



Coronial Council
of Victoria

Annual Report 2015–16

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Coronial Council of Victoria

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The Honourable Martin Pakula, MP
Attorney-General
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MELBOURNE VIC 3000

Dear Attorney

Annual Report 2015-16

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 2015 to 30 June 2016, in accordance with section 113 of the *Coroners Act 2008*.

The report was approved by the Coronial Council of Victoria on 10 August 2016.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'K. McGrath'.

Professor Katherine McGrath
Chairperson, Coronial Council of Victoria

7 October 2016

Message from the Chairperson

I am pleased to present the report on the activities of the Coronial Council of Victoria for the 2015-16 reporting period.

The Coronial Council has concentrated its efforts during the year to secure the necessary resources to undertake an important Review into Reporting Reportable Deaths in Hospitals to the Coroner.

With the generous support of the Department of Justice and Regulation, Department of Health and Human Services and the Victorian Managed Insurance Authority this project is now ready to commence and promises to provide valuable insights to assist improve reporting.

The year has also seen a review of the secretariat function, and the Council Secretariat will be transferred from Court Services Victoria back to the Department of Justice and Regulation on 1 July 2016.

The dedication and commitment of the Council members has been greatly appreciated and will continue to further the work of the Council in ensuring Victorian leadership in best practice in coronial matters.

In particular, I would like to thank retired members of the Coronial Council, Judge Ian Gray and Dr Celia Kemp for the invaluable contributions they each made during their time on the Council. I would also like to welcome two new members to the Council, Judge Sara Hinchey and Deputy Commissioner Shane Patton.

I would also like to thank Dr Yasmine Fauzee for her tireless efforts in supporting the work of the Council.

I am honoured to have served as Chairperson and look forward to continuing the important work of the Council into the coming financial year, with the assistance of Council members.

I am very pleased to present the 2015-16 Annual Report.



Professor Katherine McGrath
Chairperson, Coronial Council of Victoria

Coronial Council of Victoria

The Coronial Council of Victoria (the Council) is the first of its kind in Australia and the only known body of its kind in the world.

The Council 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 in September 2006. This strategy aimed to develop an integrated governance, legislative and service delivery framework to support a modern and responsive coronial jurisdiction.

The Council was established under Part 9 of the *Coroners Act 2008* which came into operation on 1 November 2009 (refer to Appendix 1). 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 led 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 9 July 2013.

The Council 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 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; and
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The Coronial Council met in August, November and December during the reporting period.

Further information

Council Website:

www.coronialcouncil.vic.gov.au

Council Secretariat:

Email: coronial.council@justice.vic.gov.au.

Telephone: (03) 8684 7506

Council Members

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 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

- Her Honour Judge Sara Hinchey, State Coroner
- Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine
- Deputy Commissioner Shane Patton, Victoria Police

Appointed members

- Professor Katherine McGrath – Chair
- Dr Ian Freckelton QC, Crockett Chambers
- Mr Christopher Hall, Association for Death Education and Counseling
- Dr Robert Roseby, Monash Health
- Professor Mark Stevenson, University of Melbourne

Secretariat

During the period, the Council was supported by a Secretariat provided by Court Services Victoria.



Professor Katherine McGrath

Chair, from 9 July 2013

Appointed member from March 2010

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 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 Sara Hinchey, State Coroner

Ex-officio member from February 2016

County Court Judge Sara Hinchey is 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 two Royal Commissions including the Royal Commission into Institutional Responses to Child Sexual Abuse and the 2009 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. During this time, she also appeared in the higher courts of Victoria, New South Wales, Tasmania and the ACT, as well as the Federal Court and the High Court of Australia. Her areas of interest include occupational health and safety; corporate crime; construction law; medical and other professional negligence; and professional disciplinary matters.



Deputy Commissioner Shane PATTON

Ex-officio member from February 2016

Deputy Commissioner Patton has been a member of Victoria Police for over 37 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.

Deputy Commissioner Patton has been involved in and overseen several major projects, including the creation of a Counter Terrorism Command

within his current portfolio and leading the design of 'Schools of Practice' within the Victoria Police training environment. He has had significant involvement in change management, public order and road safety strategic policy.



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, in July 2014. Prior to his appointment Dr Woodford worked as a Senior Forensic Pathologist at the Institute 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, Dr Woodford obtained a Master 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 at the Victorian, Northern Territory and Tasmanian Bars. He is a Professorial Fellow in Law and Psychiatry, University of Melbourne; Adjunct Professor of Law and Forensic Medicine, Monash University; Adjunct Professor of Law, La Trobe University; and Adjunct Professor, Auckland University of Technology.

Dr Freckelton is the founding Editor of the *Journal of Law and Medicine* and the founding Editor-in-Chief of *Psychiatry, Psychology and Law*. He is a member of the editorial boards for the *New Zealand Journal of Family Law*; *the British Journal of Interdisciplinary Studies*; *Ethics, Medicine and Public Health*; the *Deakin Law Review* and the *Australasian Journal of Forensic Sciences*. He is the author and editor of numerous books on evidence law, health law, compensation law, coronial law, disciplinary law, causation, therapeutic jurisprudence, criminal law, sentencing, policing, and scholarly misconduct.

Dr Freckelton is also a member of Mental Health Tribunal of Victoria; and the Suitability Panel of Victoria.



Mr Christopher Hall

Appointed member from March 2010

Mr 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.



Dr Robert Roseby

Appointed member from March 2010

Dr 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. 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 2003-2009.



Professor Mark Stevenson

Appointed member from 14 May 2014

Professor Mark Stevenson is an epidemiologist and Professor of Urban Transport and Public Health at the University of Melbourne. Prior to this appointment he was Director of the Monash University Accident Research Centre. Professor Stevenson 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 World Health Organisation.

Retired members

Members of the Coronial Council whose term of office ended during the reporting period.

Judge Ian Gray

Ex-officio member to December 2015

His Honour Judge Ian Gray was the Victorian State Coroner during his time with the Coronial Council. 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.

Dr Celia Kemp

Appointed member to June 2015

Dr Celia Kemp was a Senior Research Fellow in the Centre for Health Policy, Programs and Economics at the University of Melbourne during her time with the Coronial Council. 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.

Previous members

The membership of the Coronial Council of Victoria has previously included:

- Deputy Commissioner Tim Cartwright
- Judge Jennifer Coate
- Mr Stephen Dimopoulos
- Judge James Duggan
- Dr Sally Wilkins

Year in Review

Suicide Reference

In May 2012 the Attorney-General agreed to make a formal reference to the Council pursuant to section 110 of the *Coroners Act 2008* in the following terms:

The Coronial Council is requested to 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.*

The Council submitted its report for this reference to the Attorney-General on Tuesday 16 June 2014. The Victorian Attorney-General wrote to all other Attorneys-General and placed the issue of suicide reporting in the coronial jurisdiction on the agenda of the Law Crime and Community Safety Council (LCCSC).

The LCCSC referred the recommendations of the Council concerning possible standardisation of coronial legislation for suicide reporting to the National Coronial Information System (NCIS). NCIS is to consult with the jurisdictions and will report back to the LCCSC in late 2016.

Reporting of Deaths in Hospitals

The Council considered recent publications regarding the underreporting of relevant hospital deaths to the Coroner. The Council considered that the issue warranted further investigation to identify:

- the causes of under and over reporting; and
- the links between the coroners findings and hospital clinical governance systems to ensure any lessons learnt would be disseminated to all relevant hospital staff.

The Council secured \$300,000 for the Reporting Reportable Deaths in Hospitals to the Coroner Review, through the contributions provided by the Department of Justice and Regulation, the Department of Health and Human Services and the Victorian Managed Insurance Authority.

A Steering Committee was established to oversee the project. A tender process was conducted in June 2016. The project will proceed in the 2016- 2017 financial year.

Steering Committee

The Steering Committee is composed of the following members:

- Professor Katherine McGrath, Chair, Coronial Council of Victoria
- Judge Sara Hinchey, State Coroner of Victoria
- Ms Liz Cox, Principle Relationship Manager, Health, Risk Management and Insurance, Victorian Managed Insurance Authority
- Ms Glenda Gorrie, Assistant Director, Quality and Safety, Health Service Performance and Programs, Department of Health and Human Services
- Ms Elizabeth Kennedy, General Counsel and Corporate Secretary, Peter MacCallum Cancer Centre
- Mr Stephen Lodge, Assistant Director of Dispute Resolution, Civil Justice, Department of Justice and Regulation
- Dr Robert David Roseby, Head of Medical Specialties, Director of Medical Education, Monash Children's at Monash Health, Lead, IMG Workplace Based Assessment Program, Monash Health
- Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine.

Transfer of Secretariat to Department of Justice and Regulation

On establishment, Court Services Victoria assumed responsibility for providing a Secretariat to the Coronial Council of Victoria. After careful reconsideration regarding the best location for the Secretariat, a decision was made to transfer the Secretariat back to the Department of Justice and Regulation. This change will take effect on 1 July 2016.

The Year Ahead

Reporting of Reportable Deaths in Hospitals to the Coroner Review

The Review seeks to:

- i. identify the causes of the under and over reporting of reportable deaths;
- ii. identify whether it is possible to be more specific in the definition of reportable deaths to avoid unnecessary referrals to the coroner;
- iii. identify ways of reporting preliminary findings from coronial autopsies to treating clinicians;
and
- iv. offer models which will improve reporting to and feedback from the coroner.

The overall aim is the development of a model, which will inform best practise to achieve excellence in mechanisms for reporting of reportable deaths in Victorian hospitals.

The review is to produce recommendations on:

- i. refining the criteria or definition of reportable deaths;
- ii. designing a streamlined process for accurate reporting of deaths in hospitals to the coroner;
and
- iii. improved reporting to integrate coronial investigations with clinical governance.

Recommendations will then be made to the Attorney-General on proposed improvements to reporting processes to assist the coronial jurisdiction.

The project is expected to be conducted from August 2016 to February 2017.

Investigative Reference into Consumer Feedback

The Council will be progressing deliberations in 2016 for an investigative reference into consumer feedback.

Summary of Expenditure for the 2015 –16 Year

Council meetings, reference work and associated costs during the period were met from an annual appropriation through Court Services Victoria. 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 5, 0.4 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.

In 2015-16, the Council was funded by the annual appropriation granted to Court Services Victoria.

Major Expense Item	Summary of Council Expenditure
Secretariat costs	\$42,755
Sitting fees	\$3,478.00
Meeting costs/incidentals	\$241.30
Car/taxi hire	-
Communications	-
TOTAL	\$46,474.30

Appendix 1 – The *Coroners Act 2008 (Vic)*

Part 9 - Coronial Council of Victoria

S. 109 Coronial Council of Victoria

The Coronial Council of Victoria is established.

S. 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.

S. 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.

S. 112 Procedure at meetings

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

S. 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 – 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 *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.”¹

The Committee’s Report suggested a hybrid model establishing the Council as an advisory board and 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.*²

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

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

¹ Victorian Parliament Law Reform Committee (2006). *Report on the Inquiry into the Coroners Act 1985*. Parliament of Victoria, Melbourne, p.71

² Ibid, p.165

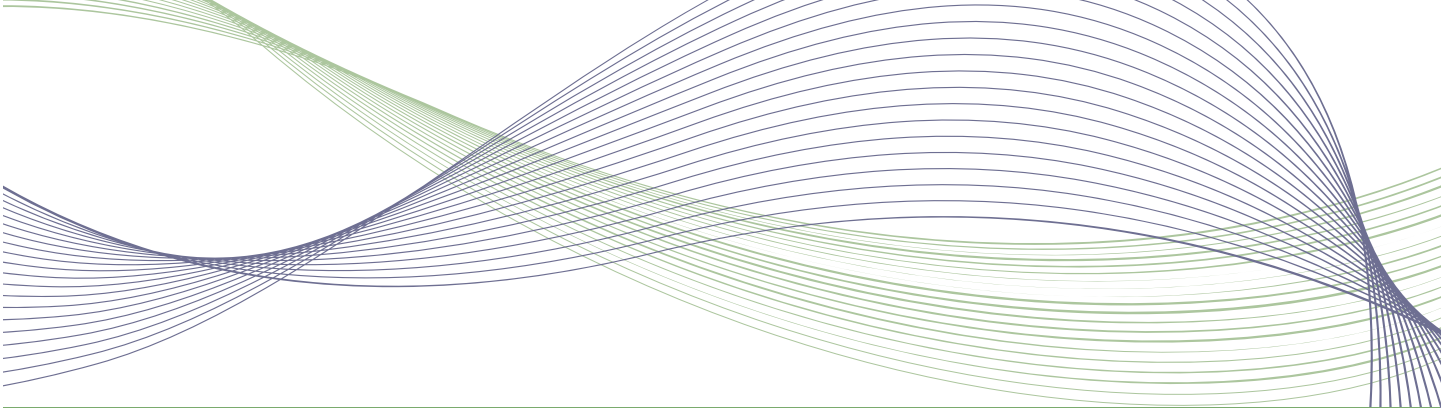
Its response was embodied in a review of the *Coroners Act 1985*. In his second reading speech for the *Coroners Bill 2008* in December 2008, then Attorney-General Mr Rob Hulls, MP introduced the Council as an advisory body to:

... 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.*³

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.

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



Coronial Council
of Victoria