Contents

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 2014–15 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 2014 to 30 June 2015.

Yours sincerely

Judge Ian Gray
State Coroner

Report from the State Coroner

It is my pleasure to present the Coroners Court of Victoria's (the Court) Annual Report for the 2014-15 financial year. In this reporting period, we maintained our focus of providing quality coronial services, improving court performance, and delivering on our mandate to reduce preventable deaths and promote public health and safety for the Victorian community. I am pleased to report significant achievements and performance improvements.

In 2014-15, the Court's caseload continued to increase and the Court rose to the challenge, maintaining a case clearance rate of 108%. Closing more coronial investigations than it initiated, the Court continued to reduce case backlog, while maintaining a focus on the quality of investigations and findings. In the reporting period, the Court improved its efficiency and introduced time standards for coronial investigations. The Court will publish these standards to demonstrate a commitment to transparency and accountability.

The work of the Coroners Prevention Unit (CPU) is of critical importance to the Court's ability to identify, research and articulate recommendations aimed at reducing preventable deaths in Victoria. The CPU also makes a significant contribution to Victoria by the publication of papers, and public presentations utilising its rich data base and strong, well respected research capacity. In the reporting year, key areas of investigation included the identification of youth suicide and the impact of exposure to suicide in the social network; prescription drug overdoses and the potential benefits of real time prescription monitoring; and the preparation of a submission to the Royal Commission into Family Violence.

The Court continues to maintain a strong partnership with the Victorian Institute of Forensic Medicine (VIFM). I extend my gratitude to Professor Noel Woodford, VIFM Director, and Dr Jodie Leditschke, Manager of the Coronial Admissions and Enquiries Office, and staff who continue to provide outstanding forensic services to the Court and the community.

The Court also has other important collaborations - with Victoria Police, and other statutory bodies, which work with the Court to manage the overall system of investigating reportable deaths I particulary thank those members of the Police Coronial Support Unit of Victoria Police who assist coroners in and out of Court on a daily basis.

The media plays a vital role in educating the public on the functions of the Coroners Court and the role the coroner plays in making recommendations aimed at further reducing preventable deaths. I am impressed by their efforts to report matters fairly and accurately, and I am encouraged by the professional and respectful manner displayed in court towards family, loved ones and other witnesses.

I acknowledge the hard work and dedication of the all members of the Court staff - the Coroners Support Service, Coroners Solicitors, In-House Legal Service, CPU and Executive Services. I thank the staff for the professionalism, dedication and compassion they display in their work, in often difficult and traumatic circumstances. In particular, I thank the Court's Chief Executive Officer, Samantha Hauge, for her hard work and leadership. I note her report and commend her for her exemplary financial management of the Court.

I sincerely thank the volunteers of the Court Network who dedicate their time to provide compassionate support to so many families and witnesses who find themselves at the Coroners Court each year.

I thank my Executive Assistant Nola Los, for her ongoing support for not only me, but for all coroners. Finally, I extend my warm gratitude to my fellow coroners and, as I did last year, I commend them for their hard work on their large caseload and their commitment to giving effect to the Court's prevention mandate.

Judge Ian Gray
State Coroner

Report from the Chief Executive Officer

In the 2014–15 reporting period, the Court has continued to maintain high performance levels, illustrating our strong commitment to meeting the growing caseload and day-to-day operations. This year, we embarked on a significant change program and I am proud of what we have been able to accomplish while juggling the challenges of change with the operational demands of the coronial jurisdiction. I wish to take this opportunity to share with the Victorian community our key achievements for 2014–15.

Following a successful budget forecast in 2013–2014, I am pleased to report the Court managed its expenses within the allocated annual appropriations budget achieving a surplus of $980,000 to be carried over into the next financial year. This achievement was through the introduction of stringent cost saving initiatives and processes. In the coming year, our focus will be on gaining cost savings and efficiencies through the Deceased Persons Transport Project and through the continuous improvement projects.

The Court returned to re-furbished premises at Southbank, reuniting with the Victorian Institute of Forensic Medicine (VIFM). The $114.4 million complex was officially opened on 29 August 2014, by the Hon Robert Clark, then Attorney-General of Victoria

The opening was a celebration of the close partnership we share with the VIFM and the invaluable support we receive in being co-located along side them once again. We are now operating a modern, technologically advanced court, and we are in good stead to continue to meet the growing needs of the Victorian coronial jurisdiction.

This year, the Court secured additional $1 million funding over four years to investigate reports of family violence deaths. The additional funding will enhance the Court's capabilities to systematically examine the distribution and determinants of family violence deaths. This intelligence, combined with an up to date understanding of family violence policy and programs in Victoria, will be applied to ensure Coroners' findings and recommendations are evidence-based and feasible.

The Court has also embarked upon the process of engaging the VIFM to develop a new case management system for the Court. This is very exciting and will provide a workflow system that is specifically tailored to our operational processes, which in turn will lead to significant improvements in efficiency and service quality.

I take this opportunity to acknowledge the talented and dedicated staff working within the Court who continue to show such commitment and passion in their work. I greatly appreciate their dedication to assisting the community of Victoria. I further acknowledge the hard work of the combined Coronial Services Centre and the invaluable support the Court receives from Court Services Victoria.

Finally, I would like to express my sincere appreciation to State Coroner Judge Ian Gray for his continual encouragement and invaluable support in my role as CEO.

Samantha Hauge
Chief Executive Officer

The Coroners Court of Victoria

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

In addition to their statutory obligations to find, where possible, identity, cause and circumstances of reportable deaths and fires, strengthening the prevention function of the Court was a defining feature of the new Act. The prevention function refers to the capacity of the jurisdiction to contribute to public health and safety through coroners' findings, and the development of comments and recommendations that are targeted at the reduction of preventable deaths and fires. Coroners maintained their discretion to make recommendations to any Minister, public statutory authority or entity relating to issues of public health and safety and the administration of justice. 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. Unless a coroner orders otherwise, all inquest findings, coronial recommendations and responses to recommendations are published on the Court website.

Preamble to the *Coroners Act 2008*

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

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

Objectives of the *Coroners Act 2008*

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

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

The Jurisdiction of the Coroner

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

Part 5 of the Act also gives coroners the power to hold inquests, which are public court hearings. Inquests are held both at the Coroners Court of Victoria in Melbourne and in regional Magistrates' Courts.

Reportable deaths

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

Usually, medical practitioners or the police report deaths to the coroner. A member of the community must also notify the Court of a reportable death if they have grounds to believe that the death has not already been reported.

During the reporting period, there were 6,336 reportable deaths reported to the coroner, an increase of 69 reportable deaths in the previous reporting period.

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

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

Reviewable deaths

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

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

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

During the reporting period there were seven reviewable deaths reported to the Court, which is consistent with the previous year.

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

Fires

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

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

During the reporting period, there were five fires with death.

There were two fires without death reported.

Operational Structure of the Coroners Court of Victoria

The Court is comprised of ten full-time coroners and one reserve coroner, including the State Coroner and the Deputy State Coroner. In Melbourne, the Court is staffed by in-house solicitors, registrars, family liaison officers, researchers and case investigators, and administrative staff. At the Court, staff are grouped into specialist teams to assist Coroners with particular aspects of their investigations. The administration of the Court is led by the CEO.

The Coroners

State Coroner
Judge Ian Gray

Deputy State Coroner
Mr Iain West

Coroners
Ms Audrey Jamieson
Ms Caitlin English
Ms Jacinta Heffey (retired February 2014)
Ms Jacqui Hawkins
Mr John Olle
Ms Paresa Spanos
Mr Peter White
Mr Phil Byrne
Ms Rosemary Carlin

Court Administration

Chief Executive Officer
Ms Samantha Hauge

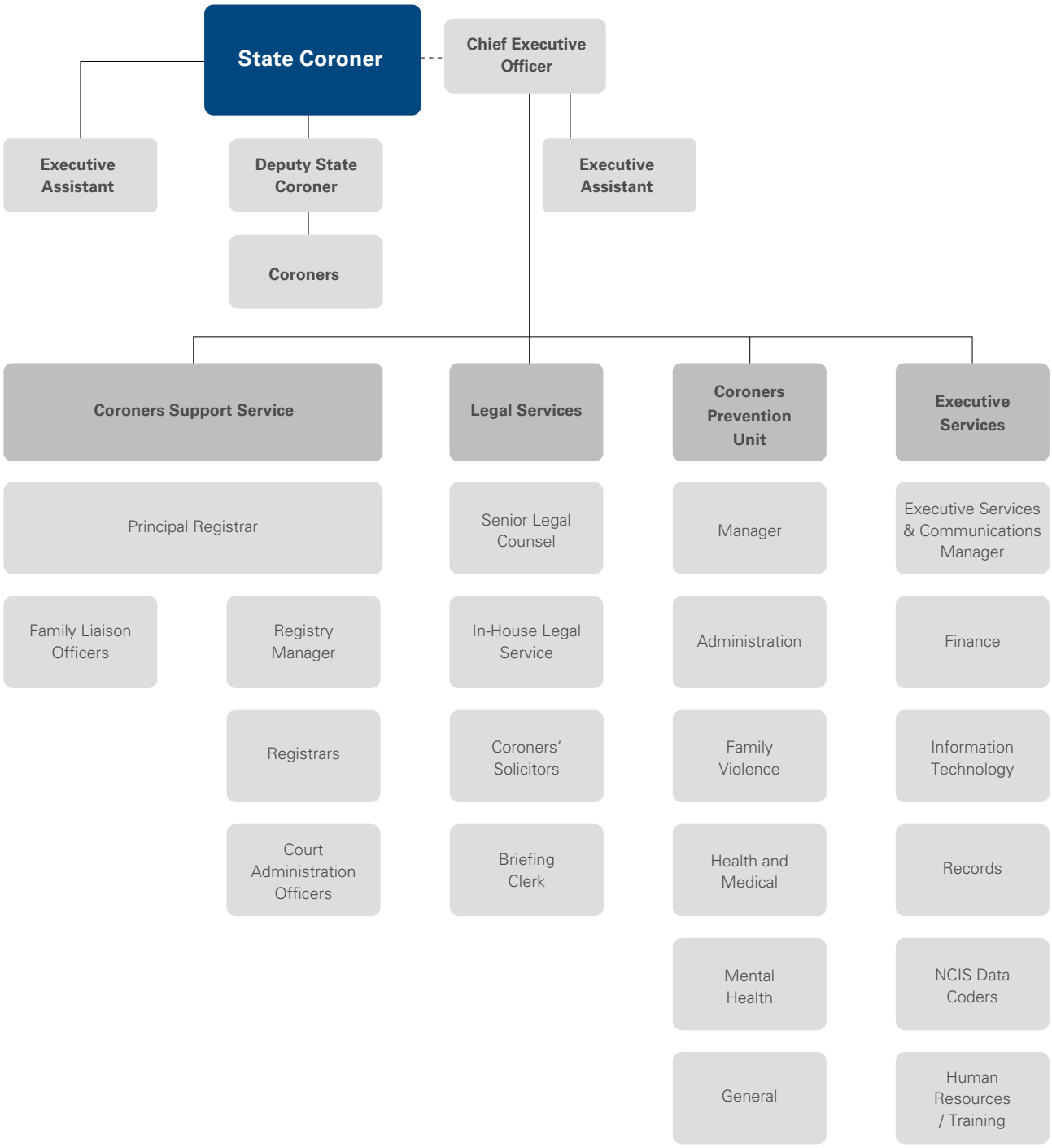
Principal Registrar
Ms Margaret Craddock

Executive Services Manager
Ms Renee Swanson (from September 2014)

Senior Legal Counsel
Ms Jodie Burns

Coroners Prevention Unit Manager
Dr Lyndal Bugeja

Organisational chart



Court Operations and Initiatives

Court Services Victoria

The Coroners Court is supported in the performance of its functions by Court Services Victoria (CSV), a statutory body corporate established on 1 July 2014 by an Act of Parliament, the *Court Services Victoria Act 2014* (Vic). CSV exists to provide administrative services and facilities to support the judicial, quasi-judicial and administrative functions of the Victorian courts, Victorian Civil and Administrative Tribunal and the Judicial College of Victoria.

These functions were previously provided by the Department of Justice. CSV is governed by a Courts Council and is designed to enable Victorian courts and the VCAT to operate independently of the direction of the executive branch of government. The new CSV is accountable directly to the Parliament.

In this reporting period, the Court has worked with CSV and other courts and tribunals to support the establishment and to build the foundations for the long-term sustainability of CSV. The Court has assisted in the development of new policies, procedures and business processes that promote an appropriate courts culture.

The Court is already realising the benefits of this significant change through more court–focussed services and enhanced administrative services for the judiciary and court users.

The Coroners Court Annual Report is separate and distinct from the Court Services Victoria Annual Report. For more about CSV, including its 2014–15 annual report, visit **courts.vic.gov.au**.

Coroners Court redevelopment

In August 2014, the Coroners and staff returned to the redeveloped coronial services centre in Southbank to resume co-location with the Victorian Institute of Forensic Medicine (VIFM). The building was officially opened on 29 August 2014, by The Hon Robert Clarke, Attorney-General with State Coroner Judge Gray and VIFM Director Professor Noel Woodford.

The $114.4 million complex, re-built on its original site at 65 Kavanagh Street, Southbank is a world-class facility and centre of excellence in clinical forensic medicine expertise, death investigation and tissue banking.

It comprises three new coronial courtrooms, coroner's chambers, a refurbished mortuary, two new homicide rooms, a clinical forensic medicine department and re-developed toxicology, molecular biology and histopathology laboratories. The new Donor Tissue Bank of Victoria is still under construction and is expected to open in the next reporting year.

The purpose built Coronial Admissions & Enquiries Office (CAE) sees coroners and pathologists meeting and deliberating, and families supported in comforting surrounds. The co-location of the Court and VIFM has enabled a stronger, more collaborative partnership between the two organisations.

Coroners Court case management system

During the reporting period, the Court worked with CSV to prepare a business case to replace its electronic case management system, CourtView. Since CourtView was implemented in 2012, the Court has experienced significant issues as coronial processes were not enabled by fit-for-purpose technology, which resulted in process inefficiencies.

CSV is working with the Court to engage the Victorian Institute of Forensic Medicine (VIFM) to develop a new case management system. The new system will be specifically tailored to the Court's operational processes leading to significant improvements in efficiencies; and service quality. Significant cost savings will also be achieved as hefty CourtView software maintenance and support costs will be eliminated. VIFM IT will manage and support the application, enabling responsive change and great scope for ongoing improvement.

The project to develop the new case management system is due to commence on 1 July 2015 for twelve months.

Victorian Coronial Council

The Coronial Council of Victoria was established in 2010, under the *Coroners Act 2008*.

The Council is independent of the Coroners Court of Victoria and provides advice to the Attorney-General regarding:

- the coronial system in Victoria and the preventative role of the Court;
- the way in which the coronial system engages with families and respects the cultural diversity of the community at large; and
- other matters of its own motion or at the request of the Attorney-General.

It is the only known body of its kind in the Australian coronial jurisdiction.

Under section 111 of the *Coroners Act 2008*, the Council consists of three members *ex officio* and between five to seven members appointed by the Governor in Council on recommendation by the Attorney-General.

During the reporting period, The *Court Services Victoria Act 2014* (CSV Act) came into operation. From 1 July 2014, Court Services Victoria assumed responsibility for providing Secretariat support to the Coronial Council of Victoria.

The Council met four times during the reporting period. The Council:

- completed its reference into suicide reporting in the coronial jurisdiction which resulted in a number of recommendations aimed at improving reporting of suicides to better understand intent and the risk factors
- submitted its report for its reference on legal representation for families involved in coronial inquests to the Attorney- General, recommending that legislation be enacted to allow the State Coroner to direct legal assistance from Victorian Legal Aid.
- initiated a reference to review reporting of deaths in Victorian hospitals, the processes and anecdotal reports of under-reporting.

More information may be obtained from the Coronial Council of Victoria Annual Report.

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

Victorian Coronial Council Members

His Honour Judge Ian L Gray
Associate Professor David Ranson, Deputy Director representing the Director, Victorian Institute of Forensic Medicine

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

Professor Katherine McGrath – Chair

Dr Ian Freckelton QC

Mr Christopher Hall

Dr Celia Kemp

Dr Robert Roseby

Professor Mark Stevenson (from May 2014)

The Court Network

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

Court Network is a unique court support service operating throughout Victoria and Queensland. They are a court-based service explicitly and are solely concerned with the needs of court users with information, support and referral services provided by over 400 trained volunteers. Court Networkers support family members and friends of the deceased person and attend the proceedings in the coronial jurisdiction and supported at least 1,019 court users in the 2014–15 financial year.

Student placements and volunteers

The Coroners Court supports a number of university programs by providing industry-based learning internships. In the reporting period, the Court accommodated 25 students and volunteers in the In-House Legal Services, Coroners Prevention Unit and Executive Services.

Nine practical legal training (PLT) graduates completed placements with the In-House Legal Services. The PLT graduates had the opportunity to work with coroners and solicitors, attending inquests, case management meetings and drafting research papers.

Three coroners participated in a twelve-week mentor program organised by LaTrobe University. Three students shadowed the coroners to gain an understanding of what was required to effectively participate in the inquisitorial jurisdiction.

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

- Royal Melbourne Institute of Technology's Criminal Justice Administration
- Melbourne Law School's Juris Doctor Program
- University of Melbourne Doctor of Medicine.

In addition, members of the CPU commenced or continued co-supervision of four students undertaking Honours in Criminal Justice Administration, one student undertaking a Masters of Public Health and three Doctor of Philosophy candidates.

The Executive Services team supported students and volunteers by providing placements on projects for the National Coronial Information System.

Coronial Legal Professionals

During this reporting period, a small group of Court staff established the Coronial Legal Professionals (CLP), an independent professional network for individuals working, or with an interest in the coronial jurisdiction. The CLP holds regular social and professional development events to create a forum for sharing knowledge and experience amongst those who perform coronial work.

The CLP organising committee is comprised of various Coroners Court of Victoria staff, including members from the Coroners Support Service, the In-House Legal Service and the Coroners Prevention Unit. Membership now includes legal professionals from within Victoria, interstate and internationally, as well as members of Victoria Police and the Victorian Institute of Forensic Medicine.

The inaugural event took place on 19 March 2015, with outstanding attendance and enthusiastic responses to the organisation's formation. State Coroner Judge Ian Gray hosted the event and Associate Professor David Ranson, VIFM, delivered an engaging presentation regarding his role in the MH17 investigation. In the future, the CLP looks forward to hosting various events including a panel discussion on the rule of evidence in the coronial jurisdiction and social events.

Coroners and Coronial Investigations

Coronial findings

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

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

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

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

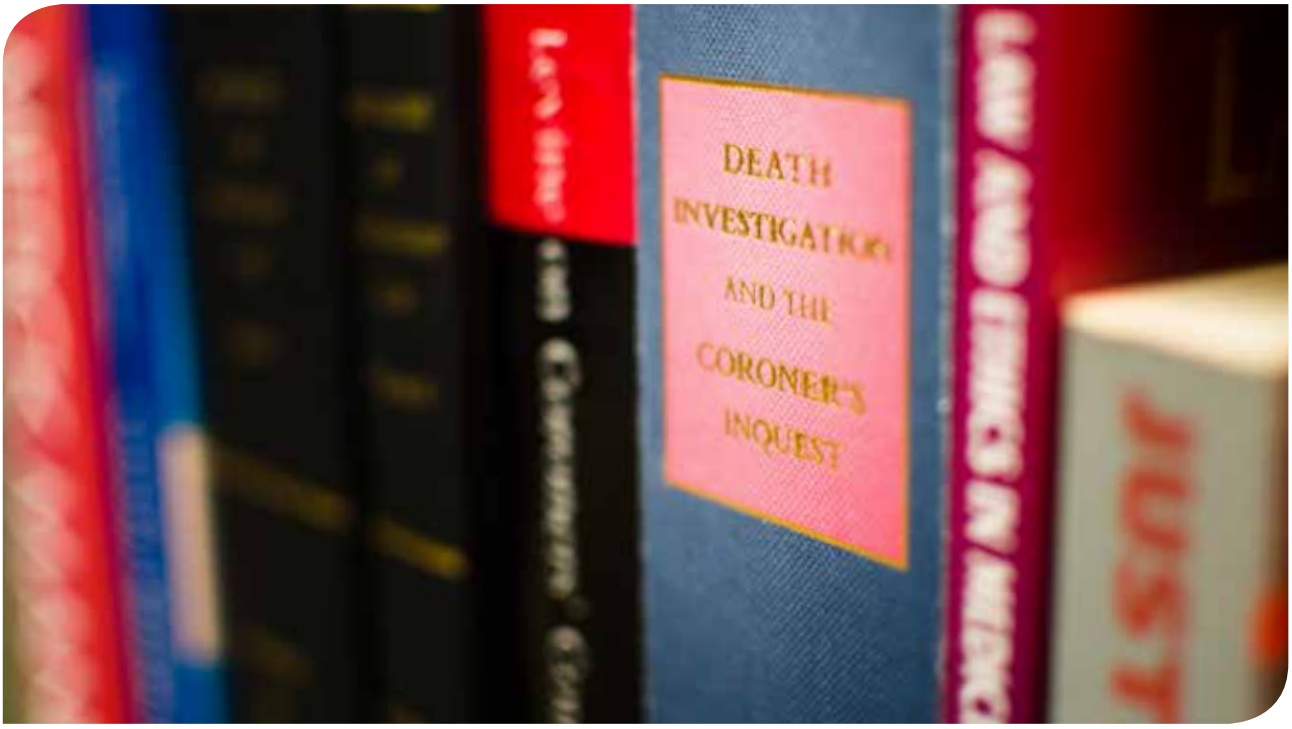
Coroners delivered 3,402 findings in the 2014–15 financial year. For a full breakdown of findings figures see page 38.

Coronial recommendations

In addition to the findings that a coroner must make under the Act, an important purpose of a coronial investigation is to contribute to public health and safety through recommendations aimed at the reduction of preventable deaths and fires. Section 72 (2) of the Act allows coroners to make recommendations to any Minister, public statutory authority or entity on any matter connected to their investigation.

In the 2014–15 reporting period, there were 104 coronial findings, which contained recommendations. For a full breakdown of recommendation statistics see page 38.

Notable findings with recommendations in this reporting period relate to the prevention of deaths from suicide, prescription drugs and police pursuits.



Youth suicide in local communities

In November 2014, a coroner delivered findings into the 2009 suicide deaths of seven young people aged 18 years and under residing in the City of Greater Geelong. The deaths were investigated as a suicide cluster, defined as "a group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation". (Centre for Disease Control, 1994).

The investigations looked at whether exposure to suicidal behaviour in the social network was a factor in an individual's risk of suicide. The coroner considered the presence and role of bullying and cyber-bullying on youth suicide, as well as the media coverage of youth suicide and the potential for it to trigger further suicides among vulnerable and impulsive young people.

Although not all cases involved the same factors, all seven investigations referred to the local post-vention response by the Department of Education and Early Childhood Development, education institutions and health services and found that: *[…] there is an opportunity to reinvigorate suicide prevention activity in Victoria. What appears to be lacking is:*

- *ongoing gathering of real time intelligence on the frequency and rate of suicide in local communities*
- *exchange of intelligence and advice between local community organisations and the state and national organisations responsible for suicide prevention*
- *a nuanced understanding of the presence and combination of risk factors that might influence suicidal activity amongst groups in the community.*

In handing down his findings, the coroner referred to the response of Victoria Police, local health services and local governments to a youth suicide cluster in the City of Casey. Also, the role of local government in suicide prevention had been previously recognised following a major inquiry into the nature and extent of suicide in Victoria in the late 1990s conducted by the Victorian Suicide Prevention Task Force.

The coroner recommended that the Department of Health Human Services, together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist consider the role of local government in suicide prevention and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.

In this reporting period, both Victoria Police and the Department of Health & Human Services agreed to implement this recommendation.

Prescription drugs

In December 2014, a coroner delivered her inquest findings into the 2012 prescription drug related death of a 38-year-old man.

The man was found in a park in the early morning. An autopsy revealed that he had died from pneumonia after taking a combination of prescription drugs, including methadone and benzodiazepines. He had a past medical history, which included a long history of mental illness; he had been diagnosed as suffering from schizophrenia disorder and in the past had at least one psychotic episode.

During the investigation, the coroner raised concerns about the prescribing practises of the two different doctors who were treating the man. In particular, the coroner noted that one doctor, treating the man for drug dependency transferred the man onto a methadone program, whilst the other doctor was also prescribing the man benzodiazepines, which are tranquilizers used to treat anxiety and insomnia.

She referred to numerous coroners findings recommending that doctors have access to real time prescription monitoring electronically. In handing down her findings, one of the coroners recommendations was that the Victorian Department of Health & Human Services must implement a real-time prescription monitoring system that records information on dispensing of all Schedule 8 drugs and all Schedule 4 drugs of dependence in Victoria. This information could be made available to all Victorian pharmaceutical drug prescribers and dispensers, so they can use the information to inform their clinical practice and reduce the harms and deaths associated with pharmaceutical drugs.

In March 2015, the Department of Health & Human Services responded to the recommendations, acknowledging the growing public health issue of prescription shopping and deaths from prescription medicine misuse. The Victorian Government agreed that a national real-time prescription monitoring system would be the most effective tool in assisting doctors and pharmacists.

On request of the Minister for Health, the Department of Heath & Human Services would proceed with arrangements to sign a sub-licence agreement with the Commonwealth to gain access to the Electronic Recording and Reporting of Controlled Drugs software. The Department advised that the Victorian Minister for Health will write to the Commonwealth Minister for Health to begin discussions regarding establishing a partnership for implementing a national system.

Police pursuits

In July 2014, a coroner delivered a finding with inquest into the 2006 death of a 17-year-old girl who lost her life in a motor vehicle collision, while she was a passenger in a vehicle being pursued by police in Carrum Downs.

On the night of the incident, police chased a vehicle on the suspicion that it may have been involved in reported 'burnouts'. The police officers formed the view that the driver of the vehicle was aware of the police presence and was trying to avoid interception, which resulted in the high-speed chase. The collision occurred when the driver lost control of the car, striking a tree at a minimum speed of 138 kmph (in 50 kmph zone).

This matter was one of 10 deaths involving police pursuits being investigated by the Coroners Court.

The primary focus of the inquest was to investigate whether the applicable Victoria Police policies and procedures were complied with in relation to the conduct of the police pursuit.

During the inquest, the coroner found that the Victorian Police manuals did not explain how a member was to apply the various risk assessments associated with police pursuits. The coroner noted the need to put the protection of life above the need to arrest.

When handing down his finding the coroner made four recommendations:

1 That police should never pursue a vehicle simply because it is fleeing. A pursuit should only be undertaken when police hold a pre-existing belief on reasonable grounds that intercepting the vehicle is necessary:
   - to prevent a serious risk to public health or safety; or
   - in response to a serious criminal offence that has been committed, or is about to be committed, which involves serious harm to a person or persons

2 The current Victoria Police risk assessment model for police pursuits should be redeveloped and an alternative more appropriate model be adopted, such as the 'traffic light model,' so as to guide police members as to what weight should be given to one particular risk factor over another. Any risk assessment model should be commensurate with appropriate industry practise in other safety critical environments.

3 All police vehicles should be fitted with In Car Video

4 That Victoria Police introduce processes to ensure all police members record and report all incidents of vehicles fleeing police, to improve the evidence base for development, evaluation and review of police pursuit policies that strike the optimum balance between law enforcement and public safety imperatives.

In October 2014, Victoria Police responded to the recommendations, advising that all recommendations were either being implemented or were under consideration. Victoria Police has now overhauled the policy to chase suspects, forbidding pursuits where a driver is fleeing a minor offence, such as a traffic offense, even if lights and sirens have been activated. Police will only undertake "imperative pursuits" where the apprehension of the driver or its occupants is essential to protect the health and safety of the Victorian community.

Violence in young males

In September 2014, a coroner delivered his findings without inquest into the death of a twenty-year-old male who died from a stab wound in a fight.

The investigation revealed that the fight had been organised by another young male in retaliation for an alleged assault committed by the deceased and his friends on another male in the area. At the scene of the fight the male was stabbed in the back. The male was then transported to the Royal Melbourne Hospital where he passed away shortly after.

In the findings the coroner highlighted the importance of educating boys on the harsh consequences and dangers of violence. He stated that this story should be taught in schools to demonstrate how such an apparently simple enterprise can lead to such tragic consequences.

When handing down his finding the coroner made a single recommendation that the Victorian Government Department of Justice and Regulation use the circumstances of this matter as an example to use in the 'Choices for Boys' program, to assist teenagers aged between 15 and 17 years in appreciating the importance of considering the consequences of their actions, walking away from violent situations and never carrying a weapon.

As a response to the coroner's recommendations the Department of Justice and Regulation will now use the circumstances of this death in the 'Choices for Boys' program.

Coroner presentations and committee membership

The coroners, in their role as judicial officers, made a number of conference presentations, participated in various committees and councils and assisted with the delivery of professional development programs by the Judicial College of Victoria.

Asia Pacific Coroners Society Conference

In November 2014, the Coroners Court of Victoria hosted the annual Asia Pacific Coroners Society (APCS) Conference in Melbourne.

The theme of the 2014 Conference was "Asking the Right Questions" and the 145 delegates from Australia, New Zealand, Cook Islands, Samoa, Singapore and the United Kingdom were challenged to consider what are the right questions when working in the coronial jurisdiction.

Presenters from Victoria, interstate and overseas covered topics such as:

- End of life planning and decision making
- Privilege against self incrimination and coronial law
- Suicide: who's really at risk
- Prescription drug deaths
- Recent developments in forensic pathology
- Long-term missing persons and cold case investigations
- There were also presentations on crime writing, when crime pays and a background into the documentary 'Trigger Point'.

Delegates from the fields of coronial law, forensic medicine and public health also had the opportunity to tour the newly redeveloped coronial complex combining the Court and VIFM in Southbank. The purpose-designed facilities have become the envy of those from other states.

The social program included a welcome reception at Government House hosted by the Governor of Victoria, a gala dinner at the Melbourne Museum and dinner on the Melbourne Tramcar Restaurant.

Feedback from conference delegates labelled the conference a huge success. The organising committee, comprising of Victorian coroners and court staff, were commended for their efforts in developing an informative and entertaining program incorporating groundbreaking research relevant to all Victorian, interstate and international delegates.

The APCS was established to promote the advancement of best practices and education of coronial law and practice Membership is open to coroners and those involved within the coronial jurisdiction – pathologists, forensic scientists, police, lawyers and grief counsellors.

Conference presentations

- Asia Pacific Coroners Society Conference
- International Medicine in Addiction Conference
- Law Week – Sisters In Crime panel
- Monash Medical Year 3 MBBS medical students
- West Gippsland Health Care Group AGM
- Detective Training Course – VIFM – 3 presentations to date.

Committee and council memberships

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

Coroners professional education

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

- a two-day intensive workshop as an ongoing professional development to coroners state-wide
- publication and maintenance of a Coroners Bench Book to help coroners stay up-to-date with the latest developments in Australian coronial law
- monthly circulation of Coroners Prevention Unit research
- twilight sessions – 'Withdrawing Life Support in Intensive Care' (September 2014) and 'Human Rights in the Coronial Jurisdiction' (June 2015).

Coroners Court of Victoria 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.

The Research Committee met monthly throughout the financial year 2014–15 under co-chairs Coroner Paresa Spanos and Coroner Audrey Jamieson, and reviewed 43 proposals, which was a substantial increase on the 26 proposals reviewed during the 2013–14 financial year.

MH 17 disaster identification and repatriation process

On 17 July 2014, Malaysian Airlines flight MH 17 was shot down over eastern Ukraine. All 298 passengers and crew were killed, including 27 Australian citizens. On the request of the Australian Federal Police, Victoria's Deputy State Coroner Iain West was sent to Amsterdam, The Netherlands, who, under the provisions of 1944 Convention on International Civil Aviation, was delegated responsibility for investigating the incident by Ukraine Government.

Coroner West observed the ante mortem/ post mortem reconciliation process at Hilversum Army Base, where passengers were formally identified. This was to ensure that procedures were the same as they would be if the identification process were done in Australia.

During the visit, Coroner West observed the operations of the Disaster Victim Identification (DVI) Board, tasked with investigating the more complex identification findings. The Board comprised of a government prosecutor, DVI commanders, as well as medical and scientific experts from the Netherlands, Germany, United Kingdom, Australia and Malaysia.

The Coroners Court of Victoria assumed the responsibility for facilitating the repatriation process for all the Australians who lost their lives on MH 17. The Victorian Institute of Forensic Medicine (VIFM) was the receiving centre on behalf of all States and Territories to ensure that the process was consistent for everyone and undertaken as quickly as possible.

Coroner West credits the high level of cooperation between States and Territories for enabling the repatriation process as being seamless and efficient.

The Court acknowledges the work of Associate Professor David Ranson, Forensic Pathologist and Deputy Director of VIFM, who travelled to The Netherlands with Coroner West to assist with the identification process of MH 17 passengers and crew. The Court extends its appreciation to the VIFM Coronial Admissions and Enquiries Office staff for assisting the families in the repatriation process.

In the coming financial year, the Court plans to hold a hearing into the deaths of the Victorian residents.

Report of the Coroners Support Service

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

Principal Registrar

Deceased transportation services

Under the *Coroners Act 2008*, a deceased person whose death is reportable is taken into the care of the coroner while medical examinations are undertaken as part of the investigation into the death. The Court is therefore charged with the responsibility of transporting deceased persons from the place of death (where that death occurs anywhere in the state) to a coronial mortuary. External contractors, usually private funeral directors, are engaged to provide this service. There are currently 36 separate contractors (one metropolitan and 35 regional) providing this service.

As reported in previous annual reports, the cost of deceased person's transportation has continued to have a significant impact on the Court's operating budget. To address this, Court Service Victoria supported the Court to commence the Transport of Deceased Persons Project. During the reporting period, the Transport of Deceased Persons Project issued a Request for Tender. In 2014, the tender process was closed with a non-awarded result due to unacceptable pricing submitted by the market that exceeded the available budget. Extensions to existing contracts were negotiated in late 2014, and the service is currently provided until 31 December 2015.

The Transport of Deceased Persons Project continued to explore options to provide a financially sustainable service and established a sequence of events to prepare for a future market test to provide transport of deceased persons services at a value for money outcome. The Transport of Deceased Persons Project aims to issue a Request for Tender during the next reporting period.

Compliments and complaints

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

- 12 Compliments
- 26 Complaints
- 13 Service Delivery issues

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

Registry

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

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

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

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

Court Administration Officers

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

Family Liaison Officers

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

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

Report of Legal Services

The Coroners' Solicitors

A coroner's solicitor provides legal assistance and support to their allocated coroner through statutory and case law analysis, development of precedents, practice directions and guidelines and the application of legal developments where precedent may not be well defined.

A coroner's solicitor assists the coroner in all aspects of coronial investigations, including the drafting of legal documents and correspondence. They work in close collaboration and consultation with the coroner, the Coroners Support Service, the Coroners Prevention Unit, the Police Coronial Support Unit and other court business units, to build and retain relevant knowledge and expertise within the court.

Coroners' solicitors assist the coroners to prepare their findings by examining the coronial brief and other relevant material, evaluating evidence, and providing advice and memoranda of research to their coroner. The coroners' solicitors assist in ensuring the efficient closure of all files, while supporting a comprehensive coronial investigation. This additional support for the coroners has resulted in the Court achieving a reduction in lengthy and protracted coronial investigations, an important factor in the Court's considerations under section 8 of the *Coroners Act 2008* (Vic).

Coroners' solicitors may appear as counsel assisting the coroner in mention and directions hearings and summary inquests.

The In-House Legal Service

The Coroners Court In-House Legal Service (IHLS) comprises two permanent full-time solicitors and one part-time solicitor. The IHLS assist coroners with 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 the reporting period, the IHLS assumed the conduct of all potential police conflict matters and:

- appeared as counsel assisting a coroner in three inquests
- appeared as counsel assisting a coroner in 31 directions hearings, mentions etc
- performed the role of instructing solicitor to counsel assisting a coroner in 65 inquest sitting days
- instructed counsel in nine Supreme Court appeals*
- instructed counsel in one High Court appeal
- provided 108 separate complex legal briefings to coroners
- provided and participated in ongoing professional development for coroners and coroners' solicitors.

**A person can apply to the Supreme Court to appeal coroners' decisions to perform an autopsy, refusal to grant an inquest, refusal to reopen an investigation, have a finding set aside and to object to an order of exhumation.*

In addition, the IHLS:

- actively case managed police conflict investigations
- drafted a range of complex legal documents
- 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 Victorian Institute of Forensic Medicine and the Court to ensure efficiencies between each organisation.

Representations

Legal Services are represented at the following committees:

- Judicial Education Committee
- Occupational Health and Safety Committee
- Coroners Court Research; and
- Coroners Court and Victorian Institute of Forensic Medicine Joint Operations Committee.

Report of the Coroners Prevention Unit

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

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

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

Coroner referral and completion statistics

Since the establishment of the CPU in October 2009, coroners have sought assistance for approximately 3,000 investigations and the CPU has provided approximately 2,700 separate pieces of advice to coroners. The annual frequency of advice sought and provided by stream of activity is shown in the table below.

Coroner referrals to the Coroners Prevention Unit

STREAM OF ACTIVITY	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Referrals Received						
Family Violence	7	23	14	15	6	20
General	73	123	141	110	107	78
Health and Medical	-	262	258	250	387	513
Mental Health	19	53	71	65	114	82
Other Business Units	1	11	18	18	26	6
External Agency	8	14	29	17	9	8
Total	**108**	**486**	**531**	**475**	**649**	**707**
Referrals Completed						
Family Violence	10	10	15	17	4	18
General	57	90	126	112	114	87
Health and Medical	-	121	267	299	358	469
Mental Health	3	23	63	66	93	107
Other Business Units	1	10	16	20	26	6
External Agency	5	10	33	18	11	6
Total	**76**	**264**	**520**	**532**	**606**	**693**

Coroners' recommendations on public health and safety

During the reporting period, coroners made a number of key recommendations to improve public health and safety in Victoria, which were accepted by public statutory authorities or entities. Examples of recommendations based on CPU advice included:

- amendment to the Victoria Police pursuit policy
- the intention to introduce prescription drug monitoring programs to reduce harms association with prescription drug misuse
- the development of a suicide prevention policy framework for Victoria
- regulatory bodies review avenues to improve the clinical governance of nurses scope of practice in mental health crisis assessment and treatment services
- avenues for third parties (health/legal/community services, family members and friends) to report suspected family violence to an authority with a mandate and resource to respond
- consideration by health services for the establishment of protocols for the obstetric management of colleagues or friends.

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 incidents. The VSRFVD conducts in-depth reviews of deaths that meet the following criteria to contribute to strengthening the response to family violence across the state:

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

Since the establishment of the VSRFVD, 384 deaths have been identified as resulting from the actions or inactions of another person. The following table shows the preliminary classification of determined and suspected homicides reported to the Court from 1 January 2009 to 30 June 2015. Note that 37 (9.6%) deaths require additional information for classification purposes.

Annual frequency of suspected homicides reported to the Coroners Court by relationship, Victoria 1 January 2009–30 June 2015

DECEASED-OFFENDER RELATIONSHIP	YEAR							TOTAL
	2009	2010	2011	2012	2013	2014	2015 (ToJune 30)	
Intimate Partner	7	9	9	8	12	9	6	**60**
Parent-Child	9	7	9	8	9	8	5	**55**
Other Intimate or Familial (Including Kinship)	6	8	9	8	4	5	6	**46**
Not Intimate or Familial	31	30	33	20	27	36	9	**186**
Still Inquiring	-	1	3	3	4	7	15	**33**
Unknown	3	1	-	-	-	-	-	**4**
Total	**56**	**56**	**63**	**47**	**56**	**65**	**41**	**384**

Where the deceased-offender relationship was established (347 or 90.4%), 161 (46.4%) were family homicides, that is, that they occurred between parties in an intimate, familial or family like relationship. Of the 161 family homicides, 60 (37.3%) occurred between intimate partners. Of these, 42 (70.0%) occurred between current partners, 18 (30.0%) between former partners. Homicides amongst parents and children comprised a further 55 (34.2%) of the 161 family homicides. Just over half of the homicides in this category were of parents killing their children (54.5%). The remaining 46 (28.6%) of the 161 family homicides occurred between parties in other intimate or familial relationships.

Frequency of parent-child homicides by offending party and relationship, Victoria 1 January 2009–30 June 2015

RELATIONSHIP TYPE	OFFENDING PARTY			TOTAL
	PARENT OFFENDER	CHILD OFFENDER	STILL INQUIRING	
Father-Daughter	8	1	-	**9**
Father-Son	8	14	-	**22**
Mother-Daughter	7	2	-	**9**
Mother-Son	6	6	-	**12**
Still Inquiring	1	1	1	**3**
Total	**30**	**24**	**1**	**55**

This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs from the previous report (2013–14) because of this re-classification process. The annual frequency of family homicides ranged from 22 in 2009 to 27 in 2011. For the period 1 January to 30 June 2015, 17 family homicides have been identified.

During the 2014–2015 reporting period, coroners completed investigations into 20 family homicides resulting from 17 separate incidents. From these investigations, coroners made comments and recommendations about mechanisms to reduce the risk of family homicide. A key recommendation made during the reporting period related to the need for additional avenues for reporting incidents of family violence to authorities. The State Coroner Judge Gray made the following comments and recommendation following his investigation into the tragic death of Nicole Millar:

> *Members of a victim's social network can play a significant role in addressing violence and abuse. Oftentimes, friends, family members and work colleagues are the first to know or suspect that violence is occurring. Their actions, both big and small, can make a meaningful difference toward helping victims increase their safety and address a problematic relationship. In order for this to occur, it is necessary for the community to have a sound understanding about the range of behaviours that comprise family violence, and the options available to assist those at risk. In addition, it is important that messages emphasising that family violence is a crime and not condoned in the community continue to be expressed.*
>
> *In a large number of family violence homicides reviewed as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD), there was evidence that family members, friends, neighbours and/or co-workers were aware or suspected that violence was occurring in the relationship. It has also been identified that these 'third parties' do not feel equipped to assist or are concerned that becoming involved may make the situation more dangerous for the victim or themselves.*
>
> *To address this, various violence prevention initiatives have been implemented, ranging from increased community awareness to legislative provisions such as the Northern Territory's mandatory reporting of domestic violence laws. In Victoria, responses to this issue have also included a community education component, such as the Commonwealth Government's 1800 RESPECT telephone counselling initiative. These initiatives have featured strategies to develop a shared understanding of family violence, promote community resources and services and encourage attitudinal and behavioural change.*
>
> *However, the circumstances surrounding Ms Millar's death and many others indicate that families, friends, colleagues and neighbours need an effective mechanism to bring suspected family violence to the attention of an authority empowered and equipped to respond in a timely manner. Noting that Crime Stoppers is a recognised brand and has accountability mechanisms, I consider that it has the potential to fill the gap between public awareness campaigns and emergency services with respect to family violence.*
>
> *Crime Stoppers has developed the Say Something campaign, which urges young people who witness acts of violence to be brave and look out for their friends by reporting incidents of violence confidentially. A website and iPhone app are available to help empower young people to report crime easily and online without identifying themselves. I therefore recommend that Victoria Police, together with Crime Stoppers, conduct a trial extending the Say Something campaign to family violence.*

A response to this recommendation has been received and the Court were advised that funding is being sought for implementation of the recommendation.

Collaborative projects

A collaborative research project with the University of Melbourne funded by the beyondblue Victorian Centre of Excellence in anxiety and depression continued in this reporting period. The study examined service contacts amongst persons who died from suicide in Victoria during 2009 and 2010. During the reporting period, the data analysis was completed and consultation on the results was conducted with key stakeholders via expert consultation forums. The final report on the outcomes of the study will be published during the next reporting period.

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

In addition, two collaborative projects commenced during the reporting period.

The CPU in partnership with Turning Point Drug and Alcohol Centre was awarded a grant through the Victorian Law Enforcement Drug Fund, to examine the sources of pharmaceutical drugs that contributed to Victorian overdose deaths between 2011 and 2013. The aim of the study is to develop a better understanding of how people access these drugs: by prescription from one doctor or multiple doctors, via family and friends, illegal purchase (diversion) or otherwise. The findings will directly inform efforts to reduce overdose deaths involving pharmaceutical drugs.

The CPU also commenced a collaborative project with the Amy Gillett Foundation, Monash University and the Transport Accident Commission to examine contributing factors to fatal cyclist crashes. Using the Safe Systems Approach, the collaboration comprised a systematic review of publications that reported on contributing factors and an in-depth retrospective case series review of fatal cyclist crashes investigated by coroners. A review panel comprising a coroner, road safety policy makers and experts will be convened to review the project findings prior to publication.

Education and training

Health and medical information days

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

Representations

- Asia-Pacific Coroners Society Conference Organising Committee
- Violence Against Women and Children Interdepartmental Committee
- Road Fatalities Review Panel (observer)
- Transport Industry Safety Group.

Presentations

- During the reporting period, CPU staff were invited to deliver the following presentations at conferences and meetings.
- Bugeja L, Corkill P. The development and impact of PFD wear regulations on drowning of recreational boating occupants in Victoria. National Drowning Prevention Summit 2014. 6 August 2014.
- Dwyer J. Suicide among drug dependent people, Victoria 2009–2010. Talking Point Seminar Series, Turning Point. 27 August 2014.
- Dwyer J, Sutherland G. Victorian Suicide Register. University of Melbourne Centre for Mental Health Seminar Series. 4 September 2014.
- Dwyer J. Suicidal drug overdose in Victoria. Tasmanian Suicide Prevention Community Network Annual Suicide Prevention Forum. 25 September 2014.
- Dwyer J. Suicide among people with dual diagnosis, Victoria 2009–2010. Alcohol, Tobacco and Other Drugs Council Tasmania. 26 September 2014.
- Dwyer J. Prescription drugs: too much of a good thing? Asia Pacific Coroners Society Conference 2014. 13 November 2014.
- Spanos P, Neate S, Jelinek G. A split diagnosis: how difficult is it to identify aortic dissection? Asia Pacific Coroners Society Conference 2014. 13 November 2014.

- Bugeja L. Development of the Victorian Suicide Register to Advance Suicide Prevention. Asia Pacific Coroners Society Conference 2014. 14 November 2014.
- Hyland M. What strategies are in place and/or required to address risk factors for middle-aged men? Asia Pacific Coroners Society Conference 2014. 14 November 2014.
- Bugeja L. Enabling public health and safety through the coroners' death investigation system: the Coroners Prevention Unit. Court Services Victoria Court Familiarisation Program. 11 December 2014.
- Bugeja L. The medico-legal investigation of suicide. headspace School Support Conference. 11 December 2014.
- Bugeja L. Coroners' investigation of suicide. Living is for Everyone Workshop Series. 10 February 2015.

Publications

- Sutherland G, Kemp C, Bugeja L, Sewell G, Pirkis J, Studdert DM. What happens to coroners' recommendations for improving public health and safety? Organisational responses under a mandatory response regime in Victoria, Australia. BMC Public Health. 14:732, 2014.
- Jelinek GA, Bugeja L, Spanos P, Neate SL, Bergman RL, Ranson DL. Collaboration between the coroner and emergency physicians: efforts to improve outcomes from aortic dissection. Medical Journal of Australia. 201(10), 607–609, 2014.
- Murphy B, Liddell M, Bugeja L. Service contacts proximate to intimate partner homicides in Victoria. Journal of Family Violence. Published online 31 May 2015.

Report of Executive Services

Communications and publications

During the reporting period, the Court updated and uploaded information about the coronial process on to the Court's website. The updated publications *The Coroners Process – Information for families and friends* and *What do I do now?* were also printed. The Court distributed 3,189 copies of The Coroners Process – *Information for families and friends* and 4,396 copies of *What do I do now?* to hospitals, police, courts, community workers, social workers and funeral directors. These distributions were in addition to publications normally provided by the court to families engaged in the coronial process and persons attending the Court's public information sessions.

The Court's website continued to be relied upon as an information repository to make information available to families, the community and key stakeholders. During the reporting period, 201 new findings and 62 new rulings were uploaded onto the Court website. In addition, there was a significant increase in the frequency of visits to the Court's website. The table below indicates the number of visits (1,310,057) to pages on the Court website during the reporting period. This is an increase of 141,815 visits from the 2013–2014 reporting period (1,168,242)

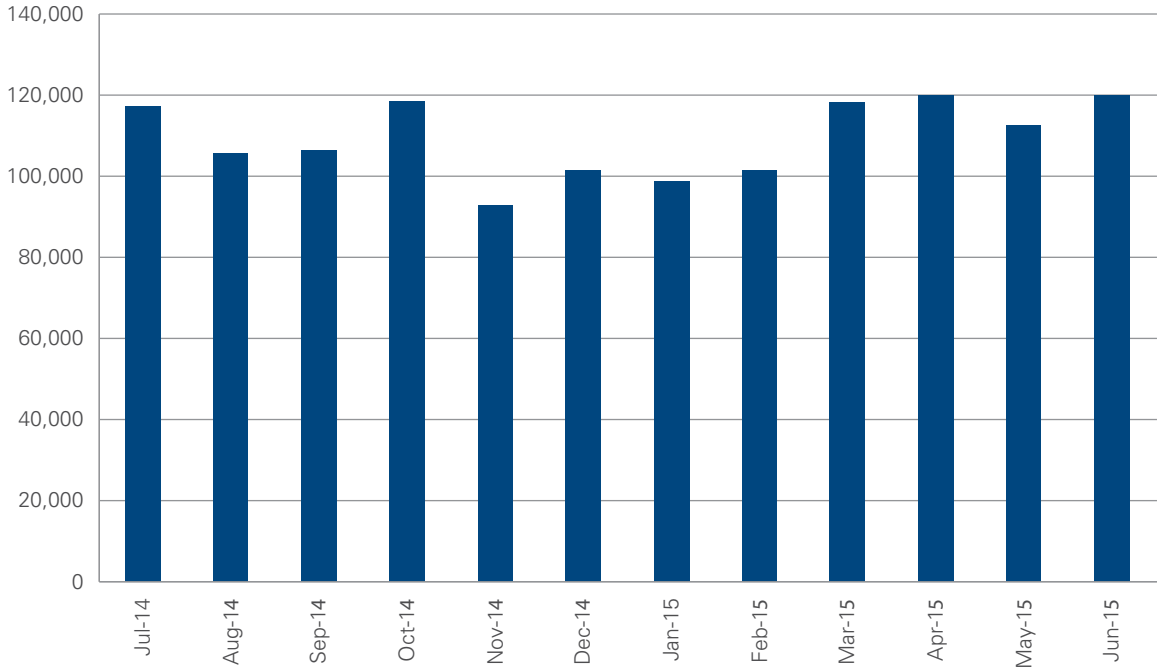
Media enquiries

The Court media unit assists journalists and media representatives seeking to prepare balanced reports about the coronial matters and the Court's activities. The Court responds to information requests and media enquiries in order to promote fair and accurate reporting. In the 2014–15 reporting period, the media unit averaged over 60 information requests each month, or approximately 720 media enquiries per year.

Records management

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

During the reporting period, the Court received an estimated 3,920 requests for access to coronial documents. Of these, 2,468 were requests from external agencies, an increase of over 283%, compared to the 811 requests received in 2013–14. Another 1,452 were requests initiated by Court staff.



** data collated from Google Analytics*

Human resources

Average full time equivalent as at June 30 2015

	SPECIAL APPROPRIATION	BASE BUDGET	OTHER FUNDED	TOTAL
Judicial Officers	9.0	-	-	**9.0**
Ongoing Staff	-	46.3	-	**46.3**
Fixed-Term Staff	-	7.2	0.8	**8.0**
Total Average FTE	**9.0**	**53.5**	**0.08**	**63.3**

**compared with a total staffing of 63.5 average full-time equivalent as 30 June 2014*

Financial statement

In 2014–15, the Court managed its expenses within the allocated budget and reported a surplus of $0.98 million to be carried over into the next financial year. The total deficit reflected in the financial statement is generated from special appropriation expenses. A range of cost saving initiatives and processes designed to maintain a surplus within a tight budget were implemented.

In the reporting period, the Court introduced a process oriented monthly financial reporting system, which enabled immediate corrective action against over-spending. Furthermore, this reporting system identified respective process owners for each business area. 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 15% reduction in the Court's operating costs compared to 2013–14.

In 2014–15, the Court maintained the lean operating model first introduced in 2013–14. The strict controls over full-time employment (FTE) levels contributed to a $140,000 reduction in employee related costs compared to last financial year (2013–14).

The 2013–14 introductions of the Court's in-house legal counsel have continued to produce significant cost savings. This reporting year, the Court reduced its cost on external legal professional services by 22%.

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 as part of the investigation into the death. The cost of providing this service is significant, representing over 25% 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 $700,000.

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

NOTE: Please see the Financial Statement (Erratum) at the end of this document

Operating statement for the financial year 2014–2015

	NOTES	2010–11	2011–12	2012–13	2013–14	2014–15
INCOME FROM TRANSACTIONS						
Output Appropriation		8,731,700	10,087,600	9,998,190	11,252,900	10,575,075
Special Appropriation		2,427,000	3,182,600	2,895,706	3,479,417	3,557,484
Other Income		(317)		351	-	-
Total Income		**11,158,383**	**13,270,200**	**12,894,247**	**14,732,317**	**14,132,559**
EXPENSES FROM TRANSACTIONS						
Employee Benefits	NOTE 1	7,948,768	8,597,502	8,269,596	8,090,138	7,997,022
Depreciation and Amortisation		421,405	93,465	86,527	84,905	14,000
Interest Expense		2,974	2,722	1,559	1,493	2,496
Grants and Other Transfers	NOTE 2	32,610	34,114	1,317	-	-
Supplies and Services	NOTE 3	3,262,224	3,839,448	3,458,268	3,040,797	2,479,372
Deceased Removal and Transfers	NOTE 4	2,080,571	1,932,225	2,584,540	2,656,673	3,866,179
Total Expense from Transactions		**13,748,552**	**14,499,476**	**14,401,807**	**13,948,481**	**14,359,068**
Net Result from Transactions (Net Operating Balance)		**(2,590,169)**	**(1,229,276)**	**(1,507,560)**	**783,836**	**(226,509)**
OTHER ECONOMIC FLOWS						
Other Gains(Losses) from other Economic Flows	NOTE 5	(760)	(19,307)	(6,896)	- 6,372	
Total other Economic Flows included in Net Result		**(760)**	**(19,307)**	**(6,896)**	**- 6,372**	**0**
Net Result		**(2,590,929)**	**(1,248,583)**	**(1,514,456)**	**790,208**	**(226,509)**

Note 1 – Employee benefits

See average full time equivalent table on page 35.

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: Please see the Financial Statement (Erratum) at the end of this document

Note 3 – Supplies and services

2014–15 Staff Training and Development is included in expenses 'Employee Benefits'.

	2010–11	2011–12	2012–13	2013–14	2014–15
Contractors and Consultants	838,662	865,186	529,427	180,319	113,233
Legal Professional Services	1,225,705	941,878	766,365	530,257	415,141
Medical Professional Services	149,983	28,469	258,296	165,691	77,945
Information Technology	163,409	97,819	98,737	87,237	118,908
Printing and Stationary	201,418	166,479	117,121	92,540	69,534
Postage and Communication	165,976	172,865	111,913	117,185	98,059
Travel and Personal Expenses	51,015	44,400	23,801	30,357	41,481
Staff Training and Development	47,384	33,662	11,386	29,436	-
Witness Expense	36,492	36,199	39,571	34,717	30,777
Other Operating Expense	382,180	1,452,491	1,501,605	1,773,057	1,514,294
Total Supplies and Services	**3,262,224**	**3,839,448**	**3,458,268**	**3,040,798**	**2,479,372**

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

	2010–11	2011–12	2012–13	2013–14	2014–15
Metropolitan areas	749,851	687,597	935,892	1,121,753	1,730,220
Regional areas	1,330,720	1,244,628	1,648,649	1,534,920	2,135,959
Total	**2,080,571**	**1,932,225**	**2,584,540**	**2,656,673**	**3,866,179**

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

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

NOTE 6 – Operating statement

The above operating statement represents the actual result achieved in 2014–15 by the Coroners Court.

Operational Statistics

Case initiations and closures

	2010–11	2011–12	2012–13	2013–14	2014–15
Cases Opened	4,857	5,029	5,934	6,267	6,336
Cases Closed	5,586	4,949	5,342	7,270	6,884
Case Clearance Rate (Cases Opened / Cases Closed)	115%	98%	93%	116%	108%
Cases referred to the Court by the Registry of Births, Deaths and Marriages	657	680	593	635	621

Case progress

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

	2010–11	2011–12	2012–13	2013–14	2014–15
0–12 Months	2,263	2,908	3,194	2,843	2,607
12–24 Months	850	845	1,034	720	655
> 24 Months	1,396	1,203	1,072	646	603
Total Number of Lodgements Pending	**4,509**	**4,956**	**5,300**	**4,209**	**3865***

**As at 1 July 2015, 63 cases in the total 3865 pending lodgements could not be actioned as they were the subject of ongoing police criminal investigations or court proceedings in other jurisdictions. Coronial investigations in such cases are suspended until the police and/or other court proceedings are complete.*

Objections to autopsy

	2010–11	2011–12	2012–13	2013–14	2014–15
Objections Upheld	61	45*	90	86	108
Objections Refused	70	51*	-*	-*	-*
Objections Withdrawn	16	18*	-*	-*	-*
Total Number of Objections	**147**	**114***	**152**	**105**	**124**

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

Coroners' findings

FINDING INTO DEATH WITH INQUEST	FINDING INTO FIRES WITH INQUEST	FINDING INTO DEATH WITHOUT INQUEST	FINDING INTO FIRES WITHOUT INQUEST	TOTAL
195	0	3,207	0	3,402

Coroners' recommendations

Of the 3,402 findings made by coroners during the reporting period, 104 contained recommendations. A coroner can make more than one recommendation in a single finding. The table below indicates the total number of recommendations made by coroners during the reporting period.

	2010–11	2011–12	2012–13	2013–14	2014–15
Total Number of Recommendations	**144**	**217**	**243**	**261**	**294**

Responses to coroners' recommendations

	2010–11	2011–12	2012–13	2013–14	2014–15
Responses to Recommendations Received	52	90	106	282	223*

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

Financial Statement (Erratum)

Following the publishing of the 2014–15 annual reported result, the Court became aware of differences in accounting treatment relating to previous financial year values, in the 2012-13 and 2013-14 period. With the primary focus on the 2014-15 figures of which Courts Services Victoria were aiming to implement a consistent methodology across all Court jurisdictions, these re-published values have now been amended using the same approach.

The current report had already been produced when the difference in the accounting treatment was identified. The Court is committed to providing accurate transparent reports to the Victorian Parliament and public, therefore this erratum has been produced to provide better comparative financial figures for 2012-13 and 2013-14.

Operating statement for the financial year 2014–2015

	NOTES	2010–11	2011–12	2012–13	2013–14	2014–15
INCOME FROM TRANSACTIONS						
Output Appropriation		8,731,700	10,087,600	9,998,190	11,252,900	10,575,075
Special Appropriation		2,427,000	3,182,600	2,895,706	3,479,417	3,557,484
Other Income		(317)		351	-	-
Total Income		**11,158,383**	**13,270,200**	**12,894,247**	**14,732,317**	**14,132,559**
EXPENSES FROM TRANSACTIONS						
Employee Benefits	NOTE 1	7,948,768	8,597,502	8,262,673	8,090,030	7,997,022
Depreciation and Amortisation		421,405	93,465	86,527	84,905	14,000
Interest Expense		2,974	2,722	1,559	1,493	2,496
Grants and Other Transfers	NOTE 2	32,610	34,114	1,317	-	-
Supplies and Services	NOTE 3	3,262,224	3,839,448	3,458,268	3,040,797	2,479,372
Deceased Removal and Transfers	NOTE 4	2,080,571	1,932,225	2,584,540	2,656,673	3,866,179
Total Expense from Transactions		**13,748,552**	**14,499,476**	**14,394,884**	**13,873,898**	**14,359,068**
Net Result from Transactions (Net Operating Balance)		**(2,590,169)**	**(1,229,276)**	**(1,500,637)**	**858,419**	**(226,509)**
OTHER ECONOMIC FLOWS						
Other Gains(Losses) from other Economic Flows	NOTE 5	(760)	(19,307)	-	6,264	-
Total other Economic Flows included in Net Result		**(760)**	**(19,307)**	**-**	**6,264**	**-**
Net Result		**(2,590,929)**	**(1,248,583)**	**(1,500,637)**	**864,683**	**(226,509)**

Notes:

- *The 2012-13 Other Economic Flows value of ($6,896) has been amended to reflect employee benefits, as this relates to Special Appropriation Long Service Leave Provisions which is in accordance with accounting standards. This results in amendments to Total Expense from Transactions and the Net result.*
- *The 2013-14 Other Economic Flows value of ($6,372) was amended to ($6,264) to reflect employee benefits, as this relates to Special Appropriation Long Service Leave Provisions which is in accordance with accounting standards. This results in amendments to Total Expense from Transactions and the Net result. Further, a misprint of the Total Expense from Transactions has been amended, reducing the Total Expense from Transactions and improving the net result for 2013-14 by $74,475.*

Note 3 – Supplies and services

2014–15 Staff Training and Development is included in expenses 'Employee Benefits'.

	2010–11	2011–12	2012–13	2013–14	2014–15
Contractors and Consultants	838,662	865,186	529,472	180,319	113,233
Legal Professional Services	1,225,705	941,878	766,365	530,257	415,141
Medical Professional Services	149,983	28,469	258,296	165,691	77,945
Information Technology	163,409	97,819	98,737	87,237	118,908
Printing and Stationary	201,418	166,479	117,121	92,540	69,534
Postage and Communication	165,976	172,865	111,913	117,185	98,059
Travel and Personal Expenses	51,015	44,400	23,801	30,357	41,481
Staff Training and Development	47,384	33,662	11,386	29,436	-
Witness Expense	36,492	36,199	39,571	34,717	30,777
Other Operating Expense	382,180	1,452,491	1,501,605	1,773,057	1,514,294
Total Supplies and Services	**3,262,224**	**3,839,448**	**3,458,268**	**3,040,798**	**2,479,372**

Notes:

- *The 2012-13 Contractors and Consultants value has been amended as a result of a misprint from $529,427 to $529,472.*

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Authorised by Coroners Court of Victoria