2022-23 Annual Report

of the Coronial Council of Victoria

VICTORIA State Government | Justice and Community Safety

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Coronial Council of Victoria

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Hon Jaclyn Symes MP
Attorney-General
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27 September 2023

Dear Attorney-General

Coronial Council of Victoria Annual Report 2022-23

On behalf of the Coronial Council of Victoria, I present to you the Council's Annual Report for the period of 1 July 2022 to 30 June 2023, in accordance with section 113 of the *Coroners Act 2008 (Vic).*

The report was approved by the Council on 22 September 2023.

Yours sincerely

Clare Morton
Chair, Coronial Council of Victoria

Message from the Chair

It is with pleasure that I present the eleventh annual report of the Coronial Council of Victoria (the Council) for the 2022-23 reporting period.

Over the 2022-23 reporting period the Council has undertaken a significant amount of work focused on improving the coronial system in Victoria.

The primary focus has been on a reference from the Attorney-General on how to improve the coronial process for older Victorians. This reference was prompted by a growing aging population and the need to strike an appropriate balance between maintaining the rights of older Victorians, meeting the expectations of Victorian families, ensuring accountability for error and neglect, and better enabling Victoria's coronial system to focus its efforts on the deaths of older persons that warrant coronial investigation and that can provide safety and prevention opportunities for the wider Victorian community.

I thank the members of the steering committee and the reference group for their valuable contributions to this work. A significant component of the work conducted in the first half of 2022 has been consulting with over 35 key organisations, including medical schools, hospitals, general practitioners, medical indemnity insurers, Victorian and Commonwealth Government entities, community groups, interstate and international jurisdictions, aged care providers, carer groups, disability sector, multicultural and multifaith groups, LGBTIQ+ representatives, the funeral industry, Aboriginal organisations and the Court and VIFM. They have together made a huge contribution to this reference, and I thank them for their valuable insights.

I am delighted to report that during the year Council members Professor Ian Freckelton AO KC, Associate Professor Robert Roseby and Mr Christopher Hall were all reappointed for a further term, thus recognising the valuable contribution each person has made to the work of Council.

The Council is fortunate in the secretariat support provided by the Department of Justice and Community Safety (department). On behalf of all Council members, I sincerely thank Fran Cataldo and Lisa Vu for their magnificent support and tireless work on Council matters. I would also like to thank Judge John Cain, State Coroner and Professor Noel Woodford, Director, Victorian Institute of Forensic Medicine (VIFM) for their support, advice and leadership over the year and also the staff of the Coroners Court and VIFM for their patience and assistance in providing information essential to the work of the Council.

I would also like to thank all Council members for their ongoing support and enthusiasm for the work of the Council. They bring a wealth of experience and tremendous skill to Council deliberations and are particularly generous with their time. It is my great pleasure to work with them.

I look forward to continuing the work of the Council in the coming year, with the support of Council members.

I am pleased to present the 2022-23 Coronial Council Annual Report.

Clare Morton

Chair, Coronial Council of Victoria

The Coronial Council of Victoria

The Council is an advisory body established under Part 9 of the *Coroners Act 2008* (Vic). It is independent of the Coroners Court of Victoria (the Court) and has functions to provide advice and make recommendations to the Attorney-General on:

- issues of importance to the Victorian coronial system
- matters relating to the preventative role of the 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 identifies emerging medical, legal, scientific or other expert issues in the coronial process, adopts a consultative approach in its recommendations and advice and considers the views of various community groups that are affected by the death investigation processes as well as other adjacent coronial services.

The Council is the only known body of its kind in Australia and across the world. A summary of the Council's history can be found at **Appendix 1**.

In undertaking its function and responsibilities, the Council is expected to act in a way that:

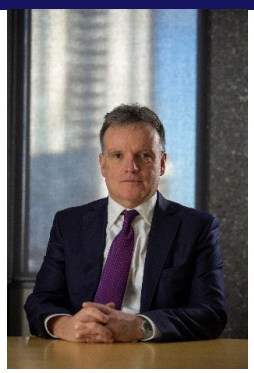
- does not impinge on the independence of a coroner's decision-making and investigation of death, or the role of the State Coroner
- delivers strategic advice reflecting the changing physical, social and political environment to foster a modern and responsive coronial system
- promotes and strengthens 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 on 1 August 2022, 17 October 2022, 5 December 2022, 6 February 2023, 3 April 2023 and 5 June 2023.

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

Members of the Coronial Council

Clare Morton	Chair, 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. Previous roles include: Executive Director, Sexual Harassment and Respect at Court Services Victoria. Executive Officer at the Magistrates' Court of Victoria and Acting CEO of the Coroners Court of Victoria. In this role Ms Morton was responsible for 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	Coroners Court of Victoria, *ex officio* member from December 2019
	Judge Cain was appointed Victoria's State Coroner in December 2019. Judge 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 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	Victoria Police, *ex officio* member delegate from April 2019
	Deputy Commissioner Steendam has been a member of Victoria Police for over 37 years. She commenced as Deputy Commissioner, Specialist Operations in November 2018, and currently has portfolio responsibility for Road Policing Command, Family Violence Command, the Forensic Services Department and the 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	Victorian Institute of Forensic Medicine, *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 KC	Barrister, Crockett Chambers appointed member from March 2010
	Dr Ian Freckelton is a King'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. Until 2023 he was a judge of the Supreme Court of Nauru. He is a Professor of Law and a Professorial Fellow in 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 KC was also a member of the Mental Health Tribunal of Victoria for 25 years. He is an elected Fellow of the Australian Academy of Health and Medical Sciences, the Australian Academy of Law and the Academy of Social Sciences Australia. Dr Freckelton KC is the author of many books (including 'Death Investigation and the Coroner's Inquest'); editor of the 'Journal of Law and Medicine'; and the founding editor of 'Psychiatry, Psychology and Law'.
Christopher Hall	CEO, Grief Australia, appointed member from March 2010
	For the past 26 years Christopher Hall has held the position of Director and Chief Executive Officer of Grief Australia. He is a psychologist specialising in grief and bereavement. Christopher was elected President of the Association for Death Education and Counseling in 2015. In 2007, he was elected to the Board of Directors of the International Work Group on Dying, Death and Bereavement and served as chair from 2010-2013 and as the Secretary/Treasurer from 2010 until 2022. The Association for Death Education and Counseling in 2018 awarded him the ADEC Service Award for his commitment to the field and advancing the study of dying, death and bereavement. A Fellow of the Australian Institute of Management. Christopher is also an Honorary Fellow of the Department of Psychiatry at the University of Melbourne. He serves as the Editor of the journal *Grief Matters*: *The Australian Journal of Grief and Bereavement* and is a former Associate Editor of *Death Studies*. Since 2010, Christopher has been a member of the Coronial Council of Victoria.

Maria Dimopoulos AM	Director, Myriad Kofkin Global, 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 the current Chair of Safe and Equal, the peak body representing family violence services in Victoria. Ms Dimopoulos is current the Director of Myriad Kofkin Global.
Adjunct Clinical Associate Professor Robert Roseby	Head of Medical Specialities, Director of Medical Education, Monash Children's at Monash Health, 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. He is a member of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, and chair of its Child and Adolescent subcommittee. 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	Associate Professor, Monash University and adjunct, Murdoch Children's Research Institute, 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 200 research articles, predominantly focused on evidence-based approaches to dementia prevention, and risk factors for trauma and stress related disorders across the lifecourse. 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	Consultant psychiatrist, 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 2022-23

Section 111 of the *Coroners Act 2008* (Vic) provides that the Council is to consist 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. Appointed members are chosen to provide a diversity of experience to the Council, including for expertise in their given fields and understanding of 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, Coroners Court of Victoria

Chief Commissioner of Police

Deputy Commissioner Wendy Steendam AM APM, Victoria Police

Director of the Victorian Institute of Forensic Medicine

Professor Noel Woodford, Victorian Institute of Forensic Medicine

Appointment members

Dr Ian Freckelton AO KC

Mr Christopher Hall

Adjunct Clinical Associate Professor Robert Roseby

Ms Maria Dimopoulos AM

Dr Joanne Ryan

Dr Suzy Redston

Council Secretariat

The Department of Justice and Community Safety (the department) provided the Council with secretariat and project support.

The year in review

During the reporting period, the Attorney-General approved the publishing of the Council's Report on the Review into improving the experience of bereaved families with the coronial system. Further information is provided below.

On 28 October 2022, the Attorney-General requested that the Council consider and advise how Victoria's coronial system can best respond to the deaths of older Victorians. This reference has been the focus of the Council's work over the reporting period and the Council's work on this reference is detailed in the section below.

During the year, Council heard from experts in relation to matters of significance for the coronial system. Council members undertook a consultation with the Department of Health on the Victorian Suicide Prevention Strategy and heard from subject matter experts on the impact of family violence reforms on matters that come before the Coroners Court and the impact of the reforms on family violence service providers. Council members also received a presentation from Victoria Police Road Police Command on road trauma with a focus on mental health and suicide from the perspective of road policing. These presentations provided useful information for Council members in their consideration of issues debated at the bi-monthly Council meetings.

To assist scoping the new reference, Council members heard from the Aged Care Quality and Safety Commission on their regulatory work in the aged care sector, Gerard Mansour, the then Commissioner for Senior Victorians on issues impacting older Victorians, Professor Freckelton AO KC on legal issues, Professor Woodford and Dr Ranson from the perspective of the pathologist, and Barrister Kylie Evans on human rights considerations relevant to the reference.

In the reporting period, the Council considered the suitability of various aspects of current legislation.

At each Council meeting the State Coroner provided a verbal report to Council updating members on developments in the Coroners Court and the Chair of the Council provided an update on the progress of the reference, seeking Council members feedback on key issues.

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.

As part of the review, Council engaged RMIT's Centre for Innovative Justice to provide advice on restorative justice practices, and Dr Jane Mowll to provide advice on bereavement support in the coronial process. Valuable feedback on the coronial process was provided by bereaved families and organisational stakeholders working within the coronial system. A series of reforms were recommended by the Council to improve the experiences of the bereaved families as they navigate through the coronial process during a very difficult time in their lives.

On 1 June 2023 the Attorney-General approved the Council to publish the report on the Council's website noting that the Victorian government is carefully considering the review in detail.

Review into deaths of older Victorians

On 28 October 2022, the Attorney-General requested the Council consider and advise how Victoria's coronial system can best respond to the deaths of older Victorians. As part of this reference, Council is considering how Victoria's coronial system deals with reportable deaths of older persons, and whether there are opportunities to improve the system's ability to focus its efforts and resources where they are of most benefit to the lives of Victorians. The reference also requires the Council to identify a best practice model for the investigation of the reportable deaths of older Victorians including methods for early identification of natural cause deaths and options to triage or divert natural causes deaths from the Coroners Court. Further the Council has been asked to make certain that there are safeguards in place

that ensure unexpected or suspicious deaths of older persons result in coronial investigations. This new reference builds on the Council's own-motion April 2020 *Review of Reportable Deaths in Victoria* Report.

This current reference acknowledges Victoria's increasing and aging population and the importance of balancing the rights of families and the needs of the broader community with regard to maximising community health, safety and welfare and preventing avoidable deaths. The reference highlights the challenge in seeking to achieve a balance between maintaining proper oversight of these deaths and avoiding the delay and resource burden associated with reporting a death where no further investigation is ultimately required.

During the reporting period governance arrangements were set up, including a steering committee and reference group of key stakeholders. Importantly the reference is being undertaken in consultation with stakeholders with relevant experience and over 35 consultations have been held in the 2022-23 period. Current work includes finalising a detailed literature review which analyses relevant literature, case law and legislation on the reportable deaths of older Victorians, including learnings from coronial systems in other Australian and international jurisdictions on how they monitor systemic issues arising from the deaths of older persons. The literature review also incorporates academic research on best practice approaches for the investigation of deaths of older Victorians, national and Victorian data, and related work including Royal Commissions and inquests.

Implementation of earlier reviews

The Council continues to oversee the implementation of recommendations from the 2020 Own-motion Review of Reportable Deaths in Victoria and the 2020 reference into the appropriate and responsive care of deaths in multifaith and multicultural communities.

During the 2022-23 period the Court has adopted two key recommendations made in the Council's 2020 *Review into the handling of deaths in multicultural and multifaith communities* with the employment of a Multicultural Advisor and the establishment of a Multifaith Advisory Committee comprising leaders of multifaith groups. The implementation of these two recommendations will ensure a more effective engagement with these communities.

Council expenditure in 2022-23

The Council's financial information forms part of the Department of Justice and Community Safety's annual financial statements and therefore audited as part of the department's 2022-23 annual report process.

Council sitting fees are paid in accordance with the Victorian Government's *Appointment and Remuneration Guidelines (the Guidelines)*. 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.

Looking Ahead

The Council is continually working to improve the coronial system outcomes for all Victorians recognising that bereaved families engage with the Court at a particularly traumatic time in their lives.

The focus of the Council's work over the remainder of this year is on completion of the current reference into improving the coronial process for older Victorians. This includes finalising the literature review, the draft recommendations, and the final report. Towards the end of 2023 the Council will review its detailed workplan, consult with the Court, the VIFM, key stakeholders, government and the department before embarking on the next piece of work.

Council will also continue to track the implementation progress of the recommendations from previous reports, including Council's most recent report on the Review into improving the experiences of bereaved families with the coronial process.

In addition, Council will respond to any emerging issues and will continue to engage with coronial subject matter experts to ensure Council members are well briefed on current issues.

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*.

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) (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.