2016

ANNUAL REPORT

Coroners Court of Victoria

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Coroners Court of Victoria

19 September 2015

The Honourable Martin Pakula MP

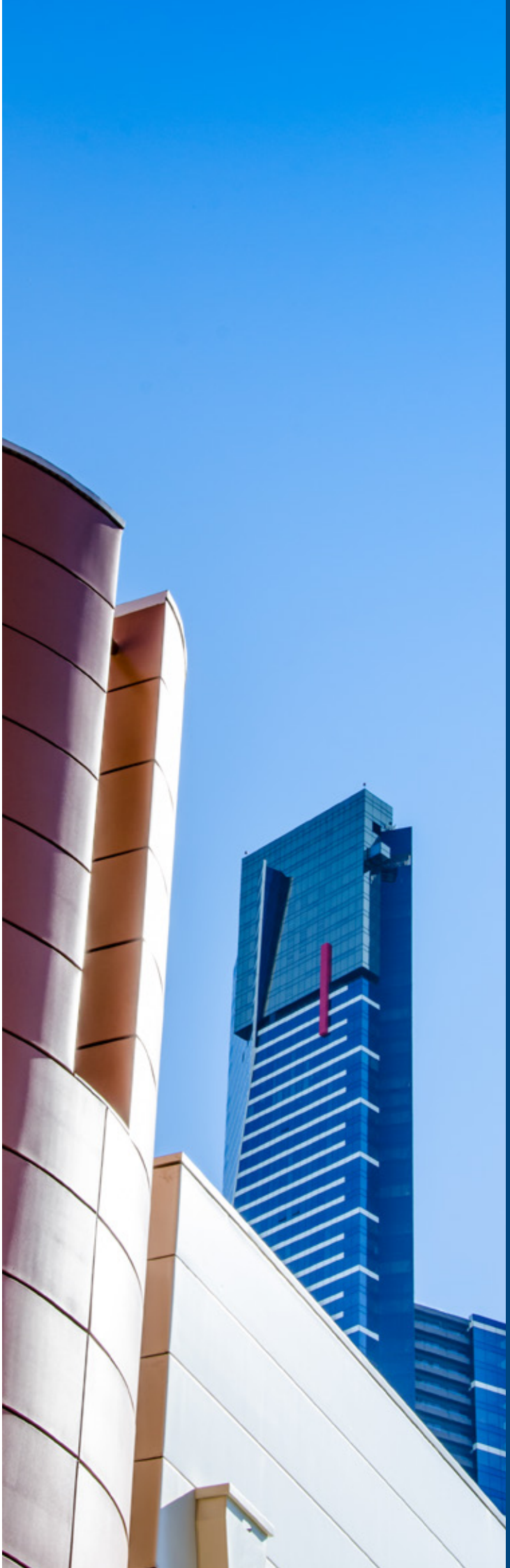
Attorney General
Level 26, 121 Exhibition Street
Melbourne VIC 3000

Dear Attorney-General

In accordance with the requirements under Section 102 of the Coroners Act 2008, I am pleased to present the 2015-16 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 2015 to 30 June 2016.

Judge Sara Hinchey
State Coroner




We seek the truth and
strive for justice...

Judge Sara Hinchey
State Coroner

"The Court is entering an exciting new phase of excellence and innovation. Its role in preventing reportable deaths has never been stronger... I feel privileged to be able to continue the hard work of my predecessors and to reap the rewards of the vision shown by them."

It is with great pleasure that I present the Annual Report of the Coroners Court of Victoria for the 2015-16 financial year.

The achievements during this period owe as much to the hard work of my predecessor, Judge Ian Gray, as to the efforts of the Court under my administration. It was a great privilege to be appointed to be the fifth State Coroner of Victoria and I acknowledge the outstanding period of service which His Honour gave to the Court prior to my appointment.

Our vision

In June 2016, the Court launched its 2016-2019 Strategic Plan. This Plan embodies the values that are integral to the work of the Court: Integrity, Collaboration, Accountability, Respect and Excellence. Through the execution of our Strategic Plan, the Court will continue to be a world leader in the provision of coronial services, supporting the administration of justice, reducing preventable deaths and promoting public health and safety for the Victorian community.

In undertaking its work, the Court remains focused on the objectives and purposes of the Coroners Act 2008, which, significantly, reminds us that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress experienced by families and others following the death of a loved one. The growing and ageing Victorian population continues to see the workload of the Court increase annually. I am pleased to report that the Court has again risen to meet this challenge, continuing to finalise more cases than it received this financial year. In turn, this has seen a pleasing reduction in the overall backlog of cases managed by the Court.

Innovation and achievement

My predecessor, Judge Ian Gray introduced and published a timeliness standard to which the Court has regard in managing each of its investigations.

More recently, daily transcript has been introduced in most inquest hearings, to ensure the timely conclusion of those cases and to reduce to the extent possible, the need for adjournments during the running of inquests, especially those that are lengthy or complex.

The Court has continued to adopt the practise of hearing expert evidence concurrently where appropriate – a method which in numerous cases has seen the making of significant admissions by parties, thus reducing the time and expense required to finalise a matter. Similarly, the early utilisiation of Directions hearings has resulted in better scoping of the issues for determination in particular cases, leading to more certainty for parties, the efficient investigation of the reportable death, and in some cases avoiding the need for the matter to proceed to a public hearing.

The Coroners Prevention Unit

The Coroners Prevention Unit (CPU) is staffed by a highly qualified and exceptional team of professionals. Members of the CPU work closely with the Coroners to assist them with understanding the issues that arise out of a particular case and identify and research matters that may lead to recommendations aimed at reducing preventable deaths in Victoria. The Health and Medical Triage service provided by the CPU has recently been expanded to provide a triage service five days per week to Coroners, a measure which it is anticipated will lead to even more efficient investigation of those reportable deaths.

Staff of the CPU also make a significant contribution to the Victorian community through the publication of research papers, the presentation of public lectures and the maintenance of its rich database of information gathered from the findings made by the Court.

Relationship with stakeholders

Never has the close collaboration of the Court with its medical counterparts at the Victorian institute of Forensic Medicine (VIFM) been more apparent than at the International Chief Coroners Conference which I attended in London in May 2016. At that conference, which hosted delegates from around the world, the Melbourne Death investigation Service – comprised of both the Court and VIFM - was lauded as the benchmark to which other jurisdictions ought aspire.

I feel incredibly privileged and excited to be part of a world renowned death investigation partnership. I extend my congratulations to Professor Noel Woodford, the VIFM Director, for his shared vision and aspiration to excellence. I give my sincerest thanks to the outstanding Coronial Admissions and Enquiries staff, ably led by Dr Jodie Leditschke, and to all VIFM staff who continue to provide world class forensic services to the Court and to the community.

The Court works on a daily basis with members of Victoria Police, acting both as Coroner's investigators and also as part of the Police Coronial Support Unit.

The Court acknowledges the outstanding work performed by members of the Homicide and Missing Persons Squads and the Cold Case unit, all of whom have collaborated closely with the Court to ensure that many historical files can be closed in the most efficient manner possible.

The Court also acknowledges the close relationship that it continues to have with the Chief Commissioner of Police and each of the Deputy and Assistant Commissioners, who willingly provide their support, advice and assistance to the Court whenever required.

I wish to thank the other State and Territory Coroners for their collaboration in relation to matters that affect every jurisdiction. There is much to be learned from our shared experience. The advice and support that each provides is an invaluable resource.

Once again, I sincerely thank the volunteers of Court Network who dedicate their time to provide compassionate support to so many families and witnesses who find themselves taking part in Coronial proceedings. Their services are provided without fuss, often under very difficult circumstances. Their work is much appreciated.

A balanced work life – focus on the health and wellbeing of our staff

In recognition of the vicarious trauma often experienced by our staff, the Court has this year focused to an increasing degree on ensuring their continued health and wellbeing. Professional debriefing will shortly be provided to all staff who work closely with bereaved families and other loved ones. This will enhance the staff's existing capacity to manage the daily stressors which arise in this unique workplace. The Court's commitment to supporting the health and wellbeing of all staff will be acknowledged through the introduction in the coming financial year of a formal Health and Wellbeing Strategy.

Thanks

I extend my congratulations and sincere thanks to the outstanding team of Coroners who manage the very large annual caseload with diligence and dedication. The work of the Coroners has been pivotal in realising significant change in the last year – most notably in relation to the laws relating to real time prescribing and end of life choices.

The Court also notes with satisfaction the work of the current Government to remove dangerous railway level crossings and its recently announced commitment that by 2027, it will reduce by half the number of suicides in Victoria. Each of these measures addresses matters in relation to which the Court has made numerous recommendations – the response of the Government to the work of the Court demonstrates the importance of the prevention role which the Court plays in our society.

I would like to thank all of the staff at the Court for their hard work and dedication throughout the year. As the incoming State Coroner, I have been overwhelmed by the warm welcome that has been extended to me since my appointment in December 2015. The staff are the life blood of our Court. Their efforts are exceptional. They are a pleasure to work with.

Lastly, I applaud the Court's Chief Executive Officer, Samantha Hauge and thank her for her hard work and leadership. I note her report and commend her once again for her exemplary financial management of the Court.

"Through the execution of our Strategic Plan, the Court will continue to be a world leader in the provision of coronial services, supporting the administration of justice, reducing preventable deaths and promoting public health and safety for the Victorian community."

Toward the future

The Court is entering an exciting new phase of excellence and innovation. Its role in preventing reportable deaths has never been stronger. I am proud of the significant achievements which have been made by the Court over the past five years. I feel privileged to be able to continue the hard work of my predecessors and to reap the rewards of the vision shown by them.

Yours sincerely

Judge Sara Hinchey

State Coroner

Samantha Hauge
CEO

“This report provides an opportunity for the Court to demonstrate its accountability to the Victorian Parliament, to the Victorian community and importantly, to Victorian families who through the loss of a loved one, find themselves involved in our jurisdiction.”

It is with pleasure that I report on the administration of the Coroners Court of Victoria (the Court) for the financial year 2015-16.

Performance and Efficient Operations

It has been another exciting and challenging year for the Court as we have responded to ever increasing caseloads, and continued to look for ways to innovate and improve service delivery. Since the organisational restructure in August 2013, the Court has continued to achieve a case finalisation rate in excess of 100 per cent.

This year was no exception, with the Court achieving a case finalisation rate of 103 per cent. In addition, a healthy 80 per cent of all reported matters were finalised within 12 months, and 45 per cent of those matters were finalised within three months, which is the highest finalisation rate achieved in the last five years and is attributable to process improvements in the administrative area for natural causes deaths. During the reporting period, there has been a concentrated effort to address cases that have been lodged for 24 months or longer. In the 2014-15 reporting period, this figure was 603. The Court has now reduced this figure down to 354, with 105 matters currently unable to be actioned as they are the subject of ongoing criminal investigation or court proceeding in another jurisdiction. Continued efforts to prioritise and finalise these matters will continue into the next reporting period.

Healthy Fiscal Position

After another successful budget forecast in 2014-2015, I am delighted to report that the Court has again managed its expenses with a healthy surplus to be carried into the next financial year. This surplus will allow the Court to implement a number of initiatives designed to improve the service we provide to the community. An example of improvement initiatives to be implemented is the development of Electronic Document Lodgement, which will significantly reduce the manual handling of paper file documents and provide an option for external users to submit documents electronically.

In addition, the Court will commission the building of a Family Portal which will provide an option for families to have relevant documentation published securely online for the family to view, and allow families to add information. During the year the Court has explored and implemented some cost recovery measures, with more in development. This will enhance the Court's financial autonomy and advance the longer-term fiscal sustainability of the Court.

New Case Management System

In 2015 the Court identified a need for a bespoke case management system that supports the unique operational requirements of the Court, and allows coroners and staff efficiently to manage a coronial investigation from the notification of a reportable death to case completion. Consequently, the Court engaged the Victorian Institute of Forensic Medicine (VIFM) to develop a new electronic case management system that interfaces with VIFM's case management system, which will lead to significant improvements in efficiency. The new system is now known as the Coroners Case Management System (CCMS), and will be launched on 29 August 2016.

CCMS requires on-going maintenance and development to ensure it continues to meet the needs of the Court. Therefore, the CCMS will subsequently be managed and supported by the team of in-house ICT specialists at VIFM. This will enable responsive change and great scope for ongoing improvement to continue to deliver excellence in coronial services.

Transport of Deceased Persons

Of significant note is that the Court undertook a successful procurement process to secure the services of new transport of deceased persons supplier for metropolitan Melbourne and for regional repatriation. The new provider, St John Ambulance Australia (Vic), will provide improved service delivery and logistical capability; utilisation of a modern communication and coordination centre and greater insights into improvements that can be made to service performance.

Improved Data Collection

Improved data collection for the identification of Aboriginal and Torres Strait Islanders has been a focus for the Court over the past year. Historically, identification of Aboriginal and Torres Strait Islanders has been largely reliant on police recording indigenous origin information when they provide their initial reports of death to the Coroner; in many cases this information was not recorded, and consequently the indigenous status for many deceased was not known and in addition, there were a large number with an unknown status.

Following a proactive change in how the Court now identifies indigenous origin, the Court conducted a before and after review to identify whether there were improvements in the identification of indigenous origin amongst persons who come into our care. Preliminary results indicated no notable increase in the frequency of deceased identified who were of indigenous origin; however there was a substantial decrease in the overall frequency of deceased for whom indigenous origin status was unknown.

Commitment to Collaboration

The Coroners Prevention Unit continues to build collaborative partnerships with external organisations that have expertise in a range of areas pertinent to public health and safety. Some of these collaborations have allowed the Court to establish externally funded positions, which has resulted in the Court being able to advance the evidence-base in areas of suicide, drug-related harms and road safety. In turn, the results of this collaboration are provided to Coroners to inform recommendations which may be directed to public or statutory authorities and other entities.

Special Mention

The Law Institute of Victoria Awards are held to celebrate outstanding law firms and individuals who have truly advanced the legal profession, contributed to community or demonstrated excellence in legal practise in Victoria. In October 2015 nominations opened for the awards, in February 2016 short-listed finalists were determined and winners were announced at the Awards Ceremony and Gala Dinner held on the evening of 20 May 2016. I am thrilled to advise that Coroners Court Senior Legal Counsel Jodie Burns won the Victorian Government Lawyer of the Year award. This is a wonderful achievement and recognition of Jodie's merits. Her dedication, passion and perseverance are exemplary and inspiring.

Appreciation

Our staff are the backbone in delivering exceptional coronial services to the Victorian community. I would like to thank them for their dedication and professionalism; they have my utmost respect and admiration.

I would also like to extend my gratitude to Judge Ian Gray who was our State Coroner until December 2016. He was committed to the work of the Court, and implemented many significant enhancements to the operation of the Court during his time. His support and encouragement for me in my role was deeply appreciated.

Finally, I record my sincere appreciation and gratitude to Judge Sara Hinchey. Judge Hinchey has provided me with invaluable support, encouragement and wise counsel. The ideas and directions that Judge Hinchey has for the Court are visionary and exciting, and it is a journey that I look forward to sharing.

Samantha Hauge

Chief Executive Officer

Case Study 1

Prescription drug shopping

Mr F died from bronchopneumonia against a background of methadone and benzodiazepine use.

The Coroners' investigation

During the investigation into Mr F's death, the Coroner identified a range of potential issues relating to the medical treatment received, including:

- Mr F was prescribed methadone to treat his opioid dependence while suffering asthma and recurring chest infections. Methadone is a powerful respiratory depressant and, in a person with respiratory disease, there is a risk it might further, fatally, compromise respiration. This risk is explicitly highlighted in methadone product information, but is not reflected in clinical guidelines and policies for treating opioid dependence.
- Mr F was engaged in 'doctor shopping' to obtain addictive pharmaceutical drugs from a large number of doctors for an extended period. In the year leading up to his death, he was prescribed drugs of dependence (including diazepam, oxycodone, methadone and tramadol) by at least 20 doctors at 10 different clinics.
- There was no evidence that prescribing doctors made an effort to check whether Mr F was drug dependent or engaged in doctor shopping.

What the Coroner found

The Coroner recommended that the Commonwealth Department of Health and Victorian Department of Health and Human Services review the guidance they provide to doctors on how to prescribe methadone safely to opioid dependent clients who suffer respiratory disease, to ensure it is clear and explicit and reflects best clinical practice.

Additionally, the Coroner acknowledged the challenges that clinicians face when determining whether to prescribe a drug to a patient, including the limited means they have to establish whether a patient is engaged in doctor shopping for excessive - often dangerous - quantities of drugs. She noted that hundreds of Victorian deaths are linked to pharmaceutical drugs each year; in particular the annual frequency of Victorian overdose deaths increased every year between 2010 and 2015, with pharmaceutical drugs being the most frequent contributors, playing a role in around 80% of the deaths.

In this context, the Coroner discussed the ongoing urgent need for Victoria to implement a real-time prescription monitoring (RTPM) system that stores information on drug dispensing, and is it available electronically so that a doctor or pharmacist consulting with a patient can establish instantly what other drugs the patient has recently obtained. An RTPM system - which Victoria's coroners have been calling on the government to introduce for at least 15 years - would enable clinicians to identify issues such as doctor shopping as well as to coordinate the care they provide to patients.

The Coroner concluded:

Mr F's death further reinforces the immediate need for a real-time prescription monitoring system to assist doctors in their clinical decision-making around drug prescribing, which should not await the involvement of all other states and territories. With this in mind, she recommended that the Victorian Department of Health and Human Services immediately proceed with implementing a real time prescription monitoring system in Victoria to tackle the ever-increasing toll of pharmaceutical drug related deaths in the state.

What has been done as a result?

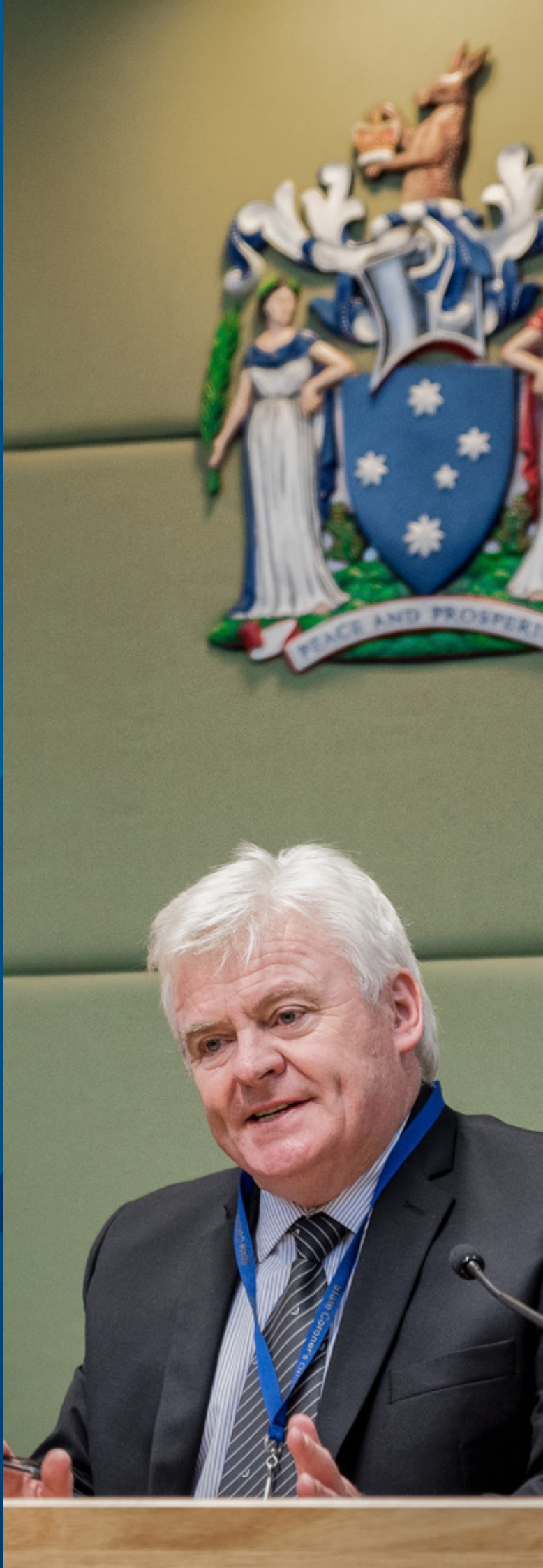
Three weeks after the Coroner's finding, the Minister for Health the Hon Jill Hennessy MP announced that the Victorian Budget 2016-17 included funding to implement a state-based RTPM system.

The announcement emphasised the important role Victoria's coroners played in advocating for this, noting that "21 coronial findings" since 2012 had "[called] for the implementation of a Victorian real-time prescription monitoring system".

Case Study 2

Drowning of a child under 10 years of age at a beach location

BP was a nine year old boy who drowned whilst playing in waters off Seaford beach with friends in the summer holidays of January 2012.



The Coroners' investigation

The coroner's investigation revealed that although BP had had swimming lessons whilst at primary school he was not a good swimmer and fearful of deep water. The beach where he was playing was described as shallow with a sand bank 10 metres from shore.

The water gained depth between two sandbanks to reach a depth above a child's head. Drowning is the leading cause of death of children aged 0-14 years. A recent report from Life Saving Victoria estimated that three out of five children are leaving primary school without the ability to swim to basic standards, defined as being able to swim 50 metres or stay afloat for two minutes.

What the Coroner found

The coroner noted neither the state curriculum Australian Victoria Essential Learning Standards (AusVELS) nor the Australian Curriculum, the two curricula applicable to Victorian schools, had water safety education or swimming lessons as part of the compulsory curriculum.

Agreeing with the recommendation in the Life Saving Victoria report Sink or swim: the state of Victorian primary school children's swimming ability, the Coroner recommended that swimming and water safety education should be a compulsory skill taught within the primary school curriculum to all Victorian children. The response from the Commonwealth Department of Education and Training, recognised the importance of water safety skills. It indicated that the Australian Curriculum allows state and territory education authorities to deliver programs, such as water safety skills, should they choose to implement the curriculum in this way.

The response from the Victorian Department of Education & Training supported the recommendation that swimming instruction and water safety education be part of the curriculum in all Victorian primary schools.

It noted that swimming skills are within AusVELS, however schools make local decisions about how they will implement this curriculum. The Department indicated that it does not collect data about the implementation of swimming instruction in Victorian government schools.

What has been done as a result?

As a result of the coroner's recommendation, the Department indicated its commitment to taking a range of actions to promote and encourage swimming instruction and water safety education in Victorian government schools.

It also indicated that it would inform the Catholic Education Commission of Victoria, Independent Schools Victoria and other school system owners, of the Coroner's recommendation and the Department's response.

Overview

Our Purpose

The purpose of the Coroners Court is to fulfil its statutory obligations under the Coroners Act 2008 (Vic) by independently investigating reportable deaths and fires to reduce preventable deaths and to promote public health and safety within the Victorian community.

Our Vision

To be a leader in coronial services, which support the administration of justice and deliver service excellence by fulfilling our primary purpose of providing timely findings following coronial investigation of reportable deaths. In addition the Court contributes to reducing preventable deaths and promoting public health and safety for the Victorian community.

Our Values

Integrity
We show integrity by consistently applying ethical and principled behaviour which reflects trust and honesty.

Collaboration
We show collaboration by working together with our stakeholders to achieve better results for the community.

Accountability
We commit to the actions we take to achieve the best possible outcome for the Coroners Court of Victoria.

Respect
We show respect by considering others and treating them with dignity, empathy, sensitivity and courtesy.

Excellent Service
We strive to do our best to deliver quality service, focussing on improving the way we work within the Court, to provide excellent service to the Victorian community.


PEACE AND PROSPERITY

Case Study 3

End of life care of a terminally ill patient

AA was an 85 year old man living at home with advanced cancer. He was being managed by a hospital community palliative care service. After falling at home he was admitted to hospital and found to have fractured his femur. He was operated on to repair the fracture. AA deteriorated post operatively and died in hospital three days after the surgery. His family had hoped he would die at home ‘with dignity’.

The Coroners' investigation

The coroner's investigation raised the question of why a major surgical procedure was offered and consented to by family for a terminally ill patient receiving palliative care. The hospital records did not indicate that any alternative to surgery was considered or discussed with AA or his family.

An independent expert opinion was sought from an Intensivist with a particular interest in end of life decision making and advanced care planning. The expert opined that at the time of his fracture, AA was probably in the last weeks of his life and that there were two alternatives to surgery: conservative management of the fracture with the aim of prolonging life; or a solely palliative approach (terminal palliation) in which treatment attains complete pain relief, but culminates in death.

The expert listed several reasons why a terminal palliative approach might have been preferable in this case; including that AA experienced unnecessary suffering without any benefit and that surgery removed the opportunity for him to die at home. However, the expert also noted that such an approach is not consistent with hopes for patient improvement. Had the option of terminal palliation been discussed with AA and his family it is entirely possible they would not have agreed. The expert further noted that surgery in such cases is widely accepted as appropriate treatment, indeed it is regarded as mandatory for good care.

The expert's opinion was provided to the Royal Australasian College of Surgeons (RACS) for comment. The Coroner was advised that RACS had no relevant guidelines. Instead, reliance is placed on individual surgeons having family discussions about likely outcomes and obtaining fully informed consent before any surgery.

What the Coroner found

The Coroner considered it would be helpful, and in line with RACS' values of advocating for surgical standards and education, that RACS provide guidance to surgeons in respect of a matter of increasing relevance to their profession. Accordingly, the Coroner made the following two recommendations:

1. That the Royal Australasian College of Surgeons considers the need to develop guidelines for cases where end of life patients sustain significant fractures.

2. That any such guidelines provide that the option of terminal (end of life) palliation be discussed with the patient and family in situations where surgical repair is likely to have little or no benefit to the patient.

What has been done as a result?

At the date of writing the RACS is yet to provide a response.

About The Coroners Court Of Victoria

Mandate and Purpose

The Coroners Court of Victoria is a specialist inquisitorial Court that has jurisdiction under the *Coroners Act 2008 (Vic)* (the Act) to investigate reportable and reviewable deaths and fires. The Act also sets out the Court's statutory obligations to find, where possible, the identity of the deceased, the cause and circumstances of reportable deaths and the cause and origin of reportable fires.

The Act outlines the prevention function of the Court as a defining feature. 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 on any matter connected with a death and fire that are targeted at the reduction of preventable deaths and fires.

Coroners make recommendations on any matter connected to a death or fire to any Minister, public statutory authority or entity, including in relation to issues of public health and safety and the administration of justice. Significantly, 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.

Areas of Investigation

Reportable Deaths

Coroners are required to investigate a death if it is reportable under the Act. Section 4 of the Act states that a death is 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 and Regulation 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.*

During the reporting period, there were 6,366 notifications made to the coroner, an increase of 30 compared with the previous reporting period.

Reviewable Deaths

Coroners must also investigate a category of deaths known as 'reviewable deaths'. Section 5 of the Act defines a reviewable death to be 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 must have died in Victoria, or the cause of death occurred in Victoria, or the child lived in Victoria but died elsewhere.

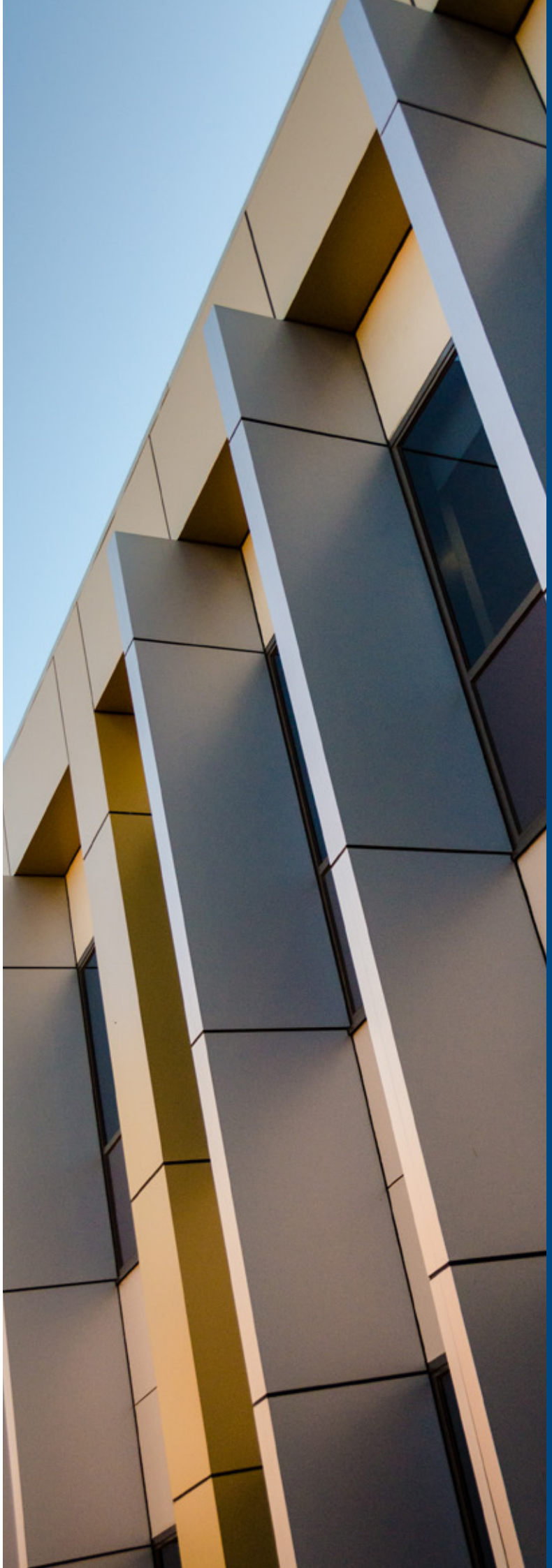
Importantly the Act has changed the definition of reviewable deaths to exclude stillborn children and children who lived their entire lives in hospital, unless otherwise determined by a coroner.

During the reporting period there were two reviewable deaths reported to the Court, which is a decrease of five from the previous reporting period. (Figure excludes reviewable deaths that were also deemed reportable deaths).

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.

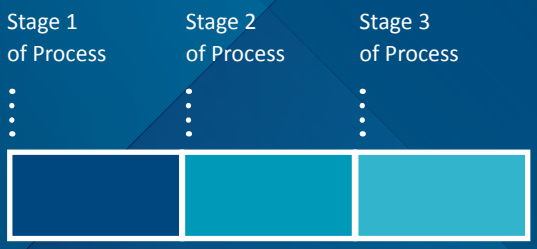
During the reporting period, there were three fires without death reported, which is an increase of one from the previous reporting period.

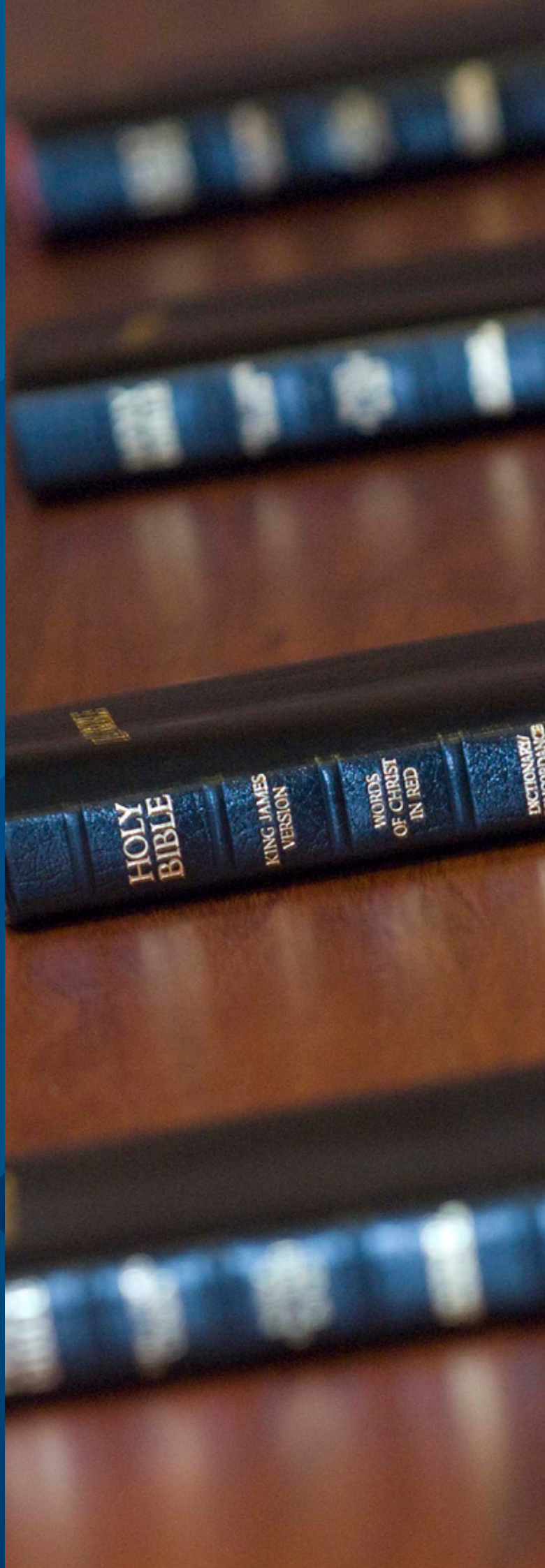


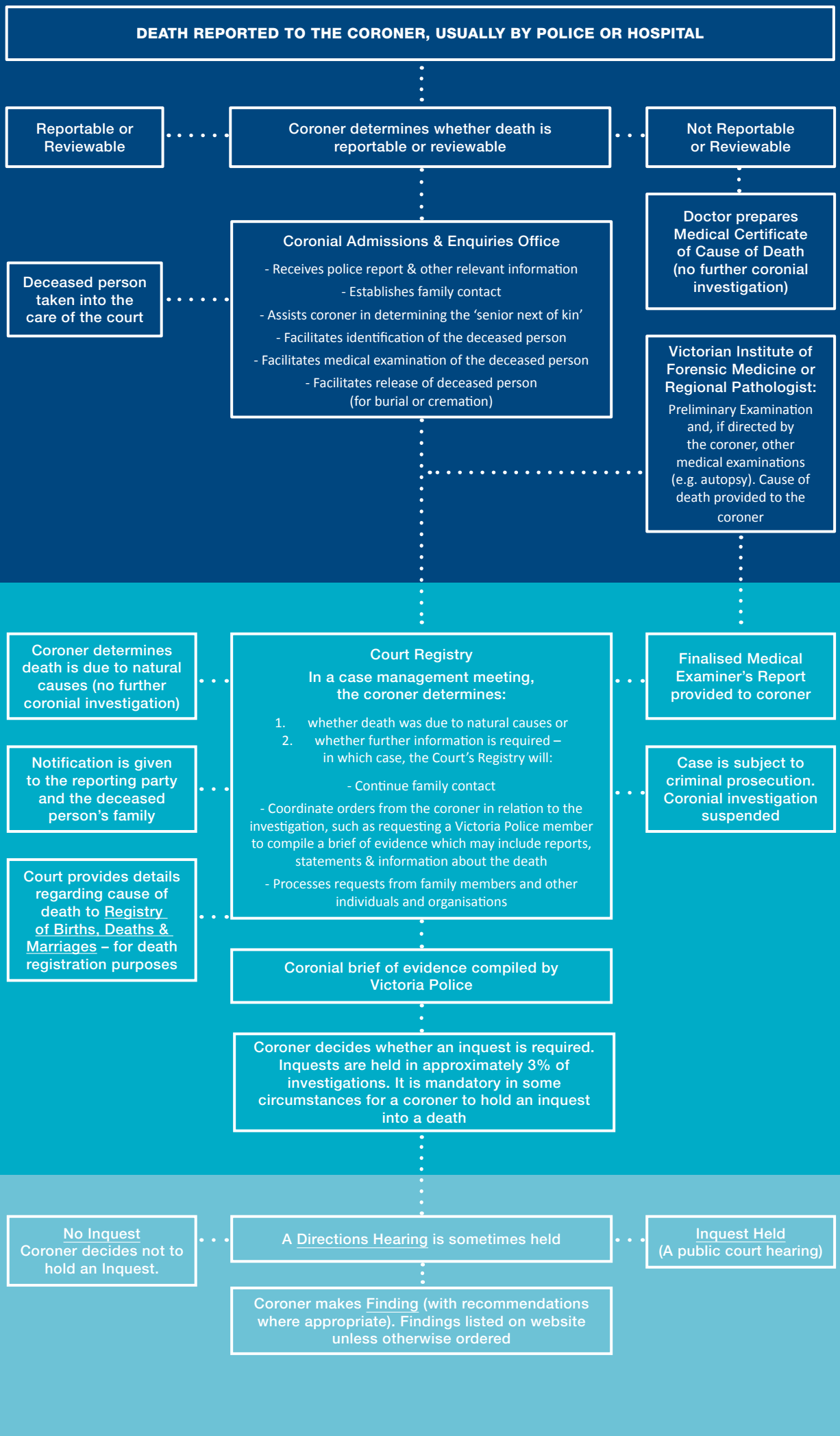
The Coronial Process

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.



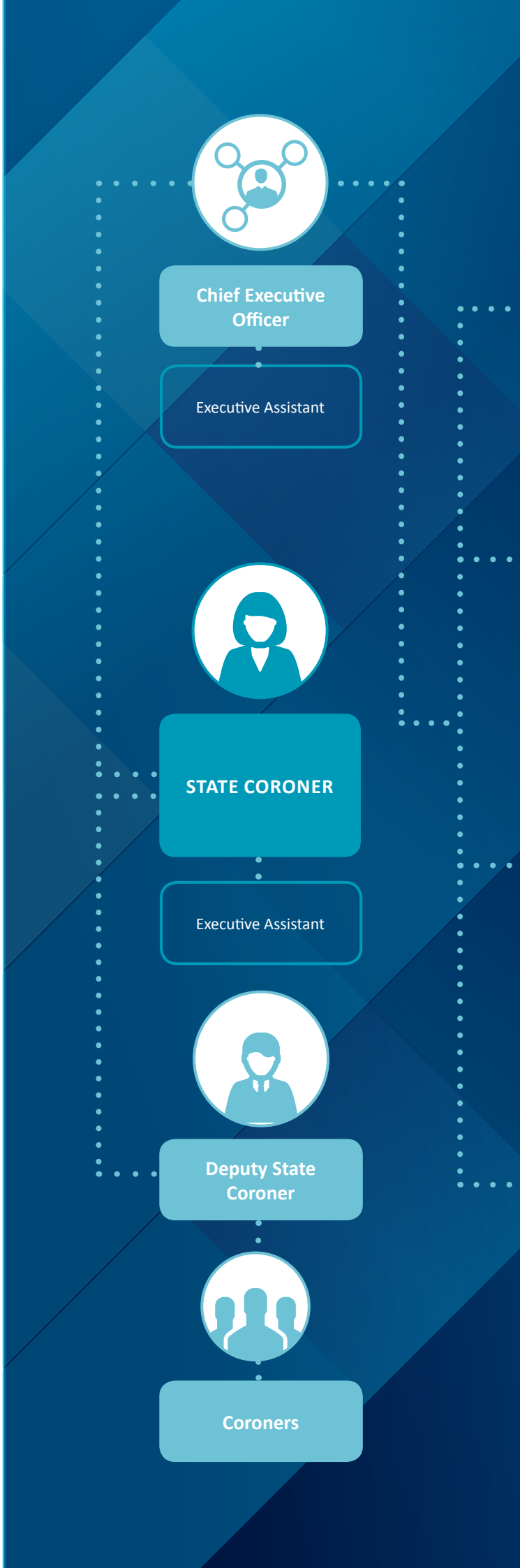


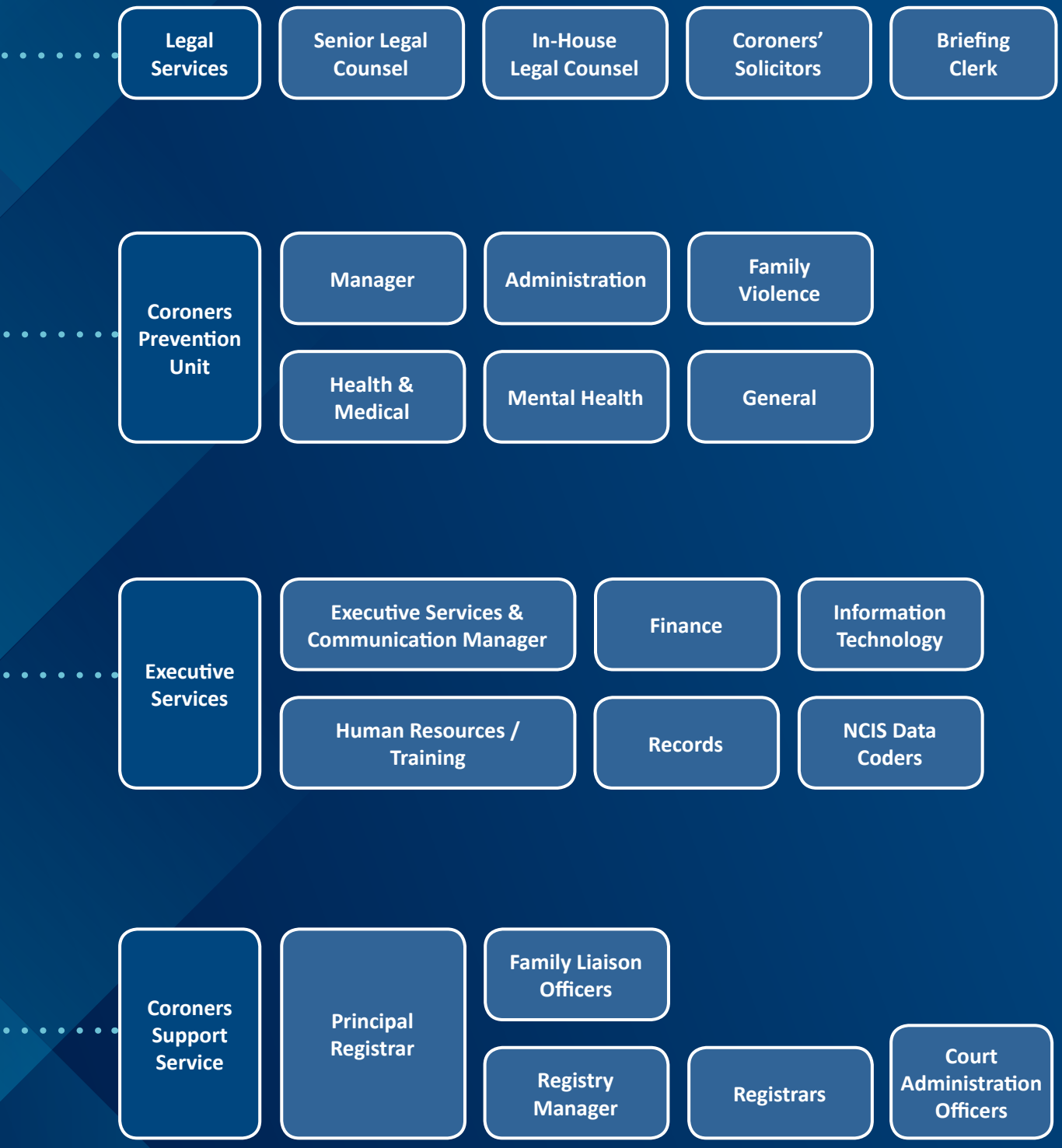

DEATH REPORTED TO THE CORONER, USUALLY BY POLICE OR HOSPITAL
Reportable or Reviewable
Coroner determines whether death is reportable or reviewable
Not Reportable or Reviewable
Doctor prepares Medical Certificate of Cause of Death (no further coronial investigation)
Deceased person taken into the care of the court
Coronial Admissions & Enquiries Office
- Receives police report & other relevant information
- Establishes family contact
- Assists coroner in determining the 'senior next of kin'
- Facilitates identification of the deceased person
- Facilitates medical examination of the deceased person
- Facilitates release of deceased person (for burial or cremation)
Victorian Institute of Forensic Medicine or Regional Pathologist:
Preliminary Examination and, if directed by the coroner, other medical examinations (e.g. autopsy). Cause of death provided to the coroner
Coroner determines death is due to natural causes (no further coronial investigation)
Court Registry
In a case management meeting, the coroner determines:
1. whether death was due to natural causes or
2. whether further information is required – in which case, the Court's Registry will:
- Continue family contact
- Coordinate orders from the coroner in relation to the investigation, such as requesting a Victoria Police member to compile a brief of evidence which may include reports, statements & information about the death
- Processes requests from family members and other individuals and organisations
Finalised Medical Examiner's Report provided to coroner
Notification is given to the reporting party and the deceased person's family
Case is subject to criminal prosecution. Coronial investigation suspended
Court provides details regarding cause of death to Registry of Births, Deaths & Marriages – for death registration purposes
Coronial brief of evidence compiled by Victoria Police
Coroner decides whether an inquest is required. Inquests are held in approximately 3% of investigations. It is mandatory in some circumstances for a coroner to hold an inquest into a death
No Inquest
Coroner decides not to hold an Inquest.
A Directions Hearing is sometimes held
Inquest Held
(A public court hearing)
Coroner makes Finding (with recommendations where appropriate). Findings listed on website unless otherwise ordered

Our Organisational Structure

The Court is comprised of nine full-time Coroners and one reserve Coroner, including the State Coroner and the Deputy State Coroner.

The administration of the Court is led by the CEO who is supported by four business units: Coroners Support Service; Legal Services; the Coroners Prevention Unit; and Executive Services.




Legal Services
Senior Legal Counsel
In-House Legal Counsel
Coroners' Solicitors
Briefing Clerk
Coroners Prevention Unit
Manager
Administration
Family Violence
Health & Medical
Mental Health
General
Executive Services
Executive Services & Communication Manager
Finance
Information Technology
Human Resources / Training
Records
NCIS Data Coders
Coroners Support Service
Principal Registrar
Family Liaison Officers
Registry Manager
Registrars
Court Administration Officers

Case Study 4

Suicide in the context of family violence

Police officers attended Mr S's home in response to a report of family violence and as a result he was told that he would be named as the Respondent to an intervention order that contained a condition stating that he must leave the family home.

This condition would have separated Mr S from his children. When police returned to the property to execute a warrant, Mr S was found deceased from what appeared to be suicide.

The Coroner held an inquest into the death of Mr S, which included an examination of the incidence of suicides of male perpetrators of intimate partner violence. Until the Coroners Court of Victoria highlighted the issue to Victoria Police, the risk of male perpetrators of intimate partner violence committing suicide, was not a known or considered issue.

The Coroners' investigation

The Coroner found that Mr S intended to end his life. The stressors impacting on his life at the time of his death included: a breakdown in his relationship, not being able to live with his children, financial hardship, a belief that his wife had been unfaithful and that he would struggle to return to work with this issue being present. Mr S also had been diagnosed and treated for depression. The Coroner found that the combination of these factors contributed to Mr S's decision to end his life.

What the Coroner found

The Coroner recognised that the primary consideration for police officers to a family violence incident is to ensure the safety of the affected family member and their children and to hold the perpetrator accountable. Despite this, the Coroner identified that the Victoria Police L17 is a risk assessment focused on the likelihood of family violence re-occurring. She considered it necessary and appropriate that perpetrators of family violence be the subject of a risk assessment, including the risk of suicide.

The Coroner commented that police officers, as first-responders, have a unique opportunity to assess the mental well-being of an alleged family violence perpetrator. By turning their attention to assess the risk to a perpetrator, they are potentially minimising the risk of harm to others, as well as harm to the perpetrator themselves.

What has been done as a result?

Victoria Police has implemented the proposed changes and made the following comments:

Victoria Police welcomes your finding in respect of the inquest into the death of Mr S.

Your thorough investigation into this matter has highlighted an alarming area of concern for Victoria Police and the community and the VSR data relating to family violence perpetrator suicides demonstrates that active steps are required by Victoria Police to address this significant issue...In light of your findings, Victoria Police are committed to enhancing our response to family violence perpetrator welfare and will be taking steps to best address this issue through training and policy.

I can confirm that your finding has been forwarded to our Family Violence Command Policy and Projects Unit for further research and development of policy and training.

This finding has now highlighted the importance of identifying the potential increased suicide risk in perpetrators of intimate partner violence.

Our Coroners

State Coroner
Judge Sara Hinchey

(From 12/2015), BSc LLB

County Court Judge Sara Hinchey is the Victorian State Coroner. Her Honour has appeared before the Coroners Court in some of the state's most high-profile inquests.

Her inquisitorial experience also extends to appearances before two Royal Commissions including the Royal Commission into Institutional Responses to Child Sexual Abuse and the 2009 Victorian Bushfires Royal Commission.

Judge Hinchey was appointed as a Judge of the County Court in May 2015 following more than 19 years' experience as a trial and appellate barrister. During this time, she also appeared in the higher courts of Victoria, New South Wales, Tasmania and the ACT, as well as the Federal Court and the High Court of Australia.

Her areas of interest include occupational health and safety; corporate crime; construction law; medical and other professional negligence; and professional disciplinary matters.

- Asia Pacific Coroners Society Member
- Coronial Council of Victoria
- CCOV/VIFM Joint Operations Steering Committee
- CSV Assets and Security Portfolio Committee
- CSV Courts Council Member
- CSV Finance Portfolio Committee
- CSV Human Resources Portfolio Committee
- CSV IT Portfolio Committee
- National Coronial Information System Board of Management
- State DVI Committee
- State and Territory Coroners Committee
- Transport of Deceased Persons Steering Committee
- Victorian Systemic Review of Family Violence Death Reference Group
- VIFM Council

State Coroner Judge Ian Gray

(To 12/2015), LLB

Judge Ian Gray was Victoria's fourth State Coroner serving from November 2012 to December 2015. Prior to his role as State Coroner, Judge Gray was the Chief Magistrate of Victoria and the Northern Territory.

Deputy State Coroner Iain West

B Juris LLB

Deputy State Coroner Iain West was admitted to practise in 1975. He was a barrister for eleven years before being appointed a Magistrate in 1985. Iain West was appointed the Deputy State Coroner of Victoria in 1993.

- Coroners and Pathologists Advisory Group
- State DVI Committee

Coroner Phillip Byrne

LLB

Coroner Phillip Byrne was appointed a Magistrate/ Coroner in 1982. He subsequently spent 18 years as a Co-ordinating Magistrate for the Wimmera Mallee Region, headquartered at Bendigo. At that time Magistrates in country regions undertook coronial duties. He retired in 2000 only to subsequently return on assignment, to work full time as a coroner, from 2003-2006 and 2013 to present.

Coroner Rosemary Carlin

LLB(Hons) B(Sc)

Coroner Rosemary Carlin commenced her legal career as a solicitor for the Commonwealth Director of Public Prosecutions. In 1991 she became a barrister and for the next 16 years prosecuted criminal trials for Victoria, the Northern Territory and the Commonwealth. At different times she held the positions of Crown Prosecutor for Victoria, Senior Crown Prosecutor for the Northern Territory and In-house Counsel for the Commonwealth Director of Public Prosecutions. In 2007 she was appointed a Magistrate and in 2014 began working exclusively as a Coroner.

- Coroners' Education Committee
- Donor Tissue Bank of Victoria Committee
- Health and Legal Counsel Forum
- Victims of Crime Consultative Committee

Coroner Caitlin English

BA(Hons) LLB MPP

Coroner Catlin English worked as a solicitor at Minter Ellison, Victoria Legal Aid and the Public Interest Law Clearinghouse. She completed a Churchill Fellowship in 1999 and was appointed as a Magistrate in June 2000. She has presided in all jurisdictions of the court, including six years at Broadmeadows Magistrates' Court where she sat in the Koori court. She was on the editorial committee of the Magistrate's Bench Book for twelve years. She was assigned to the Coroners Court in February 2014.

- Coroners' Education Committee
- CSV Koori Inclusion Action Plan Steering Committee
- Human Rights Bench Book Committee of the Judicial College of Victoria

Coroner Jacqui Hawkins

BA(Hons) LLB

Coroner Jacqui Hawkins was appointed as a coroner on 1 January 2014. Prior to her appointment, she was Senior Legal Counsel for the Coroners Court of Victoria and established the In House Legal Service for the Court. Prior to joining the Coroners Court, Coroner Hawkins was a Partner at Lander & Rogers in the Workplace Relations and Safety Group. She specialised in Occupational Health and Safety and was the partner responsible for the Specialist Inquest Panel on the Victorian Government Legal Panel.

- Asia Pacific Coroners Society Member
- CCMS Steering Committee
- Health and Legal Counsel Forum
- Transport Industry Safety Group
- Coroners' Education Committee

Coroner Audrey Jamieson

BA LLB Grad. Dip. Bioethics

Coroner Audrey Jamieson was appointed a Magistrate on 21 December 2004 and has worked as a Coroner since June 2005. Coroner Jamieson started her working career as a nurse and later enter the legal profession after completing her degrees at Monash University. She did her Articles of Clerkship at Holding Redlich Lawyers before moving to Maurice Blackburn Lawyers in 1992. At the time of her appointment she was a partner at Maurice Blackburn Lawyers and an accredited specialist with the Law Institute of Victoria in personal injury litigation.

- CCOV Research Committee
- Coroners' Education Committee
- Health and Legal Counsel Forum
- VIFM Ethics Committee

Coroner John Olle

LLB BEc

Coroner John Olle worked as a solicitor at McCarthy & Co, Rye and signed the Bar Roll in 1983 appearing predominantly in County Court trials and Coronial Inquests. He was appointed a Coroner in 2008.

- CCOV OH&S Committee

Coroner Paresa Spanos

BA LLM

Coroner Paresa Spanos graduated from the University of Melbourne in 1981 and was employed as an articled clerk/litigation lawyer in private practise. She then worked for ten years at the Commonwealth Director of Public Prosecutions, first in Trials and Appeals, then as a Medifraud Specialist before becoming Senior Assistant Director in 1989 and heading the Major Fraud and later General Prosecutions Branches.

Coroner Spanos was appointed a Magistrate in 1994 sitting both in Melbourne and the suburban courts, with periodic appointments to the Children's Court. Since 2005, she has worked exclusively as a coroner on a range of coronial investigations. From 2005-2013, Coroner Spanos was a member of the Victorian Child Death Review Committee.

- Asia Pacific Coroners Society Member
- CCOV Research Committee
- Coroners and Pathologists Advisory Group
- Health and Legal Counsel Forum
- Victorian Magistrates Association
- Hellenic Australian Lawyers

Coroner Peter White

LLB LLM

Coroner Peter White undertook his Articles of Clerkship and worked as a solicitor at Maurice Blackburn and Co before leaving in mid 1973 to work as a government lawyer in the then soon to be independent Papua New Guinea. His work in PNG included work as a Crown Prosecutor and later as a parliamentary advisor to the Minister for Justice.

Following independence, Coroner White was appointed as legal counsel to the newly created Ombudsman Commission. In June 1977 he was appointed as Senior Magistrate in the North Coast Region based in Lae and later as the Senior Magistrate in the Highlands Region, based in Goroka. Coroner White held this post until mid 1983 when he left PNG to take up an appointment as a Magistrate in Hong Kong.

Thereafter he worked for the Hong Kong judiciary as a Magistrate and in other judicial capacities and in 2002 he was appointed as a Coroner, a position he held until his return to Australia in 2006. He was appointed as a Coroner in Victoria in March 2007.

- CSV Audit and Risk Portfolio Committee
- CCOV Audit and Risk Committee

Our Executive

Samantha Hauge
Chief Executive Officer

BSW

Samantha Hauge has held the role of Chief Executive Officer at the Coroners Court of Victoria since February 2013. Samantha first commenced at the Coroners Court in 2008 where she established and managed the Coroners Prevention Unit.

Prior to this, Samantha spent approximately 16 years working for the Department of Human Services, initially as a child protection worker and later in a number of managerial positions. During her time with DHS, she spent a number of years as a senior court officer appearing at the Melbourne Children's Court and working as a senior policy and program advisor for the Office of Children, Child Protection and Family Services.

Samantha has also worked as a counsellor at the Victorian Society for the Prevention of Child Abuse and Neglect and in other counselling positions in women and children services.

- CCOV Audit and Risk Committee
- CCOV Finance Committee
- CCMS Steering Committee
- Transport of Deceased Persons Steering Committee
- Coronial Services Centre Emergency Management Steering Committee
- CCOV/VIFM Steering Committee
- CCOV/VIFM Joint Operations Committee
- CSV Human Resource Portfolio Committee
- CSV Human Resource Policy Working Group
- CSV Finance Portfolio Committee
- CSV Assets and Security Portfolio Committee
- CSV Koori Inclusion Action Plan (KIAP) Steering Committee

Dr Lyndal Bugeja
Operations Manager

(From 03/2016) BA (Hons) PhD

Lyndal has spent most of her career conducting research and policy analysis to support coronial investigations. Her area of interest is in the development of evidence-based recommendations that can improve population level public health and safety.

She has held a number of positions at the Court and as the Operations Manager has managed the day-to-day activities of the Executive Services Team, the implementation of the Coroners Case Management System, the Victorian Systemic Review of Family Violence Deaths and other major projects and collaborations.

- Coronial Services Centre Emergency Management Steering Committee
- CCMS Steering Committee
- CCOV Audit and Risk Committee
- CCOV Deputy Chief Fire Warden
- Co-Convenor, Injury Special Interest Group of the Public Health Association of Australia
- CSV IT Portfolio Committee
- CSV Audit and Risk Committee
- Transport Industry Safety Group

Jodie Burns
Senior Legal Counsel

BA(Hons) LLB

Jodie Burns joined the Coroners Court of Victoria in November 2012 and now holds the role of Senior Legal Counsel. She was admitted to practise law in 1994. Prior to joining the Coroners Court, Jodie held the role of WorkSafe Victoria's Senior Lawyer (Coronial and Prevention).

Jodie has worked previously at the Department of Treasury and Finance, National Crime Authority/Australian Crime Commission, the Office of Public Prosecutions and the Victorian Government Solicitor's Office.

In these roles, she has advised Ministers; responded to Ombudsman enquiries; appeared as counsel in court; managed complex criminal prosecutions for health and safety, fraud related, drug, homicide related, sex and bullying offences; settled and made application for telephone intercept and listening device warrants; developed policy and precedents to address legislative changes and been involved with the drafting of legislation, including the Coroners Act 2008 and advising on the powers of Victorian WorkCover Authority inspectors and the appropriateness of the sentencing structure for the Occupational Health and Safety Act 2004.

- CCOV Audit and Risk Committee
- CCOV / VIFM Joint Operations Committee

Alex Cottrell
Registry Manager

Alex has been the Registry Manager of the Coroners Court of Victoria since 2012. Prior to this she held various positions at the Court including Human Resources Officer, Project Officer and Operations Manager. Alex has a background in Human Resources from Correctional Services South Australia.

- CCOV Audit and Risk Committee

Margaret Craddock
Principal Registrar

Chartered Insurance Institute UK - Financial Planning Certificates: FPC1, FPC2, FPC3 and FPC4

Margaret has been the Principal Registrar of the Coroners Court of Victoria since 2012.

She came to the Court with extensive experience of coronial investigations having previously worked at the Coroners Office in both South Australia and Queensland.

Prior to this Margaret managed a Coroners Office in the United Kingdom covering the counties of Berkshire, Buckinghamshire and Oxfordshire.

- CCOV Audit and Risk Committee
- CCOV/VIFM Steering Committee
- Coroners and Pathologist Working Group
- CCOV / VIFM Joint Operations Committee
- Transport of Deceased Persons Steering Committee

Dr Jeremy Dwyer
Acting Manager
Coroners Prevention Unit

BA(Hons) BSC PhD

Jeremy joined the Coroners Prevention Unit as a case investigator in 2009, after completing his PhD and working in the School of Political and Social Inquiry at Monash University.

Jeremy has assisted coroners with investigations into a range of deaths including overdoses, suicides, police contact deaths and transport crashes.

He is particularly interested in using information technology to understand better the circumstances in which deaths occur and how they can be prevented; to this end he has been heavily involved in the Court's Victorian Suicide Register and Victorian Overdose Deaths Register.

- CCOV Audit and Risk Committee
- CCOV Deputy Chief Fire Warden
- Chair, CCOV Research Committee

Renee Swanson
Executive Service & Communications Manager

(To 01/2016)
BBus (Man Mktg) Grad. Cert. Public Sector Management

Renee has been the Executive Services & Strategic Communications Manager at the Coroners Court of Victoria since 2014. She manages the multi-functional Executive Services team, as well as all communications functions for the Court, working with media, court users, government agencies and various other stakeholders to deliver best practice communications.

She came to the Court with extensive public sector experience in the fields of communications and strategic planning. Before joining the Coroners Court, she held positions in VicRoads and the Department of Transport. In these roles she managed the communications functions for a Council of Australia Government's policy reform project investigating alternative options for heavy vehicle road pricing and funding, as well as various public transport infrastructure projects. Renee is currently on secondment with the Department of Justice and Regulation until December 2016.

- CCOV Audit and Risk Committee
- CSV Audit and Risk Committee
- CSV Communications Community of Practice
- CSV Courts Excellence Community of Practice
- CSV Crisis, Incident, Continuity and Security Working Group
- CSV e-Lodgement Strategy Working Group


PEACE
Court

Presentations

In addition to their work investigating deaths and fires, the coroners and staff made a number of presentations at conferences and meetings, including evidence to two major public inquiries.

- 2015-2016 Boating Season Opening
- 4th Annual Disaster Research @ Monash Symposium
- 12th Australasian Injury Prevention and Safety Promotion Conference
- Asia Pacific Coroners Society Conference
- Australasian Road Safety Conference
- Australian Society of Post Anaesthesia and Anaesthesia Nurses
- Victorian Bar Readers Course
- Community of Practice Safety Culture and Climate Symposium
- Connections Uniting Care Conference
- Coroners Court of Victoria Health Information Day
- Department of Health and Human Services Graduate Students
- Disaster Victim Identification, Coroners Intensive New Zealand
- Greens Barristers List Seminar
- Headspace Centre Managers Meeting
- Judicial College of Victoria, Coroners Intensive
- Legislative Council Legal and Social Issues Committee Inquiry into End of Life Choices
- Melbourne High School Law Society
- Metropolitan Fire Brigade, Fire Investigation Unit
- Monash University, MBBS students
- National Suicide Prevention Conference
- NorthWest Mental Health Monday Colloquium
- Office of Chief Psychiatrist Mortality and Morbidity Committee
- Royal Australasian College of Pathologists
- Royal Commission into Family Violence
- School Counsellors and Psychologists Conference
- St Vincent's Hospital Grand Round
- University of Melbourne, Masters of Law students
- Western Primary Health Network, Deakin University Geelong Campus
- Western Primary Health Network, Deakin University Warrnambool Campus
- Victorian Institute of Forensic Medicine Family Violence Seminar: Behind Crimes in the Home
- Victorian Institute of Forensic Medicine Lunchtime Lecture
- Victorian Institute of Forensic Medicine, MBBS Pathology Students
- Victoria Police, Detective Training School
- Victoria Police Sex Offenders Registry Asia Pacific Conference
- Victorian Parliamentary Inquiry into Dying with Dignity
- Victoria University, Law students

Operational Statistics

Case initiations and closures

	2011-12	2012-13	2013-14	2014-15	2015-16
Cases Opened	5,029	5,934	6,267	6,336	6,366
Cases Closed	4,949	5,342	7,270	6,884	6,582
Case Clearance Rate (Cases Opened / Cases Closed)	98%	93%	116%	108%	103%
Cases referred to the Court by the Registry of Births, Deaths and Marriages	680	593	635	621	459

Case progress

	2011-12	2012-13	2013-14	2014-15	2015-16
0–12 Months	2,908	3,194	2,843	2,607	2,553
12–24 Months	845	1,034	720	655	586
> 24 Months	1,203	1,072	646	603	354
Total Number of Lodgements Pending	4,956	5,300	4,209	3,865	3,493

Objections to autopsy

	2011-12	2012-13	2013-15	2014-15	2015-16
Objections Upheld	45*	90	86	108	76
Objections Refused	51*	-*	-*	-*	-*
Objections Withdrawn	18*	-*	-*	-*	-*
Total Number of Objections	114*	152	105	124	85

Coroners' findings

Finding Into Death With Inquest	Finding Into Fires With Inquest	Finding Into Death Without Inquest	Finding Into Fires Without Inquest	Total
131	1	3,389	5	3,526

* 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 issue within the next reporting period.

Case Study 5

Police Shooting

On the evening of 23 September 2014, members of the Joint Counter Terrorism Team (JCTT) arranged to meet Mr H who had received official notification the day before that his passport had been cancelled. In the months prior, Mr H had been attending a mosque associated with extremist views and a few days earlier had waved a Shahada flag at police at a local shopping centre. The JCTT were to meet with Mr H to assess the level of threat he posed and planned to talk to him at home with his parents. As he hadn't been home, the JCTT members rang him at 7pm, asking him to meet them at the local Police Station.

Mr H arrived at the station shortly after and was sitting on the bonnet of his car as two officers from the JCTT walked across the car park to meet him. Both officers shook the young male's hand and then told him they needed to search him. At that moment Mr H pulled out a large knife and lunged at the first officer, stabbing him in the arm. The officer lost his footing and fell to the ground and Mr H then turned to the other officer, who was looking in his car, and stabbed him. When the first officer regained his footing he saw Mr H on top of the other officer, repeatedly stabbing him. He drew his weapon and shot Mr H once, killing him instantly. A search indicated Mr H had a second knife concealed in a scabbard and a Shahada flag on him.

The Coroners' investigation

CCTV footage gathered during the investigation indicated the entire incident, from the officers first walking across the car-park, took approximately a minute. This was a particularly difficult investigation due to the complexities and sensitivity around some of the evidence that required a high level of confidentiality and secrecy, touching on matters of national security.

Mr H had come to the attention of ASIO, who were concerned about the risk he might pose to national security, and his phone and movements had been subject to surveillance. An inquest was conducted which examined what had been identified about the possible risk Mr H posed, whether there were signs of him becoming radicalised and/or planning attacks and how his attitudes and actions were affected by the cancellation of his passport.

Mr H's reaction to the raids and arrests of alleged terrorism suspects in Sydney and Brisbane on 18 September 2014, and a Fatwa issued by an extremist Muslim cleric which called upon Islamic State followers to target the Australian government and public, were explored. In late August 2014 Mr H made inquiries about purchasing weapons and on 21 September 2014 he had purchased two knives from a disposals store.

The inquest also examined what was known by the JCTT and ASIO of the potential which Mr H had to act the way he did, what risks assessment had been undertaken and ultimately how the decision to speak with Mr H on that evening was made.

What has been done as a result?

Evidence is still being gathered as part of this investigation and the coroner's findings are expected to be delivered late in 2016.

Report of Business Units

Coroners Support Service

Coroner's Registrars

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 coroner's registrar's 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 coroner's registrar's other 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 the everyday work of a coroner's registrar. 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 conducting 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 to 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 the availability of external counselling and support agencies that can assist with their grief and loss.

Legal Services

Senior Legal Counsel

The senior legal counsel manages the legal services for the State Coroner, Deputy State Coroner and other Coroners in Victoria. This includes providing assistance to coroners with their investigation into reportable deaths, liaising with many internal and external parties including Victoria Police, the VIFM, families, lawyers and interested parties. It also includes preparing memoranda of advice for coroners, preparing matters for inquest, appearing as counsel to assist the coroner at inquests, and appearing and instructing at Supreme Court Appeals on behalf of the Court.

The senior legal counsel supervises the legal resources assisting available to assist the coroners as part of the Coroners Support Service. The position provides an in-house legal function, not only to provide resources in an efficient and cost effective manner, but also in order to build and retain relevant knowledge and expertise within the Court.

Reporting to the Chief Executive Officer, the senior legal counsel is a member of the CCOV Operational Executive Team, which assists the CEO in formulating and driving the strategic direction of the Court. The senior legal counsel also represents the Court at the Joint Operations Committee to ensure that the Court and the VIFM work together effectively and efficiently.

In-House Legal Service

The Police Coronial Support Unit (PCSU) assists coroners in many coronial investigations that proceed to inquest, excluding those investigations where the conduct of a police officer will or may come under scrutiny (e.g. death resulting from a police shooting or police pursuit, while a person is being taken into, or was in, custody).

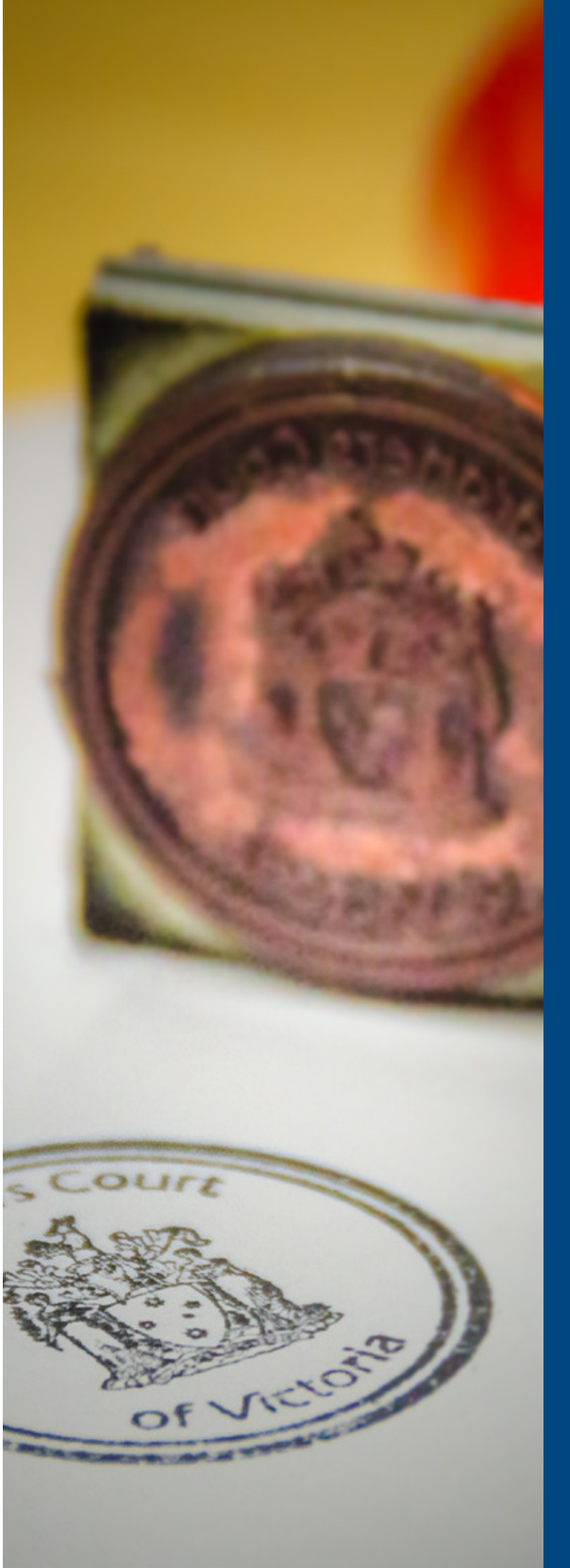
In these cases, in order to avoid any possible conflict of interest, a coroner will engage the In-House Legal Service (IHLS). The Court's IHLS comprises two permanent full-time solicitors.

In the reporting period, the IHLS assumed the conduct of all potential police conflict matters and:

- 76 police contact / conflict files
- provided 43 advices on a range of matters ranging from oral advice to short file work
- appeared as counsel assisting a coroner in six inquests
- appeared as counsel assisting a coroner in 11 directions hearings and mentions
- performed the role of instructing solicitor to counsel assisting a coroner in 59 inquest sitting days
- instructed counsel in six Supreme Court appeals
- instructed counsel in one High Court appeal
- provided and participated in ongoing professional development for coroners and coroners' solicitors

In addition, the IHLS:

- actively managed police conflict investigations
- drafted a range of complex legal documents including assisting coroners to draft findings with and without inquest
- liaised extensively with the legal profession, hospitals, Victoria Police, families and other stakeholders, and provided guidance to court staff on a range of legal issues
- assisted the State Coroner to develop a number of internal protocols, including guidelines for discretionary inquests
- participated in developing joint protocols between the VIFM and the Court to ensure efficiencies between each organisation.



Coroners' Legal Officers[1]

A coroner's legal officer provides legal assistance and support to their allocated coroner in aspects of their coronial investigations by:

- drafting legal documents and correspondence;
- developing and implementing practical strategies for the operation of the Court;
- collaborating and consulting with the coroner, the coroner's support service, the CPU, the Police Coronial Support Unit (PCSU) and other Court business units, and to build and retain relevant knowledge and expertise within the Court;
- assisting the coroners to determine whether a matter will need to be finalised by way of a natural causes finding, finding without circumstances, or finding with circumstances (with or without inquest);
- drafting findings without inquest, examining the coronial brief and other relevant material, evaluating the evidence, ensuring statutory obligations are met and that the evidence is within the scope of the coronial jurisdiction, and providing advice, memoranda of research and draft findings to their coroner;
- drafting letters of instruction to experts and correspondence requesting statements or further information from witnesses;
- undertaking extensive legal research on statute and/or case law;
- appearing, where appropriate, as counsel assisting the coroner in mention and directions hearings and summary inquests, where PCSU are not engaged;
- developing, where required, precedent and template documents, including court forms and sample correspondence;
- assisting in developing Court policies and procedures;
- providing presentations to colleagues about changes to the Coroners Act, Rules and Forms and/or Regulations, procedures and policies and their impact on the Court.;
- representing the Court on a range of committees and organisations including, but not limited to, the CCOV Occupational Health and Safety Committee, the CCOV Research and Ethics Committee and the Coronial Legal Professionals' Network.

The coroners' legal officer roles have enhanced the expediency of file closures while supporting coroners to provide a comprehensive and efficient coronial investigation. This additional support for the coroners has resulted in the Court achieving a reduction in lengthy and/or protracted coronial investigations, an important factor in the Court considerations under section 8 of the Coroners Act 2008 (Vic).

To assist with reducing the delays coroners' legal officers apply a 'whole of court' approach and assist other coroners with their open cases. This ensures that the Court's resources are allocated equitably and used efficiently.

In 2015-2016, the Court introduced a roving coroners' legal officer, which has further enhanced the Court's efficiencies providing legal assistance to any coroner who requires further assistance on a 'needs' basis, and filling in for other coroners' legal officers when they are on leave.

State Coroner's Solicitor

In addition to the responsibilities outlined above for the coroners' legal officers for the reporting period, the State Coroner's solicitor:

- consulted and collaborated with external stakeholders, such as Court Services Victoria (CSV), to develop policy advice on the Court's priority areas;
- liaised with the Court and VIFM staff and other stakeholders such as CSV, on court procedures and processes;
- assisted with development of legislation, such as recent amendments to the Coroners Act 2008 (Vic), Coroners Court Rules (2009) and Coroners Regulations (2009).

[1] In the last reporting period the Court advertised the role as a Coroner's Legal Officer rather than a Coroner's Solicitor. Successful applicants were not required to hold a practising certificate.

Coroners Prevention Unit

The Coroners Prevention Unit (CPU) assists coroners to identify opportunities to reduce preventable deaths and improve public health and safety. Coroners' referrals to the CPU usually originate from investigations into individual deaths, and are addressed by case investigators working across four streams:

- Health and Medical, focusing on deaths where coroners require clinical advice about healthcare provided (or not provided) to the deceased and whether this might have contributed to the death.
- Mental Health, examining deaths of people with suspected or diagnosed mental illness and the treatment and support they received in the lead-up to their deaths.
- Family Violence, examining deaths that occur in a context of family violence as defined by the Family Violence Protection Act 2008 (Vic).
- General, providing advice to coroners on deaths where specialist clinical knowledge is not required.

The scope of advice the CPU provides in response to a coroner's referral can vary greatly depending on the issues the coroner wishes to address, and might encompass any or all of the following:

- the circumstances in which the death occurred, including factors that might have contributed to the fatal outcome.
- the frequency of previous and subsequent similar deaths in Victoria.
- common risk factors associated with the type of death under investigation.
- interventions that are proven or suspected to reduce the incidence of future similar deaths.
- regulations, standards, codes of practice or guidelines that might be relevant to the circumstances of the death.
- previous recommendations made by coroners investigating similar deaths.
- feasible, evidence-based recommendations the coroner could consider to reduce the incidence of similar deaths in the future.

In formulating its advice, the CPU consults with stakeholders and independent experts, and draws on internal resources including a basic database of all deaths reported to the Court; several databases with detailed information about particular types of deaths (the Suicide Register, Overdose Deaths Register, and Homicide Register); and a database of Victorian coroners' recommendations.

The Health and Medical case investigators are supported by clinical consultants including a paediatric registrar from Monash Children's Hospital undertaking advanced clinical training. During the 2015-16 reporting period, coroners made 617 referrals to the CPU regarding deaths under investigation. The bulk of the referrals were directed to the Health and Medical stream (421) and Mental Health stream (110), with a lower number of General referrals (59) and Family Violence referrals (27).

While there was an overall decrease from the 707 coronial referrals received during the 2014-15 reporting period, there was variation between streams: referrals to the Health and Medical and General streams declined (from 513 and 78 referrals respectively in 2014-15), but referrals to the Mental Health and Family Violence streams increased (from 82 and 20 referrals respectively in 2014-15).

CPU case investigators completed 676 referrals for coroners during the 2015-16 reporting period, which was approximately the same completion level as during 2014-15 (693 referrals).

While coroners' referrals in individual deaths comprise the bulk of the CPU's work, where the State Coroner determines that it is appropriate, assistance is also provided to organisations outside the Court. During the 2015-16 reporting period the CPU provided submissions, data and/or other assistance to organisations including the Parliament of Victoria, the Victorian Auditor-General's Office, Victoria Police, the Victorian Department of Health and Human Services, and Jesuit Social Services.

Amongst the investigations into reportable deaths, 300 recommendations were made. These recommendations were made in coroners' findings for 101 deaths. Also during the reporting period, the Court received responses to 237 recommendations across findings for 95 deaths.

Executive Services

Strategic Communications

During the reporting period the Court's Strategic Plan 2016-19 was completed. The plan identifies three strategic directions that the Court will focus on over the next three years: engaging our community; investing in our people; and achieving our business priorities. The plan is publicly available on the Court's website. 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, 205 new findings and 35 new rulings were uploaded onto the Court website. In addition, there was an increase in the frequency of visits to the Court's website, from 1,310,057 during the 2014–2015 reporting period to 1,963,991. This is an increase of 653,934. The Court also assists journalists and media representatives seeking to prepare balanced reports about coronial investigations and the Court's activities.

In the 2015–16 reporting period, approximately 65 information requests from the media were received each month.

Records Management

The Court receives many requests for access to information and documents contained within coronial files. As such, the Court' Record's Officer receives, responds and records these requests, including liaising with the Public Records Office of Victoria. During the reporting period, the Court received 1,795 requests for access to coronial documents, of which 1,792 were from external agencies.

Human Resources

The average full time equivalent of Court staff during the 2015-16 reporting period was 59.85. This represents a decrease compared to total staffing of 63.3 average full-time equivalent as 30 June 2015.

	Special Appropriation	Base Budget	Other Funded	Total
Judicial Officers	9.00			9.00
Ongoing Staff		37.70		37.70
Fixed-Term Staff		13.15		13.15
Total Average FTE	9.00	50.85	-	59.85

Financial Statement

In 2015–16, the Court managed its expenses within the allocated budget and reported a surplus of $515,720. The above surplus was arrived at after accounting for budget saving of $ 1.4 Million which had been carried over into the next financial year. A range of cost saving initiatives and processes designed to maintain a surplus within a tight budget, were implemented.

The process oriented monthly financial reporting system enabled immediate corrective action against over-spending. The increased transparency and real time budget information has facilitated continuous improvements in each business areas. The robust internal controls and effective financial reporting system have resulted in a 27% reduction in the Court's total supplies and services cost, compared to 2014–15. In 2015–16, the Court maintained the lean operating model first introduced in 2013–14. The strict controls over full-time employment (FTE) levels has managed to keep the increase in employee related costs below 1% compared to last financial year (2014–15). The 2013–14 introduction of the Court's in-house legal counsel has continued to produce significant cost savings. This reporting year, the Court reduced its cost on external legal professional services by 48%, compared to last financial year.

As part of the investigation into a death, the Court provides services for removing and transferring deceased persons from the place of death (any place within Victorian boundaries) to a coronial mortuary, where medical examinations are undertaken. The cost of providing this service is significant, representing over 30% of the total budget. To counteract the increasing costs, the Court implemented new internal controls in the invoice payment process and introduced initiatives to reduce waiting times fees. These new measures have already saved the Court approximately $275,000.

The Court remains committed to further improvements in this area in the next reporting period.

Case Study 6

Food allergies and anaphylaxis

JI was 15 years old when he died in September 2012 from the consequences of consuming a cookie containing nuts to which he was allergic.

The cookie was provided to him at a children's sports training camp, despite prior forewarning to the camp organisers of his allergy and hence, his dietary requirements. The camp organisers purchased food from Subway without regard to the information provided by parents about their children's dietary requirements and food allergies.

The food purchased from Subway included a platter of cookies; all of which either contained nuts or were likely to be contaminated with nuts. Subway was not provided with specific information about dietary requirements / allergies at the time of purchase. No labelling of food content was provided by Subway or placed with the cookies by the event organisers back at the camp. JI assumed the cookie to contain white chocolate chip rather than macadamia nuts.

The Coroners' investigation

During the coroner's investigation, it was revealed that JI did not immediately develop any signs of an allergic response to the consumption of the allergen. However, after approximately 40 minutes and following exercise, he had a sudden onset of respiratory symptoms assumed to be related to his pre-existing asthma.

Attempts were made to administer Ventolin to JI but he was not administered his EpiPen, which remained in his father's motor vehicle. JI suffered a cardiac arrest and despite the subsequent administration of adrenalin by ambulance paramedics, he died in hospital six days later. The Coroner held an inquest and delivered the finding on 29 April 2016.

What the Coroner found

The coroners' finding contained eight recommendations aimed at decreasing the risks for sufferers of anaphylaxis, which were directed at organisations including the Royal College of General Practitioners, the Royal College of Physicians, the Australian Society of Clinical Immunology and Allergy, Subway Systems Australia, the Victorian Ministers for Sport and Health, and the Victorian Karting Association.


Coroners Court of Victoria

Court Initiatives

Court Network

Court Network was founded by Carmel Benjamin AM in 1980, starting in the small Melbourne Court of Prahran. Today, over 400 trained Court Network volunteers assist Court users across both Victoria and Queensland. It is a not-for-profit organisation providing support, information and referral to persons attending Court. A Court Network Reference Group commenced in September 2015.

The Reference Group meets quarterly with representatives from Court Network and on behalf of all jurisdictions across Victoria. This Reference Group provides a forum for exchange of information about the services provided and to develop upon the relationship between Court Services Victoria and Court Network. There are ten Court Network volunteers allocated to the Coroners Court of Victoria. Statistics for the 2015-16 financial year showed that Court Network Volunteers provided services to 604 people at the Coroners Court, both families and witnesses.

CCOV Research Committee

The Coroners Court of Victoria Research Committee advises the State Coroner regarding the appropriateness of applications to conduct research using Victorian coronial data. The Research Committee is not a human research ethics committee, but rather considers the impact a research proposal might have on the Court.

Relevant considerations in this respect include the purpose of the research, its resource implications for the Court, the risk that families might be traumatised by the research process, and the risk that persons both living and deceased might be identified in the public sphere. During the 2015-16 reporting period, the Research Committee was chaired by Coroners Prevention Unit Acting Manager Jeremy Dwyer, with Coroners Paresa Spanos and Audrey Jamieson providing judicial oversight. Advice was provided to the State Coroner regarding 56 proposals.

Deceased Transport

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. In the reporting period there were 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. The Transport of Deceased Persons project explored options to provide a financially sustainable service.

During this reporting period the Transport of Deceased Persons project issued a Request for Tender for Metropolitan services. The tender specifically targeted potential metropolitan suppliers for removal and transfer of deceased persons into the mortuary at Southbank and for the repatriation of deceased persons to Regional Victoria. The successful tenderer for the Metropolitan service area and for the repatriation of deceased person to regional Victoria was St John Ambulance. The Court is looking forward to working with St John Ambulance and continuing to assist grieving families by providing an efficient and safe service.

The Regional Services Request for Proposal was released on 30 September 2015 and closed 29 October 2015. The Request for Proposal specially targeted potential suppliers in regional Victoria for removal and transfer of deceased persons to coronial mortuaries based in Southbank, Bendigo and Ballarat. This tender process has not yet concluded. In the interim, the Transfer of Deceased Persons project continues to work with the current regional suppliers, the Australian Funeral Directors Association and the National Funeral Directors Association.

E-Medical Deposition

The Coroners Act 2008 provides an obligation for a registered medical practitioner, who is either present at or after a reportable death, to notify a coroner or VIFM of the death without delay.

Historically, medical practitioners have used a document commonly referred to as the e-Medical Deposition to notify details of a reportable death. This form could be accessed from an online portable and consisted of a PDF document. Recognising the competing demands upon busy medical practitioners' time, both the Court and VIFM considered that this process was not as efficient and progressive as it should be, factoring in available technology. The Court and VIFM jointly developed an interactive web based e-Medical Deposition designed to work with all web browsers (e.g. chrome, IE9, IE11, Mozilla, Safari etc.) as well as IPads, IPhones and Android Phones.

Koori Inclusion Action Plan

During the reporting period, the Court continued to strengthen its Koori Inclusion Action Plan. The main focus during this period was to develop a Koori specific information brochure for the community about what to do when a person passes away and comes into the care of the Coroner. This was developed in consultation with the Koori community and we expect the brochure to be available in September 2016.

Title: Striving for a better tomorrow

Acknowledgement: This artwork, titled Striving For A Better Tomorrow, is reproduced with the permission of the artist, Mr Dixon Patten. Mr Patten is a traditional descendant from the Gunnai and Yorta Yorta peoples.

The aim of the new e-Medical Deposition was to provide a user friendly method for medical practitioners to notify a reportable death, including introducing relevant text to prompt and therefore assist with the completion of the form. Representatives from Victorian hospitals were invited to provide feedback on the content and application of the new e-Medical Deposition, which received an overwhelmingly positive response.

Submissions and Evidence to Inquiries

Royal Commission into Family Violence

During the reporting period, the Court provided information and evidence to the Royal Commission into Family Violence. A written submission was made responding to the 21 questions outlined in the Issues Paper. A copy of this submission is available from **http://www.rcfv.com.au/.** Verbal evidence was also given by Dr Lyndal Bugeja on 14 October 2015 on the topic of Evaluating, reporting and reviewing.

Inquiry into End of Life Choices

During the reporting period the Parliament of Victoria's Legislative Council Standing Committee on Legal and Social Issues held an Inquiry into End of Life Choices, to examine whether there is a need for new laws in Victoria to allow citizens to make informed decisions regarding how they manage their end of life choices. In response to an invitation from the Committee's Secretary, on 26 August 2015 the Court made a submission to the Inquiry, which comprised a summary of (CPU) research into Victorian suicide deaths for the period 2009-2012 where the deceased was suffering an irreversible deterioration in physical health due to disease or injury. A series of five case studies drawn from deaths investigated by Victorian coroners was also included, illustrating the range of circumstances in which people commit suicide while experiencing irreversible deterioration in physical health.

On 7 October 2015, Coroner Caitlin English, Coroner John Olle and CPU Acting Manager Jeremy Dwyer subsequently attended the public hearing of the Standing Committee on Legal and Social Issues, to discuss the submission and the issues being examined by the Inquiry. Coroner English emphasised at the outset of the hearing that:

> **[...] we are not advocating a policy position; that is for you as legislators. But we are a specialist court, and we do have information of a specialist factual nature. We also have research that we believe is important for the committee to consider as part of your consideration of end-of-life choices.**

Coroner English and Coroner Olle spoke about investigations they had conducted into suicides of people with serious - often terminal - health diagnoses, including the course of their illnesses and treatment, the reasons why they wanted to die, and the ways in which they took their lives. Dr Dwyer provided a general thematic overview of suicide among people in irreversible physical decline.

Following the public hearing, on 20 May 2016 the Court provided a further written submission to the Inquiry, which described in more detail the CPU data from the first submission and expanded its scope to include the year 2013. The Final Report of the Inquiry, tabled on 9 June 2016, quoted extensively from the Court's two submissions and the evidence given at the public hearing, as well as drawing upon other Victorian coronial findings.

The Government's legislative response to the recommendations contained in the Final Report is expected in the next six months.

Victorian Systemic Review of Family Violence Deaths

Each year in Victoria, approximately 40% 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 deaths.

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 evidence appears to indicate that the death occurred as a result of external causes where such external causes were attributed, directly or indirectly, to a person through the application of assaultive force; and
- 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); and
- 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).

Since the establishment of the VSRFVD, 448 deaths have been identified to have occurred directly or indirectly, through the application of assaultive force.

The table below shows the preliminary classification of determined and suspected homicides reported to the Court from 1 January 2009 to 30 June 2016. Note that, 20 (4.5%) deaths require additional information for classification purposes.

Where the deceased-offender relationship was established (428, 95.5%), 193 (43.1%) 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 slightly from the previous report (2014-15) because of this re-classification process.

The annual frequency of family homicides ranged from 22 in 2012 to 28 in 2011. For the period 1 January to 30 June 2016, 20 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	2009	2010	2011	2012	2013	2014	2015	2016 (June 30)	Total
Intimate Partner	7	9	10	6	14	9	10	7	72
Parent-Child	10	7	9	8	9	9	11	7	70
Other Intimate or Familial (Including Kinship)	6	8	9	8	4	6	4	6	51
Not Intimate or Familial	31	31	35	21	27	38	34	18	235
Unknown	2	1	2	1	2	2	6	4	20
Total	56	56	65	44	56	64	65	42	448

Annual frequency of suspected homicides reported to the Court by mechanism of death, Victoria 1 January 2009-30 June 2016

Mechanism of death	2009	2010	2011	2012	2013	2014	2015	2016 (June 30)	Total
Blunt object	5	7	9	2	2	8	4	1	38
Bodily force	16	10	10	8	7	7	11	6	75
Firearm	6	14	8	8	12	9	9	10	76
Sharp object	22	20	31	14	23	25	22	10	167
Threat to breathing	-	-	2	4	4	6	6	1	23
Other	7	5	5	8	8	9	12	4	58
Still Inquiring	-	-	-	-	-	-	1	10	11
Total	56	56	65	44	56	64	65	42	448

Of the 448 homicides, over a third of fatal injuries were sustained by sharp objects (167, 37.3%). The category “Other mechanism of deaths” (58, 13.0%) included where the cause of death is unascertained, intentional motor vehicle collisions and effects of fire

Intimate Partner Homicides

Of the 193 family homicides, 72 (37.3%) occurred between intimate partners. Of these, 51 (70.8%) occurred between current partner, 20 (27.8%) between former partners and the remaining death the relationship status at the time of the incident was unknown.

Further examination of these 72 intimate partner homicides showed that 56 (77.8%) occurred in a family violence context. The majority of these were killed by their current partner (37,66.1%). Note that, 14 (25.0%) deaths require additional information for classification purposes. The remaining two deaths did not occur in a family violence context.

Findings were handed down this year into the deaths of Sirin Bayram, Sherry Robinson, Sargun Ragi, Leanna Patterson, Zahra Rahimzadegan, Kelly Thompson and Asim Kumar, who were killed by their respective partners.

Frequency of intimate partner homicides by relationship status and family violence role, Victoria 1 January 2009-30 June 2016

Deceased's family violence role	Current partner	Former partner	Total
Victim	27	19	46
Perpetrator	7	-	7
Victim and Perpetrator	3	-	3
Total	37	19	56

Parent-Child Homicides

Homicides amongst parents and children comprised a further 70 (36.3%) of the 193 family homicides between 2009 and 2016. Just over half of the homicides in this category were of parents killing their children (42, 60.0%), the majority by fathers.

Findings were handed down this year into the deaths of Darcey Iris, Yasmina Acar, and Luke Batty who were all killed by their respective fathers.

Findings were also handed down into to the deaths of Baby D and Philip and Mathew George, who were killed by their mother.

Frequency of parent-child homicides by offending party and relationship, Victoria 1 January 2009–30 June 2016

Relationship Type	Parent Offender	Child Offender	Total
Father-Daughter	12	2	14
Father-Son	12	16	28
Mother-Daughter	8	2	10
Mother-Son	8	8	16
Still Inquiring	2	-	2
Total	42	28	70

Other Intimate or Familial Homicides

The remaining 51 (26.4%) of the 193 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 (4, 7.8%)

Extended family members:

- In-laws (6, 11.8%)
- Uncle - Aunt / Nephew - Niece (6, 11.8%)
- Grandparent / grandchild (3, 5.9%)
- Cousins (2, 3.9%)
- Kinship relationships (1, 2.0%)

The other type of relationship in this category was sexual relationships (9, 17.6%) and relationship triangles; that is conflict between couples and either a new partner or ex-partner (11, 21.6%).

The remaining 9 (17.6%) deaths occurred in the context of other familial relationships, for example, 'ex-boyfriend/ex-girlfriends father'. Within the 51 other intimate or familial homicides, 22 (44.0%) were identified as taking place within the context of family violence.

VSRFVD Reference Group

Expert advice and consultative support is provided to the VSRFVD by a Reference Group. The Reference Group assists in the identification of system wide issues pertaining to family violence, as well as advising on policy and program developments occurring at a local, state and national level. The wealth of collective knowledge and experience held within the Reference Group is a significant resource to the VSRFVD.

The Reference Group is comprised of members from both government and non-government organisations, including Koori family violence services; legal services, police, and the Magistrates' Court; culturally and linguistically diverse services; disability, health and welfare organisations; academics and policy analysts.

VSRFVD Review Panel

During the 2015/16 reporting period, the VSRFVD Review Panel was established. Members from the VSRFVD Reference Group in conjunction with other organisational representatives are invited to take part in the panel, where their area of expertise relates to factors present in the circumstances of a death (or number of deaths) under investigation. On this basis, the composition changes between meetings. Three meetings were held that have covered six fatalities.

The purpose of the VSRFVD Review Panel is to:

- confirm systemic and human factors identified by the Court amongst family violence homicides tabled for discussion;
- confirm and identify gaps in current family violence prevention policy or programs that if addressed may mitigate the risk of future incidents of family violence; and
- contribute to the formulation of prevention-focussed recommendations for the Coroner.

Case Examples

Due to the family violence context and history, the following deaths were investigated as part of the Victorian Systemic Review into Family Violence Deaths (VSRFVD).

Case 1 – ZR

On 16 December 2011, ZR was killed by her husband, NA, during an argument over a suspected affair. NA pleaded guilty to manslaughter and was sentenced to 11 years imprisonment. ZR was Iranian and her husband Afghani, they met and married in Iran before migrating to Australia in 1999. NR had a history of perpetrating physical violence and threats of harm against both ZR and their two children (aged 15 and 11 at the time of ZR's death).

ZR had left the marriage on at least four occasions and two intervention order applications were made by or on behalf of the deceased in the five years preceding her death. In 2007, both ZR and NA converted from Islam to Christianity and became active members of CityLife Church. ZR reportedly experienced pressure from the church community to address her marital issues and in November 2011, ZR and NA accessed marriage counselling through CityLife Community Care (CLCC), a service provided by CityLife Church.

Factors identified as contributing to the fatal incident were cultural issues, childhood history of family violence and trauma, financial difficulties, mental health symptoms, a relationship breakdown and probable separation, and a long history of physical violence and threatening behaviour within the relationship.

Significant issues were identified with the provision of marriage counselling in a context of family violence. Specifically, the counsellors and service failed to consider whether marriage counselling was appropriate with a couple who had a history of family violence, and no family violence screening or risk assessment was conducted. As a consequence no referral was made to specialist family violence services nor a safety plan developed.

This case was referred to the VSRFVD Review Panel who contributed sector expertise in family violence. Former State Coroner, Judge Ian Gray made a finding into ZR's death without inquest and made five recommendations to CityLife Community Care (CLCC) regarding improved practice in identifying and responding to family violence during the provision of marriage counselling. In response, CLCC advised that they are making changes to organisational policies and procedures, providing additional training to staff, and have engaged an independent consultant with expertise in child/family welfare to implement the Coroner's recommendations.

Case 2 – Baby AA

On 25 April 2012, baby AA died at the age of eight weeks due to head injuries. Her twin was subsequently found to have similar non-accidental injuries leading to brain damage. There was evidence of recent and previous blunt head trauma suggesting at least two separate episodes. Their mother, Ms A, accepted that she must have been responsible for the injuries although she had no knowledge of doing so and reported no intent to harm them.

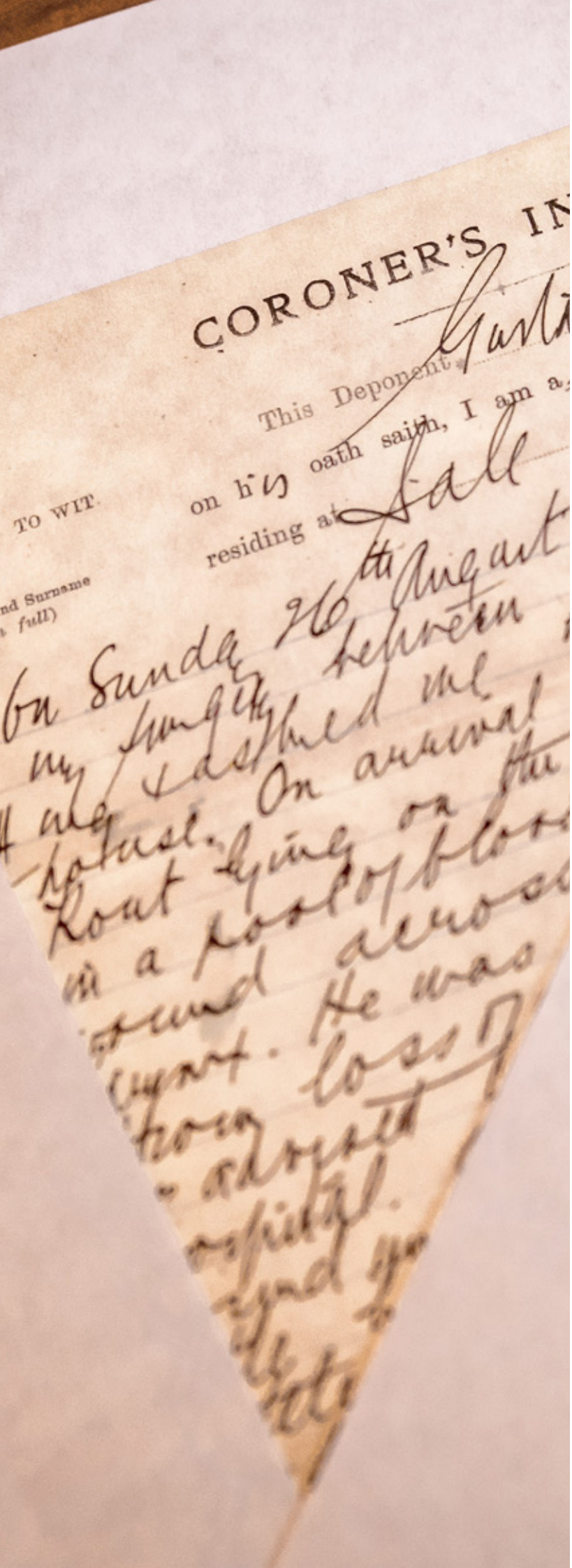
Ms A was convicted of infanticide and recklessly causing serious injury, and released on a Community Corrections Order for one year. The sentencing Judge identified Ms A to be a loving mother suffering from "significant emotional and psychological compromise" who had already been punished for the tragedy.

The family had a number of contacts with health service providers including the Royal Women's Hospital, Moreland City Council Maternal and Child Health Service (MCHS), Royal Children's Hospital and a General Practitioner. The family were referred to the Unsettled Babies Clinic and Enhanced Maternal and Child Health Service, and Ms A referred to a psychologist under a Mental Health Care Plan.

Former State Coroner, Judge Ian Gray held an inquest to investigate whether the responses of the various health services involved with the family were appropriate in identifying and responding to physical injuries on the twins, and Ms A's deteriorating mental health. A potential lost prevention opportunity was identified in how the MCHS responded to bruising observed on the twins during their four and eight week check-ups.

In submissions to the Court, the Department of Education and Training (DET) advised that it will amend the MCH Guidelines to provide information specific to identifying and responding to physical injury, specifically recommending a report to DHHS Child protection when bruising is noted in a non-mobile infant.

Judge Gray further identified that information sharing was an issue in this case. Although multiple health services and practitioners were involved with the family, they were unaware of the observations and decisions of each other. As such, Judge Gray recommended that a shared database be created to enable those services who are monitoring and treating infants or children to access that child's full medical record in real time.



Australian Domestic and Family Violence Death Review Network

The VSRFVD team are members of the Australian Domestic and Family Violence Death Review Network.

This Network was established in 2011 and is comprised of representatives from each jurisdiction with an operational death review process.

Current membership includes NSW, Victoria, South Australia, Western Australia and Queensland. The ACT (pilot) and New Zealand processes are special observers to the Network.

The Network's goals are to:

- better understand the context and circumstances in which domestic and family violence related deaths occur;
- identify practise and system changes that may prevent or reduce the likelihood of domestic and family violence deaths;
- identify, collect, analyse and report national data concerning domestic and family violence related deaths; and
- analyse and compare domestic and family violence death review findings and recommendations.

Victoria will take over from NSW as the chair of the Australian Domestic and Family Violence Death Review Network in the 2016/2017 reporting period.

Operating Statement – Financial Year 2015-2016

	Notes	2011–12	2012–13	2013–14	2014–15	2015–16
Income from Transactions						
Output Appropriation		10,087,600	9,998,190	11,252,900	10,575,075	11,167,000
Special Appropriation		3,182,600	2,895,706	3,479,417	3,557,484	3,562,858
Other Income			351	-		-
TOTAL INCOME		13,270,200	12,894,247	14,732,317	14,132,559	14,729,858
Expenses from Transactions						
Employee Benefits	NOTE 1	8,597,502	8,262,673	8,090,030	7,997,022	8,058,346
Depreciation and Amortisation		93,465	86,527	84,905	14,000	13,642
Interest Expense		2,722	1,559	1,493	2,496	1,995
Grants and Other Transfers	NOTE 2	34,114	1,317	-	-	-
Supplies and Services	NOTE 3	3,839,448	3,458,268	3,040,797	2,479,372	1,793,972
Deceased Removal and Transfers	NOTE 4	1,932,225	2,584,540	2,656,673	3,866,179	4,261,649
Total Expense from Transactions		14,499,476	14,394,884	13,873,898	14,359,068	14,129,604
Net Result from Transactions (Net Operating Balance)		(1,229,276)	(1,500,637)	858,419	(226,509)	600,255
Other Economic Flows						
Other Gains(Losses) from other Economic Flows	NOTE 5	(19,307)	-	6,264	-	(84,535)
Total other Economic Flows included in Net Result		(19,307)	-	6,264	-	(84,535)
Net Result		(1,248,583)	(1,500,637)	864,683	(226,509)	515,720

- 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 Coroners’ recommendations powers in Australia”.

- Note 3 – Supplies and services
  From FY 2014-15 Staff Training and Development expenses are classified under employee benefits.

	2011–12	2012–13	2013–14	2014–15	2015–16
Contractors and Consultants	865,186	529,472	180,319	113,233	325,810
Legal Professional Services	941,878	766,365	530,257	415,141	217,707
Medical Professional Services	28,469	258,296	165,691	77,945	59,415
Information Technology	97,819	98,737	87,237	118,908	595,634
Printing and Stationary	166,479	117,121	92,540	69,534	92,770
Postage and Communication	172,865	111,913	117,185	98,059	133,991
Travel and Personal Expenses	44,400	23,801	30,357	41,481	59,562
Staff Training and Development	33,662	11,386	29,436	-	-
Witness Expense	36,199	39,571	34,717	30,777	17,584
Other Operating Expense	1,452,491	1,501,605	1,773,057	1,514,294	291,500
Total Supplies and Services	3,839,448	3,458,268	3,040,798	2,479,372	1,793,972

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

	2011–12	2012–13	2013–14	2014–15	2015–16
Metropolitan areas	687,597	935,892	1,121,753	1,730,220	1,997,002
Regional areas	1,244,628	1,648,649	1,534,920	2,135,959	2,264,647
Total	1,932,225	2,584,540	2,656,673	3,866,179	4,261,649

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

Net gain / (loss) from the revaluation of long service leave liability.

Case Study 7

Heatwave

On 19 January 2014, during a heatwave where temperatures soared into the low 40's, Ms B and her partner Mr D were found deceased in their home in West Heidelberg. At the time, both Ms B and Mr D were clients of North East Area Mental Health Service (NEAMHS).

The Department of Health "Heatwave Plan for Victoria" recognises that various categories of people are at heightened risk during periods of extreme heat. Among those categories are people suffering from mental illness, particularly schizophrenia and those on anti-psychotic medication.

How widely that information was disseminated/ conveyed to health services generally, was unclear.

The Coroners' investigation

The investigation revealed that Ms B and Mr D fitted into the heightened risk category on several bases:

- both suffered mental illness
- both were on Clozapine, anti-psychotic medication
- both were somewhat socially isolated.

What the Coroner found

The Coroner concluded the couple were not aware, nor alerted to the danger the prolonged heatwave represented to them. At that time, NEAMHS did not have in place a specific heatwave plan. Subsequently, following an internal review following the deaths of Ms B and Mr D, Austin Health developed and promulgated a guideline titled "Extreme Weather: Alert and Response". Consequently their practises and procedures were refined to ensure more effective management of mental health clients during heatwave conditions.

What has been done as a result?

Having formed the view that the Health Department Heatwave Plan for Victoria, while conveying important information, is population based and somewhat generic, the coroner made the following recommendation:

The Chief Psychiatrist issue a directive requiring all public mental health services to develop and introduce an appropriate guideline that identifies, among other things, the clinical responsibilities for case managed and at-risk clients at times of extreme weather conditions.

The purpose of the recommendation was to suggest the formulation of a mental health specific plan, similar to that developed by Austin Health, which can be directed to all public mental health services by the Office of the Chief Psychiatrist.

The Court has been advised that the Chief Psychiatrist proposes to adopt the recommendation.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