# Coronial Council of Victoria

# ANNUAL REPORT 2021–22

VICTORIA
State Government

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# Coronial Council of Victoria

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Hon Jaclyn Symes MP
Attorney-General
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21 October 2022

Dear Attorney-General

**Coronial Council Annual Report 2021–22**

On behalf of the Coronial Council of Victoria, I present to you the Council's Annual Report for the period of 1 July 2021 to 30 June 2022, in accordance with section 113 of the *Coroners Act 2008 (Vic)*.

The report was approved by the Council on 8 September 2022.

**Clare Morton**
Chair, Coronial Council of Victoria

# Message from the Chair

It is with pleasure that I present the tenth annual report of the Coronial Council of Victoria (the Council) for the 2021–22 reporting period.

During 2021–22, the Council undertook a range of work including consultation with industry experts to better understand issues impacting how reportable deaths are determined by medical professionals. This consultation followed the Council's 2020 own motion review of reportable deaths in Victoria. The Council also prepared and submitted its report to the Attorney-General on options to reform Victoria's coronial system so that it better responds to the needs of bereaved families. In addition, the Council explored potential topics for future work having regard to:

- issues of importance to Victoria's coronial system
- matters relating to the preventative role played by the Coroners Court of Victoria (CCOV), and
- the way in which the coronial system engages with families and respects their cultural diversity.

In March 2022, the Council submitted its report to the Attorney-General on how the current coronial process could be improved to better meet the needs of bereaved families. The review was undertaken in response to a September 2020 reference from the former Attorney-General.

The Council's 2022 report considers the advice of bereavement and restorative justice experts, as well as the views of families and key organisations working within the coronial system. The Council recognises that it is critical for families to have access to effective policy and program supports during their interaction with the coronial process which for many, will be the most difficult and traumatic times of their lives.

The Attorney-General is considering the Council's advice on options to improve the experience of families, and is expected to provide her response to the recommendations in due course.

I acknowledge and thank Expert Panel members and coronial system partners for their support and advice over the last year. I also wish to thank the bereaved family members who volunteered their time to contribute their views and suggestions on the Council's recent report, with the ultimate goal of improving the experience of the coronial system for other families.

I extend my thanks to all Council members who are particularly generous with their time and who have brought their tremendous skills and experience to the work of the Council. I value their contribution and support.  I particularly thank the State Coroner, John Cain and the Director of the Victorian Institute of Forensic Medicine, Noel Woodford for their support and leadership. I also welcome Dr Suzy Redston, having joined the Council in June 2022.

The Council is grateful for the continued secretariat and project support from the Department of Justice and Community Safety, which has facilitated the progress of our work and advice to the Attorney-General.

I look forward to the Council's continued work in providing advice that seeks to strengthen the ability of Victoria's coronial system to respond to the changing needs of the Victorian community.

**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 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 August, October and December 2021, and in February, April and June 2022.

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. Ms Morton has just completed a part-time fixed term appointment as Executive Director, Sexual Harassment and Respect at Court Services Victoria. Immediately before this, Ms Morton was an Executive Officer at the Magistrates' Court of Victoria and acting CEO of the Coroners Court of Victoria, taking the Court through organisational and health and wellbeing reforms. Prior to that, she was Director of Community Operations and Victims Support Agency for 10 years. Ms Morton is a Non-Executive Board member of Victoria Legal Aid and has been the President 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 AM, APM

*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 has 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 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. 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 is the former deputy chair of the Victorian Multicultural Commission and former 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, and is the current Chair of Safe and Equal, the peak body representing family violence services in Victoria.

## 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.

## Dr Suzy Redston

*Appointed member from May 2022*

After exploring the breadth of medicine in her first few post-graduate years in her roles as an Australian Army doctor and emergency medicine trainee Dr Redston decided to focus on the mind and trained in Psychiatry. After receiving her fellowship to the Royal Australian and New Zealand College of Psychiatrists she has worked continuously in both private and public mental health in Victoria. Her leadership roles have included 5 years as the Clinical Director of Ethics Psychological Trauma and Recovery Service at Austin Health and 5 years as the Medical Director of the Mental Health Division at Austin Health including through the first two years of the pandemic. Her areas of interest have been eating disorders and trauma related mental illnesses. She is trained in a number of psychotherapies.

# Council Membership 2021–2022

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 AM, APM, 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
Dr Suzy Redston

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

# The year in review

During 2021–22, the Council completed a review into improving the experience of bereaved family members within the coronial process. The Council's work on this report is detailed in the section below.

The Council also continued to progress work resulting from the 2020 own-motion review of reportable deaths. In September 2021, a sub-committee of Council met with medical and industry experts to better understand issues impacting how medical professionals determine whether a death should be reported to the Coroners Court. This consultation helped identify the need for medical training and greater support for junior medical professionals.

In early 2022, the Council worked with the CCOV and VIFM to hold an afternoon tea to thank multifaith leaders who contributed to the Council's 2020 *Review into the appropriate and responsive care of deaths in multicultural communities by the CCOV and related entities involved in coronial processes*. The event also provided an opportunity for key community members to undertake a tour of CCOV and VIFM which increased their understanding of the experiences of family members when confronted with the coronial process.

During the year, subject matter experts made presentations at Council meetings on issues including restorative justice and bereavement support services for families, implications of government policy on pandemic measures, the findings of the Royal Commission into Victoria's Mental Health System and in particular suicide prevention recommendations, coronial evidence considered by the Royal Commission into Defence and Veteran Suicide, data and evidence gathering by the Coroners Prevention Unit and how it strategically supports the work of Victoria's coronial system, and an overview of the work of the Child and Adolescent Subcommittee of Consultative Council on Obstetric and Paediatric Mortality and Morbidity. These presentations provided helpful context for current matters, and potentially future matters to be considered by Council.

## Review into improving the experience of bereaved families with the coronial process

On 23 March 2022, the Council submitted its report to the Attorney-General on how the current coronial process can better meet the needs of bereaved families. The review was undertaken in response to a September 2020 reference from the former Attorney-General.

The Council's Review provided an important opportunity to meaningfully address feedback provided by bereaved Victorian families to the Attorney-General, CCOV, and the Department of Justice and Community Safety (the department).

To inform its considerations, the Council engaged RMIT's Centre for Innovative Justice and Dr Jane Mowll, a bereavement expert. to provide advice on restorative justice practices and bereavement support respectively. The final report makes recommendations that aim to improve the experience of bereaved families in their interactions with the CCOV and the VIFM. Part of the consultants' work involved consultations with bereaved family members and organisational stakeholders working within the coronial process The consultations with bereaved families were undertaken following appropriate approval from the department's Justice Human Research Ethics Committee.

The Council has made a range of recommendations including the establishment of an 18 month pilot that offers families access to grief and bereavement support during critical periods of the coronial process, and also restorative justice options at appropriate times. The Council believes that these reforms will assist families in the processing of their grief, and minimise the exacerbation of trauma related issues.

The Review is currently being considered by the Attorney General.

Work on this reference also 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.

## Operating in a COVID-19 environment

Like many organisations, the continuation of the COVID-19 pandemic resulted in the Council progressing its work through online meetings and discussions to ensure a safe environment for members and stakeholders, in line with standard pandemic work arrangements.

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

## Implementation of earlier reviews

The Council is pleased to see the adoption of some key recommendations made in the Council's 2020 *Review into the handling of deaths in multicultural and multifaith communities*. That report examined the appropriate and responsive care of deaths in multicultural communities by the CCOV and related entities involved in coronial processes.

In consulting affected families as part of that Review, the Council became aware of the critical importance of communicating certain forms of death (such as suicide), in a sensitive manner to culturally and religiously diverse families. Families reported being particularly distressed at having to present death certificates which identified the cause of death to third parties.

Consequently, the Council made recommendations that explored opportunities for improved communications and recommended that Births Deaths and Marriages (BDM) ". . . develop an abridged death certificate in addition to the full form of the death certificate, which can be provided to third parties, and omits any graphic information in relation to the cause of death."

In addition to the standard death certificate, from 1 July 2022, BDM will offer a new abridged death certificate that excludes the cause of death and burial information. The new certificate will be accepted for administration processes at organisations such as banks, government entities and utility companies. The new certificate offers families the choice to withhold sensitive information such as cause of death, and speeds up the administration of estates as families no longer need to await the outcome of a coronial investigation to receive a death certificate.

The Council is also pleased to report that as a consequence of its Multifaith Review, VIFM has reviewed its protocols, and where possible, VIFM now considers and abides by requests by family members, including those based on their religious or cultural rituals. Religious preference and awareness sessions will also be held for all mortuary and Coronial Admissions and Enquiries staff.

In addition, where practical, the CCOV and VIFM now adopt expedited case management processes for cultural and religious cases with prioritisation of cases due to cultural and religious reasons highlighted on daily action sheets

# Summary of expenditure in 2021–22

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 2022. Significant expenditure items detailed in the table are:

- Project costs – comprised of three consultancies engaged for the review of the experiences of bereaved families within the coronial process report. 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 | $277,523.20 |
| Secretariat costs | $60,892.32 |
| Meeting costs / sitting fees / incidentals | $9,602.77 |
| **TOTAL** | **$348,018.29** |

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

In 2021–22, there were three consultancies where the total fees payable was $10,000 or greater. The total expenditure for the engagement of consultants who provided expert advice for the review of the experiences of bereaved families within the coronial process, was a total of $277,523.20.

# Looking Ahead

The Council's future meetings will consider a range of topics including family violence in a coronial context, and interactions with family violence support services in the period leading up to deaths. The Council will also consider the experience of the CCOV as a result of reforms introduced following the 2015 Royal Commission into Family Violence.

During 2022-2023 the Council will continue to explore issues and topics that may inform future work, with a view to recommending possible reforms that will ultimately 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;

(e) 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.


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