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Letter to the Attorney-General of Victoria

The Honourable Robert Clark, MP
Attorney-General
121 Exhibition Street
MELBOURNE VIC 3000

13 August 2014

Dear Attorney

Annual Report 2013-14

On behalf of the Coronial Council of Victoria, I present to you the Annual Report of the Coronial Council of Victoria for the period of 1 July 2013 to 30 June 2014, in accordance with section 113 of the Coroners Act 2008.

The report was approved by the Coronial Council of Victoria on 11 August 2014.

Yours sincerely,

[Signature]
Professor Katherine McGrath
Chair, Coronial Council of Victoria
Message from the Chairperson

I am pleased to present the report on the activities of the Coronial Council of Victoria for the 2013-14 reporting period.

A number of changes took place in the Council membership during the year. The Governor in Council appointed me as Chair in July 2013 after Judge James Duggan retired in May and Dr Sally Wilkins retired in August 2013. I would like to recognise the importance of their individual and collective contribution to the work of the Council, especially in its establishment, as inaugural members.

In addition, two new members were appointed by the Governor in Council - Dr Celia Kemp (Senior Research Fellow in the Centre for Health Policy, Programs and Economics at the University of Melbourne) and Professor Mark Stevenson (Director of the Monash University Accident Research Centre), in May 2014. These new members bring additional expertise to the Council’s knowledge base.

As part of a broader self-review, the Council agreed to develop a work plan that will form the basis of its focus for the 2014 calendar year and beyond. Development of the work plan will be an annual proposition, mapping out issues of interest for possible investigative reference work. The Council also agreed to standardise its approach to investigating issues, including developing an agreed process for devising a research plan, assessing required resources, and a nominal lifecycle for reporting.

During the period, the Council focussed its investigative and reference work on a number of issues of relevance to the Coronial jurisdiction.

The major issues have included developing a research paper on the complex issues involved in improving the accuracy of suicide statistics reported in both Victoria and Australia as a necessary prelude to the development of more effective preventative measures. The Council consulted widely with other bodies and agencies involved in reporting suicide statistics around the country. There is strong national support for improving the process by which these statistics are identified. The final report has now been forwarded to the Attorney-General with a set of recommendations for an increased contribution that could be made by the Coronial system on this important public health measure.

The Council also completed its investigation into the issue of access to legal representation for families involved in complex coronial inquests. In doing so, the Council determined that the number of cases in which unrepresented families face large and well-resourced organisations or government departments is rare, and that the State Coroner should have legislative discretion to require legal representation be provided. A letter of recommendations for possible legislative change has been submitted to the Attorney-General for consideration.

The Council has commenced new research – its first ‘own-motion’ reference – into the reporting of deaths in hospitals. This work aims to investigate reporting processes (from the moment of death until a report is received by the Coroner) to determine whether they can be improved. The Council also seeks to determine whether the number of deaths in hospitals is underreported and whether this is linked to knowledge about reporting processes. The Council expects to provide advice and recommendations to the Attorney-General in late 2015.

I would like to thank all members of Council for their diligence and contribution during the year, and staff of the Coroners Court of Victoria for their support and assistance.

I also extend my thanks to the Council Secretariat for providing efficient and responsive support throughout the 2013-14 period.

Professor Katherine McGrath MB BS, FRCPA FAICD
Chairperson
The Coronial Council of Victoria

The Coronial Council of Victoria was established under Part 9 of the Coroners Act 2008 (refer to Appendix 1). It is unique in Australia and the only known body of its kind in the world. The Council is independent of the Coroners Court of Victoria and provides advice and recommendations to the Attorney-General regarding matters of importance to the coronial system in Victoria. These may include:

- the identification of themes, trends and patterns that are seen to emerge;
- legislative issues; and
- proposed law and practice reform.

The Council was initially chaired by Judge James Duggan, who lead it through its first two references – the first on improving processes for people affected by coronial investigations in the course of their employment; the second on whether asbestos related deaths should be reportable.

Professor Katherine McGrath was appointed Chair by Order in Council dated 09 July 2013.

The Coronial Council of Victoria was developed as part of the Victorian Government’s broad reform strategy following the release of the Victorian Parliament Law Reform Committee’s Final Report on the Coroners Act 1985 (the VPLRC Report) in September 2006. This strategy aimed to develop an integrated governance, legislative and service delivery framework to support a modern and responsive coronial jurisdiction. Since the VPLRC Report, there has been significant reform to the coronial system, including the introduction of the Coroners Act 2008 (the Act) which came into operation on 1 November 2009.

The Coronial Council is the first of its kind in Australia and is designed to be sufficiently flexible to deal with the complexities of the coronial jurisdiction in Victoria.

The Council is expected to act in a way that:

- does not impinge on the independence of a coroner’s decision-making and investigation of death as well as the role of the State Coroner;
- delivers strategic advice reflecting the changing physical, social and political environment to foster a modern and responsive coronial system;
- promotes andstrengthens different relationships including collaboration between agencies across the coronial system;
- focuses on advice to strengthen services to families and improve the prevention role of the coroner;
- ensures that the views of bereaved families are reflected in the development of advice and recommendations;
- complements existing governance structures in the State coronial jurisdiction; and
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

Further information
Details about the work of the Council can be accessed on its website at http://www.coronialcouncil.vic.gov.au, or by contacting the Council Secretariat by email to Coronial.Council@courts.vic.gov.au, or by phone to 03 9032 0828.
The Council Members

Professor Katherine McGrath
Chair, from 9 July 2013

Professor Katherine McGrath is a widely respected health care executive with over 30 years experience in government, public and private health, clinical and academic posts. Her roles have included Deputy Director General of NSW Health and Chief Executive Officer of the Hunter Area Health Service, and she was a founding commissioner of the Australian Commission for Safety and Quality in Healthcare.

Professor McGrath has been a member of the Council since it was established, and was appointed Chair by Order in Council dated 9 July 2013.

Judge Ian Gray
State Coroner, Coroners Court of Victoria

His Honour Judge Ian Gray is the Victorian State Coroner. He was a barrister and solicitor prior to working in the Northern Territory between 1987 and 1997, first with the Northern Lands Council and then as magistrate before becoming Chief Magistrate in 1992. Upon his return to Melbourne, he returned to the Victorian Bar and in 2001 he was appointed Chief Magistrate of Victoria and led the Magistrates’ Court through over a decade of extensive change.

Professor Stephen Cordner AM
Director, Victorian Institute of Forensic Medicine

Professor Stephen Cordner was appointed Foundation Professor of Forensic Medicine at Monash University and Foundation Director of the Victorian Institute of Forensic Medicine (VIFM) in 1987. He was awarded Member of the Order of Australia (AM) in January 2005 for services to forensic medicine.

Professor Cordner was also represented on the Council from time to time by Deputy Director, Associate Professor David Ranson.

Deputy Commissioner Graham Ashton AM
Representing the Chief Commissioner of Police

Deputy Commissioner Graham Ashton is a former Australian Federal Police Officer and was tasked with Operational Command of the Australian law enforcement and mass casualty response to the Bali bombings, for which he was awarded Member of the Order of Australia (AM) in October 2003. In addition to his counter-terrorism experience, Deputy Commissioner Ashton also has extensive background in policing serious and organised crime. He joined Victoria Police in December 2009 and was appointed Deputy Commissioner in early 2012.

Under section 111 of the Coroners Act 2008, the Council consists of three members ex officio and between five and seven members appointed by the Governor in Council on recommendation by the Attorney-General. Members are appointed for up to three years and are eligible for re-appointment and remuneration under the Appointment and Remuneration Guidelines for Victorian Government Bodies and Advisory Committees.

The appointed members were chosen on the basis of merit and for the diversity of experience they bring to the role. This includes an understanding of the issues that affect the coronial jurisdiction, as well as other aspects that intersect with it.

Ex officio members
His Honour Judge Ian Gray
State Coroner
Professor Stephen Cordner AM
Director, Victorian Institute of Forensic Medicine
Deputy Commissioner Graham Ashton AM
representing Chief Commissioner, Victoria Police

Appointed members
Professor Katherine McGrath – Chair
Dr Ian Freckelton QC
Mr Christopher Hall
Dr Celia Kemp (from May 2014)
Dr Robert Roseby
Professor Mark Stevenson (from May 2014)
Dr Sally Wilkins (to August 2013)
Dr Celia Kemp
Appointed member, from 14 May 2014

Dr Celia Kemp is a Senior Research Fellow in the Centre for Health Policy, Programs and Economics at the University of Melbourne. She has worked as a medical intern at St Vincent’s Hospital in Darlinghurst; a Prosecutor in the Office of the Director of Public Prosecutions in the Northern Territory; the Senior Counsel Assisting the State Coroner in Western Australia; and the Deputy Coroner of the Northern Territory.

Dr Ian Freckelton QC
Appointed member

Dr Ian Freckelton is a Queen’s Counsel in full-time practice at the Victorian, Northern Territory and Tasmanian Bars. He is a Professorial Fellow in Law and Psychiatry at the University of Melbourne and an Adjunct Professor of Law and Forensic Medicine at Monash University. He is the author of many books (including *Death Investigation and the Coroner’s Inquest* with Associate Professor David Ranson) and is the Editor of the *Journal of Law and Medicine*.

Mr Christopher Hall
Appointed member

Mr Christopher Hall is a psychologist and the Chief Executive Officer of the Australian Centre for Grief and Bereavement (ACGB). The Centre is a clinical, educational and research organisation, and operates the State-wide Specialist Bereavement Service, funded by the Department of Health. More broadly, Mr Hall has been Chair of the International Work Group on Death, Dying and Bereavement, and is a Board Member of the US Association for Death Education and Counselling.

Dr Robert Roseby
Appointed member

Dr Robert Roseby is a Respiratory (and General) paediatrician and Head of Medical Education at Monash Children’s Hospital, and visiting paediatrician to the Western Suburbs Indigenous Gathering Place. Previous roles include co-chair of the Board of Inquiry into the NT Child Protection System 2009-10, Deputy Director of Adolescent Medicine at the Royal Children’s Hospital 2009-12, and Head of Paediatrics at Alice Springs Hospital 2003-09. Dr Roseby now has significant involvement with the Royal Australians College of Physicians.

Professor Mark Stevenson
Appointed member, from 14 May 2014

Professor Mark Stevenson is an epidemiologist and Director of the Monash University Accident Research Centre. He is a National Health and Medical Research Council Fellow and a lifetime Fellow of the Australasian College of Road Safety. Professor Stevenson has extensive research experience in road trauma and considerable public health experience in low-income countries. He is currently an advisor for injury to the Director General of the Work Health Organisation.

Dr Sally Wilkins
Appointed member, to August 2013

Dr Sally Wilkins is a Consultant Psychiatrist and has worked in the Victorian mental health sector for over 30 years. From 2002 to 2009, Dr Wilkins was Head of Community Psychiatry at The Alfred Hospital, where she was responsible for major reform of all community-based psychiatric programs.

Secretariat

During the period, the Council was supported by a Secretariat provided by the Courts and Tribunals Service of the Department of Justice.
The Year in Review

Council review and reform
The Council met five times during 2013-14. A subcommittee met separately to progress the Council’s work in the area of suicide reporting.

Having been in operation for over three years, the Council took the opportunity to review its work practices and membership. In doing so, it agreed to work against an annual plan, and develop a standardised approach to conducting its investigative reference work.

With the retirement of Judge James Duggan, Mr Stephen Dimopoulos, and Dr Sally Wilkins from the membership, the Council reviewed its composition, skills and expertise. This resulted in additional membership that will allow the Council to canvas a broader field of stakeholders in its deliberations.

Suicide reporting reference
In May 2012, the Attorney-General requested that the Council investigate suicide reporting in the coronial jurisdiction, and provide advice on:

1. the application of legal principles regarding suicide, including the operation of the presumption against suicide under the common law and consideration of the evidence broadly considered necessary to establish the mental element of suicide;
2. whether a change to the existing law regarding the standard of proof for a finding of suicide is desirable;
3. policy that enables a consistent approach to coronial determination of intent; and
4. the reporting of suicide in the media including an appropriate position for the Coroners Court to adopt on this issue.

In formulating its advice, the Council may have regard to the interests of families, the Registry of Births Deaths and Marriages, public health bodies, and any other relevant entities.

The Council was also invited to make comments or recommendations on any other matter it thought relevant to the issue.

Suicide accounts for more deaths in Australia than transport accidents and homicides combined, and is the leading cause of death for men and women under the age of 34.

The key problem identified by the Council is that inconsistencies in the way coroners determine whether reporting of a suicide is in the public interest, and the words they use to do so, hinder the accurate collection of suicide data. Too often, when the deceased took an action that caused their death, the circumstances of death are described generally but an explicit finding is not made about whether or not the deceased intended to end their life. Also, there continues to be stigma in the community associated with the classification of the death of a loved one as suicide.

While there remains diverse opinion on the issue, the Council proposed in its report legislative amendment in the Victorian jurisdiction to require coroners to make clear findings about the intention of people whose actions cause their own death. The Council believes that similar requirements should be legislated throughout Australia.

The Council also recommended that the State Coroner issue a Practice Direction to make reporting of cases where the deceased caused their own death always in the public interest; to make the circumstances reported inclusive of risk factors for suicide; and to encourage use of standardised terminology to describe such deaths.

Finally, the Council supported the adoption by Victoria Police of the National Police Form for the collection of consistent and detailed information related to such deaths.

Legal representation for families involved in coronial inquests
During the reporting period, the Council finalised its examination of access to legal representation for families involved in large and complex coronial inquests.

The Council believes that while most cases do not require legal representation for the family due to the role of counsel assisting the Coroner, there are rare occasions where such assistance would be beneficial. This is especially true in the few complex cases where large, well-funded and sometimes multiple organisations are involved.

The Council asserted in a letter to the Attorney-General that families need to be legally represented in order to have a fair balance in the views put forward for the Coroners consideration. In doing so, it made recommendations that the State Coroner be given legislative discretion to identify the need for legal aid to be granted to families in certain circumstances.
The Year Ahead

Council work practice and planning
The Council intends to continue its self-review work to align its new work planning process with annual reporting periods. It will also further refine a standard approach to reference work, while conducting regular investigative work as referred from time to time. The Council anticipates some follow up work consequent on the Attorney-General’s response to its suicide reporting reference, and its recommendations on legal representation for families – both completed in the last period.

Implementation of Council recommendations
The Council is considering a monitoring and review role, to track action taken in response to its reference work advice and recommendations. The Council also proposes to review the University of Melbourne report on the Coroners Court restructure.

Periodic activity and trend data reports
The Council intends to request and consider issues and trends reported in various stakeholder reports, for possible further investigation via its reference work processes. It is proposed that such stakeholders could include:

- Consumer feedback (compiled from various market studies and reports);
- impacted organisations (institutions who are often the receiver of recommendations, or whose staff are often acting as witnesses);
- the Coroners Prevention Unit – annual report to the Council of trend data;
- an annual presentation from the Coroners Court of Victoria;
- an annual presentation from the Victorian Institute of Forensic Medicine; and
- a presentation from Victoria Police on the effectiveness of processes involved in coronial investigations.

Reporting of Deaths in Hospitals
The Council has established a committee to commence its first own-motion reference into the reporting of deaths in hospitals. Given the scope of work anticipated, and the limited resources available, the Council intends to partner with a research organisation or government entity to conduct research into this area.

The Council believes there is evidence to suggest that the number of deaths in Victorian hospitals required to be reported to the Coroner are underreported.

Anecdotal reports support this assertion and suggest that there are many reasons for this, including confusion (especially among junior medical staff) as to which deaths are reportable, confusion over the reporting process, and fear of investigation.

The purpose of reporting deaths in hospitals is to identify the causal factors in order to allow preventative measures to be designed and implemented. The role of the Coroner has become more important as autopsy rates in hospitals have declined. It is also an important part of the reinvigorated system for focussing on patient safety in hospitals. As such, it contributes to the system of clinical governance being implemented as part of the recently developed standards for hospital care of the Australian Commission on Quality and Safety in Healthcare.

The Council expects to provide advice and recommendations to the Attorney-General on this matter in 2015.

Transfer of Secretariat
The Court Services Victoria Act 2014 will come into operation on 1 July 2014.

The object of the Act is to support judicial independence in the administration of justice by establishing Court Services Victoria to provide the corporate administrative services and facilities necessary for the Victorian courts and the Victorian Civil Administrative Tribunal to operate independently of the direction of the executive branch of government.

On establishment, Court Services Victoria will assume responsibility for providing a Secretariat to the Coronial Council of Victoria. Council funding will continue at agreed rates, from within the annual Court Services Victoria budget allocation.
Summary of Expenditure for 2013-14

Council meetings, reference work and associated costs during the period were met from an annual appropriation through the Courts and Tribunals Service within the Department of Justice. These costs included sitting fees paid in accordance with the Appointment and Remuneration Guidelines for Victorian Government Boards, Statutory Bodies and Advisory Committees (updated July 2012), meeting costs and incidentals, transport, communications and reference work.

Members who also hold full-time positions in the Victorian Public Sector at Executive Officer level or equivalent, are not eligible for remuneration under the Guidelines.

The figures below represent an indicative summary of the Council’s expenditure for the reporting period.

The largest expense is that of the Secretariat. This figure represents salary and on-costs for one Secretariat officer (at VPS 4, 0.6 FTE). The Secretariat is responsible for preparing meeting papers, attending meetings and relevant conferences, undertaking research and performing administrative and operational matters on behalf of the Council, as directed by the Chair.

From 1 July 2014, the Coronial Council of Victoria will be funded by Court Services Victoria.

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<th>Expense Item</th>
<th>Council Expenditure (approx)</th>
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<td>Sitting fees</td>
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<td>Meeting costs and incidentals</td>
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<td>Car/taxi hire</td>
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<td>Communications</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$76,650.00</strong></td>
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Appendix 1 – The Coroners Act 2008

Part 9—Coronial Council of Victoria

109 Coronial Council of Victoria

The Coronial Council of Victoria is established.

110 Function of the Council

(1) The function of the Council is to provide advice, and make recommendations, to the Attorney-General either—
(a) of its own motion; or
(b) at the request of the Attorney-General.

(2) Advice and recommendations prepared under subsection (1) must be in respect of—
(a) issues of importance to the coronial system in Victoria;
(b) matters relating to the preventative role played by the Coroners Court;
(c) the way in which the coronial system engages with families and respects the cultural diversity of families;
(d) any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

111 Members of the Council

(1) The Council consists of—
(a) the State Coroner; and
(b) the Director of the Institute; and
(c) the Chief Commissioner of Police; and
(d) 5 to 7 other members appointed by the Governor in Council on the recommendation of the Attorney-General.

(2) A member of the Council appointed under subsection (1)(d)—
(a) holds office for the term, not exceeding 3 years, that is specified in his or her instrument of appointment; and
(b) is eligible for re-appointment; and
(c) may resign from office by delivering a letter of resignation to the Attorney-General; and
(d) is entitled to the remuneration and allowances specified in the instrument of appointment and to be reimbursed for expenses.

(3) The Governor in Council, on the recommendation of the Attorney-General, must appoint a member appointed under subsection (1)(d) to be the Chairperson of the Council.

112 Procedure at meetings

(1) The Chairperson or, in his or her absence, a member of the Council elected by the members present at the meeting, must preside at a meeting of the Council.

(2) The person presiding at the meeting must ensure that decisions made at the meeting, including any recommendations, are recorded in writing.

(3) 5 members constitute a quorum of the Council.

(4) Subject to this section, the Council may otherwise regulate its own procedure.

113 Annual report

(1) As soon as practicable each year but not later than 31 October, the Council must submit to the Attorney-General a report—
(a) of its operations for the year ending on 30 June that year; and
(b) that includes any prescribed matter.

(2) The Attorney-General must cause each annual report submitted to him or her under this section to be presented to each House of Parliament within 7 sitting days of that House after receiving it.
Appendix 2 – Establishment of the Coronal Council

In December 2004, the Governor in Council referred an inquiry to the Victorian Parliament Law Reform Committee (the Committee), into the effectiveness of the Coroners Act 1985. The Committee was asked to consider whether the Act provided an appropriate legislative framework for death and fire investigation in the state. In its deliberations, the Committee considered many aspects of the work of the coronial system, including policy development advice by a council-like body.

The Committee endorsed the formalisation of a public policy approach to death investigation and supported the proposal by the Victorian Institute of Forensic Medicine that a Coronial Council be established “…to take on the role of reviewing research and providing the policy direction for death investigation.”

The Committee’s Report suggested a hybrid model establishing the Council as an advisory board as well as a reference group for engaging with the community and stakeholders. It also suggested a number of purposes such as setting public policy and developing guidelines to support the operations of the coronial jurisdiction.

Through examining alternative models for increasing the efficiency and effectiveness of death investigation in other jurisdictions, the Committee considered that:

the issues concerning the way in which these kinds of deaths are reported and investigated required further strategic and expert analysis and that this could most appropriately be undertaken by a coronial council as proposed by VIFM. On advice from the council, and after due consideration of public policy implications by the Department of Justice, appropriate matters can then be included in the regulations as prescribed circumstances. Formalising the process in this way may address some of VIFM’s concerns in relation to the imposition of increased workloads without corresponding increases in funding. A request to the government to amend the regulations would require finding implications to be specifically addressed.

The Committee also formed the view that a council would strengthen the relationship between key stakeholders – including the State Coroners Office and the Victorian Institute of Forensic Medicine.

In its response to the Report, the Government supported the proposal for a Coronal Council to advise the coronial system as a whole.

Its response was embodied in a review of the Coroners Act 1985. In his second reading speech for the Coroners Bill 2008 in December 2008, then-Attorney-General Mr Rob Hulls, MP introduced the Council as an advisory body to:

…provide advice to the Attorney-General … regarding the operation of the coronial system. The council will ensure that the coronial system will continue to be effective and responsive to the needs of people who interact with the coronial system in the future.

The council will consider emerging issues of importance to the Victorian coronial system, matters relating to the prevention role of the Coroners Court, the way the coronial system engages with families and respects the cultural diversity of families and any other matters referred by the Attorney-General.

It was proposed that the Council could be a body that is advisory in that it could identify issues where a particular field of medical, legal, scientific or other expertise would be relevant, and consultative in that it is reflective of various community groups that are affected by death investigation processes. It was thought that this would ensure that the coronial process is consistent with a therapeutic approach that takes account of stakeholder views.

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2 ibid, p165
3 Victoria, Coroners Bill, Second Reading Speech, Legislative Assembly, 4 December 2008 – Mr Rob Hulls, Attorney-General