Coroners Court
of Victoria

Annual Report

2023–2024

Coroners Court
of Victoria

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 2024.*

Judge John Cain, State Coroner

October 2024

Acknowledgement

The Coroners Court of Victoria (CCOV) acknowledges the Traditional Owners and continuing custodians of the land on which it is located, the Wurundjeri Woi Wurrung peoples of the Kulin Nation. CCOV respectfully acknowledges all Traditional Owners across Victoria and pays respect to all Elders both past and present.

Published by the Coroners Court of Victoria

65 Kavanagh Street Southbank VIC 3006

October 2024

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**

Need help reading this report?

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

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

ISSN – 2202–1310

Contents

At a glance

INVESTIGATIONS

7413 new investigations opened

7147 investigations finalised

96.4% closure rate

TIMELINES

8 Average months to investigate

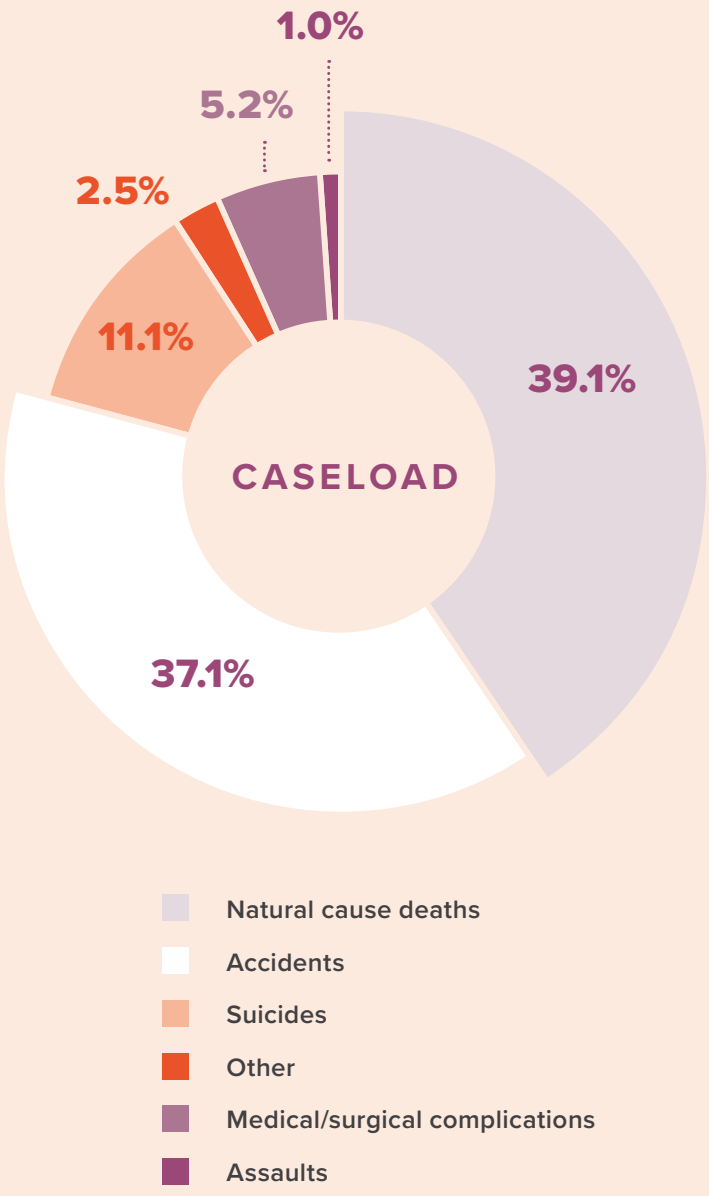
81.8% in <12 months

53.4% in <3 months

INQUESTS

80 inquests finalised

1.1% of investigations closed following inquest



RECOMMENDATIONS

187 recommendations made

98 accepted

7 not accepted

80 under consideration, awaiting response or overdue

DATA & DOCUMENTS

6299 requests for documents

33 requests from organisations for coronial data

38 research requests granted

The year in review

From the State Coroner

Judge John Cain

This year the Court has continued to successfully implement key priorities from our 2020–2024 strategic plan; to reform and modernise our processes, alongside efforts to better support our coroners, staff and people engaging with the Court – including family members who have lost a loved one or a person involved in an investigation – and the broader Victorian community.

In 2023–24, our workload has remained steady with 7413 new investigations opened compared to 7480 last year. In this time, we finalised 7147 investigations – a very impressive effort from our coroners and staff.

In the interests of public safety and wellbeing, our publications containing data from the Victorian Suicide Register (VSR) and the Victorian Overdose Death Register (VODR) have continued in 2023–24, along with the *CCOV Recommendations Report*. Additionally, through the efforts of the Coroners Prevention Unit (CPU), we have worked with university researchers and other entities to deepen our collective understanding of suicide prevention and access to means, suicide in the context of gambling, and how data about diverse communities is captured in the VSR.

This year, we collaborated with Australia's National Research Organisation for Women's Safety (ANROWS) to publish a study on filicides in a domestic and family violence context as part of the Australian Domestic and Family Violence Death Review network (ADFVDRN). We were also invited to consult in relation to the Victorian Department of Health's review of the *Voluntary Assisted Dying Act* and to the *Crimes Amendment (Non-fatal Strangulation) Bill 2023*.

In July 2023, we welcomed new coroner, Ingrid Giles. Prior to her appointment, Coroner Giles was well known at the Court, having been a member of the CCOV in-house legal team where she held the position of senior legal counsel. Coroner Giles has been a wonderful addition to the coronial team and has already contributed significantly to the work of the Court in her new capacity as a coroner.

While we gained a coroner in 2023–24, we farewelled former Deputy State Coroner Jacqui Hawkins in October 2023. Before her appointment as a coroner in 2014 and subsequent elevation to Deputy State Coroner in April 2022, former Deputy State Coroner Hawkins established the Court's in-house legal service in her capacity as senior legal counsel. Her contributions to the Court over the last decade are immeasurable and I take this opportunity to express my thanks to former Deputy State Coroner Hawkins and wish her well for her future endeavours.

Our achievements have been many this year. In line with our modernisation agenda, a pilot program was initiated to investigate how artificial intelligence (AI) may be integrated into the work of the Court. Carried out entirely in-house, the successful pilot looked at how AI can be used to reduce staff exposure to distressing images and the associated vicarious trauma that can arise from such exposure. The use of AI to navigate very large documents to reduce the administrative load on our staff was also trialled. We look forward to further exploring how this technology can support staff and aid the Court in the future.

I will take the opportunity to extend my thanks to all the coroners and staff for their on-going dedication to the jurisdiction. The work we do can be confronting and is certainly not for the faint of heart. Our team, led by our CEO Carolyn Gale, continues to deliver amazing results for the Victorian community. The team approach each day with outstanding professionalism and compassion for the people engaging with the Court in often challenging circumstances. I am very privileged to be supported in my role by such extraordinary people.

From the CEO

Carolyn Gale

It has been another big year at the Court – we have weathered the ups and downs, kept pace with our workload, developed a new strategic plan for the next three years, and made significant achievements to the benefit of the Victorian community. Once again, I am incredibly proud of the hard work put in by our coroners and staff to improve the health and safety of all Victorians.

In line with our 2020–2024 strategic directions plan, we have continued to improve our processes and supports for coroners, staff, and friends and families in contact with the Court in 2023–24. We have increased our reach in demystifying the coronial process for diverse communities, regularly shared our data both publicly and in collaboration with other organisations involved in death prevention, and further developed our staff wellbeing programs.

We have also put in place a new strategic plan that will apply for the next three years. Looking ahead, we will be redoubling our efforts in supporting families with dignity throughout the coronial process, empowering our people to reach their highest potential and to work with purpose. We remain committed to applying modern, informed and independent approaches to our work, and sharing our findings, recommendations and data to help keep Victorians safer.

Our achievements this year have included a successful foray into artificial intelligence – exploring how it can be used to reduce the impact of vicarious trauma on staff and how it can be used to reduce hours spent on repetitive administrative tasks. We have overseen an amendment to the *Coroners Act 2008* to clarify the role of police appointed coronial investigators, produced a new resource explaining the potential impact of trauma to Court visitors, and produced a new practice note providing guidelines on the proper pronunciation of names and forms of address in Court.

Without the on-going efforts and dedication of our exceptional coroners and staff, we could not have achieved the positive outcomes recorded in 2023–24. Every year I am taken aback by the tireless, professional approach applied to the work of the Court by our team – all while maintaining compassion and care for people experiencing loss in often confronting settings.

Furthermore, I extend my thanks to our partner agencies – the Victorian Institute of Forensic Medicine and Victoria Police. Both organisations provide invaluable contributions to the coronial investigative process. Without them, the Court would not be able to investigate every reportable death in the State with the rigour and attention to detail expected by the community.

Finally, special thanks to the State Coroner, Judge John Cain for his strong leadership and dedication to the continuous improvement of the Court.

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 2023–24 period, the Coroners Court of Victoria farewelled former Deputy State Coroner Jacqui Hawkins, with Deputy State Coroner Paresa Spanos assuming the role in October 2023. The Court also welcomed Coroner Ingrid Giles in July 2023.

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 1991–2002. Between 2002–2006, 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, the Aboriginal Justice Forum, and the Council of Chief Coroners.

Deputy State Coroner Paresa Antoniadis Spanos – BA LLB

Paresa Spanos was appointed a magistrate in 1994 and has worked exclusively as a coroner since 2005. She was appointed Deputy State Coroner in October 2023.

Deputy State Coroner Spanos graduated from the University of Melbourne in 1981 with Bachelor of Laws and Bachelor of Arts degrees. Her Honour began her legal career as an articled clerk/litigation lawyer in private practice before joining the Commonwealth Director of Public Prosecutions, Melbourne Office, in 1984. Her Honour worked at the Commonwealth DPP for 10 years, initially as a legal officer in the trials and appeal section and, from 1989, as senior assistant director, first in the major fraud branch and then in general prosecutions.

As a magistrate, Deputy State Coroner Spanos worked across all jurisdictions – civil, criminal, family violence and the Victims of Crime Assistance Tribunal sitting first at (the old) Melbourne Magistrates' Court before working in the Broadmeadows, Melbourne and Heidelberg regions, as well as completing several tours of duty in the Children's Court of Victoria.

Deputy State Coroner Spanos was the Children's Courts representative on the Victorian Child Death Review Committee from 2005–2013; a member of the steering group involved in the Ernst & Young review of the Coroners Court in 2012, which led to the current structure and staffing of the court; a member of the organising committee of the Asia Pacific Coroners Society annual conference held in Melbourne in 2014 and currently involved in the planning of the conference to be held in Melbourne in October 2025; a member of the CCOV's Research Committee from 2012–2022; the Court's representative on the Victims of Crime Consultative Committee from 2020–2023; and a member and current chair of the Coroners and Pathologists Advisory Group, part of the CCOV/VIFM collaboration.

Deputy State Coroner (former) Jacqui Hawkins – BA(Hons) LLB

Deputy State Coroner Jacqui Hawkins was appointed a coroner in January 2014 and was appointed a magistrate and Deputy State Coroner in April 2022. She held the position of Deputy State Coroner until October 2023. Prior to her appointment, she was the Court's senior legal counsel and established the in-house legal service. Deputy State 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.

During her time as Deputy State Coroner, Her Honour was a member of the Coroners Pathologists Advisory Group, the Koori Initiatives Committee, the Coroners Education Committee, the Judicial College Judicial Wellbeing Steering Committee, the Judicial College Koori Steering Committee, the Judicial Officers' Aboriginal Cultural Awareness Committee, the Suicide Prevention and Response Secretaries Sub-Committee, the Aboriginal Justice Forum, and the Asia Pacific Coroners Society.

Coroner Audrey Jamieson – BA LLB Grad Dip Bioethics

Coroner Audrey Jamieson was appointed a magistrate in December 2004 and has worked exclusively as a coroner since June 2005. Coroner Jamieson started her career as a nurse before obtaining arts and laws 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, and the Asia Pacific Coroners Society. Coroner Jamieson is also a member of VIFM's Ethics Committee, appointed by the VIFM Council as the Court's representative, assisting in the ethical assessment of research applications. She also chairs the Coroners Education Committee

Coroner John Olle – LLB BEc

Coroner John Olle was appointed a coroner in September 2008. He commenced his legal career as a solicitor with McCarthy & Co in Rye. Three years later he joined the Victorian Bar, where he practiced as a barrister for 25 years. He appeared primarily in the criminal and coronial jurisdictions.

Coroner Olle is a member of the Asia Pacific Coroners Society, and the Suicide Prevention and Response Victorian Secretaries' Board Subcommittee.

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 has supervised the Monash University clinical placement program. He is also the Managing Coroner for the Court's Direct Pro Bono Referral Scheme, and a member of the Research Committee.

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 and later completed a postgraduate diploma in forensic science from La Trobe University.

As a solicitor she held roles including the Royal Commission into Aboriginal Deaths in Custody, Victoria Legal Aid and Women's Legal Service Victoria. While working in government, she managed the Coronial System Reform Project, overseeing the development and passage of the *Coroners Act 2008,* which established the Coroners 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 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.

Coroner David Ryan – BA LLB (Hons)

Coroner David Ryan was appointed a coroner in June 2021. Prior to this appointment, His Honour was a judicial registrar of the Federal Court of Australia and held several longstanding positions at the Victorian Government Solicitor's Office (VSGO), including the role of managing principal solicitor. His work at VGSO focused on government litigation including inquests.

Coroner Catherine Fitzgerald – BA LLB (Hons)

Coroner Fitzgerald was appointed a coroner in April 2022. Her Honour was admitted to practice in 2004, and practised as a barrister prior to being appointed, having signed the Victorian Bar roll in 2016. Coroner Fitzgerald has extensive experience in criminal and coronial cases.

Her Honour began her career as a solicitor at the New South Wales Office of the Director of Public Prosecutions and was subsequently a State Prosecutor at the Office of the Director of Public Prosecutions for Western Australia, Counsel Assisting at the Coroners Court of Western Australia and a Senior Federal Prosecutor for the Commonwealth Director of Public Prosecutions in Melbourne.

As a barrister, Coroner Fitzgerald appeared before the Supreme, County and Magistrates' Courts in a variety of criminal matters for both prosecution and defence. Her Honour appeared as counsel assisting and represented interested parties in numerous coronial inquests.

Coroner Fitzgerald is a member of the Coroner's Education Committee, the Coroners and Pathologists Advisory Group and the Missing Persons Working Group.

Coroner Paul Lawrie – LLB

Coroner Lawrie was appointed in August 2022. For the past 23 years he has practised as a barrister, also serving on the Victorian Bar Ethics Committee and mentoring six readers. His practice at the Bar has involved criminal defence and prosecution matters, as well as personal injury cases.

Coroner Lawrie regularly appeared in coronial inquests from 2000, acting for family members, Victoria Police and most recently as counsel assisting.

Prior to commencing at the Bar, Coroner Lawrie was a solicitor and articled clerk at Clayton Utz from 1997–1999. He was previously a member of Victoria Police, working as a general duties officer from 1986–1990 and then as a prosecutor and instructor from 1990–1997. His Honour holds a Bachelor of Laws from Deakin University.

Coroner Ingrid Giles – BA LLB LLM (Human Rights Law)

Coroner Giles was appointed in July 2023, having initially joined the Court in 2020 as Senior Legal Counsel. In this role, she appeared as counsel assisting in complex coronial matters, with a focus on Aboriginal passings, and appeared/instructed in multiple appeal cases in the Supreme Court and Court of Appeal.

Prior to joining the Coroners Court, Coroner Giles held roles as a lawyer at the Law and Advocacy Centre for Women from 2018–2020, as well as in the Appeals Chamber and Trial Divisions of the International Criminal Court, The Hague, from 2013–2018. Prior to this, her Honour held legal and policy roles in NGOs and government both in Australia and overseas and completed a Master of Laws (Human Rights Law) at London School of Economics and Political Science.

Coroner Giles is a member of several internal and external committees at the Court, including the Aboriginal Initiatives Committee, Indigenous Inquests Advisory Group, Court User Group, Bench Book Committee, Diversity and Inclusion Committee, and chairs the Working Group on the definition of persons 'in care'. She is also a member of the Court Services Victoria Pride Network, Australia and New Zealand Society of International Law and Asia Pacific Coroners Society.

About the Coroners Court

Our roles

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

Independently investigating deaths and fires

Certain deaths and fires are reported to the Court for independent investigation. Coronial investigations seek to establish the facts – when, where, how and why the death or fire occurred. At the conclusion of an investigation, the coroner will make findings about the identity of a deceased person, the cause of death and, in many instances, the circumstances in which a death or a fire occurred.

1. Investigations into deaths and fires on page 19

Reducing preventable deaths

A coroner may also make recommendations or comment on matters connected to the death, including issues relating to public health and safety or the administration of justice.

2. Reducing preventable deaths on 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.

3. Promoting public health and safety on 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.

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 testing as directed by a coroner
- providing expert reports on the medical cause of death for the investigating coroner.

PCSU supports coroners by helping members of Victoria Police compile coronial briefs and serving as the coroner's assistant at some inquests. PCSU members also provide training to Victoria Police in relation to the coronial jurisdiction and assist police officers who take on the role of coronial investigators.

Our place in Victoria's court system

The Coroners Court of Victoria 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 – the aim of the Court is to discover the circumstances that contributed to a death, not apportion blame, or determine criminal guilt or civil liability.

Additionally, while all cases that come before the Court are thoroughly investigated, many matters do not proceed to a hearing in a courtroom; rather, a coronial finding is made 'in chambers'.

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

Strategic Directions 2020–2024

The Coroners Court Strategic Directions 2020–2024 present the Court's vision, goals and priorities for a period of four years. The plan aims to facilitate an increased use of technology to improve efficiencies in Court processes; enhance engagement with families and friends experiencing loss; 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.

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 2023–2024

Multifaith and Multicultural Advisory Committee – information sessions and community visits

Established in January 2023, the CCOV Multifaith and Multicultural Advisory Committee (MAC) comprises 17 members including 11 community spokespeople along with representatives from the Court, VIFM and PCSU.

The MAC aims to both demystify coronial and forensic processes for diverse communities and to inform coroners, Court and VIFM staff about differing cultural practices such as funerary rites and appropriate care of deceased people. To date, feedback from community groups participating in the program has been overwhelmingly positive.

In the 18 months since the MAC was established, it has organised four educational sessions for all coroners and staff, two of which took place during 2023–24. The first session held in this reporting period involved the Greek Orthodox, Druze, and Pasifika communities, and the second centred on the experiences and role of women in African and Fijian death rituals.

The program has also facilitated visits to the Court by faith and community leaders this year, including the Board of Imams Victoria, Muslim funeral directors, members of the Rabbinical Council of Victoria, and a group of Samoan pastors and Elders based in Victoria.

In addition to education sessions and tours of the Court and VIFM facilities, the MAC has arranged for coroners to visit various community groups to speak about the coronial process. In 2023–24, coroners and Court staff have met with the Vietnamese Buddhist community at Melbourne's Chùa Ấn Quang Monastery and the Chùa Quang Minh temple, the UBUNTU Mamas at Afri-Aus Care, and Afghani refugees and other groups at Wellsprings for Women. Coroners have also presented to the Greek, Hindu and Jewish communities in this timeframe.

AI pilot program

During 2023–24, the Court initiated a pilot program to identify and explore workflows and tasks within the Court that could be improved or enhanced with the assistance of artificial intelligence (AI) with a focus on ethical use and staff wellbeing.

The bespoke pilot program centred on reducing the impact of vicarious trauma on the Court workforce by utilising AI to remove or redact distressing images that staff do not need to view. It also explored the possibility of using AI to review very large documents to identify key pieces of information; supporting coroners, solicitors and case investigators to analyse and review case material more efficiently.

The outcomes demonstrate that using AI at the Court in these ways is feasible. Aiming to support staff rather than remove human oversight, it has the potential to significantly reduce staff exposure to confronting material and time spent on repetitive administrative tasks.

Built entirely in-house, the pilot program was carried out on a secure, isolated system with no data passed to other entities or uploaded to the cloud or internet. The Court continues to evaluate the project's effectiveness, exploring responsible expansion while prioritising ethical considerations and stakeholder engagement throughout the process.

Changes to the *Coroners Act 2008* – clarifying the role of the coronial investigator

In October 2023, the Coroners Act was amended to formalise the role of the coronial investigator and to provide the coroner with an explicit power to direct the coronial investigator in relation to the investigation.

The amendments followed a recommendation made by then Deputy State Coroner Caitlin English following the inquest into the passing of Tanya Day.

The role of the coronial investigator is now defined in the Act as a police officer nominated by the Chief Commissioner of Police to assist a coroner in relation to the investigation into a reportable death.

The coroner is empowered to issue a written direction to the coronial investigator, who has a duty to comply with all reasonable and lawful directions. There is a limited exception to this duty for directions that are, in the opinion of the Chief Commissioner, unreasonable or likely to compromise a criminal investigation.

These legislative reforms are intended to improve the transparency and independence of the coronial system by providing a clear legislative framework around the role of the coronial investigator.

New initiatives to support members of the community engaging with the Court

New Practice Note for pronunciation of names and forms of address in coronial proceedings

In June 2024, the Court introduced a new practice note to provide guidance on expectations for the correct pronunciation of names and forms of address in coronial proceedings.

The practice note emphasises the importance of treating all Court participants with equal dignity, respect and courtesy, and recognises that a person's name, and how they are addressed, is integral to their sense of identity. Adopting correct pronunciation, and forms of address, is vital to upholding respect and aligns with community expectations.

The practice note formalises the process by which families, interested parties and legal representatives can provide, and the Court can seek, clarification on correct pronunciation of names and appropriate forms of address, prior to and during a hearing.

The practice note aligns with similar practice notes issued by other Victorian jurisdictions.

Medical family liaison officer – pilot program

In 2023–24, a successful pilot program was trialled to explore how families experiencing the loss of a loved one due to medical complications can be better supported. To this end, a medical family liaison officer (FLO) has been appointed to assist families to understand medical information included in the investigation into the death of a loved one.

The medical FLO is available to help discuss concerns held by families with investigating coroners, manage expectations for families as investigations progress, clarify which concerns of care fall within scope, and provide referrals for families to health services or regulatory bodies outside the scope of a coronial investigation.

The medical FLO also assists with interpreting medical examination reports and explaining the cause of death to families where there was no involvement from a family health nurse and no autopsy conducted.

Supporting witnesses, families and friends engaging with the Court

Engaging with the Court as a family member or friend of a deceased person, or as a witness during an investigation, can be distressing. Following feedback from witnesses who experienced difficulties when providing evidence in Court, the FLO team developed a printed resource called *Information for Witnesses, Family and Friends. Attending Hearings at the Coroners Court of Victoria: Impact of Exposure to Trauma & Self Care.*

The document provides an overview of the impacts of exposure to trauma, self-care suggestions for people attending the Court and links to support services assisting with grief, crisis support and mental health services.

Supporting professional development for students

This year, the Court offered for the first time a professional development opportunity for students studying social work as part of a broader initiative to prevent family violence deaths. Under the program, the CPU Family Violence team welcomed social work students who assisted with research into key systemic and policy issues under consideration by the Victorian Systemic Review of Family Violence Deaths (VSRFVD).

Following the implementation of recommendation 209 from the *Royal Commission into Family Violence*, which establishes the minimum qualifications needed to become a specialist family violence practitioner, students studying social work are required to undertake two 500-hour placements to meet the requirements.

This placement opportunity offered by CCOV provides a broad view of how the family violence response system in Victoria operates, an understanding of some of the challenges and opportunities currently existing in the sector, along with an understanding of the coroner's role in preventing future family violence related 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	2022–23 actual	2023–24 estimates	2023–24 actual
Quantity				
Average cost per case	$	4123	3840	4697
The variance between the estimate and the full year result is due to higher expenditure and lower case numbers than previous years				
Case clearance	%	101.9	100	96.4
A total number of 7147 investigations were finalised against 7413 new coronial investigations opened in 2023–24				
Quality				
Court file integrity: availability, accuracy and completeness	%	97.9	90	91
The result reflects the Court's use of an electronic file management system which has streamlined and automated case management controls and processes				
Timeliness				
On-time case processing: matters resolved or otherwise finalised within established timeframes	%	77.7	80	82
Of the 7147 matters closed, 5845 were closed within 12 months or less.				

Case study 1

Coroner calls for trial drug checking service following the death of a 38-year-old man after he ingested a synthetic opioid.

SL was 38 years old when he died of mixed drug toxicity in December 2022. SL had a long history of heroin use, along with complex mental and physical health concerns. SL was supported by a general practitioner, community mental health staff and drug and alcohol counsellors prior to his death.

On the morning of 5 December 2022, SL's father, KG attended SL's home to drop off his medication and found SL deceased on his bed. When Victoria Police attended the scene, they found various drug-related paraphernalia in the room and a small wound on SL's arm indicative of a recent injection site.

Post-mortem toxicology indicated the presence of several prescription drugs (all at therapeutic levels) as well as methamphetamine, however, heroin was not present in his system. Instead, the toxicology testing returned a positive result for metonitazene – a member of the nitazene drug family – a group of highly potent novel synthetic opioids which can be 300 times stronger than morphine. Nitazenes first began circulating in markets across Europe, the United States of America, and Canada around 2019 and are often sold as other drugs such as heroin, oxycodone or MDMA.

The investigating coroner found that, at the time of use, SL appeared to have believed he was injecting heroin and was unaware he was consuming a synthetic opioid. The coroner further found that SL's death was one of at least 16 Victorian overdose deaths involving nitazenes since the start of 2021. In some of these cases, there was direct evidence that the deceased thought they were consuming substances other than nitazenes.

The coroner determined that, while there was no guarantee that a drug checking service may have been utilised by SL, or that the testing outcome would have acted as a deterrent if he had, such a service would have at least provided him an opportunity to learn more about the drugs in his possession, assisting him to make an informed decision.

Since 2021, five coronial recommendations have been made for drug checking services in Victoria, to reduce the risk of similar deaths occurring in the future.

In this case, the coroner recommended that the Victorian Department of Health trial a drug checking service to gather evidence, experience and insights into how drug checking might reduce risks (including preventable deaths) associated with the use of drugs obtained through unregulated drug markets.

In its response, the Victorian Department of Health accepted the recommendation in full and confirmed that planning is underway to implement an 18-month trial of a mobile drug checking service from late 2024, with a fixed site service anticipated in mid-2025.

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.

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 2023–24, the Court commenced 7413 investigations, and finalised 7147. The resulting closure rate for this period is 96.4 per cent, a decrease from last year's closure rate of 101.9 per cent.

Table 2: Investigations opened and finalised

	2019–20	2020–21	2021–22	2022–23	2023–24
Number of investigations commenced	7323	7053	7200	7480	7413
Number of investigations finalised	6841	6591	7543	7620	7147
Closure rate	94%	93.4%	104.8%	101.9%	96.4%

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 a criminal prosecution or appeal, these matters must also be finalised prior to the completion of the coronial investigation. In most cases this will result in a significant increase in the time needed to finalise a coronial investigation.

The average duration of investigations closed in 2023–24 was eight months with 53.4 per cent of these finalised within three months. In most of these cases, the coroner found that the deaths were natural cause deaths.

Table 3: Duration of closed investigations

	2019–20	2020–21	2021–22	2022–23	2023–24
0–12 months	5637	5288	5782	5920	5845
12–24 months	846	886	1068	963	725
>24 months	358	417	693	737	577

Table 4: Average duration of cases before they are closed

	2019–20	2020–21	2021–22	2022–23	2023–24
Duration (days)	213.4	232.2	255.3	259.9	247.2

Inquests

An inquest is a public hearing into a death or fire. It is an inquisitorial rather than an adversarial process meaning that the coroner does not make findings of guilt or apportion blame. Instead, the coroner aims to discover the circumstances of the death.

Only a small proportion of investigations require an inquest. An inquest must be 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). The coroner may also hold an inquest into any death they are investigating if the circumstances surrounding the death or fire are unclear, or if there are broader issues of public health and safety that need to be examined by way of public hearing.

Whenever possible, the Court uses its powers to obtain statements and other evidence, and direction and mention hearings, to reduce the need for inquests. This is done principally to reduce the time in which families and friends of the deceased 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, or reduce its length and complexity.

The Court utilises available tools 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. The Court also obtains statements of agreed facts from parties where appropriate to reduce the need to hear evidence about those facts.

Of the cases finalised in 2023–24, 80 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. Over the reporting period, 60 inquests were held at the Court.

Table 5: Cases closed with inquests

	2019–20	2020–21	2021–22	2022–23	2023–24
Number of cases closed with an inquest	58	60	78	82	80
Percentage of cases closed with an inquest	0.85%	0.73%	1.01%	1.08%	1.11%

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 to the coroner within three months 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 2

Coroner calls for changes to improve player safety in contact sports.

On 20 July 2021, ST, a 38-year-old man, died by suicide at his home. The post-mortem examination revealed that ST suffered from severe chronic traumatic encephalopathy (CTE). CTE refers to progressive neurodegeneration triggered by repeated experiences of head trauma, culminating in chronic cognitive and neuropsychiatric symptoms.

The investigation identified that ST had sustained multiple head injuries during his professional career in the Australian Football League (AFL), and his subsequent boxing career. Epidemiological research demonstrates that individuals that suffer brain injuries, including in sport, may develop CTE. The investigating coroner found that ST displayed clinical features consistent with the presence of CTE prior to his death, including cognitive and episodic memory impairment, as well as depression, anxiety and paranoia.

The coronial investigation focused on opportunities to reduce the risk of CTE occurring as a consequence of repetitive head trauma and concussion in sport, particularly in Australian Rules football and professional and amateur boxing. At the inquest, the coroner heard evidence from the chief medical officer of the AFL, the chair of the Professional Boxing and Combat Sports Board, and the medical director and director of clinical research at the Dr Robert C. Cantu Concussion Centre.

In the finding, the coroner highlighted the importance of risk reduction, prevention and education to reduce the risk of repetitive head trauma in contact sports. He noted that while it is not possible to completely remove the risk of head injuries from contact sports, the main pathway to reducing repetitive head trauma is through changes to rules and regulations within sport and by modification to training methods to decrease the likelihood of head trauma.

To prevent similar deaths, the coroner made 21 recommendations directed to the AFL, Australian Football League Players Association (AFLPA), Royal Australasian College of General Practitioners (RACGP), Victorian Department of Jobs, Skills, Industry and Regions (DJSIR), the Victorian Professional Boxing and Combat Sports Board (Board) and the Commonwealth Department of Health and Aged Care.

The recommendations covered the following areas:

- limiting exposure to repetitive head injuries in Australian Rules football, and professional and amateur boxing
- employing independent medical practitioners to assist club doctors in the assessment of suspected or actual head injuries, and empower concussion spotters to remove a player from the field for medical assessment
- increasing educational awareness within sporting codes and the medical profession of the risks of concussion and the short and long-term effects of repetitive head trauma
- reviewing the regulatory framework for amateur boxing and combat sports
- promoting use of instrumented mouthguards and standardised neurological testing in elite and professional sporting codes to improve understanding of head injuries
- supporting brain research through end-of-life brain donation, and funding of brain banks.

A majority of the recommendations have been supported in full or in principle, with three still under consideration.

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 1.8 per cent of findings in 2023–24. This figure was calculated excluding natural cause findings and cases where a coroner determined the death was not reportable.

The number of recommendations decreased in 2023–24 from 221 to 187. 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.

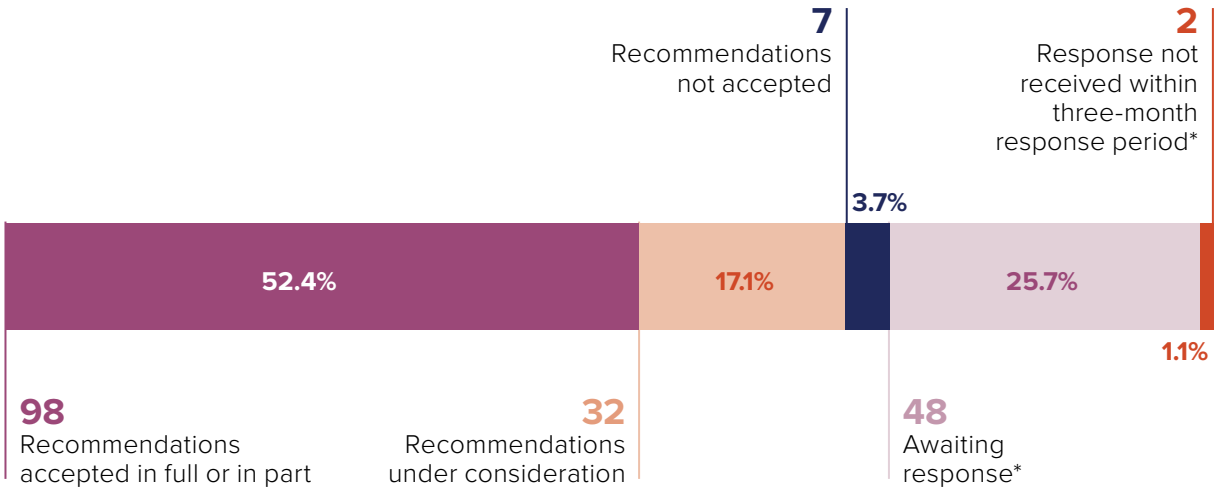
Any agency or person who receives a recommendation from a coroner must respond, in writing, within three months stating what action, if any, has or will be taken. The Court also publishes a bi-annual report collating all recommendations over a 12-month period and the status of responses received.

In the past year, 98 of the 187 recommendations made by coroners were accepted in full or part for implementation and 32 recommendations are under consideration. There were seven recommendations that were not accepted and two instances where responses were not received within the required time frame.

Table 6: Recommendations made in closed investigations

	2019–20	2020–21	2021–22	2022–23	2023–24
Number of investigations closed with recommendations	78	93	81	95	77
Number of recommendations made	166	204	199	221	187

Figure 1: Responses to recommendations from closed investigations



*'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), medical 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 supports coronial investigations by undertaking both individual and collaborative research projects aimed at developing a better understanding of the circumstances in which deaths occur in Victoria to identify new prevention opportunities.

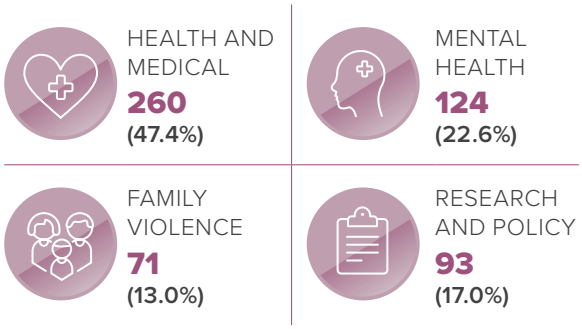
Throughout the 2023–24 reporting period, coroners made 548 referrals to the CPU about deaths under investigation. The advice coroners sought input on, included:

- the circumstances in which the death occurred, including factors that may have contributed to the fatal incident
- the frequency of previous and subsequent similar deaths in Victoria, including recurring themes and shared features
- interventions that have been proved or are suspected to reduce the risk that similar deaths will occur in future
- regulations, standards, codes of practice or guidelines that might be relevant to the circumstances in which the death occurred
- insights gleaned from previous coronial investigations into similar deaths, including past recommendations
- feasible, evidence-based recommendations for prevention opportunities which the coroner can consider in finalising the investigation.

During 2023–24, 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:** to advise coroners on the clinical appropriateness of mental health treatment provided (or not provided) in the lead-up to deaths of people experiencing mental ill health. The mental health team also incorporates a disability case investigation function – examining deaths of people engaged in disability services.
- **Family violence:** for deaths that occurred in a context of family violence. This includes homicides and suicides where there was a reported or unreported history of family violence as defined by the *Family Violence Protection Act 2008*.
- **Research and Policy:** For cases where coroners are seeking data and public health insights to inform their investigations.

Figure 2: Theme of coroners' referrals for 2023–24



Paediatric placement program

Under this program, a senior paediatric trainee is based at the Court two days a week in the Health and Medical Investigations Team (HMIT). In this 12-month role, the trainee works under the supervision of a consultant paediatrician, providing clinical advice to coroners and assistance with case reviews of relevant deaths under investigation.

During 2023–24, the Court engaged two senior paediatric trainees. The first commenced a placement with the Court in February 2023 for a 12-month period. The second joined the Court in February 2024 and will remain in the role until February 2025.

External experts

To complement in-house specialist knowledge, coroners also consult with independent experts. In 2023–24, the Court engaged 49 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 in the Coroners Court of Victoria Death Surveillance Database. Monitoring all reportable deaths in a systemic way 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 2023–24, causes of death reported to the Court were consistent with previous years – 39.1 per cent of deaths reported to the Court were caused by natural causes, 37.1 per cent were accidental (due to falls, road accidents, drowning and similar), and 11.1 per cent were suicides.

Table 7: Cases reported to the Court in 2023–24

Cause of death	Frequency	Percentage
Natural causes	**2899**	**39.1**
Unintentional	**2753**	**37.1**
Falls	1815	24.5
Poisoning	421	5.7
Transport	306	4.1
Drowning	48	0.6
Other	163	2.2
Suicide	**820**	**11.1**
Hanging	407	5.5
Poisoning	152	2.1
Firearm	30	0.4
Rail	40	0.5
Jump from height	36	0.5
Other	155	2.1
Assault	**76**	**1.0**
Complications of medical or surgical care	**383**	**5.2**
Other*	**189**	**2.6**
Not reportable	**149**	**2.0**
Still enquiring	**144**	**1.9**

* '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 an increase in Victorian overdose deaths with 601 deaths in 2023–24 compared to 514 in 2022–23. A heightened number of overdose deaths were observed in the second half of 2023 and continued into the first half of 2024. Many of these cases are still under investigation and awaiting final toxicology results. Early analysis suggests the increase is not driven by any specific issue, factor or population.

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	Number of deaths
2019–20	540
2020–21	498
2021–22	529
2022–23	514
2023–24	601

Victorian Suicide Register

Established by the Court in 2011, the Victorian Suicide Register (VSR) 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 2023–24, suicides comprised 11.1 per cent of all deaths reported to the Court. The number of reported suicides increased to 820, up from 786 in the previous reporting period. Suicides were elevated in the period between September 2023 and March 2024. The reasons for the increase are not immediately apparent from inspection of the data, as there were no standout groups (defined by sex, age group or geographical region of residence) to which the increase was restricted.

Table 9: Annual reports of suicide

Financial year	Number of deaths
2019–20	687
2020–21	662
2021–22	697
2022–23	786
2023–24	820

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. Information recorded in the VHR includes:

- socio-demographic characteristics
- location information
- presence and nature of physical and mental illness
- in cases of family violence, information on whether there has been involvement with eternal support services, and the nature of the family violence.

The VHR is a live database that includes open and closed criminal and coronial investigations. Data is subject to re-classification and updating as further information becomes available through the coronial investigation process.

Victorian Systemic Review of Family Violence Deaths

The Victorian Systemic Review of Family Violence Deaths (VSRFVD) is a legislated function of the Court that conducts in-depth reviews, identifies risks, contributory factors and trends of deaths suspected to have resulted from family violence.

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

The VSRFVD can review family violence related deaths in the following categories:

- Homicides
- Suicides (of family violence victims or perpetrators)
- Bystander deaths
- Third party deaths
- Other family violence related deaths as directed by the coroner.

The Court maintains a strong commitment to the reduction of family violence related deaths.

Homicide incidents in 2023–24

In 2023-24, there were 52 probable homicide incidents in Victoria that were reported to the Court. This is an increase from 38 homicide incidents in the previous year (Table 10). Over one third of these incidents (36.5 per cent) were identified as family violence related. The 52 identified homicide incidents resulted in 54 deaths.

The data for this reporting period was extracted from the VHR on 15 July 2023 and includes all homicides reported to the Court between 1 July 2023 and 30 June 2024. This reference period is based on the date the homicide incident occurred. This data includes data relating to open and closed coronial investigations and, as such, it is subject to change as new information becomes available during the investigation process.

It is noted that detailed data is not provided with respect to homicide offenders, as the criminal proceedings for many homicides that occurred in 2023–24 remained ongoing at the time of this report.

Table 10: Homicides incidents by year – July 2019 to June 2024.

Type of homicide	2019–20	2020–21	2021–22	2022–23	2023–24
Family violence related	20	23	17	11	19
Not family violence related	43	32	28	21	20
Unknown	2	0	7	6	13

Most of the family violence incidents in 2023–24 resulted in the death of one homicide victim (84.6 per cent (Table 12)).

Homicides by relationship

The 52 identified probable homicide incidents resulted in 54 deaths.

Where a familial relationship was identified between the homicide offender and homicide victim, the relationship was most likely to be of a current or former intimate partner (24.1 per cent). This was followed by other intimate or familial relationships (7.4 per cent) and then child-parent relationships (5.6 per cent) (Table 11).

Table 11: Homicide Victims by relationship to offenders July 2019 to June 2024.

	2019–20	2020–21	2021–22	2022–23	2023–24
Intimate partner	13	11	9	5	13
Child-parent*	0	4	3	4	3
Parent-child#	5	5	6	1	1
Other intimate or familial	3	5	1	1	4
Not intimate or familial	45	34	30	24	20
Unknown	2	0	7	6	13

* Child-parent indicates relationship only, and that the offender was the child of the victim. It does not indicate age (that is, the child who was the offender may be an adult).

Parent-child indicates relationship only, and that the offender was the parent of the victim. It does not indicate age (that is, the child victim may be an adult).

Table 12: Homicide incidents by number of deaths – July 2019 to June 2024.

Number of deaths from incident	2019–20	2020–21	2021–22	2022–23	2023–24
Single	59	50	47	35	44
Multiple*	6	5	5	3	8

*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 2023–24, 82.4 per cent of female deaths by homicide occurred in a family violence context. Conversely, males were more often homicide victims in non-family violence related homicides (45.9 per cent). This was consistent with data across the preceding five years (Table 13).

Table 13: Homicide victims by sex – July 2019 to June 2024.

Sex of homicide victim	Type of homicide	2018–19	2019–20	2020–21	2021–22	2022–23
Male	Family violence related	8	9	5	5	7
	Not family violence related	41	30	28	22	17
	Unknown	2	0	6	6	13
Female	Family violence related	13	16	14	6	14
	Not family violence related	4	4	2	2	3
	Unknown	0	0	1	0	0

Recommendations in family violence investigations 2023–24

A total of 31 recommendations were made across seven family violence-related closed coronial investigations in 2023–24.

Eighteen of the recommendations were directed towards the Department of Families, Fairness and Housing, eight were directed to the Department of Health and five were directed to the Department of Justice and Community Safety and/or Corrections Victoria.

One recommendation was directed to the Federal Government relating to Medicare and supporting GPs to identify and manage family violence.

External engagement

Networks

The Court continued to be an active member of the Australian Domestic and Family Violence Death Review Network (the Network) in 2023–24. The Network consists of representatives from family violence death review mechanisms in states and territories throughout Australia.

This year, the Network continued its collaboration with Australia's National Research Organisation for Women's Safety (ANROWS) and released a report on the first national figures for filicides that have occurred in Australia in the context of domestic and family violence. The study examined 113 cases of filicide occurring from 2010–2018. Of these, 86 cases (76 per cent) had an identifiable history of domestic and family violence.

VSRFVD Panels

The VSRFVD conducts panels with community experts to consider various systemic issues that it identifies in family violence related deaths. In 2023–24, two panels were convened by the State Coroner to discuss briefing papers prepared by the VSRFVD to consider the issues and evidence available.

The first panel considered multi-disciplinary responses to family violence with discussions covering models involving specialist family violence practitioners working alongside police to attend family violence incidents.

The second panel examined issues of adult safeguarding in Victoria, where a person with care and support needs is at risk of experiencing abuse or neglect from a carer who is also a family member, and their care and support needs prevent them from accessing other supports.

Case study 3

Coroner calls for safer carnival rides following the death of a 6-year-old boy

On 17 April 2017, 6-year-old, EM, was ejected from a popular carnival ride, the Cha Cha, at an Easter carnival in Rye. EM hit his head on the ride's metal frame and died from his injuries five days later.

The coronial investigation focused on the immediate circumstances and causes of the incident, including:

- whether the rules for riding the Cha Cha, including height restrictions, were enforced by the ride operator at the time of incident
- whether the ride operator on the day was appropriately trained and competent to operate the Cha Cha unsupervised
- whether the restraint system fitted to the Cha Cha at the time of the fatal incident was compliant with the relevant Australian standard for carnival rides.

The coroner also examined the adequacy of the regulatory system for ensuring the safety of amusement rides in Victoria and prevention opportunities.

At inquest, the coroner heard evidence from multiple witnesses including patrons of the carnival who had ridden on the Cha Cha around the time of the incident, employees of the carnival operator, and a structural engineer.

The evidence indicated that, at the time of the incident, EM was seated in the ride in a configuration that was contrary to the rules. While EM's height allowed him to ride by himself, he was placed with another child whose shorter height meant they were only permitted to ride with an adult. As both children were small, the U-shaped rod restraint was not effective to go between their legs or otherwise hold them in place during the ride.

The coroner found the ride operator had received informal training prior to the incident regarding the rules and safety protocols of the Cha Cha in the form of a 'buddy system' from experienced operators. The ride operator acted contrary to that training in managing the placement of children on the fatal ride. However, there was insufficient evidence as to whether he had been trained to a satisfactory level to allow him to operate the ride without supervision, as the carnival operator did not maintain appropriate documentation of training procedures or accreditation for the ride.

Further, the coroner found that the Cha Cha was not fitted with a Type 3 safety restraint as required by Australian Standards of the time. The coroner's investigation revealed that the Cha Cha operated for many years prior to the fatal incident without compliant restraints, despite an engineering certificate and WorkSafe inspections.

The coroner concluded that the combination of inadequate training, failure to enforce the rules for riding the Cha Cha, and substandard safety restraints led to EM's tragic death. In light of these findings, her Honour concluded that EM's death was preventable.

To prevent similar deaths, the coroner recommended to the Minister for WorkSafe that:

- there be more rigorous design registration and safety regulations for all carnival rides operating in Victoria
- WorkSafe Victoria be empowered to refuse and cancel plant and/or design registration of amusement structures if the design is unsafe
- carnival operators maintain better record keeping relating to training and ride certification
- a review be undertaken to improve ride operator training standards and accreditation, including the consideration of minimum training standards for amusement ride operators
- the national audit tool used by WorkSafe Inspectors for annual inspections be enhanced to address inspectors' concerns that it has limited utility for the delivery of safety outcomes.

The Minister has instructed WorkSafe to consider the recommendations and the current regulatory framework governing amusement structures in Victoria, with the aim to implement regulatory change that will strengthen the safety of carnival operations in the State.

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 contributions from the Court

This year, the Court continued to share data with organisations working to better understand preventable deaths in the community. The on-going focus on utilising coronial data and information in this way enables a broader network of those engaged in death prevention to access accurate information, improving health and safety for the Victorian community.

In 2023–24, the Court, in collaboration with the University of Melbourne, contributed to two published studies evaluating the success of certain suicide prevention initiatives. The first focused on the effectiveness of trackside fencing in preventing railway suicides, and the second evaluated suicide prevention outcomes associated with safety barriers installed on Melbourne's Westgate Bridge. A further study, in collaboration with researchers from Federation University and Monash University, involved a population-based cross-sectional study of gambling related suicides in Victoria.

The Court worked with Monash University researchers on a project examining the availability and quality of data collected about diverse communities in the VSR, and established a research project with the University of Melbourne to explore how real-time suicide surveillance data can be used to detect and respond to spikes and emerging trends in suicides.

This year, the Court collated data to contribute to the Victorian Department of Health's review of the *Voluntary Assisted Dying Act 2017* and put in place an agreement with the Victorian Department of Health to share certain information on overdose deaths to assist them with their drug harm modelling.

The Court also provided data and information for family violence initiatives in 2023–24, with submissions made to the Legislative Assembly Legal and Social Issues Committee's inquiry into capturing data on family violence perpetrators in Victoria and provided data to the Crime Statistics Agency in relation to family violence homicides. The Court was consulted on the *Crimes Amendment (Non-fatal Strangulation) Bill 2023* and collaborated with Australia's National Research Organisation for Women's Safety (ANROWS) and the Australian Domestic and Family Violence Death Review Network to publish a study on filicides in a domestic and family violence context.

Supporting research

During the 2023–24 reporting period, the Court's Research Committee met on eight occasions to assess 22 new applications for access to coronial data, as well as 17 applications to amend previously approved research projects.

Of these applications, 38 were ultimately approved. The approval process in some cases required correspondence with the applicants and changes to research design to address coronial concerns. 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 this year covered a broad range of topics, including:

- deaths relating to farm vehicle operation
- clinical characteristics of deaths relating to anaphylaxis and asthma
- statistical tools to detect and respond to suicide clusters.

Access and education

The Court is regularly approached to assist external organisations with coronial data for the purposes of death prevention. In 2023–24, the Court responded to 33 requests from external organisations for data and other assistance, including:

- Victoria Police
- Victorian Department of Health
- Kidsafe Victoria
- Local government councils.

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 inclusion in 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 2023–24 the Court received 6299 external requests to access information and documentation contained in coronial files. Such information may include medical examination reports, toxicology reports, information for media including documents tendered in Court, and unpublished findings.

Table 14: Requests for coronial documents

Financial year	Number of deaths
2019–20	4600
2020–21	5588
2021–22	6144
2022–23	5891
2023–24	6299

Information and support

In the days and months following the death of a loved one, it is important for friends and families to understand the coronial process. The Court is committed to providing support throughout this difficult time, in part by providing clear and readily understood information.

Family liaison officers provide critical support to families and friends of the deceased, explaining the 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 containing information about the coronial process and available supports for people whose loved one's death is being investigated. These resources include a family brochure *What happens now?, The Coroners Process* booklet and *Information for Witnesses, Family and Friends Attending Hearings at the Coroners Court of Victoria: Impact of Exposure to Trauma & Self Care*. Translation and interpretation services are also offered to families and friends for whom English is not their preferred language.

Stakeholder education and engagement

During 2023–24, coroners delivered 30 individual presentations to stakeholders. These formal and informal presentations – ranging from community visits to guest lectures and conference talks – provide opportunities for industry stakeholders and community groups to gain an insight into the coronial process.

This year, attendance at these sessions ranged from 15 to 200 people and audiences included Victoria Police, clinicians and other health professionals, medical students, legal practitioners and members of the public.

Hospitals and health practitioners

The Coroners Prevention Unit (CPU), in collaboration with the coroners and VIFM staff, presented at a hospital information session in November 2023 on coronial death investigations associated with health care. The session was attended by 100 medical specialists in East Gippsland.

Involving coroners and staff, these education sessions cover the work of the Court in a medical context, along with updates and other changes to forensic and investigative processes.

Law Week, May 2024

For Victorian Law Week this year, the Court held a mock inquest to demystify the inner workings of the coronial process. The event, titled 'Behind closed doors: a look into the coroner's process', pieced together the events of a fictional, fatal motor vehicle collision, featuring a full cast of witnesses, legal representatives, Court staff and experts.

The event highlighted the broad range of professionals involved in a coronial investigation including police, legal practitioners, expert witnesses and forensic pathologists. Approximately 60 people attended the sold-out event, and feedback was overwhelmingly positive.

Case Study 4

Coroner calls for improved messaging in warning signs for swimmers at Aireys Inlet

TZ was a strong and experienced swimmer who swam regularly with a local swimming group in Aireys Inlet.

On the morning of 27 March 2022, TZ joined the swimming group at Sandy Gully Beach in Aireys Inlet. The conditions were rough that morning, with waves dumping heavily onto the sandbar. At about 7:00 am, as TZ approached the shore, several large waves crashed onto the back of his head. He was assisted back to shore and appeared to be struggling to maintain balance. TZ reported having hurt his neck or upper back.

Emergency services were contacted at approximately 7:30 am and paramedics arrived approximately 25 minutes later. On assessment, TZ was found to have sustained a haematoma to the left side of his forehead and was unable to walk unaided. TZ was spinally immobilised and connected to an electrocardiogram for monitoring.

TZ's extraction from the beach proved complex due to the sandbar and distance between him and the closest stairs, which ascended about 100 m to the carpark. An air ambulance was considered by rescuers but would add further delay and the landing site was difficult. The Victorian State Emergency Service was called to assist and TZ was eventually transported to the carpark via a buggy designed to transport immobilised patients over uneven terrain. TZ was loaded into an ambulance at around 9:25 am, approximately 90 minutes after the initial arrival of paramedics, and transported to hospital.

The coroner considered the delay in extracting TZ from the beach was not unreasonable given the severity of his injuries, which required him to be immobilised, along with challenging beach access and limited communications coverage.

Despite the efforts of medical staff, TZ's condition continued to deteriorate, and he died in hospital three days later. A forensic pathologist concluded that TZ had suffered fatal vascular and cervical spine injuries, his head having struck the ocean floor with the force of a wave.

The coroner reviewed the existing signage at Sandy Gully Beach, located at the beginning of the path from the carpark to the beach, which included advice that the beach is not patrolled and a warning to swimmers of various hazards, including strong currents and submerged objects. The coroner noted the absence of any caution regarding potential heavy and crashing waves.

The coroner acknowledged that even experienced swimmers are at risk in challenging conditions and considered that the dangerous surf at Sandy Gully Beach—a remote location with difficult access—warranted additional signage warning swimmers of large and heavy crashing waves. The coroner recommended that the Great Ocean Road Coast and Parks Authority review its signage to include a warning to swimmers about the possibility of heavy and crashing waves at Sandy Gully Beach.

The Authority accepted the recommendation and agreed to amend three aquatic safety signs at Aireys Inlet to include a warning of 'large breaking waves', in alignment with existing signage elsewhere. The Authority referred to an audit conducted by Life Saving Victoria (LSV) in 2021, which recommended a clear and consistent approach to aquatic safety signage at the Authority's sites. The Authority further advised it had since implemented all recommendations arising from the LSV audit.

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.

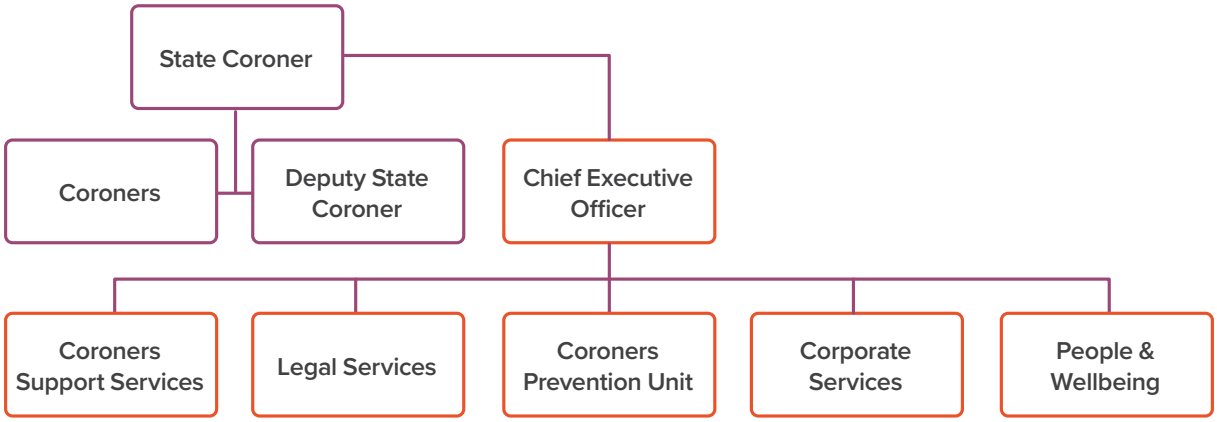
The Court sits within the governance structure of Court Services Victoria (CSV), an independent statutory body. As a member of the Courts Council, the State Coroner is supported in the strategic and operational performance of the Court by the Court's CEO and its staff.

Organisational structure

The Court employs 106 staff to support the coroners in their independent investigations and manage the administration of the Court. The organisation comprises the Office of the Chief Executive Officer which includes a business transformation function, and five divisions - each 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 hearings. 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. In May 2024, the finance function was centralised within CSV.
- **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. In May 2024, the People and Wellbeing function was centralised within CSV with the Court being supported on-site by a strategic people partner.

Organisation chart



Workplace profile

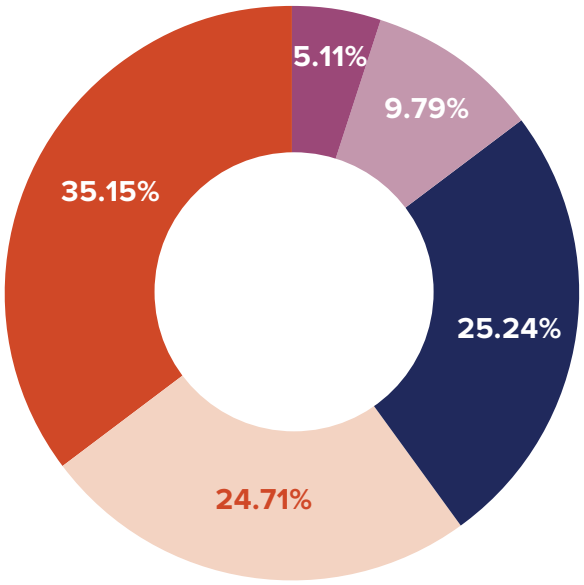
At 30 June 2024, the Court had 106 staff members (91.9 full-time equivalent (FTE)), not including coroners. This includes 95 permanent staff, 28.4 per cent of which were employed on a part-time basis.

Table 15: Workplace profile as at 30 June 2024

	June 2024					
	All employees		Ongoing		Fixed term/casual	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
Male	22	19.2	18	3	0	1
Female	83	71.7	49	24	5	5
Self-Described	1	1.0	1	0	0	0
Total	106	91.9	68	27	5	6
	All employees		Ongoing		Fixed term/casual	
			Staff numbers		Staff numbers	
	Staff numbers	FTE	Full-time	Part-time	Full-time	Part-time
VPS2	15	12.4	7	3	3	2
VPS3	25	23.3	18	5	2	0
VPS4	31	27.9	21	7	0	3
VPS5	16	14.3	10	5	0	1
VPS6	11	10.8	10	1	0	0
STS/7	7	2.2	1	6	0	0
Executive	1	1.0	1	0	0	0
Total	106	91.9	68	27	5	6

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

Figure 3: Divisional headcount at 30 June 2024



Division	Number FTE	Number Headcount
Office of CEO*	4.7	5
Corporate Services	9	10
Legal Services	23.2	24
Coroners Prevention Unit	22.7	30
Coroners Support Services	32.3	37
Total	91.9	106

* The Office of the CEO includes staff supporting the CEO and State Coroner and those involved in delivering the strategic transformation agenda and digital uplift 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. These committees oversee critical business functions, provide a clear decision-making framework, and ensure the Court makes appropriate decisions in both day-to-day work and large-scale projects or procurements.

Coroners Court Executive Committee

The Coroners Court Executive Committee, headed by the Chief Executive Officer, comprises 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 including:

- 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.

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 2023–24 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 2023–24 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 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 2023–24, the Court participated in internal audits at a CSV-wide level regarding:

- Aboriginal Justice Agreement implementation
- Occupational health and safety including employee wellbeing
- Standing directions.

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 Court staff who support them. A continued focus for 2023–24 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 and wellbeing

The Court is keenly aware of the sensitive and sometimes graphic nature of the material that coroners and staff are exposed to. In response, there has been a focus on creating an environment with effective and safe systems of work, a strong and collegiate culture, and effective monitoring of health, safety and wellbeing.

During 2023–24 the following programs and initiatives were delivered or commenced:

- Introduction of a vicarious trauma induction series for staff to be incorporated into the Court's induction program. The series includes eLearns, podcasts and supporting resources to safely orient new starters to a coronial environment.
- Commencement of a reflective practice pilot program for family liaison officers to enable collective conversations about the human dimension of their work and an opportunity to share knowledge, reflections and experiences.
- Formation of a working group to identify opportunities to strengthen our trauma informed response when responding to complex behaviour.
- A range of health and wellbeing program offerings continued to be available including health checks, flu vaccinations, access to the Headspace app, wellbeing support services (including a wellbeing assessment tool), webinars and the Dogs@Work program.

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

In 2023–24, the Court focused on initiatives aimed at continually attracting and retaining a diverse and high performing workforce. These included:

- Implementing a refreshed supervision framework following a review to ensure it remains fit for purpose and is an effective mechanism for staff support, wellbeing and development.
- The continued strengthening of hybrid work arrangements to attract and retain employees, balance the employee's needs with service delivery requirements, build a positive workplace culture and help everyone achieve a better work-life balance.
- Promoting sessions that enhance a supportive and inclusive work culture, such as Disability Confident Workplaces, Empowering LGBTIQ+ Allies Training and Koori Cultural Awareness Training.
- With a continued focus on strengthening leadership capability to help our staff grow and thrive, a purposeful leadership roundtable series was commenced with court leaders to provide an opportunity to share insights and discuss topical leadership matters.
- Engaging with staff across the Court to discuss results of the People Matter Survey and to confirm the further work needed to build a strong and collaborative culture.

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 training to enhance an employee's knowledge and capacity to fulfil their role and contribute to delivering the Court's strategic objectives.

Case Study 5

Coronial investigation highlights need to enhance supports for international student wellbeing following suicides of five students in 2020

This cluster of cases comprised parallel investigations into the suicide deaths of five international students in 2020. The students were born in five different countries, attended four different universities across Victoria and were residing in diverse living arrangements.

The coronial investigation focused on whether there were any recurring themes and circumstances that might point to better opportunities to support international students and thereby reduce the risk of further suicides.

To assist in these investigations, the coroner commissioned Orygen, a not-for-profit youth mental health service and research organisation, to prepare an evidence-based *Quality Evaluation Framework* to assist in assessing the policies and programs in place across universities to support their international students.

The *Quality Evaluation Framework* identifies ten areas (five university-wide and five specific to international students) where universities are recommended to review their policies, guidelines and practices, including suicide prevention and postvention, staff training in mental health and suicide awareness, and initial orientation for international students. In each area, the *Quality Evaluation Framework* describes minimum expectations that should be met, along with best practice guidelines.

During the investigation, the five students' respective universities provided detailed and thorough information to the Court about available supports for students in general and international students in particular.

Upon review, a significant feature of the students' circumstances was how little engagement they had with health and wellbeing services at their respective universities, despite availability. The coroner found that, for the most part, the students had not accessed any relevant services at their universities including health, counselling or psychological services. The evidence also suggested they had little, if any, engagement with health services external to their universities, and some had not disclosed mental health issues or suicidality to family or friends.

Ultimately, the coroner was not able to develop any clear insights into how help-seeking among international students might be promoted but considered that universities may find the *Quality Evaluation Framework* useful as a tool for developing and reviewing supports for international students.

The coroner recommended that:

i. the Suicide Prevention and Response Office (under the auspices of the Victorian Department of Health) review the Orygen *Quality Evaluation Framework* and consider whether such a resource would assist universities to assess and review how they support international student health and wellbeing

ii. the Victorian Department of Health consider developing and maintaining a resource of this type to assist Victorian universities in implementing and reviewing their programs targeted at international student wellbeing. The resource could be regularly revised in collaboration with the universities to share new research, program design and ideas for monitoring international student wellbeing and encouraging help-seeking among those who may be experiencing mental health crises or suicidality.

The Department of Health accepted both recommendations in full.

Glossary

AFL	Australian Football League
AFLPA	Australian Football League Players Association
ANROWS	Australia's National Research Organisation for Women's Safety
BP3	Victorian Budget Papers Number 3
CPU	Coroners Prevention Unit
CSV	Court Services Victoria
CTE	Chronic traumatic encephalopathy
DJSIR	Victorian Department of Jobs, Skills, Industry and Regions
DPP	Director of Public Prosecutions
FLO	Family Liaison Officer
FTE	Full time equivalent
HMIT	Health and Medical Investigations Team
LSV	Lifesaving Victoria
MDMA	3,4-Methylenedioxymethamphetamine, commonly known as ecstasy
NCIS	National Coronial Information System
PCSU	Police Coronial Support Unit
STS	Senior Technical Specialists
The Coroners Act/The 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
VSR	Victorian Suicide Register
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

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. Judicial review may also be sought in relation to certain decisions made by a coroner.

In appeals, the Court's role is usually limited to assisting the Supreme Court in relation to the applicable law, questions of jurisdiction and power, as well as the practices and procedures of the Court that are relevant to the appeal. It does not make any submissions on the merits of an appeal, consistent with the principles set out in *R v Australian Broadcasting Tribunal; Ex parte Hardiman* (1980) 144 CLR 13 (the *Hardiman* principle). The Court will provide the Supreme Court with information or documents that may assist the Court in determining the appeal. This may include provision of an affidavit recounting salient aspects of the procedural history of the coronial investigation and exhibit relevant aspects of the documents held by the Court, including documentary material that was before the investigating Coroner at the time of making their decision.

In 2023–24, the following appeals were finalised:

- Marsom v Coroners Court of Victoria (S ECI 2022 04424) – Appeal against determination that death not a reportable death – Orders made 13 July 2023 – Appeal discontinued.
- Filgate v Coroners Court of Victoria (S ECI 2023 02821) – Appeal against determination not to hold an inquest and not to make findings – Orders made 8 August 2023 – Determination quashed and matter remitted by consent for re-determination.
- Runacres v Coroners Court of Victoria [2024] VSC 304 – Appeal against findings of a coroner – Judgment issued on 11 June 2024 – Appeal dismissed.

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 matters that are outside of the Court's responsibilities, such as Victorian Government policy, legislation or legal representation.

Judicial Commission of Victoria

Complaints about the conduct or capacity of Victorian judicial officers or members of the Victorian Civil and Administrative Tribunal (VCAT) may be made to the Judicial Commission of Victoria. The Commission is established under the *Judicial Commission of Victoria Act 2016*. The Commission cannot investigate the correctness of a decision made by a judicial officer or VCAT member; nor can it investigate complaints about federal courts or tribunals, such as the Family Court of Australia and Administrative Appeals Tribunal; nor can it investigate complaints about court or VCAT staff.

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

Freedom of information

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

Applications for documents relating to Court administration may be made to CSV, or through https://ovic.vic.gov.au/.

Coroners Court
of Victoria