CORONIAL COUNCIL of Victoria

Annual Report 2018–19

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Coronial Council of Victoria

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23 September 2019

Hon Jill Hennessy MP
Attorney-General
121 Exhibition Street
MELBOURNE VIC 3000

Dear Attorney

Coronial Council Annual Report 2018–19

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 2018 to 30 June 2019, in accordance with section 113 of the *Coroners Act 2008*.

The report was approved by the Coronial Council of Victoria on 4 September 2019.

Yours sincerely

Clare Morton
Chair, Coronial Council of Victoria

Message from the Chair

I am pleased to report on the activities of the Coronial Council of Victoria for the 2018-19 reporting period.

During the past year, the Council commenced an own-motion review of reportable deaths in Victoria (Review). The Review examined the definition of 'reportable death' in the *Coroners Act 2008*, and the systems and processes by which deaths are reported to the Coroner and initially responded to by the Coroners Court and the Victorian Institute of Forensic Medicine.

The Council has produced a draft report and identified some key areas for further detailed work. These areas of future work will help to ensure that the Court investigates those deaths where there is the greatest public benefit. I acknowledge in particular the contributions of Dr Katherine McGrath (former Chair of the Council), Paul Dolan (consultant), members of the steering committee, and stakeholders.

The 2018-19 financial year has been one of change for the Council itself.

Two *ex officio* members departed the Council in April 2019, the previous Acting State Coroner, Iain West, and Deputy Commissioner Shane Patton, who had been a member since February 2016. I thank Iain and Shane for their contributions to the work of the Council, and welcome Acting State Coroner Caitlin English and Deputy Commissioner Wendy Steendam as *ex officio* members.

I would like to thank Dr McGrath, whose appointment as Chair ended on 30 June 2019. Katherine was a member of the Council since February 2010 and Chair since July 2013. Her work on the Council and contribution to Victoria's coronial system have been invaluable. Over her tenure, Katherine has overseen important reviews, including the *Reference on Asbestos Related Deaths*; the *Suicide Reporting in the Coronial Jurisdiction*; and the *Coronial Council's Appeals Reference Report*. I wish her all the best.

I also thank Adjunct Clinical Associate Professor Robert Roseby for his role as interim Chair.

Finally, I acknowledge my fellow Council members for their ongoing support and dedication to the work of the Council, and the Department of Justice and Community Safety for its secretariat support.

I was honoured to have been appointed as Chair on 20 August 2019 and look forward to continuing the important work of the Council.

I am pleased to present the 2018-19 Coronial Council Annual Report.

Clare Morton
Chair, Coronial Council of Victoria

The Coronial Council of Victoria

Established under Part 9 of the *Coroners Act 2008,* the Coronial Council of Victoria is independent of the Coroners Court of Victoria. The Council's function is to provide advice, and make recommendations, to the Attorney-General on:

- issues of importance to the coronial system in Victoria
- matters relating to the preventative role of the Coroners Court
- the way in which the coronial system engages with, 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 Council is a body that is *advisory,* in that it can identify issues where a particular field of medical, legal, scientific or other expertise would be relevant, and is *consultative*, in that it is reflective of various community groups that are affected by death investigation processes.

The Council is unique in Australia and is the only known body of its kind in the world. A history of the Council can be found in Appendix 1.

In undertaking its function, 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 and strengthens 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
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

During the reporting period, the Council met in July and November 2018, and in May and June 2019.

Further information
coronialcouncil.vic.gov.au
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The Council Members

Dr Katherine McGrath

Chair from 9 July 2013 to 30 June 2019, appointed member from March 2010

Dr Katherine McGrath is a health care executive with over 30 years' experience in government, public health, private health, and clinical and academic posts.

Dr McGrath's previous roles include Deputy Director General of NSW Health and Chief Executive Officer of the Hunter Area Health Service. She was a founding commissioner of the Australian Commission for Safety and Quality in Healthcare. Dr McGrath has been a member of the Council since it was established in 2010, and was appointed Chair on 9 July 2013. Her appointment ended on 30 June 2019.

Acting State Coroner Caitlin English

Ex officio member from April 2019

Coroner Caitlin English was appointed as Deputy State Coroner 16 April 2019 and since then served as Acting State Coroner. Prior to becoming a coroner in 2014, Coroner English was a magistrate for more than 13 years, including six years at the Broadmeadows Magistrates' Court where she sat on the Koori Court and Children's Court. Her Honour started her career as a solicitor at Minton Ellison, followed by the Legal Aid Commission of Victoria (now Victoria Legal Aid) and the Public Interest Law Clearing House (now Justice Connect). In 1999, she completed a Churchill Fellowship, reporting on the delivery of pro bono legal services in the United States and England.

Deputy Commissioner Wendy Steendam

Ex officio member delegate from April 2019

Deputy Commissioner Steendam has been a member of Victoria Police for over 34 years. She commenced as Deputy Commissioner, Specialist Operations in November 2018, with portfolio responsibility for Counter Terrorism Command, Road Policing Command, Crime Command, Intelligence and Covers Support Command, Forensic Services Department and Legal Services Department.

Deputy Commissioner Steendam has delivered far-reaching reforms in areas including violence against women and children, cultural change and strategic policy, information management, crime, drugs and counter-terrorism.

Professor Noel Woodford

Ex officio member from July 2014

Professor Noel Woodford holds the Chair in Forensic Medicine at Monash University and was appointed Director at the Victorian Institute of Forensic Medicine (VIFM) in July 2014.

Prior to his appointment, Professor Woodford worked as a senior forensic pathologist at VIFM from 2003. Previously, he was a Consultant Home Office Pathologist and Senior Lecturer in Forensic Pathology in the Department of Forensic Pathology at Sheffield University, UK. Whilst in the UK, Professor Woodford obtained a Masters of Laws in Medical Law from the University of Cardiff. His special interests include sudden unexpected natural adult death and radiological imaging as an adjunct to medico-legal death investigation.

Dr Ian Freckelton QC

Appointed member from March 2010

Dr Ian Freckelton is a Queen's Counsel in full-time practice as a barrister. He has appeared in many of Australia's leading coronial cases at trial and on appeal over the past 25 years. He is also a judge of the Supreme Court of Nauru; a Professorial Fellow in Law and Psychiatry, University of Melbourne; an Adjunct Professor of Forensic Medicine, Monash University; an Adjunct Professor of Law, La Trobe University; and an Adjunct Professor, Queensland University of Technology. Dr Freckelton QC is also a member of the Mental Health Tribunal of Victoria and the Australian Advisory Council on Medicinal Cannabis. He is an elected Fellow of the Australian Academy of Law and the Academy of Social Sciences Australia.

Dr Freckelton QC is the author of many books (including 'Death Investigation and the Coroner's Inquest'); editor of the 'Journal of Law and Medicine'; and editor-in-chief of 'Psychiatry, Psychology and Law'.

Christopher Hall

Appointed member from March 2010

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

Adjunct Clinical Associate Professor Robert Roseby

Appointed member from March 2010

Adjunct Clinical Associate Professor Robert Roseby is a respiratory (and general) paediatrician, Head of Medical Specialties and Head of Medical Education at Monash Children's Hospital, and visiting paediatrician to the Western Suburbs Indigenous Gathering Place. He is a member of the Child and Adolescent subcommittee of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. His previous roles include the co-chair of the Board of Inquiry into the Northern Territory 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 2003–2009.

Maria Dimopoulos

Appointed member from July 2017

Maria Dimopoulos specialises in the intersections of diversity, gender equality and the law. Maria has over 25 years' experience in policy formulation for all tiers of government, research for social planning and legal education. She is a member of the Judicial Council on Cultural Diversity and a Board member for the Castan Centre for Human Rights.

Michele Lewis

Appointed member from July 2017

Michele Lewis was appointed as mecwacare's Chief Executive in 2007. Ms Lewis has over 40 years' experience in health and aged care, including senior management at clinical and strategic levels within the acute, sub-acute, aged and community sectors. Her areas of interest include governance and risk, consumer choice, financial management, and diversity.

Maryjane Crabtree

Appointed member from July 2017

Maryjane Crabtree was a senior litigation partner at Allens for 23 years, and acted in several high profile coronial inquests. She retired from the partnership in 2016, to give her time to contribute to a range of organisations in the legal, health, education and sporting sectors. Among other positions, she is currently a director of the Law Institute of Victoria, Deputy President of Epworth Healthcare, and a member of the ethics committee of the Australian Institute of Health and Welfare.

Council Membership 2018–19

Under section 111 of the *Coroners Act 2008*, the Council consists of three *ex officio* members and between five and seven members appointed by the Governor in Council on the recommendation of the Attorney-General.

Members are appointed for up to three years and are eligible for re-appointment. The appointed members were chosen for the diversity of experience they bring to the role, including an understanding of the issues that affect, and intersect with, the coronial jurisdiction.

Ex officio members

State Coroner

Her Honour Judge Sara Hinchey (until August 2018)

Acting State Coroner Iain West (August 2018 to April 2019)

Acting State Coroner Caitlin English (from April 2019)

Chief Commissioner of Police

Deputy Commissioner Shane Patton APM, Victoria Police (until April 2019)

Deputy Commissioner Wendy Steendam, Victoria Police (from April 2019)

Director of Victorian Institute of Forensic Medicine

Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine

Appointed members

Dr Katherine McGrath

Dr Ian Freckelton QC

Christopher Hall

Adjunct Clinical Associate Professor Robert Roseby

Maria Dimopoulos

Michele Lewis

Maryjane Crabtree

Council Secretariat

The Council was supported by a secretariat provided by the Department of Justice and Community Safety.

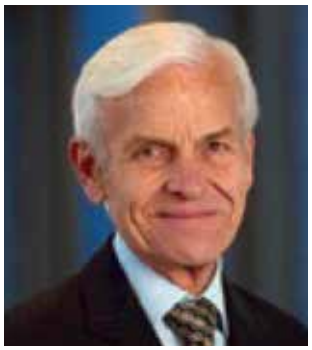
Former members

Members of the Coronial Council whose membership concluded during the reporting period.

Judge Sara Hinchey

Ex officio member from February 2016 to August 2018

County Court Judge Sara Hinchey was the Victorian State Coroner. Her Honour has appeared before the Coroners Court in some of the State's most high-profile inquests. Her inquisitorial experience also extends to appearances before the Royal Commission into Institutional Responses to Child Sexual Abuse and the Victorian Bushfires Royal Commission. Judge Hinchey was appointed as a Judge of the County Court in May 2015 following more than 19 years' experience as a trial and appellate barrister.



Iain West

Ex officio member from August 2018 to April 2019

Iain West was Acting State Coroner from August 2018 until his retirement in April 2019. He was admitted to practice in 1975 and was a barrister for 11 years before being appointed a magistrate in 1985. Mr West was appointed Deputy State Coroner in 1993 and was a member of the Coroners and Pathologists Advisory Group, and the State Disaster Victim Identification Committee.

Deputy Commissioner Shane Patton APM

Ex officio member delegate from February 2016 to April 2019

Deputy Commissioner Shane Patton has been a member of Victoria Police for nearly 40 years and in June 2015 was promoted to Deputy Commissioner, Specialist Operations. This position has overall responsibility for the portfolios of Crime, Road Policing, Forensics, Intelligence and Covert Support and Legal Services. Since joining Victoria Police, he has had a varied career in a wide range of diverse policing roles including operational uniform policing, criminal investigations, internal investigations, prosecutions, public transport safety, traffic and education. He has also has been involved in, and overseen, several major projects, including the creation of a Counter Terrorism Command within his current portfolio.

The Year in Review

During 2018-19, the Council commenced an own-motion review of reportable deaths in Victoria (Review) and saw the implementation of four recommendations from its Appeals Reference Report of 2017-18.

Review of reportable deaths in Victoria

The Council's Review to date has examined the definition of 'reportable death' in the *Coroners Act 2008*, and the processes by which deaths are reported to, and dealt with by, the Coroners Court and the Victorian Institute of Forensic Medicine.

The impetus for the Review was a 2017 report prepared by KPMG for the Council, *Reporting Reportable Deaths in Hospitals to the Coroner* (KPMG Report). The KPMG Report found there to be a degree of both under-reporting and over-reporting of deaths in hospitals, a problem that the Council considered might extend outside the hospital setting, such as in primary care or aged care settings. Combined with concerns about potential growth in demand for coronial services, and that Victoria's ageing population is a possible contributor to any such growth, the Council considered the Review a worthwhile and necessary undertaking.

The Review aims to ensure that the Court investigates those deaths where there is the greatest public benefit. To this end, the Review has focused on three areas:

- what deaths are reported under the current definition of reportable death in the Coroners Act, and whether these represent the deaths that should be investigated by the Court
- the processes by which deaths are reported to the Coroners Court, and initially responded to by the Court and the Victorian Institute of Forensic Medicine
- improvements that can be made to the reportable deaths system.

During 2018-19, the Review was conducted by Project Lead, Mr Paul Dolan (Tektology Pty Ltd), with close support from Dr Katherine McGrath, and overseen by a steering committee. The steering committee comprised members with relevant experience and expertise, particularly in the private and public health sectors.

The Review engaged a wide range of stakeholders, including private and public hospitals, government departments and agencies, aged care providers and relevant peak bodies. Feedback was obtained through a formal submission process, and targeted meetings. It also obtained data from the National Coronial Information System, and the Coroners Prevention Unit at the Coroners Court.

Implementation of recommendations from the Council's Appeals Reference Report

The *Justice Legislation Miscellaneous Amendment Act 2018* (Act) was passed in September 2018. This Act amended the *Coroners Act 2008* to give effect to four of the Council's recommendations from its 2017-18 Appeals Reference Report, by:

- providing that findings made under the previous Coroners Acts of 1958 and 1985 may be set aside by the Coroners Court (with or without re-opening the investigation), when the Court is satisfied that there are new facts and circumstances that make it appropriate to do so (recommendation 1)
- allowing the Coroners Court to amend the wording of a coroner's decision in certain circumstances (recommendation 2)
- clarifying the meaning of a question of law for the purposes of an appeal to the Supreme Court against a coronial finding (recommendation 8)
- increasing the time limit for commencing an appeal against a coroner's refusal to re-open an investigation, from 28 days to 90 days (recommendation 9).

These amendments commenced on 28 October 2018. A further amendment requires the Attorney-General to commence a review of the operation and effectiveness of these amendments by March 2022.

Summary of Expenditure for the 2018–19 Year

Council meetings, project work and associated costs during the reporting period were funded by annual appropriation through the Department of Justice and Community Safety.

These costs included sitting fees, paid in accordance with the government's *Appointment and Remuneration Guidelines,* meeting costs and other incidentals. Council members who hold full-time positions in the Victorian Public Sector at Executive Officer level or equivalent, are not eligible for remuneration under the Guidelines.

The table below includes all expense items for the reporting period ending 30 June 2019. Significant expenditure items detailed in the table are:

- project costs – comprising one consultant engaged on the review of reportable deaths in Victoria, and project costs
- secretariat costs – salary and on-costs for a Secretariat Officer (VPSG4, 0.5 FTE), and incidentals. The secretariat is responsible for preparing meeting papers, attending meetings, undertaking research, and performing administrative and operational matters on behalf of the Council, as directed by the Chair.

Major Expense Items	Summary of Council Expenditure ($)
Project costs	187,509.00
Secretariat costs	40,946.00
Meeting costs / sitting fees / incidentals	8,896.00
TOTAL	**237,350.00**

Details of consultancies (valued at $10,000 or greater)

In 2018–19, there was one consultant engaged where the total fees payable were $10,000 or greater. The total expenditure during 2018–19 in relation to this consultant was $80,000 (excluding GST). Details about this consultant can be viewed on the Council's website: coronialcouncil.vic.gov.au.

There were no consultancies engaged during 2018–19, where the total fees payable to an individual consultancy were less than $10,000.

Appendix 1 – History of the Coronial 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 previous *Coroners Act 1985*.

The Committee was asked to consider whether the Act provided an appropriate legislative framework for:

- the independent investigation of deaths and fires in Victoria;
- the making of recommendations to prevent deaths and fires in Victoria, and improve the safety of Victorians; and
- the provision of support for the families, friends and others associated with a deceased person who is the subject of a coronial inquiry.

The Committee's Final Report, published in September 2006, recommended that the Department of Justice establish a Coronial Council.[1] The Committee considered that a Council 'would ensure that appropriate policy decisions relating to the Coroner's Office could have input from experts with medical and epidemiological expertise, as well as in other areas as deemed appropriate and depending on the council's mandate'.[2]

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.'[3] It 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.[4]

In its response to the Committee's Final Report, the Government supported the proposal for a Coronial Council to advise on the coronial system as a whole.

In his second reading speech for the Coroners Bill 2008, the then Attorney-General, the Hon Rob Hulls MP, introduced the Coronial Council of Victoria as an advisory body to:

> *'...provide advice to the Attorney-General, of its own motion or at the Attorney-General's request, 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.'*[5]

The Council was established under section 109 of the *Coroners Act 2008*.

1 Law Reform Committee, Parliament of Victoria, *Coroners Act 1985: Report* (2006) 609 (Recommendation 138).
2 Ibid 608.
3 Ibid.
4 Ibid 608–9.
5 Victoria, *Parliamentary Debates,* Legislative Assembly, 9 October 2008, 4038 (Rob Hulls, Attorney-General).

Appendix 2 – *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— of its operations for the year ending on 30 June that year; and 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.

This report is authorised by the Coronial Council of Victoria
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