Coroners Court
of Victoria

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of Victoria

Annual Report

2019–20

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 2020.

John Cain, State Coroner
December 2020

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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December 2020

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At a glance

INVESTIGATIONS

7323 NEW investigations opened

6841 investigations finalised

93.4% closure rate

CASELOAD

TIMELINES

7.1 Average months to investigate

82.4% in <12 months

50.2% in <3 months

INQUESTS

58 inquests finalised

0.85% of investigations closed following inquest

RECOMMENDATIONS

166 recommendations made

92 accepted

9 not accepted

65 awaiting response or under consideration

DATA & DOCUMENTS

4600 requests for documents

47 requests from organisations for coronial data

46 research requests granted

Contents

The year in review

From the State Coroner

I was appointed State Coroner in October 2019 and have used the time since my appointment to familiarise myself with the systems and processes of the Court.

The vital and important role that the Court performs in investigating reportable deaths cannot be underestimated. There are approximately 7000 reportable deaths each year and regardless of whether it is a death that attracts public attention or any one of the other unexpected deaths referred to the Court each year, every case is thoroughly investigated to determine identity, cause of death and the circumstances of the death.

To deliver this important service to the Victorian community, we are fortunate to have a strong partnership with the Victorian Institute of Forensic Medicine (VIFM) who provide great support and advice to coroners in their investigations. The VIFM staff are world leaders in the work they do, and we greatly appreciate and value their collaboration.

In addition to determining identity, cause of death and the circumstances of death, coroners also play a significant role in making recommendations or comments that are directed to preventing deaths occurring in similar circumstances in the future. In the last year coroners made 166 recommendations for prevention opportunities. Coroners identify prevention opportunities that are focused on saving lives, that are practical and are capable of implementation.

We have a great asset in the staff employed by the Court, and they provide wonderful support to the coroners. Whether this is the registrars managing the daily work flow and timetable of the Court, the coroners' solicitors assisting in investigations and preparation of findings, or the staff of the Coroners Prevention Unit providing expert advice on medical, family violence, suicide or general prevention issues, we are assisted by an extremely dedicated and committed staff. In addition, we have a great corporate services team who keep the organisation running efficiently. Our staff are driven

by a strong desire to contribute to their community through their work at the Court. The subject matter is often confronting and challenging but they demonstrate great empathy, guidance and support to families. Families often provide feedback to us expressing their appreciation about the great work of the staff.

The strength of the Court staff was clearly demonstrated in March when at the beginning of the Coronavirus (COVID-19) pandemic, with very limited preparation time, we transitioned from office based and paper dependant work to working from home via digital solutions. In a matter of days, we had reduced the number of staff onsite to less than one third and provided support to coroners and staff to transform parts of their homes into functional workspaces. Even with this disruption we have managed to maintain our work output and, in some areas, improved it.

The Court's CEO Carolyn Gale and her team, together with the Court Services Victoria staff, have done a marvellous job leading us through this transition. The positive response from staff was outstanding and the cooperation from our stakeholders was greatly appreciated. The challenge ahead is to capture and adopt those practises that have worked well during the restrictions and build a new and improved 'normal' when restrictions are lifted. We have also commenced a significant technology upgrade that will allow us to move further towards a paperless environment and facilitate remote working and inquest hearings.

Our work volume has increased by ten per cent in the year with 7323 deaths being reported as compared to 6657 last year. Suicide frequencies continue to be a significant and concerning part of the Court's work. Ten per cent of all reportable deaths are suicides and if you exclude reportable deaths that are natural then suicide represents 20 to 25 per cent of the work of the Court. In excess of 700 suicides were reported to the Court last financial year; that is approximately two and a half times greater than the road toll for the same period. There is much work to be done in this area. Our data collection is the best in the country but tackling how we, as a community, reduce this number continues to be a complex challenge. There is no doubt that the response, like the response to reducing road deaths, is multi-faceted with government, health professionals and the broader community working together on the solution. The work of the Royal Commission into Victoria's Mental Health System is timely and vitally important to framing some options and we eagerly await the report.

The Court is very conscious of the need to support families through the coronial process. For many families it is unfamiliar and sometimes intimidating. Families are required to navigate the coronial process at a time of grief and sadness, with many other issues to simultaneously manage. In the last year the Court has improved the support for families by increasing the number of Family Liaison Officers from four to six.

In addition, our Koori Engagement Unit is a great asset to the Court, not only providing quality support to families and communities but also informing and educating coroners and Court staff about Sorry Business, the cultural practices and protocols that apply to Aboriginal and Torres Strait Islander passings, to ensure that the particular needs of these families are met.

We still have more to do in making it easier for families to understand the work of the Court, how they engage with the Court and how to provide information and support that responds to their needs. This will be a focus of our work in the next year.

In addition, the Coronial Council has been working on a report for the Attorney General in relation to multifaith and culturally and linguistically diverse (CALD) families. We anticipate that the recommendations from the Coronial Council will provide some direction to the Court on steps it can take to be more responsive and supportive of CALD and multifaith families.

In the period prior to my appointment, Deputy State Coroner Caitlin English held the position of Acting State Coroner. I would like to acknowledge the significant work of Deputy State Coroner English in her time as Acting State Coroner in providing excellent leadership and direction to the Court. Deputy State Coroner English has also been a great support to me since my appointment and guided me through the early stages of this role - I am very grateful for her support and assistance. I would also like to thank all my fellow coroners who have been very welcoming and a source of great support. I am very fortunate to work with a group of talented coroners who have such a strong commitment to supporting families through the coronial process and contributing to a safer community.

From the CEO

It has been a year of significant change and adaptation at the Court and I have continued to be impressed by the dedication and skill of the coroners and staff that undertake this important work.

Their passion and commitment is evident every day in the care and respect given to families experiencing loss, and their ongoing dedication to preventing unnecessary deaths in Victoria.

During the 2019—20 financial year, there have been plenty of achievements at the Court, including extensive digital works benefiting both staff and Court users, enhanced staff wellbeing programs, a new family survey and a renewed focus on making our data publicly available to enhance health and prevention programs in the community.

The COVID-19 pandemic presented an unexpected challenge to the Court this year. Fortunately, the Court had already commenced extensive work on a digital transformation to modernise both the workplace and access for Court users. As a result, we were able to reduce the number of staff onsite at the beginning of the crisis in Victoria, with the remainder able to work remotely. I am so proud of how well the coroners and staff handled this rapid change, maintaining close bonds and supporting each other through these difficult times.

The digital works have also improved access to Court services. Since March 2020, the Court has been holding hearings online, with witnesses, experts, and other participants able to provide evidence and other input into proceedings via video. I extend my sincere thanks to all the people who have made this possible.

Over 2019—20, the Court added a People and Wellbeing division and work is well underway on action points in the Court's Health and Wellbeing Plan 2018—20. Progress has been made in strengthening health and safety governance arrangements, changes in how staff are supported and supervised in their roles, and the creation of a Reducing Exposure Risk Working Group to identify further opportunities for improvement. This health and wellbeing focus has been of significant importance during the COVID-19 pandemic and has been instrumental in keeping our staff connected though the crisis. Enhanced programs during the pandemic included resilience workshops, online vicarious trauma training, meditation and yoga classes, and other online social activities, expanding the network of workplace support to staff wherever they were working from.

This year, the Court has committed to making more of the current data it collects on reportable deaths in Victoria publicly available. This initiative aims to support targeted, data driven programs to help reduce reportable deaths in Victoria. The first report released under this renewed focus is the *Victorian suicides of Aboriginal and Torres Strait Islander people*. The report, developed in consultation with the Coroners Koori Engagement Unit (CKEU), is available online.

The year in review

Last year we designed a family survey to find out more about how families feel about their experiences with the Court. The survey has been well received by Court users and the number of responses has continued to grow since it was introduced. The feedback we have received to date has been largely positive and it has been a pleasure to pass this feedback onto our staff. The survey will continue to be an integral part of our work so we can keep identifying systemic improvements for the people engaging with the Court.

In closing, I would like to thank all the coroners and staff for their professionalism and dedication to the vital work of the Court. I would also like to extend my thanks to our key partner agencies; the Victorian Institute of Forensic Medicine, our Court Network volunteers, and Victoria Police. Furthermore, many thanks to Deputy State Coroner English for her leadership of the Court as Acting State Coroner prior to the appointment of Judge John Cain who joined us late last year. Finally, I would like to express my appreciation to Judge John Cain for his vision and dedication to transforming the Court to keep up with and better meet the needs of the Victorian community.

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.

State Coroner, Judge John Cain commenced as the Court's head of jurisdiction in December 2019, and Deputy State Coroner Caitlin English led the Court's eleven coroners as Acting State Coroner from April 2019 to December 2019.

During the 2019—20 reporting year, the Coroners Court of Victoria farewelled Coroner Rosemary Carlin, who was appointed as a judge of the County Court, Coroner Hodgson, who returned to the Magistrates' Court, and welcomed Coroner Leveasque Peterson.

State Coroner Judge

John Cain LLB BEc

John Cain was appointed State Coroner in October 2019, prior to which he was Victoria's Solicitor for Public Prosecution since November 2015.

Judge Cain completed a Bachelor of Economics and a Bachelor of Law at Monash University before completing the Legal Professional Services Firm course at Harvard Business School in 2010.

His legal career began at Maurice Blackburn in 1982, where he was appointed a partner in 1987 and then managing partner from 1991 to 2002.

Between 2002 and 2006, Judge Cain was CEO of the Law Institute of Victoria and became the Victorian Government Solicitor in 2006 until 2011, after which he became managing partner at Herbert Geer (now Thomson Geer).

In his capacity as State Coroner, Judge Cain serves as 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, and the Council of Chief Coroners.

The Coroners

Deputy State Coroner

Caitlin English – BA(Hons) LLB MPP

Coroner Caitlin English was appointed as Deputy State Coroner in April 2019 and served as Acting State Coroner prior to the appointment of Judge John Cain. Before 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, Coroner English served as 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 a chair of the Coroners Education Committee, the Coroners and Pathologists Advisory Group, the Court's Koori Committee and the Judicial College of Victoria's Wellbeing Committee.

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 was 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.

In September 2019, Coroner Carlin left the Coroners Court to take up an appointment as a judge of the County Court of Victoria.

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.

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.

The Coroners

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

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, and 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.

Coroner Hodgson 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.

In February 2020, Coroner Hodgson left her position at the Coroners Court and returned to serving at the Magistrates' Court of Victoria.

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 and Supreme, County and Magistrates' Courts in a variety of matters, including professional negligence and personal injury law, human rights, discrimination and confiscation proceedings. 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 lectures in death investigation with VIFM, and supervised the Monash University clinical placement program. 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 including the Royal Commission into Aboriginal Deaths in Custody, Victoria Legal Aid 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. In addition, she worked on the establishment of the Neighbourhood Justice Centre, adult Koori Courts and the Children's Koori Court.

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

Coroner

Leveasque Peterson BA/LLB

Coroner Peterson was appointed a coroner in February 2020. Prior to her appointment, Her Honour served as the Assistant Victorian Government Solicitor for two years, supervising the regulatory practice and representing the State's response for the Royal Commissions into Victoria's Mental Health System and Aged Care. Admitted to legal practice in 1994, Coroner Peterson has had a broad regulatory, administrative law and inquiries practice in private practice and as a government lawyer representing governments, departments and statutory agencies.

During the 2009 Victorian Bushfires Royal Commission, Coroner Peterson represented 77 local councils and subsequently assisted in the local government response to recommendations made by the Royal Commission.

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 19**

Reducing preventable deaths

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

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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 36**

Our history

Victoria's first coroner was appointed in 1841, 30 years before Victoria established its first morgue in Melbourne. It was not until 1888 that the first permanent coroners' courthouse was constructed and 100 years later, 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 2008* 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.

Coronial services in Victoria

Victoria's coroners are supported by several organisations to deliver coronial services, including the 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 Coroners 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 2019—20

Coroners Court Family Survey

To better understand the needs of families, the Court developed and implemented a family survey during the 2019—20 reporting period. The survey was designed to provide an evidence-based approach to identify systemic improvements for Court users.

Feedback from families collected though the survey has been overwhelmingly positive, with engagement numbers continuing to grow every month that the survey is sent out. This growth in engagement has been facilitated by the increasing use of digital communication methods overall by the Court.

This data has been invaluable in improving Court services and will continue to be a feature of family engagement.

Coroners Court public data initiative

The Court collects a broad range of data about deaths in Victoria during its investigative and prevention work. This year, the Court has committed to making more of this data publicly available to support agencies and organisations in the community and health sphere to develop stronger, evidence-based programs to help prevent reportable deaths.

The first report released as part of this initiative is the *Victorian suicides of Aboriginal and Torres Strait Islander people*. This report is available online and presents an analysis of all Indigenous passings identified as suicides in Victoria between 2009 and 2020. The data captured includes demographic information, stressors specific to the experiences of Indigenous people in Victoria, and socio-economic factors.

Given that suicide frequencies are twice that of the non-Indigenous population, especially amongst young people, it is vital that accurate and culturally responsive data is accessible across the Indigenous mental health and suicide prevention sector.

Digital Transformation at the Court

Over the last two years, the Court has been engaged in a large-scale program of digital transformation to improve access to the Court. This digital work has encompassed both internal and external Court functions, ranging from improved flexibility for staff, to easier access to forms, Court materials and online hearings for Court users.

This project included rolling out laptop computers equipped with remote access applications to 90 per cent of staff prior to the COVID-19 pandemic, which allowed for a smooth transition to work from home for most Court staff. Fast tracking of approval for additional monitors and other ergonomic devices was achieved to ensure on-going staff wellbeing.

Since March 2020, all coronial hearings, including inquests, have been held online using the Webex platform. Providing an online Court experience has improved efficiency and fostered participation making it possible for families, experts and other parties to give evidence or watch the proceedings via video link. This upgrade ensured that the Court could safely continue its work during the COVID-19 pandemic.

There have also been major upgrades to the Court's case management systems and databases, resulting in more detailed information being captured and improved efficiency in responding to queries.

This digital transformation has allowed the Court to work efficiently through the challenges of 2020 as it continues to find ways to integrate digital upgrades into its day to day functions.

Enhanced staff well-being programs

Over the 2019—20 reporting period, the Court introduced a People and Wellbeing division and has made significant headway in enacting improved health and wellbeing initiatives under the Health and Wellbeing Plan 2018—20. Health and safety governance processes have been strengthened and improvements have been made to staff support and supervision to better ensure that their needs are being met. Vicarious trauma and resilience workshops were delivered, creating broader awareness of the exposure risks associated with the Court's work, and self-care strategies.

With the COVID-19 pandemic resulting in the majority of Court staff working at home from March 2020, keeping people connected and healthy has been of utmost importance. This has been achieved through the introduction of more online social events, yoga and mediation sessions available daily, and other health programs.

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	2018—19 actual	2019—20 estimates	2019—20 actual
Quantity				
Average cost per case	$	4311	4291	3882
The 2019—20 actual is lower than the estimate due to the Court's ability to increase the number of finalised cases for the year and reduce its average cost per case accordingly.				
Case clearance	%	89	100	93.4
The 2019—20 outcome deviates from the estimate. Although the case clearance rate increased in 2019—20 compared to 2018—19, it was impacted by a rising number of new cases.				
Quality				
Court file integrity: availability, accuracy and completeness	%	67	90	86
The Court refreshed its file management training in 2019—20 and achieved a result of 86 per cent by year-end. It is anticipated that the benefits of this training will be further reflected in future years to meet the 90per cent target.				
Timeliness				
On time case processing: matters resolved or otherwise finalised within established timeframes	%	82.8	80	82.4
Of the 6841 cases finalised, a total of 5637 were closed within agreed timeframes, being less than 12 months.				

1. Investigations into deaths and fires

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 2019—20, the Court commenced more investigations than it finalised, resulting in a 93.4 per cent closure rate for investigations into deaths and fires. This increase from last year's closure rate of 89 per cent is a significant achievement given the disruptive impact of the COVID-19 pandemic and is due to the uptake of more efficient processes at the Court, including an expanded repertoire of digital services.

Of the 6841 cases closed in 2019—20, 51.3 per cent were closed following a coronial investigation. The remaining closures were administrative closures, which do not require a coronial determination.

Many of the 6.6 per cent of cases initiated but not finalised in 2019—20 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.

Table 2: Investigations opened and finalised

	2015—16	2016—17	2017—18	2018—19	2019—20
Number of investigations commenced	6305	6248	6642	6757	7323
Number of investigations finalised	6596	6285	6500	6010	6841
Closure rate	104.6%	100.6%	97.9%	89%	93.4%

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 2019—20 was 7.1 months with 50.2 per cent of these finalised within three months. In most of these cases, the coroner's investigation deemed them to be natural cause deaths.

Table 3: Duration of closed investigations

	2015—16	2016—17	2017—18	2018—19	2019—20
0–12 months	5289	5047	5526	4978	5637
12–24 months	785	855	722	785	846
>24 months	522	383	252	247	358

Table 4: Average duration of cases before they are closed

	2015—16	2016—17	2017—18	2018—19	2019—20
Duration (days)	253.5	236.7	205.8	213.3	213.4

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.

Only 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.

The Court has introduced several initiatives to help reduce the duration of inquests along with corresponding costs for families, witnesses, and the Court - for example allowing witnesses from interstate or overseas to give evidence via video conferencing technology. In cases where evidence is required from a number of expert witnesses, they can be invited to come together and consider a series of questions formulated by the coroner to collectively reach consensus in areas of common agreement and disagreement, rather than giving evidence individually.

Of the cases finalised in 2019—20, 58 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 17 inquests were held at the Court.

Investigations into deaths and fires

Table 5: Cases closed with inquests

	2015—16	2016—17	2017—18	2018—19	2019—20
Number of cases closed with an inquest	131	82	49	59	58
Percentage of cases closed with an inquest	2.0%	1.3%	0.7%	1%	0.85%

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 online, 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.

In addition to making findings and recommendations, coroners may also comment on any matter connected with a death, including matters relating to public health and safety or the administration of justice.

Case study 1

Mental health and financial support for returned veterans

Mr B, a 32-year-old army veteran, was found deceased at his home in St Kilda having passed away from suicide. He was located with his service medals, military equipment and documentation relating to his service history, mental health issues and Department of Veterans' Affairs (DVA) claims.

The investigating coroner found that Mr B had a history of psychological injuries including post-traumatic stress disorder (PTSD) associated with his service in the army. Mr B's mental health had deteriorated in the years leading up to his death in the setting of financial and emotional stressors exacerbated by the delays and difficulties he faced in claiming financial support and compensation from DVA for his service-related injuries.

During the inquest, DVA conceded that there were failures surrounding the management of Mr B's case that contributed to his decision to end his life. Mr B's passing was the catalyst for a comprehensive system-wide review and reform of DVA and Defence processes including an increased focus on promoting mental health, collection of service information in Australian census data, and improved information sharing between Defence and DVA. The DVA also shifted its model from an adversarial claims-based system to a veteran-centric management approach, and enshrined the Australian Defence Veterans' Covenant in legislation. Furthermore, a Veteran Family Advocate within the DVA was announced along with a dedicated National Commissioner for Defence and Veterans Suicide Prevention.

The coroner acknowledged that there had been improvements in veterans' experiences of the DVA claims processes since Mr B's death due to these reforms.

The investigating coroner identified further areas for improvement and made five recommendations, including more robust sharing of information between the Department of Defence and the Coroners Court to assist in the design and implementation of suicide prevention initiatives, implementation of a public awareness campaign to build veterans' trust and confidence in the DVA, harmonisation of legislation governing the veterans' compensation and rehabilitation scheme, and an extension of the remit of the National Commissioner to include proactive powers to investigate veteran complaints and audit DVA processes.

In response, the Commonwealth Government has agreed to implement three of the five recommendations. The recommendation to harmonise legislation governing the veterans' compensation and rehabilitation scheme remains under consideration and an alternative was implemented in the place of the remaining recommendation prescribing the powers of the National Commissioner.

Prior to the delivery of the finding, the Commonwealth Government announced that it would be establishing a National Commissioner for Defence and Veterans Suicide Prevention. The Government has recently introduced the enabling legislation for the establishment of this National Commissioner who will inquire into the factors and systemic issues contributing to veteran suicides, and recommend actions and strategies to support the prevention of future suicides.

On 27 July 2020, the Council of Attorneys-General agreed to work together, in consultation with the Council of Chief Coroners, to establish a new National Coronial Centre for Defence and Veteran Suicides.

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

Recommendations are made where, following an investigation into a reportable death or fire, a coroner has identified systemic issues or other learnings that can help prevent similar incidents occurring in the future. Coronial recommendations are rigorously prepared to ensure they are informed by and based on the evidence before the Court.

If a coroner determines that the care and circumstances relating to an incident were handled appropriately by the parties involved, or that existing failures have since been adequately addressed, or that no prevention opportunities can be identified relating to that death, recommendations will not be made.

While the vast majority of cases investigated do not result in recommendations, this investigative process is key to the Court's prevention process.

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.

Coroners made recommendations in 2.2 per cent of findings in 2019—20. This figure excludes natural cause deaths, where a coroner determined the case was not reportable and therefore the coronial investigation was discontinued.

The number of recommendations increased in 2019—20 to 166. It should be noted that the number of recommendations made each year is dependent on the matters before the coroners and associated opportunities for prevention. The Court's focus, as always, was on providing robust, evidence-based investigations to help protect the Victorian community against preventable deaths.

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.

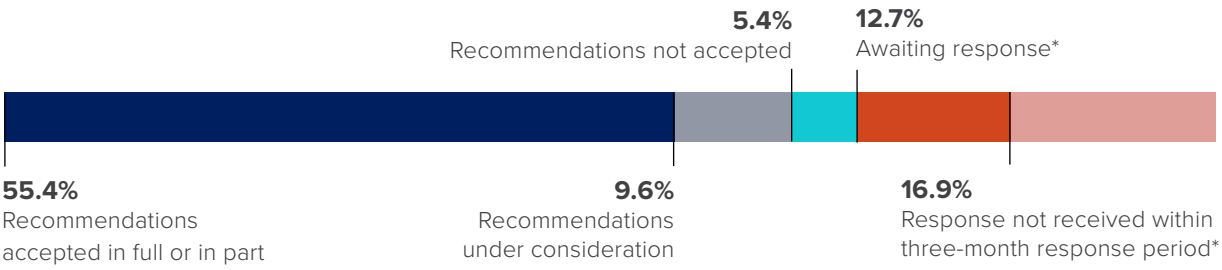
In the past year, 92 recommendations made by coroners were accepted in full or part for implementation and 37 further recommendations are under consideration. There were nine recommendations that were not accepted for a variety of reasons, and 28 instances where responses were not received within the required time frame.

Table 6: Recommendations made in closed investigations

	2015—16	2016—17	2017—18	2018—19	2019—20
Number of investigations closed with recommendations	105	65	48	69	78
Number of recommendations made	296	127	108	154	166

Reducing preventable deaths

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.

Expert advice

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

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 well-researched, evidence-based recommendations. It is the only multidisciplinary team of its kind in Australia, comprising of specialist staff who work to identify any potential failures and other factors that contributed to the incident. Coroners can refer matters to the CPU at any point during an investigation.

Additionally, the CPU undertakes both individual and collaborative research projects to support coronial investigations, underpinning a better understanding of preventable deaths in Victoria.

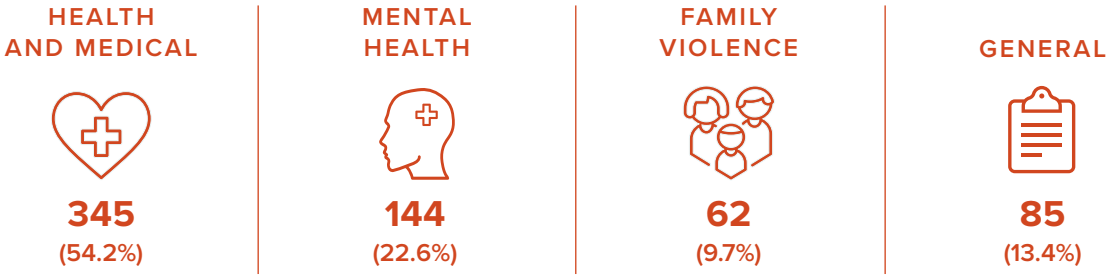
Throughout the 2019—20 reporting period, coroners made 636 referrals to the CPU about deaths under investigation. The advice coroners sought input on included:

- 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 2019—20, 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.

Figure 2: Theme of coroners' referrals for 2019—20



Paediatric placement program

Through its relationship with Monash Children's Hospital, the Court engaged two paediatric registrars in 2019. Ongoing funding from the Commonwealth Government has been approved for this program. The paediatric registrars are based at the Court for one day a week each, providing clinical advice to coroners and assistance with case reviews of relevant deaths under investigation.

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2019—20, the Court engaged 25 external experts to supply reports and give testimony in inquests. External experts assist coroners to understand specific complex matters and are selected for their qualifications, training and specialist knowledge.

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 2018—19 Annual Report because of this re-classification process.

In 2019—20, causes of death reported to the Court were consistent with previous years. Just over 39 per cent of deaths reported to the Court were caused by natural causes, 34.6 per cent were accidental (due to falls, road accidents, drowning and similar), and 9.8 per cent were suicides.

Table 7: Cases reported to the Court in 2019—20

Cause of death	Frequency	Percentage
Natural causes	**2868**	**39.2**
Unintentional	**2525**	**34.4**
Falls	1647	22.5
Poisoning	406	5.5
Transport	251	3.4
Drowning	28	0.4
Other	193	2.6
Suicide	**714**	**9.8**
Hanging	359	4.9
Poisoning	142	1.9
Firearm	35	0.5
Rail	33	0.5
Jump from height	36	0.5
Other	109	1.5
Assault	**72**	**1.0**
Complications of medical or surgical care	**497**	**6.8**
Other*	**219**	**3.0**
Not reportable	**390**	**5.3**
Still enquiring	**38**	**0.5**
Total	**7323**	**100**

* 'Other' here includes other reportable deaths, deaths still under enquiry, legal intervention deaths and deaths from undetermined intent.

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.

There was a small reduction in Victorian overdose deaths during 2019—20 from 526 in 2018—19 to 514. While it is too early to draw conclusions from this data, the Court notes that a number of important drug harm reduction programs have been implemented in Victoria that may be taking effect. These initiatives include the introduction of a supervised injecting facility in Melbourne and the SafeScript real-time prescription monitoring system.

Frequencies reported from the VODR can change over time as coronial investigations progress and more information becomes available.

Table 8: Overdose deaths reported

Financial year	Number of deaths
2015—16	472
2016—17	528
2017—18	515
2018—19	526
2019—20	514

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 2019—20 suicides comprised 9.8 per cent of all deaths reported to the Court. The number of reported suicides reduced to 714, down from 749 in the previous year. It is too early to determine whether this represents a trend.

Table 9: Annual reports of suicide

Financial year	Number of deaths
2015—16	644
2016—17	660
2017—18	685
2018—19	749
2019—20	714

Victorian Homicide Register

The Court created the Victorian Homicide Register (VHR) to track and analyse homicides across the state and identify themes for targeted prevention opportunities.

The database contains detailed information on all Victorian homicides reported to the coroner since 1 January 2000 including:

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

The VHR is a live database based on open and closed criminal and coronial investigations and is subject to re-classification and updating as further information becomes available.

The Victorian Family Violence Data Portal

The Court also contributes VHR data to the Victorian Family Violence Data Portal, which is maintained by the Crime Statistics Agency. The Victorian Family Violence Data Portal contains data from the VHR relating to homicides in Victoria from 1 June 2014 onwards, and is updated annually.

Victorian Systemic Review of Family Violence Deaths

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) is a dedicated function at the Court that conducts in-depth reviews of deaths suspected to have resulted from family violence.

Led by the State Coroner, the VSRFVD consists of staff from across the Court, including a manager, senior solicitor, case investigators, family liaison officer, registrar and project officer.

The Victorian Homicide Register (VHR) serves as the key data source for the two published Victorian Systemic Review of Family Violence Deaths reports, analysing common factors in family violence deaths between 2000 and 2010 and 2011 and 2015 respectively.

Reducing preventable deaths

The Court has a strong commitment to the reduction of family violence related deaths through the thorough investigation of such deaths and the sharing of data and information to assist the sector in strengthening responses to those living with family violence.

Homicide incidents in 2019—20

In the 2019—20 reporting period, there were 67 homicide incidents in Victoria that were reported to the Court. This is an increase from 52 homicide incidents in the previous year (**Table 10**). Almost one third of these incidents (28.8 per cent, n=19) were identified as family violence related. The 67 identified homicide incidents resulted in the deaths of 72 homicide victims.

Family Violence Death Reviews

The data for this reporting period was extracted from the VHR on 13 July 2020 and includes all homicides reported to the Court between 1 July 2019 and 30 June 2020. This reference period is based on the date the homicide incident occurred.

It is noted that detailed data is not provided with respect to homicide offenders, as the criminal proceedings for many homicides that occurred in 2019—20 remain ongoing at the time of this report.

Most of the family violence incidents in 2019—20 resulted in the death of one homicide victim (91%) (**Table 12**).

Homicides by relationship

The 67 identified homicide incidents resulted in the deaths of 72 homicide victims.

Where a familial relationship was identified between the homicide offender and homicide victim, the relationship was most likely to be of a current or former intimate partner (65 per cent, n=13). This was followed by parent-child relationships (20.0 per cent, n=4) and other intimate or familial relationships (15 per cent, n=3) (**Table 11**).

Table 10: Homicides incidents by year – July 2015 to June 2020

Type of homicide	2015—16	2016—17	2017—18	2018—19	2019—20
Family violence related	33	22	21	15	19
Not family violence related	38	25	38	27	28
Unknown	≤3	7	5	10	20

Table 11: Homicides victims by relationship to offender – July 2015 to June 2020.

	2015—16	2016—17	2017—18	2018—19	2019—20
Intimate partner	15	14	14	12	**13**
Parent-child	11	7	5	≤3	**4**
Other intimate or familial	7	≤3	≤3	≤3	**3**
Not intimate or familial	38	30	38	28	**32**
Unknown	≤3	7	5	11	**20***

* The higher number of 'unknown' cases in the 2019—20 period is reflective of the fact that many of these investigations remain ongoing and the offender and their relationship to the deceased has not yet been confirmed. This data is subject to change as new information is made available.

Table 12: Homicides incidents by number of deaths – July 2015 to June 2020

Number of deaths from incident	2015—16	2016—17	2017—18	2018—19	2019—20
Single	95.9%	87.0%	96.9%	90.4%	91%
Multiple*	4.1%	13.0%	3.1%	9.6%	9%

* Multiple death incidents include incidents where there were multiple homicide victims as well as incidents in which the offender also died (for example homicide-suicides).

Table 13: Homicide victims by sex – July 2015 to June 2019

Sex of homicide victim	Type of homicide	2015—16	2016—17	2017—18	2018—19	2019—20
Male	**Family violence related**	14	13	7	≤3	8
	Not family violence related	33	26	34	22	42
Female	**Family violence related**	19	11	14	12	12
	Not family violence related	5	4	4	6	10

Sex

In 2019—20, females were more often the victim of family violence related homicides (70.5 per cent, n=12), whereas males were more often homicide victims in non-family violence related homicides (74.2 per cent, n=23). This was consistent with data across the preceding five years (**Table 13**).

Recommendations in Family Violence Investigations 2019—20

A total of 16 recommendations were made across six of the family violence-related closed coronial investigations in 2019—20. These recommendations can be grouped into three key themes:

Passings of Aboriginal young persons in the Mallee Region

Two closed coronial cases involved the passings of young Aboriginal persons by suicide in the Mallee Region. Both passings occurred in the context of a history of family violence and highlighted the need to improve the support for Aboriginal young persons in this region.

Coroners recommended:

- the expansion of the Mental Health Advice and Response Service to Mildura Magistrates' Court
- improved access to culturally appropriate support for Aboriginal and Torres Strait Islander persons attending hospital
- improved family violence training and processes for mental health services at the Mildura Base Hospital
- improved collaboration between Child Protection and the Aboriginal Child Specialist Advice and Support Service, and
- implementation of Aboriginal youth mentoring programs and service models targeted towards Aboriginal persons with complex needs.

Victoria Police responses to family violence

Two closed coronial cases made recommendations with respect to the Victoria Police response to family violence highlighting gaps where service provision could be improved.

The investigating coroners recommended the improvement of information recording processes to ensure agencies who receive a Victoria Police Form L17 referral are provided with updated information about police engagement with the parties, and family violence reports received via telephone are recorded appropriately in Law Enforcement Assistance Program (LEAP).

They also recommended improved information and training in relation to the withholding of children by a parent as a family violence risk factor, as well as improved policies and procedures for Protective Services Officers in relation to responding to family violence reports.

Health services and family violence

In two family violence related homicides, the homicide offender had proximate contact with health services prior to the homicide. Following investigation of these cases coroners recommended that maternal health and wellbeing checks performed by maternal and child health nurses be increased, and post-natal depression screening be conducted following any significant changes in circumstances reported by a family.

Investigating coroners also recommended that information and resources on family violence made available to general practitioners be updated, and that an index of suspicion be developed for general practitioners working with patients who are potential perpetrators of family violence.

Case study 2

Family violence responses reviewed following murder

Ms W was murdered by her ex-partner, Mr M, on a public street in Sunshine in 2014 shortly after they had attended the Sunshine Magistrates' Court for Family Violence Intervention Order proceedings. Evidence provided to the Court indicated that there had been a long history of family violence perpetrated by Mr M against Ms W, including physical assaults and an attempted strangulation on at least one occasion.

In the months prior to the homicide, Ms W and Mr M had separated and were in the process of going through legal proceedings in relation to their children and Family Violence Intervention Orders. Mr M continued to perpetrate family violence during this time and there were clear indications that it was escalating. Prior to her death, Ms W had engaged with a range of services including Victoria Police, the Department of Health and Human Services – Child Protection, Sunshine Magistrates' Court, the Federal Circuit Court, Victoria Legal Aid, health practitioners, and specialist family violence services.

The coroner noted that although Ms W had sought assistance, there were systemic failures by these services to make proper enquiries, adequately assess the family violence risk, and share relevant information about serious risk factors before closing their investigations or discontinuing support. These failures included Ms W being advised to take actions contrary to her own safety to access legal assistance, and failures in the handling of family violence reports made to Victoria Police and Child Protection services.

At the time of investigation, the coroner recognised that many of the concerns in this case had been adequately canvassed by submissions to the Royal Commission into Family Violence and a full inquest was not necessary. The coroner recommended that Victoria Police make changes to how police record calls made to stations regarding family violence incidents to make it easier for other officers to find this information when accessing records about the parties involved.

Additionally, to improve the safety of children involved in family violence incidents, the coroner recommended that the Victoria Police Code of Practice for the Investigation of Family Violence be updated to reflect that the withholding of children is an act of control that can be considered abuse.

The coroner also recommended that an integrated system be developed between Victoria Police and No to Violence/Men's Referral Service to ensure more effective monitoring of L17 referrals for perpetrators of family violence who are referred to a men's behavioural change program Victoria Police and No to Violence noted that work to implement these recommendations is in progress.

No to Violence also advised it would work with Family Safety Victoria (FSV) on the establishment of regular forums for L17 perpetrator respondent agencies, Victoria Police and FSV to discuss issues and strategies for improving referral information and pathways.

External engagement

Networks

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

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

The Court also continues to be an active member of the Australian Domestic and Family Violence Death Review Network, which consists of representatives from family violence death review mechanisms in states and territories throughout Australia.

Training and conferences

The VSRFVD has also presented to the Judicial Advisory Group on Family Violence and the Family Violence division of the Magistrates' Court of Victoria.

A representative of the VSRFVD also chaired a discussion at the Addressing Filicide: Fourth International Conference for Cross National Dialogue.

Case Study 3

Training overhaul following infant death

Baby F's mother was admitted to the Royal Women's Hospital to give birth to twins early due to concerns about foetal health and development. Her treating doctors induced labour and then chose to perform a caesarean section when complications arose. While conducting the caesarean, it became clear that Baby F's head was impacted in the pelvis. The two obstetric registrars present, along with assisting midwives, were unsuccessful in delivering Baby F. A consultant obstetrician was called and was able to complete the delivery.

Soon after, it became clear that Baby F had suffered serious head injuries during the delivery, and died shortly after birth. His twin brother suffered no injuries and was born healthy.

The investigating coroner found that Baby F's head injuries were caused by one of the obstetric registrars as they attempted to deliver him before the obstetrician was called in to assist.

The Coroners Prevention Unit identified two other recent cases in which infants had died from similar injuries, one investigated by a Queensland coroner and another by a Victorian coroner. Both investigations had resulted in recommendations including a change to a guideline published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) in July 2017.

The investigating coroner in Baby F's death found that, if this revised guideline had been in place and adhered to when Baby F was born, the outcome could have been different.

Immediately after Baby F's death, and before the coroner's investigation, the Royal Women's Hospital performed an internal review and put in place a number of measures recognised by the coroner to mitigate the risks brought to light by Baby F's death.

To prevent similar deaths, the investigating coroner made five recommendations beyond the work already being done, including that the Royal Women's Hospital and RANZCOG review a number of their practices and guidelines, and that they work with Safer Care Victoria to develop multi-discipline, scenario-based training modules including techniques for safe delivery of a baby in similar emergency circumstances.

The Royal Women's Hospital have confirmed that such training is available to staff and RANZCOG has commenced the development of appropriate training scenarios. Safer Care Victoria have affirmed that they emphasise the importance of following evidence-based guidelines and participating in such training for health practitioners in this context.

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 2019—20 the Coroners Court of Victoria continued to collaborate with researchers in public health and medicine to develop new insights into preventable death. These collaborations included three articles that were published in refereed journals:

- An analysis of differences between young and older adolescent suicides, conducted in collaboration with researchers from Monash Children's Hospital and Monash University, which was published in the *Australian and New Zealand Journal of Public Health.*
- A collaborative study with researchers from St Vincent's Hospital and the University of Melbourne to understand better the links between suicidality and the cancer experience, which was published in *Psycho-Oncology.*
- A study of farmer suicides compared to non-farmer suicides in regional Victoria, which involved collaborators from Deakin University and Federation University Australia, and was published in the *International Journal of Environmental Research and Public Health.*

A renewed focus on publicly available data

Over the reporting period, the Court has renewed its focus on providing publicly available data on issues affecting various segments of the Victorian community. The Court's intention in making current data available is to assist services and providers in tailoring their offerings to better meet the needs of the broader community.

A recent example is the *Victorian suicides of Aboriginal and Torres Strait Islander people* released on 30 June 2020 and made available online. This report presents an analysis of all Indigenous passings identified as suicides in Victoria between 2009—2020, including socio-economic demographics and contextual stressors.

Suicide frequencies for Aboriginal and Torres Strait Islander people in Victoria are twice that of the state's non-Indigenous population, with young Indigenous Victorians being most at risk. Accessible, accurate and culturally responsive data is vital to developing stronger action plans within the Indigenous mental health and suicide prevention sector.

The report was developed by the Coroners Koori Engagement Unit (CKEU) and Coroners Prevention Unit, utilising data from the Victorian Suicide Register.

Since the establishment of the Koori led CKEU in 2019, the Court has enhanced identification and accuracy of information regarding current and historic Aboriginal and Torres Strait Islander reportable passings.

Key findings in the report include:

- Between 1 January 2009 and 30 April 2020, there were 117 Aboriginal and Torres Strait Islander suicides in Victoria.
- Of these, 82 were male and 35 were female.
- At risk age groups for males were 25-34 (24.4 per cent), 45-54 (24.4 per cent), 35-44 (23.2 per cent) and 18-24 (19.5 per cent).
- Over 65 per cent of suicides amongst females occurred in the age groups 18-24 (34.3 per cent) and 25-34 (31.4 per cent).
- Frequency of suicides were higher in regional areas (59.8 per cent) than in metropolitan areas (40.2 per cent).
- Compared to non-Indigenous Victorians, Aboriginal and Torres Strait Islander people had experienced higher rates of contact with the justice system, substance use and interpersonal stressors prior to passing.

Promoting public health and safety

Victorian Systemic Review of Family Violence Deaths

In June 2020 the Court released the *Victorian Systemic Review of Family Violence Deaths Report 2011—2015* on family violence related homicides in Victoria.

This report followed the previous VSRFVD report – covering between 2000 and 2010 – and aimed to address gaps in data identified by the Royal Commission into Family Violence. The data for this report was drawn from the VHR.

The key findings of the report show that, consistent with national data, family homicides were most likely to be committed by adult males, and Victorian females were most likely to be killed by a current or former intimate partner. In more than half the cases examined, there was a history of family violence prior to the homicide incident. Mental health issues and substance abuse were prevalent in more than two thirds of cases and under a quarter of cases, respectively. A copy of the full report is available on the Court website.

Supporting research

During 2019—20 the Court's Research Committee met eight times to assess 46 applications for access to coronial data.

Of these applications, 44 were approved and two were referred back to the applicants for clarification and redrafting.

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:

- Work-related fatalities
- Deaths in house fires
- Heroin-involved overdose deaths
- The role of alcohol in death
- Risk factors and pathways to homicide.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2019—20, the Court responded to 47 requests from external organisations for data and other assistance, including:

- Victoria Police
- Victorian Department of Health and Human Services
- Australian Institute of Health and Welfare
- Various media organisations
- Victorian Crime Statistics Agency
- Health services.

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 2019—20 the Court received 4600 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports or unpublished findings.

Table 14: Requests for coronial documents

	Form 45 requests
2015—16	4668
2016—17	5063
2017—18	5237
2018—19	5741
2019—20	4600

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 range 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 resources 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 2019—20, coroners delivered nine presentations to stakeholders. There has been a reduction in the number of presentations delivered this reporting period due to difficulties associated with the COVID-19 pandemic.

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, accommodating 64 health practitioners at a time, 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 the 2019—20 financial year only two sessions were held as the planned sessions for March and June 2020 were cancelled due to COVID-19. The cancellation of these sessions was in line with other Victorian health services, where education and professional development classes are on hold due to staff involvement in the pandemic response. The classes were not moved to a virtual platform due to health worker fatigue and competing priorities during the crisis. Information sessions have not yet resumed.

Law Week

The Court and VIFM held a hypothetical investigation into the death of the musician, Prince for the opening night of Law Week 2020. The event, which attracted a sell-out crowd of 500, featured a panel discussion with Judge Cain, Coroner Hawkins, the Director of VIFM Professor Noel Woodford, Chief Toxicologist Dr Dimitri Gerostamoulos and Dr Jodie Leditschke.

The panel highlighted the Victorian coronial system, demonstrating how an unexpected death like Prince's would be investigated here, the issues that would be considered, and the prevention opportunities that the case could provide.

Case Study 4

Corrections procedures reviewed following death in custody

At the time of his death, Mr F was serving a six-year and five-month sentence at the Middleton Prison, a minimum-security facility where prisoners live in shared cottage-style accommodation.

On the day of his death, Mr F assaulted two prison officers before returning to his room. The cottage-style accommodation meant that prison officers had no ability to lock Mr F in his room, and, unlike normal prison cells, there was no way for prison officers to see into his room without opening the door.

Following the assault, emergency response protocols were initiated, and over the following hours, prison officers unsuccessfully attempted to communicate with Mr F, who remained in his room. A decision was made to transfer him to Barwon Prison and a team of specialist prison officers from the Security and Emergency Services Group (SESG) arrived to remove him from his room.

As part of the extraction process, CS gas (a type of tear gas) was sprayed into Mr F's room with the aim of rendering him compliant. When SESG members entered the room, a struggle ensued and Mr F was dragged from his room, face down with his hands cuffed behind him and a plastic shield held on top of him.

Mr F was taken to the bathroom for decontamination where officers continued to restrain him, applying varying amounts of downward force to the plastic shield still held on top of him. At some point, Mr F became unresponsive and was carried outside where he received medical attention from prison nurses. Mr F did not regain consciousness and passed away shortly thereafter.

The investigating coroner examined the use of CS gas in the incident, the extraction technique, including the force used, and the adequacy of the response by attending nursing staff. It was found that the CS gas was not a major cause of Mr F's death, however it did contribute to his increased respiratory demand, along with the preceding struggle. The method of restraint, however, was a significant contributing factor. Holding Mr F on the bathroom floor, in a prone position with his hands behind his back and a shield on top of him prevented him from meeting his increased need for oxygen (a state of hypoventilation), which ultimately led to his loss of consciousness and subsequent death. The coroner also found that the nurses present did not provide adequate care for Mr F's critical state.

To prevent similar deaths, the coroner made several recommendations to Corrections Victoria, including that the medical care provider update its training and relevant materials regarding cell extraction and positional asphyxia, and that the configuration of the bedrooms at Middleton Prison be reviewed to allow prison officers to see inside the cells without opening the door in emergency situations. The Department of Justice and Community Safety accepted the recommendation about cell configuration in principle.

4. Corporate governance and support

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.

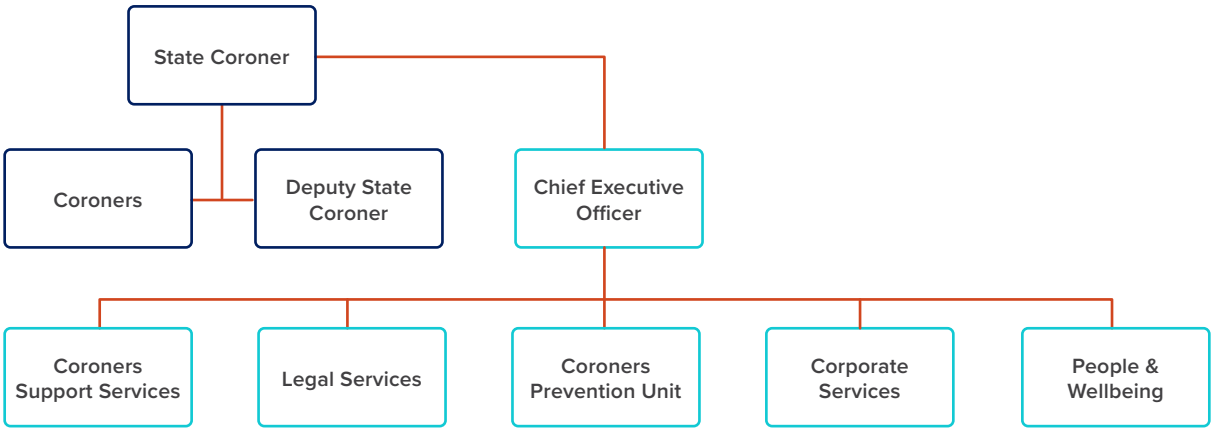
The Court is one of the courts and tribunals which sit within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its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

Organisational structure

The Court employs 105 staff who support the coroners in their independent investigations and manage the administration of the Court. The organisation comprises the Office of the CEO which includes a business transformation function, and five divisions, each of which is led by a Director:

- **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, and risk and audit functions.
- **People and Wellbeing** supports the delivery of a range of human resource services through effective management of the Court's workforce, including workforce planning, attraction and retention, induction, performance management, health and wellbeing, learning and development and workforce metrics and reporting.

Organisation chart



Workplace profile

At 30 June 2020, the Court had 105 staff members (89 full-time equivalent (FTE)), not including coroners. This includes 86 permanent staff, 29 per cent of whom 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 2020.

Table 15: Workplace profile as at 30 June 2020

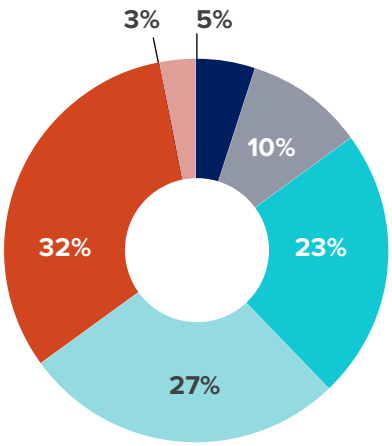
	June 2020					
	All employees		Ongoing		Fixed term/casual	
	Staff numbers	FTE	Staff numbers		Staff numbers	
			Full-time	Part-time	Full-time	Part-time
Male	20	16.8	15	4	1	0
Female	85	72.1	45	22	11	7
Total	**105**	**88.9**	**61**	**25**	**11**	**8**
VPS2	17	15.4	10	3	4	0
VPS3	11	8.1	5	2	0	4
VPS4	37	32.5	21	9	5	2
VPS5	12	11	8	2	0	2
VPS6	10	10	9	0	1	0
STS/7	6	1	0	6	0	0
Registrar Grade 3	9	8.7	7	1	1	0
Allied Health 3	2	1.2	0	2	0	0
Solicitor Grade 3	0	0	0	0	0	0
Executive	1	1	1	0	0	0
Total	**105**	**88.9**	**61**	**25**	**11**	**8**

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

Corporate governance and support

Figure 3: Divisional headcount at 30 June 2020

Division	Number FTE	Number Headcount
Office of CEO*	4.85	5
Corporate Services	9.2	11
Legal Services	24	25
Coroners Prevention Unit	18.8	28
Coroners Support Services	29.07	33
People and Wellbeing	3	3
Total	**88.9**	**105**



* The Office of the CEO includes staff supporting the CEO and involved in delivering the strategic transformation agenda of the Court.

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 Coroners Court 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.

Coroners Court Executive Committee

The Coroners Court Executive Committee, headed by the CEO, includes the heads of the Court's five business units, and the Director Strategic Programs. 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 Coroners Court 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.

CSV support

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 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, as well as the Victorian Government Risk Management Framework.

In the 2019—20 reporting period, the Coroners Court Risk Management Committee actively reviewed all relevant risk registers and continued to identify emerging risks to build and refine the Court's risk profile.

Corporate governance and support

Business continuity planning

During 2019—20 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 March 2020. The updated plan provides clarity and guidance on contingencies for maintaining essential business resources and services in the event of interruptions, including a detailed pandemic response plan which was enacted in response to COVID-19.

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 2019—20, the Court participated in internal audits at a CSV-wide level regarding:

- core financial processes and controls
- the CSV risk management framework
- 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 an engaging, healthy and supportive workplace

The most important resources of the Court are our people – the coroners and the Court's staff who support them. The primary focus of 2019—20 has been on developing and implementing activities and initiatives designed to build an engaged, high performing, respectful, and safe work culture that delivers excellent services to the Victorian community.

To support this a People and Wellbeing division was established, including the appointment of the Director People and Wellbeing to effectively support organisational health, people and performance, and to continue to deliver on the Court's comprehensive Health and Wellbeing Plan 2018—20.

Health, safety and wellbeing

The Court is keenly aware of the sensitive and sometimes graphic nature of the material coroners and staff are exposed to and focusses its effort on ensuring effective and safe systems of work, a strong and collegiate culture, and effective monitoring of health, safety and wellbeing.

Work against the actions within the Health and Wellbeing Plan 2018—20 during 2019—20 has progressed with a number of programs and initiatives either delivered or underway. These include:

- Strengthening health and safety governance arrangements so that the Court takes all the steps it can to ensure the safety of its workforce, including clearly defined roles, responsibilities and accountabilities for health, safety and wellbeing.
- Implementing recommendations of a review into the Court's operating structure to ensure that staff have good supervision and are well-supported, and that job roles and functions are clear.
- Delivering vicarious trauma workshops to support staff and coroners with a focus on creating greater awareness of exposure risks, self-care strategies and available support mechanisms.
- The creation of a Reducing Exposure Risk Working Group to identify further opportunities and make recommendations to reduce the inadvertent exposure to traumatic or distressing material.
- The introduction of a suite of supports for coroners and staff including health assessments, resilience workshops, and a Court therapy dog program.

The impact of COVID-19 resulted in the majority of the Court's workforce working remotely. The Court quickly adapted to the changing landscape of work with a focus on supporting staff wellbeing, productivity, and engagement. A regular contact regime was established to keep the workforce connected and additional wellbeing programs introduced such as:

- Online vicarious trauma training
- Meditation and yoga
- A step challenge
- Mental health first aid and refresher training
- Online social activities

Building and maintaining a work environment where our people can grow and thrive

In 2019—20, the Court also focused on initiatives to continually attract and retain a diverse and high-performing workforce. These included:

- A review of the recruitment and selection process to ensure that the Court continues to attract and select staff who possess the skills, knowledge and personal attributes to not only undertake their role to a high standard but are also able to effectively manage the inherent exposures within the Court environment without undue impact on their mental health and wellbeing.
- Implementation of a refreshed induction package to welcome new employees and to ensure they have a good understanding of the work of the Court, and the knowledge and support to effectively and safely perform in their roles.
- The development of a line management supervision framework to support managers in having quality and regular one-to-one supervision discussions with their staff, including guidance on and understanding of their work, professional development opportunities and wellbeing support.

Performance and development

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

The Court's Learning and Development Program provides opportunities to build staff capability and develop new skills. It offers targeted training 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.

The Court is currently working with a recognised training provider to further develop Sorry Business training to encompass more aspects of the Court's business. While this progress has been slowed by COVID-19, the Court remains committed to this program.

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, 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.

Corporate governance and support

Participation

The Court also participates in inter-organisational programs with VIFM to foster a culture of collaboration. 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.

In September 2019, Court staff and VIFM came together to enshrine cultural understandings between the Court and the Koori community. This event featured a smoking ceremony conducted by Uncle Colin Hunter, and the presentation of a possum skin cloak to Troy Williamson, the Court's Koori Family Engagement Coordinator. A plaque acknowledging the Wurundjeri and Boon Wurrung people as the owners of the land on which the Court is situated was also unveiled.

Social Club

Connecting staff with the Court's neighbour at VIFM, the joint Social Club organised regular networking and team building events up until February 2020. During that time, staff participated in an International Women's Day event with the Hon. Jennifer Coate, an exercise challenge and other various activities. Unfortunately, due to the COVID-19 pandemic, social club activities have been put on hold.

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 during 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.

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
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 available and circumstances 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

Eligible parties may appeal to the Supreme Court against various decisions that coroners make, including a coroner's findings and other determinations including that a death is not a reportable death, decisions about autopsy, exhumations, release of the body, decisions not to hold an inquest, and refusals not to re-open a coronial investigation. Time limits apply to the making of appeals and vary depending on the ground of appeal.

In 2019—20, the following appeals were finalised:

- *Makovnik v State of Victoria*, S ECI 2018 00849. Appeal in relation to determination not to hold inquest. Proceeding discontinued on 19 July 2019.
- *Darmos & Ors v Coroners Court of Victoria*, S ECI 2019 03130. Appeal in relation to determination not to hold inquest. Proceeding discontinued on 1 October 2019.

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.

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 matter 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 **https://ovic.vic.gov.au/**.

Coroners Court
of Victoria