CORONERS COURT
OF VICTORIA

2017 ANNUAL REPORT

Dear Attorney-General

In accordance with section 102 of the *Coroners Act 2008*, I am pleased to present the Coroners Court of Victoria's Annual Report for the year ended 30 June 2017.

Judge Sara Hinchey, State Coroner
October 2017

Published by the
Coroners Court of Victoria
65 Kavanagh Street Southbank Vic 3006
September 2017

We value your feedback

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

Please send your feedback to **mediaenquiries@coronerscourt.vic.gov.au**.

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If you need this report in an accessible format, please contact us on 1300 309 519 or email **mediaenquiries@coronerscourt.vic.gov.au.**

This document can also be found at **www.coronerscourt.vic.gov.au**.

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Acknowledgement

The Coroners Court of Victoria is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture and Elders both past and present.

AT A GLANCE

INVESTIGATIONS

6248
NEW INVESTIGATIONS OPENED

6285
INVESTIGATIONS FINALISED

100.6%
CLOSURE RATE

CAUSE OF DEATHS REPORTED TO THE COURT

- NATURAL DEATHS 40%
- ACCIDENTS 33%
- SUICIDES 11%
- OTHER 10%
- MEDICAL / SURGICAL COMPLICATIONS 5%
- HOMICIDES 1%

INQUESTS

93
INQUESTS HELD

→ REPRESENTS 1.3% OF INVESTIGATIONS

AVERAGE
7.9 MONTHS
TO FINALISE MATTERS

4 OUT OF 5
CLOSED IN <12 MONTHS

44% in < 3 months

→ AVERAGE PENDING CASES LESS THAN A YEAR OLD

RECOMMENDATIONS

127
RECOMMENDATIONS

73%
ACCEPTED

11%
NOT ACCEPTED

DATA & DOCUMENTS

5063
REQUESTS FOR CORONIAL DOCUMENTS

23
ORGANISATIONS PROVIDED WITH CORONIAL DATA

40
RESEARCH REQUEST GRANTED

The Coroners Court of Victoria's Annual Report 2016-17 is a comprehensive report of the services we provide to families who have lost loved ones, as well as to the wider Victorian community.

This report is a key accountability document and the main way we report on our activities to important stakeholders – namely Victorian families, the Parliament of Victoria, the Coronial Council of Victoria, reporting bodies and other organisations that support or use our services.

This report analyses our operational environment and performance, and reveals how we will continue to promote public health and safety and the administration of justice in the year ahead. It also includes a summary of our financial performance, with full accounts published in the Court Services Victoria (CSV) Annual Report, available at **www.courts.vic.gov.au**.

HOW TO READ THIS REPORT

The operational chapters of this report align with the Court's three main roles, namely:

1. investigating deaths and fires
2. reducing preventable deaths
3. promoting public health and safety and the administration of justice

Each chapter describes and analyses our performance and achievements, the challenges we faced and what we are planning in the year ahead.

Please note:

Wherever possible, we openly and transparently share coronial information. However, there are some activities we cannot report on publicly, such as active investigations.

All case studies are from investigations closed by the Court in the past year. They have been deidentified out of respect for the families.

Some content in this report may be distressing to some readers.

A list of helpful contacts and support services is available at **www.coronerscourt.vic.gov.au.**

GLOSSARY

BP3	Budget Paper 3
CCOV	Coroners Court of Victoria
CEO	Chief Executive Officer
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
IFCE	International Framework for Court Excellence
FTE	Full-time equivalent
FVIO	Family violence intervention order
LGA	Local government area
NCIS	National Coronial Information System
OH&S	Occupational health and safety
PALMS	Performance and Learning Management System
PCSU	Police Coronial Support Unit
VAPPI	Victorian action plan for pandemic influenza
VCAT	Victorian Civil and Administrative Tribunal
VIFM	Victorian Institute of Forensic Medicine
VPS	Victorian Public Service
VSRFVD	Victorian Systemic Review of Family Violence Deaths

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THE YEAR IN REVIEW

From the State Coroner

I am pleased to present the Annual Report of the Coroners Court of Victoria for the 2016-17 financial year.

Our strategic direction

It has been another significant year of achievement for the Coroners Court of Victoria.

The Coroners have made numerous important and meaningful evidence-based recommendations that have contributed to informing key social policy decisions, which are aimed at reducing the number of preventable deaths and strengthening the public health and safety of the community.

The Court appreciates that the coronial process can be extremely difficult for family members and loved ones of a deceased person taken into the Court's care. With that in mind, the Court continues to reflect upon and improve its service to the Victorian public.

The Court has continued to build and enhance important stakeholder partnerships involved in the coronial process, to ensure that the coronial system operates in a fair and efficient manner.

During the 2016-17 financial year, the average length of time a case remained open, declined by nearly 10%. Since the end of the 2012-13 financial year, there has been a 30% decline in the average length of time that a case is open. The improvement in timely resolution of death investigations significantly benefits the families and other loved ones of the deceased.

Increased efficiencies

Investigating a death reported to the Court can be a very time-consuming process, but equally we recognise that prolonged coronial investigations can add to the distress of a deceased person's loved ones, which is why timely case completion is a foremost priority across the Court.

In the 2016-17 financial year the Court continued its focus on progressing and finalising coronial investigations in a timely manner, particularly focusing on finalising those that were still ongoing more than a year after the death was reported.

I am pleased to report that the average number of coronial investigations which have been open for more than 12 months has reduced over the last four years from 1224 in 2012-13 to 500 in the last financial year. This is a tremendous achievement by the Coroners and their staff and is the result of the collegiate relationship across the Court.

As we work towards achieving our strategic objectives, I am confident that we can continue to meet key challenges and continue our strong commitment to the Victorian community and our partners.

Focus on drug harm prevention

Drug use and misuse directly contributes to hundreds of deaths investigated by Victorian Coroners each year. In my capacity as the State Coroner, I was invited to appear before two Victorian Parliamentary Inquiries this year, to share the Court's experience and insight in relation to what can be done to reduce drug-related harm.

At the Law Reform, Road and Community Safety Committee's Inquiry into Drug Law Reform, I answered questions on a wide range of topics relevant to this important issue, including opioid replacement therapy, real-time prescription monitoring, over-the-counter medications, drug dependence as a stressor in suicide, and combination drug use. The key message from the Court concerned the mix of strategies which is needed in order to address the problems created by drug use and misuse.

The Standing Committee on Legal and Social Issues invited me to give evidence regarding the proposal for a Victorian Bill to establish a supervised injecting facility in inner Melbourne. In answering questions from the Committee, I expanded upon the position previously articulated by three of my colleagues, that the evidence confirms that a supervised injecting facility would not only reduce the risk of overdose among those who attended there to inject drugs, but would also create opportunities to engage injecting drug users with much needed education and support, in order to reduce their risk of harm into the future.

Stakeholder partnerships

As part of our commitment to delivering better outcomes for the Victorian community, an integral component of the coronial process is working collaboratively with the Victorian Institute of Forensic Medicine (VIFM). I would like to thank VIFM for its significant role in providing expert scientific and medical advice and reports to inform the investigations undertaken by the Court. I also acknowledge the significant role that VIFM has in liaising with and assisting the family members and loved ones of a deceased person through the coronial process.

The Court also continues to value the significant contribution of Victoria Police in providing individual police officers to perform the role of Coroner's investigator in each matter before the Court. A Coroner's investigator, acting on the direction of the relevant Coroner, is vital to ensuring that a Coronial investigation is completed in the most efficient and timely manner possible.

I would like to also acknowledge the Court Network, as they continue to play a vital role in providing support and assistance to many families and witnesses that come to the Coroners Court.

Thanks

I extend my sincere gratitude and thanks to the Coroners for their ongoing commitment to the important work of the Court. Our Coroners investigate more than 6500 deaths annually, which epitomises their dedication and conscientiousness. Their work is instrumental to informing key social policy decisions and is the means by which the Court can focus on reducing preventable deaths for the community.

I would also like to take this opportunity to thank and congratulate the staff for their ongoing commitment to and support of all Court operations. The Coroners recognise that the staff work tirelessly and are the engine room of the Court. I am exceptionally proud to work with such dedicated staff.

In conclusion, I note the report of the Court's Chief Executive Officer, Samantha Hauge, and thank her for her leadership and management of the Court.

Looking forward

The safety and wellbeing of our staff is paramount to the Court. Many of the staff liaise daily with bereaved families and loved ones. I am pleased that the professional debriefing program for staff continues to be provided. The feedback from staff has been that the program provides them with the professional support they need to manage the daily stress and impact of working at the Coroners Court.

As outlined throughout this report, the Court has achieved many goals this year. I have no doubt that there will be many more to follow as we continue working through our strategic plan and vision for the Court.

Judge Sara Hinchey

State Coroner

THE YEAR IN REVIEW

From the CEO

Victorian families are at the centre of everything we do – from conducting thorough investigations, providing respectful services and how we share court information and documents. To support families as best we can, we operate from a strong financial position and plan ahead to pre-empt where to direct our efforts or increase resources. With significant growth forecast for our organisation, our continued high performance over the past year has prepared us well for the challenges ahead.

Providing timely closures

Understanding that families face a difficult time after the death of a loved one, we have continued to focus on ways to minimise delays at all stages of the coronial process and deliver coronial findings in a timely manner.

For the fourth year running, the Court finalised more investigations than were initiated. Four out of five investigations were completed within 12 months – a significant result considering many matters before the Court cannot be finalised as they are the subject of a criminal investigation or court proceeding in another jurisdiction.

While each investigation is approached individually, achieving a low investigation timeframe average of 7.9 months indicates to us that we are operating efficiently and professionally. In the year ahead we will continue to clarify and streamline our processes and information requirements, in order to produce timely findings to the Victorian community.

We have also been working closely with VIFM to establish a new streamlined process for investigating deaths due to age-related falls, specifically femoral fractures, which occur among elderly people in a hospital setting. Following a period of consultation with hospitals and funeral directors, we envisage that these cases will no longer require the deceased person to be transported to the Coronial Services Centre for medical examination, rather, they can be transported direct to a funeral home. Importantly, this process aims to bring significant relief to Victorian families who are often frustrated by the process, intrusion and delays caused by what they see as unnecessary medical examinations.

Managing our finances responsibly

One of the biggest expenses this Court faces is the transfer of deceased persons to the Coronial Services Centre in Southbank for the medical examination and identification purposes. Historically, this has accounted for a third of our expenditure, and due to factors outside the control of the Court, we knew these costs would continue to rise. Over the past two years, we introduced two initiatives which have (and will continue to) reduce the cost of investigating reportable deaths down.

After a rigorous tender process, the Court awarded the contract for metropolitan Melbourne and regional repatriation to St John Ambulance (Vic) to supply the service at a standard rate. The first nine months of these new contractual arrangements has already seen a reduction in expenditure and improved service delivery. Transfer costs in regional areas has also been standardised.

I am also delighted to again report that the Court has managed its expenses for the year, following a successful budget forecast in 2015-16.

Looking after our staff

As always, I'm most touched when I receive letters from Victorian families, who write to tell me of the respectful and empathetic service they received from our staff. Many of them, even at such a difficult time, acknowledge what a challenging job our Court staff have.

The impact of vicarious trauma is becoming more widely understood, and it is vitally important for us to keep improving the support we provide to our staff, who are often exposed to distressing situations or information.

Adding to our Employee Assistance Program, Quiet Room and peer support programs, this year we introduced mandatory staff debriefing sessions with qualified psychologists. Every staff member now undertakes two compulsory debriefing sessions, with an option of having an additional two voluntary sessions.

Increasing our capacity to deliver

Following new State Budget allocations for family violence, and in response to high profile incidents (such as the Bourke Street tragedy), the Court will increase its staffing numbers in the coming year. The dedicated positions will undoubtedly improve our ability to investigate certain deaths and fires. The roles include Legal Officers, Family Liaison Officers and Registrars.

However, the extra staff also presents a challenge for the Court. Refurbishment works will need to take place in the new financial year to ensure we can meet our seating capacity for the growth in staffing.

Improving access to information

We continue to experience growing demand for court documents and data. Over the past five years, formal requests for coronial records have grown by 65 per cent. While we are considering options to recover costs associated with recalling, reviewing and distributing coronial documents, the Court also recognised a significant requirement to improve the way we openly share information.

The Court has therefore commenced the development of a new website to ensure information is easy to find and understand, and will be reviewing key communication materials. By doing so, we anticipate seeing a reduction in the number of telephone calls, emails and formal applications we receive requesting information. Other projects under consideration include online submitting of forms and a family information portal.

Acknowledging the work and support of others

The Court works closely with many organisations to deliver coronial services. I would like to thank our colleagues at Court Services Victoria who support many of our administrative and corporate functions that allow us to focus on our core duties.

I would also like to thank the volunteers of Court Network, who dedicate their time to provide compassionate support to the families and witnesses involved in court proceedings.

My sincere gratitude goes to the State Coroner, Judge Sara Hinchey, for her support and leadership throughout the year. And finally, I would like to recognise the outstanding work of our staff who manage sensitive situations with compassion, dedication and professionalism to help serve the Victorian community.

Samantha Hauge
Chief Executive Officer

THE CORONERS

Led by the State Coroner Judge Sara Hinchey, the Coroners Court of Victoria (CCOV) has nine full-time Coroners and one reserve Coroner.

Coroners are independent judicial officers. In Victoria, all Coroners except the State Coroner, are Magistrates or lawyers who have been practising for at least five years. Appointed for five-year terms, the State Coroner must be a Judge of the County Court and the Deputy State Coroner must be a Magistrate.

STATE CORONER JUDGE SARA HINCHEY

BSc LLB

Prior to her appointment as a County Court Judge in May 2015, Her Honour had extensive experience as a barrister, appearing in numerous high-profile inquests, as well as maintaining a broad ranging practice including commercial law, occupational health and safety, corporate crime, professional negligence and professional disciplinary matters.

Her inquisitorial experience included briefs in relation to the Royal Commissions into Institutional Responses to Child Sexual Abuse and the 2009 Victorian Bushfires. Throughout her career, Her Honour regularly appeared in the higher courts of Australia including the Federal and High Courts.

Her Honour is Chair of the Victorian Systemic Review into Family Violence Deaths, and a member of the Coronial Council, the Asia Pacific Coroners Society, the National Coronial Information System Board of Management, the Board of the Judicial Commission, the Board of the Judicial College of Victoria, the Interim Board of the Law Library of Victoria, the State Disaster Victim Identification Committee and the Council of Chief Coroners. She is also a member of the CSV Courts Council, CCOV/VIFM Joint Operations Steering Committee, the Coroners' Education Committee, the VIFM Council and the Health and Legal Counsel Forum.

DEPUTY STATE CORONER IAIN WEST

B Juris LLB

Deputy State Coroner Iain West was admitted to practise in 1975. He was a barrister for 11 years before being appointed a Magistrate in 1985. He was appointed the Deputy State Coroner in 1993.

Coroner West is a member of the Coroners and Pathologists Advisory Group and the State Disaster Victim Identification Committee. His Honour may also attend meetings on behalf of the State Coroner.

CORONER PHILLIP BYRNE

LLB

Coroner Phillip Byrne was appointed a Magistrate in 1982 and has more than 30 years' experience as a Coroner. He joined the Magistrates' Court in 1961, working as a Clerk of the Courts for 20 years, supporting the day-to-day operations of metropolitan and regional courts. He obtained his Bachelor of Laws from Melbourne University during this time, and following his appointment as a Magistrate spent 19 years as a Co-ordinating Magistrate for the Wimmera Mallee region, headquartered in Bendigo.

Coroner Byrne retired in 2000 but returned to work as a Coroner from 2003 to 2006. He has been a reserve Coroner since 2013.

CORONER ROSEMARY CARLIN

LLB(Hons) BSc

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

Coroner Carlin is a member of the Coroners' Education Committee, the Donor Tissue Bank of Victoria Committee, Victims of Crime Consultative Committee and the Asia Pacific Coroners Society.

CORONER JACQUI HAWKINS

BA(Hons) LLB

Coroner Jacqui Hawkins was appointed as a Coroner in January 2014. Prior to her appointment, she was the Court's Senior Legal Counsel and established the In-house Legal Service. Coroner Hawkins was previously 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. Coroner Hawkins is a member of the Asia Pacific Coroners Society, the Health and Legal Counsel Forum, the CSV Information Technology Portfolio Committee and the Coroners' Education Committee.

CORONER CAITLIN ENGLISH

BA(Hons) LLB MPP

Coroner Caitlin English was appointed a Magistrate in June 2000, working as a Coroner since 2014. Prior to this, she worked as a solicitor at MinterEllison, Victoria Legal Aid and the Public Interest Law Clearing House. She completed a Churchill Fellowship in 1999 and has presided in all jurisdictions of the Magistrates' 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 12 years. Coroner English was a member of the Coroners' Education Committee and the CSV Koori Inclusion Action Plan Steering Committee, prior to taking long service leave in 2017.

CORONER JOHN OLLE

LLB BEc

Coroner John Olle was appointed as a Coroner in September 2008. Having started out as a solicitor with McCarthy & Co in Rye on the Mornington Peninsula, he signed the Bar Roll just three years into his legal career in 1983. As a barrister of more than 25 years' experience, Coroner Olle appeared mostly in civil matters and criminal defence trials in the County Court jurisdiction, as well as before inquests at the Coroners Court of Victoria. Coroner Olle is a member of the Court's Occupational Health and Safety Committee, and is also a member of the Asia Pacific Coroners Society.

CORONER AUDREY JAMIESON

BA LLB Grad Dip Bioethics

Coroner Audrey Jamieson was appointed a Magistrate in December 2004 and has been a Coroner since June 2005. Coroner Jamieson started her career as a nurse before obtaining arts and law degrees from Monash University. She did her Articles of Clerkship at Holding Redlich Lawyers before moving to Maurice Blackburn Lawyers in 1992 where she became Partner and an accredited specialist in personal injury litigation with the Law Institute of Victoria. Coroner Jamieson is Chair of the Coroners Education Committee and member of the Court's Research Committee, the Judicial Advisory Group on Family Violence, the Chief Magistrate's Family Violence Taskforce and the Asia Pacific Coroners Society.

CORONER GREG MCNAMARA

LLB

Coroner Greg McNamara was appointed as a Magistrate in December 2003, and worked exclusively as a Coroner from January to July 2017. He did his Articles of Clerkship at Purves & Purves in 1975, before joining his father's legal practice in St Kilda. He joined the Victorian Bar shortly afterwards, practising as a barrister in both civil and criminal matters for 23 years, mostly in the Magistrates' Court of Victoria.

Coroner McNamara is a member of the Executive Committee of the Council of Magistrates (to June 2017) and has been a member of the Parole Board of Victoria since December 2013.

CORONER PARESA SPANOS

BA LLB

Coroner Paresa Spanos was appointed a Magistrate in 1994 and has worked exclusively as a Coroner since 2005. Coroner Spanos graduated from the University of Melbourne in 1981 and was employed as an articled clerk/litigation lawyer in private practice. She worked for 10 years with the Commonwealth Director of Public Prosecutions, primarily in trials and appeals. As Senior Assistant Director, Her Honour headed the major fraud and general prosecutions branches.

Coroner Spanos is the Court's Judicial Member of the CSV Human Resources Portfolio Group, a member of Hellenic Australian Lawyers and was a member of the Victorian Child Death Review Committee.

CORONER PETER WHITE

LLB LLM

Coroner Peter White was appointed as a Coroner in March 2007. After starting his career in Melbourne, Coroner White moved to Papua New Guinea in 1973 to work as a government lawyer, Crown Prosecutor and parliamentary advisor. Following the country's independence, Coroner White was appointed legal counsel to the Ombudsman Commission and later as a regional senior Magistrate. In 1983, Coroner White took up an appointment as a Magistrate in Hong Kong, where he was later appointed as a Coroner. Coroner White is a member of the Judicial Officers Aboriginal Awareness Committee.

ABOUT THE CORONERS COURT

OUR ROLES

Independently investigating deaths and fires

Certain deaths and fires are reported to the Coroners for independent investigation. Their investigations seek to establish the facts – when, where, how and why the death or fire happened. From page 14.

Reducing preventable deaths

Wherever possible, the Coroner will suggest ways to prevent similar deaths or fires by making well informed and practical recommendations, based on the evidence before them. From page 24.

Promoting public health and safety and the administration of justice

The Court regularly reports on data and trends regarding preventable deaths in Victoria to help inform public health responses. From page 36.

The Court's functions, powers and obligations are detailed in the Coroners Act 2008.

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, focusing on improving the way we work within the Court, to provide excellent services to the Victorian community.

OUR VISION

A Court that delivers outstanding service to the Victorian community and families who have lost loved ones.

OUR HISTORY

Victoria's first Coroner was appointed in 1841, 30 years before Melbourne established a morgue in 1871. It was not until 1888 that the first permanent Coroners' courthouse was constructed and in 1988, the Court moved to the purpose-built Coronial Services Centre in Southbank.

The Coroners Court of Victoria as it is today was established on 1 November 2009 when the Coroners Act 2008 came into effect. This was the most significant reform of the Victorian coronial jurisdiction in 25 years and replaced the former State Coroner's Office.

CORONIAL SERVICES IN VICTORIA

Victoria's Coroners are supported by coronial services delivered by a number of different organisations including the Victorian Institute of Forensic Medicine (VIFM), the Police Coronial Support Unit (PCSU) and the Donor Tissue Bank of Victoria.

To streamline coronial investigations, we are all co-located at the Coronial Services Centre in Southbank – away from the central courts precinct in the Melbourne CBD.

Among many important roles, VIFM supports Coroners by:

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

PCSU also supports Coroners by helping Victoria Police officers nominated to perform the role of the coroners investigators, compile a thorough coronial brief, as well as appearing as the Coroner's Assistant at some inquests.

OUR PLACE IN VICTORIA'S COURT SYSTEM

The Coroners Court of Victoria is part of Court Services Victoria (CSV), a statutory authority established in July 2014 to protect and promote the independence of each of the courts and the judiciary.

As a distinct entity of CSV, the Court is accountable directly to Parliament. While CSV provides and supports some administrative and corporate functions for the Court, the State Coroner is responsible for establishing how the business of the Court is managed.

The Coroners Court operates differently to other courts. Unlike other courts which are adversarial in nature, we have an inquisitorial jurisdiction. This means the Court actively investigates the matters before it. Additionally, while all cases that come before the Court are thoroughly investigated, the vast majority of matters do not proceed to a hearing in a courtroom. Rather, a finding is made 'in chambers'.

STRATEGIC PLAN 2016–2019

The Coroners Court Strategic Plan details how we work to achieve our vision over three years.

Feeding into our business planning cycle and budget process, the Strategic Plan 2016–19 ensures we put in place the processes, resources and technology to realise three strategic directions:

1. Engaging our community and stakeholders
2. Investing in our people
3. Achieving our priorities

Each year we develop and implement a business plan to ensure we deliver key activities, measure our success and track our progress.

1. ENGAGING OUR COMMUNITY AND STAKEHOLDERS

The Court will deliver the highest quality services for our stakeholders and the community. Our focus is to provide a better service to those who find themselves involved in the jurisdiction as a result of the death of a loved one. We aim to deal with the community with sensitivity and professionalism.

Key focus areas

- Service ethos: Provide professional coronial services
- Community and professional education: Improve the understanding of the role of the Court and of court practices in order to set realistic expectations
- Maintaining strong partnerships: Work together with partner organisations to ensure the best outcomes for the Victorian community

2. INVESTING IN OUR PEOPLE

The most important resources of the Court are its people – the Coroners and the Court's staff who support them. In delivering a professional service, the Court promotes a culture of excellence in line with its values, by engaging staff through consultation and professional development.

Key focus areas

- Workforce planning: Provide a highly skilled and multidisciplinary team that meets current and future needs
- Staff health, safety and wellbeing: Create a high performance culture within a productive and rewarding workplace

3. ACHIEVING OUR PRIORITIES

Following a period of significant change, the Court has implemented its new operating model and continues to monitor its performance to ensure that it remains responsive to the needs of the community.

The Court is accountable for its performance and continues to aspire to provide the community with confidence that valuable public resources continue to be well managed.

Key focus areas

- International Framework of Court Excellence (IFCE): Sustain the efficient and effective performance of the Court
- Legislation and internal business systems review: Review and recommend amendments to relevant legislation and develop the Court's internal business systems to deliver coronial services that meet the future requirements of the Victorian community
- Performance measures and management capability: Improve transparency and accountability through the development of performance measures and management capability
- Court efficiency and sustainability: Promote a more sustainable Court through efficient procurement practices and the implementation of a cost recovery model to self-fund promotion of public safety in the area of preventable deaths
- Information technology: Implement changes to technology that the Court has local control over

INTERNATIONAL FRAMEWORK FOR COURT EXCELLENCE

The IFCE is designed to help courts measure and improve their performance. Global measures from the framework were integrated into the Court's output performance measures outlined in the Victorian Budget Papers (BP3), which are detailed below.

TABLE 1: PERFORMANCE AGAINST BP3 MEASURES

Major outputs/deliverables	Unit of measure	2015-16 actual	2016-17 estimate	2016-17 actual
Quantity				
Average cost per case	$	2566	2909	3014
The average cost per case includes the cost of transporting deceased persons. It was higher than estimated, due to a combination of: lower than assumed cases (6285 instead of 6500) and increased corporate expenditure.				
Case clearance	%	104.6	100.0	100.6
Finalisation of investigations remains high, with the Court closing more matters than are opened (page 21).				
Quality				
Court file integrity: availability, accuracy and completeness	%	-	90.0	89.9
This year's result sets a benchmark for future performance against what is a brand new measure.				
Timeliness				
On-time case processing – matters resolved or otherwise finalised within established timeframes	%	80.2	75.0	80.3
The proportion of investigations finalised within 12 months continues to be higher than expected (page 20). As a result of continuing high performance, we have increased our benchmark to 80 per cent in 2017-18.				

OPERATING STATEMENT – FINANCIAL YEAR 2016-2017

Demonstrating sound financial management, the Court returned a surplus of $84,870 in 2016-17. With staffing levels set to increase again in 2017-18, the Coroners Court continues to explore opportunities for longer-term fiscal sustainability through efficient processes and cost recovery measures in order to provide value for money in our services.

INCOME

Funded by the Victorian Government, the Court received annual appropriation of $13.05 million through CSV. Income slightly increased from 2015-16, due to additional funding for the transport of deceased persons project (page 15).

On par with recent years, we also received $3.5 million in special appropriation, covering Coroners' salaries and related judicial costs.

EXPENDITURE

Employee salaries and benefits continue to be the main expense for the Court, accounting for a steady 56 per cent of total expenditure.

TABLE 1: INCOME AND EXPENDITURE SOURCES

	2012-13	2013-14	2014-15	2015-16	2016-17
Output appropriation	$9,998,190	$11,252,900	$10,575,075	$11,167,000	$11,304,286
Special appropriation	$2,895,706	$3,479,417	$3,557,484	$3,562,858	$3,493,479
Other income	$351	-	-	-	-
Total	$12,894,247	$14,732,317	$14,132,559	$14,729,858	**$14,797,765**
Employee benefits	$8,262,673	$8,090,030	$7,997,022	$8,058,346	$8,389,629
Deceased removal and transfers	$2,584,540	$2,656,673	$3,866,179	$4,261,649	$4,271,233
Supplies and services (1)	$3,458,268	$3,040,797	$2,479,372	$1,793,972	$2,143,569
Depreciation and amortisation	$86,527	$84,905	$14,000	$13,642	$1,837
Interest expense	$1,559	$1,493	$2,496	$1,995	$262
Grants and other transfers	$1,317 (2)	-	-	-	-
Total expense from transactions	$14,394,884	$13,873,898	$14,359,068	$14,129,604	$14,806,530
Net result from transactions (net operating balance)	($1,500,637)	$858,419	($226,509)	$600,255	($8,765)
Other gains(losses) from other economic flows (3)		$6,264	-	($84,535)	$93,635
Net result	($1,500,637)	$864,683	($226,509)	$515,720	**$84,870**

Expenditure

(1) From 2014-15, staff training and development expenses are classified under employee benefits.

(2) Grant payment to the University of Melbourne working collaboratively with the Court on a project partially funded by the Australian Research Council.

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

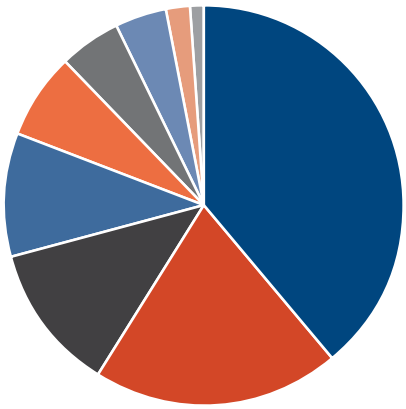
The Court's net result was $84,870 – the second year in a row the Court has returned a surplus.

The Court's budget is prepared and approved under section 41 of the Court Services Victoria Act 2014. The below is a summary only, with more detail provided in the CSV Annual Report available at **www.courts.vic.gov.au**.
Note: the figures published here may differ from those published in the CSV annual report, due to adjustments made in the time between publications.

Supplies and services

Over the past year, we continued to make considerable savings in the areas of information technology, printing and stationery and medical professional services. However, expenses for contractors and consultants increased in the past year, as we expanded the number of consultants in our medical and legal teams.

FIGURE 1: SUPPLIES AND SERVICES 2016-17



Other operating expenses includes storage, utilities and facility management.

- Contractors & consultants **$842,044**
- Information technology **$422,319**
- Other operating expense **$266,322**
- Legal professional services **$220,078**
- Postage & communication **$142,500**
- Travel & personal expenses **$98,032**
- Printing & stationery **$80,960**
- Medical professional services **$49,907**
- Witness expenses **$21,407**

01

INVESTIGATING DEATHS AND FIRES

Certain deaths and fires are reported to the Coroners Court for independent investigation. Conducted by one of 10 Coroners, an investigation seeks to establish the facts – when, where, how and why the death or fire happened. This chapter details the Coroners' caseload, how investigations were managed and their outcomes.

CHALLENGES AND ACHIEVEMENTS

Supporting families through a difficult time

People generally become aware of the Coroners Court for the first time through the reportable death of a loved one. At this time they are understandably not well placed to understand why the Coroner is involved, or the coronial process.

To help us better support families affected by loss, we employed an additional Family Liaison Officer in 2016-17. Our three officers help explain coronial processes and findings to families, as well as help Court staff when they are liaising with families on sensitive matters. The Court also continued to work with Court Network volunteers who support families and others during inquests.

Additionally, the Court looked at proactive ways to educate the community about the Victorian coronial system. Building on this over the next year will include continued education to correct misconceptions about who conducts medical examinations, how coronial and criminal investigations intersect, investigation timeframes and the proportion of investigations that go to inquest.

Improving information for families

Following a death, families are often searching for answers and wanting to finalise their loved ones' estate. To help families quickly obtain vital documents, over the past year the Court:

- clarified our procedures for handling queries about death certificates with the Registry of Births, Death and Marriages, providing essential information for families seeking to arrange funerals, or finalise insurance, banking and other matters
- continued to work with Victorian Institute of Forensic Medicine (VIFM) to ensure timely provision of Medical Examination Reports, which provide details about the cause of a death to families and medical practitioners

Coronial information may also be very complex for families to understand. In partnership with VIFM, the Court introduced family-oriented Medical Examination Reports which provide easy-to-understand information on cause of death. We also reviewed our suite of letter templates to ensure correspondence with families is informative and respectful.

Reducing investigation timeframes

Out of consideration for families, the Court always seeks to balance a careful and thorough investigation with timeliness. Over the past few years, we have introduced a number of initiatives to reduce the time it takes to investigate, including focusing on holding efficient inquests (page 20), as well as streamlining internal processes.

As a result, the average time taken to finalise matters in 2016-17 has dropped to 7.9 months compared to 8.4 months in 2015-16. This average is affected by:

- the closure of some historic cases from the early 2000s, which had remained open as they were unsolved homicides
- the high proportion of natural cause deaths, which are generally finalised within three months due to improved administration processes.

The Court will review its timeliness standards in 2017-18, to help provide clarity in relation to the coronial process.

Improving service quality to statewide transport

From late 2016, the Court implemented new contractual arrangements for the transport of deceased persons, ensuring improved service delivery and oversee contractor performance.

When deaths are reported to the Coroner, the deceased is usually transported to the Coronial Services Centre in Southbank for the purposes of identification and medical examination. This service was previously delivered by 38 contracted funeral directors, with other non-contracted funeral directors supporting some remote areas.

Following a significant consultation and procurement process, St John Ambulance (Victoria) was awarded a contract for all metropolitan transfers and statewide repatriation of a deceased person. A further 22 regional contractors were offered new contracts covering nearly 80 per cent of regional Victoria. The final remaining contracts will be negotiated in 2017-18. All new contracts included clearly defined service standards.

Historically, the cost of transferring deceased persons has comprised more than 30 per cent of our total budget. While costs will vary each year depending on the number and location of a deceased person, the new arrangements have already led to a reduction in expenditure for metropolitan areas. The average price per transfer in metropolitan areas fell by 13 per cent.

We anticipate seeing a general reduction in regional costs once the Court has finalised all contracts, introducing transparent fixed rates.

TABLE 4: TRANSFER AND REPATRIATION COSTS

	2012-13	2013-14	2014-15	2015-16	2016-17
Metropolitan areas	$935,892	$1,121,753	$1,730,220	$1,997,002	$1,841,651
Regional areas	$1,648,649	$1,534,920	$2,135,959	$2,264,647	$2,429,582
Total	**$2,584,540**	**$2,656,673**	**$3,866,179**	**$4,261,649**	**$4,271,233**

Saving costs through an In-House Legal Service

Over the past year, the Court has continued to save costs of external legal services, through use of our In-House Legal Service (page 13). In the past five years, legal costs have fallen by 72 per cent – from $766,365 to $220,078.

Our two, full-time Principal In-House Solicitors are briefed on matters that present a potential conflict of interest to PCSU (for example, an inquest into a death in police custody, or one that results from a police shooting or police pursuit). This year, the In-House Legal Service:

- assisted the Coroner with 57 police contact or conflict investigations
- appeared as Counsel Assisting the Coroner in six inquests and five direction hearings and mentions, and performed the role of instructing solicitor in 24 inquest sitting days and one directions hearing
- instructed counsel in five Supreme Court appeals (page 55).

CASELOAD

Even if the cause of the death or fire seems clear, it is important for a Coroner to determine to the extent that is possible, exactly what happened.

The includes establishing, where possible:

- the identity of the person who has died
- the cause of the death or fire
- the circumstances in which the death or fire occurred.

TABLE 5: INVESTIGATIONS OPENED AND FINALISED

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of investigations commenced	5934	6267	6336	6305	6248
Number of investigations finalised	5534	7270	6884	6582	6285
Closure rate	93.3%	116.0%	108.6%	104.6%	100.6%
Cases referred to the Court by the Registry of Births, Deaths and Marriages	593	635	621	459	221

The Court caseload remained steady, while the Court continues to finalise more investigations than it opens.

With the closure rate being maintained at more than 100 per cent, the number of pending cases is also steady at a low 3785 cases. Many of these cases cannot be progressed as they are the subject of an ongoing criminal investigation or court proceeding in another jurisdiction. This is a significant reduction from the historic peak of 5897 pending cases in 2008-09.

In the past year, we continued to refine our process for holding mandatory inquests to finalise historic, unsolved homicides (for example, Purana Taskforce cases). Consequently, the Court has now closed almost all historic homicide cases.

Types of investigations

By law, the Coroner must investigate certain deaths, including when:

- the death is unexpected, unnatural or violent or resulted from an accident or injury
- the death unexpectedly occurs during or after a medical procedure
- the identity of the person or their cause of death is not known
- the person was in custody or care.

Reportable deaths made up 98 per cent of our closed investigations in 2016-17. Administrative case closures and one fire investigation made up the remainder. The Court did not close any reviewable death investigations – when the death of a second (or subsequent) child of a particular parent or parents is reported.

CORONER'S FINDINGS

FINDING INTO DEATH WITH INQUEST

82

FINDING INTO FIRES WITH INQUEST

0

FINDING INTO DEATH WITHOUT INQUEST

3340

FINDING INTO FIRES WITHOUT INQUEST

1

CASE STUDY

EDUCATION FOR TAXI DRIVERS AFTER CARBON MONOXIDE DEATH

After noticing a taxi had been parked on their street for more than an hour with the engine running, concerned residents contacted police. Inside the vehicle, police members found a 30-year-old taxi driver, deceased.

An autopsy was conducted, but no physical causes of death could be found. A few days later, toxicology tests revealed that the man died of carbon monoxide poisoning.

The investigation

Internal taxi footage showed the driver taking a morning nap. Four hours later, the man started fitting and became still after 40 minutes. It was hours later that he was found by police officers.

With the cause of death unknown at the time, the taxi company was permitted to take the vehicle and return it to the fleet. But once carbon monoxide poisoning was confirmed, the vehicle was seized and the history of the vehicle was investigated. It was discovered that another driver had previously reported a carbon monoxide issue with the vehicle.

New tests undertaken on the vehicle found the exhaust pipe was broken and there was a gap in the back seat, allowing exhaust gases to leak into the cabin of the vehicle from the boot. Expert advice to the Court also highlighted the dangers of sleeping in a vehicle with the engine running.

Recommendations

As a result of the investigation, the taxi company involved undertook to install carbon monoxide detectors in their vehicles.

To prevent similar deaths, the investigating Coroner recommended the Taxi Services Commission consider:

- introducing regular and mandatory carbon monoxide testing of vehicles
- educating drivers on the dangers of resting in the vehicle with the engine running.

The Commission advised that, rather than mandating carbon monoxide monitoring, it would continue to focus on educating drivers and ensuring operators undertake regular vehicle maintenance as a means of minimising the possibility of carbon monoxide poisoning.

It also amended its Fatigue Management Guidelines to explicitly advise drivers to turn off the engine while resting in the vehicle.


PEACE AND PROSPERITY

TIMELINESS

Every death and fire investigation requires an individual approach and the duration of each investigation varies depending on:

- the complexity of the matter
- whether an inquest will be held
- whether there are other investigations that need to be undertaken by other authorities first
- whether the matter is before another court – for example, someone has been charged with criminal offences.

The average duration of investigations closed in 2016-17 was 7.9 months. A large proportion of investigations (44 per cent, or 2767 cases) were finalised in three months – these are generally natural cause deaths that a Coroner has determined required no further investigation. It is also worth noting that the number of cases open for 24 months or longer reduced by approximately 25 per cent as opposed to the 2015-16 figures.

Open cases duration

While the average duration of closed investigations is low, the Court also has an ever-diminishing number of open cases that are older than 24 months. Five years ago, the Court had 2165 open investigations older than 12 months. At 30 June 2017, that figure had shrunk to 984. This is a significant result, given many of these cases are the subject of an ongoing criminal investigation or court proceeding in another jurisdiction, and therefore are unable to be finalised by the Court.

The number of days an open case has been under investigation is also steadily falling. This is another good indicator that the Court is meeting the needs of the community for timely resolution of cases.

TABLE 6: DURATION OF CLOSED INVESTIGATIONS

0-12 months	4257	5369	5667	5289	
12-24 months	538	1210	730	785	
>24 months	739	1044	487	522	

TABLE 7: AVERAGE DURATION OF OPEN CASES BEFORE THE COURT AT 30 JUNE

Duration (days)	478.4	417.2	403.5	364.2	

INQUESTS

Inquests involve a public hearing and were held in relation to 1.3% of reportable deaths and fires in the last financial year.

Regardless of whether an inquest is held, a coroner must conduct an investigation into:

(a) all reportable and reviewable deaths and make findings, if possible, as to the identity of the deceased, the medical of death and, where there is a public interest, the circumstances in which the death occurred;

(b) a fire (where there is a determination to investigate a particular fire) and make findings, if possible, as to the cause and origin of the fire and the circumstances in which the fire occurred.

The *Coroners Act 2008* provides that it is mandatory for a coroner to hold an inquest into a death, if the death or cause of death occurred in Victoria and:

(a) a coroner suspects that the death was a result of homicide and no person has been charged with an indictable offence in respect of the death; or

(b) the deceased was immediately before their death a person placed in custody or care, and the death is not considered to be from natural causes; or

(c) the identity of the deceased person is unknown.

Where is it not mandatory to hold an inquest, the decision whether to hold an inquest is at the discretion of the investigating coroner. The Court's website contains a publication titled "*Guidance on whether to request an inquest*" which sets out some of the considerations that a coroner may take into account when exercising their discretion to hold an inquest.

All requests for an inquest must be made on either a Form 26 'Request for Inquest into Death' or a Form 27 'Request for Inquest into Fire'. These forms are also available on the Court's website.

FINDINGS

In most coronial investigations, the Coroner will hand down a finding, regardless of whether an inquest was held.

In 2016-17, the majority of Coroners' findings (98.7 per cent) were completed on the papers.

Findings are required to be published:

- when an inquest was held; or
- when recommendations are made; or
- following an investigation of a death of a deceased who was, immediately before the death, a person placed in custody or care and the death was due to natural causes.

A coroner may also direct that a finding be published if they consider that it is in the public interest to do so.

TABLE 8: INQUESTS HELD

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of metropolitan inquests held	181	191	170	122	82
Number of regional inquests held	28	25	26	9	11
Percentage of closed investigations with inquest *	3.8%	2.8%	2.8%	2.0%	1.3%

** Not all investigations for which inquests were held were closed in the same financial year.*

CASE STUDY

OVERDOSE DEATH LEADS TO REVIEW OF TAKEAWAY METHADONE POLICY

A 17-year-old was found unconscious by his father at the home they shared. After being rushed to hospital, a decision was made to withdraw life support due to the brain injury suffered by the teenager.

A medical examination and toxicology test later confirmed that the teenager died from cardiac arrest due to methadone toxicity. The coroner investigated how the boy – who had a mild intellectual disability was able to access methadone at home.

The investigation

Looking into his living circumstances, the Coroner found the teenager was highly vulnerable and stressed. In the year prior to his death, his grandfather – who he was extremely close to – died, and he moved in with his father who encouraged him to use heroin and ice. The father was also on the methadone program.

After discovering his unconscious son, the father told paramedics he may have taken some of his methadone from the fridge, because 'maybe he thought it would help him, as it helps me'.

The opioid replacement therapy program in Victoria allows for doctors to prescribe some participants with takeaway methadone doses. Participants are encouraged to store the methadone securely.

The Court identified 68 deaths between 2007 and 2013 involving methadone that had been prescribed to someone else. In 32 of those cases, the methadone had been taken without permission, usually from a family member because it was not stored securely. Between 2010 and 2013, there were five overdose deaths of teenage children who accessed someone else's methadone.

Recommendations

To help prevent further deaths – particularly those of children and teenagers – the investigating Coroner recommended that the Department of Health and Human Services review its methadone program policy. In particular, that it should consider whether any further action could be taken to encourage safe storage of methadone, for example, in lockable boxes.

Shortly after the investigation, the Department released its revised policy, including the requirement for prescribers to conduct a monthly review of patients prescribed with takeaway methadone in the first two years, and ask questions about secure storage. Lockable boxes are included as a suggested option in the policy.

"I thank you for providing me with the finding document of the death of my sister-in-law. In doing so you have given me the closure I have long sought to a sad and confronting situation some years past"

YEAR AHEAD

Introducing a streamlined process for frequently reported deaths

Together with VIFM, the Court is planning a new process for investigating hospital deaths of elderly people who die from complications after a fall and fractured femur. Every year, Coroners receive more than 1000 reports of deaths in people aged over 70 years due to age-related fractures (primarily a fractured neck of femur) following a fall. The ageing population of Victoria dictates that the number of reported deaths in this category will continue to increase.

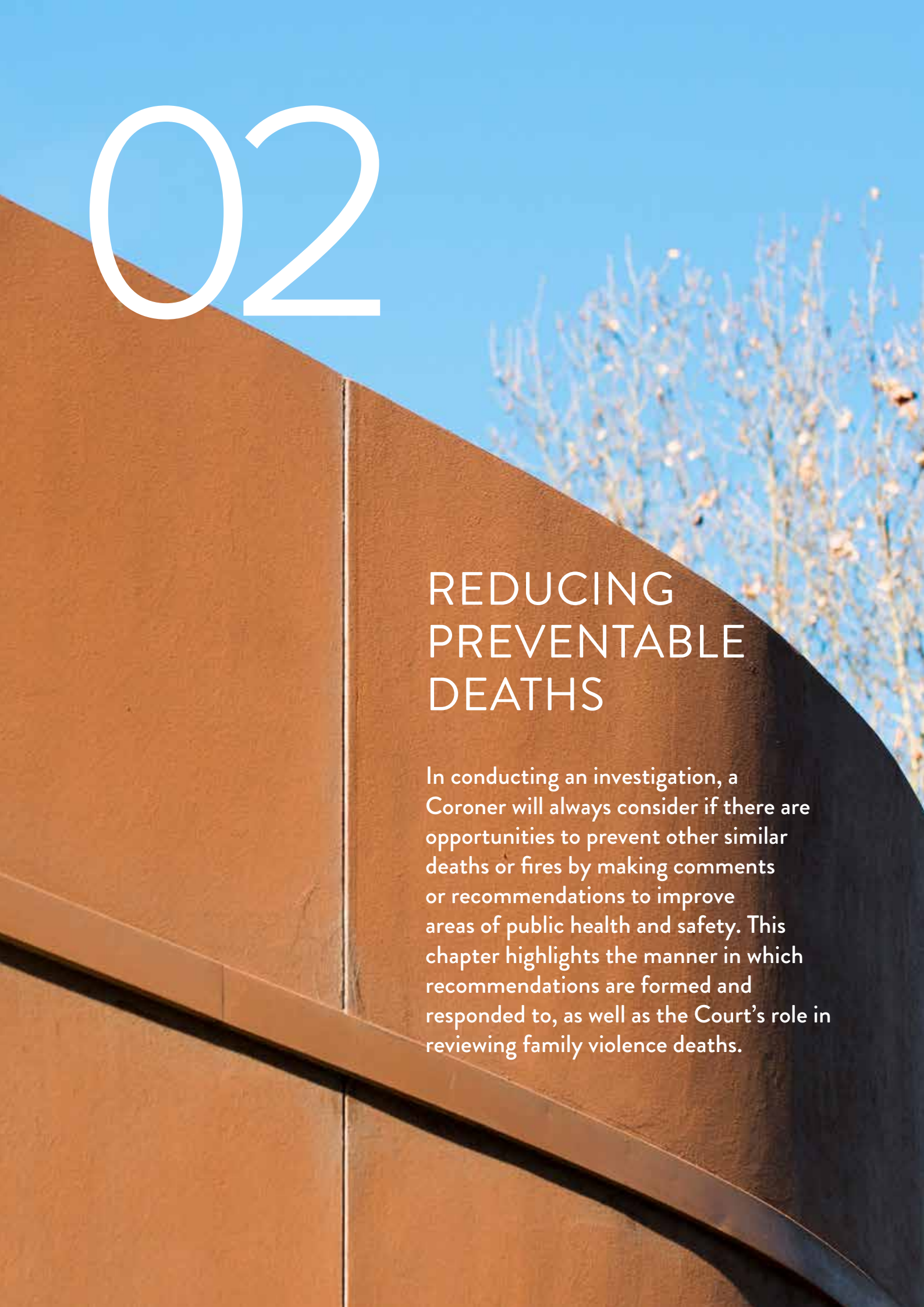
The new process, to be piloted in 2017/18, allows for the deceased person to be held at the hospital or funeral home following the report of the death to the Coroner, rather than being transported to the Coronial Services Centre of Southbank.

This will seek to protect families from unnecessary frustration and delays, reduce investigations timeframes and save the Court in transportation costs. If there are any concerns about treatment or cause of death, usual processes involving transportation to coronial services, will be followed. Under a staged roll out, the process will apply to hospitals initially, and may be expanded to aged care facilities.

Increasing resources to enable more timely investigations

Towards the end of 2016-17, the Court commenced recruitment for an additional seven legal officers. These positions will be crucial in continuing to reduce investigation timeframes, and improve our capacity to manage more complex matters in-house. The expanded Legal Services team will support Coroners to finalise their investigations efficiently by:

- reviewing the coronial brief and evaluating the evidence
- requesting witness statements and engaging expert witnesses where appropriate (page 27)
- drafting findings without inquest.



02

REDUCING PREVENTABLE DEATHS

In conducting an investigation, a Coroner will always consider if there are opportunities to prevent other similar deaths or fires by making comments or recommendations to improve areas of public health and safety. This chapter highlights the manner in which recommendations are formed and responded to, as well as the Court's role in reviewing family violence deaths.

CHALLENGES AND ACHIEVEMENTS

Influencing change over time

Coroners carefully consider the recommendations they make to ensure they are informed by and based on the evidence before the Court. As seen by the Victorian Government's commitment to reform pool safety measures for rental properties (page 28), positive change in public safety can occur as a result of the weight of coronial recommendations.

To ensure coronial recommendations are well received and practical to implement, the Court has access to:

- the Coroners Prevention Unit (CPU), the only multi-disciplinary team of its kind in Australia, whose mandate is to assist Coroners to identify opportunities to strengthen public health and safety and the administration of justice through the formulation of evidence-based and feasible recommendations
- an In-House Legal Service to provide advice on existing laws and regulations
- external expert specialist opinions, as required.

As a result of this approach, 73 per cent of recommendations made in the past year were accepted in full or in part for implementation, while a further 11 per cent were under consideration.

Commencing Victoria's first disability services death review

Following recommendations from a Parliamentary inquiry, the Court established a new resource to support the Disability Services Commissioner review and report on the deaths of people in disability services in Victoria.

In May 2016, the Victorian Parliament Family and Community Development Committee released the Inquiry into Abuse in Disability Services Report. The Inquiry received evidence that people with a disability may have died of neglect, but noted there was no process to systematically review deaths in disability services in Victoria.

The Inquiry recommended the Disability Services Commissioner undertake a comprehensive review of deaths in disability services to identify ways to better manage risks for people in disability care (such as choking and respiratory risks) and to improve medical and emergency management relating to people with a disability. The Disability Services Commissioner will publish a comprehensive, annual review of these deaths.

Funded by the Department of Health and Human Services, the Court appointed a Disability Death Review Case Investigator who will review clinical evidence to identify contributing factors to the death and assess the adequacy of risk assessments and treatment. This may include a review of the scientific research and clinical guidelines and engagement with relevant experts, including the Disability Services Commissioner. From this range of information, advice will be prepared for Coroners on prevention-focused and feasible recommendations for consideration.

RECOMMENDATIONS

While every death and fire reported to the Court requires an individual investigative approach, there is always a focus on whether anything could have been done differently to prevent the death or similar deaths occurring in the future.

The Court often investigates and documents the circumstances in which a death occurred. This information can assist in the making of recommendations in relation to a specific death, as well as establishing a pool of knowledge to which coroners can refer when investigating similar matters in the future.

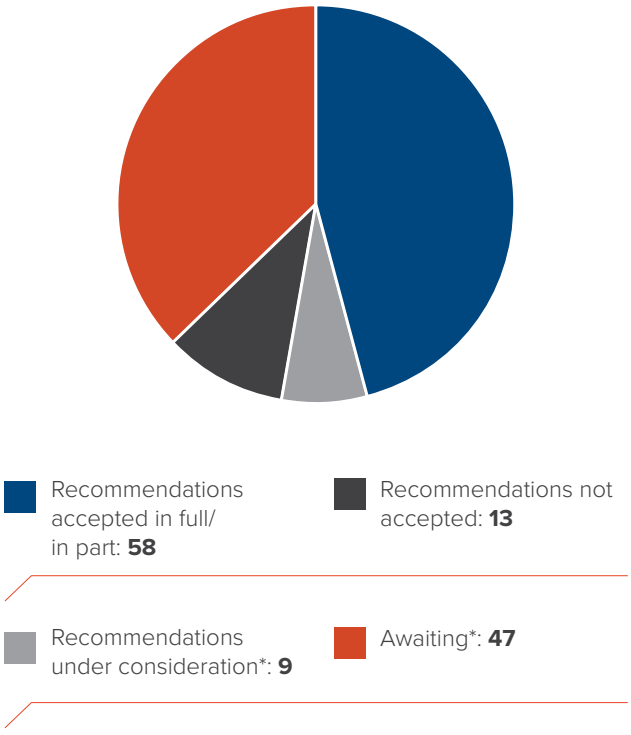
Recommendations can be made to any Minister, public statutory authority or entity in relation to a matter connected with a death, including recommendations relating to public health and safety or the administration of justice. The Coroner may also report to the Attorney-General in relation to a death which the Coroner has investigated.

Coroners made recommendations in 1.9 per cent of findings made under section 67 of the Coroners Act in 2016-17. This excludes natural cause deaths and deaths where the Coroner discontinued the investigation.

While the number of recommendations made fell over the past year, it is acknowledged this figure is entirely dependent on the matters before the Court, and associated opportunities for prevention. As always, the Court focused on providing robust and informed recommendations in order to increase the likelihood of a recommendation being accepted and implemented.

Excluding responses not yet received, a high 73 per cent of coronial recommendations made in the past year were accepted. This shows that coronial recommendations are taken very seriously by recipients. Only 11 per cent of recommendations were not accepted – this was generally because the organisation had pre-emptively taken steps to improve their processes and procedures as a result of a preventable death.

FIGURE 2: RESPONSE TO RECOMMENDATIONS FROM CLOSED INVESTIGATIONS



** The party receiving recommendations from the Coroner must respond within three months detailing what action they will take (if any) in response to the recommendations. 'Awaiting' includes those not yet required to respond.*

TABLE 9: RECOMMENDATIONS MADE IN CLOSED INVESTIGATIONS

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of investigations closed with recommendations	82	101	111	105	65
Number of recommendations made	254	306	305	296	127

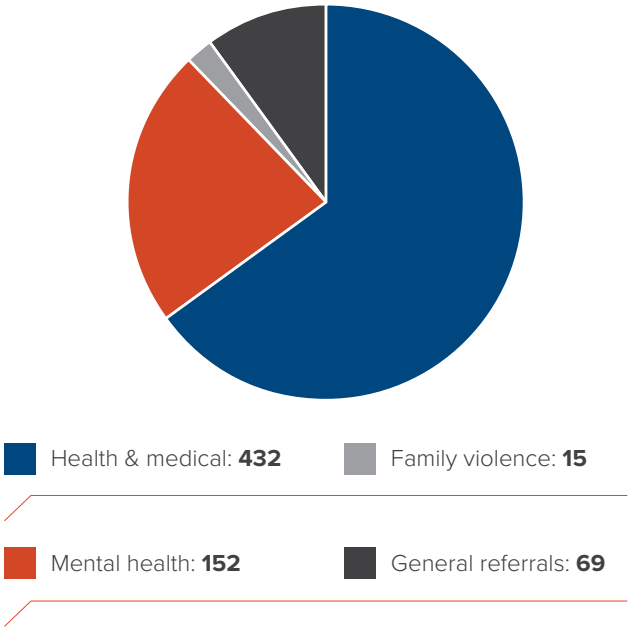
Getting expert advice

Coroners made 668 referrals to the CPU regarding deaths under investigation – an increase from the 598 referrals in 2015-16.

Coroners requested advice on:

- the circumstances in which the death occurred, including factors that may have contributed to the death
- the frequency of previous and subsequent similar deaths in Victoria, and common risk factors
- previous interventions that have been proven or are suspected to reduce the incidence of future similar deaths
- regulations, standards, codes of practice or guidelines that might be relevant to reduce similar deaths
- previous coronial recommendations and other feasible, evidence-based recommendations to reduce similar deaths.

FIGURE 3: THEME OF REFERRALS



Case investigators worked across four streams:

- **Health and medical:** focusing on deaths where Coroners require clinical advice about healthcare provided (or that should have been 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 provided (and that should have been provided) 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*
- **General:** providing non-clinical advice to Coroners on deaths such as drug overdoses and motor vehicle accidents.

In providing advice to Coroners on recommendations, the Court consults with stakeholders and independent experts to complement in-house specialist knowledge and expertise. In the past year, we engaged 33 external experts to provide expert reports and give testimony as part of an inquest, at a cost of $49,907.

In early 2016-17 the CPU significantly increased its capacity to provide medical specialist advice to Coroners in response to a growing demand in the number of cases. The CPU now has five doctors with different specialities each working one day per week, and has continued its relationship with Monash Children's Hospital in hosting a paediatric registrar who is undertaking advanced clinical training. The Court also hosted a six-month sabbatical visit by a highly recognised emergency medicine senior specialist, to undertake research including that into deaths from aortic dissection and identifying prevention opportunities.

CASE STUDY

BACKYARD DROWNINGS PROMPT LEGISLATIVE REFORM

Upon waking from an afternoon nap, a mother found her two-year-old son missing. After searching the house and ringing friends, she found him in the pool in the backyard of their rental property. Despite attempts to revive him, the child died.

Looking back through past coronial investigations, the Coroner found that this was the fourth time a child had drowned in a backyard pool at a rental property between 2010 and 2015. The Coroner investigated why this was continuing to happen.

The investigation

Inspecting the rental property, the coroners investigator observed there were two gates to enter the pool area. However, one gate did not automatically lock on closure and the other did not automatically close or lock. Additionally, the fence was in poor condition and not well attached to the ground.

The investigation concluded that the fence and gates had likely been in poor condition for some time. However, a routine inspection of the property six months earlier did not mention pool fencing, as there was no specific checkbox on the real estate agent's form in relation to this issue. Additionally, there was no requirement to ensure pool fencing continued to meet building safety standards.

The Coroner found that in the 15 years to 2015, 26 children had died in backyard pool drownings. In three cases, the gates were found to be faulty and in another three cases, the pool fence was faulty.

Recommendations

To prevent similar deaths in the future, the Coroner recommended:

- a pool safety certificate be issued before a property is sold or leased, and other measures from Queensland's pool safety framework
- a statewide pool register be used to identify all properties in Victoria with a backyard pool or spa to allow for enhanced regulation
- a standard routine inspection report be created for rental properties, including references to pool/spa fences and gates.

Shortly after the finding was handed down, the Victorian Government released proposed changes to the *Building Act 1993*, granting inspectors new powers to enter premises and check whether barriers comply. The Minister for Planning also stated the Government would consider a statewide pool register and mandatory inspections every three years.

TRENDS AND PATTERNS

Since its inception, the Court has developed and maintained a comprehensive and detailed set of records on reportable deaths in Victoria. This information provides us with a unique viewpoint on emerging trends and patterns in certain kinds of deaths. It also helps in the development of coronial recommendations to reduce the incidence of similar deaths in the future.

For the purposes of annual reporting, preliminary analysis of cause of death is set out in this chapter. This data is indicative only, and is subject to review as Coroners progress their investigation and more information becomes available. A more comprehensive review will be conducted at a later stage.

Consistent with the caseload in previous years:

- almost 40 per cent of cases reported to the Coroner were deaths caused by natural causes
- a further third of deaths were accidental, due to falls, road accidents or drowning
- eleven per cent were suicides.

TABLE 10: CAUSE OF DEATHS REPORTED TO THE COURT IN 2016-17

	Number
Deaths from natural causes	**2498**
Unintentional	**2113**
Falls	1332
Poisoning	320
Transport	310
Drowning	39
Other	112
Intentional self-harm (suicide)	**686**
Hanging	322
Poisoning	125
Firearm	38
Rail	34
Jump from height	31
Other	136
Complications of medical and surgical care	**331**
Other *	**262**
Non-reportable deaths	**239**
Still enquiring	**210**

**Other categories of unintentional deaths include undetermined intent (103), other reportable deaths (89), assault (68) and legal intervention (2). Please note, this case analysis was completed at a different time to overall performance figures. As Court records are updated every day, this resulted in a different total number of reported deaths to the Coroner as detailed on page 17.*

CASE STUDY

INDUSTRY REGULATIONS CONSIDERED TO SHUT DOWN SUICIDE 'HOTSPOTS'

Early one morning, a 68-year-old woman with a history of bipolar affective disorder and suicide attempts left the hospital where she was being treated as a voluntary patient.

She travelled to a multi-storey car park in Melbourne's central business district, took the stairs to the rooftop of the car park and jumped to her death. The car park had become a suicide 'hotspot'; a fact that was well known to nearby businesses and workers who witnessed the event or aftermath. In fact, just four months later another person died by suicide there. The Coroner investigated what else could be done to prevent future suicides.

The investigation

A search of coronial records found the woman's death was the fifth suicide from the same car park since January 2000 – amounting to one death every three years. More broadly, between 2010 and 2015, there were 20 similar suicides from publicly accessible buildings in the City of Melbourne. According to evidence, the car park's operator was well aware the location had become a suicide 'hotspot' and that people were travelling some distance specifically to complete suicide there.

The operator had installed barriers on most levels, but not on all sides or all levels. There were no local laws or policies, or building laws or regulations, which required measures be taken to prevent suicides from publicly accessible buildings.

In response to a request from the Coroner, and to multiple complaints from neighbouring buildings and businesses, the operator advised that to install suicide barriers around all levels would be cost-prohibitive and would make the car park darker. The operator stated the car park was in compliance with current building regulations and they were therefore under no obligation to make any changes to it.

Recommendations

The Coroner found the car park's operator had little desire to ensure the safety of people who use the car park, or to prevent further suicides from the location.

While the Coroner noted this 'callous attitude' was unlikely to be shared by other building owners or operators, His Honour recommended:

- the Department of Environment, Land, Water and Planning implement amendments to the Building Act and Building Regulations 2006 to provide municipal building surveyors with powers to require modification to publicly accessible buildings which have been used as a suicide location
- the Australian Building Codes Board consider implementing a requirement for improved jumping suicide prevention measures on commercial, industrial and public buildings under the National Construction Code, with particular attention to car parks.

The recommendations are being considered for implementation and have been raised at both the state and national level.

Victorian Drug Overdose Register

Of the intentional and unintentional poisoning deaths detailed in Table 11, 480 deaths were due to pharmaceutical or illegal drug overdose in 2016-17.

While most recent data is as yet unconfirmed, Victoria is continuing to see an increase in overdose deaths.

The Court created and manages the Victorian Drug Overdose Register which contains detailed information of illegal and pharmaceutical drug overdose deaths in Victoria since 2009. Information from this register has been highlighted in the past year, and is provided in greater detail from page 38.

Victorian Suicide Register

In an effort to inform suicide prevention measures, the Court created and manages the Victorian Suicide Register which contains detailed information relating to the more than 15,000 suicides that have occurred in Victoria since the year 2000.

While the primary purpose of the Register is to help Coroners with their work, it also serves as a source of information for academic research and assisting government and community organisations to develop suicide prevention policy and projects (page 30).

In 2016-17, suicide made up 10.8 per cent of all deaths reported to the Coroner.

While the figures in Table 12 are subject to investigation and confirmation, the number of suicides over the past five years has gradually risen.

TABLE 11: DRUG OVERDOSE INVESTIGATIONS CLOSED

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of deaths	388	390	396	473	480

TABLE 12: ANNUAL REPORTS OF SUICIDE

	2012-13	2013-14	2014-15	2015-16	2016-17
Number of deaths	609	610	637	641	686

VICTORIAN HOMICIDE REGISTER

The Court created and manages the Victorian Homicide Register which contains detailed information on all Victorian homicides reported to the Coroner since 1 January 2000. It comprises 223 data fields capturing information such as: socio-demographic characteristics; location information; presence and nature of physical and mental illness; service contact; and in cases of family violence, information on the presence and nature of the violence. The register indicates there were 62 homicides in Victoria in 2016-17, a decrease from 74 the year before but on a similar level with previous years (Table 13).

The Victorian Homicide Register serves as the data source for the Victorian Systemic Review of Family Violence Deaths (VSRFVD). The State Coroner initially takes carriage of all homicides and family violence matters, to ensure consistency in the handling of the investigation and Victoria Police liaison in these matters. Once underway, homicides which are determined not to be family violence related may be allocated to another Coroner for investigation.

FAMILY VIOLENCE DEATH REVIEW

Victoria's Coroners have long been engaged in efforts to understand why family violence-related deaths occur and how they may be prevented. In 2009 the Court established the VSRFVD. To further strengthen the response to family violence across the state, the Court has a dedicated team that conducts in-depth reviews of deaths that meet the following criteria:

- The evidence appears to indicate 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.
- The deceased and offender were or had previously been in an intimate or familial relationship as defined by the Family Violence Protection Act or in a 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. (Note: these are referred to as family homicides.)

In the past five years, 76 deaths have been reviewed and their investigations closed, with 18 of those investigations being reviewed and closed in the past year.

Homicides by relationship

In the past year, 37 per cent of homicides occurred between family members or partners. Many of these deaths occur in the context of family violence.

TABLE 13: HOMICIDES BY RELATIONSHIP

	2012-13	2013-14	2014-15	2015-16	2016-17	Total
Intimate partner	7	15	10	14	14	60
Parent-child	10	8	8	11	7	44
Other intimate or familial (including kinship)	7	5	5	8	2	27
Not intimate or familial	26	34	34	37	28	159
Unknown	-	2	5	4	11	22
Total	**50**	**64**	**62**	**74**	**62**	**312**

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 2015-16 Annual Report because of this re-classification process.

- Familial homicides occur most commonly between current or former intimate partners, a trend that continued in 2016-17.
- The number of parent-child homicides declined over the past year. Over the past five years, more than half of these homicides were perpetrated by parents.
- The remaining family violence homicides occurred between parties in 'other intimate or familial relationships', such as between siblings or extended family members (including in-laws).

EXPLORING POSSIBLE WARNING SIGNS

In March 2017, the Court made a submission to the Sentencing Advisory Council to help inform the Victorian Government on the desirability of, and methods of accommodating, 'swift and certain' approaches to family violence offenders in the sentencing regime.

As part of its submission, the Court analysed intimate partner homicides between 2007-08 to 2014-15 to help identify prevention or intervention opportunities. Limited to closed investigations, an examination of the 50 cases of intimate partner homicides found:

- eighty-six per cent of the 43 persons killed did not have a family violence intervention order (FVIO) in place against the offender
- of the seven people killed who did have a FVIO in place, three of the offenders had previously breached that FVIO
- six people killed had in the past a previous FVIO breached by the offender.

Six of the offenders (12 per cent) were on some form of criminal sanction or monitoring at the time of the homicide. Of this group:

- three were on bail
- two were on an adjourned undertaking or good behaviour bond
- one was on parole.

CASE STUDY

INVESTIGATION HIGHLIGHTS TRAGEDY OF FILICIDE

A father – angry about the ongoing custody dispute with his ex-partner – murdered his two young daughters during a visit to his home. Upon ringing Victoria Police to report the double murder, he told them he smothered the girls, aged three and four, then bathed them. He was later found guilty of the murders and sentenced to life imprisonment.

It was clear to family and friends that the separation had been acrimonious, and that there were genuine concerns about him harming his ex-partner. The Coroner investigated if there were any warning signs that he was about to murder his children.

The investigation

The investigation found that the man threatened his ex-partner on numerous occasions, related to ongoing disputes about the children's living and care arrangements.

At one point, his ex-partner was advised by a dispute resolution centre to consider a Family Violence Intervention Order. Concerns about her safety were such that on the day of the murders, she stayed nearby with another relative, and her parents were close just in case she needed them.

The Victorian Homicide Register shows 88 Victorian children were killed by a parent or step-parent from 1 January 2000 to 30 April 2016. Seven deaths had occurred in the context of a child custody dispute, arising from four separate incidents.

In investigating the deaths, the State Coroner identified known risk factors for family violence, including an acrimonious separation, and conflict in parenting and child custody and care arrangements.

Just as in expert evidence provided in the coronial investigation into the death of Luke Batty, the State Coroner concluded there was no validate risk assessment that could have predicted the deaths.

Recommendations

In concluding the investigation, the State Coroner supported implementation of pertinent recommendations made from the Victorian Royal Commission into Family Violence, namely:

- the Victorian Government review and begin implementing the revised Family Violence Risk Assessment and Risk Management Framework, including a rating or weighting of risk factors
- the Victorian Government amend the Family Violence Protection Act to include any children in a family violence intervention order.

The Victorian Government made a commitment to implement all recommendations made by the Royal Commission and released the report 'Ending Family Violence: Victoria's Plan for Change' to deliver its reforms.

CONTRIBUTING TO A JOINT APPROACH TO FAMILY VIOLENCE RESPONSES

In March 2016, the Royal Commission into Family Violence recommended the Victorian Government establish a legislative basis for the Court's VSRFVD and provide adequate funding to enable the Court to perform this function, with these recommendations to be implemented within 12 months.

Subsequently, the Coroners Act was amended to establish a legislative basis for the VSRFVD, with amending legislation receiving Royal Assent on 16 May 2017. On commencement of the amendments the Act will specify the VSRFVD's objectives and functions, that the Court includes information relating to family or domestic violence intervention orders in its findings, recommendations and reports, and that it reports on the operation of the VSRFVD in the Court's Annual Report. At the time of the report, the Court was being consulted on the commencement date of the amendments.

Community engagement

The VSRFVD Reference Group was established to provide family violence-related information and advice to the Coroner and the Coroners Prevention Unit (CPU), and held one meeting during the reporting year.

State and national bodies

As an important party in implementing recommendations from the Royal Commission into Family Violence, the Court was represented by Her Honour Coroner Audrey Jamieson on:

- **the Judicial Advisory Group on Family Violence** which was established by the Courts Council in 2016 to provide advice to CSV's governing body on the implementation of Royal Commission recommendations from a Victorian court-system-wide perspective
- **the Chief Magistrate's Family Violence Task Force** which provides a direct link to the Victorian Government for critical, strategic, and cross-sectoral advice concerning issues related to the broad intersection of justice and family violence, arising from the Royal Commission.

The Court is a founding and active member of the **Australian Domestic and Family Violence Death Review Network** which was established in 2011 to:

- improve knowledge regarding the frequency, nature and determinants of domestic and family violence deaths
- identify practice and system changes that may improve outcomes for people affected by domestic and family violence and reduce these types of deaths
- identify, collect, analyse and report data on domestic and family violence-related deaths
- analyse and compare domestic and family violence deaths, findings and recommendations.

The Network is examining ways to bring together data from across Australian jurisdictions to identify trends and family violence death prevention opportunities at a national level.

The Court was a co-contributor with other network members to the chapter 'Domestic Violence Fatality Reviews in Australia' in the book entitled 'Domestic Homicides and Death Reviews: An International perspective' published in April 2017.

YEAR AHEAD

Increasing resources for investigating family violence deaths

The State Budget for 2017-18 provided funding of $1.9 million over four years to allow the Court to expand its family violence team and strengthen its ability to review family violence related deaths, fulfilling our obligations under the VSRFVD.

The VSRFVD team will be led by a new Manager, while court resources will be targeted to a dedicated Family Violence Legal Officer, Family Violence Registrar and Family Violence Family Liaison Officer, in addition to the existing Case Investigator positions.

Developing a framework for prevention

The CPU will review current practices and implement an investigative framework and set of standard operating procedures to improve the development of public health and safety responses to prevention. This approach will streamline internal processes and enhance the nature, extent and quality of advice provided to Coroners by the CPU.

03

PROMOTING PUBLIC HEALTH AND SAFETY AND THE ADMINISTRATION OF JUSTICE

The Court regularly reports on preventable deaths, and encourages access to court documents and data to help educate the community on coronial matters. This chapter details some of the research being undertaken by and with the Court, as well as the demand for Court services and information.

CHALLENGES AND ACHIEVEMENTS

Guiding release of information

While the Court is committed to being as open and transparent as possible, there are operational and legal constraints on the release of court documents.

Over the past year, the Court provided more clarity about the release of information through an updated request form, a new media policy and procedure, and a new information sheet concerning the release of court documents. These aimed to provide consistent expectations among stakeholders who request access to court documents – including families, legal practitioners, medical professionals, government agencies, community groups and media.

Supporting research that makes a difference

The Court's Research Committee this year assessed 40 applications to access coronial data for research purposes. The research spanned a broad range of topics including:

- work-related fatalities
- fatalities related to diving
- homicides among older Victorians
- mortality in epilepsy
- suicide and chronic pain
- deaths of young people involved in the youth justice system.

The Committee meets quarterly and advises the State Coroner regarding the appropriateness of applications, assessing the purpose of the research, resource implications for the Court and family considerations.

Launching new online video for health practitioners

A new online video for health practitioners has been developed to allow healthcare professionals the opportunity to access helpful information on the operation of the Coronial system and death reporting requirements without having to physically attend the Court for information sessions. This is of particular benefit to regional healthcare professionals across the State as well as to those who are on long waiting lists to attend.

The video will be shared through the Court's YouTube channel and available on the Court's redeveloped website in 2017-18.

Respecting cultural beliefs

In recognition of how death is treated by people from varying cultural and religious beliefs, the Court this year launched a brochure for Victoria's Koori community. The brochure contains information about the coronial process, such as why the Coroner may be notified of a death, why medical examinations and autopsies might be needed and when a funeral can be organised.

This was a key achievement from our Koori Inclusion Plan, which was developed in consultation with the Koori community.

Over the next year, the Court will lay a plaque at the entrance of the Coronial Services Centre that acknowledges the Traditional Owners of the land. We will also formally engage the services of Koori Court Elders to be available to attend court hearings with Koori families.

DRUG OVERDOSE DEATHS

In 2016, 477 people died from overdosing on illegal and pharmaceutical drugs. This number may rise as cause of death is confirmed through finalised coronial investigations. The number of overdose deaths has been steadily climbing since the early 2000s.

Analysis of trends in the Court's Victorian Drug Overdose Register over the past five years, found that about 70 per cent of Victorian overdose deaths involve multiple drugs, not just a single drug.

The most frequent contributing drugs are pharmaceutical drugs (not illegal drugs or alcohol), contributing to about 80 per cent of overdose deaths each year.

TABLE 14: VICTORIAN OVERDOSE DEATHS

	2012	2013	2014	2015	2016
Overall number	367	380	387	453	477
Involved pharmaceutical drugs	306	313	316	358	372
Involved illegal drugs	133	166	164	227	257
Involved alcohol	80	94	94	106	118

The proportion of deaths involving pharmaceutical drugs and alcohol has been relatively steady. However, in the past few years, the proportion of overdoses involving illegal drugs has increased significantly.

Contributing to drug law reform inquiries

In late 2015, the Victorian Law Reform, Road and Community Safety Parliamentary Committee launched an inquiry which examined:

- the effectiveness of laws, procedures and regulations relating to illicit and synthetic drugs and the misuse of prescription medication in minimising drug-related health, social and economic harm
- the practice of other Australian states and territories and overseas jurisdictions and their approach to drug law reform and how other positive reforms could be adopted into Victorian law.

In making a submission to the inquiry, the Court conducted significant analysis of court data, common issues and recurring recommendations in the past year. The State Coroner appeared before the Committee in May 2017.

The Committee is due to report by March 2018.

On 22 February 2017, the Victorian Parliament Legislative Council requested the Victorian Parliament Legal and Social Issues Committee to conduct an Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017. The terms of reference of this inquiry included a review and consideration of:

- the recommendations in Coroner Hawkins' Finding from the inquest into the Death of Ms A, delivered on 20 February 2017 and other relevant reports
- the nature and extent of current, relevant regulations
- the nature and extent of associated, relevant policing policy.

The State Coroner appeared before the Committee in June 2017. The Committee is due to report by 5 September 2017.

Common themes

Since 2009, Victorian Coroners have made 128 recommendations from 49 findings addressing issues relating to drug harm reduction.

BENZODIAZEPINES

While examining the topic of pharmaceutical drug-related harm, it is important to draw particular attention to the risk of harm posed by benzodiazepines.

Benzodiazepines continue to be the most frequent contributing drug group, playing a role in 98 per cent of multi-drug overdose deaths between 2009 and 2016.

While seldom fatally toxic by themselves, benzodiazepines are highly addictive and potentiate the effects of every other drug which depresses central nervous system function, often with fatal results.

ILLEGAL DRUGS IN THE CITY OF YARRA

In the past year, Victorian Coroners published findings into two overdose deaths in the City of Yarra. Both involved people from outside the municipality who travelled to North Richmond to purchase and use heroin. Both were found in public spaces and rushed to hospital.

Analysis of coronial data found the City of Yarra had the highest frequency of heroin-involved overdose deaths in 2016 (18 of 190 deaths).

And over the past eight years, the City of Yarra had the highest average annual rate of fatal overdose in Victoria, being 23.7 fatal overdoses per 100,000 residents per year. Melbourne (16.4) and Port Phillip (9.0) were the next highest local government areas (LGA) for fatal overdose. The regional LGAs with the highest rates of overdose death were Glenelg (12.8) and Latrobe (10.2).

Between 2012 and 2016, the City of Yarra also had the highest proportion of overdose deaths in non-residential locations such as parks, car parks and public toilets.

For 69 per cent of fatal heroin overdoses in the City of Yarra, the deceased's usual place of residence was outside the municipality.

TABLE 15: OVERDOSE DEATHS BY CONTRIBUTING DRUG

	2012	2013	2014	2015	2016
Benzodiazepines (eg diazepam, alprazolam, temazepam)	199	212	215	238	258
Opioids (eg methadone, oxycodone, codeine)	212	192	186	199	183
Illegal drugs (eg heroin, methamphetamine)	133	166	164	227	257
Antidepressants (eg mirtazapine, amitriptyline, citalopram)	142	134	144	161	156
Antipsychotics (eg Quetiapine, Olanzapine)	78	75	81	91	104
Other *	100	134	142	157	124

** Other includes non-benzodiazepines anti-anxiety, non-opioid analgesia and anticonvulsants.*

TABLE 16: LOCATION OF FATAL INCIDENTS IN THE CITY OF YARRA, 2012-2016

	Own home	Another's home	Non-residential	Total
Yarra	18	15	31	64
Melbourne	34	5	19	58
Port Phillip	35	9	4	48
Brimbank	28	8	8	44
Greater Dandenong	32	4	4	40

CASE STUDY

OVERDOSE DEATHS PROMPT PUBLIC HEALTH ACTION IN NORTH RICHMOND

A 34-year-old woman walked into a fast food restaurant in North Richmond and took a spoon from the service area before entering the bathroom. Forty minutes later, a staff member found her unconscious, with a syringe sticking out of the top of her leg. Despite being rushed to hospital, her condition deteriorated and she died. Her life and death shared many commonalities with a large number of overdose deaths reported to the Court in recent years, most crucially the location of North Richmond. The Coroner investigated what could be done to prevent similar deaths.

The investigation

The woman had a long history of drug taking and her medical records showed a history of mental health issues and family violence. After overdosing just three weeks before her death, she had expressed a desire to seek treatment for heroin addiction. In 2015, 20 of the 172 fatal heroin overdoses in Victoria occurred in the City of Yarra, mainly the areas of North Richmond and Abbotsford bordering Victoria Street – involving both residents and people who travelled there to purchase illegal drugs. Fourteen of those overdosed in public places, such as alleyways, toilet blocks and car parks. To understand the experiences of local businesses and residents, the investigating Coroner went to North Richmond, and witnessed firsthand injecting drug use and its aftermath. Her Honour obtained expert evidence from three eminent experts in the field of drug harm reduction, and received submissions from local alcohol and drug services, Victoria Police, the Department of Health and Human Services, Ambulance Victoria, local residents and Yarra City Council.

During the inquest, the medical director of a safe injecting facility in Sydney's Kings Cross gave evidence. She said that in 16 years of operation, the centre had managed 6500 overdoses with no fatalities, while overdoses in public areas surrounding the centre had dropped. She told the Court there was also a noticeable reduction in discarded needles and syringes, and an 80 per cent reduction in ambulance callouts for heroin overdoses in the immediate area.

Recommendations

The investigating Coroner recommended:

- the Minister for Mental Health take the necessary steps to establish a trial of a safe injecting facility in North Richmond
- the Department of Health and Human Services expand the availability of naloxone to people who may be able to administer the overdose reversal drug in the area
- the Department also review its services that support the health and wellbeing of injecting drug users in the area.

The Victorian Government accepted the latter two recommendations, among a raft of other measures aimed at reducing overdose deaths in the area. The first recommendation is being considered by the Parliamentary Inquiry into Drug Law Reform (page 38).

TABLE 17: USUAL RESIDENCE OF DECEASED IN THE CITY OF YARRA, 2012-2016

	LGA of fatal overdose	Another LGA	Total
Yarra	20	44	64
Melbourne	40	18	58
Port Phillip	36	12	48
Brimbank	36	8	44
Greater Dandenong	33	7	40

REAL-TIME PRESCRIPTION MONITORING

To support safe, clinically appropriate prescribing and dispensing of pharmaceutical drugs, Victorian Coroners have recommended implementation of a real-time prescription monitoring system.

These systems are usually promoted as a way of tackling the issue of so-called 'doctor shopping', where a patient attends multiple doctors to obtain excessive amounts of addictive drugs. But coronial investigations over the past two years highlight a broader issue of a lack of coordination of care between prescribing doctors, where they are unaware what other doctors are prescribing. This can lead to fatal outcomes.

The Victorian Government has announced it will implement a real-time prescription monitoring system next financial year. At the time of this report going to print, the Court is unaware of what drugs will be monitored through the system.

TAKEAWAY DOSING IN METHADONE MAINTENANCE THERAPY

Victorian Coroners have made numerous recommendations concerning methadone, particularly unsupervised or 'takeaway' methadone dosing. Methadone maintenance therapy helps opioid dependent people to reduce their addiction. However, many overdose deaths involve misuse of takeaway methadone. Tragically, since 2010, these have included the deaths of seven children, who overdosed on methadone that was not prescribed to them (page 22).

Last year, the Department of Health and Human Services changed its policy on takeaway dosing, to lower the number of takeaway doses which a patient could obtain, from five to four doses a week. The Court will continue to monitor the annual statistics concerning methadone overdose deaths in Victoria.

"Individuals of your organisation have demonstrated a high standard of professional rigour balanced with a genuine consideration for myself and respect for the investigation into the death of our sister"

ACCESS TO INFORMATION

Requesting the court's unique data

The Court holds extensive and detailed data regarding Victorian deaths. Over the past year, we responded to 23 requests from external organisations to provide data and other assistance to organisations, including data to assist:

- the Department of Environment, Land, Water and Planning with its reviews of balcony design and of how the Building Code treats private swimming pools and spas
- VicRoads to track jump from height suicides across the Victorian road network
- the Chief Health Officer with the Thunderstorm Asthma Inquiry
- the Chief Psychiatrist with a review of deaths in Victorian mental health services
- Parks Victoria with a review of certain port areas it manages
- various organisations (including the Department of Health and Human Services, Primary Health Networks, and local councils) to understand the geographic distribution of Victorian suicides.

The Court received many more requests for data, but due to resourcing and core operating priorities not all requests can be fulfilled by the Court.

Contributing to national data collection

To help inform research and prevention efforts on a national scale, the Court codes all closed investigation files on behalf of the National Coronial Information System (NCIS). This database contains information on the deceased and all identified factors which contributed to the death. NCIS provides paid access to detailed statistics from Australia and New Zealand.

The Court is steadily reducing the number of closed cases which require coding. The Court has a dedicated resource, who works closely with NCIS to ensure files are coded accurately and quickly.

In the past year, a total of 9591 closed cases were entered on NCIS, bringing Victorian closure rates in line with other states and territories for older 2013 cases. Quality audits conducted by NCIS show Victoria is consistently achieving a lower error rate than national averages.

Requesting coronial documents

The Court receives many requests for access to information and documents contained within coronial files. This may include documents such as a medical examination report, toxicology report or unpublished findings.

TABLE 18: REQUESTS FOR CORONIAL DOCUMENTS

	2012-13	2013-14	2014-15	2015-16	2016-17
Form 45 requests from external parties	3057	3553	4327	4668	5063

Applications continue to grow every year. In the past five years, the number of requests the Court receives has grown by 65 per cent.

Under the Coroners Regulations 2009, the Court may charge fees for photocopying documents. Fees are minimal and are reimbursed to the Court, so are not a source of income.

This reimbursement does not cover the estimated cost of managing requests for documents, retrieving off-site files and reviewing material to ensure it is appropriate for release. As other courts charge fees for searching, retrieving and reviewing court files for release, we are currently investigating cost recovering options for this service. Families are not charged for copies of recent coronial documents.

Providing information

It is important for Victorian families and the wider community to understand the coronial process, especially in the days and months following the death of a loved one. Traditionally, we have encouraged families and other stakeholders to call the Court, which can be resource intensive.

Over the past year, we have been examining ways to support families by developing more user-friendly content, forms and instructions to the more than 190,000 users who visit our website each year. This information will be launched with the Court's new website in 2017-18 (page 45).

We understand that the coronial process may be difficult to understand, especially for people from culturally and linguistically diverse backgrounds. We offer our main family brochure, 'What do I do now?' in 15 community languages. We also offer translation and interpretation services to families and other parties whenever possible.

How to access court documents

Families, interested parties and other parties involved in a coronial investigation may request access to Court documents such as:

- the medical examination report
- toxicology report
- the coronial brief
- witness statements
- exhibits and transcripts from an inquest
- photographs
- coronial findings (that are not already publicly available).

Media, researchers and members of the community may also request copies of Court documents. Access will be granted if the investigating Coroner is satisfied that the application meets the criteria under the Coroners Act.

To request access to coronial documents, please download the application, known as Form 45: Access to coronial documents including transcripts, from **www.coronerscourt.vic.gov.au**.

EDUCATION AND AWARENESS

Hospitals and health practitioners are obligated to report certain deaths to the Coroner.

To help them understand when a death must be reported and how to report it, the Court:

- holds quarterly information sessions at the Coronial Services Centre
- publishes targeted resources.

The Court held four information sessions over the past year, covering information about how medical investigations are conducted and what information is required by the Coroner. About 60 health professionals attended each session, primarily from hospitals across metropolitan Melbourne and regional Victoria.

The overall feedback from participants was extremely positive. The sessions continued to be very popular in the past year, with many registering to be on a waiting list.

Presentations

To help improve community and stakeholder awareness, Coroners and Court staff regularly present to key stakeholders and at industry events. Over the past year, Coroners presented at a total of 43 events. Many of these were to specific industry groups, such as Victoria Police, clinicians and allied health professionals, radiologists, medical students and legal practitioners.

Court staff presented at a further 57 events, on topics such as overdose from illegal and pharmaceutical drugs, and coronial recommendations.

CASE STUDY

CLARIFYING WHEN PSYCHOLOGISTS CAN BREAK CONFIDENTIALITY

Not accepting that their relationship was over, a 21-year-old man drove his ex-girlfriend to a park and fatally stabbed her in the neck.

The man who had been receiving mental healthcare, later pleaded guilty to murder and was sentenced to 19 years imprisonment. The Coroner investigated if there was anything to be learned from the mental healthcare he had received in the lead up to the murder.

The investigation

Five months before the murder, the man started seeing a psychologist once or twice a fortnight. In his final visits, the man expressed violent thoughts – but these weren't fully explored, or considered serious or specific enough for the psychologist to breach confidentiality.

Meanwhile, the man was researching murder laws, had vandalised his ex-girlfriend's car, tried to obtain a firearm and confided in a friend that he planned to kill the woman.

Under practice guidelines, psychologists may report a patient if they believe they pose a serious and imminent threat to someone's health and safety. The man's regular psychologist formed the view that he did not meet this threshold. However, with the benefit of hindsight, she told an inquest that he may have settled his plans, as he was calm at their last two sessions.

With expert opinion supporting the reasonable and appropriate standard of care provided to him, the investigating Coroner explored whether the threshold for breaching confidentiality – that is that the patient must pose a serious and immediate threat – was too high in this case.

Recommendations

After seeking industry opinion on the reporting threshold, the Coroner recommended:

- the word 'imminent' be removed as a criteria for reporting potential harm, allowing practitioners to disclose confidential information about a serious threat when they are unsure of timing
- the Psychology Board of Australia review the existing Code of Ethics and practice guidelines to clarify when and who concerns may be reported to.

YEAR AHEAD

Supporting innovative research

The Court is working collaboratively with academic research undertaken for two doctoral theses in the next year, to help inform ways to promote public health and safety:

- Examining homicides among community dwelling adults in Victoria for the period 2001-2015, comparing the epidemiology of homicides among older adults (65 years and over) to younger adults (18-64 years), by a Monash University Department of Forensic Medicine PhD candidate.
- Examining the socio-cultural determinants of adult familial homicide in Victoria during the period 2009-2016, by a University of Melbourne School of Social Work PhD candidate.

Improving online information

Due to be launched in 2017-18, the Court's redeveloped website will be more user-friendly and accessible, featuring content that is easy to find and understand. Tailored to families, health professionals, legal practitioners and media, the website will also feature new multimedia products and will be responsive to mobile devices (as more than half the site's traffic is from a phone or tablet).

Historically, the Court's website has received high visitation but low penetration, with three quarters of the 2.4 million page views related to coronial findings and orders. As a result of the redevelopment, we expect to see increased downloads of Court forms and a corresponding reduction in phone call enquiries.

The website will also feature the Court's new visual identity, which is being refreshed to create a strong, consistent and recognisable look.

Improving access to information and services

Two significant information technology projects have been held over for consideration in 2017-18, these are:

- introduction of online forms for families, lawyers and other parties to lodge requests and applications. While saving our stakeholders time and resources, this will also significantly reduce the manual handling of paper file documents at the Court.
- an online family portal providing access to secure court documents and the ability to add relevant information to an investigation.

CORPORATE GOVERNANCE

We work closely with other courts and organisations to ensure we deliver excellent services to Victorian families, by making good decisions and meeting our obligations. This chapter outlines the Court's structure, committees and workforce, as well as processes for complaints, appeals and accessing information.

The Coroners Court is one of the courts and tribunals which fall under the governance structure of Court Services Victoria (CSV), an independent statutory authority. As a member of the Courts Council, the State Coroner directs the strategic and operational performance of the Court and its staff. The Court is accountable to the community through the Parliament of Victoria.

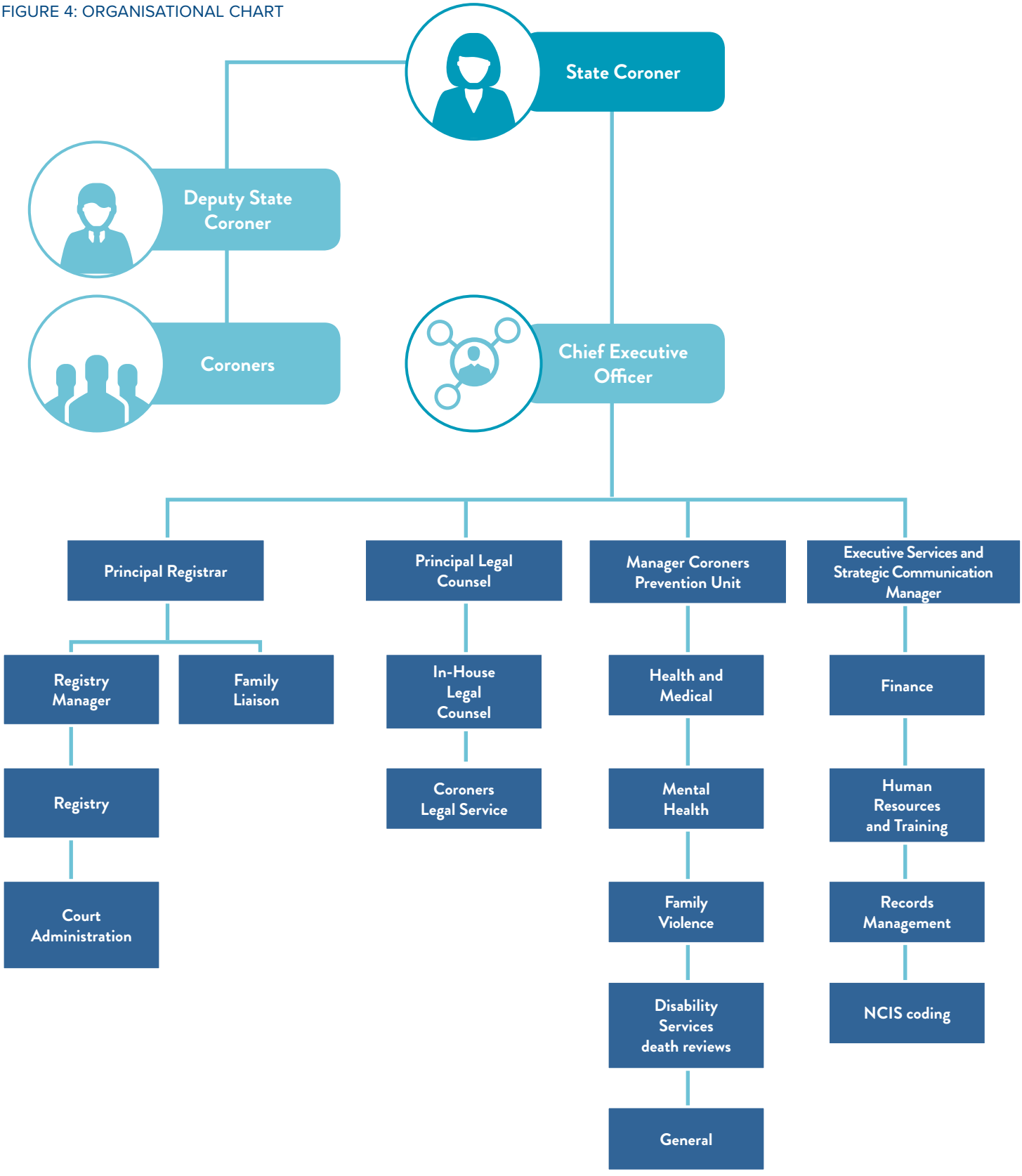
COURT STRUCTURE AND LEADERSHIP

More than 60 Court staff support the Coroners in their independent investigations, and manage the administration of the Court.

The organisation comprises four divisions, each led by a Manager:

- Coroners Support Service comprises Court administration, family liaison officers and registrars, who closely manage case files, support families, and liaise with other parties.
- Legal Services assists Coroners with their investigations by analysing evidence gathered as part of an investigation, preparing draft findings, preparing matters for inquest and appearing as counsel to assist the Coroner at inquest.
- Coroners Prevention Unit works closely with the Coroners to help them identify and research matters that may lead to the making of recommendations to prevent similar deaths.
- Executive Services supports the efficient operation of the Court through records management, finance, communications and human resources functions.

FIGURE 4: ORGANISATIONAL CHART



THE EXECUTIVE TEAM

The day-to-day operation of the Court is overseen by a Chief Executive Officer (CEO) who is appointed on the recommendation of the State Coroner. The functions of the CEO include managing the Court's administration support services and implementing the directions of the State Coroner in relation to the Court's operations.

SAMANTHA HAUGE, CEO

BSW

Samantha was appointed Chief Executive Officer in February 2013, after establishing and then managing the Court's Coroners Prevention Unit for five years. She previously worked with the (former) Department of Human Services for 16 years, initially as a child protection worker and later in various managerial positions. During this time, she appeared as a senior court officer at the Children's Court of Victoria and worked as a senior policy advisor with 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.

As CEO, Samantha is a member of the CSV Courts CEO group and CSV jurisdictional committees. She is also on the Court's Audit and Risk Committee, Finance Committee and the CCOV/VIFM Steering and Joint Operations committees.

MARGARET CRADDOCK, PRINCIPAL REGISTRAR

Margaret has been the Court's Principal Registrar since 2012 and has a wealth of coronial experience from both interstate and overseas. With qualifications from the Chartered Insurance Institute in the United Kingdom (including Financial Planning Certificates 1-4), Margaret transitioned to coronial services and quickly progressed to manager of the Coroners Office for the counties of Berkshire, Buckinghamshire and Oxfordshire. Moving to Australia in 2005, Margaret held the roles of team leader and Manager at the Coroners Courts in South Australia and Queensland.

Margaret is on the Audit and Risk Committee, CCOV/VIFM Joint Operations Committee and Coroners and Pathologist Working Group.

JODIE BURNS, SENIOR LEGAL COUNSEL

BA LLB

Admitted to practise law in 1994, Jodie joined the Court in 2012 after several senior legal government roles. She was the Senior Lawyer (Coronial and Prevention) at WorkSafe Victoria and has previously worked 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 2016, the Law Institute of Victoria awarded Jodie the honour of Government Lawyer of the Year.

Jodie is a member of the Court's Audit and Risk Committee and the CCOV/VIFM Joint Operations Committee.

MICK BOYLE, MANAGER CORONERS PREVENTION UNIT

BA, Dip CommServ (Community Development), Grad Cert SocSci (Male Family Violence)

Joining the Court in February 2017, Mick has extensive experience in family violence, suicide prevention and forensic mental health. Holding senior positions in the departments of Justice and Regulation, and Health and Human Services, he led the development of the Magistrates' Court's mandated male family violence prevention programs, the Victorian Correctional Suicide Prevention Framework and was key contributor to Victoria's first Forensic Mental Health Implementation Plan. He was previously a consultant to the AFL and Executive Officer of the state's peak body for preventing male family violence.

Mick represents the Court on the Australian Domestic and Family Violence Death Review Network.

EMMA GUMBLETON, A/STRATEGIC COMMUNICATIONS AND EXECUTIVE SERVICES MANAGER

BA (Journalism)

Starting out as a broadcast and print journalist, Emma has more than 15 years' broad experience in government media and communications, most recently leading the communications team at the Independent Broad-based Anti-Corruption Commission. She has worked at multiple independent commissions and agencies, including in health and medical investigations, water and sewerage, and public and environmental health, often establishing processes for new or infant organisations. She is an award winning corporate writer, with a strong background in emergency management and digital strategy.

Emma represents the Court on multiple CSV jurisdictional committees, including information and communication technology, risk management and business continuity.

GOVERNANCE AND ACCOUNTABILITY

To ensure that our conduct, actions and decisions are appropriate, we have various internal and external processes in place. We have two key committees that meet regularly to oversee the Court's critical business functions, provide a clear decision-making process and ensure we make appropriate decisions on both day-to-day work and large-scale projects or procurements.

Coroners group

All Coroners meet approximately once a month to discuss current issues facing the Court and common themes identified in coronial investigations, and set high level decisions and strategic directions. The Coroners also attend an annual two-day retreat for professional development.

Operational Executive

The Operational Executive Committee comprises the CEO and the heads of the Court's four divisions. It meets monthly to discuss:

- day-to-day operations
- progress on major projects
- efficient management of Court resources.

CSV representation

As with other courts, the Court complies with CSV policies and procedures to ensure that overarching strategy for Victoria's judicial system is advanced. Additionally, many of our administrative functions are provided or supported by CSV in order to streamline service delivery to the community. The State Coroner is a member of the Courts Council, CSV's governing body. We are also represented on the following key committees.

CSV portfolio committees

Coroners represent the Court on the following standing committees, established by the Courts Council:

- Assets and Security Portfolio Committee
- Finance Portfolio Committee
- Human Resources Portfolio Committee
- Information Technology Portfolio Committee

VIFM representation

Important aspects of the state's coronial services are provided by the Victorian Institute of Forensic Medicine (VIFM).

The VIFM Council

The VIFM Council is the Institute's governing body. The VIFM Council has a strategic and stewardship role in leading VIFM in accordance with the responsibilities set out in the *Public Administration Act 2004*. The State Coroner is an ex-officio member of the Council.

Coroners and Pathologist Working Group

Two Coroners and senior staff from both the Court and VIFM meet quarterly to provide expert advice on operational and other issues. It is chaired alternately by the Deputy State Coroner and the Deputy Director of VIFM Forensic Services.

The Working Group provides guidance to two joint committees:

CCOV VIFM JOINT OPERATIONS COMMITTEE

Meeting monthly, the Committee works to maintain and strengthen our working relationship and to continuously improve the quality and efficiency of the death investigation services provided by CCOV and VIFM to families of the deceased, the justice system and the community more broadly. With senior members of both organisations, it is alternately chaired by the Court's CEO, and VIFM's Chief Operating Officer.

CCOV VIFM STEERING COMMITTEE

The Committee provides strategic leadership and oversight of death investigation matters, our memorandum of understanding and joint protocols, resolution of any operational issues, and emergency management for the Coronial Services Centre. The Committee meets quarterly and is alternately chaired by the State Coroner and the Director of VIFM.

Coronial Council of Victoria

The Coronial Council of Victoria is independent of the Coroners Court and the Victorian Government. The first body of its kind in Australia, the Council was established under the Coroners Act to provide advice to the Attorney-General regarding matters of importance to the coronial system in Victoria.

The Council acts in a way that:

- does not impinge on the independence of Coroners' professional tasks
- strengthens collaboration between agencies across the service system
- focuses on advice to enhance services to families
- promotes the prevention role of the Coroners
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The State Coroner is a member of the Council.

Having previously undertaken references into suicide reporting and appropriate reporting of reportable deaths in hospitals, the Council is due to release a final report concerning the coronial appeals process in November 2017 (page 55).

AUDIT AND RISK MANAGEMENT

Risk management is an integral part of the Court's decision-making, planning and service delivery.

The Court is subject to both external and internal audits of our compliance, processes and systems that support our work decisions. We endeavour to assess and mitigate any identified issues as quickly as possible.

We comply with CSV practices, policies and procedures to ensure we manage risks and resources responsibly. This year, we undertook a significant review and update of our business continuity and risk management planning, in line with newly implemented CSV frameworks.

CCOV Audit and Risk Committee

Comprising a Coroner and the Operational Executive, the Committee meets to discuss and monitor key risks for the organisation, compliance obligations, audits and any resulting recommendations.

The Committee helps the Operational Executive fulfil its responsibilities relating to:

- the adequacy of the Court's risk management planning in identifying and managing risk
- our compliance with relevant laws, regulations, standards and codes
- achieving key reporting objectives under the IFCE (page 11).

The Committee works to a charter that meets the requirements of the *Financial Management Act 1994,* and the relevant sections of Standing Directions of the Minister for Finance 2016.

Managing risk

Over the past year, the Court significantly improved the way in which it identifies, manages and responds to organisational risk.

To align with CSV's newly implemented Risk Management Framework and the Victorian Government Risk Management Framework, we reviewed and updated our risk management plan, register and profiles.

This review will continue into the coming year until the Risk Register is fully developed.

Planning for interruptions

In 2016-17, the Court undertook a major review of its Business Continuity Plan to align with CSV's newly implemented framework and focus on key services and products that must continue if the Court's operation is disrupted. This work included a series of business impact analysis workshops, a review of key stakeholders and the development of additional tools to assist the business continuity management team to manage a disruption. All business areas contributed to the reorientation of the plan to ensure we are appropriately equipped to minimise the impact and duration of any disruption.

Having participated in a CCOV/VIFM business continuity tabletop planning exercise this year, the Court will continue to test its Business Continuity Plan in 2017-18.

PANDEMIC PLAN

In accordance with the Victorian action plan for pandemic influenza (VAPPI) 2015 requirement that all government departments have a Pandemic Plan, a Coroners Court Pandemic Plan has been developed. The Plan aligns with the template provided in the VAPPI and includes actions to be taken at each stage of an influenza pandemic once declared.

Audits

Working with CSV, we regularly audit and review our operational, administrative and financial performance and decisions under the CSV Annual Audit Plan.

In the past year, audits were conducted into procurement and budgeting processes. No CCOV-specific recommendations were made. However, the Court did improve its internal procurement processes, particularly around transport of deceased persons (page 15).

EXTERNAL AUDITS

The Victorian Auditor-General's Office is CSV's external auditor. Annual audits are conducted of Court finances, which are reported fully in the CSV Annual Report.

WORKPLACE PROFILE

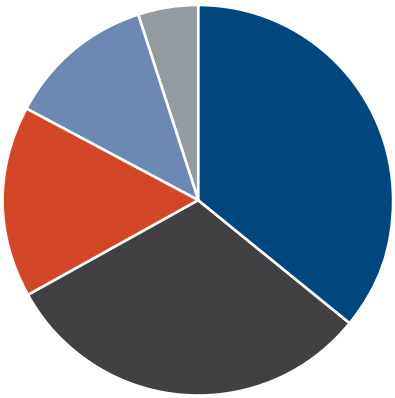
The following table discloses the head count and full-time equivalent (FTE) of all public service employees of the Court in the last full pay period in June 2017. All employees have been correctly classified in this workforce data collection.

TABLE 19: WORKPLACE PROFILE AS AT 30 JUNE

	June 2017				
	All employees		Ongoing		Fixed term/ casual
	Head count	FTE	Head count	FTE	FTE
Gender					
Male	11.0	10.0	7.0	6.0	4.0
Female	53.0	45.8	36.0	32.2	13.6
VPS2	14.0	12.2	8.0	7.6	4.6
VPS3	13.0	12.1	12.0	11.1	1.0
VPS4	25.0	20.0	13.0	10.0	10.0
VPS5	6.0	5.5	5.0	4.5	1.0
VPS6	5.0	5.0	5.0	5.0	-
Executive	1.0	1.0	-	-	1.0
Total	**64.0**	**55.8**	**43.0**	**38.2**	**17.6**

At 30 June 2017, we had 64 staff members, not including Coroners. This included 43 permanent staff, 28 per cent of who were employed on a part-time basis.

FIGURE 5: DIVISIONAL HEAD COUNT AT 30 JUNE 2017



Coroners Support Service: **23**

Executive Services: **8**

Legal Services: **20**

Office at CEO: **3**

Coroners Prevention Unit: **10**

EMPLOYMENT CONDITIONS

Complying with CSV policies and practices, the Court promotes public sector professionalism and provides for fair treatment, career opportunities and the early resolution of workplace issues.

Recruitment

The Court works in partnership with the CSV executive and leadership teams to build its capacity at each stage of the workforce lifecycle - plan, attract, engage, develop, support, reward, retain and transition of its workforce.

The Court's selection process ensures applicants are equally assessed and evaluated on the basis of the key selection criteria and other accountabilities without discrimination. All staff must pass a criminal record check.

We continued to deliver our successful induction program for new staff and reviewed position descriptions to ensure they accurately detail role requirements. In turn, this allowed us to offer development opportunities through secondments to other business units, higher duties and project-based positions. This recognised our top talent and provided pathways for employees to build careers both at CSV and within the wider Victorian Public Service.

Flexible work conditions

We have a range of work/life balance options to help employees balance the demands of work and their personal commitments. Discussion about appropriate working arrangements and flexibility in the way work can be performed is encouraged.

Our employees have reasonable access to:

- various leave options
- flexible work hours
- job-share arrangements
- study leave
- working from home.

We have taken all practical measures to comply with our obligations under the *Carers Recognition Act 2012.* These include ensuring our staff are aware of and understand the principles of the Act through our induction program and leave options.

Vicarious trauma

The Court has always been aware of the sensitive and graphic nature of the material which staff are exposed to, and while this continues to be discussed we have now embedded this information into all of our recruitment processes.

The Coroners Court Wellbeing Debriefing Program was introduced in February 2017 in recognition that our staff are regularly exposed to traumatic cases and material, and engage with distressed family and friends. It is now mandatory for all staff to attend two compulsory debriefing sessions with an experienced psychologist annually, with the option for a further two sessions during the year. This provides support mechanisms and enhances the existing capacity of staff to manage the daily stressors which arise in this unique workplace.

In addition, the Court continued to focus on ensuring continued health and wellbeing for its staff. This year we offered a range of activities and initiatives, such as:

- an Employee Assistance Program, which provides online resources, counselling and coaching to assist in dealing with general wellbeing and work and life issues
- a 'quiet room' where staff can take time out from their desk
- ergonomic assessments
- flu vaccinations.

The Court is also represented on the CCOV/VIFM Health and Wellbeing Committee and joint projects, such as the annual step challenge.

The Green Team

Consisting of staff from the Court, VIFM and PCSU, the Green Team encourages staff to think about how they can make a positive contribution to the environment. The team ran several projects over the past year, including:

- recycling programs for coffee pods, batteries, polystyrene, plastic film and medical consumables
- an edible garden and composting bins
- clothing collection drives for various charities, such as Fitted for Work, Wear for Success and Lort Smith Animal Hospital.

The Green Team also contributed funds to non-profit micro-financing company Kiva.org lending money to low-income entrepreneurs.

Social Club

Connecting staff with our neighbours at VIFM, the joint Social Club organises regular networking and team building events. Over the past year, staff participated in:

- a Christmas toy drive for The Smith Family Foundation
- the VIFM/CCOV Annual Christmas Revue
- mid-year and end-of-year social functions
- barbecues, lunches and cake days
- theatre and movie nights.

Occupational health and safety

The Court seeks to provide and maintain a healthy, safe working environment for our people and visitors in accordance with the *Occupational Health and Safety Act 2004* and associated regulations.

Occupational Health and Safety (OH&S) Committee

The Court has a dedicated OH&S Committee which actively promotes and supports a safety culture that addresses the physical and psychological wellbeing of all staff.

The Committee is responsible for checking and making recommendations on workplace OH&S issues, facilitating OH&S activities and proactive prevention programs, workplace risk assessments and ensuring compliance with OH&S policies and procedures. The Committee also ensures that there is adequate coverage of first aid and fire wardens.

We work to prevent work-related illness and injuries occurring. In the event of an illness or injury, employees are supported by their Manager and other qualified staff.

Staff performance and development

MANAGING PERFORMANCE

All employees have a Performance Development Plan which aims to support their development and performance by documenting clear goals, expectations and development opportunities.

Performance and development planning allows Managers and staff to identify and understand how their individual and team outputs contribute to the Strategic Plan (page 10) and to recognise where any learning and development could be of value.

LEARNING AND DEVELOPMENT

Our learning and development program supports management staff to build personal capability and develop new skills. This year, we continued our focus on developing employees' knowledge and skills to enhance their capability and capacity to deliver on the Court's strategic objectives.

To achieve this, staff training was provided on respect in the workplace, developing cultural intelligence, and Performance and Learning Management System (PALMS) training.

We also conducted 10 lunchtime lectures specifically for Coroners and staff presented by subject matter experts on topics such as:

- anatomy
- toxicology
- natural causes
- common causes of death
- injury interpretation
- controversies in forensic pathology
- disaster victim identification
- organ donation
- WorkSafe
- the Health Complaints Commission.

APPLICATIONS AND APPEALS

Application to reconsider an order for autopsy

Autopsies are required for less than half of all deaths reported to the Coroner. When ordered by a Coroner, autopsies are conducted by a forensic pathologist practising at VIFM, to determine if possible, the medical cause of death.

If a Coroner orders that an autopsy be performed in a particular case, an application can be made on cultural, religious or other grounds, for a Coroner to reconsider their decision. If the Coroner affirms their original decision, a person may appeal that decision to the Supreme Court.

Applications to hold an inquest

Where it is not mandatory for a coroner to hold an inquest, a person may apply to the investigating Coroner to hold an inquest as part of their investigation into a death or fire.

If a Coroner determines not to hold an inquest, the person who requested the inquest may appeal the Coroner's decision to the Supreme Court.

Applications to set aside a finding

A person may apply to the Court to set aside a finding of a Coroner and re-open an investigation. However, the Coroner can only do so if they are satisfied that there are new facts and circumstances and that it is appropriate to do so.

A Coroner's determination not to set aside a finding and re-open an investigation may be appealed to the Supreme Court within three months of the Coroner's decision.

Appeals against the finding(s) of a Coroner

A person with a sufficient interest in an investigation may appeal to the Supreme Court against the finding of a Coroner six months from the date of the finding.

Supreme Court appeals

In 2016-17, five appeals were finalised. One of those five appeals was found in favour of the applicant. Of the five appeals, two were appeals against a decision not to hold an inquest and three were appeals against a decision not to set aside a finding.

Review of rights to appeal coronial findings and re-open investigations under the Coroners Act

On 15 December 2016, the Attorney-General requested the Coronial Council (page 50) to review of the existing rights, under sections 77 and 83 of the *Coroners Act 2008*, to re-open an investigation or appeal coronial findings and to provide advice on:

- whether there is a need to amend section 77 or 83 (and sections 87 and 87A, to the extent that they are related to section 77 or 83); and
- if there is a need to make amendments, the nature of those amendments.

The Council is due to provide a report to the Attorney General by November 2017. In formulating its advice, the Coronial Council has been requested to have regard to:

- the existing operation of the appeal and re-opening provisions in the *Coroners Act 2008*;
- the historical development of appeal and re-opening provisions in the Victorian coronial jurisdiction, including changes made by the *Courts Legislation Miscellaneous Amendments Act 2014*;
- analogous appeal and re-opening provisions in other Victorian legislation;
- appeal and re-opening provisions in other Australian coronial legislation;
- the interests of families, the interests of justice, the interests of maintaining finality of decision-making, and the efficiency of the court system;
- the impact of any proposed changes to the appeal and re-opening provisions on costs and resourcing for the Coroners Court and the appellate jurisdiction;
- any other impact of any proposed changes to the appeal and re-opening provisions on the coronial system and the wider appeals system.

The Court has provided assistance, where appropriate, to the Coronial Council to enable it to conduct its review.

COMPLIMENTS AND COMPLAINTS

Feedback

The Court welcomes all feedback that can be used to improve both its services and the experiences of people who come into contact with us.

Complaints may be about the service provided by a Court staff member, the conduct of a Coroner or the Court's processes or procedures. Far outweighed by compliments, we received five complaints about our services and procedures in 2016-17. We investigated all complaints internally and as a result of the feedback, we:

- raised service issues with a staff member
- corrected minor errors in a Coroner's findings (as permitted under the Coroners Act).
- reviewed internal processes

However, the Court has no jurisdiction to address complaints about the merits of a finding or other matters that are outside of the Court's responsibilities, such as Victorian Government policy, legislation or legal representation.

The content of the complaints is kept confidential. We receive and manage complaints in accordance with the *Privacy and Data Protection Act 2014* and we keep a log of complaints to help us monitor progress and performance, and to identify trends.

HOW TO PROVIDE FEEDBACK

Compliments and complaints can be sent to:

CEO

Coroners Court Victoria

65 Kavanagh Street

Southbank Vic 3006

New Judicial Commission

From 1 July 2017, complaints about the conduct or capacity of Victorian judicial officers or members of the Victorian Civil and Administrative Tribunal (VCAT) may be made to the Judicial Commission of Victoria. The Commission is an independent organisation established under the *Judicial Commission of Victoria Act 2016*.

The Commission cannot investigate the correctness of a decision made by a judicial officer or VCAT member. Nor can it investigate complaints about federal courts or tribunals, such as the Family Court and Administrative Appeals Tribunal, nor can it investigate complaints about court or VCAT staff.

A member of the public or the legal profession can make a complaint by filling out the online complaint form. The Law Institute of Victoria and the Victorian Bar can also refer complaints on behalf of their members without disclosing the identity of the complainant.

For more information:

Judicial Commission of Victoria

GPO Box 4305
Melbourne VIC 3001

enquiries@judicialcommission.vic.gov.au

www.judicialcommission.vic.gov.au

(03) 9605 2420

ACCESS TO INFORMATION AND DOCUMENTS

Freedom of information

The Freedom of Information Act 1982 does not apply to documents held by courts in respect of their judicial functions.

Applications for documents relating to court administration may be made to CSV, or through www.foi.vic.gov.au.

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