2012/13
ANNUAL REPORT

Coroners Court of Victoria

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of Victoria

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Coroners Court of Victoria

6 May 2014

The Honourable Robert Clark MP
121 Exhibition Street
Melbourne 3000

Dear Attorney-General

In accordance with the requirements under Section 102 of the Coroners Act 2008, I am pleased to present the 2012-13 Annual Report of the Coroners Court of Victoria.

The report sets out the court's functions, duties, performance and operations during the year under review from 1 July 2012 to 30 June 2013.

Yours sincerely

Judge Ian Gray
State Coroner

Report from the State Coroner

I am pleased to present my first Annual Report on the operations of the Coroners Court of Victoria, with this publication marking the fourth Annual Report produced by the court since the introduction of the *Coroners Act 2008*.

During the reporting period, the findings and recommendations of my fellow colleagues has helped drive significant change and legislative reform aimed at reducing the number of preventable deaths in our community. Of the total 4455 written findings delivered by Victoria coroners, many identified opportunities for reform which have been put into action across a range of health and safety sectors across the State.

Coronial investigations resulted in the preparation of legislative amendments to the *Domestic Animals Act 1994* (Vic) following the finding and recommendations made by a coroner in respect of the death of a 3-year-old girl after she was the subject of a dog attack in her own home. Following the finding, the Minister for Agriculture and Food Security agreed to legislate within the next reporting period to prohibit the breeding of restricted breed dogs as well as further supporting recommendations requiring veterinary surgeons to mandatorily report restricted breed dogs that are unregistered, unneutered and not micro-chipped.

The Department of Education and Early Childhood Development also agreed to conduct a review the 2006 Anaphylaxis Guidelines for Victorian Government Schools following a finding and recommendations made by a coroner following the death of a 13-year-old boy attending a school camp.

Extensive inquiries are also underway in respect of the increasing number of deaths reported from acute methadone toxicity where the source of the methadone was a 'take-away' dose dispensed by pharmacists after being prescribed by doctors for the treatment of drug addiction. The court has recorded a sizable 35 per cent increase in these types of deaths within a 12-month period, and a number of investigations considering the current standards, policies, legislation and practices surrounding the prescribing and dispensing of take-away methadone have commenced.

In total, 71 coronial findings contained recommendations, with the total number of recommendations made within the reporting period being 243. This is an increase of 26 recommendations compared to the same time last year.

These achievements are just one indication of the amount of work that has been undertaken by coroners and staff across the court throughout the reporting period. This work is also demonstrated by the significant number of cases opened by the court in 2012-13, which included 864 more lodgements than in the previous reporting period. In addition to this, the court closed 608 more cases in 2012-13 than it did in the previous reporting period.

In late 2012 the court began the process of evaluating its existing operating model. A thorough examination of the Court's structure and finance was undertaken.

I would like to record my gratitude to members of the Victorian Institute of Forensic Medicine, and in particular to Director Stephen Cordner, who continue to provide outstanding forensic investigative services and support to this jurisdiction. I extend my sincere thanks to those members of the Police Coronial Support Unit of Victoria Police who assist coroners in and out of court on a daily basis, and to those investigating police members without whose contributions much of our work would not be possible.

I acknowledge the dedication and commitment of our court staff who continue to demonstrate high levels of professionalism and resourcefulness in sometimes extremely difficult circumstances. In particular I thank the Court's Chief Executive Officer, Samantha Hauge and Principal Registrar, Margaret Craddock.

Lastly, I extend my gratitude to my predecessor Justice Jennifer Coate and my fellow coroners who welcomed me warmly into this jurisdiction. I thank them for their tireless dedication to the work of the court.

Judge Ian Gray
State Coroner

Report from the CEO

It is with pleasure that I report on the administration of the Coroners Court of Victoria. This reporting period has resulted in a number of defining moments for the Coroners Court. In November 2012, consultancy firm Ernst & Young was engaged to undertake a review of the court's existing service model and business processes. The firm was tasked with the brief to consider improvements to the overall efficiency of the Victorian coronial jurisdiction within a financially sustainable framework. This was a much-welcomed review.

In February 2013, I announced the new proposed operating model, and the process of consultation pursuant to clause 10 of the *Victorian Public Service Workplace Determination 2012* commenced. We engaged in a consultation process with the staff and the Community and Public Sector Union in relation to the proposed changes.

In June 2013, I announced the final new operating model which will be implemented on 1 August 2013.

The new operating model provides a greater focus on improving services to the Victorian community by aligning the skills of staff with core requirements set out in the *Coroners Act 2008*. It also creates increased support for coroners and better integration of service delivery across the organisation and with the Victorian Institute of Forensic Medicine.

In addition to the new operating model, the court is currently in the process of working closely with the Department of Justice with a view to restructuring some budget allocations to better reflect the actual cost of providing our services to the Victorian community.

The court is also working to identify other areas where cost efficiencies can be gained to ensure our operations reflect value for money both now and well into the future.

In the 2012-13 reporting period, the court recorded a deficit of $1.5 million. While the court accepts that greater work must be undertaken in order to bring its actual spend in line with its allocated budget, $1.4 million less than that reported in 2010-11.

An area of significant cost to the court identified in the previous reports was the out sourcing of some legal expertise to external law firms. The Department of Justice approved a pilot program to employ two in-house solicitors in July 2011. The successful pilot period was completed in the previous reporting period and the service confirmed as part of the new operating model for the court. This service has been of immense value not only to all court stakeholders, but in particular to families who are often required to attend and participate in coronial inquests without the benefit of their own legal representation.

Also of significant note was the beyondblue grant awarded to the court in March 2013. The grant forms part of the beyondblue Victorian Centre of Excellence in Depression and Anxiety and will allow the court, in collaboration with Melbourne University, to conduct a two year study aimed at increasing understandings of the presence and patterns of service contact in suspected suicide deaths. The study aims to strengthen service engagements for people at risk of suicide and will be of immense benefit to the Victorian community.

It must be acknowledged that all our successes would not be possible without the ongoing contribution of our court staff. The reporting period provided a number of challenges particularly during the operational review period. I sincerely thank all the staff for their patience, contribution and professionalism through this time. In addition, the care and compassion they provide to the families we work with is exceptional.

This is my first report as CEO of the court, following my appointment in February 2013 and I would like to express my gratitude to my predecessor, Judy Leitch for her guidance, exceptional work ethic and unwavering dedication to this jurisdiction.

Lastly I extend my deep appreciation to State Coroner Judge Ian Gray for his leadership and encouragement during this most challenging year for the Coroners Court of Victoria.

Samantha Hauge
Chief Executive Officer

The Coroners Court of Victoria

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

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

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

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

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

Preamble to the *Coroners Act 2008*

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

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

Objectives of the *Coroners Act 2008*

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

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

Jurisdiction

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

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

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

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

Reportable deaths

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

During the reporting period, there were 4903 deaths reported to the coroner, an increase of 177 reportable deaths in previous reporting period.

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

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

Reviewable deaths

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

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

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

During the reporting period there were five* reviewable deaths reported to the court, the same number of reviewable deaths as recorded in the previous reporting period.

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

Fires

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

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

During the reporting period, there were 22 fires with death reported to the court, a decrease of six fires with death recorded in the previous reporting period.

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

Structure and organisation of the Coroners Court of Victoria

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

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

The Coroners

State Coroner
Judge Ian Gray

Deputy State Coroner
Mr Iain West

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

Regional Coroners
Ms Jacinta Heffey (based in Melbourne).

Many magistrates in regional Victoria are also appointed as coroners and will usually perform the functions of a coroner when necessary in the region.

Court Administration

Chief Executive Officer
Samantha Hauge

Initial Investigations Office
Manager: Kellie King

Registry
Principal Registrar: Margaret Craddock

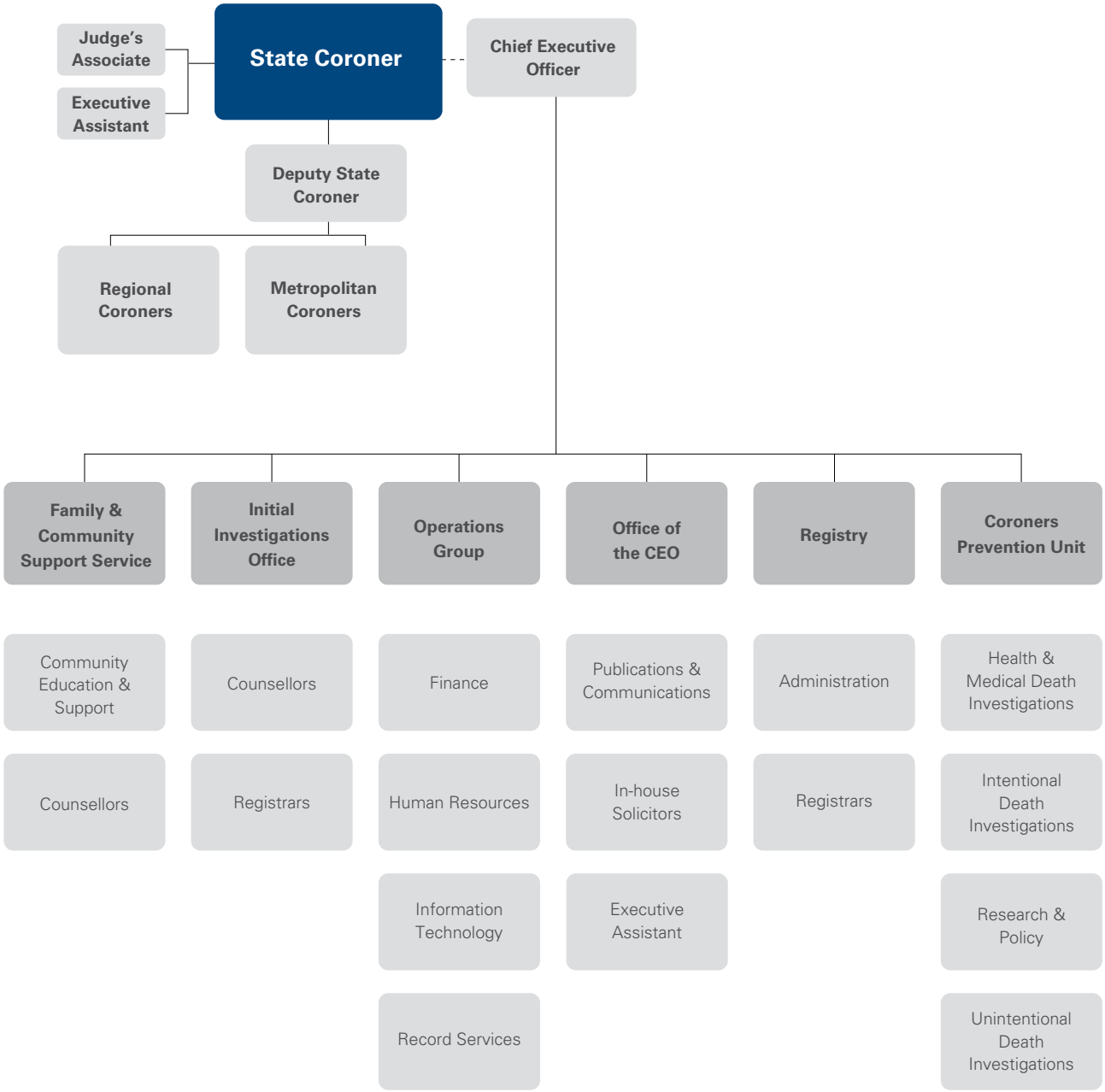
Coroners Prevention Unit
Acting Manager: Lyndal Bugjea

Family and Community Support Services
Manager: Laetitia Du Toit

In House Solicitor Service
Principle Solicitor: Jacqui Hawkins

Operations Group
Acting Manager: Lyndal Bugjea

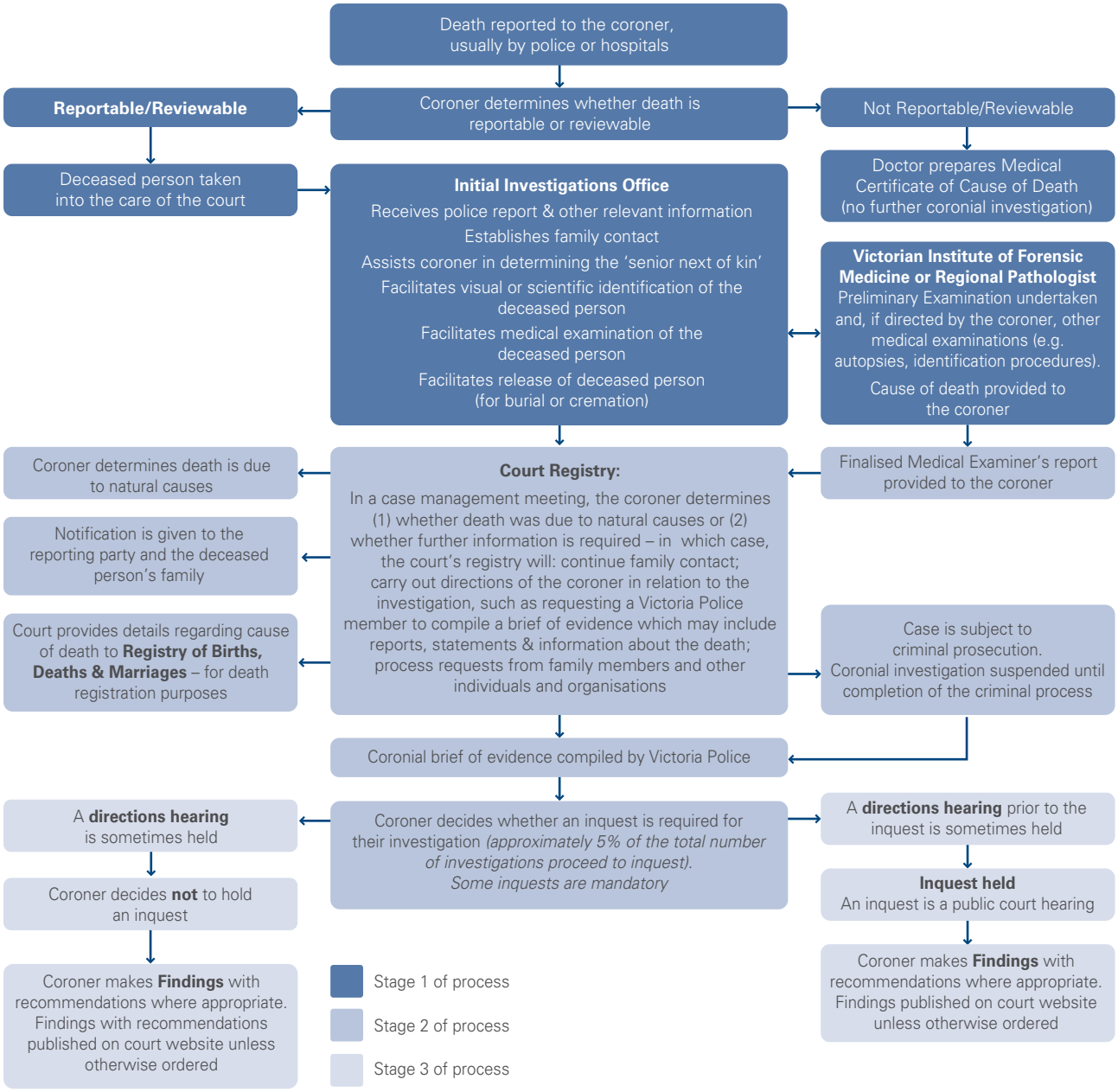
Organisational Chart



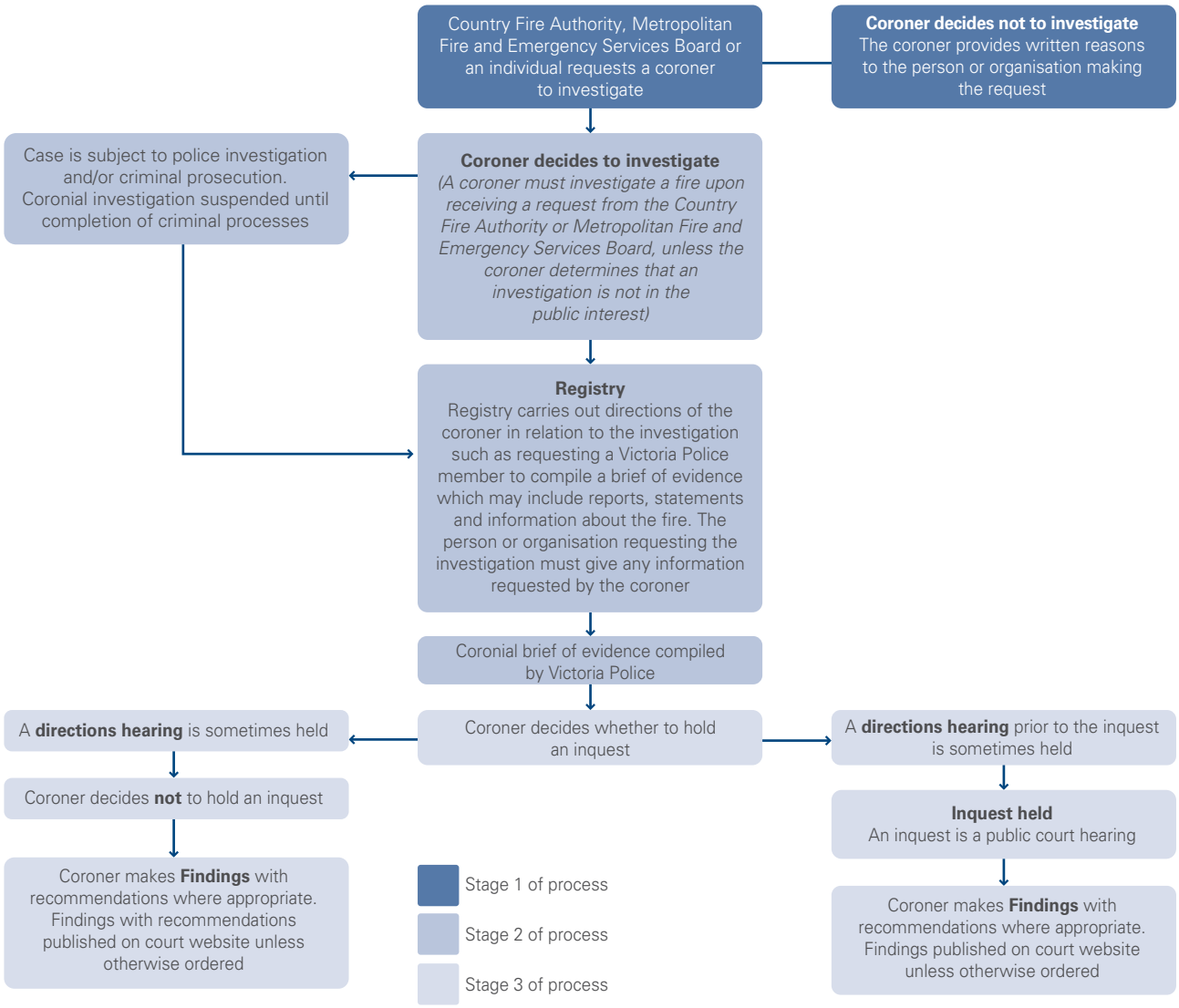
Coronial processes

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

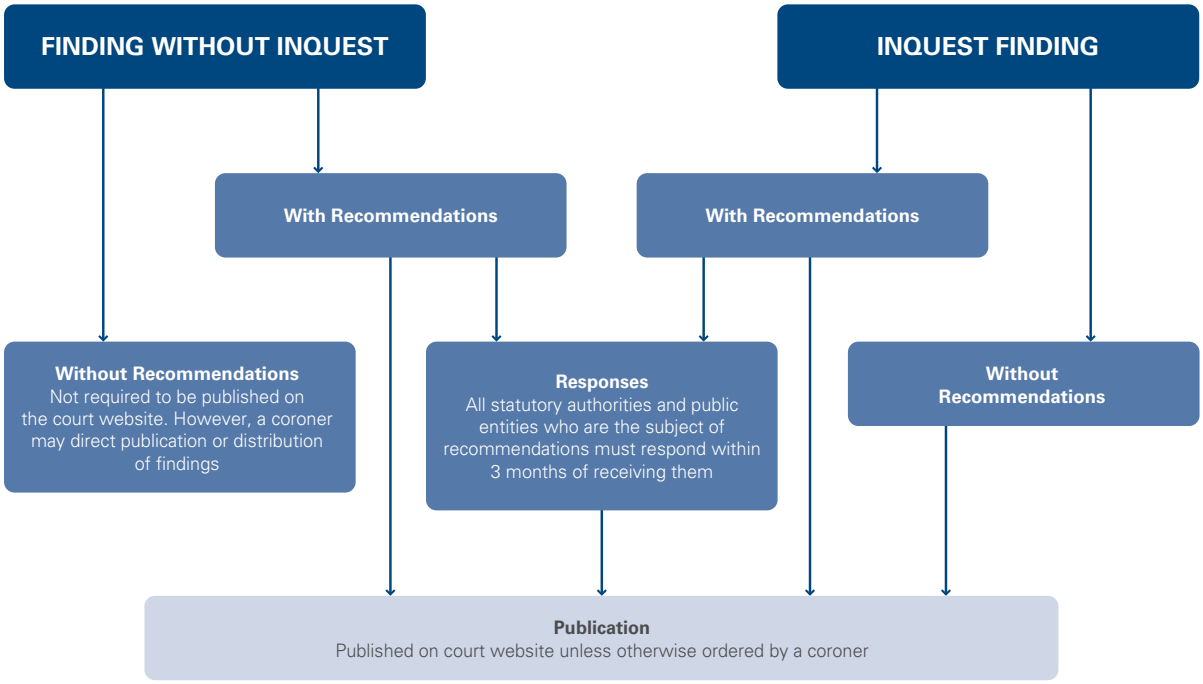
In order to achieve this, the court has established a number of processes allowing different areas within the court and services provided to the court to work together to investigate deaths and fires throughout each stage of the coronial process, as follows:



The coronial process – when fire without death occurs



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



Highlights and initiatives

Site redevelopment

Significant works on the new Coroners Court building at Kavanagh Street, Southbank, continued throughout the reporting period.

Refurbishment of the existing court rooms continued with roofing and services installation to the link-way connecting the Victorian Institute of Forensic Medicine and the court.

The last section of the main building ground slab was also completed and the erection of the structural steel roof is underway.

In addition, the old Initial Investigations (IIO) office was demolished in order to build an improved mortuary office space. During this period IIO staff were relocated to a first floor within the Victorian Institute of Forensic Medicine.

Impact on community and stakeholders

As noted in the previous reporting period, the requirement for IIO staff to be temporarily relocated impacted upon family members and other stakeholders attending the premises. Staff were required to be located away from the mortuary and limited parking for families remained an ongoing issue whilst active redevelopment works continued on site.

Funeral directors attending the premises were also impacted at times as a result of shared or limited driveway access.

Every effort was made to ensure that the impact of these issues were managed to minimise any detriment to services, where possible. The court would like to thank and acknowledge the patience and understanding shown by so many during these necessary but challenging periods.

Victorian Coronial Council

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

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

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

Statutory members include:

- State Coroner Judge Ian Gray
- Victorian Institute of Forensic Medicine Director Professor Stephen Cordner
- Victoria Police Deputy Commissioner Graham Ashton

Non-statutory members include:

- Professor Katherine McCrath (Chairperson)
- Judge James Duggan (Chairperson to May 2013)
- Mr Stephen Dimopoulos (to November 2013)
- Dr Ian Freckelton SC
- Mr Chris Hall
- Dr Sally Wilkins
- Dr Rob Roseby

The Council met on eight occasions during the 2012-13 financial year.

During the reporting period, the Council examined the issue of providing legal representation at coronial inquests following a submission by a member of the public and investigated options for obtaining legal representation at coronial inquests. The Council is developing a paper which will include a proposal for amending legislation to grant coroners the power to appoint legal aid to families in specific cases. Further work is proposed on this issue in the coming year.

During reporting period, the Council continued its work on exploring ways to improve the quality of suicide data and enhance the preventive function of Victoria's coroners. A draft report has been prepared and will be circulated to those the Council believes to be interested in providing feedback on the report.

In 2012-13 the Council also undertook work to develop its own website presence. Initially the Council's information appeared within the Coroners Court of Victoria website. As the entities are completely independent of each other, it was considered important that this be reflected publicly in the Council's website. The Council has since obtained its own site area which went 'live' in October 2012.

Court Network at the Coroners Court

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

Court Network is a unique court support service solely concerned with the needs of court users with information, support and referral services provided by more than 400 trained volunteers.

Court Networkers support family members and friends of the deceased person by attending court proceedings in the coronial jurisdiction and support around 1842 court users per year.

In-house Solicitor Service

The Police Coronial Support Unit (PCSU) provides assistance to coroners in a significant number of coronial investigations that proceed to inquest.

However, in any coronial investigation where the conduct of police will or may come under scrutiny, the coroner will not seek the assistance of PCSU to avoid any possible conflict of interest. Such matters include where a death has occurred in police presence, or as a result of a police shooting or pursuit or while the person was in police custody, or was being taken into police custody. Historically the assistance needed by coroners during the course of these investigations and inquests has been outsourced to external law firms, including the Victoria Government Solicitors Office.

As indicated in the previous annual report, the Department of Justice approved a pilot program to employ two in-house solicitors and in July 2011, the court welcomed Jacqui Hawkins and Sarah Gebert as Principal and Senior In-House Solicitors respectively to the court.

In the reporting period, the pilot program was completed and the In-house Solicitor Service has now assumed the conduct of all potential conflict matters. During the past financial year, the In-House Solicitor Service has appeared in:

- six inquests as Counsel Assisting the Coroner
- 36 directions hearings as Counsel Assisting the Coroner
- 23 inquests as the Instructing Solicitor
- 6 Supreme Court appeal matters
- 1 High Court appeal
- provided 92 separate complex legal briefings to coroners across the state
- participated in ongoing professional development for coroners.

In addition, the In-House Solicitor Service has assisted with the preparation of a range of other complex legal documents, liaised extensively with the legal profession, hospitals, police and families and given guidance to court staff on a range of legal issues.

The In-House Solicitor Service has greatly assisted coroners in their proceedings and afforded the court a greater capacity to provide and retain a high level of expert legal knowledge specific to the coronial jurisdiction.

This service is of immense value to all court stakeholders, but in particular, to families who are often required to attend and participate in coronial inquests without the benefit of their own legal representation.

Roving regional coroner

In regional Victoria, 20 magistrates also hold the office of coroner, conducting about 1200 coronial investigations each year.

In order to further support the work of regional magistrates, Sessional Acting Magistrate Jacinta Heffey was made available in August 2011 to exclusively perform coronial work for regional Victoria on a part-time basis.

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

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

In the reporting period Magistrate Heffey finalised nine complex inquest matters and continued extensive investigations on a further 27 open coronial matters.

Natural cause triage system

In the 2012-13 reporting period the court implemented formal procedures to officially imbed the natural cause triage system into its coronial case management.

As previously reported, the court wished to create greater efficiencies for families by expediting investigations into deaths found to be the result of natural causes in situations where a medical investigator has provided a report to the coroner that includes an opinion that the death was the result of natural causes.

As a result, the natural cause triage system was created, and involved families being notified in writing that the cause of death was the result of natural causes and that the coroner did not intend to investigate further. Families received an opportunity to raise any concerns in relation to the death of their loved one and, where no concerns were raised, the system aimed to finalise those investigations within 21 days.

In the 2012-13 reporting period, the court introduced a variation to a specific form within its CourtView case management system that now provides a formal option in which coroners may consider natural cause triage at the earliest opportunity during the first meeting between the duty coroner and a pathologist.

With approximately half of all deaths reported to the court each resulting in a finding of natural causes, this system represents a significant gain in improving time delays in case closures for families who would have otherwise been subjected to a longer and more protracted process.

The natural cause system has not only assisted families by allowing faster resolution of the investigations into the deaths of their loved ones, it has also allowed the court to direct its resources to those matters that, due to the cause and circumstances of the deaths, require more a complex investigation.

Coronial investigations

Coronial findings

A coroner investigating a reportable death under section 67 of the *Coroners Act 2008* (the Act) must find, if possible:

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

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

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

Coroners delivered 4455 findings in the 2012-13 financial year. For a full breakdown of findings figures see page 43.

Coronial recommendations

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

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

In the 2012-13 reporting period there were 71 coronial findings which contained recommendations. For a full breakdown of recommendation statistics see page 43.

Investigations of significant public interest

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

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

Black Saturday Bushfire deaths

During the reporting period, all the investigations into the deaths of those who died during the 2009 Black Saturday Bushfires were completed.

The investigations into the cause and origin of some of those fires remain suspended. This is because they remain the subject of ongoing criminal or civil proceedings in other jurisdictions. Suspending the coronial investigations ensures the court does not interfere with the administration of justice. The coronial matters which remain suspended include:

- *Churchill fires* – A 41-year-old man was convicted of arson related offences in relation to these fires. The court is now awaiting the receipt of the brief of evidence and will resume its investigations into the cause and origin of this fire within the next financial year. Eleven people died in the Churchill fires.
- *Kilmore East fires* – The circumstances of this fire remains the subject of civil proceedings in the Supreme Court of Victoria. The court will await the outcome of those proceedings before resuming its investigation into the cause and origin of the Kilmore East fires. The Kilmore East Fires claimed the lives of 119 people.
- *Murrindindi fires* – The circumstances of this fire remains the subject of civil proceedings in the Supreme Court of Victoria. The court will await the outcome those proceedings before resuming its investigation into the cause and origin of the Murrindindi fires. The Murrindindi fires claimed the lives of 40 people.

Level crossing deaths

The investigations into the deaths of 29 people who died in collisions between trains and vehicles at level crossings across Victoria continued during the reporting period.

The investigations into these deaths have focused on two main areas of inquiry including the emergency response and road and rail infrastructure issues.

- *Kerang* – The inquest into the 11 Kerang Level Crossing deaths concluded during the previous financial year following a further 27 days of hearings. The coroner expects to be in a position to hand down her written finding in October 2013

- *Tyabb* – A four-day inquest was held in May 2012 into the death of a 32-year-old woman who died when her vehicle was struck by a Connex diesel locomotive in Tyabb in January 2008. In August 2013, the coroner delivered her written finding and found that the cause of the collision was driver error. She found that the bells and lights at the level crossing were in operation and functioning at the time, but that for reasons that could not be determined, the driver either did not hear or notice the warning signals until it was too late.
- *Edithvale* – A two-day inquest was held in January and February 2012 into the death of a 24-year-old man who died when his car was struck by a Connex train at a level crossing in Edithvale in July 2009. In July 2012, the coroner delivered her written finding and found that the cause of the collision was predominately due to sun glare which momentarily blinded the driver as he turned left into the level crossing.
- *Trawalla* – Investigations into the deaths of a man and woman, who were occupants of a VicRail sprinter train that collided with a semi-trailer at Trawalla in April 2006, were adjourned following two directions hearings in October 2011 after the court was advised that the circumstances of the death were the subject of civil action proceedings in the Supreme Court. These matters were resolved during the reporting period and the coronial investigation into the death has resumed with a further direction hearing scheduled for November 2013.

Youth suicides

Investigations into a cluster of youth suicides continued in the reporting year, with the Coroners Prevention Unit continuing its extensive research regarding potential systemic issues unique to youth suicides. Significant work has been undertaken to determine relevant witnesses and experts who may assist the court to examine the deaths with the context of:

- bullying and cyber-bullying
- suicide contagion from exposure to suicide of persons in the social network
- media reporting of suicide.

A direction hearing is expected to be held in connection to these deaths within the next financial year.

Anaphylaxis management

During the reporting period, further investigations were undertaken in relation to the death of a 15-year-old teenage boy who experienced an anaphylactic reaction to nuts at a go-karting centre in September 2009.

A directions hearing is scheduled for August 2013 and it is expected that the coroner will examine issues regarding the safety and labelling of food packaging.

This investigation follows a finding handed down in the previous reporting period regarding the death a 13-year-old boy who died from anaphylaxis after ingesting a beef satay ration pack whilst on a school army cadet camp. This matter is reported on further on page 24.

Failure to report reportable deaths to a coroner

The inquest into the death of a of a 30-year-old man who whose death sparked a broader investigation into the issue of under reporting of deaths to the Coroners Court of Victoria was finalised in the 2012-13 reporting period.

The man had died from complications related to a drug overdose and the unnatural circumstances of his death constituted a reportable death under Section 4 of the *Coroners Act 2008*. The man was also on a Community Treatment Order at the time of his death, meaning his death was arguably reportable under section 4(2)(d) of the Act as a person who immediately before death was a patient within the meaning of the *Mental Health Act 1986*.

The death was not reported to the court by a doctor or any other hospital staff member and eventually came to the attention of the court following a notification by the Registry of Births Deaths and Marriages who identified that the death should have been reported.

An inquest held into the death in May 2012 examined whether doctors fully understand their legal obligation to report certain deaths to the court and whether they understand how to write an adequate death certificate.

The coroner, in delivering her finding, found that the death highlighted the need for further education and awareness within the medical profession about their obligations to report a death to the coroner.

The coroner further found that inaccurate completion of death certificates may result in a number of complications including:

- poor understanding by the family of the cause of their loved one's death
- impact upon the accuracy of mortality data, particularly in relation to deaths connected to falls
- leads to an unnecessary investigation of a death or prevents an investigation of a death where the circumstances of the death were such that an investigation should have occurred.

In addition to her findings, the coroner also made a number of recommendations including:

- the Department of Health consider communicating that all hospitals and health services should have appropriate programs, policies and procedures to ensure medical practitioners in their employ are educated and made aware of their legal obligations to report deaths that are reportable to the coroner
- the Medical Board of Australia – Victorian Division consider communicating to their members that medical practitioners should be reminded of their responsibility to understand their own personal legal obligations to report deaths that are reportable to the coroner
- that the Registrar of the Registry of Births, Deaths and Marriages considers amending the guidelines on the medical certificate of the cause of death to draw specific attention to the two common key omissions in deaths which are often not reported to the court – fractures and head injuries
- that the Department of Health consider communicating with hospitals and health services to implement a process of peer review of the medical cause of death by a senior medical practitioner prior to submission to the Registrar of the Registry of Births, Deaths and Marriages to minimise the possibility of medical practitioners failing to report a reportable death to the coroner.

Responses to the recommendations are due to be received within the next reporting period.

Powerboard fires

In February 2012, a coroner held her first court proceeding into two separate electrical fires.

The directions hearing touched upon a fire that burnt down a restaurant in Lygon Street, Melbourne in August 2009, while the second fire involved the death of a 12-year-old Cranbourne boy who died after a blaze broke out in the family home in December 2009.

The coroner is investigating whether overloaded and/or poorly designed powerboards had caused both fires.

A second directions hearing was held into the fires in March 2013, and the inquest is expected to begin in August 2013.

Home births

An inquest was held into the death of a baby boy who died following an attempted home birth in Clayton in December 2010.

During the proceeding the coroner heard evidence that the infant's mother had received advice from hospital staff that she should not attempt a natural home birth after her previous two pregnancies resulted in deliveries by caesarean-section. The woman attempted to birth at home with the assistance of a midwife but was transported to hospital after it became apparent that mother and baby were in difficulty. The infant died shortly after delivery.

In May 2013, the coroner delivered her written finding into the death and found:

- that the infant died from a hypoxic brain injury that occurred during the course of the labour
- that the death was preventable had the labour and delivery been undertaken in a controlled hospital setting with appropriate monitoring and medical and midwifery management
- that the failure to attend at a hospital when contractions commenced resulted in inadequate monitoring of the course of the labour and removed the opportunity to identify any complications arising and prevented early intervention, which was a contributing factor in the death
- that the failure to transfer to hospital immediately after foetal bradycardia was identified was a contributing factor in the death
- that the failure of the midwife to provide clear advice to her patient as to the risks associated with attempting a vaginal birth after caesarean in a home birth setting, sustained the misguided views of the mother which contributed to the mother disregarding the advice provided by obstetric medical clinicians
- that this conduct facilitated in the mother a level of confidence that she may safely proceed to homebirth and that this indirectly contributed to the death.

In addition to her findings, the coroner made several recommendations including:

- that the Minister for Health consider the appropriateness of regulating the practice of providing home birth services
- that the Minister for Health consider developing, in discussion with respective professional health colleges and other obstetric and midwifery experts, an information resource to enable prospective parents to be fully informed of the issues associated with the various birthing options.
- that where it is apparent that a baby is born in poor condition and unlikely to survive, that hospital maternity units adopt a protocol of retaining the placenta for pathologist examination if required (to further assist in determining the cause of death/and or when an injury or issue of compromised blood/oxygen supply which ultimately resulted in the death was sustained)

The court expects to receive responses to the recommendations early in the next reporting period.

Police pursuits

During the previous reporting period there were a number of fatal collisions reported to the court in circumstances where the deceased person was a driver or occupant of a car that was being actively pursued, or had been recently pursued by police, immediately before the collision occurred.

Deaths in police custody or whilst police are attempting to take a person into custody require mandatory inquests under the *Coroners Act 2008*, unless a person has been charged with an indictable offence in connection to the death.

In 2012-13, investigations into many of these matters were continued including the mattes relating to:

- *14 July 2011* – The death of a 39-year-old man who was the driver of a vehicle that collided with a tree off the Wangaratta-Glenrowan Rd in Wangaratta South was finalised in March 2013. The coroner found that the manner of the police pursuit did not contribute to the driver's death
- *4 December 2011* – The death of a 17-year-old girl who was a passenger in a car that lost control and crashed off the Murray-Valley Highway in Bandianna, near Albury. The circumstances of this death were the subject of a criminal proceeding. Those matters were finalised within the reporting period and the court expects to be in a position to list the matter for a coronial proceeding within the next financial year
- *17 December 2011* – The death of a 19-year-old man who was the driver of a car that lost control on Racecourse Road, Cobram. A summary inquest was held into the death in April 2013. The coroner found that the driver had a BAC of .18%, that he had also recently used cannabis and that the collision occurred 1.74km away from where the police had stopped their vehicle. The coroner found that the police had acted in accordance with their policies and procedures and that their actions did not contribute to the death

- *10 January 2012* – The death of a 19-year-old man who was a passenger in a car that lost control and collided with a guardrail on Stud Road, Dandenong. This death was the subject of criminal proceedings which were resolved in the reporting period. Sentencing remarks from the criminal proceeding are expected to be provided to the court in July 2013. The coronial investigation into this death will resume following receipt of the sentencing remarks and the finalisation of the brief of evidence

- *21 January 2012* – The death of a 42-year-old man who was the driver of a vehicle that collided with another car whilst driving down the wrong side of the Princes Freeway in Morwell. The 26-year-old driver of the vehicle he struck also died as a result of the collision. The court received the brief of evidence for this matter in March 2013 and the investigation is continuing

- *26 January 2012* – The death of a 27-year-old man who was the driver of a car that struck a power pole in Hoddle Street, Collingwood. The court received the brief of evidence in September 2012 and other additional information requested by the coroner in December 2012. The investigation into the circumstances of this death will continue in the next financial year

- *30 April 2012* – The death of a 32-year-man who was the driver of a motorcycle that collided with a sign on Blackburn Road, Mount Waverley. The court received the brief of evidence for this matter in April 2013 and has listed the case for a Summary Inquest in November 2013

- *June 2012* – The death of a 24-year-old man who was the driver of a car that lost control and crashed off the Bendigo-Maryborough Rd near the Bradford Road intersection in Shelbourne East. The court received the brief of evidence in relation to this matter in June 2013. The investigation into the circumstances of the death will continue in the next financial year

In addition to the above investigations, the court also received one further report relating to a police pursuit in the 2012-13 reporting period. This involved the death of a 37-year-old Darley man on 6 August 2012. He was the driver and sole occupant of a vehicle that collided with a truck at the intersection of Annadale Road and Lembeck Drive, Sunbury. The court is awaiting the receipt of the brief of evidence from police before further advancing the investigation.

Transplant recipients deaths

During the reporting period, a coroner finalised the investigation into the deaths of three donor transplant recipients and the donor with the delivering of a finding in May 2013.

These deaths occurred within a seven-day period in January 2007 and subsequent investigations indicated that the common thread was that each of the three deceased had received an organ from an organ donor who had died in December 2006.

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

The virus is not thought to be fatal if contracted by an otherwise healthy person, but evidence suggests in can be particularly dangerous if contracted by persons with weak or suppressed immune systems. It is common for transplant recipients to have their immune systems medically suppressed in order to decrease chances of the body rejecting the transplanted organs.

Issues considered during the inquest included:

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

In concluding her investigation the coroner found that:

- the Arena Virus is rare and at the time of the deaths it had not been previously seen in Victoria, nor has it been seen since
- that due to its noval status, it is not screened for as part of the normal tests conducted to identify suitable donors and nor was there any equipment in Victoria that would allow for the virus to be identified
- that in those circumstances, the selecting of the donor was reasonable and that his carrying the virus was not foreseeable and therefore transplant recipients contracting the virus through the donated organs could not have been prevented
- that the nature of the Arena Virus is such that the coroner was not able to determine that an earlier detection would have altered the outcome for the donor recipients.

Throughout the inquest, the coroner heard evidence that communication between the hospitals who were caring for the transplant recipients and between the hospitals and the families when their conditions began to deteriorate was not optimal. She subsequently made a number of recommendations including:

- that Donate Life be authorised by hospitals performing transplant surgery to extend their liaison role in the post transplant period to accept responsibility for intra and inter hospital communications regarding their progress and/or unusual symptoms/complications of donor organ recipients in circumstances where there were more than one recipient of organs from a single donor
- that Donate Life commence this liaison with the transplant teams for seven days post operatively and continue the intra and inter hospital communication every 48 hours until the recipient has been discharged
- in circumstances where it is more appropriate that a sage physician rather than a transplant co-ordinator, commence the liaison, that each hospital nominate who is the designated contact person for Donate Life to communicate with.

Responses to the coroner's recommendations are due to be received within the next reporting period.

Psychiatric and medical care

During the reporting period a coroner finalised the investigation into the death of a 59-year-old St Albans woman who was admitted into an acute adult psychgeriatric nursing home for treatment.

During her admission it became apparent she had developed polydipsia, or excessive thirst and/or compulsive drinking behaviour, which was largely treated by staff as part of her behavioural condition rather than a physiological issue.

However, the woman was also prescribed lithium, a drug well established in the treatment of mental illness, but which is also known to contribute to renal failure if taken in large amounts, and/or if the person taking the medication already suffers from a compromised renal function. Symptoms of renal failure often manifest as a compulsive thirst and desire to drink.

The coroner found that the cause of the woman's death was preventable and that she died from a metabolic disturbance and bronchopneumonia secondary to renal impairment and lithium toxicity.

She further found that the triad of lithium, olanzapine and valproate is commonly encountered in the treatment of people with bipolar disorder and that understanding the nature of these drugs, their interactions, and the need for monitoring of renal function and other clinical parameters, should be fundamental competencies for all clinical staff practicing in psychigeriatric nursing homes.

The coroner stated that in this case, the clinical management of the woman was shared between a GP who provided medical management and a psychiatric registrar who was providing psychiatric management and that there was a need for good communication between the two to ensure that treatment did not occur in a vacuum.

During the evidence, the hospital provided information that since the woman's death they had implemented a number of changes to procedures including:

- a more detailed triage before residents are accepted into the unit in order to understand their particular needs and whether those can be met
- a holistic review of the resident within two-three weeks of admission
- a focus on individualised clinical management throughout.

The coroner supported the changes made and further commented that had the new paradigm been operational at the time of the woman's death, the potential for her condition, and therefore clinical outcome, to have been identified would have been greatly increased.

Prison psychiatric care and prison cell design

During the reporting period, a coroner finalised his investigation into the death of a 29-year-old man who died from intentional self-harm hanging whilst incarnated at Port Phillip Prison in March 2008.

The man was known to have made six earlier attempts to take his own life whilst not in prison and made a further attempt whilst initially being held at the Melbourne Assessment Prison prior to being moved to Port Phillip Prison.

The coroner's investigation considered a number of issues including:

- the processes undertaken on his admission to Port Phillip Prison
- the conflicting views from staff regarding his mental health presentation whilst at Port Phillip Prison
- system failures which resulted in the failure of Port Phillip Prison staff receiving his individual management file which included details of his self-harm attempt whilst at the Melbourne Assessment Prison
- Correctional Services and Department of Justice policies regarding prisoner administered opiate substitute programs
- Correctional Services and Department of Justice polices concerning the employment of psychologists who do not have registration with the Psychology Board of Australia making recommendations concerning the suicide risk and mental state evaluation of prisoners within a prison setting
- the building design within the Scarborough South Unit in Port Phillip Prison in relation to known hanging points.

The coroner found that the man's death was preventable and that:

- it was highly unsatisfactory that the prison cell in which the man was admitted was designed in such a way in that it unintentionally created many hanging points, to which could be used by a person to take their own life
- that known 'at risk' prisoners should not be placed in such cells and the design of such cells should be addressed as soon as possible
- there were failures of several arrangements for the man to be seen by responsible clinicians over the 10 day period he was incarcerated at Port Phillip Prison
- that a non-clinically certified psychologist was involved in the decision to downgrade his suicide risk and that this occurred without reference to a psychiatric review
- that some note taking and records appeared to have been deceptive in an attempt to disguise the failures and/or omissions in his treatment.

The coroner went on to make a total of 15 recommendations some of which included:

- that only psychologists who obtain endorsement as clinical psychologists from the Psychology Board of Australia be permitted to undertake suicide risk assessment evaluations in the Melbourne Assessment Prison and Port Phillip Prison
- that Correction Services and the Department of Justice review policies regarding prisoner administered opiate substitute programs
- that a review be undertaken of the design of prison cells, in the context of their use for potential hanging points within the Port Philip Prison.

Developments in public health and safety

Improvements to Anaphylaxis Policy

In June 2012 a coroner found that despite the body of information on allergies and anaphylaxis available at the time, a secondary school had failed to comprehend the seriousness of peanut allergy, which contributed to the death of a 13-year-old boy attending a school camp. The boy was provided with a beef satay meal as part of the camp ration packs.

The coroner also found that the death could have been prevented had the school exercised reasonable care and attention to the obtaining and distribution of the cadet camp ration packs in light of the medication information that was known to them.

The coroner recommended that:

- the Department of Education and Early Childhood Development (DEECD) review the 2006 Anaphylaxis Guidelines for Victorian Government Schools
- the DEECD provide specific guidance to schools with respect to purchasing spare adrenaline auto-injection devices for first aid kits
- the Minister for Education introduce a requirement that all schools complete an annual risk management checklist to ensure compliance with legislative requirements
- the secondary college revise their student action management plan to incorporate strategies to prevent allergen exposure.

In July 2012, the secondary school provided a response to the coroner that in the period between the date of the death and the delivery of the recommendations, it had already undertaken a review of its student action management plan to incorporate strategies to prevent exposures to allergens for students both in and out of school settings.

The school further advised that, in accordance with the coroner's recommendations, that they would continue to review the action plan on an annual basis.

In response to the coroner's recommendations, DEECD advised that:

- there would be a review conducted of the guidelines, which they anticipated would be in place by the Victorian school term 1, 2013
- that the redraft would be in accordance with the following structure:
  - Introduction
  - Relevant Medical Information about Anaphylaxis
  - Legal Obligations (pursuant to the Act and Ministerial Order 90)
  - Anaphylaxis Management Policy (Part two of Ministerial Order 90)
  - Individual Anaphylaxis Management Plans (Part three of Ministerial Order 90)
  - Communication Plans (Part four of Ministerial Order 90)
  - Emergency Response (cl. 9 (f) of Ministerial Order 90)
  - Additional Obligations, including:
    - Purchase of additional adrenaline auto injector device/s
    - Annual Anaphylaxis Risk Management Checklist
  - Roles and Responsibilities
  - FAQs

The DEECD also recognised the need to amend Ministerial Order 90 to enable the revised guidelines and the Ministerial Order to be consistent. In doing so, the DEECD stated that this would allow the Victorian Registration and Regulation Authority to maintain and enforce compliance by all registered schools.

The DEECD further advised that once completed, they would engage in a communication strategy to ensure that all schools were aware of the revised guidelines.

Take-away methadone deaths

During the reporting period, the court received an increasing number of deaths reported from acute methadone toxicity where the source of the methadone was a 'take-away' dose dispensed by pharmacists after being prescribed by doctors for the treatment of drug addiction.

In 2011 there were 72 deaths of this type reported to the court, an increase from 52 deaths in 2010. This represents a 35 per cent increase in a 12-month period.

Investigations into these deaths will continue during the 2012-13 financial year with a number of matters proceeding to inquest.

Issues likely to be examined by coroners include:

- risk management assessments undertaken by doctors and pharmacists when prescribing and dispensing take-away doses of methadone
- co-prescription of take-away methadone with other drugs
- current standards, policies, legislation and practices surrounding the prescribing and dispensing of take-away methadone.

Co-sleeping

In the 2012-13 reporting period, the court received responses to recommendations relating to a cluster investigation involving the death of a number of infants who died in a co-sleeping setting. Co-sleeping refers to the practice of an infant sharing a sleeping surface with another sleeping person.

During an inquest held in November 2011, the coroner examined a number of issues including:

- the frequency and nature of co-sleeping deaths in Victoria
- the forensic medical evidence relating to sleep-related infant deaths and the role of co-sleeping in connection to those deaths
- a review of the evidence surrounding both the risks and benefits associated with co-sleeping; and
- a review of the messaging and dissemination of health information to parents and carers about co-sleeping.

In June 2012, the coroner delivered his written findings into the deaths and found that:

- sharing a sleep surface with an infant is an inherently dangerous activity
- ideally not in the first year of life, but certainly, until six months of age, an infant must not share a sleeping environment
- there were inconsistent public health messages provided to parents regarding co-sleeping practices.

The coroner went on to make a number of recommendations including:

- that the Department of Health and Department of Education and Early Childhood develop and align public health and health promotion advice on sharing sleep surfaces with infants to those contained in the SIDS and Kids Information Statements
- That the Department of Health and Department of Education and Early Childhood deliver consistent health and health promotion advice to caregivers on safe sleep practices for infants during a number of development milestones throughout pre and post-natal periods.

In August 2012, the Department of Education and Early Childhood provided a response to the coroner that they had undertaken significant work within the past four years to reduce the incidents of SIDS and fatal infant sleeping incidents, including the development of the Safe Sleeping Checklist in partnership with SIDS and Kids. The department further advised that they would continue to work with SIDS and Kids to implement the Safe Sleeping Checklist and would update the information in line with the coroner's recommendations.

In October 2012, the Department of Health provided a response to the coroner's recommendations advising that the recommendations were under consideration.

Dog Attack

An inquest was completed in August 2012 regarding the death of a 3-year-old girl who died from a dog attack in her family home in August 2011. In September 2012, the coroner delivered her finding into the death and found:

- that girl's deaths was preventable
- that the dog responsible for her death was a restricted breed Pit-bull Terrier
- that the father and son owners of the dog contributed to the death by their failure to comply with the law as it relates to restricted breed dogs
- that the father and son owners of the dog contributed to the death by deliberately owning and concealing a restricted breed dog from relevant authorities

- that the father and son owners of the dog contributed to the death by failing to provide containment of the dog in accordance with the legislation and regulations as they relate to restricted breed dogs
- that the failure of the owners of the dog to secure it in a manner which would prevent escape was a contributing factor in the death
- that the actions of a man who knowingly bred and supplied a restricted breed dog contributed to the death.

In addition to her findings, the coroner made a number of recommendations including:

- that the Victorian Parliament legislate to expressly prohibit the breeding of restricted breed dogs and that a criminal sanction attach to any such breeding activity
- that the *Domestic Animals Act 1994 (Vic)* be amended to require veterinary surgeons to mandatorily report to regulatory authorities if they are called upon to treat or to attend any dog which is a restricted breed dog or may be a restricted breed, which is not registered, neutered and micro-chipped
- that the onus of establishing that a dog, suspected by regulatory authorities to be a restricted breed dog, is not a restricted breed dog, be placed on the owner of the dog and that the *Domestic Animals Act 1994 (Vic)* be amended to reflect this.

In February 2013 the Minister for Agriculture and Food Security, provided a response to the recommendations stating:

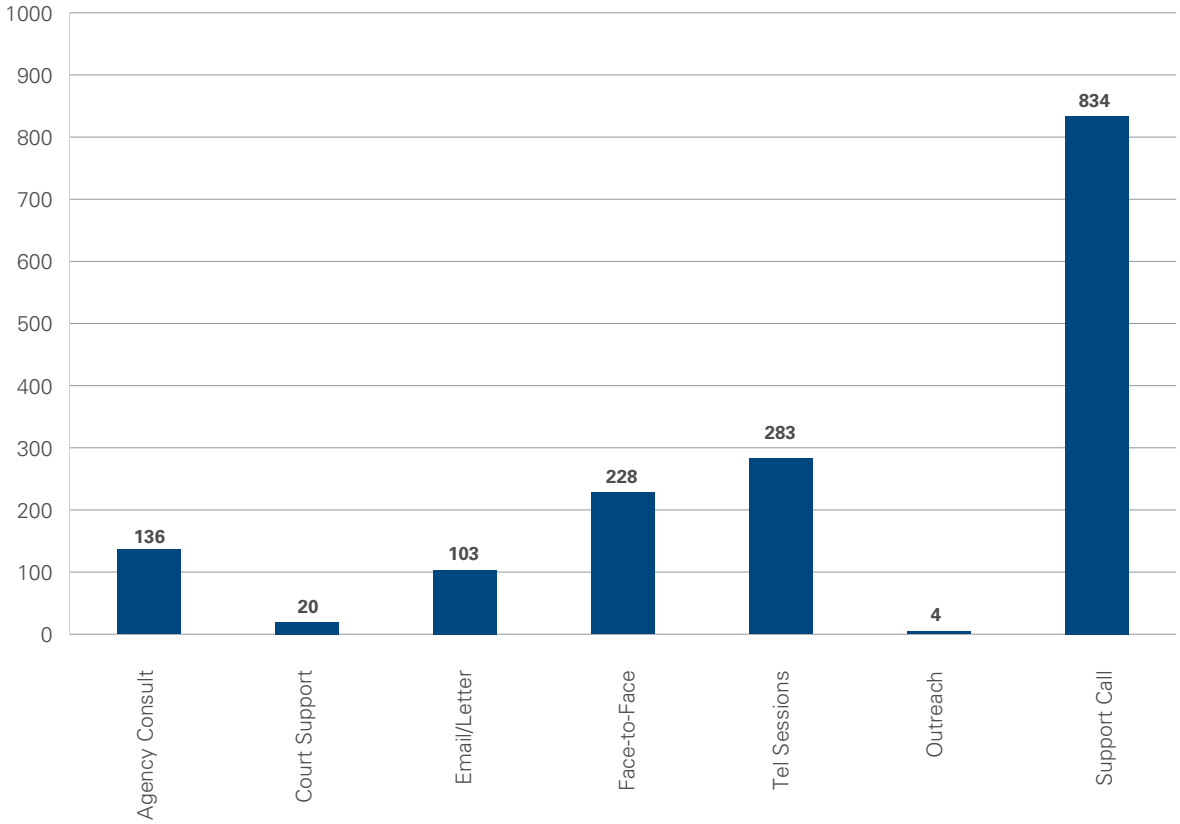
- he supported the recommendation to legislate to prohibit the breeding of restricted breed dogs and that action to incorporate amendments and penalties into the *Domestic Animals Act 1994 (Vic)* would be undertaken at the earliest opportunity
- he supported the recommendation to require veterinary surgeons to mandatorily report restricted breed dogs that are unregistered, unneutered and unmicro-chipped and would liaise with the Veterinary Practitioners Registration Board of Victoria and the Australian Veterinary Associate to determine the most effective and appropriate method for implementing the recommendation
- that he supported the recommendation to legislate to ensure that the onus of establishing whether a dog was a restricted breed dog be placed on the owner and that legislative amendments to the *Domestic Animals Act 1994 (Vic)* would be proposed at the earliest available opportunity in 2013.

Engaging the community

Supporting bereaved families

In the 2012-13 reporting period the court's Family Community Support Service undertook many contacts to assist families and friends whose loved ones' death was being investigated by the court.

Counselling sessions 1 July 2012 – 30 June 2013 (Total number of sessions 1608*)



compared with 1923 for the 2011-12 reporting period

Coroner presentations and committee membership

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

Presentations at conferences and other forums including:

- Pharmaceutical Society Forum
- Coroners Court of Victoria Information Days
- Australian Nursing Federation Conference
- Ramsay Health
- Royal Children's Hospital ("mock" Inquest)
- Family and Community Support Education Session "Aged and Palliative Care"
- LaTrobe University, School of Nursing

Membership of committees and councils, including:

- Coroners Education Steering Committee
- State Coronial Services Centre Redevelopment Steering Committee
- Courts Executive Services Steering Committee
- Victorian Institute of Forensic Medicine Council
- Australian Domestic and Family Violence Death Review Network
- Coronial Council
- National Coroners Information System Committee
- Victorian Institute of Forensic Medicine Ethics Committee

- Magistrates' Professional Development Committee
- Transport Safety Implementation Group
- Australian Coronial Heads of Jurisdiction Committee
- Coroners Court of Victoria Research Committee
- Director on the Board of Family Life
- Donor Tissue Bank of Victoria Committee

Coroners professional education

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

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

Coroners Prevention Unit presentations

Further to the court's contribution to reducing preventable deaths and promoting public health and safety, the Coroners Prevention Unit participated in a range of presentations and other community engagements including:

- "Coronial insights into understanding and preventing drug-related harms", Pharmaceutical Society of Australia
- "A coronial approach to drug-related harms", Victorian Alcohol and Drug Association
- "The coronial perspective on the relationship between law enforcement and public health", Law Enforcement and Public Health Conference
- "Coronial data on Victorian deaths involving acute drug toxicity", Yarra Drug and Health Forum
- "Investigations and the Coroner", Royal Melbourne Institute of Technology
- "Paediatric presentations to emergency departments", Judicial Collect of Victoria – Coroners Intensive
- "Young people and suicide: investigation suicide clusters in Victoria", Judicial College of Victoria – Coroners Intensive.

Website

During the reporting period, 211 new findings and 30 new rulings were uploaded onto the court website.

The court completed its work on the Coroners Court of Victoria Virtual Tour which went live in March 2013.

Launched by the Attorney-General Robert Clark and State Coroner Judge Gray, the interactive tour allows visitors to the court's website to learn about the purpose of coronial investigations and help them navigate through the court process from the time a coroner decides to hold an inquest.

The purpose of the interactive tour, made possible by a $45,000 grant from the Victoria Law Foundation, is to reduce anxiety and educate families whose death of a loved one is being investigated by a coroner as well as others who may be required to attend court to give evidence by:

- taking visitors through a step-by-step account of who will be present in court and the role they have in coronial proceedings
- explaining what happens when a person is called to give evidence
- highlighting support services available for people involved in coronial proceedings, and;
- clarifying what will occur when the coroner adjourns the hearing to prepare their written finding.

The Virtual Tour comprises an interactive Welcome page indicating the layout of a typical coronial courtroom with dropdown information 'hotspots' explaining the role of various participants and links to five specific videos.

The videos run for a combined total of 13 minutes and are targeted towards specific user groups including:

- an **Introductory** video explaining the purpose of coronial investigations and hearings
- a **Family Member** video geared specifically for families whose death of a loved one is being investigated by the court
- an **Expert Witness** video, explaining the role of expert witnesses in coronial proceedings
- a **Police Witness** video explaining the role of police in coronial investigations and proceedings
- a **General Witness** video explaining why coroners may require ordinary people to come to court and give evidence

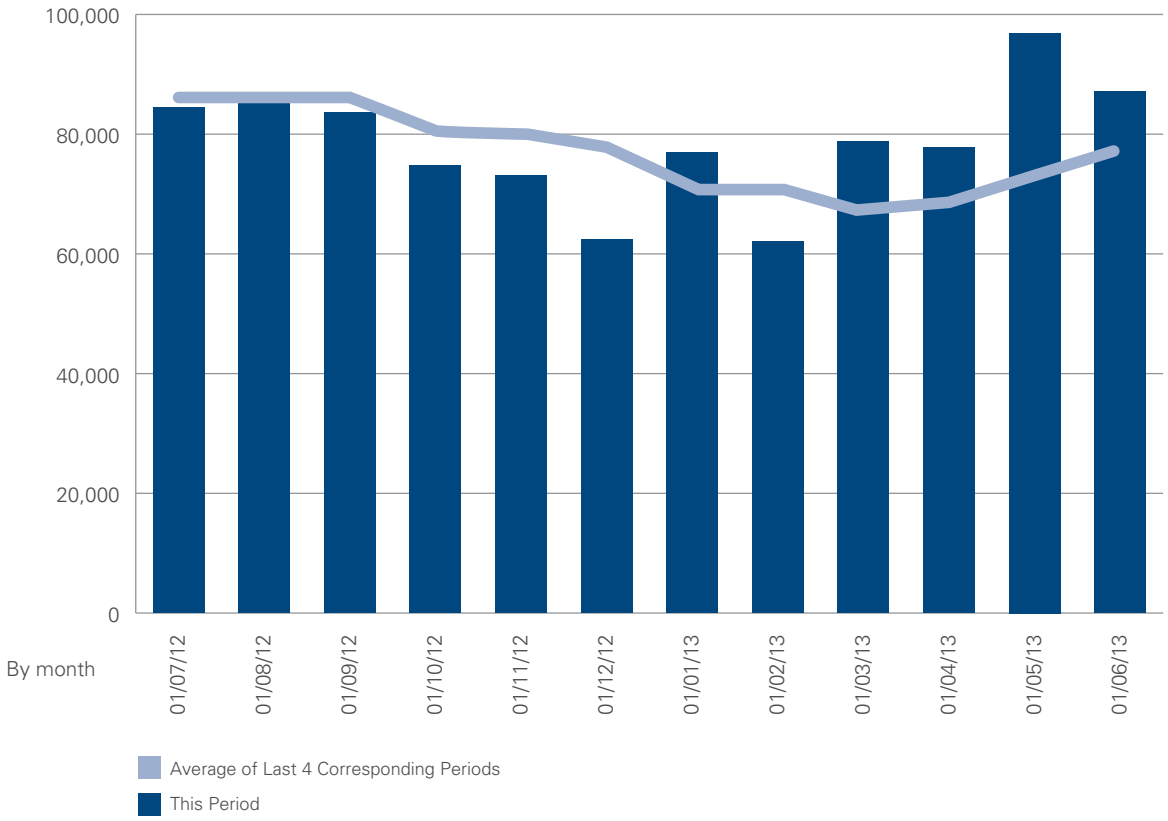
Since its launch, to the end of the reporting period in June 2013, the Virtual Tour has received almost 2000 hits from members of the public.

The most frequently viewed videos in order were:

- the Introductory video
- the Family video
- the General Witnesses video
- the Expert Witnesses video

Visits to court website

The below table indicates the number of visits (944, 295) to pages on the court website during the reporting period. This is an increase of (3.35%) per cent from visits to pages in the 2010-11 reporting period (906,648) and represents an average of 78,000 page visits per month.



** data collated from Nielson NetRatings Statistics*

Publications

During the reporting period, the court reviewed the number and type of its publications in line with its review of the organisational restructure.

It was determined that the court would reduce the overall number of publications it producers from 11 to 10 and that of those, three would continue to be published in a hardcopy format.

The court intends to review its main publication, the Coroners Process – Information for Families and Friends booklet to ensure that the information previously contained within the separate pamphlets is consolidated into the one publication.

The court intends to continue to produce the pamphlet publications in an electronic format available for download from the court's website.

List of publications

Important information about the coronial process is contained in nine publications and two booklets including:

- **What do I do now?** – an online and hardcopy brochure that provides information about what occurs when a death is first reported to the court, including the identification process and information about medical examinations required by the court
- **Inquest** – an online brochure for families following a determination by a coroner that the investigation into their loved one's death will proceed to an inquest. This brochure outlines the purpose of an inquest and what families can expect to happen during an inquest
- **Findings** – an online brochure for families when a coroner is preparing to hand down a finding. The brochure contains information about what a coroner must include in a finding, the difference between a finding with inquest and a finding without inquest, as well as a person's right to object to a finding
- **Reviewable deaths** – an online brochure containing information for families who have experienced the loss of a child where that death has been identified as a reviewable death that must be examined by a coroner
- **Disaster Victim Identification** – an online and hardcopy brochure explaining the different phases involved in identifying persons who have died in circumstances where normal identification procedures (such as visual identifications) cannot be utilised
- **Coroners Prevention Unit** – an online brochure providing information about the role and function of various research teams within the unit
- **Access to Documents** – an online brochure advising the public and interested parties on how to gain access to coronial documents
- **Information for Health Professionals** – an online publication with detailed information regarding the reporting obligations relevant to the health profession following the implementation of the *Coroners Act 2008*
- **Coroners Process–Information for Family and Friends** – a 58 page hardcopy and online booklet providing detailed information about the coronial process from the time a death is first reported to the court to the time a coroner makes a finding
- **Coroners Court of Victoria – Legal Practitioners Handbook** – an 80 page online publication that serves as a guide for legal practitioners operating within the coronial jurisdiction.

Research and prevention

The Coroners Prevention Unit (CPU) is a specialist service for coroners to strengthen the prevention role of the jurisdiction and provide coroners with assistance in investigations where improving public health and safety may be a consideration.

The CPU comprises distinct case research investigators who gather and provide expert information on particular types of deaths including:

- **Unintentional deaths** – such as drownings, fires, electrocutions, transport-related fatalities and industrial fatalities
- **Intentional deaths** – such as suicides, homicides and mental health related deaths
- **Health and medical related deaths** – such as deaths occurring during or following a medical procedure where the death is, or may be, related to the procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur.

Since its establishment in October 2009, the CPU has contributed to 1500 coronial investigations.

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

CORONERS PREVENTION UNIT DATA	2009/10	2010/11	2011/12	2012/13
Total referrals received by CPU	101	489	527	479
Referrals from metropolitan coroners	91	390	429	392
Referrals from regional coroners	3	61	55	52
Referrals from external agencies	7	17	29	19
Referrals from other business units within the court	-	21	14	16
Total referrals completed	**76**	**265**	**372**	**336**
Total referrals underway with expected completion in the next financial year	**29**	**235**	**155**	**143**

The CPU also undertake specific and targeted projects, develops policies, capture, codes and analyse data and record and monitor coroners' recommendations and responses.

Much of the information requested by external agencies relies on information that is coded by Coroners Prevention Unit staff after careful review and classification of the circumstances surrounding the death or fire reported to the court.

Coroners Prevention Unit investigations for coroners

The list below demonstrates the range and extent of investigations the unit has been requested to provide assistance with during the 2012-2013 reporting period including:

- assessment of the adequacy of medical treatment to persons receiving or recently receiving health care
- drowning of young children in private swimming pools
- family violence homicides
- pedestrian safety associated with vehicles reversing out of driveways
- quad bike rollover during employment activities
- requirements of landlords and tenants for the maintenance of fixed appliances in rental properties
- the adequacy of diagnosis, treatment and monitoring of persons experiencing mental illness
- the role of contagion in suicides of young people
- the role played by benzodiazepines in deaths from prescription drug overdoses.

Coroners Prevention Unit Collaborative Projects

In addition to completing internal and external investigative referrals, the CPU also undertook a number of collaborative research projects during the reporting period. Examples of such projects include:

The University of Melbourne and beyondblue

The Coroners Court of Victoria and the University of Melbourne were awarded funding from the beyondblue Victorian Centre for Excellence in anxiety and depression to conduct a two year study examining suspected suicides and other suspected suicide deaths that occurred between 2009 and 2010.

The study aims to gain an understanding of the presence and patterns of service contact to strengthen service engagements for people at risk of suicide. In addition, an in-depth examination of the nature, duration and proximity of the last service contact prior to death will be conducted.

Through this process we aim to develop a better understanding of how people engage with Victorian services in the lead-up to suicide, and thereby identify strategies to engage them better in service provision so that suicide prevention opportunities are enhanced.

In conjunction with a working group of representatives from organisations who come into contact with persons in the lead up to suicide, the findings and insights from this study will be translated into public awareness messages for consumers and guidelines and public policy for carers.

The University of Melbourne, Monash University and the National Health and Medical Research Council

The Coroners Court of Victoria, the Lifeline Foundation for Suicide Prevention, the University of Melbourne and Monash University were awarded funding from the National Health and Medical Research Council to develop and evaluate a suicide register.

The register will contain detailed information on those who die and the circumstances surrounding their deaths. This information is not systematically collected elsewhere, and will help prevent future suicides by informing coroners' recommendations and strengthening the broader evidence base.

Victorian Systemic Review of Family Violence Deaths

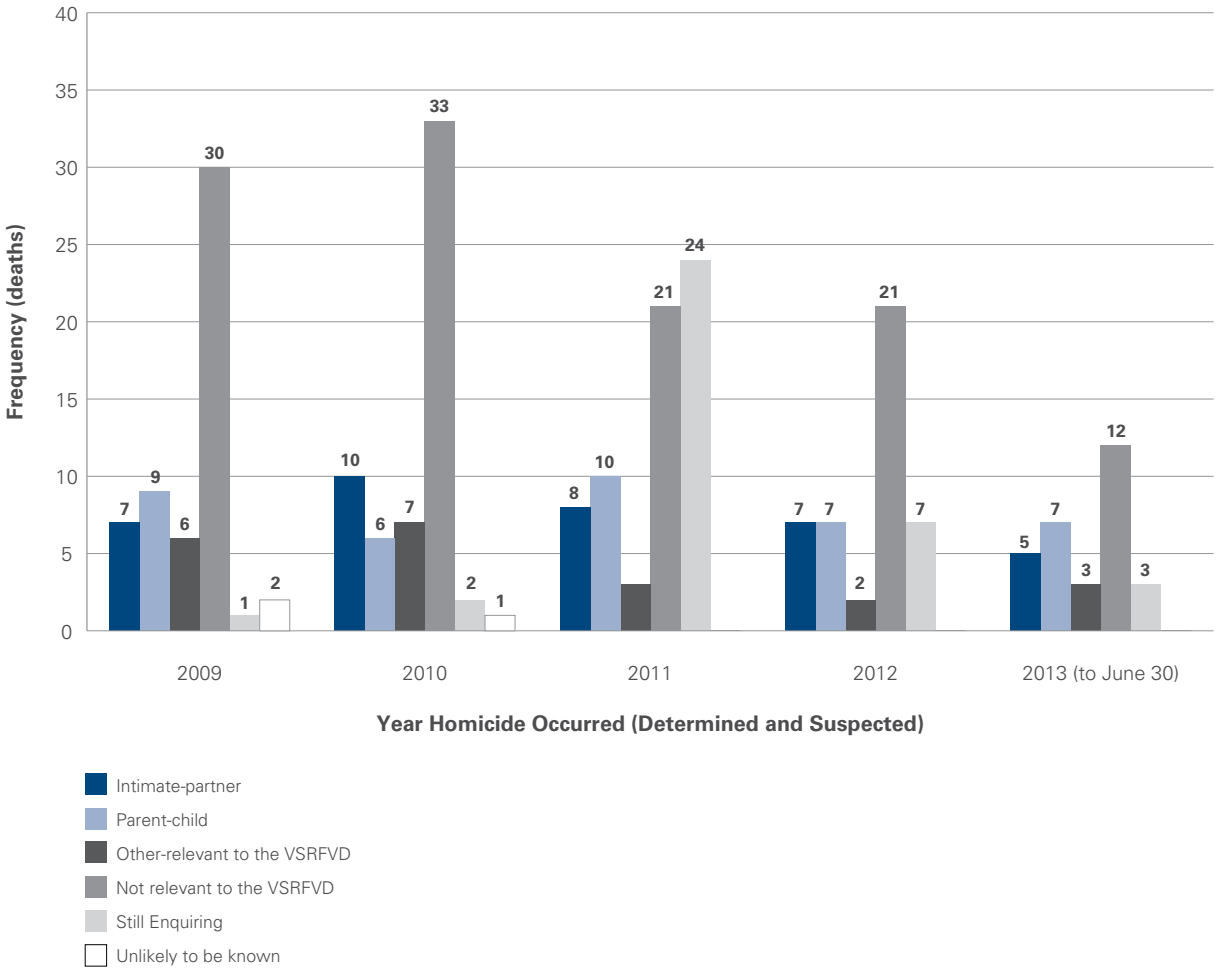
Each year in Victoria, approximately 40 per cent of all deaths attributed to homicide involve intimate partners and other family members. Many of these deaths feature a clearly documented history of family violence that precedes the fatal event. The Victorian Systemic Review of Family Violence Deaths (VSRFVD) was established to assist with the coronial investigation into these incidents. The VSRFVD has a prevention focus that is directed toward strengthening the response to family violence across the state.

The figure below shows the total number of determined and suspected homicides reported to the court from 1 January 2009 to 30 June 2013. As at 30 June 2013, 97 (38.2%) of the total 254 deaths, were classified as having an apparent relevance to the VSRFVD.

Of these:

- 39 were parent-child homicides (includes homicide of parents by children) (40.2%)
- 37 were intimate partner homicides (38.1%)
- 21 were deaths that involved other intimate and familial relationships (21.6%).

There were 117 (46.1%) determined and suspected homicides identified as not relevant to the VSRFVD, with a further 40 (15.7%) deaths requiring additional information for classification purposes.



This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs from the previous report (2011-12) because of this re-classification process.

Court Administration

Compliments and complaints register

During the previous reporting period, the court began utilising the new Relativity database to register feedback received by the court.

Relativity is a web-based information database that has been modified to include a register that records feedback from families and external stakeholders, as well as incidents that impact on service delivery.

The table below indicates the number of compliments and complaints received by the court in the 2012-13 reporting period.

Complaints*	32
Compliments	32
Service delivery issues*	7
Total	**71**

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

Organisational review

In April 2013 the court announced a proposed restructure of its operating model.

The proposed restructure followed a review undertaken by the court to identify process and organisational improvements aimed at creating a sustainable and efficient coronial system for all Victorias by:

- reducing case loads through legislative changes to the *Coroners Act 2008*
- providing better community outcomes by reducing timeframes to complete coronial investigations
- enhancing business processes including transferring the functions of the Initial Investigation Office to the Victorian Institute of Forensic Medicine
- allowing for organisational restructure of other business units within the court to better enable the court to effectively and efficiently perform its core functions.

The proposed operating model was subject to the process of consultation with court staff pursuant to clause 10 of the *Victorian Public Service Workplace Determination 2012* and as such, staff presented their comments and alternative proposals in May 2013.

In June 2013, the court announced its new operating model, which incorporated a number of submissions received by staff including:

- the creation of five court administration officer positions which will further enhance the level of administrative support provided to coroners
- the creation of the position of solicitor for each coroner
- the addition of another coroner to commence on 1 January 2014 as part of a state-wide model for investigating coronial deaths occurring in regional Victoria
- the addition of a mental health and nurse investigator within the Coroners Prevention Unit
- the increase of a part-time to full-time position of administrative assistant within the Coroners Prevention Unit.

The new model will come into effect on 1 August 2013.

Deceased transportation services

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

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

As previously reported, costs associated with deceased persons transportation have had a significant impact on the court's operating budget. The cost of transporting deceased persons to and from the court rose by $652,315 in the last financial year.

This increase is in part explained by the increase in the number of deaths within the reporting period (177 more deaths than for the previous reporting period). However, it also reflects the increasing cost of sourcing services in a specialised area within a small market where drivers for competitive pricing is relatively limited.

As such, existing contracts were extended during the 2012-13 financial year while the court continues to examine service delivery options. As part of the court's new operating model, the position of Executive and Financial Services Coordinator was created to assist with this process. It is anticipated that this role will work closely with existing contractors to assist the court in making further developments in this area.

Records management

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

During the reporting period, the court received an estimated 2500 requests for access to coronial documents. Of these, 1080 were requests from external agencies and 1420 were requests initiated by court staff.

In the next reporting period, the Records staff will begin the process of scanning and securing the court's active records in preparation for the move back to Southbank.

In addition to this, Records staff will also begin the intensive process of reviewing the Records Disposal Schedule. The schedule involves identifying and moving those records which are now eligible for storing at the Public Records Office of Victoria.

Finance Report

Overview

The court's budget and the allocations it receives from the Department of Justice have remained an area of significant focus in the 2012-13 reporting period.

As mentioned on page 36 of this report, the court has undergone an organisational review, part of which included a thorough examination of its finances.

The court is currently in the process of working closely with the Department on this issue with a view to restructuring some of the court's budget allocations to better reflect the actual cost of providing some of those services to the Victorian community.

In response to this, the court is also working to identify other areas where cost efficiencies can be gained to ensure the court's operations are economically sustainable in sthe future.

In the 2012-13 reporting period, the court recorded a deficit of $1.5 million. While the court accepts that greater work must be undertaken in order to bring the court's actual spend in line with its allocated budget, it ought to be acknowledged that this deficit is $1.4 million less than that reported in the 2010-11 reporting period.

These figures indicate a significant historical reduction in the court's overspend and, with the assistance of better efficiencies and a new budget allocation, the court remains committed to further improvements in this area in the next reporting period.

Average full time equivalent as at June 30 2013

	SPECIAL APPROPRIATION	BASE BUDGET	OTHER FUNDED	TOTAL
Judicial Officers	9.5	-	-	9.5
Ongoing staff	-	49.1	-	49.1
Fixed-term staff	-	1	2	3
Total Average FTE	9.5	50.1	2	61.6

**compared with a total staffing of 71 average full time equivalent as of 30 June 2012 and a total staffing of 78.4 average full-time equivalent as of 30 June 2011.*

Statistics and reports – Operational

Financial Statement

Comprehensive operating statement for the financial year 2012- 2013

	NOTES	2008-09	2009-10	2010-11	2011-12	2012-13
INCOME FROM TRANSACTIONS						
Output Appropriation		8,188,700	8,469,100	8,731,700	10,087,600	9,998,190
Special Appropriation		2,222,000	2,320,000	2,427,000	3,182,600	2,895,706
Other income		-	-	(317)		315
Total Income		**10,410,700**	**10,789,100**	**11,158,383**	**13,270,200**	**12,894,247**
EXPENSES FROM TRANSACTIONS						
Employee benefits	Note 1	5,395,337	6,907,580	7,948,768	8,597,502	8,269,596
Depreciation and Amortisation		410,219	418,255	421,405	93,465	86,527
Interest expense		2,167	3,504	2,974	2,722	1,559
Grants and other transfers	Note 2	-	27,572	32,610	34,114	1,317
Supplies and Services	Note 3	2,215,838	1,977,645	3,262,224	3,839,448	3,458,268
Deceased removal and transfers	Note 4	1,737,021	1,441,018	2,080,571	1,932,225	2,584,540
Total Expense from transactions		**9,760,583**	**10,775,574**	**13,748,552**	**14,499,476**	**14,401,780**
Net result from transactions (net operating balance)		**650,117**	**13,526**	**(2,590,169)**	**(1,229,276)**	**(1,507,533)**
OTHER ECONOMIC FLOWS						
Other gains (losses) from other economic flows	Note 5	(5,444)	(550)	(760)	(19,307)	(6,896)
Total other economic flows included in net result		**(5,444)**	(550)	(760)	(19,307)	(6,896)
Net Result* **		**644,673**	**12,976**	**(2,590,929)**	**(1,248,583)**	**(1,514,429)**

Note 1 – Employee benefits

See Average fulltime equivalent table on page 39.

Note 2 – Grants and other transfers

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

Note 3 – Supplies and Services

	2008-09	2009-10	2010-11	2011-12	2012-13
Contractors and consultants	209,557	676,447	838,662	865,186	529,427
Legal Professional Services	660,112	583,567	1,225,705	941,878	766,365
Medical Professional Services	37,249	78,212	149,983	28,469	258,296
Information Technology	93,239	148,121	163,409	97,819	98,737
Printing and Stationery	335,123	143,420	201,418	166,479	117,121
Postage and Communication	137,823	105,424	165,976	172, 865	111,913
Travel and Personal Expenses	63,926	70,046	51,015	44,400	23,801
Staff Training and Development	25,132	57,989	47,384	33,662	11,386
Witness Expense	19,460	42,782	36,492	36,199	39,571
Other Operating Expense	634,216	71,637	382,180	1,452,491	1,501,605
Total Supplies and Services	**2,215,838**	**1,977,645**	**3,262,224**	**3,839,448**	**3,458,268**

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

	2008-09	2009-10	2010-11	2011-12	2012-13
Metropolitan areas	644,704	385,683	749,851	687,597	935,892
Regional areas	1,092,317	1,055,335	1,330,720	1,244,628	1,648,649
	1,737,021	**1,441,018**	**2,080,571**	**1,932,225**	**2,584,540**

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

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

Case initiations and closures

	2008-09	2009-10	2010-11	2011-12	2012-13
Cases Opened	6341	5311	4857	5029	5934
Cases Closed	4728	5573	5586	4949**	5342
Case clearance rate (cases opened/ cases closed)	75%	105%	115%	98%*	93.3%
Number of cases referred to the court by the Registry of Births, Deaths and Marriages	787	742	657	680	593

Case progress

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

	2008-09	2009-10	2010-11	2011-12	2012-13
0-12 months	4034	3001	2263	2908	3194
12-24 months	1254	1558	850	845*	1034
> 24 months	340	1027	1396	1203*	1072
Total number of lodgements pending	**5628**	**5586**	**4509**	**4956**	**5300***

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

Objections to autopsy

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

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

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

Coronial recommendations

Findings

FINDINGS INTO DEATH WITH INQUEST	FINDING INTO FIRES WITH INQUEST	FINDING INTO DEATH WITHOUT INQUEST	FINDING INTO FIRES WITHOUT INQUEST	TOTAL
209	0	4243	3	4455

Total recommendations

Of the 4455 findings made by coroners during the reporting period, 71 contained recommendations. A coroner can make more than one recommendation in a single finding. The table below indicates the total number of recommendations made by coroners during the reporting period.

	2009-10	2010-11	2011-12	2012-13
Total number of recommendations	159	144	217	243

Responses to recommendations

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

	2010-2011	2011-2012	2012-2013
Responses to recommendations received	52	90	106*

** Some responses received relate to recommendations made during the 2011-12 reporting period. Also, the figures do not include required responses to recommendations made during the 2012-13 reporting period that were not due within the same reporting period.*

Court locations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WARRNAMBOOL LAW COURT
218 Koroit Street
PO Box 244
WARRNAMBOOL 3280
Ph 5564 1111
Fax 5564 1100

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