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20 October 2017

The Honourable Martin Pakula MP
Attorney-General
121 Exhibition Street
MELBOURNE VIC 3000

Dear Attorney

Coronial Council Annual Report 2016–17

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 2016 to 30 June 2017, in accordance with section 113 of the Coroners Act 2008.

The report was approved by the Coronial Council of Victoria on 15 September 2017.

Yours sincerely

Professor Katherine McGrath MB BS, FRCPA FAICD
Chairperson, Coronial Council of Victoria
Message from the Chairperson

I am pleased to present the report on the activities of the Coronial Council of Victoria for the 2016–17 reporting period.

On 1 July 2016, the Council Secretariat was transferred from Court Services Victoria to the Department of Justice and Regulation. The Council has greatly appreciated the support received from the new Secretariat.

During the reporting year, the Council has been working on a major review of the reporting of reportable hospital deaths to the Coroner. The Council is grateful for the cooperation and support of the Department of Justice and Regulation, the Department of Health and Human Services, and the Victorian Managed Insurance Authority. I would like to thank the many clinicians, hospital executives, AMA Victoria, the Postgraduate Medical Council of Victoria, and medical indemnity organisations, who participated in this project.

In November 2016, the Council was asked by the Attorney-General to undertake a formal review of the appeals and re-opening of coronial investigations processes under the Coroners Act 2008. The Council is due to provide its advice and recommendations to the Attorney-General by late 2017.

I am pleased to report that during the year, Council members Dr Robert Roseby, Dr Ian Freckelton QC and Mr Christopher Hall were all reappointed for a further term. I would like to thank Professor Mark Stevenson, whose membership of the Council came to an end in May 2017, for his contribution to the Council.

I would also like to thank Judge Sara Hinchey and the staff of the Coroners Court for their assistance and patience in providing information essential to the Council’s work.

The dedication and commitment of Council members is greatly appreciated. Their work will continue to ensure Victoria’s leadership in best practice in coronial matters.

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

I am very pleased to present the 2016–17 Annual Report.

Professor Katherine McGrath
Chairperson, Coronial Council of Victoria
The Coronial Council of Victoria

Established under Part 9 of the Coroners Act 2008 (refer to Appendix 2), the Coronial Council of Victoria is independent of the Coroners Court of Victoria. The Council’s function is to provide advice, and make recommendations, to the Attorney-General on:

• issues of importance to the coronial system in Victoria;
• matters relating to the preventative role of the Coroners Court;
• the way in which the coronial system engages with, and respects the cultural diversity of, families; and
• any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

The Council is a body that is advisory in that it can identify issues where a particular field of medical, legal, scientific or other expertise would be relevant, and is consultative, in that it is reflective of various community groups that are affected by death investigation processes.

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

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

• does not impinge on the independence of a coroner’s decision-making and investigation of death as well as the role of the State Coroner;
• delivers strategic advice reflecting the changing physical, social and political environment to foster a modern and responsive coronial system;
• promotes and strengthens different relationships including collaboration between agencies across the coronial system;
• focuses on advice to strengthen services to families and improve the prevention role of the coroner;
• ensures that the views of bereaved families are reflected in the development of advice and recommendations;
• complements existing governance structures in the State coronial jurisdiction; and
• promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

During the reporting period, the Council met in July and October 2016, and in February, April and June 2017.

Further information
www.coronialcouncil.vic.gov.au
coronial.council@justice.vic.gov.au
(03) 8684 1224
The Council Members

**Professor Katherine McGrath**  
Chair from 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, and clinical and academic posts.

Professor McGrath’s roles have included Deputy Director General of NSW Health and Chief Executive Officer of the Hunter Area Health Service, and she was 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 on 9 July 2013.

**Judge Sara Hinchey**  
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 the Royal Commission into Institutional Responses to Child Sexual Abuse and the Victorian Bushfires Royal Commission.

Judge Hinchey was appointed as a Judge of the County Court in May 2015 following more than 19 years’ experience as a trial and appellate barrister. During this time, she 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 APM**  
Ex officio member from February 2016

Deputy Commissioner Shane 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, as well as 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.
The Council Members (cont.)

**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 Masters of Laws in Medical Law from the University of Cardiff. His special interests include sudden unexpected natural adult death and radiological imaging as an adjunct to medico-legal death investigation.

**Dr Ian Freckelton QC**  
*Appointed member from March 2010*

Dr Ian Freckelton is a Queen’s Counsel in full-time practice as a barrister throughout Australia. 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 Professorial Fellow in Law and Psychiatry, University of Melbourne; an Adjunct Professor of Forensic Medicine, Monash University; an Adjunct Professor of Law, La Trobe University; and an Adjunct Professor, Queensland University of Technology. Dr Freckelton 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 is the founding editor of the ‘Journal of Law and Medicine’ and the founding editor-in-chief of ‘Psychiatry, Psychology and Law’. He is the author and editor of leading texts on coronial law, health law, evidence law, compensation law, disciplinary law, causation, therapeutic jurisprudence, mental health law, criminal law, sentencing, policing, and scholarly misconduct.

**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 Counselling.
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. 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.

Professor Mark Stevenson
Appointed member from May 2014 to May 2017

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. He has extensive research experience in road trauma and considerable public health experience in low-income countries, and is an advisor for injury to the Director General of the World Health Organisation.

Council Membership 2016–17

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

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

Ex officio members
Her Honour Judge Sara Hinchey, State Coroner
Deputy Commissioner Shane Patton APM, Victoria Police
Professor Noel Woodford, Victorian Institute of Forensic Medicine

Appointed members
Professor Katherine McGrath
Dr Ian Freckelton QC
Mr Christopher Hall
Dr Robert Roseby
Professor Mark Stevenson (until May 2017)

Council Secretariat

During the reporting period, the Council was supported by a Secretariat provided by the Department of Justice and Regulation.
The Year in Review

The function of the Coronial Council of Victoria is to provide advice, and make recommendations, to the Attorney-General of its own motion, or at the Attorney-General’s request, regarding the operation of the coronial system.

During the reporting year, the Council worked on two reviews:
- Reporting Reportable Deaths in Hospitals to the Coroner; and
- Coronal Appeals reference.

Reporting Reportable Deaths in Hospitals to the Coroner

During 2015–17, the Council undertook an own motion review into the reporting of reportable deaths in hospitals to the coroner.

This review stemmed from concerns raised about inappropriate reporting – including both under-reporting and over-reporting – of deaths in hospitals to the coroner. The Council considered that further investigation was warranted into the causes of under and over reporting, and the links between coronial findings and hospital clinical governance systems.

A Steering Committee was established to oversee the review. The Council secured joint funding for this review from: the Department of Justice and Regulation; the Department of Health and Human Services; and the Victorian Managed Insurance Authority.

KPMG were engaged to undertake the review and make recommendations to the Council directed at improving reporting practices in Victoria.

It is anticipated that the outcomes of this review will be made available in late 2017.

Coronal Appeals Reference

On 15 December 2016, the Attorney-General, the Hon Martin Pakula MP, asked the Council to review the appeal and re-opening of investigation provisions in the Coroners Act 2008.

The terms of reference require the Council to provide advice on whether there is a need to amend these provisions, and if so, the nature of those amendments. In formulating its advice, the Council is to have regard to:
- the existing operation of the appeal and re-opening provisions in the Act;
- the historical development of appeal and re-opening provisions in the Victorian coronial jurisdiction, including changes made by the Courts Legislation Miscellaneous Amendments Act 2014;
- analogous appeal and re-opening provisions in other Victorian legislation;
- appeal and re-opening provisions in other Australian coronial legislation;
- the interests of families, the interests of justice, the interests of maintaining finality of decision-making, and the efficiency of the court system;
- the impact of any proposed changes to the appeal and re-opening provisions on costs and resourcing for the Coroners Court and the appellate jurisdiction; and
- any other impact of any proposed changes to the appeal and re-opening provisions on the coronial system and the wider appeals system.

The Council’s advice is due to be provided to the Attorney-General by late 2017.
Summary of Expenditure for the 2016–17 Year

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

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 other incidentals. Council 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 Council received a joint funding contribution from the Department of Justice and Regulation, the Department of Health and Human Services, and the Victorian Managed Insurance Authority towards the Reporting Reportable Deaths in Hospitals to the Coroner review.

The table below includes all expense items for the reporting period ending 30 June 2017. Significant expenditure items detailed in the table are:

- Project / Reference costs—comprising consultants engaged on the Reporting Reportable Deaths in Hospitals to the Coroner review and the Coronial Appeals reference, and project costs.
- Secretariat costs—salary and on-costs for one Secretariat Officer (VPSG4, 0.5 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.
- Project manager costs—salary and on-costs for one project manager (VPSG6, 1.0 FTE) from early 2017 to manage the Coronial Appeals reference, which is expected to be completed by late 2017.

<table>
<thead>
<tr>
<th>Major Expense Items</th>
<th>Summary of Council Expenditure ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretariat / Project Manager costs</td>
<td>69,010.59</td>
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<tr>
<td>Sitting fees</td>
<td>6,222.00</td>
</tr>
<tr>
<td>Project / Reference costs</td>
<td>225,458.74</td>
</tr>
<tr>
<td>Meeting costs / incidentals</td>
<td>2,060.18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>302,751.51</strong></td>
</tr>
</tbody>
</table>

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

In 2016–17, there were three consultancies engaged where the total fees payable to consultants were $10,000 or greater. The total expenditure incurred during 2016–17 in relation to these consultancies was $220,318.00 (excluding GST). Details of these consultancies can be viewed on the Council’s website: www.coronialcouncil.vic.gov.au.

There were no consultants engaged during 2016–17, where the total fees payable to an individual consultancy were less than $10,000.
Appendix 1 – History of the Coronial Council

In December 2004, the Governor in Council referred an inquiry to the Victorian Parliament Law Reform Committee (the Committee), into the effectiveness of the previous Coroners Act 1985. The Committee was asked to consider whether the Act provided an appropriate legislative framework for:

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

The Committee’s Final Report, published in September 2006, recommended that the Department of Justice establish a Coronial Council. 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’.

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.” 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.

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

In his second reading speech for the Coroners Bill 2008, 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 Coroner’s 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.

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

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2 Ibid 608.
3 Ibid.
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 Coroner’s 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—
- (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.