Coroners Court
of Victoria

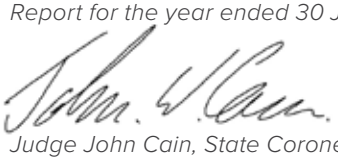
Coroners Court
of Victoria

Annual Report

2020—21

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 2021.*



Judge John Cain, State Coroner

October 2021

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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65 Kavanagh Street Southbank VIC 3006
October 2021

We value your feedback

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

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

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

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At a glance

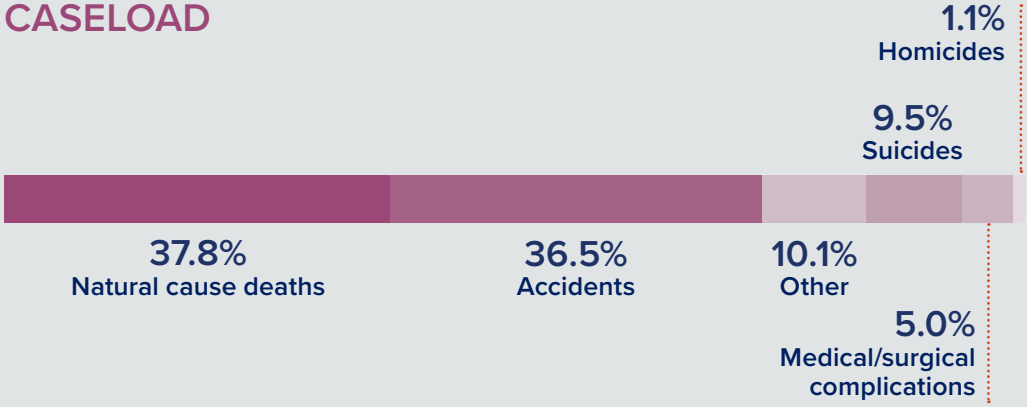
INVESTIGATIONS

7053 new investigations opened

6591 investigations finalised

93.4% closure rate

CASELOAD



TIMELINES

7.9
Average months to investigate

79.6% in <12 months

45.7% in <3 months

INQUESTS

60 inquests finalised

0.91% of investigations closed following inquest

RECOMMENDATIONS

204
recommendations made

122 accepted

10 not accepted

72 awaiting response or under consideration

DATA & DOCUMENTS

5588
requests for documents

54 requests from organisations for coronial data

43 research requests granted

Contents

The year in review

From the State Coroner

Despite the significant challenges of the last year, the Coroners Court has successfully driven a reform and modernisation agenda — guided by our new 2020—2024 Strategic Plan — while continuing to finalise over 6500 cases and promote public health and community safety.

These achievements would not have been possible without the staff and coroners of the Court, who are dedicated to making a positive difference in the Victorian community. Their commitment and ability to navigate the challenges of ongoing working from home arrangements, new digital environments and a major renovation at the Court, have been the foundation of our success this year. I am proud and fortunate to call them my colleagues.

I was also delighted to welcome two new coroners to the Court in February 2021. Coroner Kate Despot and Coroner Katherine Lorenz have embraced the challenges of the jurisdiction and bring depth and breadth of experience to the Court. Their addition will undoubtably help us manage the increasing workload and deliver an enhanced and improved service to families and the broader community.

As the lockdown environment has continued, the Court has remained agile and responsive to the increased use of online hearings and welcomed the move towards a paperless environment. The necessity of these changes in response to the pandemic has not been an impediment, rather an opportunity to utilise digital technology to improve our operation and overall efficiency into the future. A key enhancement has been the implementation of our new online case management system which enables staff and coroners to work seamlessly from home. The new software integrates multiple file and communication systems into one platform, reducing the Court's reliance on physical artefacts and providing us with new data insights that will inform efficiencies across the Court. The speed and success of the system roll out is another credit to the engagement and dedication of all those involved.

Our continued excellent relationship with the Victorian Institute of Forensic Medicine (VIFM) has been integral to this work — enabling our new system to integrate with VIFM's case initiation system so important

forensic information collected in the early stages of investigation is shared in real-time. Our partnership with VIFM is a unique feature of the Victorian coronial system and I am very grateful to Professor Noel Woodford and the VIFM team for their ongoing assistance and expertise.

The Court has an important role in independently investigating all deaths in custody. In 2020—21, the Court introduced new practice directions to improve the conduct of these investigations, in particular Indigenous passings in custody. We recognise significant changes can still be made to ensure coronial investigations into Indigenous passings in custody do not perpetuate cycles of grief and loss for families. The new directions aim to embed culturally responsive practices and make the Court a safer and more supportive place.

Throughout 2020—21, our commitment to improving the support offered to bereaved families in contact with the Court has been ongoing. I am pleased to report that we have expanded the capacity of our Family Liaison Officers and Coroners Koori Engagement Unit whose work enables the Court to better help families as they confront the death of a loved one. We also seek regular feedback through family surveys to make sure our services are responsive and accessible — I am happy to report that the commentary from families is overwhelmingly positive.

The Court has also engaged the RMIT's Centre for Innovative Justice to facilitate new ways of supporting families and enhance the therapeutic aspects of the coronial process. Through their work we can connect and hear from families and peer groups, including those impacted by the investigation into the deaths at St Basil's Homes for the Aged.

The Court's work relies on a network of experts and we collaborate with stakeholders across the justice and health systems. To this end, how we work with our stakeholders remains an ongoing priority. The re-establishment of the Court Users' Group has provided an important forum for the members of the legal profession, coroners and court staff to discuss how best to manage the workload of the Court.

We have also reactivated the Victorian Systemic Review of Family Violence Deaths (VSRFVD) Review Panel. The VSRFVD panel provides an opportunity for the Court to consult with key stakeholders in the Victorian family violence system on critical issues, strengthening our ability to contribute to the prevention of family violence related deaths. The VSRFVD team also achieved great results this year reviewing and finalising a large number of cases and reducing the backlog.

The Coroners Prevention Unit continues to produce vital work to assist coroners in identifying death prevention opportunities and maintaining data that helps us to highlight areas of particular concern. Data managed by the team includes information on suicides, overdoses and homicides in Victoria and this is also shared with State and Commonwealth governments to inform their work in improving health and safety.

In 2020—21, the Court has prioritised the timely release of this data to increase public awareness and support local and government programs. In August 2020, we launched the first monthly suicide data report, which presents up-to-date analysis of all Victorian suicides with five years of comparative data. Open, safe and transparent conversations are crucial to improving mental health outcomes and these reports ensure everyone has access to the facts.

The Court also now publishes a quarterly Recommendations Report that documents recommendations made by coroners and the status of the responses from relevant organisations. We hope that these reports will improve the transparency of entities' responses to recommendations and their role in making changes that reduce preventable deaths in the community.

As we look forward to 2022, the Court has taken proactive steps towards COVID-normal and welcoming the public back into the building. The COVID normal environment will present complexities but, as has been demonstrated, the Court staff and coroners are up to the challenge.

I work with an outstanding group of coroners and thank them for their support and assistance. In particular, Deputy State Coroner Caitlin English has continued to be an exceptional deputy and I am very grateful to her for the help and advice she provides to me. Our CEO Carolyn Gale is also a critical leader in the Court and continues to deliver great outcomes. Finally, I want to thank the staff of the Court who demonstrate an unwavering commitment through their work to create better outcomes for families and community. They are a very special group who continue to exceed expectations.

From the CEO

This year has presented many challenges to the Court and I cannot speak highly enough of the efforts made by our staff to keep the vital operations of the Court on track during 2020 and 2021.

The ongoing dedication, care, and commitment to the Court's work demonstrated by our staff during the COVID-19 pandemic is inspirational.

The COVID-19 pandemic has continued to impact the Court during the 2020—21 period, with our on-site staff reduced to a small group and the remainder working remotely for much of the year. Fortunately, our ongoing works aimed at modernising and improving digital technologies at the Court has enabled us to pivot in line with changing restrictions with minimal disruption to our day-to-day duties.

In 2020, the Court has committed to a new strategic directions plan (2020—2024) based on four pillars: reducing preventable deaths through independent investigations, findings and recommendations, enhancing efficiency and timeliness of our work through adoption of new technologies, improving support for families through the coronial process, and supporting our workforce to develop and thrive. Work is already underway at the Court to meet these goals, including a renewed focus on making our data publicly available to support prevention programs, continuing improvements to our IT systems, and a suite of health and wellbeing offerings for our staff.

Our achievements have been significant over the course of the 2020—21 year. They include a new practice direction for coronial investigations into the passings of Aboriginal and Torres Strait Islander people in Victoria, the implementation of Birrung — the Court's new digital file management system — and a further commitment to transparency at the Court with two new regular reports added to the publication schedule.

The new practice direction outlining coronial investigation protocols for Indigenous passings in custody formalises many of the services and culturally safe practices embedded at the Court since the Coroners Koori Engagement Unit (CKEU) was established in 2019. These practices include ensuring that a cultural brief is prepared for coroners investigating Indigenous passings, the addition of smoking ceremonies, the display of culturally significant items

at hearings, and the use of appropriate language and warnings where applicable.

As part of our digital transformation — an effort to modernise the Court's operations and increase efficiency — our IT systems have been further upgraded to better facilitate flexible working arrangements and online hearings. Birrung has now been adopted Court-wide following an extensive training program, improving access to files and enhancing collaborative working processes.

Last year, the Court committed to making more of its data publicly accessible to broaden awareness of the work of the Court and to help support prevention programs in the community. This year, two new reports have been regularly published on the Court's website — the *Coroners Court Monthly Suicide Data Report* and the quarterly *Coroners Court Recommendations Report*, now in its third edition.

Finally, I would like to sincerely thank all the coroners and staff for the dedication and professionalism with which they approach the important work of the Court. Special thanks to our partner agencies, the Victorian Institute of Forensic Medicine and Victoria Police, without whom we could not perform our duties. Many thanks to Judge John Cain for his leadership and commitment to modernising the Court to meet the needs of the 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.

During the 2020—21 reporting year, the Coroners Court of Victoria welcomed Coroner Katherine Lorenz and Coroner Kate Despot.

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 Laws 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.

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 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 Audrey Jamieson — BA LLB Grad Dip Bioethics

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

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

Coroner John Olle — LLB BEc

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

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

Coroner 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 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 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 as well 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.

Coroner Katherine Lorenz — BA LLB (Hons)

Coroner Katherine Lorenz was appointed a coroner in December 2020. Coroner Lorenz began her career in 2002, completing her articles of clerkship at Mallesons Stephen Jaques (now King and Wood Mallesons), where she developed her practice in commercial litigation. In 2009, Her Honour held the position of special counsel at the Australian Wheat Board, followed by a period as special counsel at Clayton Utz specialising in complex commercial advisory and litigious matters. From here, Coroner Lorenz served as an Executive Director at The Royal Children's Hospital and then Monash Health.

Prior to her coronial appointment, Coroner Lorenz held the position of Chief Executive Officer at the Victorian Bar from late 2018. She was responsible, during this time, for managing the organisation through the early stages of the COVID-19 pandemic, ensuring that its essential services could operate safely and effectively though the crisis.

Coroner Kate Despot — BA LLB

Coroner Kate Despot was appointed a coroner in December 2020 and commenced this role in February 2021. Since her admission to practice in 2003, Coroner Despot has worked primarily in the public sector focusing on criminal law and compliance and regulation.

During her career, Coroner Despot has worked with the Office of Public Prosecutions and served in senior leadership positions at the Victorian Building Authority and WorkSafe Victoria.

Her Honour most recently held the position of Executive Director of Legal and Governance and General Counsel at WorkSafe Victoria prior to her coronial appointment. Her honour has significant experience in overseeing occupational health and safety law in Victoria.

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

Unexpected deaths and fires are reported to the Court for independent investigation. Coronial investigations seek to establish certain facts, such as the identity of a deceased person and the cause of death, and in many instances, the circumstances in which a death or a fire occurred.

From page 19

Reducing preventable deaths

A coroner may also comment on matters relating to public health and safety, or the administration of justice, or make recommendations directed at preventing similar deaths based on the evidence.

From page 23

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 32

Our history

Victoria's first coroner was appointed in 1841, 30 years before Victoria established its first morgue in Melbourne. The first permanent coroners' courthouse was constructed in 1888 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.

Our Values

Integrity and Independence

- We are open, transparent, honest and accountable
- We work to uphold public trust in the work of the Court

Responsiveness and Respect

- We are inclusive, empathetic and informative to the families and friends of those who have died

Excellence

- We deliver outcomes that are accurate and timely and contribute to reducing preventable death
- We embrace ways to learn and improve

Teamwork

- We are collegiate and supportive, learn from each other and welcome a diversity of skills and views

Human Rights

- We engage with the Charter of Human Rights and responsibilities as a public authority and through our investigations

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 members of Victoria Police compile thorough coronial briefs, as well as appearing as the coroner's assistant at some inquests. PCSU members also 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.

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 majority of matters do not proceed to a hearing in a courtroom; rather, a finding is made 'in chambers'.

Strategic Goals

The Coroners Court Strategic Directions 2020—2024 present the Court's vision, goals and priorities for the coming four years.

The plan has been developed to usher in an increased use of technology to improve efficiencies in Court processes; enhance engagement with families and friends; increase awareness about the role and processes of the Court; and strengthen support for coroners and staff as they undertake what can be very confronting work.

Achieving these goals is the shared commitment of all coroners and staff to the Victorian community. Developed in response to a growing demand (approximately 16 per cent increase in cases over the last five years) for coronial services due to population growth, this plan has been informed by recent public enquiries into mental health, aged care, and disability.

The Court has started implementing operational changes to meet these aims, including improvements in IT capabilities, steps taken towards a paperlite future, and increased transparency though new publicly available reports. These initial steps are reflected in the Court's achievements during 2020—21.

The Court's strategic goals and the planned outcomes under this plan are:

1. Reducing preventable deaths through independent investigations, findings and recommendations

- Coronial investigations and recommendations contribute to improve community understanding of preventable deaths and how to reduce similar incidents, with a particular focus on suicide deaths
- Coronial investigations of like cases conducted together produce higher impact recommendations for prevention of systemic issues
- Coronial data is accessible and able to inform further development of prevention approaches in the community
- Coronial investigations and recommendations lead to sustainable change for the Victorian community.

2. Enhancing the efficiency and timeliness of our work through adoption of new technologies

- A modern, efficient, digitally enabled court
- Average case investigation times are reduced
- Flexible working conditions for staff
- An environmentally sustainable Court.

3. Improving support for families throughout the coronial process

- Families are confident in their engagement with the Court
- As far as possible the coronial process does not add to the trauma of families
- Families are well informed about the progress of their case
- Families are assisted to receive the support they need.

4. Supporting our workforce to develop and thrive

- A safe workplace for coroners and staff
- The Court continues to attract the best and brightest talent
- Staff and coroners are supported to build their careers
- Coroners and staff feel empowered to raise issues that affect them
- Health and safety at the Court is everyone's responsibility
- Vicarious trauma is well understood and managed.

Achievements 2020—21

New protocol for coronial investigations into Indigenous passings in custody

In September 2020, the Court introduced a new practice direction outlining protocols for the conduct of coronial investigations into Indigenous passings in custody.

The practice direction formalises a range of culturally safe practices and services embedded at the Court since the Coroners Koori Engagement Unit (CKEU) was established in 2019.

The new practice direction strengthens the Court's response to recommendations made by the Royal Commission into Aboriginal Deaths in Custody regarding coronial process. It includes:

- Where practicable, the State Coroner and/or delegated coroner will always attend the scene of the passing in custody of an Indigenous person, in consultation with the CKEU
- Within 48 hours of a death, the Court will contact the Victorian Aboriginal Legal Service to facilitate legal advice for senior next of kin on their rights in relation to the coronial process
- A directions hearing will be convened within 28 days of the passing, to confirm the coroner's investigator and due date for coronial brief and potential scope of inquiry
- The CKEU will provide the deceased's family with ongoing advice on coronial process throughout the investigation
- A cultural brief will be prepared for the investigating coroner by the CKEU to ensure awareness of relevant cultural issues specific to the deceased and their community
- Hearings will be convened in a culturally appropriate manner with acknowledgement of country, smoking ceremonies, in court display and use of culturally significant items, and appropriate warnings when names of deceased persons are used.

While the Royal Commission recommendations were handed down almost 30 years ago, the Court recognises significant improvements can still be made to enhance the investigation of Indigenous passings in custody and ensure that the coronial process does not perpetuate cycles of grief and loss for Indigenous families.

Updated IT systems and processes — ongoing digital transformation at the Court

Under its Strategic Directions (2020—2024) plan, the Court has been engaged in a large-scale program of digital transformation to increase efficiency and improve access to the Court.

To date, this digital work has encompassed both internal and external Court functions, ranging from improved network connections and flexibility for staff, to easier access to Court materials and online hearings for users.

Significantly, the Court has adopted a hybrid model for all coronial hearings including inquests. Online access to hearings has been incorporated via WebEx since March 2020 in response to the COVID-19 pandemic. This approach required upgrades to existing IT systems to ensure that the Court could safely continue its work during the COVID-19 pandemic. These upgrades have facilitated participation in proceedings for families, experts, and witnesses, and allowed other interested parties such as media to watch proceedings.

The Court has increased its IT capabilities and capacity to hold virtual hearings over the 2020—21 year by:

- fitting out three new meeting rooms with web cameras and new screens to facilitate hybrid meetings for staff and external parties
- implementing new cabling and networking capabilities on-site as part of the office refurbishment at the Court
- improving systems required to swap between in-person and virtual court hearings, ensuring that the Court can respond quickly to changing COVID-19 restrictions.

New case management system and digital filing — Birrung

In 2020, the Court began its transition from primarily paper record keeping to a new digital filing system called Birrung.

The name, Birrung, meaning star in the Dhurga language, was chosen by the Court's Koori Engagement Unit as stars have traditionally guided people on journeys throughout history.

Birrung is a custom-built database system based on the Dynamics 365 Customer Service Module and the initial phase of the project was completed in approximately five months. The system has been designed and built with the oversight of senior registrars, solicitors and coroners at the Court, ensuring that the system is reflective of the processes and requirements of the Court.

Under this project, the Court has upgraded its legacy systems and transitioned from servers kept on premises to cloud storage for its files. Transitioning to a SharePoint cloud system has allowed the Court to make more of its processes completely digital, improving efficiency and access across all Court functions.

The next stage of this project aims to include a family access portal in Birrung. This work will enable family members of deceased persons to access a secure section of Birrung to help guide them through the coronial process.

Birrung's Court-wide adoption has been supported by a comprehensive operational and IT training program for all staff and represents a significant step forward towards a paper-lite future.

New public data reports and transparency of the Court's work

During coronial investigations, the Court collects a broad range of data about unexpected deaths in Victoria.

Throughout the reporting period, the Court has renewed its efforts to make more of this data publicly available — to promote awareness of coronial investigations and support prevention initiatives in the community.

After the successful launch of new public data reports in the 2019—20 financial year, including the biannual *Victorian suicides of Aboriginal and Torres Strait Islander people* report, the Court has expanded its regular publications to include the *Coroners Court Monthly Suicide Data Report* in August 2020 and the quarterly *Coroners Court Recommendations Report* in March 2021.

The *Coroners Court Monthly Suicide Data Report* is published on the Court's website each month and provides an update on the number of suicides recorded in the state. It also contains demographic information including a breakdown by age, gender, and location (regional versus metropolitan areas).

The *Coroners Court Recommendations Report* is a quarterly report that contains all coronial recommendations made over a previous 12-month period along with responses to recommendations. The first and second editions covered recommendations made between January 2020 — 31 December 2020, and 1 April 2020 — 31 March 2021 respectively. The third edition, including matters from 1 July 2020 — 30 June 2021, is expected in early October 2021.

In sharing this data, the Court aims to grow awareness, facilitate conversations in the community about difficult topics like suicide and drug harms and assist the prevention sector in strengthening programs aimed at reducing preventable deaths.

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	2019—20 actual	2020—21 estimates	2020—21 actual
Quantity				
Average cost per case	$	3882	4309	4123
The 2020—21 actual is lower than the estimate due to the Court's ability to close a higher number of cases for the year and reduce its average cost per case accordingly.				
Case clearance	%	93.4	100	93.4
Continued high caseloads and service demand in 2020—21 meant that fewer matters were finalised than the number of new matters coming into the Court. The appointment of two new coroners in the second half of 2020—21 is expected to help manage demand and increase the clearance rate moving forward.				
Quality				
Court file integrity: availability, accuracy and completeness	%	86	90	N/A
In responding to COVID-19, the Court moved from physical to electronic methods for managing court files and paper files were no longer maintained. Electronic files will become business-as-usual at the court, and the standard operating procedures relating to the measurement of file integrity will be updated to reflect this change so that audits are able to occur moving forward.				
Timeliness				
Ontime case processing: matters resolved or otherwise finalised within established timeframes	%	82.4	80	79.6
Of the 6591 cases finalised, a total of 5247 were closed within agreed timeframes, being less than 12 months.				

1. Investigations into deaths and fires

Certain deaths and fires require independent investigation by the Coroners Court of Victoria. Through their investigations, coroners seek to establish certain facts, such as the identity of a deceased person and their cause of death, and in many instances, the circumstances in which a death or a fire occurred.

These findings can 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.
- deaths of children where the death is a second or subsequent child to have died of the same parent, unless the child has died in a hospital and always remained an in-patient, and the death is not otherwise reportable.

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 2020—21, the Court commenced more investigations than it finalised, resulting in a 93.4 per cent closure rate for investigations into deaths and fires. The result is consistent with last year's closure rate and reflects a continued high service demand for coronial services, which will be addressed through the recent appointments of two new coroners in 2020—21. An additional coroner will be appointed in the 2021—22 financial year.

Many of the 7 per cent of cases initiated but not finalised in 2020—21 are the subject of ongoing investigations or court proceedings in other jurisdictions. These include criminal proceedings, WorkSafe investigations and investigations by the Disability Services Commissioner.

Table 2: Investigations opened and finalised

	2016—17	2017—18	2018—19	2019—20	2020—21
Number of investigations commenced	6248	6642	6757	7323	7053
Number of investigations finalised	6285	6500	6010	6841	6591
Closure rate	100.6%	97.9%	89%	94%	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 2020—21 was 7.9 months with 45.7 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

	2016—17	2017—18	2018—19	2019—20	2020—21
0–12 months	5047	5526	4978	5637	5247
12–24 months	855	722	785	846	886
>24 months	383	252	247	358	417

Table 4: Average duration of cases before they are closed

	2016—17	2017—18	2018—19	2019—20	2020—21
Duration (days)	236.7	205.8	213.3	213.4	232.2

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 direction 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 utilises 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 2020—21, 60 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 48 inquests were held at the Court.

Table 5: Cases closed with inquests

	2016—17	2017—18	2018—19	2019—20	2020—21
Number of cases closed with an inquest	82	49	59	58	60
Percentage of cases closed with an inquest	1.3%	0.7%	1%	0.85%	0.91%

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 online.

If a public statutory authority or entity receives recommendations made by a coroner, they must provide a written response within three months to the coroner 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 online.

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

Drug testing services needed in Victoria to reduce harm to users

Between July 2016 and January 2017, five men aged between 17 and 32 died in separate incidents after ingesting what they believed to be MDMA and/or magic mushrooms.

In four cases the men died of mixed drug toxicity following seizures and respiratory distress. In the fifth case, the deceased leapt from a 10th floor balcony and died from his injuries combined with mixed drug toxicity.

Each of the men exhibited erratic and distressed behaviour after taking the substance, including headbutting walls and furniture, hallucination, and paranoia. Post-mortem analysis found that the drug the men used was in fact a combination of two highly potent 'novel psychoactive substances' (NPS) — 25C-NBOMe and 4-Fluoroamphetamine (4-FA).

The investigating coroner noted that drugs obtained from unregulated markets always carry high risks, with consumers not knowing the contents, potency or authenticity of the product. These risks are heightened with NPS which are poorly understood in terms of their potency, effects on individuals and interactions with other drugs — in part, because these substances tend to be transient within the drug market and replaced by new forms regularly. As such, Her Honour stated that mitigating the harms of these drugs requires interventions targeted at NPS overall, rather than just 25C-NBOMe and 4-FA.

During the investigation, Dr Monica Barratt, a Senior Research Fellow at RMIT University with expertise in drug harm reduction and NPS was consulted. She identified two interventions that could reduce drug harms in Victoria: a public drug checking service where samples are rapidly analysed for content and purity, and an early warning network to alert the public to dangerous drugs in the community.

Submissions were also made by government departments, academic experts, and organisations working to reduce drug harms, who gave varying responses regarding the appropriateness and practicalities of implementing both initiatives.

The investigating coroner concluded that for as long as illicit drug use exists in the community, Victorians will continue to be exposed to the risks of unregulated drug markets. Furthermore, the successful operation of drug early warning systems internationally, coupled with submissions from those working in harm minimisation, demonstrated that these evidence-based interventions could save lives.

Her Honour recommended that the Victorian Department of Health urgently implement a drug checking service and a drug early warning network.

In its response, the Department of Health stated that, while there is no active plan for the implementation of a drug checking service, it continues to consider evidence for further harm reduction strategies to support health and social outcomes for people who use drugs including opportunities to enhance Victoria's drug monitoring systems to protect public health.

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.

Where prevention opportunities are identified, the coroner will direct 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 2.7 per cent of findings in 2020—21. This figure was calculated excluding natural cause findings, cases where a coroner determined the death was not reportable, and cases finalised without a coronial investigation.

The number of recommendations increased in 2020—21 from 166 to 204. 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 is on providing robust, evidence-based investigations to help protect the Victorian community against preventable deaths.

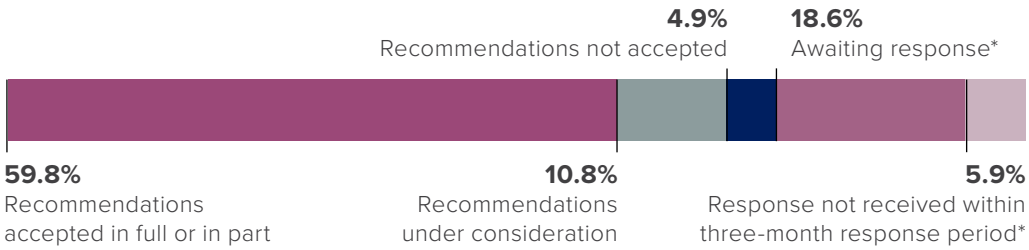
Any agency or person who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken.

In the past year, 122 of the 204 recommendations made by coroners were accepted in full or part for implementation and 22 recommendations are under consideration. There were 10 recommendations that were not accepted, and 12 instances where responses were not received within the required time frame.

Table 6: Recommendations made in closed investigations

	2016—17	2017—18	2018—19	2019—20	2020—21
Number of investigations closed with recommendations	65	48	69	78	93
Number of recommendations made	127	108	154	166	204

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 at the time the data was extracted.

Expert advice

When developing coronial recommendations, coroners draw on a range of resources including the Coroners Prevention Unit (CPU), 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 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.

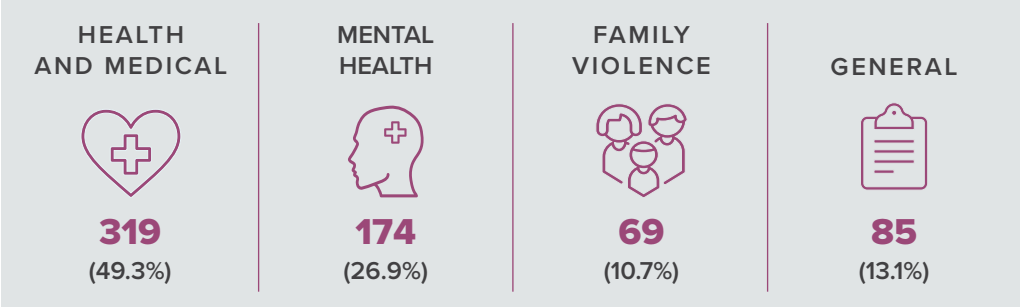
Throughout the 2020—21 reporting period, coroners made 647 referrals to the CPU about deaths under investigation. The advice coroners sought input on, included:

- 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 2020—21, 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 2020—21



Paediatric placement program

Through its relationship with Monash Children's Hospital, the Court engaged a trainee paediatric registrar from September 2020 to June 2021. The paediatric registrar was based at the Court for one day a week, 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 2020—21, the Court engaged 44 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 comprehensive records on reportable deaths in Victoria — the Victorian Surveillance Database. Monitoring all reportable deaths in a systemic way provides benefits for coroners. It provides a unique insight into emerging trends in certain kinds of deaths while 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 previous Annual Reports because of this re-classification process.

In 2020—21, causes of death reported to the Court were consistent with previous years - 37.8 per cent of deaths reported to the Court were caused by natural causes, 36.5 per cent were accidental (due to falls, road accidents, drowning and similar), and 9.5 per cent were suicides.

Table 7: Cases reported to the Court in 2020—21

Cause of death	Frequency	Percentage
Natural causes	**2667**	**37.8**
Unintentional	**2577**	**36.5**
Falls	1822	25.8
Poisoning	325	4.6
Transport	224	3.2
Drowning	56	0.8
Other	150	2.1
Suicide	**672**	**9.5**
Hanging	353	5.0
Poisoning	108	1.5
Firearm	33	0.5
Rail	30	0.4
Jump from height	33	0.5
Other	115	1.6
Assault	**75**	**1.1**
Complications of medical or surgical care	**349**	**5.0**
Other*	**270**	**3.8**
Not reportable	**169**	**2.4**
Still enquiring	**274**	**3.9**

* 'Other' here includes other reportable deaths, 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 notable reduction in Victorian overdose deaths during 2020—21 from 537 in 2019—20 to 454. While this may reflect an underlying decline in fatal drug-related harms in Victoria, caution is urged in drawing premature conclusions.

Frequencies reported from the VODR can change over time as coronial investigations progress and more information becomes available. Through the coroner's investigation, an overdose death initially characterised as involving one drug might be determined to have involved two other drugs; or a death initially thought to be unrelated to drug consumption might be found to be a fatal overdose.

Revisions in how drugs are grouped and categorised for analysis can also occur when the Court revises its approach to understanding and describing drug-related harms, usually in response to expert advice and feedback.

Table 8: Overdose deaths reported

Financial year	2016—17	2017—18	2018—19	2019—20	2020—21
Number of deaths	529	517	538	537	454

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 2020—21, suicides comprised 9.5 per cent of all deaths reported to the Court. The number of reported suicides reduced to 672, down from 714 in the previous year. A similar downward trend has been observed in other states and several other countries during the COVID-19 pandemic.

Table 9: Annual reports of suicide

Financial year	2016—17	2017—18	2018—19	2019—20	2020—21
Number of deaths	660	685	749	714	672

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 contact in 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.

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 information to assist the sector in strengthening responses to those living with family violence.

Homicide incidents in 2020—21

In the 2020—21 reporting period, there were 59 homicide incidents in Victoria that were reported to the Court. This is a decrease from 67 homicide incidents in the previous year (Table 1). Over one third of these incidents (40.6 per cent, n=24) were identified as family violence related. The 59 identified homicide incidents resulted in the deaths of 63 homicide victims.

Family Violence Death Reviews

The data for this reporting period was extracted from the VHR on 31 August 2021 and includes all homicides reported to the Court between 1 July 2020 and 30 June 2021. 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 2020—21 remain ongoing at the time of this report.

Table 10: Homicides incidents by year — July 2016 to June 2021

Type of homicide	2016—17	2017—18	2018—19	2019—20	2020—21
Family violence related	22	21	15	19	24
Not family violence related	25	38	27	28	18
Unknown	7	5	10	20	17

Most of the family violence incidents in 2020—21 resulted in the death of one homicide victim (96.6%) (Table 12).

Homicides by relationship

The 59 identified homicide incidents resulted in the deaths of 63 homicide victims.

Where a familial relationship was identified between the homicide offender and homicide victim (n=26), the relationship was most likely to be of a current or former intimate partner 42.3 per cent (n=11). This was followed by parent-child relationships (34.6 per cent, n=9) and other intimate or familial relationships (23.1 per cent, n=6) (Table 11).

Table 11: Homicide Victims by relationship to offenders 2016 to June 2021

	2016—17	2017—18	2018—19	2019—20	2020—21
Intimate partner	14	14	12	13	11
Parent-child	7	5	≤3	4	9
Other intimate or familial	≤3	≤3	≤3	3	6
Not intimate or familial	30	38	28	32	20
Unknown	7	5	11	20	17

Table 12: Homicides incidents by number of deaths — July 2016 to June 2021

Number of deaths from incident	2016—17	2017—18	2018—19	2019—20	2020—21
Single	87.0%	96.9%	90.4%	91%	96.6%
Multiple*	13.0%	3.1%	9.6%	9%	3.4%

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

Homicide victims by sex

In 2020—21, females were more often the victim of family violence related homicides (61.5 per cent, n=16), whereas males were more often homicide victims in non-family violence related homicides (83.8 per cent, n=31). This was consistent with data across the preceding five years (Table 13).

Table 13: Homicide victims by sex — July 2016 to June 2021

Sex of homicide victim	Type of homicide	2016—17	2017—18	2018—19	2019—20	2020—21
Male	Family violence related	13	7	≤3	8	10
	Not family violence related	26	34	22	42	31
Female	Family violence related	11	14	12	12	16
	Not family violence related	4	4	6	10	6

Recommendations in Family Violence Investigations 2020—21

A total of 35 recommendations were made across 13 family violence-related closed coronial investigations in 2020—21. Three key themes emerged from these recommendations:

- Victoria Police responses to family violence
- Corrections Victoria and Youth Justice responses to family violence
- Third-party witnesses and informal supports.

Victoria Police responses to family violence

Almost half (12) of the recommendations made in family violence-related closed coronial investigations in 2020—21 were directed towards Victoria Police and their response to family violence matters.

These recommendations related to the improvement of Victoria Police procedures and guidelines on a range of matters including:

- welfare checks
- information sharing
- firearms licence applications and renewals
- recording family violence incidents reported via telephone
- responses to adolescent perpetrators of family violence
- suspect welfare management of family violence perpetrators
- the investigation of family violence related suicides.

Corrections Victoria and Youth Justice responses to family violence

Two cases involved homicides committed by family violence perpetrators who were being supervised under a Community Corrections Order or Youth Justice Order at the time of the homicide.

These investigations resulted in several recommendations made to Corrections Victoria and the Department of Justice and Community Safety directed towards improving case management and the monitoring of non-compliance with such orders, the drafting of judicial monitoring reports, information sharing, and family violence risk assessment and management.

Third party witnesses and informal supports

The court identified a number of cases where multiple third parties, such as friends and family members, were aware of or witnessed family violence occurring in a relationship prior to a fatal incident, however no services were ever accessed in relation to that family violence.

The Court held a VSRFVD review panel meeting with stakeholders from key agencies in the sector to discuss currently available supports to assist these third parties helping persons affected by family violence and encouraging them to access services, and where there are gaps. This review resulted in recommendations being made, in three cases, that the Victorian Government and Family Safety Victoria develop a research-based strategy in consultation with victim survivors, informal supporters and priority communities, to provide targeted information and services to informal supporters assisting persons affected by family violence.

Case study 2

Community Corrections and Ambulance Victoria responses reviewed following family violence related death

Ms C was severely assaulted by her partner, Mr T, in her home in Port Fairy in June 2016. Ms C presented herself at Port Fairy Hospital for medical treatment and was interviewed by police before being discharged two days later.

Ms C developed severe pain and difficulty breathing after visiting a friend and called for an ambulance to attend in the middle of the night. Ms C spoke with an Emergency Services Telecommunications Authority operator and was initially triaged to have an ambulance attend until an Ambulance Victoria clinician reviewed the call and downgraded the urgency, requiring Ms C to self-present at hospital within four hours and arrange her own transportation.

When Ms C returned home from her friend's house, she succumbed to her injuries having suffered a ruptured spleen and significant internal bleeding.

The investigating coroner found that the Ambulance Victoria systems in place did not adequately address issues pertinent to domestic violence and other vulnerable patients. For example, failing to take into account the impact that such incidents may have on an injured person's ability to comprehend advice given, and follow advice given for accessing services.

Ultimately, Ambulance Victoria conceded that the decision to downgrade the call and not send an ambulance was due to a lack of training and staff errors which contributed to Ms C's death.

Ambulance Victoria has accepted recommendations made by the investigating coroner to improve training and policies regarding the triage of emergency calls made by victims of family violence to avoid similar deaths.

Mr T was on a community corrections order (CCO) at the time of the fatal incident as part of a sentence imposed in September 2015 at the Warrnambool Magistrates Court. Mr T failed to significantly comply with his CCO and did not seek treatment as required by his order. Mr T was not served with a charge and summons for contravening his CCO until after Ms C's death.

The investigating coroner found that Community Corrections staff were poorly supervised and mismanagement of offenders subject to CCOs was a significant systemic issue in 2016. Corrections Victoria largely relied on a paper-based system, with insufficient record keeping by case managers. Recommendations were accepted by the Department of Justice and Community Safety to improve and overhaul electronic case management systems and improve training for staff in preparing reports for judicial officers who deal with CCO offender compliance.

Corrections Victoria also committed to a suite of reforms to strengthen the management of family violence perpetrators who are subject to CCOs in line with legislative changes.

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 chaired the Australian Domestic and Family Violence Death Review Network (the Network), which consists of representatives from family violence death review mechanisms in states and territories throughout Australia.

During the Court's tenure as chair, it oversaw the commencement and progression of a project between the Network and Australia's National Research Organisation for Women's Safety (ANROWS) to compile and publish national data on family violence related deaths, which will be released in the coming year.

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 2020—21 the Coroners Court of Victoria collaborated with researchers in public health and medicine to develop new insights into preventable deaths.

The Coroners Court of Victoria contributed data and expertise to the International COVID-19 Suicide Prevention Research Collaboration for a study of suicides before and after the onset of the COVID-19 pandemic across 21 regions and countries around the world. The study, the results of which were published in Lancet Psychiatry, showed that in most places the suicide rate remained steady or declined slightly after the onset of the pandemic.

A long-running collaborative project between the Court, Monash University Accident Research Centre, Melbourne School of Population and Global Health and Victorian Department of Health, culminated in a published paper in PLOS ONE. The project used data from the Coroners Court of Victoria and Victorian Department of Health to understand the prevalence of hospital contacts among people who suicide in Victoria. The study highlighted the challenges for suicide prevention among males in Victoria, who generally had comparatively low levels of health system engagement prior to suicide.

Other research partners with whom collaborative projects progressed during the reporting period included the National Centre for Farmer Health at Deakin University; St Vincent's Hospital; the Spectrum State-wide Service for Personality Disorder at Eastern Health; the Department of Forensic Medicine at Monash University; and the Melbourne School of Population and Global Health at the University of Melbourne.

An increased focus on publicly available data 2020—21

Over the reporting period, the Court has continued to increase its 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 working in the prevention space to tailor their offerings to better meet the needs of the community.

Over the 2020—21 financial year, the Court added the *Coroners Court Suicide Data Report* and the *Coroners Court Recommendations Report* to its repertoire of regularly published reports.

Coroners Court Suicide Data Report

In Victoria all deaths from suspected non-natural causes including suspected suicides are required to be reported to the Court. The Coroners Court reviews newly reported deaths on a daily basis to identify those that occur in circumstances consistent with suicide. These deaths are then added to the Victorian Suicide Register (VSR).

At the end of each month, data from the VSR is extracted and published on the Court's website in the *Coroners Court Suicide Data Report*. The report contains an analysis of all suicide deaths in Victoria over the preceding month, along with comparative data for the previous five years, demographic information including age and gender, and the distribution of suicides in metropolitan versus regional areas. The report has been published monthly since August 2020.

Over the course of the 2020—21 financial year, the reports show that there has not been a significant increase in suicides attributable to the COVID-19 pandemic, or significant changes in suicide trends in the state.

Coroners Court Recommendations Report

The *Coroners Court of Victoria Recommendations Report* is a quarterly publication collating all recommendations made in a twelve-month period and the status of responses.

The Court plays a unique and important role in protecting the Victorian community. Each year the Court independently investigates around 7000 cases of sudden or unexpected deaths, deaths of people in care or custody, and fires — to reveal when, where, how and why the incidents occurred. This report illustrates the work of the Court, highlighting the broad range of reportable deaths that it investigates each year and the prevention opportunities they present.

Supporting research

During 2020—21 the Court's Research Committee met on eight occasions to assess 27 new applications for access to coronial data, as well as 18 applications to amend previously approved research projects.

Of these applications, 43 were ultimately approved. The approval process in some cases required correspondence with the applicants and changes to research design in order to address coronial concerns. One application was withdrawn during the consultation process, and one application was not endorsed.

In making its decisions, 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:

- Burn-related deaths
- Deaths involving consumer products
- Suicide clusters
- Filicide
- Motor vehicle involved deaths.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2020—21, the Court responded to 54 requests from external organisations for data and other assistance, including:

- Victoria Police
- Victorian Department of Health
- Australian Institute of Health and Welfare
- Lifeline
- National Children's Commissioner
- Royal Commission into the Casino Operator and Licence
- Kidsafe Victoria
- National Transport Commission.

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 2020—21 the Court received 5588 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

	2016—17	2017—18	2018—19	2019—20	2020—21
Form 45 requests	5063	5237	5741	4600	5588

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 and explain 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 2020—21, coroners delivered six presentations to stakeholders.

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. The Court holds quarterly information sessions to help health practitioners understand when a death must be reported, and the coronial investigation process for health care related deaths.

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. The sessions are further supported by a range of publications and other targeted resources produced by the Court.

In the 2020—21 reporting period, virtual education sessions were held in October 2020 and June 2021.

Law Week

The Court and the Victorian Institute of Forensic Medicine held a joint panel discussion for Law Week 2021 on the topic of alcohol and its impact on health and wellbeing.

The event, featuring the Hon. Judge John Cain, the Victorian State Coroner, along with Dr Jennifer Schumann, Head of the Drug Intelligence Unit at VIFM, Dr Linda Iles, Head of Pathology at VIFM, Dr Jo Ann Parkin, Clinical Forensic Physician at VIFM, and Associate Professor Nicola Cunningham from VIFM and St Vincent's Hospital in Melbourne was held online and attracted an audience of over 100 people. The event was recorded and made available across several channels for people who could not attend the event live.

The panel highlighted the Victorian coronial process, discussed the various ways that alcohol can contribute to unexpected deaths, and highlighted the range of prevention opportunities that can arise from unexpected deaths involving alcohol.

Case Study 4

Training overhaul for staff on risks of physical restraint for safer bars

Mr B, a 45-year-old man with a history of drug induced psychosis, panic attacks and paranoia, died in a licenced premises after he was physically restrained by venue staff. He had underlying coronary artery disease and had recently used cocaine.

Mr B saw several acquaintances at the licenced venue throughout the evening. He seemed well before becoming fearful, paranoid and erratic at about 2am. Mr B's agitated behaviour escalated over the course of about 13 minutes. He yelled out requesting police and telephoned emergency services several times stating that someone was going to kill him. He threw a bottle against a window, and broke a wine glass though he did not appear to be threatening anyone in particular. The investigating coroner found that Mr B was experiencing drug induced psychosis.

The bar owner, a bartender, and a patron restrained Mr B after a scuffle. He was restrained prone on the ground, with the weight of an adult on his back for approximately two minutes. When police arrived, they handcuffed him and attempted to sit him up. However, Mr B was falling in and out of consciousness, so they placed him in the recovery position and requested an ambulance. A short time later Mr B stopped breathing. Police commenced CPR, but he could not be revived.

The investigating coroner identified that whilst the bar staff and patrons acted in good faith, they did not have sufficient skills and knowledge to manage someone who was having a mental health episode (drug induced psychosis). They were also unaware of the risks associated with physically restraining someone and positional asphyxia. The investigation revealed that the premises was not required to employ licenced security guards or crowd controllers, who have some training on these issues, and the training mandated for the bar owner and employee had little to no information on these issues.

The Victorian Commission for Gambling and Liquor Regulation (VCGLR) acknowledged that late night licenced premises operate in a higher risk environment in terms of anti-social behaviour and physical assaults. The coroner considered that more should be done to educate those who are licenced to operate these premises and employed in this setting, giving them the knowledge and skills to provide a safe environment for patrons and staff.

The investigating coroner made recommendations to the VCGLR and the Department of Justice and Community Safety (DJCS) to educate and promote awareness by way of a safety alert/guidance note for distribution to licenced bar owners and an update to the Responsible Service of Alcohol Training (RSA) to include information about the risks and dangers associated with managing people who experience mental health episodes and aggressive behaviours, and the risks associated with the apprehension and physical restraint of these people.

In response, the VCGLR and DJCS agreed to develop a guidance note and update the portion of RSA training controlled by the VCGLR. They further undertook to write to the Australian Skills Quality Authority (ASQA) requesting the ASQA consider amending the portion of nationally accredited RSA training to incorporate this information.

4. Corporate governance and support

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

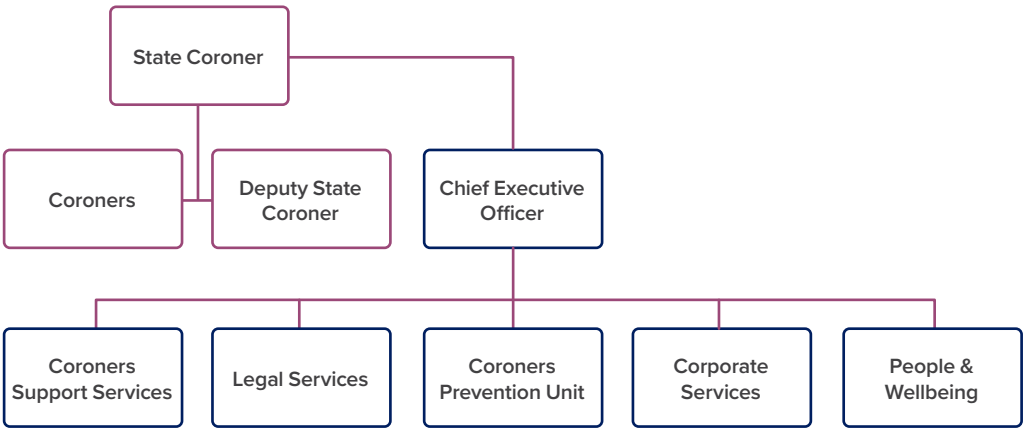
The Court is one of the courts and tribunals which sit within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its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

Organisational structure

The Court employs 115 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. Legal Services also has carriage of Supreme Court appeal proceedings that may arise from coronial matters, and advises the Court and coroners on other legal and policy matters.
- **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 2021, the Court had 115 staff members (98.5 full-time equivalent (FTE)), not including coroners. This includes 91 permanent staff, 35 per cent of which 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 2021.

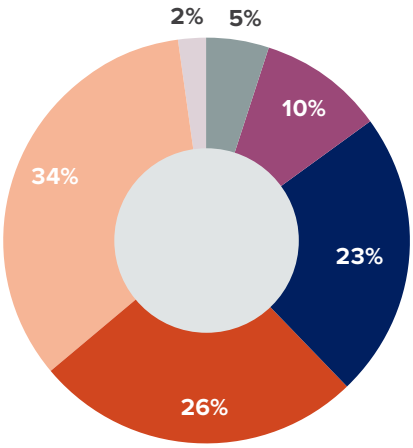
Table 15: Workplace profile at 30 June 2021

	June 2021					
	All employees		Ongoing		Fixed term/casual	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
Male	23	20.1	15	4	4	0
Female	92	78.4	44	28	15	5
Total	**115**	**98.5**	**59**	**32**	**19**	**5**
	All employees		**Ongoing**		**Fixed term/casual**	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
VPS2	15	12.2	7	5	3	0
VPS3	26	24.1	15	4	6	1
VPS4	41	34.7	17	11	9	3
VPS5	17	16	12	4	0	1
VPS6	10	9.5	7	2	1	0
STS/7	6	1	0	6	0	0
Executive	1	1	1	0	0	0
Total	**115**	**98.5**	**59**	**32**	**19**	**5**

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

Figure 3: Divisional headcount at 30 June 2021

Division	Number FTE	Number Headcount
Office of CEO*	4.8	6
Corporate Services	10.4	12
Legal Services	25.1	26
Coroners Prevention Unit	21.4	30
Coroners Support Services	34.8	39
People and Wellbeing	2	2
Total	**98.5**	**115**



* 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 oversee critical business functions, provide a clear decision-making framework, and ensures 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. 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 Directors of each of the Court's five business units, as well as the Director of 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 2020—21 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.

Business continuity planning

During 2020—21 the Court reviewed its business continuity plan in line with CSV's Business Continuity Policy & Framework. The plan provides clear 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 2020—21, 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. A key focus of 2020—21 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.

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 during 2020—21 has progressed with many programs and initiatives delivered. These include:

- A newly established Health and Wellbeing Committee providing a forum in which to engage with staff and coroners on matters affecting their health and wellbeing, and to support the implementation of initiatives that promote a positive safety culture.
- An independent review into the impact of the Health and Wellbeing Plan. The review found that the achieved implementation of its goals and actions to a high standard.
- Continued implementation of recommendations stemming from a review into the Court's operating structure to ensure that staff have good supervision, are well-supported, and that job roles and functions are clear.
- Delivering on-line vicarious trauma workshops to support staff with a focus on creating greater awareness of exposure risks, self-care strategies and available support mechanisms.
- Progress of the Reducing Exposure Risk Working Group to identify further opportunities and make recommendations to reduce the inadvertent exposure to traumatic or distressing material.

The impact of COVID-19 resulted in the majority of the Court's workforce working remotely through 2020—21. The Court quickly adapted 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:

- Resilience workshops
- Meditation, pilates, yoga and stretch sessions
- A step challenge
- Online social activities.

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

In 2020—21, the Court also focused on initiatives to continually attract and retain a diverse and high-performing workforce. These included:

- Strengthening 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 effectively manage the inherent exposures within the Court environment without undue impact on their mental health and wellbeing.
- Roll-out 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.
- Implementation 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.
- The development of a Capability Framework to establish a set of core capabilities to support the professional development of Court staff and to assist the Court in selecting best-fit candidates.

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. With a focus on strengthening leadership capability for high performance, a 12-month Purposeful Leadership program was developed. In 2020—21, the program commenced with Leading for Positive Mental Health.

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 hybrid work arrangements involving a mix of working in the office or at home. This has been particularly relevant during lockdown periods, where the Court's workforce has been supported to work effectively from home.

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 coroners 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 2020—21, the following appeals were finalised:

- *Childs v Coroners Court of Victoria* **[2020] VSC 755 (16 November 2020)**
- *Bruinink v Coroners Court of Victoria* **[2021] VSC 159 (31 March 2021)**

A further two proceedings were discontinued or held in abeyance, and one is currently on foot.

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