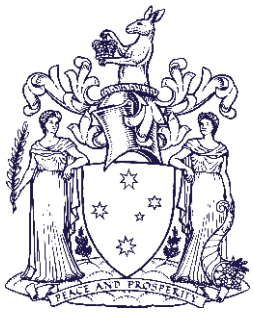

Coronial Council of Victoria

ANNUAL REPORT 2020–21

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Hon Jaclyn Symes MP
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29 September 2021

Dear Attorney-General

Coronial Council Annual Report 2020–21

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 2020 to 30 June 2021, in accordance with section 113 of the *Coroners Act 2008 (Vic)*.

The report was approved by the Coronial Council of Victoria on 22 September 2021.

Yours sincerely

Clare Morton
Chair, Coronial Council of Victoria

Message from the Chair

It is with pleasure that I present the ninth annual report of the Coronial Council of Victoria for the 2020–21 reporting period.

Throughout 2020–21, the Council maintained a busy work program while responding to a changed work environment as a result of the Coronavirus (COVID-19) pandemic. Consideration of how the coronial process can effectively respond to the challenges presented by COVID-19 was a consistent theme of the Council's meetings over the reporting period.

Significant work undertaken by the Council included considering a ten-year best practice coronial system for Victoria. Part of this work involved reviewing opportunities for the Council to support the work of the Coroners Court of Victoria and the Victorian Institute of Forensic Medicine (VIFM). This year has highlighted the importance of developing true partnerships and I thank the State Coroner, Judge John Cain and the Director of VIFM, Professor Noel Woodford for their support and leadership.

During 2020–21, the Council finalised the Report into the review into the appropriate and responsive care of deaths in multifaith and multicultural communities by the Coroners Court of Victoria and related entities involved in coronial processes. This report involved significant consultation with Victoria's multifaith and multicultural communities and contained a series of recommendations directed at improving coronial processes for these communities.

I acknowledge and thank the Expert Panel members, the Reference Group members, multifaith and multicultural community leaders and community stakeholders for their valuable contributions to this work. I also thank the Victorian Multicultural Commission for its support and advice.

The Council also continued to work on a recommendation from the review of reportable deaths in Victoria including developing a scoping plan and an implementation plan to review the potentially unclear definition of reportable deaths in section 4(2) of the *Coroners Act 2008 (Vic)*.

The Council has continued to be well supported by the secretariat team at the Department of Justice and Community Safety. In particular, I would like to thank Shereen Boland for her tireless efforts in supporting the work of the Council.

I would like to welcome Dr Joanne Ryan to the Council and thank outgoing member Michele Lewis for her contribution during her time on the Council.

I would also like to extend my thanks to all Council members for bringing their enthusiasm, and tremendous skills and experience to the work of the Council. I am extremely grateful for their contribution and support. It is a great pleasure to work with them.

I look forward to continuing the important work of Council into the coming financial year, with the assistance of Council members.

Clare Morton
Chair, Coronial Council of Victoria

The Coronial Council of Victoria

Established under Part 9 of the *Coroners Act 2008* (Vic), the Council is independent of the Coroners Court of Victoria (CCOV). 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 CCOV
- 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 an advisory body that can identify emerging medical, legal, scientific or other expert issues in the coronial process, and consultative in its approach as it ensures its work considers the views 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, or 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-focused role of coroners
- 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, September and November 2020, and in February, April and June 2021.

For further information, please contact the Council's secretariat at coronial.council@justice.vic.gov.au.

Clare Morton
Chair, Coronial Council of Victoria

Council Members

Clare Morton

Chair and appointed member from August 2019

Clare Morton was appointed as Chair of the Coronial Council on 20 August 2019.

She brings extensive and broad-ranging experience and knowledge to the role of Chairperson, having worked as a legal and policy professional as well as an Executive Officer within both the legal and government sectors.

Ms Morton has extensive experience in the Victorian public sector. Currently Ms Morton is working part-time as an Executive Director, Sexual Harassment and Respect at Court Services Victoria overseeing the implementation of the recommendations from the Review of Sexual Harassment in Victorian Courts and the Victorian Civil and Administrative Tribunal (VCAT). Prior to this, Ms Morton was an Executive Officer at the Magistrates' Court of Victoria and acting CEO of the CCOV, taking the Court through organisational, and health and wellbeing reforms. Previously, she was Director of Community Operations and Victims Support Agency in the Department of Justice and Community Safety for 10 years. Ms Morton is a Non-Executive Director of Victoria Legal Aid and is involved in the community having served as the Chairperson of Refugee Legal since 2007.

State Coroner Judge John Cain

Ex officio member from December 2019

Judge John Cain was appointed Victoria's State Coroner in December 2019.

Judge John Cain has over 30 years of legal experience. In addition to State Coroner, he also serves as a County Court Judge. Some of his previous roles included: Solicitor for Public Prosecutions for Victoria, Victorian Government Solicitor, Managing Partner of Maurice Blackburn and Thomson Geer law firms, and Chief Executive of the Law Institute of Victoria.

In addition to being a leader within the Victorian legal community, Judge John Cain has contributed to significant reforms for victims and witnesses in the criminal justice system, and has been instrumental in driving technology reform and staff wellbeing projects including introducing programs to address workplace vicarious trauma.

Deputy Commissioner Wendy Steendam

Ex officio member delegate from April 2019

Deputy Commissioner Steendam has been a member of Victoria Police for over 35 years. She commenced as Deputy Commissioner, Specialist Operations in November 2018, and currently portfolio responsibility for Road Policing Command, Family Violence Command, Intelligence and Covert Support Command, the Forensic Services Department, the Legal Services Department and Victoria Police' response to the Royal Commission into the Management of Police Informants.

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 AO 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, Griffith University; and an Adjunct Professor, Queensland University of Technology. Dr Freckelton QC is also a member of the Victorian Bar Council. 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 founding editor 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 Counselling

Maria Dimopoulos AM

Appointed member from July 2017

Maria Dimopoulos specialises in the intersections of diversity, gender equality and the law. She has over 25 years' experience in policy formulation across all tiers of government, research for social planning and legal education. Ms Dimopoulos was the former deputy chair of the Victorian Multicultural Commission and is the current Chairperson of the National Harmony Alliance – Refugee and Migrant Women for Change. She continues to be an active member of various organisations committed to access to justice, including the Judicial Council on Cultural Diversity.

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.

Dr Joanne Ryan

Appointed member from April 2021

Associate Professor Joanne Ryan is an epidemiologist and Head of the Biological Neuropsychiatry and Dementia Unit in the School of Public Health and Preventive Medicine at Monash University. She has authored more than 140 research articles, predominantly focused on understanding the causes of depression, anxiety, trauma and stress related disorders and dementia, as well as evidence-based approaches to prevention.

Current positions include Senior Editorial Board member of BMC Psychiatry and Cochrane UK (Dementia and Cognitive Improvement Group), as well as Research governance positions and Academic roles in Research training and Equal Opportunity programs at Monash University.

Council Membership 2020–2021

Under section 111 of the *Coroners Act 2008* (Vic), 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 reappointment. 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.

Council membership

Chair of the Coronial Council of Victoria

- Ms Clare Morton

State Coroner

- State Coroner Judge John Cain

Chief Commissioner of Police

- Deputy Commissioner Wendy Steendam, Victoria Police.

Director of Victorian Institute of Forensic Medicine

- Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine.

Appointed members

- Dr Ian Freckelton AO QC
- Mr Christopher Hall
- Adjunct Clinical Associate Professor Robert Roseby
- Ms Maria Dimopoulos AM
- Dr Joanne Ryan

Council Secretariat

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

Former members

Detailed below is the member of the Council whose membership concluded during the reporting period.

Michele Lewis

Appointed member from July 2017 until August 2020

Michele Lewis was appointed as Mecwacare's Chief Executive Office in 2007. Ms Lewis has over 41 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.

The year in review

During 2020–21, the Council completed a review into the appropriate and responsive care of deaths in multifaith and multicultural communities, as it relates to the CCOV and other entities involved in coronial processes. The Council also continued to progress work resulting from the reportable deaths reference in relation to reviewing the potentially unclear terminology used in section 4(2) of the *Coroners Act 2008 (Vic)*.

The reports made a series of recommendations which have been accepted in principle by the Attorney-General. Implementation of these recommendations will be undertaken by the CCOV, VIFM and related entities involved in the coronial process. The Council will work with the department to provide oversight of the implementation process.

During the year, subject matter experts made presentations at Council meetings on issues including restorative justice, bereavement support services provided to families, support provided to Aboriginal families, exploration of the themes of a best practice coronial service, and consideration of a best practice approach to coroners' written findings. These presentations provided important context for the matters being considered by the Council including a November 2020 reference from the former Attorney-General requesting a review of the experiences of bereaved families within the coronial process, including the CCOV and related entities involved in the coronial process.

This project represents an important opportunity to meaningfully address feedback provided by bereaved Victorian families to the Attorney-General, CCOV, and Department of Justice and Community Safety (the department). Noting that bereaved families often engage with the coronial process at some of the most difficult and traumatic times of their lives, the objective of this project is for the Council to provide advice and make recommendations to the Attorney-General on ways to improve the experiences of bereaved families within the coronial process in order to more effectively meet their needs.

Work on this reference has involved a range of project activities including the establishment of appropriate governance arrangements, and the development of a comprehensive literature review which considers all points of intersection that a bereaved family member has with the coronial process, discusses how other coronial jurisdictions respond to bereaved family needs, and summarises a range of academic research on best practice approaches for engaging with bereaved family members.

The RMIT's Centre for Innovative Justice was engaged to undertake consultations with bereaved family members and organisational stakeholders working within the coronial process. An approval to consult bereaved families was obtained from the department's Justice Human Research Ethics Committee. The next steps will be to explore best practice restorative justice conferencing and bereavement support models. Due to the COVID-19 pandemic and the impact it will likely have on necessary consultations, the Council has sought a slight extension of the November 2021 due date for its final report

Review into the handling of deaths in multicultural and multifaith communities

On 5 February 2020, the Attorney-General requested that the Council review the handling of deaths in multifaith and culturally and linguistically diverse (CALD) communities by the Coroners Court and related entities involved in coronial processes.

The review was informed by an analysis of death and funeral practices within a cross-section of ethnic groups and faiths in Victoria; coronial and death investigation laws in both domestic and international jurisdictions; operational practices and guidance material for key staff within the coronial system; and academic research on areas for coronial process improvement.

The review recognises that the majority of world ethnic groups observe cultural and religious end-of-life rites considered both sacred and necessary to prepare the deceased for their next journey, and that these practices intersect with all aspects of the coronial process. The recommendations proposed by the Council respond to issues of cultural and religious significance but note these matters will also ensure the coronial process is responsive and sensitive to a broad range of cohort needs

The Council submitted its final report to the Attorney-General in 2020.

For more information on this review, please refer to the Council's 2019-2020 annual report that can be downloaded at https://www.justice.vic.gov.au/justice-system/courts-and-tribunals/coronial-council-annual-reports.

Operating in a COVID-19 environment

Coronavirus (COVID-19) has continued to impact the work of the Council and the day-to-day operations of the coronial system. During 2020–21, the Council continued to meet on-line, and meetings with all stakeholders were also held on-line.

During the reporting period, the State Coroner provided regular up-dates to the Council on the operational impacts of COVID-19 on the court.

COVID-19 has continued to highlight the importance of emergency planning in the context of pandemics including those involving mass fatalities. Accordingly, work conducted by the Council into the appropriate and responsive care of deaths in multicultural and multifaith communities included consideration of the needs of the multicultural and multifaith communities in any disaster emergency management processes.

Implementation of completed review findings

In addition to the references that were completed in 2020, the Council continued to oversee the implementation of recommendations from the Council's 2017 reference into the rights to appeal coronial findings and re-open investigations, and its 2017 reference into the reporting of reportable deaths in hospitals to the coroner.

Throughout this year, the Council worked with the department to develop stronger project management, including regularly updating a consolidated recommendation tracking register. The tracking register has been a useful tool to provide Council members with a clear picture of which recommendations have been implemented and has meant outstanding recommendations have been following up promptly. It has been pleasing to see that the vast majority of recommendations from the two 2017 reviews have been completed.

Summary of expenditure in 2020–21

The Council's meetings, project work and associated costs during the reporting period were funded by annual appropriation through the department.

These costs included sitting fees, paid in accordance with the Victorian Government's *Appointment and Remuneration Guidelines (the Guidelines)*, meeting costs and other incidentals. The 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 2021. Significant expenditure items detailed in the table are:

- **Project costs** – *comprised of one consultancy engaged to lead the consultation process for the review into multifaith and culturally and linguistically diverse (CALD) communities and one consultancy engaged to lead the stakeholder consultation strategy for the review into the experiences of bereaved families within the coronial process. This is also inclusive of project costs for Council members to perform additional research, project management, and documentation of findings for reference work outside the scope of their role as Council members.*
- **Secretariat costs** – salary and 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	$40,531.50
Secretariat costs	$66,554.91
Meeting costs / sitting fees / incidentals	$13,629.91
TOTAL	**$120,716.00**

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

In 2020–21, there were three consultancies where the total fees payable was $10,000 or greater. The total expenditure for consultancies during 2020-21 was $40,531.50.

For consultancies relating to general Coronial Council affairs, the total expenditure was $10,199.00. With consultancies that were engaged for the review into multifaith and culturally and linguistically diverse (CALD) communities, the total expenditure was $11,270.00. For consultancies relating to the review into the experiences of bereaved families within the coronial process the total expenditure was $19,062.50.

There were no consultancies engaged during 2020–21 where the total fees payable to an individual consultancy was less than $10,000.

Looking Ahead

The Council recognises that people engage with the CCOV at some of the most traumatic times in their lives, and has a comprehensive work plan which analyses and makes recommendations on ways to improve the experiences of bereaved families engaging with the coronial system.

In addition, the Council is committed to responding to emerging issues that will have an impact on the ongoing improvement of the Victorian coronial system.

Over the remainder of 2021 the Council's focus will be to progress the review of the experiences of bereaved families within the coronial process, including with the CCOV and related entities involved in the coronial process. This includes consultations with bereaved families and organisational stakeholders and developing a best practice bereavement support model and a best practice restorative justice conferencing model.

Council will also track and oversee implementation of the most recent review of reportable deaths in Victoria and the review into the appropriate and responsive care of deaths in multicultural and multifaith communities. The work to clarify the definition of 'reportable death' and potentially unclear terminology in section 4(2) of the *Coroners Act 2008* (Vic), is fundamental to clarifying which deaths should be investigated by the CCOV, and should remove any process ambiguities which are currently experienced when making decisions on which deaths are reportable. As part of this work, the Council will consider the development of training materials and the delivery of training for medical practitioners and other stakeholders with reporting obligations.

The Council looks forward to continuing its work to improve coronial system outcomes in Victoria.

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 VIFM 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 to establish 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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