



Media release

From Rob Hudson MP, Chair

DRAFT MEDIA RELEASE

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PARLIAMENTARY INQUIRY RECOMMENDS REFORMS TO THE CORONERS SERVICE

The Victorian Parliament Law Reform Committee today released its report on the Coroners Act 1985 recommending changes to the coronial system in Victoria.

The Committee was asked to find areas where the Coroners Act should be changed or modernised to better meet the needs of the community, and to compare the Act with its interstate and overseas counterparts.

Chair of the Parliamentary Law Reform Committee, Mr Rob Hudson, said the Committee found the Coroners Act had served the Victorian community well.

“It has allowed the development of a coronial system which is highly regarded world-wide, and has been used as a model for similar legislation in other jurisdictions,” he said.

“While the Committee found the existing coronial system in Victoria has a sound legislative foundation, and has been a leader in injury and death prevention over many years, there are a number of areas in which it could be improved and modernised.

The Committee has recommended:

- Process improvements to modernise and update the death certification process in Victoria.
- Improving the consistency and quality of coronial services across the State by introducing a state-wide case management system and enhanced training for Coroners and support staff.
- Enhancing the prevention role of Coroners.
- Improving public awareness of the Coroner’s role.
- Reviewing the Coroner’s jurisdiction, particularly in relation to child deaths, deaths in care.

- The establishment of a Coronial Council to determine future policy direction.
- Better coordination between agencies in relation to missing person cases.
- Improved information and communication to families and others affected by a death.

“Changes recommended by the committee will complement significant changes at the State Coroner’s Office, announced by Attorney-General Rob Hulls earlier this year, which focused on making the coronial process more responsive to the needs of families,” Mr Hudson said.

“When a person dies and a coroner investigates the death, family members need to know what will happen to the body, what the investigation involves, how long it will take, what evidence has emerged and what their rights are within the coronial process.

“Information is important and empowering during times of grief. It must be provided with appropriate sensitivity given the tragic circumstances of an unexpected death.

“The Committee has undertaken a substantial and complex task in reviewing the Coroners Act.

“This is a complex area of service delivery involving a number of different agencies and services.

“The Committee received an enormous amount of information from stakeholders and the community, and has produced a detailed and wide-ranging report.

“We have endeavoured to reflect the divergent views of those who made submissions or gave evidence before the Committee.

“On behalf of the Committee I would like to thank everyone who contributed to the inquiry.

“The Government will respond to the report within six months. Due to the complexity of the issues involved it will be important for the Government to obtain feedback from stakeholders on the committee’s recommendations before determining the final detail of any changes.

“I am confident the Committee’s recommendations will help strengthen the coronial system in Victoria.”

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