Coroners Court
of Victoria

Coroners Court
of Victoria

Annual Report

2018–19

Dear Attorney-General

In accordance with section 102 of the Coroners Act 2008, *I am pleased to present the Coroners Court of Victoria's Annual Report for the year ended 30 June 2019.*

Caitlin English, Acting State Coroner
November 2019

Acknowledgement

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

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November 2019

We value your feedback

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At a glance

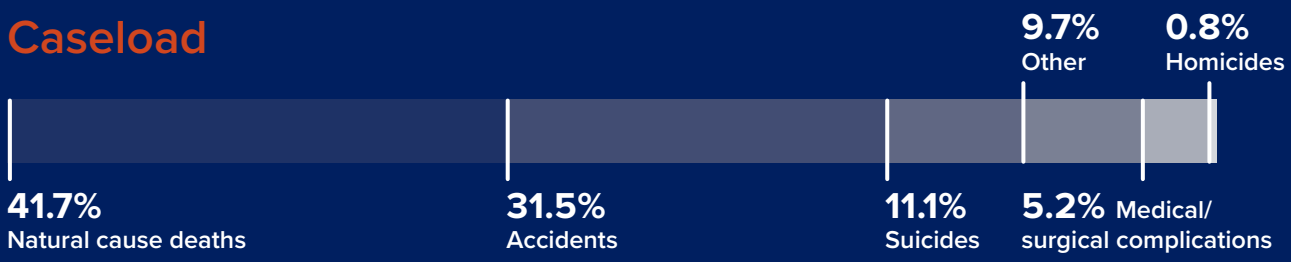
Investigations

6757 NEW investigations opened

6010 investigations finalised

89% closure rate

Caseload



Timelines

7.1*
Average months to investigate

82.8% in <12 months

46% in <3 months

Inquests

41 inquests held

1% of investigations closed following inquest

Recommendations

154
recommendations made

59.1% accepted

6.5% not accepted

34.4% awaiting response or under consideration

Data and documents

5741 requests for documents

39 requests from organisations for coronial data

58 research requests granted

* Correction: In the 2017–18 Annual Report the average number of months to investigate was incorrectly reported as 11.8 months. Actual average for 2017–18 was 6.9 months.

Contents

The year in review

From the Acting State Coroner

I am pleased to present the 2018–19 Annual Report on the operations of the Coroners Court of Victoria.

The Court plays a unique and important role in Victoria's judicial system. Each year we actively investigate over 6500 deaths to establish facts – who, how and the circumstances in which someone has died. In doing so, we ask if the event was preventable and whether it reveals systemic issues, to help protect the Victorian community. Indeed, it has often been said that we speak for the dead to protect the living.

At the heart of each investigation is a family who has lost a loved one. The Court recognises that the loss of a loved one is very difficult, especially when the death is sudden and unexpected. We are very conscious that the reporting of a death to the coroner is an external intervention into family life at what is a deeply private time of loss. With this understanding, we continue to work towards delivering the best service we can to families and the Victorian public.

This year the Court focused on enhancing communication and support – to ensure those who come into contact with our jurisdiction have the information and resources they need to make important decisions and actively participate in the coronial process.

This has included the introduction of the Court's first Pro Bono Scheme, supported by the Victoria Bar. Through the scheme families can access the advice of counsel on matters early in an investigation, empowering them with an understanding of the decisions they may need to make regarding next of kin or an autopsy.

We also launched a new user-focused website, with accessible, clear content and navigation designed to quickly and easily guide various court users – including families, witnesses and medical professionals – to the information they require.

The year in review

In March 2019, a Koori Family Engagement Coordinator was appointed to better serve Aboriginal and Torres Strait Islander families involved in coronial investigations. Developed in consultation with the Aboriginal Justice Caucus and Aboriginal and Torres Strait Islander community groups, the role provides a range of services to support families and ensure culturally safe practices are embedded within Court processes. This role includes incorporating Sorry Business practices throughout coronial investigations and coordinating smoking ceremonies and Welcomes to Country during inquests.

This has been welcomed by Aboriginal and Torres Strait Islander communities and the Court will continue to implement and expand services to make sure the jurisdiction recognises and respects their cultural traditions and needs.

Throughout 2018–19, the Court has also sought to improve awareness and understanding of the coronial jurisdiction amongst the broader community. In collaboration with the Victorian Institute of Forensic Medicine (VIFM), we produced a web series that provides insight into the day-to-day work of coroners and pathologists in an accessible and modern way. The great strength of the legal model of death investigation is its close intersection with science and forensic medicine. The series will launch in November 2019 and help the community to understand our role and thus build confidence in the coronial system.

Given the focus of our work, we continue to take steps to support the health and wellbeing of coroners and staff.

I extend my thanks to State Coroner Judge Sara Hinchey for her leadership of the Court. I also acknowledge Deputy State Coroner Iain West and Coroner Peter White, both of whom retired this year and thank them for their many years of service to the Court and to the Victorian community.

"Throughout 2018–19, the Court has also sought to improve awareness and understanding of the coronial jurisdiction amongst the broader community."

I thank and acknowledge our colleagues at VIFM. I also acknowledge the significant support the Court receives from Victoria Police through the Police Coronial Support Unit, and I thank the volunteers from Court Network who provide support for families and court users.

I thank our interim CEO, Clare Morton and welcome and acknowledge the leadership of our current CEO Carolyn Gale. To all the staff, I thank you for your commitment and professionalism throughout the year.

Finally, I thank my coronial colleagues for their support, and acknowledge their enduring passion for the important role of our Court, as together we honour the privilege of bearing witness.

Caitlin English
Acting State Coroner

From the CEO

I joined the Court as the ongoing Chief Executive Officer in February 2019. Firstly, I would like to extend my thanks to interim CEO Clare Morton, who oversaw the Court for much of the reporting period and set the Court on a new and positive trajectory.

It is an honour to join this fascinating jurisdiction. Some might imagine that given the difficult issues and cases we investigate, the Court is a sombre place to work. I have found it to be quite the opposite – the focus on supporting families and preventing deaths gives the workplace a meaningful and positive drive. This is evident in the dedicated and skilled coroners and staff that show such commitment and passion in their work.

During the 2018–19 financial year there have been plenty of achievements at the Court.

The Court is committed to valuing and respecting Victoria's culturally diverse community. For the first time the Court introduced several initiatives to improve outcomes for the Aboriginal and Torres Strait Islander community in the coronial jurisdiction. To make the Court a safer place, the Court has introduced smoking ceremonies and Welcomes to Country at the commencement of hearings. And a dedicated Koori Family Engagement Coordinator was appointed to provide support to families throughout investigations. Our coroners and staff also participated in Sorry Business training to ensure they have the cultural information required to assist with the coronial process and support families.

This is important work. Reforms that make the Court a safer, better understood and more welcoming place for Aboriginal and Torres Strait Islander families are overdue and it is terrific to see this beginning.

For all families, involvement with the Court is not something they have anticipated. How we make our involvement with families the best it can be is both our challenge and our responsibility. We must always strive to be better. This year we have designed a family survey to find out about their experiences, what we do well and how we can improve. As far as we can determine this is a first for an Australian coronial jurisdiction. The survey will commence in 2019–20 and the findings will inform how we better meet the needs of families at perhaps the most difficult time in their lives.

The work of the Court is highly collaborative and strong relationships with our partners and stakeholders are essential. This year the Court set out to understand how our many partner agencies view the Court and its functions. Improving awareness of the work of the jurisdiction and ongoing education tailored to the needs of particular stakeholders such as hospitals, legal firms and funeral services were key findings. We also identified significant opportunities afforded by our unique and rich data holdings for more research partnerships focused on prevention opportunities. These findings will be a key platform for the work of the Court in 2019–20.

The year in review

This year the Court has also invested in an expansion of health and wellbeing programs. The Court investigates more than 6500 deaths annually and most staff and all coroners are exposed to the details of these cases daily. Protecting against the cumulative impacts of vicarious trauma and responding quickly and effectively to distressing circumstances is critical to the safety and wellbeing of coroners and staff. Court initiatives have included mandatory regular debriefings and counselling for all staff and coroners; staff training in mental health first aid; a staff led redesign of the working environment to increase workstations and breakout areas and incorporate ergonomic furniture; and the introduction of a Court (therapy) dog program.

Ensuring the Court is modern and meets current and emerging needs of all its users is vital. During 2018–19, the Court accessed additional funding streams for the first time to commence a digital transformation program, implement a suite of in-court technology upgrades, and make improvements to the Court's working space. Each of these initiatives will form the basis of a digital future and position the Court to deliver more efficient, accessible, state of the art services to the Victorian community.

In closing I would like to extend my thanks to all the coroners and staff for their professionalism and dedication, and to our key partner agencies; the Victorian Institute of Forensic Medicine, Victoria Police and our Court Network volunteers for their ongoing support and service.

"Reforms that make the Court a safer, better understood and more welcoming place for Aboriginal and Torres Strait Islander families are overdue and it is terrific to see this beginning."

I would also like to express my appreciation to former Acting State Coroner Iain West for his support, wise counsel and invaluable introduction to the Court. And finally, I would like to sincerely thank Acting State Coroner Caitlin English for her inspirational guidance, enthusiasm and support in my role as new CEO.

Carolyn Gale
Chief Executive Officer

The coroners

Coroners are independent judicial officers appointed by the Governor in Council at the recommendation of the Attorney-General.

In Victoria, all coroners are either magistrates or directly appointed under the *Coroners Act 2008* (the Coroners Act). To be directly appointed, a coroner must be an Australian lawyer who has been practising for at least five years.

During the 2018–19 reporting year, the Coroners Court of Victoria farewelled at retirement age Deputy State Coroner Iain West and Coroner Peter White.

State Coroner Judge Sara Hinchey commenced a leave of absence in August 2018. As at 30 June 2019, the Court's 11 coroners are led by Acting State Coroner Caitlin English.

State Coroner

Judge Sara Hinchey – BSc LLB

Prior to her appointment as a County Court Judge in May 2015, Her Honour had extensive experience as a barrister, appearing in numerous high-profile inquests, as well as maintaining a broad-ranging practice including commercial law, occupational health and safety, corporate crime, professional negligence and professional disciplinary matters. Her inquisitorial experience included briefs in relation to the royal commissions into *Institutional Responses to Child Sexual Abuse* and the *2009 Victorian Bushfires*. Throughout her career, Her Honour regularly appeared in the higher courts of Australia including the Federal and High Courts.

The coroners

Acting State Coroner and Deputy State Coroner

Caitlin English – BA(Hons) LLB MPP

Coroner Caitlin English was appointed as Deputy State Coroner in April 2019 and since then has served as Acting State Coroner. Prior to becoming a coroner in 2014, Coroner English was a magistrate for more than 13 years, including six years at the Broadmeadows Magistrates' Court where she sat on the Koori Court and Children's Court. Her Honour started her career as a solicitor at Minter Ellison, followed by the Legal Aid Commission of Victoria (now Victoria Legal Aid) and the Public Interest Law Clearing House (now Justice Connect). In 1999 she completed a Churchill Fellowship, reporting on the delivery of pro bono legal services in the United States and England.

In her capacity as Acting State Coroner, Her Honour is a member of the Courts Council, the Coronial Council, the Asia Pacific Coroners Society, the National Coronial Information System (NCIS) Board of Management, the Board of the Judicial Commission, the Board of the Judicial College of Victoria, the Interim Board of the Law Library of Victoria, the Victorian Disaster Victim Identification Committee, the Council of Chief Coroners and the Victorian Judicial Officer's Aboriginal Cultural Awareness Committee. She is also Chair of the Coroners Education Committee and the Coroners and Pathologists Advisory Group, and is a member of the Victorian Institute of Forensic Medicine (VIFM) Council, the Courts Koori Portfolio Committee and the Magistrates' Court Judicial Wellbeing Committee.

Deputy State Coroner

Iain West (retired April 2019) – B Juris LLB

Deputy State Coroner Iain West was admitted to practise in 1975. He was a barrister for 11 years before being appointed a magistrate in 1985. He was appointed the Deputy State Coroner in 1993. Coroner West was a member of the Coroners and Pathologists Advisory Group and the Victorian Disaster Victim Identification Committee.

His Honour served as Acting State Coroner from August 2018 until his retirement in April 2019.

Coroner

Phillip Byrne – LLB

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

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

Coroner

Rosemary Carlin – LLB(Hons) BSc

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

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

Coroner

Jacqui Hawkins – BA(Hons) LLB

Coroner Jacqui Hawkins was appointed a coroner in January 2014. Prior to her appointment, she was the Court's Senior Legal Counsel and established the in-house legal service. Coroner Hawkins was previously a partner at Lander & Rogers in their workplace relations and safety group. She specialised in occupational health and safety and was the partner responsible for the specialist inquest panel on the Victorian Government Legal Services Panel.

Coroner Hawkins is a member of the Asia Pacific Coroners Society, and Court Services Victoria's Information Technology Portfolio Committee.

The coroners

Coroner

Audrey Jamieson – BA LLB Grad Dip Bioethics

Coroner Audrey Jamieson was appointed a magistrate in December 2004 and has been a coroner since June 2005. Coroner Jamieson started her career as a nurse before obtaining arts and law degrees from Monash University. She did her articles of clerkship at Holding Redlich Lawyers before moving to Maurice Blackburn Lawyers in 1992 where she became a partner and an accredited specialist in personal injury litigation with the Law Institute of Victoria.

Coroner Jamieson is a member of the Court's Research Committee, the Judicial Advisory Group on Family Violence, the Chief Magistrate's Family Violence Taskforce and the Asia Pacific Coroners Society. Coroner Jamieson also sits on VIFM's Ethics Committee as the Court's representative; assisting in the ethical assessment of research applications.

Coroner

John Olle – LLB BEc

Coroner John Olle was appointed a coroner in September 2008. Having started out as a solicitor with McCarthy & Co in Rye on the Mornington Peninsula, he joined the bar just three years into his legal career in 1983. As a barrister of more than 25 years' experience, Coroner Olle appeared mostly in civil matters and criminal defence trials in the County Court of Victoria jurisdiction, as well as before inquests at the Coroners Court of Victoria.

Coroner Olle is a member of the Asia Pacific Coroners Society, the Court's Occupational Health and Safety Committee, the Coroner's Education Committee, and sits on VIFM and the Court's joint Missing Persons Working Group.

Coroner

Paresa Spanos – BA LLB

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

Coroner Spanos is the Court's Judicial Member of the Courts Council Human Resources Portfolio Committee, is a member of the Court and VIFM's Coroners and Pathologists Advisory Group and is a member of Hellenic Australian Lawyers. From 2005 to 2013 she was also a member of the Victorian Child Death Review Committee.

Coroner

Peter White (retired November 2018) – LLB LLM

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

Coroner White was a member of the Judicial Officers' Aboriginal Cultural Awareness Committee.

His Honour left the Court at retirement age in November 2018.

Coroner

Darren Bracken – LLB(Hons)

Coroner Darren Bracken was appointed a coroner in February 2018, after more than 20 years' experience as a barrister in Australia and overseas. As a barrister His Honour appeared in all Victorian jurisdictions, the Federal Court of Australia and the High Court of Australia, in addition to many appearances before the Coroners Court and the 2009 Victorian Bushfires Royal Commission.

Coroner Bracken is the President of the Medico-Legal Society of Victoria, a member of the Coroners' Education Committee and most recently has contributed to the Court's operational review of its forms, processes and regulations.

Coroner

Michelle Hodgson – BA LLB

Coroner Michelle Hodgson commenced as a fulltime coroner in July 2018. Appointed a magistrate in 2008, Her Honour has presided in all jurisdictions of the Magistrates' Court and worked on a number of coronial matters as Regional Coordinating Magistrate for the Grampians Region from 2013 to 2015.

Her Honour began her legal career as a solicitor in 1993, and practiced in criminal law on behalf of Victoria Legal Aid, the Victorian Aboriginal Legal Service and the Fitzroy Legal Service. Starting as a barrister in 1998, Her Honour established a broad criminal-based practice, prosecuting and defending in complex criminal trials in the County and Supreme Court. Her Honour also appeared before the High Court, the Federal Court and the Coroners Court.

Her Honour has been a judicial member of the Adult Parole Board of Victoria since 2018.

The coroners

Coroner

Simon McGregor – BA LLB

Coroner McGregor was appointed a coroner in September 2018. After being admitted to practice in 1994, His Honour became a member of the Victorian Bar in 1997. As a barrister he appeared before the Court of Appeal, Supreme, County and Magistrates' Courts in a variety of matters, including professional negligence and personal injury law, human rights, discrimination and commercial law. He has also appeared in a range of other matters, including the Royal Commission into Institutional Responses to Child Sexual Abuse and as counsel assisting in several coronial inquests, including deaths in custody.

Coroner McGregor is a member of the Common Law Bar Association Committee and a co-convenor of the Victorian Bar Charter of Human Rights Discussion Group. He is also the Court's Managing Coroner for the Court's new Direct Pro Bono Referral Scheme.

Coroner

Sarah Gebert – LLB, BSc, PostGradDip (ForensicSc)

Coroner Gebert was appointed in June 2019, after serving for eight years as the Court's principal in-house solicitor; assisting with investigations, preparing matters for inquest, and managing Supreme Court appeals. Her Honour obtained degrees in law and science from Monash University in 1988 and was admitted to practice as a barrister and solicitor in the same year. As a solicitor she held roles with Victoria Legal Aid, Mirimbiak Nations Aboriginal Corporation and Women's Legal Service Victoria. From 2007 to 2011 she managed the Coronial System Reform Project, overseeing the development and passage of the Coroners Act which established the Court as a specialist inquisitorial court.

Coroner Gebert also holds a postgraduate diploma in forensic science from La Trobe University, which she completed in 2002.

About the Coroners Court

Our roles

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

Independently investigating deaths and fires

Certain deaths and fires are reported to the Court for independent investigation. Coronial investigations seek to establish the facts – when, where, how and why the death or fire occurred.

From **page 20**

Reducing preventable deaths

Wherever possible, a coroner will comment or make recommendations to prevent similar deaths based on the evidence.

From **page 26**

Promoting public health and safety

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

From **page 34**

Our history

Victoria's first coroner was appointed in 1841, 30 years before Victoria established its first morgue in Melbourne in 1871. It was not until 1888 that the first permanent coroners' courthouse was constructed and 100 years later, in 1988, the Court moved to the purpose-built Coronial Services Centre in Southbank.

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

About

Coronial services in Victoria

Victoria's coroners are supported by a number of different organisations to deliver coronial services, including Victorian Institute of Forensic Medicine (VIFM) and the Police Coronial Support Unit (PCSU).

Among many important roles, VIFM supports coroners by:

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

PCSU supports coroners by helping Victoria Police members compile thorough coronial briefs, as well as appearing as the Coroner's Assistant at some inquests. PCSU members provide training to Victoria Police in relation to the coronial jurisdiction and assist those police members who take on the role of coroner's investigators

Our place in Victoria's court system

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

The Court is responsible for judicial business in accordance with law, and CSV provides and supports administrative and corporate functions. The State Coroner, as head of jurisdiction, is supported by CSV jurisdiction-based staff under the management of the Court's Chief Executive Officer.

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

Achievements 2018–19

Improving communication with families

Families who come into contact with the coronial system have often lost their loved one in unexpected and tragic circumstances. During this difficult time, it is vital that they have the information they need to understand the coronial process and make important decisions.

Coronial information can be complex to understand. To help families, the Court aims to provide them with timely, clear and sensitive information and advice through:

- Family letters, which provide information on the initiation and closure of an investigation, as well as progress updates throughout the coroner's investigation.
- The *Coroners Process* booklet which contains information about coronial process, such as why the coroner may be notified of a death, why medical examinations and autopsies may be needed and when a funeral can be organised.

In 2018–19, the Court commenced a review and update of the family letters and *The Coroners Process* booklet, including redrafting of content into plain language, to ensure material provided to families is consistent, informative and respectful.

To support families from culturally and linguistically diverse backgrounds, the Court commenced translating the brochure for families *What happens now?* into 15 languages. Translation and interpretation services are also offered to families and friends for whom English is not their preferred language and who need to communicate with the Court.

To better understand the needs of families, the Court developed a family survey during the reporting period. The survey will be implemented in 2019–20 and provides an evidence based approach to guide and improve future communication with families.

Supporting Aboriginal and Torres Strait Islander families

To better serve Aboriginal and Torres Strait Islander families and ensure culturally safe practices are intertwined with Court practices, several initiatives were implemented in 2018–19.

A Koori Family Engagement Coordinator was recruited to provide support to the families and friends of deceased Aboriginal and Torres Strait Islander people. The coordinator works with families and communities and offers to put cultural practices in place in the early stages following a passing – incorporating Sorry Business requirements within the coronial process.

During the reporting period the Court introduced smoking ceremonies and Welcomes to Country at the commencement of inquests where culturally appropriate.

Achievements

In June 2019, the Court held a two-day workshop on site, facilitated by Yarn Strong Sista to create a possum skin cloak for use by Aboriginal and Torres Strait Islander families at the Court. It was attended by community representatives, Court staff and coroners. The cloak is used for viewings, hearings and meetings to wrap families in culture and healing during times of grief and Sorry Business.

All coroners and staff completed Koori awareness and Sorry Business training. Knowledge of the requirements and traditions surrounding Sorry Business will assist staff in properly communicating with Aboriginal and Torres Strait Islander families and understanding cultural practices and protocols.

Pro Bono Scheme

To improve access to justice and support for those affected by the coronial process, a new Pro Bono Scheme was launched between the Court and the Victorian Bar in June 2019. Under the scheme, pro bono counsel is available to families to provide legal advice about the appointment of senior next of kin, autopsies and the release of a body. A referral for pro bono assistance throughout the investigation may also be made in exceptional circumstances – where it is both necessary and in the interests of justice.

The scheme is facilitated by the generous support of the barristers of the Victorian Bar who, at the request of the Court, volunteer to provide independent legal assistance. The scheme will be reviewed after 12 months to assess its success, future viability and areas for improvement.

Stakeholder Needs Analysis

Coronial investigations are supported by various stakeholders, including police, forensic specialists, legal and medical professionals. To ensure the Court maintains strong relationships with its stakeholders that contribute to thorough coronial investigations, the Court undertook a Stakeholder Needs Analysis project in 2018–19. Through the analysis 35 external stakeholders were interviewed to gain insight into what services they value, or would value, most from the Court. This feedback is critical to ensuring the Court is responsive and will assist in the development of the Court's strategic engagement priorities in 2019–20.

Launch of new website

The Court's website is an important source of information for families and the community. In 2018–19 more than 186,000 users visited the site, an almost five per cent increase compared to 2017–18.

To improve the quality of information available to the Victorian community and others interested in learning about improving public health and safety, the Court launched a new website in December 2018.

The Court took a user-focused approach to the website design and content. The new site has a variety of features designed to help families and members of the community, including:

- Improved homepage navigation to help families quickly find information about what happens when the death of their loved one is reported to the coroner.
- One-click navigation to the findings page – the site's most visited page – allowing easy access to the findings handed down by the coroner, as well as related orders and rulings, and any responses to recommendations made within a finding.

The Court will continue to monitor traffic and feedback to create further improvements to the site.

Output performance

The Court's output performance measures are included in the Victorian Budget Papers (BP3), and detailed below:

Table 1: Performance against BP3 measures

Major outputs/deliverables	Unit of measure	2017–18 actual	2018–19 estimates	2018–19 actual
Quantity				
Average cost per case	$	3376	3688	4311
The average cost per case in 2018–19 was $4311. Average cost per case is calculated on the Court's financial year budget, divided by the number of cases closed. In 2018–19, for the first time, the Court accessed additional funding streams to invest in court-wide improvements, including funding for new Koori justice initiatives, staff health and wellbeing programs and digital upgrades to court infrastructure.				
Case clearance	%	97.9	100	89
A total of 6010 matters were finalised against the 6757 matters initiated with the Court in 2018–19.				
Quality				
Court file integrity: availability, accuracy and completeness	%	87.6	90	67
The Court File Integrity Measure consists of three main components: availability, accuracy and completeness. Quarterly audits are carried out on a random selection of court files to measure integrity. A file must pass all three tests to meet integrity standards. In 2018–19, 67 per cent of cases selected in the audits passed all tests. In reviewing the results, the Court has identified a deficit in staff induction around tracking court file location, or availability, and is working to remediate this.				
Timeliness				
Ontime case processing – matters resolved or otherwise finalised within established timeframes	%	85.4	80	82.8
Of the 6010 cases finalised, a total of 4978 were closed within agreed timeframes (being less than 12 months).				

1. Investigations into deaths and fires

Certain deaths and fires require independent investigation by the Coroners Court of Victoria. Through their investigations, coroners seek to establish facts – when, where, how and why the death or fire occurred – and inform public health and safety strategies to reduce preventable incidents. This chapter provides an overview of these investigations, their management and their outcomes.

Investigations

Types of investigations

Certain types of deaths are required by law to be investigated by a coroner. They include:

- unexpected, unnatural or violent deaths
- deaths resulting directly or indirectly from an accident or injury
- deaths during or after a medical procedure where a registered medical practitioner would not have reasonably expected the death
- deaths of people in custody or care
- cases where the identity of the person or their cause of death is not known.

Coroners may also investigate fires, even where there is no loss of life, if they consider it to be in the public interest. Investigations into fires comprise a very small number of investigations.

Closure rate

In 2018–19, the Court commenced more investigations than it finalised, resulting in an 89 per cent closure rate for investigations into deaths and fires.

Of the 6010 cases closed in 2018–19, 99.1 per cent were closed following a coronial investigation. The remaining closures were administrative closures, which do not require a coronial determination

Many of the cases initiated but not finalised in 2018–19 are the subject of ongoing investigations or court proceedings in other jurisdictions. They include criminal proceedings, Worksafe investigations, and investigations by the Disability Services Commissioner.

The closure rate increased in the last six months of the reporting period from 82.7 per cent for the period 1 July to 31 December 2018 to 95.3 per cent for the period 1 January to 30 June 2019.

Table 2: Investigations opened and finalised

	2014–15	2015–16	2016–17	2017–18	2018–19
Number of investigations commenced	6336	6305	6248	6642	6757
Number of investigations finalised	6884	6596	6285	6500	6010
Closure rate	108.6%	104.6%	100.6%	97.9%	89%

Table 3: Duration of closed investigations

	2014–15	2015–16	2016–17	2017–18	2018–19
0–12 months	5667	5289	5047	5526	4978
12–24 months	730	785	855	722	785
>24 months	487	522	383	252	247

Investigations into deaths and fires

Table 4: Average duration of cases before they are closed

	2014–15	2015–16	2016–17	2017–18	2018–19
Duration (days)	244.5	253.5	236.7	205.8	213.3

Timeliness

Each death and fire investigation requires an individual approach, and the duration of each investigation varies. The complexity of the matter and whether an inquest will be held are two factors that contribute to the duration of a case. In some cases, investigations by other authorities need to take place before a coronial investigation can be finalised. If the case is before another jurisdiction, such as in criminal and appeal proceedings, these matters must also be finalised prior to the completion of the coronial investigation. In most cases this will result in an increase in the time needed to finalise a coronial investigation.

The average duration of investigations closed in 2018–19 was 7.1 months with 46 per cent of these finalised within three months. In most of these cases, the coroner's investigation deemed them to be natural cause deaths.

Inquests

An inquest is a public hearing into a death or fire. It is an inquisitorial rather than an adversarial process and the coroner does not make findings of guilt or apportion blame.

A small proportion of investigations require an inquest. Mandatory inquests are held for deaths that occur in custody or care (where the coroner considers the death was not due to natural causes) and homicides (where no person has been charged in relation to the death).

Whenever possible, the Court uses directions and mention hearings to reduce the need for inquests. This is done principally to reduce the time in which families and friends who have lost loved ones are involved in the coronial process. These hearings allow coroners to obtain relevant evidence and develop a scope of enquiry early in an investigation, which may reduce the need for an inquest.

Of the cases finalised in 2018–19, 59 were closed with an inquest. It should be noted that not all investigations closed with an inquest had their inquests held during this reporting period. In the reporting period 41 inquests were held at the Court.

Table 5: Cases closed with inquests

	2014–15	2015–16	2016–17	2017–18	2018–19
Number of cases closed following metropolitan inquests	170	122	71*	43	51
Number of cases closed following regional inquests	26	9	11	6	8
Percentage of investigations closed with an inquest	2.8%	2.0%	1.3%	0.7%	1%

*Correction: In the 2017–18 Annual Report number of metropolitan cases closed following inquest was reported as 72. The correct figure is 71.

To reduce the duration of inquests, the Court has instituted several initiatives. These include hearing multiple experts give evidence concurrently and allowing witnesses from interstate or overseas to give evidence by video conference. The approaches reduce time and cost for families, witnesses and the Court.

Findings

At the end of their investigation, a coroner will hand down a finding. Findings can be made with or without an inquest.

A coroner investigating a reportable death must find, if possible:

- the identity of the person who died
- the cause of death
- the circumstances of the death.

A coroner investigating a fire must find, if possible:

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

In a finding a coroner may comment on any matter connected with the death, or make recommendations on any matter connected with a death or fire, relating to public health and safety and the administration of justice.

The findings, comments and recommendations made following an inquest must be published on the internet; unless the coroner otherwise directs.

Findings following an investigation into the death of a person in custody or care, where the death was found to be due to natural causes, must also be published. The findings, comments and recommendations made following an investigation may be published on the internet.

If a public statutory authority or entity receives recommendations made by the coroners, they must provide a written response within three months to the coroners specifying a statement of action that has or will be taken in relation to the recommendation. This may include alternatives to or non-acceptance of the recommendation. The coroner must publish that response on the internet.

Case study 1

Open flue gas heaters removed from public housing after carbon monoxide death

Ms S was found deceased in her Department of Health and Human Services (DHHS) unit. Witnesses reported that there were no immediate indications of the cause of death, but that upon entering the unit they were met with an intense heat and had difficulty breathing. Toxicology tests later revealed that Ms S had died from carbon monoxide toxicity.

The investigating coroner found that Ms S was exposed to fatal levels of carbon monoxide from the Vulcan Heritage Gas Space Heater Series 48 Open Flued Gas Heater (OFG heater) installed in her unit.

At an inquest the coroner established that a number of events led to build-up of carbon monoxide in Ms S's apartment. Namely that:

- the addition of weather seals on doors in the unit prevented ventilation
- the use of an internal exhaust fan in the kitchen created conditions known as 'negative pressure' where the heater did not effectively combust and then released high levels of carbon monoxide into the room
- the heater had been inadequately tested for carbon monoxide leaking.

In reviewing these factors the coroner noted the serious risk posed by OFG heaters. 'When there is inadequate ventilation, combined with the use of internal exhaust fans, this type of heater is not only unsuitable for use in these conditions, but potentially, life-threatening' said the coroner.

At the time of the inquest, DHHS reported that more than 6,500 OFG heaters were installed in public housing.

To prevent similar deaths occurring, the investigating coroner made eight recommendations including the phasing out of all OFG heaters, mandatory professional development for gas fitters and plumbers, and the implementation of a widespread media and public awareness campaign highlighting the dangers of OFG heaters.

In response to the recommendations the Victorian Government committed to a complete replacement of all heaters in public housing, and Energy Safe Victoria banned further sales of this type of heater in Victoria. The Australian Gas Association also committed to supporting the coroner's recommendation to phase out all OFG heaters.

The manufacturer of the heater published a consumer safety notification in *The Age* and the *Herald Sun* about the necessity of regular servicing and maintenance of these heaters. The Victorian Building Authority in partnership with Energy Safe Victoria delivered negative pressure and carbon monoxide testing training to more than 2,500 plumbers and gasfitters, provided online instructional training videos, and introduced an online exam in order to renew a plumbing or gas fitting registration or licence.

In response to the recommendations the Victorian Government committed to a complete replacement of all OFG heaters in public housing.

2. Reducing preventable deaths

Throughout their investigations, coroners consider all opportunities to provide comments and recommendations to prevent similar deaths or fires. This chapter explains how recommendations are formed and responded to, and the Court's role in reviewing family violence deaths.

Recommendations

While coroners seek to establish the individual circumstances of every death and fire reported to the Court, their investigations also focus on identifying lessons and addressing systemic issues to prevent similar incidents in the future.

Following a reportable death, agencies involved often conduct their own internal reviews and identify and implement health and safety strategies. In other cases the coroner may identify prevention opportunities in the circumstances of the death.

Where prevention measures are identified, the coroner will make recommendations to any relevant minister, public statutory authority or entity. Any matter connected with a death may be included, such as recommendations relating to public health and safety or the administration of justice. A coroner may also report to the Attorney-General in relation to a death or fire they have investigated.

Coronial recommendations are rigorously prepared to ensure they are informed by and based on the evidence before the Court.

Coroners made recommendations in 2.1 per cent of findings in 2018–19. This figure excludes natural cause deaths where the person was not in custody or care and deaths where a coroner determined the case was not reportable and therefore the coronial investigation was discontinued.

The number of recommendations increased in 2018–19 to 154. It should be noted that the number of recommendations made each year is entirely dependent on the matters before the coroners and associated opportunities for prevention. The Court's focus, as always, was on providing robust and evidence-based recommendations to protect the Victorian community.

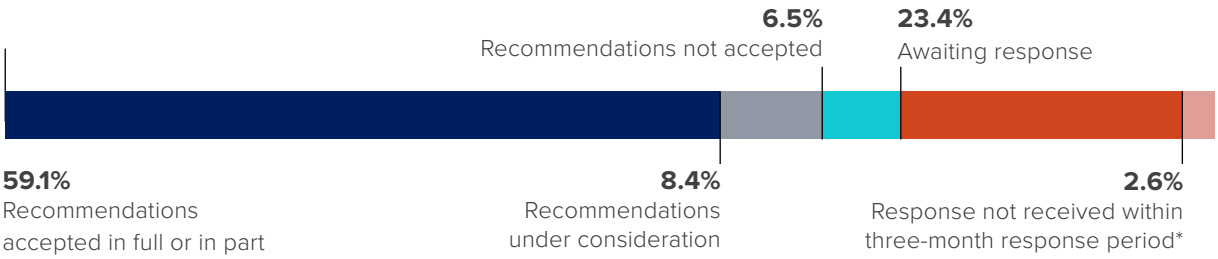
Any agency or person who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken.

In the past year, 91 recommendations made by coroners were accepted in full or part for implementation and 13 further recommendations are under consideration. There were 10 recommendations that were not accepted for a variety of reasons.

Table 6: Recommendations made in closed investigations

	2014–15	2015–16	2016–17	2017–18	2018–19
Number of investigations closed with recommendations	111	105	65	48	69
Number of recommendations made	305	296	127	108	154

Figure 1: Responses to recommendations from closed investigations



* The party receiving recommendations from the coroner must respond within three months detailing what action (if any) they will take in response to the recommendations.

'Awaiting' includes those not yet required to respond.

Reducing preventable deaths

Expert advice

When developing coronial recommendations, coroners draw on a range of resources including the Coroners Prevention Unit (CPU), external agencies, independent experts and paediatric registrars.

Coroners Prevention Unit

The CPU was established within the Court's administrative arm to assist coroners in identifying opportunities to strengthen public health and safety through the formulation of well-researched, evidence-based recommendations. It is the only multidisciplinary team of its kind in Australia.

Coroners made 671 referrals to the CPU about deaths under investigation. The advice coroners sought input on included:

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

During 2018–19, coroners made referrals into four expert streams within CPU:

Health and medical: for deaths where coroners required clinical advice on the healthcare provided (or not provided) to the deceased and whether this might have contributed to the death.

Mental health: for deaths of people with suspected or diagnosed mental illness and the treatment provided (or not provided) in the lead-up to their deaths.

Family violence: for deaths that occurred in a context of family violence as defined by the *Family Violence Protection Act 2008*.

General: for cases where non-clinical advice is required such as deaths from drug overdoses or motor vehicle accidents.

Paediatric placement program

The Court has a relationship with Monash Children's Hospital and in 2019 engaged two paediatric registrars who are undertaking advanced clinical training. Funded by the Commonwealth Government, the paediatric registrar is based at the court for two days a week and provides clinical advice to coroners and assists with case reviews of deaths under investigation.

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2018–19, the Court engaged 40 external experts to supply reports and give testimony as part of an inquest. External experts assist coroners to understand specific complex matters and are selected for their qualifications, training and specialist knowledge.

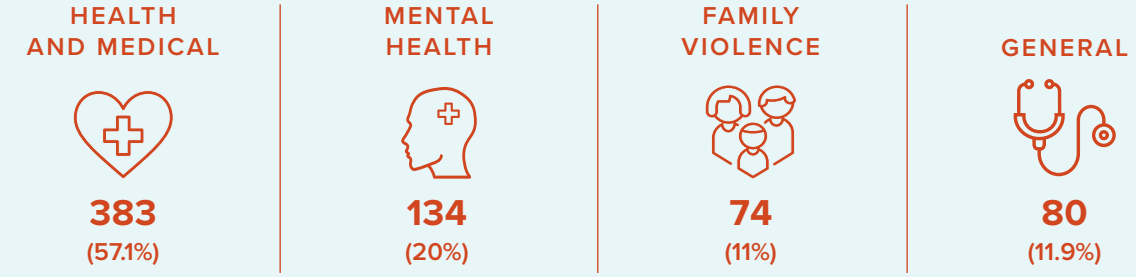


Figure 2: Theme of coroner's referrals for 2018–19

Trends and patterns

The Court has developed and maintains a comprehensive set of records on reportable deaths in Victoria – the Victorian Surveillance Database. Monitoring all reportable deaths in a systemic way provides coroners with a unique insight into emerging trends in certain kinds of deaths; assisting the development of coronial recommendations that reduce the incidences of similar deaths in the future.

The preliminary analysis of causes of death is reported annually. This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs slightly from the 2017–18 Annual Report because of this re-classification process.

In 2018–19, causes of death reported to the Court were consistent with previous years. Just over 40 per cent of deaths reported to the Court were caused by natural causes, 31.5 per cent were accidental (due to falls, road accidents, drowning and similar), and 11.1 per cent were suicides.

Table 7: Cases reported to the Court in 2018–19

Cause of death	Number	Percentage
Natural causes	**2816**	**41.7**
Unintentional	**2131**	**31.5**
Falls	1306	19.3
Poisoning	334	4.9
Transport	304	4.5
Drowning	50	0.7
Other	137	2.0
Suicide	**749**	**11.1**
Hanging	365	5.4
Poisoning	149	2.2
Firearm	44	0.7
Rail	45	0.7
Jump from height	26	0.4
Other	120	1.8
Assault	**53**	**0.8**
Complications of Medical or Surgical Care	**350**	**5.2**
Other death*	**246**	**3.6**
Not reportable	**342**	**5.1**
Still inquiring	**70**	**1.0**
Total	**6757**	**100**

* 'Other' comprises of 106 (1.6 per cent) deaths from unascertained causes, 41 (0.6 per cent) other reportable deaths, 2 (0.03 per cent) fires without death, 96 (1.4 per cent) deaths from undetermined intent, 1 (0.01) legal intervention cases.

Reducing preventable deaths

Victorian Overdose Death Register

The Victorian Overdose Death Register (VODR) was established by the Court in 2012 and provides detailed information for Victoria regarding overdose deaths involving pharmaceutical drugs, illegal drugs and/or alcohol. The number of Victorian overdose deaths during 2018–19 was similar to the previous two reporting periods. Frequencies reported from the VODR can change over time as coronial investigations progress and more information becomes available.

Table 8: Drug overdose deaths reported

Financial year	Number of deaths
2014–15	396
2015–16	472
2016–17	528
2017–18	515
2018–19	526

Victorian Suicide Register

Established by the Court in 2011, the Victorian Suicide Register contains detailed information relating to suicides that have occurred in Victoria since 2000.

The primary purpose of the register is to support coroners in conducting investigations and identifying evidence-based opportunities to reduce suicide. In addition, the register serves as an important resource for government and community organisations in the development of suicide prevention policy and initiatives, and for academic research.

In 2018–19 suicides comprised 11 per cent of all deaths reported to the Court. The annual number of suicides gradually but steadily rose between 1 July 2014 and 30 June 2018 reporting periods (averaging around three per cent increase). It is not clear at present whether the increase in suicide deaths between 2017 and 2018 reflects a new trend or is a temporary departure from the longer-term trend. The Court is monitoring suicides closely to gain further understanding.

Table 9: Annual reports of suicide

Financial year	Number of deaths
2014–15	627
2015–16	644
2016–17	660
2017–18	685
2018–19	749

Victorian Homicide Register

The Court created and manages the Victorian Homicide Register (VHR), which contains detailed information on all Victorian homicides reported to the Coroner since 1 January 2000. It captures information such as:

- socio-demographic characteristics
- location
- presence and nature of physical and mental illness
- service contact
- in cases of family violence, information on the presence and nature of the violence.

The VHR serves as the data source for the Victorian Systemic Review of Family Violence Deaths (VSRFVD).

In 2018–19, the VHR recorded that there were 50 homicide fatalities in Victoria, down from 61 in the previous financial year. This is the lowest number of homicides reported in Victoria in the previous five years and continues the trend of an overall reduction in homicides during the past four years.

Family Violence Death Reviews

Victoria's coroners have long been engaged in efforts to understand why family violence-related deaths occur and how they may be prevented. In 2009 the Court established the VSRFVD, to further strengthen the response to family violence across the state. Led by the State Coroner and managed by a dedicated team, the VSRFVD unit conducts in-depth reviews of deaths suspected to have resulted from family violence to identify risks, examine patterns in family violence-related deaths, and support coroners in making prevention-focused recommendations.

In March 2016, the Royal Commission into Family Violence recommended the Victorian Government establish a legislative basis for the Court's VSRFVD unit, and this was given effect through an amendment to the Coroners Act. The amended Coroners Act:

- specifies the VSRFVD's functions
- enables the Court to include information relating to family or domestic violence intervention orders in its findings, recommendations and reports, and
- requires the Court to report on the operation of the VSRFVD in its annual report.

The VSRFVD examines deaths where:

- the deceased and offender were or had previously been in an intimate or familial relationship as defined by the *Family Violence Protection Act 2008* (Vic) or in a family like relationship, such as a kinship relationship as defined by the Victorian Indigenous Family Violence Taskforce (2003)
- the death occurred during an episode of family violence or
- there was an identifiable history of family violence proximate to or causal to the death.

In the past financial year, coroners referred 77 cases to the VSRFVD team for consultation and investigation. In this same year the VSRFVD completed 51 referrals.

Homicides by relationship

During 2018–19, 30 per cent of homicides occurred between family members including intimate partners, parents and children and other intimate or familial (including kinship) relationships.

Data from the VHR indicates that family violence related homicides most commonly occur between current or former intimate partners. In the 2018–19 financial year, intimate partner homicides accounted for 80 per cent of all family violence related homicides in Victoria. This remains consistent with data presented in previous years.

Of the remaining family violence homicides, one was identified as a filicide, and two were recorded as occurring between parties in 'other intimate or familial relationships' such as between siblings or extended family members (including in-laws).

Table 10: Homicides by relationship

	2014–15	2015–16	2016–17	2017–18	2018–19	Total
Intimate partner	10	15	15	14	**12**	**66**
Parent-child	7	11	8	3	**1**	**30**
Other intimate or familial (including kinship)	6	8	3	1	**2**	**20**
Not intimate or familial	35	37	31	33	**24**	**160**
Unknown	1	2	7	10	**11**	**31**
Total	**59**	**73**	**64**	**61**	**50**	**307**

This data includes open and closed criminal and coronial investigations and is therefore subject to re-classification as further information becomes available. Data presented in this report differs slightly from the 2017–18 Annual Report because of this re-classification process.

Reducing preventable deaths

Contributing to a joint approach to family violence responses

Australian Domestic and Family Violence Death Review Network

The Court is a founding and active member of the Australian Domestic and Family Violence Death Review Network (the Network). The Network represents a unique collaboration between domestic and family violence death review mechanisms operating across Australia.

The Network was established in 2011 to:

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

In 2018–19, the VSRFVD remained an active member of the Network and contributed to progressing its objectives.

Victorian Family Violence Database

The Court has become a regular contributor of data to the Victorian Family Violence Database, which is maintained by the Crime Statistics Agency. This data is drawn from the VHR and encompasses family violence homicides which occurred in Victoria between 2013 and 2018. This data includes information about family violence homicide incidents and demographic information about family violence homicide offenders and victims.

Judicial Committees

The Court is represented by Coroner Audrey Jamieson on the Judicial Advisory Group on Family Violence and the Chief Magistrate's Family Violence Task Force.

The Judicial Advisory Group on Family Violence, established by the Courts Council in 2016, provides advice to CSV's governing body on the implementation of the Royal Commission into Family Violence's recommendations from a Victorian court system-wide perspective.

The Chief Magistrate's Family Violence Taskforce provides a link to Government for critical, strategic, and cross-sector advice on issues related to justice and family violence. The Taskforce involves key justice sector stakeholders to co-design a broader response to implementing the Royal Commission's recommendations.

Upcoming projects

In 2019, the VSRFVD commenced work on a detailed report on family violence-related homicides that occurred in Victoria between 2011 and 2015. This report will also consider key themes arising from coronial findings and will supplement the court's 2012 report examining family violence deaths from 2000–10. It is projected that this report will be released in late 2019.

Case study 2

Mental health support for international students

Mr L, an international university student from China, died after he jumped from his apartment balcony. His mental health had deteriorated since arriving in Australia, with his sister reporting that he faced language barriers with local students and felt depressed and frustrated from difficulties understanding his university classes. The coroner investigated to see what could be done to prevent similar deaths occurring.

A review of coronial records found 27 suicides of other international students in Victoria between 2009 and 2015. To explore if there were distinct factors that contributed to suicides of international students, the circumstances of the death were compared with a cohort of suicides among Australian-born students. The analysis indicated a systemic issue with engaging international students in mental health services in Victoria with:

- a lower prevalence of diagnosed mental illness among the international student suicides (14.8 per cent) than in the Australian-born student suicide cohort (66.7 per cent)
- that only 22.2 per cent of the international student suicide cohort attended a health service for a mental health related issue within six weeks of death. By contrast, 57.1 per cent of the Australian-born student suicide cohort had such an attendance within six weeks of death.

This conclusion was supported by multiple studies that reveal international students in Australia were less likely than domestic students to seek assistance for mental health issues because of cultural, financial, linguistic and other obstacles.

The coroner stated that while engagement with mental health services may not have prevented Mr L's death, '...at the very least this would have created prevention opportunities that did not otherwise exist'.

27 suicides of other international students in Victoria between 2009 and 2015

During the investigation the coroner found that the Australian Government Department of Education has a code of practice which requires international student education providers to make a written record of any critical incident (including deaths) and remedial action taken. However, the standard does not require education providers to act beyond maintaining a record, which the coroner commented was a 'major missed opportunity from a prevention perspective'.

The investigating coroner recommended the Department:

- update the code of practice to require incident records for deaths of international students be provided to the coroner
- consult with Victorian organisations that provide education and support to international students, to identify strategies to engage vulnerable students with mental health services.

The Federal Minister for Education accepted the coroner's recommendation to consult with Victorian education providers and accepted in principle the recommended changes to the code of practice, subject to practical and legal implications.

3. Promoting public health and safety

The Court is committed to ensuring coronial data and findings are shared to improve community awareness and support the development of improved public health and safety knowledge and policies. This chapter outlines some of the research being undertaken by and with the Court, and the demand for the Court's services and information.

Research at the Court

In 2018–19, the Court analysed data from the Victorian Suicide Register to compile several submissions to assist the Royal Commission into Victoria's Mental Health System. The Royal Commission is an important opportunity for Victoria to accelerate improvements in access to mental health services, service navigation and models of care.

The following data, drawn from the Court's submissions to the Royal Commission, focuses particularly on differences between suicide in Metropolitan Melbourne and Regional Victoria.

Annual Frequency

Approximately two-thirds of Victoria's suicides each year occur in Metropolitan Melbourne (**Table 11**). However, approximately three-quarters of Victoria's population resides in Metropolitan Melbourne. This means that while the frequency of suicides is greater in Metropolitan Melbourne than Regional Victoria, the rate of suicide (measured as the suicide rate per 100,000 population) is lower in Metropolitan Melbourne than Regional Victoria.

The suicide rate in Victoria varies not just by location of usual residence (Metropolitan Melbourne versus Regional Victoria), but also by age group and sex. The graphs on page 34 illustrate this variation.

The first graph (**Figure 3**) shows the suicide rate by sex and age group in Metropolitan Melbourne. For both males and females, the rate is lowest among those in the youngest age group, then increases to a peak in middle age, before declining again in the older age groups, though for men there is a second peak in the rate among those aged 85 years and older. The suicide rate among women is substantially lower than among men in all age groups.

The second graph (**Figure 4**) shows the suicide rate by sex and age group in Regional Victoria. While rates generally follow the same pattern as in Metropolitan Melbourne, for almost all age groups the suicide rates for men in Regional Victoria are significantly higher than in Metropolitan Melbourne, while the suicide rates for women are very similar between Metropolitan Melbourne and Regional Victoria.

Table 11: Annual frequency of suicides among usual residents of Metropolitan Melbourne and Regional Victoria, 2009–18

Year	Metropolitan Melbourne	Regional Victoria	Total
2009	395	182	577
2010	345	182	527
2011	370	168	538
2012	383	202	585
2013	408	184	592
2014	392	223	615
2015	433	184	617
2016	434	204	638
2017	461	201	662
2018	467	225	692

Figure 3: Average annual rate of suicides by deceased sex, age group and usual place of residence, Victoria 2009–18 – Metropolitan Melbourne

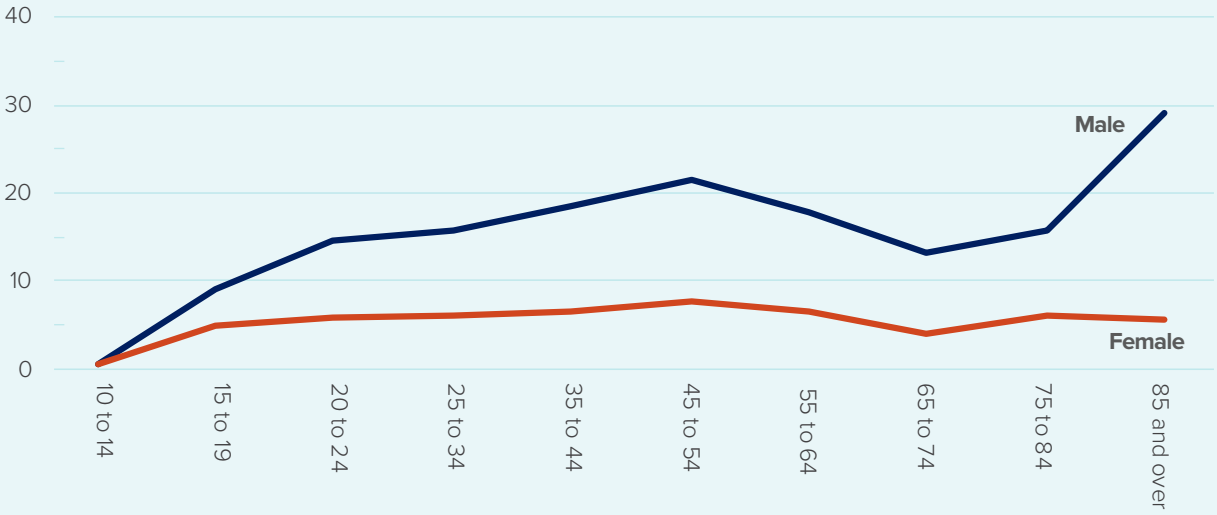


Figure 4: Average annual rate of suicides by deceased sex, age group and usual place of residence, Victoria 2009–18 – Regional Victoria

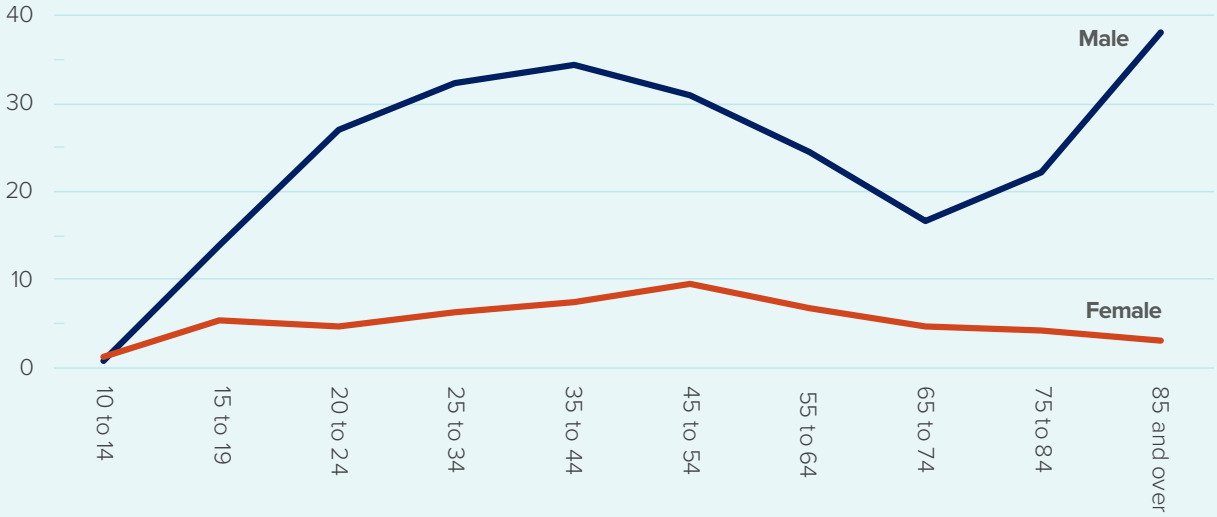


Table 12: Annual frequency of suicides among usual residents of Metropolitan Melbourne and Regional Victoria, 2009–15

	Metropolitan Melbourne		Regional Victoria	
Mental illness	**Male**	**Female**	**Male**	**Female**
Diagnosed	53.9	70.9	42.7	58.8
Suspected (no diagnosis)	22.9	14.6	25.0	20.4
Neither diagnosed nor suspected	23.2	14.5	32.3	20.8
Total	100.0	100.0	100.0	100.0

Suicide and mental health

Across both Metropolitan Melbourne and Regional Victoria, a higher proportion of female suicide deceased had a diagnosed mental illness, and a higher proportion of male deceased had a suspected mental illness or no mental illness. Further analysis of this data (not shown here) revealed a markedly higher proportion of females than males had diagnosed mood disorders (primarily depression), neurotic and stress-related and somatoform disorders (primarily anxiety), and disorders of adult personality and behaviour (primarily borderline personality disorder). This is consistent with findings from interstate and international research.

Comparing between suicide deceased by usual residence location, a higher proportion of the Metropolitan Melbourne residents (both male and female) had a diagnosed mental illness than Regional Victoria residents.

Health service contacts for mental health related issues

In the 12 months leading up to suicide, about 60 per cent of deceased had contact with a health service for mental health related issues (**Table 13**). Women had higher levels of contact than men and people residing in Metropolitan Melbourne had higher levels of contact than people residing in Regional Victoria. Of particular note, contact with specialist mental health services such as psychiatrists, psychologists or a Crisis Assessment and Treatment Team (CATT), was much lower in Regional Victoria than Metropolitan Melbourne.

The data further indicates that general practitioners were the most frequently involved clinicians in providing treatment to all people (male and female, residing in Metropolitan Melbourne and Regional Victoria) for mental health related issues in the 12 months leading up to suicide.

The data that the Court collated and submitted to the Royal Commission into Victoria's Mental Health System, suggests there are differences between suicides in Metropolitan Melbourne and Regional Victoria with respect to demographic profile, diagnosed mental illness, and contact with health services for mental health related issues.

Table 13: Proportion by sex and usual place of residence and involved clinician, of deceased who received treatment for mental health related issues within 12 months of suicide, Victoria 2009–15

Mental health treatment within 12 months of suicide	Metropolitan Melbourne		Regional Victoria	
	Male	Female	Male	Female
Any treatment within 12 months	**62.2**	**77.5**	**49.8**	**65.5**
Psychiatrist	29.7	46.4	20.4	32.2
Psychologist	15.0	21.8	10.8	15.3
Other mental health practitioner	21.3	33.0	18.7	29.4
General practitioner	45.1	58.0	35.4	49.8
Emergency department clinician	16.4	22.7	12.1	16.9
CATT	11.5	18.9	3.6	5.1
Drug and alcohol clinician	5.5	4.7	3.9	5.1
No treatment within 12 months	**37.8**	**22.5**	**50.2**	**34.5**
Total	**100.0**	**100.0**	**100.0**	**100.0**

Supporting research

During 2018–19 the Court's Research Committee met eight times to assess 60 applications for access to coronial data.

Of these applications, 58 were approved, one was rejected, and one is still under discussion with the applicants.

In making its decision, the committee considers the resource implications for the Court and the impact such access might have on families and friends of deceased people. The committee provides advice on the appropriateness of applications to the State Coroner, who determines whether the Court will endorse the research.

The applications assessed covered a broad range of topics, including:

- fatal house fires
- suicide and employment
- motor vehicle collisions
- deaths in aged care
- suicide among older members of the Victorian community
- fatal heroin overdose in Victoria.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2018–19, the Court responded to 39 requests from external organisations for data and other assistance, including:

- Requests from Victoria Police, local councils and local community groups for data on suicides in particular regions, to inform local suicide prevention initiatives.
- Requests from the Victorian Department of Health and Human Services for comprehensive suicide data spanning the state, to support the development and implementation of suicide prevention strategies.
- Requests from the Victorian Department of Health and Human Services as well as local councils for data on overdose deaths to inform drug harm reduction initiatives.
- Requests from coroners in other jurisdictions for findings and data in a range of areas, to assist their consideration of prevention-focused issues.

Contributing to national data collection

To support and inform research and prevention efforts on a national scale, the Court codes all closed investigation files for contribution to the National Coronial Information System (NCIS). This database contains information on reportable and reviewable deaths and all identified factors determined to have contributed to the death. The NCIS provides access to detailed coronial information from Australia and New Zealand to those who need it.

Requests for documents

In 2018–19 the Court received 5741 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports or unpublished findings. These applications, continue to grow, with the number of requests received by the Court increasing by 32.7 per cent during the past five years.

Table 14: Requests for coronial documents

2014–15	4327
2015–16	4668
2016–17	5063
2017–18	5237
2018–19	5741

Information and support

It is important for Victorian families and the wider community to understand the coronial process, particularly in the days and months following the death of a loved one. The Court is committed to providing better ways to offer support throughout this difficult time, in part through the provision of clear and readily understood information.

Family Liaison Officers provide critical support to families and friends affected by loss, explaining coronial processes and findings. This team also works closely with Court staff, liaising with families on sensitive matters.

The Court also produces a number of communications resources to assist families in understanding the coronial process and to provide information about support available to families and friends whose loved one's death is being investigated. These include a family brochure *What happens now?* and *The Coroners Process* booklet

Translation and interpretation services are also offered to families and friends for whom English is not their preferred language and who need to communicate with the Court.

Stakeholder education and engagement

During 2018–19, coroners delivered over 30 presentations and Court staff provided a further five presentations on topics including overdose from illegal and pharmaceutical drugs and coronial recommendations.

These formal and informal presentations to key stakeholders and industry events provide the community with information and insights into the coronial process. Stakeholders include Victoria Police, clinicians, allied health professionals, radiologists, medical students and legal practitioners.

Hospitals and health practitioners

Hospitals and health practitioners are important participants in the coronial process as they are obligated to report certain medical deaths. To help them understand when a death must be reported, and the coronial investigation process for health care related deaths, the Court holds quarterly information sessions. These sessions are offered to all staff within the healthcare sector and provide a detailed overview of the coronial process – from the time of initial reporting, to Coronial Admissions and Enquiries through to the delivery of findings. These information sessions are further supported by a range of publications and other targeted resources produced by the Court.

In 2018–19 more than 200 practitioners attended the sessions, primarily from hospitals across Metropolitan Melbourne and Regional Victoria. To help educate more practitioners, especially those in regional settings, the Court has produced a series of films addressing the key points from the presentation. This new resource will be distributed to hospital education specialists in 2019–20 to support them in their in-hospital training sessions.

Community

As part of an ongoing program to help the community understand the coronial process, the Court is developing a proactive community education program to address a range of common misconceptions about the Victorian coronial system.

Key areas of focus are medical examinations, the intersection of coronial and criminal investigations, investigation timeframes and the proportion of investigations that go to inquest. To improve community awareness and understanding of the Victorian coronial process, the Court and VIFM have co-produced an 9-episode web series, *Afterlife*, which explores the day-to-day activities of coroners, staff from the Court, VIFM and Coronial Admissions and Enquiries.

Law Week

During the Victoria Law Foundation's 2019 Law Week, the Court and VIFM held two screenings of the first episode of the *Afterlife* web series, each followed by a panel discussion on the coronial system with Acting State Coroner English and key Court and VIFM colleagues.

More than 350 people attended across both events – including members of the public, legal students and other stakeholders – to learn about why the Court becomes involved in the investigation of certain deaths and what the medico-legal death investigation process looks like. The Court has received very positive feedback.

Case study 3

Domestic violence responses reviewed following murder

There was a known history of family violence against Ms R prior to being murdered by her partner, Mr M.

A few months before her death, Mr M threatened Ms R with a knife and chocked her after she asked him to move out of her house. Police applied for a family violence intervention order (FVIO) but there was a delay in recording the relevant details onto Law Enforcement Assistance Program (LEAP), the Victoria Police database.

Mr M was eventually bailed to appear at a hearing of the FVIO application and was released on the condition that he did not contact or approach Ms R. However, days later, he attended Ms R's house and a dispute ensued. Police attended but as his bail conditions had not been entered into the police database, attending police members did not know he had breached his bail conditions. Police obtained a Family Violence Safety Notice, which was an interim protective measure to protect Ms R until another FVIO application could be heard at the Magistrates' Court.

The two FVIO applications were consolidated and heard in the Magistrates' Court. A 12-month FVIO was issued by consent. The order prohibited Mr M from approaching or contacting Ms R.

Mr M was also charged in relation to the first family incident in which he held a knife to Ms R's throat and threatened her. He was summonsed to appear at the Magistrates' Court at a later date.

Despite the FVIO, Ms R and Mr M resumed contact and during an argument Mr M killed Ms R. Mr M pleaded guilty to Ms R's death and was jailed for a minimum of 16 years.

The coroner investigated to see what opportunities Victoria Police had to prevent Ms R's death.

The evidence identified eight failures by Victoria Police to comply with policies and procedures, including the Code of Practice for the Investigation of Family Violence, prior to the fatal incident.

To improve responses to family violence, the coroner recommended that Victoria Police conduct systemic reviews of family violence-related deaths where there was a known history of family violence between the offender and deceased.

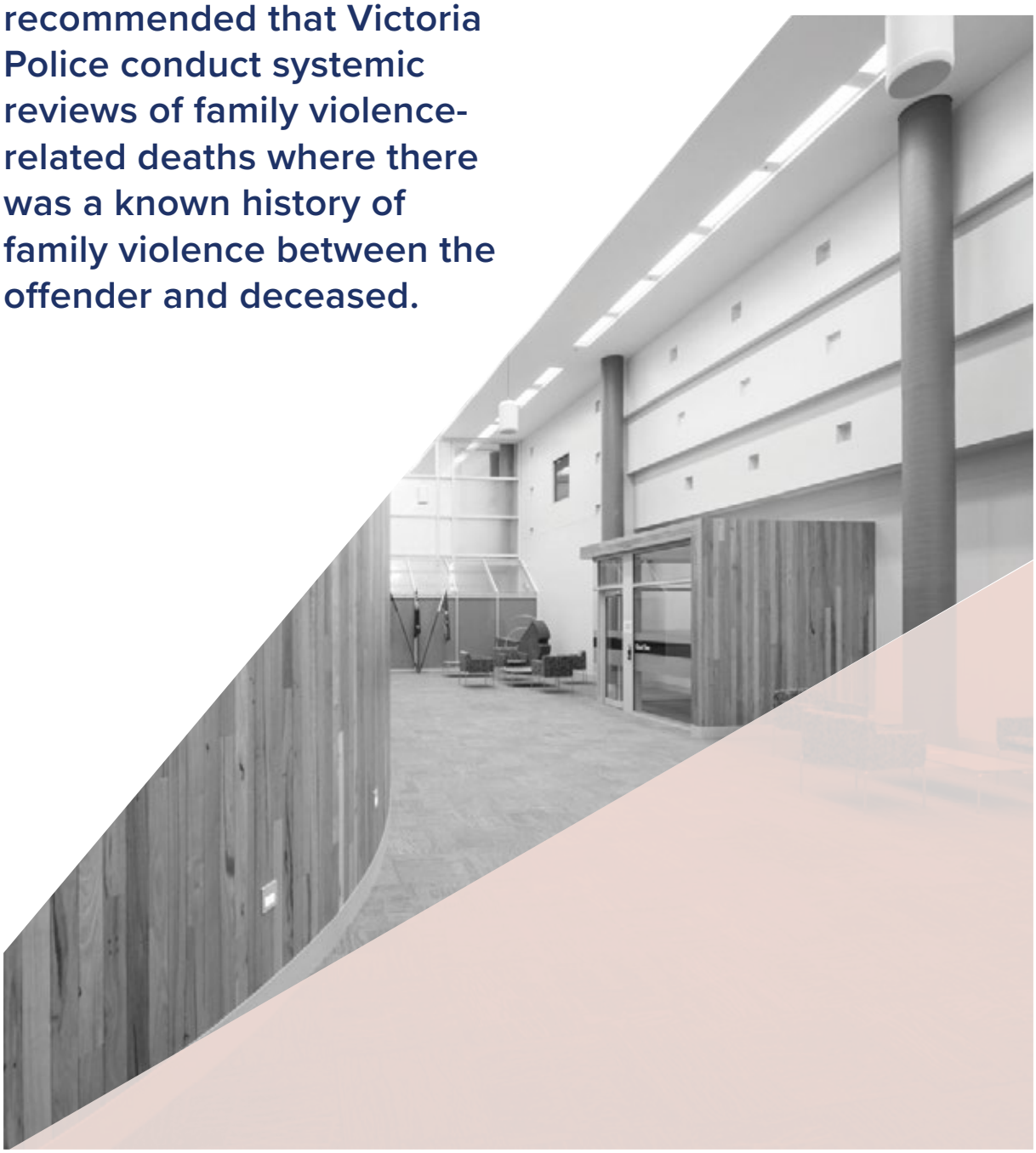
Her Honour recommended that the Victorian Government also annually review the adequacy of resources and funding provided to family violence support services to ensure that the demand for services in Victoria is met.

To improve victim safety, the coroner also supported the creation of strangulation as a stand-alone indictable offence to increase perpetrator accountability noting that the introduction of such an offence would help ensure these serious crimes are treated commensurate with the risk it poses to victims.

Victoria Police agreed to implement the coroner's recommendation to conduct a systemic review. In its response, Victoria Police committed to ensuring that a review process is established, which will identify whether there are systemic compliance, process, or legislative issues relevant to the police response to family violence deaths that occurred prior to a family violence homicide.

One-third of family violence homicides involved previously known family violence.

To improve responses to family violence, the coroner recommended that Victoria Police conduct systemic reviews of family violence-related deaths where there was a known history of family violence between the offender and deceased.



4. Corporate governance and support

The Court works closely with other jurisdictions and organisations to deliver the best possible services to Victorian families. By fostering a strong culture of collaboration, the Court can fulfil its functions while making good decisions for the benefit of the community. This chapter outlines the Court's structure, committees and workforce.

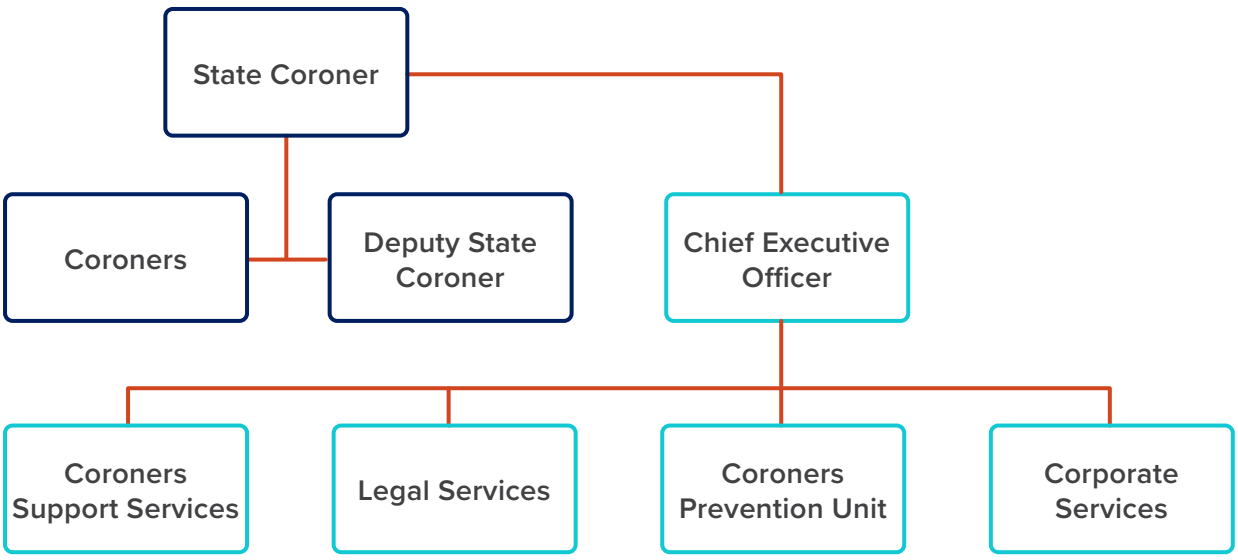
The Court is one of the courts and tribunals which sit within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its staff.

Organisational structure

The Court employs 98 staff who support the coroners in their independent investigations and manage the administration of the Court. The organisation comprises four divisions, each of which is led by a manager:

- **Coroners Support Services** closely manages case files, providing support to families and liaising with other parties. This division includes Court administration, family liaison officers and registrars.
- **Legal Services** assists coroners with their investigations by analysing evidence, preparing draft findings, preparing matters for inquest and appearing as counsel to assist the coroner at inquests.
- **Coroners Prevention Unit** works closely with the coroners to help them identify and research matters that may lead to recommendations being made to prevent similar deaths.
- **Corporate Services** supports the efficient operation of the Court through governance, records management, finance and procurement, information technology, media and communications, policy, risk and audit and human resources functions.

Organisation chart



Workplace profile

At 30 June 2019, the Court had 98 staff members (85.4 full-time equivalent (FTE)), not including coroners. This includes 74 permanent staff, 31 per cent of who were employed on a part-time basis.

The following table presents the staff numbers and FTE of all public service employees of the Court in the last full pay period in June 2019.

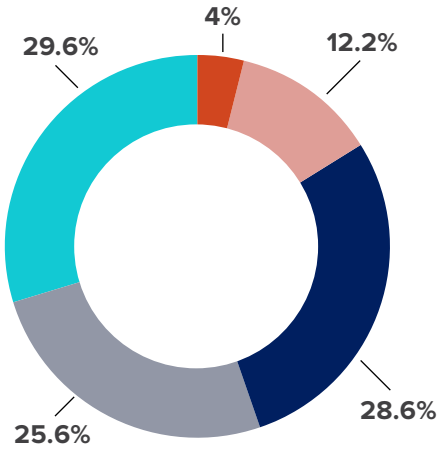
Table 15: Workplace profile as at 30 June 2019

	June 2019					
	All employees		Ongoing		Fixed term/casual	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
Male	21	17.8	12	4	5	0
Female	77	67.6	39	19	16	3
Total	**98**	**85.4**	**51**	**23**	**21**	**3**
VPS2	14	12.8	9	2	3	0
VPS3	21	19.8	12	4	5	0
VPS4	36	32.8	19	5	9	3
VPS5	9	8.5	5	2	2	0
VPS6	7	7	5	0	2	0
STS	6	1	0	6	0	0
Registrar Grade 3	1	0.6	0	1	0	0
Allied Health 3	2	1.1	0	2	0	0
Solicitor Grade 3	1	0.8	0	1	0	0
Executive	1	1	1	0	0	0
Total	**98**	**85.4**	**51**	**23**	**21**	**3**

Note: Victorian Public Service (VPS) and Senior Technical Specialists (STS)

Table 16: Divisional headcount at 30 June 2019

Division	Number FTE	Number Headcount
Office of CEO	3.95	4
Corporate Services	10.8	12
Legal Services	27.1	28
Coroners Prevention Unit	18.1	25
Coroners Support Services	25.46	29
Total	**85.4**	**98**



Governance and accountability

Various internal and external governance processes guide the Court's conduct, actions and decisions. The Court has two senior committees – the Council of Coroners and Operational Executive Committee – that meet regularly to oversee critical business functions, provide a clear decision-making framework and ensure the Court makes appropriate decisions in both day-to-day work and large-scale projects or procurements.

Council of Coroners

The Council of Coroners, chaired by the State Coroner, directs the administrative support provided by jurisdiction-based staff, under management of the Court CEO. Meeting quarterly for formal, business reporting from the Operational Executive on operations of the Court, the Council:

- examines themes and issues identified within the business units
- makes high-level decisions in relation to the operations of the Court
- sets the strategic direction of the Court.

Operational Executive Committee

The Operational Executive Committee, headed by the CEO, includes the heads of the Court's four business units and the Strategic Program Manager and Principal Project Officer. The committee meets fortnightly and is accountable for:

- day-to-day operations
- progress on major projects
- Court performance and efficient management of Court resources
- implementing the strategic direction of the Court.

The Operational Executive Committee supports the Council of Coroners to make strategic decisions by providing timely information and advice on operational matters.

Courts Council

As Head of the Coronial Jurisdiction, the State Coroner is a member of the Courts Council, CSV's governing body. Coroners represent the Coroners Court of Victoria on several standing committees established by the Courts Council:

- Strategic Planning, Infrastructure and Services Portfolio Committee
- Finance Portfolio Committee
- Human Resources Portfolio Committee
- Information Technology Portfolio Committee
- Courts Koori Portfolio Committee.

Corporate governance and support

CSV representation

The Coroners Court of Victoria, like other courts, operates using CSV policies and procedures to ensure that the overarching strategy for Victoria's judicial system is advanced. Additionally, CSV Jurisdiction Services provide or support many of the Court's administrative functions to streamline service delivery to the community.

Joint VIFM and Coroner Governance Committees

The VIFM Council

VIFM provides important aspects of the State's coronial services. To support collaboration the State Coroner represents the Court as a member of the VIFM Council. The VIFM Council is the institute's governing body, taking a strategic and stewardship role in leading VIFM in accordance with the responsibilities set out in the *Public Administration Act 2004*.

Coroners and Pathologists Working Group

Two coroners and senior staff from both the Court and VIFM meet quarterly to provide expert advice on operational and other issues. The working group is chaired alternately by the Deputy State Coroner and the Deputy Director of VIFM Forensic Services. It provides guidance to two joint committees – the Joint VIFM and Coroners Court Steering Committee and the Joint Operations Committee.

Joint VIFM and Coroners Court Steering Committee

This committee provides strategic leadership and oversight of death investigation matters, resolution of operational issues and emergency management for the State Coronial Services Centre. Also responsible for overseeing joint protocols and the memorandum of understanding between the two organisations, the committee meets quarterly and is alternately chaired by the State Coroner and the Director of VIFM.

Joint Operations Committee

This committee's focus is on strengthening and maintaining the working relationship between the Court and VIFM. It seeks to inform and enable regular improvements in the quality and efficiency of the death investigation services provided by the Court and VIFM to families of the deceased, the justice system and the Victorian community. Senior staff from both organisations comprise the Joint Operations Committee and is alternately chaired by the Court's CEO and VIFM's Chief Operating Officer.

Coronial Council of Victoria

Established under the *Coroners Act 2008* to provide advice to the Attorney-General about matters of importance to the coronial system in Victoria, the Council was the first body of its kind in Australia. Independent of both the Court and the Victorian Government, the Council's function is to provide advice and make recommendations to the Attorney-General in respect of:

- issues of importance to the coronial system in Victoria
- matters relating to the preventative role played by the Court
- the way in which the coronial system engages with families and respects the cultural diversity of families
- any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

The State Coroner is a member of the Coronial Council.

Minimising risk

Risk management is integral to all aspects of the Court's decision-making, planning and service delivery.

The Court ensures that risks and resources are managed responsibly and complies with all CSV practices, policies and procedures. Throughout the past year the Court has continued to review risk-management planning to align with CSV's Risk Management Framework and the Victorian Government's Risk Management Framework.

A review of the Court's risk management action plan and registers was completed in 2018–19. The review confirmed the Court's current risk profile and operational improvements for the ongoing identification and management of risk at the Court.

Business continuity planning

During 2018–19 the Court reviewed its business continuity plan in line with CSV's Business Continuity Policy & Framework.

An updated business continuity plan for the Court was released in February 2019. The updated plan provides greater clarity and guidance on contingencies for maintaining essential business resources and services in the event of interruptions.

The Court also worked in close partnership with the VIFM to ensure joint business continuity and emergency management procedures continued to be well aligned.

Audits

The Court's operational, administrative and financial performance and decisions are reviewed every year in the CSV Annual Audit Plan, which is undertaken in a collaboration between the Court and CSV.

In 2018–19, the Court participated in internal audits at a CSV-wide level regarding:

- core financial processes and controls
- the CSV risk management framework
- fraud and corruption risk assessments
- physical security
- digital readiness
- procurement compliance.

The Court's administrative functions are also subject to external audits by the Victorian Auditor-General's Office (VAGO).

The Court's finances, along with those of all other jurisdictions, are included in VAGO's annual audit of CSV's finances and are reported in full in the CSV Annual Report.

Providing a safe and healthy workplace

The most important resources of the Court are our people – the coroners and the Court's staff who support them. The Court promotes public sector professionalism and provides for fair treatment, career opportunities and the early resolution of workplace issues in compliance with CSV policies and practices.

Health and wellbeing

The Court is keenly aware of the sensitive and sometimes graphic nature of the material coroners and staff are exposed to and works to embed strong work health and wellbeing systems.

A range of activities and initiatives implemented by the Court during 2018–19 provided support for staff health and wellbeing. Activities included the establishment of a Wellbeing Steering Committee in September 2018, to prepare a Health and Wellbeing Plan. The plan was developed collaboratively between coroners, senior managers, staff and experts in health, safety and wellbeing. Through the plan the Court has:

- engaged an external consultant to do a functional review of the Court's operating structure to ensure team structures support staff wellbeing, provide good supervision and career progression opportunities
- completed a health and wellbeing audit of existing programs and introduced a program of wellbeing activities including a series of mindfulness sessions and the introduction of a Court (therapy) dog program where staff enjoy a calming environment with well-trained therapy dogs
- commenced an accommodation project to look at how the Court can build in more communal break-out spaces, as well as ergonomic work stations, to maximise staff health and wellbeing
- introduced additional counselling programs to support all staff and assist managers to manage the health and wellbeing of their teams
- undertaken a staff survey to identify the workplace culture and to implement a tailored response
- offered mental health first aid training for staff.

The Court's Wellbeing Debriefing Program, introduced in 2017, also provides support mechanisms to enhance the existing capacity of staff to manage the daily stressors which arise in this unique workplace. As part of the program, all staff attend two compulsory debriefing sessions annually with an experienced psychologist, with the option for a further two sessions if required.

All Court staff also have access to the Employee Assistance Program, which provides online resources, counselling and coaching to assist in dealing with general wellbeing.

Corporate governance and support

Recruitment

The Court strives to build and maintain the capacity of its workforce at each stage of the employee lifecycle, from recruitment and engagement through to rewarding, retaining and transitioning staff.

A range of workplace initiatives, led by in-house human resources staff, contribute to and support a skilled workforce and embrace a fair and equitable recruitment process. The design of this process ensure candidates are equally assessed and evaluated based on the key selection criteria and other accountabilities, without discrimination.

Flexibility

To help employees balance the demands of work and personal commitments, the Court offers flexible working arrangements which employees are encouraged to access. These include reasonable access to a range of leave options (including the new family violence leave provisions), flexible work hours, job-share arrangements, study leave and options to work from home where this can be managed within the requirements of the business.

The Court complies with the *Carers Recognition Act 2012* and, through the staff induction program and available leave options, has sought to ensure that all staff understand the principles of the Act.

Participation

The Court also participates in inter-organisational programs with VIFM to foster a culture of collaboration, including the Social Club and the Green Team. These programs not only help build a culture of participation and collaboration while encouraging health and wellbeing but also provide the opportunity to support the community.

Social Club

Connecting staff with the Court's neighbour at VIFM, the joint Social Club organises regular networking and team building events. During the past year, staff participated in an International Women's Day event, a Step-tember exercise challenge and other various activities.

The Green Team

A host of environmental and social initiatives and enablement opportunities have been provided by The Green Team to encourage staff to consider their contribution to their world. Comprising staff from the Court, VIFM and PCSU the Green Team continued to develop and implement many projects over the past year, including coffee pod and battery recycling programs and a book exchange.

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

Performance and development

Management and staff planning in the areas of performance and development allows all staff to understand their output, whether from an individual or the team, and identifies areas for further learning and development. Every employee has an individual Performance Development Plan to support their ongoing performance and development by documenting clear goals, expectations and development opportunities.

The Learning and Development Program supports management and staff by providing opportunities to build staff capability and develop new skills. It offers targeted training and development to enhance an employee's knowledge and capacity to fulfil their role and contribute to delivering the Court's strategic objectives. Highlighted programs focusing on inclusion and support included Sorry Business training, mental health first aid training, Koori awareness training and Lifeline training.

Glossary

BP3	Victorian Budget Papers Number 3
CATT	Crisis Assessment and Treatment Team
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
DHHS	Department of Health and Human Services
DPP	Director of Public Prosecutions
FTE	Full-time equivalent
FVIO	Family violence intervention order
NCIS	National Coronial Information System
OFG heater	Open Flued Gas Heater
PCSU	Police Coronial Support Unit
STS	Senior Technical Specialists
The Coroners Act	*Coroners Act 2008*
VAGO	Victorian Auditor-General's Office
VCAT	Victorian Civil and Administrative Tribunal
VHR	Victorian Homicide Register
VIFM	Victorian Institute of Forensic Medicine
VODR	Victorian Overdose Death Register
VPS	Victorian Public Service
VSRFVD	Victorian Systemic Review of Family Violence Deaths

Appendices

Applications and appeals

Application to reconsider an order for autopsy

Autopsies are conducted to help determine the exact cause of death and, if required, will be ordered by a coroner and conducted by a forensic pathologist practising at VIFM. Fewer than half of all deaths reported to the Court require an autopsy.

A senior next of kin may ask a coroner to reconsider their decision on cultural, religious or other grounds.

If a coroner affirms their original decision, a senior next of kin may appeal that decision to the Supreme Court within 48 hours.

Application to hold an inquest

A person may apply to an investigating coroner to hold an inquest as part of an investigation into a death or fire.

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

Application to re-open an investigation

A person may apply to the Court to set aside a finding or findings of a coroner and re-open an investigation. It should be noted, however, that a coroner can only re-open an investigation if they are satisfied there are new facts and circumstances are available that make it appropriate to do so.

If a coroner determines not to set aside a finding or findings and re-open an investigation, the person may appeal to the Supreme Court within 90 days of the coroner's decision.

Appeals against the finding(s) of a coroner

A person with a sufficient interest in an investigation may appeal to the Supreme Court against the finding(s) of a coroner. An interested party may appeal against the finding(s) of a coroner after an inquest. These appeals must be lodged within six months of the finding being finalised.

Supreme Court appeals

In 2018–19, one appeal was finalised:

Trinh v The Coroners Court of Victoria [2019] VSC 133. A coroner determined to release a body to the mother of the deceased rather than the alleged domestic partner. The coroner was not satisfied on the evidence before her that the deceased had a spouse or domestic partner immediately before his death. The purported domestic partner appealed to the Supreme Court. Justice Macaulay decided there was no error of law and dismissed the appeal. In doing so, His Honour discussed what amounts to a "manifestly unreasonable" decision.

Feedback

The Court welcomes feedback and considers it important to improving services and the experience of those involved in the coronial process. While feedback is predominantly positive, complaints regarding service provision, the conduct of coroners and the Court's processes or procedures do occur.

In 2018–19, the Court developed and implemented a new Feedback and Complaints Policy to help the Court monitor its operations and incorporate feedback into the ways it conducts business.

Complaints and information relating to them are confidential. The Court receives and manages complaints in accordance with the *Privacy and Data Protection Act 2014*.

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

Judicial Commission of Victoria

Complaints about the conduct or capacity of Victorian judicial officers or members of the Victorian Civil and Administrative Tribunal (VCAT) may be made to the Judicial Commission of Victoria. The Commission is established under the *Judicial Commission of Victoria Act 2016*.

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

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

Freedom of information

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

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

Coroners Court
of Victoria