred to the court by the Registry of Births, Deaths and Marriages	742	657	680	593	635

Case progress

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

	2009–10	2010–11	2011–12	2012–13	2013–14
0–12 months	3,001	2,263	2,908	3,194	2,843
12–24 months	1,558	850	845*	1,034	720
> 24 months	1,027	1,396	1,203*	1,072	646
Total number of lodgements pending	**5,586**	**4,509**	**4,956**	**5,300***	**4,209**

** 571 cases in the total number of lodgements cannot be actioned as they are currently the subject of police criminal investigations or court proceedings in other jurisdictions. As such, the coronial investigations are suspended until the police and / or other court proceedings are complete.*

Objections to autopsy

	2009–10	2010–11	2011–12	2012–13	2013–14
Objections upheld	285	61	45*	90	86
Objections refused	84	70	51*	-*	-*
Objections withdrawn	41	16	18*	-*	-*
Total number of objections	**410****	**147**	**114***	**152**	**105**

** Changes to the Court's case management system from Suncor to CourtView has left the Court unable to distinguish the number of objections to autopsy refused and the number of objections that were later withdrawn by the family of the deceased. The Court is working towards addressing this reporting functionality within the next reporting period.*

*** Total figures in the 2009–2010 reporting period include 282 objections made under the previous* Coroners Act 1985.

Coroners' findings

FINDING INTO DEATH WITH INQUEST	FINDING INTO FIRES WITH INQUEST	FINDING INTO DEATH WITHOUT INQUEST	FINDING INTO FIRES WITHOUT INQUEST	TOTAL
221	0	4,032	6	4,259

Coroners' recommendations

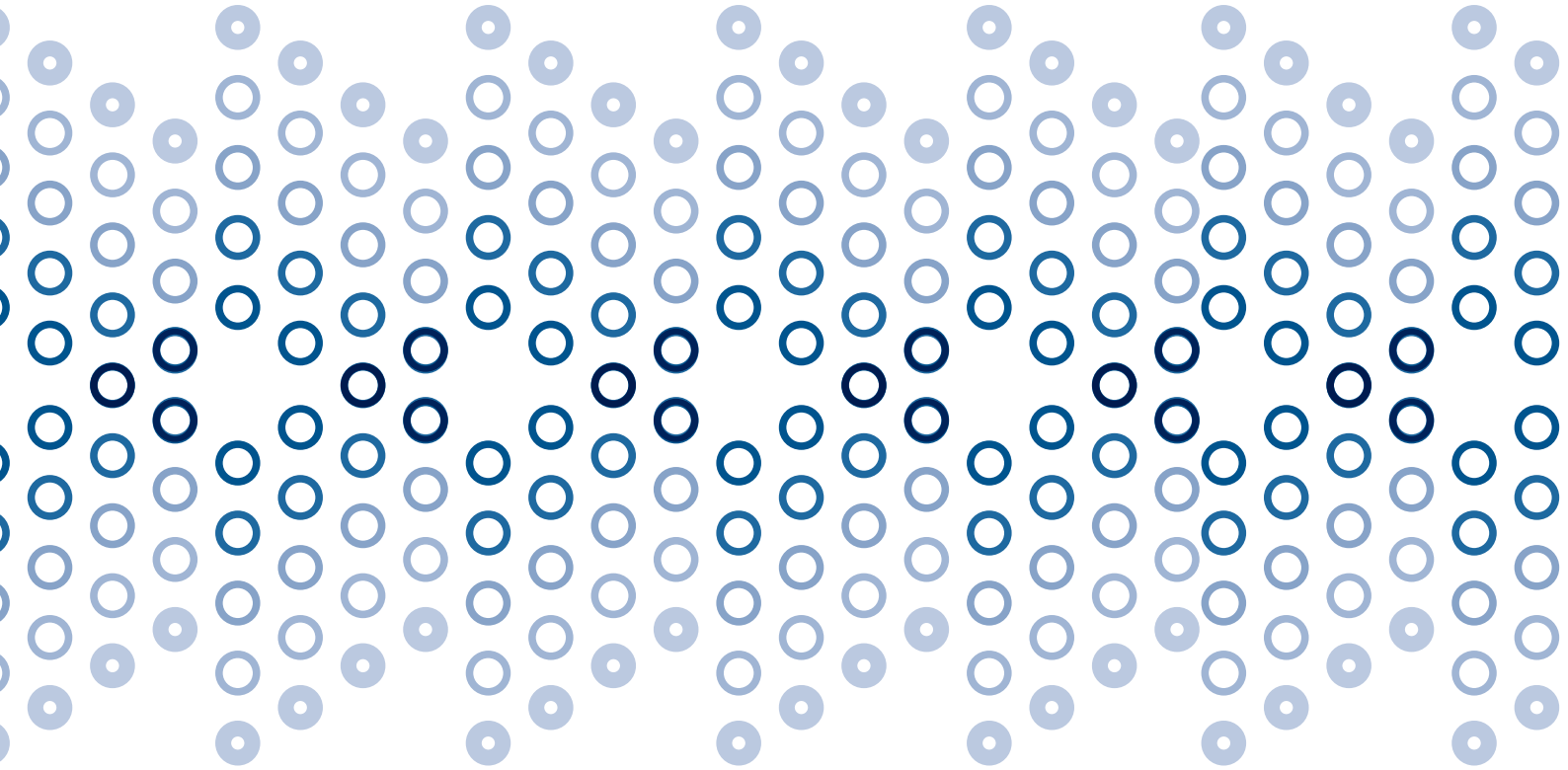
Of the 4,259 findings made by coroners during the reporting period, 90 contained recommendations. A coroner can make more than one recommendation in a single finding. The table below indicates the total number of recommendations made by coroners during the reporting period.

	2010–11	2011–12	2012–13	2013–14
Total number of recommendations	**144**	**217**	**243**	**261**

Responses to coroners' recommendations

	2010–11	2011–12	2012–13	2013–14
Responses to recommendations received	52	90	106	282*

** Some responses received related to recommendations made during the 2012–2013 reporting period. Also the figures do not include required response to recommendations made during the 2013–2014 reporting period that were not due within the same reporting period.*



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