GOVERNMENT RESPONSE TO THE VICTORIAN PARLIAMENT LAW REFORM COMMITTEE'S *CORONERS ACT 1985* - FINAL REPORT

The Government welcomes the Victorian Parliament Law Reform Committee's final report on the *Coroners Act 1985*.

The report is the first review of Victoria's coronial system in over 20 years. As the report notes, the *Coroners Act 1985* 'was an innovative piece of legislation when introduced'.[1] It established the office of the State Coroner and the forerunner to the Victorian Institute of Forensic Medicine, creating a strong foundation of legal and medical expertise.

The coronial system continues to serve the community by providing independent and open investigations into sudden, traumatic or unexplained deaths.

Just as Victoria has changed since 1985, so has the role of the coroner. The community rightly expects investigations to be sensitive to the needs of grieving families and others touched by sudden death. Coroners are increasingly focused not just on determining facts about past deaths, but on ways to prevent deaths and injury in the future, particularly where systemic issues may be a factor.

That is why, in December 2004, the Government asked the Committee to review the *Coroners Act 1985* and to recommend areas where it could be modernised.

The Committee has made 138 recommendations for legislative and operational reform across the coronial system, from the way doctors certify and report deaths to the role of families in coronial investigations.

This response sets out the Government's commitment to ongoing improvement. The Government will rejuvenate the coronial system, focusing on its core purposes and strengths and renewing Victoria's place as a leader in coronial practice.

Many of the Committee's recommendations are already being addressed. The Committee's review coincided with a period of significant change at the State Coroner's Office, including improved services for families and the appointment of a Chief Executive Officer to drive organisational change.[2]

The Government will continue this process by rewriting the *Coroners Act 1985* and upgrading services to support families better.

This reform process will be a long term one. As the Chair of the Committee stated, this is a complex area of service delivery involving many different agencies and services.[3]

The Department established a steering committee following the tabling of the Committee's report, which included the State Coroner's Office and the Victorian Institute of Forensic Medicine, to consider the report and the operational and funding implications

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[1] Victorian Parliament Law Reform Committee, *Coroners Act 1985 - Final Report*, September 2006, p xliii

[2] Office of the Attorney-General, Media Release, 'Statement from Attorney-General Rob Hulls', 21 July 2006, www.dpc.vic.gov.au/pressrel

[3] Victorian Parliament Law Reform Committee, Media Release, 'Parliamentary inquiry recommends reform to the coroners service', 14 September 2006, www.parliament.vic.gov.au/lawreform

for different agencies. The steering committee has identified a range of issues arising from the Committee's recommendations, as well as alternative ways to address the issues raised by the report. The steering committee's discussions have informed this response.

It is also proposed that there be further consultation with the legal and medical professions, community groups and families before the detail of changes is determined.

This response describes the actions that have been implemented or that the Government and other agencies are taking to address the issues raised by the Committee, and sets out the Government's plans for the development of longer term reform.

Death certification and reporting of deaths to the coroner

The Committee's report notes that an effective coronial system depends on an effective system of death certification, so that deaths that should be reported to the coroner for investigation are in fact reported to the coroner.

Doctors currently have obligations to certify and report deaths under the *Births, Deaths and Marriages Registration Act 1996* and the *Coroners Act 1985*. Other persons (for example, other health professionals) who have reasonable grounds to believe that a death should have been reported to a coroner, but has not been, also have an obligation to report the death under the *Coroners Act 1985*.

The Committee's report proposes legislative changes that they believe will promote timely verification of the fact that a person has died and accurate certification of the cause of death, including by replacing certification by a single doctor with a more team-based approach in some cases.

The Committee has also recommended measures to address concerns that doctors are under-reporting deaths to the coroner, including better training for doctors about their legal obligations, increased penalties for non-compliance and further research.

In addition, the Committee's report proposes a new system of independent medical scrutiny of all death certificates in Victoria.

Verification and certification of death

Verification and certification of death currently takes place within the health system and the Government believes that reforms to these processes are best promoted using the expertise available to that system, without shifting responsibility or creating a new system.

The Government is already taking action to support the health system in response to some of the Committee's recommendations. The Department of Human Services is working on a protocol for the most timely verification of death pending consideration of the need for legislative reform (recommendation 1). The Government will be referring the Committee's recommendations regarding Medicare benefits for death and cremation certificates to the Commonwealth Government (recommendation 27).

The Government will also consult with health stakeholders about possible improvements to the certificates submitted by doctors. The Government will clarify doctors' legal obligations in cases where they certify deaths without viewing the body of the deceased,

and consult further regarding whether they should be required to explain why they can certify the cause of death in those circumstances (see recommendation 25(b)(i)).

The Committee's proposals to impose additional legal obligations on doctors, including team-based certification, raise more difficult issues (recommendations 6 and 25-26). Although the Government supports efforts to improve accuracy, it is concerned that complying with these additional obligations would delay the certification process.

The Government notes that Victoria's health system already has its own quality assurance systems in place. The Government considers that these processes, along with the other reforms outlined in this response, are a more efficient way to address the issues raised by the Committee.

Reporting of deaths to the coroner

While the Committee's report has noted the absence of comprehensive statistics and research regarding reporting of deaths to the coroner,[4] the Government acknowledges the Committee's concerns about the potential for under-reporting.

Individual doctors are responsible for complying with their reporting obligations under the *Coroners Act 1985*. There are penalties for failing to report deaths and non-compliance may constitute professional misconduct.

The coronial system is already working with the health system to help doctors meet their reporting obligations. The Victorian Institute of Forensic Medicine has published guidance on reporting requirements in conjunction with the Medical Practitioners Board of Victoria. The State Coroner's Office has established a forum for discussion with public hospitals, and is working with the Department of Human Services on emerging issues.

The Government will examine additional ways to support doctors and other health professionals. The Government will clarify the types of deaths that should be reported to the coroner,[5] and will examine non-legislative options to improve education and information about the coronial system (see recommendations 5 and 33-34).

The Government will also examine ways to hold doctors who ignore the law more accountable. While the Government is not convinced that the Committee's particular recommendations would be effective (recommendations 3 and 15), it will review the penalties for failing to report deaths and arrangements for referral to disciplinary bodies.

The Government also supports further research in this area (recommendation 4), but considers that it would be preferable to wait until these and related reforms have had a chance to take effect. In the meantime, the Government will review the need for collection of additional mortality statistics (recommendation 2). Improved data-sharing between coronial and health agencies will also ensure that reporting trends can be monitored more easily in the future.

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[4] Victorian Parliament Law Reform Committee, *Coroners Act 1985 - Final Report*, pp 39, 47-48

[5] See discussion about reportable deaths on p 4

Scrutiny of death certificates

The Government appreciates the Committee's views about the potential for scrutiny of death certificates to help detect criminal behaviour or medical error by doctors.

The Government took steps to improve the scrutiny of death certificates following the inquiry into Dr Harold Shipman's conviction for murdering 15 patients in the United Kingdom. Since 2003 the Registry of Births, Deaths and Marriages has been routinely reviewing certificates provided by doctors and referring appropriate cases to the coroner.

The Government places a high priority on quality assurance and continuous improvement in the health system to reduce the risk of medical error by doctors.

The fact that other members of the community can report suspicious deaths to the coroner in Victoria also ensures that reporting does not depend solely on individual doctors.

The Committee's proposal for further medical review of death certificates by the Victorian Institute of Forensic Medicine raises difficult issues (recommendations 7-14). In 2005 there were 32,606 deaths registered in Victoria.[6] Reviewing each of these certificates and following up possible lines of inquiry would require considerable medico-legal resources and significant funding. The Government is conscious that there was little consensus amongst the submissions to the Committee about whether this system offered the most appropriate solution. The Government is also conscious that there could still be no guarantee that such a system would in fact detect conduct like that of Dr Shipman.

For these reasons, the Government will focus on strengthening existing monitoring systems in Victoria, including improving the Registry of Births, Deaths and Marriages' capacity to analyse reporting statistics for unusual or suspicious trends. The Government will continue to work with the State Coroner's Office and others to examine ways to strengthen these monitoring systems.

Reportable deaths and fires

The Committee has recommended legislative amendments to clarify the types of deaths that are reportable to the coroner under the *Coroners Act 1985*, particularly deaths involving health procedures and deaths in custody.

The Committee's report also proposes extending the coroner's power to investigate other types of deaths, including mental health-related deaths and deaths in aged care. The Committee has recommended increased liaison between the State Coroner's Office and Corrections Victoria regarding the deaths of former prisoners, and further consideration of whether particular workplace deaths should be reported to the coroner.

Although the Committee's report focuses on death investigations, the Committee has recommended that coroners retain their existing power to investigate non-fatal fires.

Clarifying the coroner's jurisdiction

The Government appreciates the Committee's view that there is a need to clarify which kinds of health procedure-related deaths should be reported to the coroner. The

[6] Australian Bureau of Statistics, *Deaths, Australia 2005*, 2006, p 32

Government will work with health stakeholders to make this clearer in the development of the new Act (recommendations 16-18).

The Government will also examine ways to bring the Act into line with the Royal Commission into Aboriginal Deaths in Custody's definition of 'death in custody' (recommendation 19). Coroners have construed their powers widely in this area and the Government will give a clearer legislative basis to this practice in the new Act.

Extending the coroner's jurisdiction

The boundaries of the coroner's jurisdiction are defined by the public interest. This ensures that coroners are able to investigate those deaths which require independent and public oversight. It helps the coronial system to target its resources effectively. It also recognises that coronial investigations represent state intervention in a private experience for families and should be limited to appropriate cases.

The coroner's existing jurisdiction under the *Coroners Act 1985* is already broad and covers many of the deaths falling within the expanded jurisdiction proposed by the Committee.

The deaths of mental health patients in private hospitals and persons subject to community treatment orders, for example, are already reported under the *Coroners Act 1985* (recommendations 21 and 22).

Corrections Victoria reports the deaths of persons on parole or serving orders in the community under the supervision of Community Correctional Services to the coroner.

The *Coroners Act* 1985 also requires all deaths that appear to have been unexpected, unnatural or violent or to have resulted from accident or injury to be reported to the coroner, regardless of where they occur or the status of the deceased.

The Government will review the definition of 'in care' deaths as it applies to children under the new *Children, Youth and Families Act 2005* and persons with a disability as defined by the new *Disability Act 2006* to ensure that it remains current and appropriate (recommendations 20(a) and (b) and 23).

The Government is concerned, however, that the Committee's other recommendations will only serve to bring a number of additional deaths from natural causes into the coronial system (recommendations 20(c) and (d) and 31), or create substantial administrative obligations for agencies (recommendation 24). There are other offices and agencies that already monitor or investigate some of these areas, such as the Commonwealth Department of Health and Ageing.

The Government considers that, at this stage, the coronial system's resources would be more effectively used by concentrating on its core responsibility to investigate those accidental and suspicious deaths already covered in the *Coroners Act 1985*.

Fires

Although the coroner's powers to investigate fires under the *Coroners Act* 1985 are extensive, coronial investigations into fires have been relatively rare in Victoria. In

practice, the State Coroner and emergency services agencies work together in accordance under the *Victorian Fire Investigation Policy and Procedures*.

The Government accepts the Committee's view that coroners can play a valuable leadership and coordinating role in fire investigations and that their powers should be retained. The Government supports the Committee's recommendations (recommendations 68 and 69) and will work with the State Coroner's Office and emergency services agencies to ensure that the new Act better reflects current practice.

Death investigations and inquests

The Committee's report includes a series of recommendations designed to improve investigations and inquest processes.

Missing persons

The Government supports the Committee's recommendation that Victoria Police and the State Coroner's Office develop guidelines for reporting missing persons to the coroner (recommendation 35). The agencies have advised that they are already working to develop guidelines in response to findings made by the State Coroner in August 2006.[7]

Legal advice has confirmed that pre-1999 inquests into unidentified persons can continue without the legislative amendments proposed by the Committee (recommendation 36).

Stillbirths

The Government acknowledges that the submissions to the Committee contained conflicting views on whether coroners should have jurisdiction to investigate stillbirths. The Government accepts the Committee's recommendation that stillbirths continue to be investigated by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity rather than the coroner (recommendation 37).

The Government is preparing legislation that will clearly identify the Council's functions. The Department of Human Services has reviewed the Council's role, powers and functions in the course of its consultations regarding this legislation (recommendation 38).

Training for coroners

The role of the coroner is a specialised one that requires skills beyond those traditionally associated with judicial officers and lawyers. In addition to expertise in the law and legal processes, coroners need skills in investigation management, knowledge of medico-legal and public health and safety issues and an understanding of the needs of grieving families.

The Government supports ongoing training and education for coroners. The Government established the Judicial College of Victoria to keep judicial officers in touch with the community and up to date with developments in the law. The College includes information about its training activities in its annual reports.

The State Coroner's Office is working with the Judicial College to develop an appropriate training package for coroners in 2007 and future years (recommendations 50-51 and 79).

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[7] Coroners Case No 3407/96

The State Coroner's Office is also developing targeted information for new coroners and staff, including those in regional Victoria.

Investigative assistance

Coroners also require the assistance of expert investigators to carry out their functions effectively, including police officers, lawyers and other specialists.

Although the Committee has recommended that coroners should have the power to direct police officers concerning coronial investigations (recommendation 42), the Government appreciates Victoria Police's concern about its independence and the competing interests faced by its officers. The Government will work with Victoria Police and the State Coroner's Office to examine alternative ways to address the issues raised by the Committee.

The Committee has also recommended that coroners be required to appoint a lawyer to assist with investigations into deaths in custody and police-related deaths (recommendations 43 and 44). The Act already gives the coroner the discretion to appoint counsel assisting and coroners have done so in appropriate cases. The Government will consider the need for legislative amendments in the development of the new Act.

The Government will consider the need for legislative provisions to support coroners' use of specialist advisers as well (recommendation 45). The Government also funds the Clinical Liaison Service and Work-Related Liaison Service to assist coroners with health related and work related deaths respectively and will review those Services to ensure that they are structured and funded appropriately (see recommendation 76).

Other recommendations

The Committee's recommendations in relation to warrant powers and procedures (recommendation 41) and the privilege against self-incrimination (recommendations 61-65) will be considered in the context of ongoing work on a new Warrants Act[8] and the implementation of the Uniform Evidence Act in Victoria.

Other recommendations raise legislative and procedural issues that will be considered in the development of the new Act, with a particular emphasis on fair, efficient and timely investigations and appeals (recommendations 28, 29, 39, 40, 52-56, 59-60, 66-67, 80, 112-114 and 125).

In light of the recent review of the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody,[9] the Government will also take the opportunity to review the Commission's recommendations on coronial investigations in consultation with the indigenous community.

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[8] Government Response to the Victorian Parliament Law Reform Committee's Warrant Powers and Procedures Final Report, May 2006, www.parliament.vic.gov.au/lawreform/

[9] Victorian Department of Justice, *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody*, 2005

Support for families

The Committee's report notes that officers in the coronial system have made improvements to help support families and others affected by sudden death, but concludes that the needs of families can only be adequately protected by legislation.

The Committee has recommended legislative amendments to create a series of rights for families, to regulate the conduct of autopsies and to protect privacy (recommendations 90, 94-96, 98-101, 106-111, 116-117, 119-120, 122-125, 127).

The Committee has also recommended initiatives to improve coronial services, including minimising delays, addressing cultural issues, increasing legal assistance and improving information and counselling (recommendations 97, 104-105, 113-115, 118, 126, 128).

The Government expects grieving families to be treated with compassion and respect and expects the coronial system to be sensitive to their needs.

The Government will rewrite the Act to enshrine support for families in the objects of the Act (recommendation 90) and to introduce principles to guide coroners and staff in relation to the conduct of autopsies and the role of families in coronial investigations. The Act will also preserve appropriate rights such as the right to object to an autopsy.

The Government will consider supporting upgraded services as well, particularly through staff training, counselling and better identification facilities.

The Government will consult families in Melbourne and regional Victoria in shaping the detail of these changes.

The autopsy provisions in the *Human Tissue Act 1982* are based on national uniform legislation and the Committee's recommended amendments to that Act (recommendation 110) will require consideration at a national level.

In the meantime, the State Coroner's Office and the Government are already taking action to address many of the issues raised by families and the Committee:

- the State Coroner's Office will be implementing a new case management system in mid-2007 that will minimise the length of investigations (recommendation 97);
- the State Coroner has issued advice that autopsies should only be ordered by coroners and delegations to staff have been reviewed (recommendation 105);
- the State Coroner's Office has reviewed its records management practices and has improved security for medical files (recommendation 119) and other sensitive information (recommendation 121). The State Coroner's Office will also be engaging a records manager in early 2007;
- the Government is working with the courts on new legislation regulating access to court documents, including documents held by the State Coroner's Office. The Department of Justice is working with the State Coroner's Office, the Office of the Victorian Privacy Commissioner and the Health Services Commissioner as part of this process (recommendations 116-118 and 122).
- counselling and support services for grieving families have been reviewed by a group of experienced clinicians (recommendation 126). New staffing arrangements are

being implemented in March 2007 to ensure continuous access to counselling and information across the state; and
- an updated booklet for families on the coronial process has been published and distributed, along with multilingual information sheets (recommendation 128).

The Government and State Coroner's Office are going beyond the Committee's recommendations to improve support for families in other ways:

- coroners and staff at the State Coroner's Office have completed training on grief and bereavement issues, which will continue on an ongoing basis;
- a new Quality Improvement Officer at the State Coroner's Office has implemented a complaints policy to respond to concerns raised by families at an early stage and to identify areas for improvement. As of January 2007, all outstanding complaints had received a response; and
- the identification suite at the Coronial Services Centre has been refurbished to make it more welcoming for families and more sensitive to different cultural needs. New staffing arrangements will be introduced in March 2007 to ensure that counsellors are available to assist families.

The Government is conscious that different families will have different needs and that, in a diverse community, the coronial system needs to be sensitive to different cultural and religious practices surrounding death. The Government will consider the need for modern and culturally relevant definitions of family (recommendations 91-93). The State Coroner's Office is also establishing a cultural diversity role to address cultural issues (recommendations 102-103).

The Government is also conscious that there are circumstances in which the needs of families need to be balanced against broader public interests in an investigation, for example in cases where the death may have resulted from criminal activity. These issues will also be taken into account in shaping the detail of reforms in this area.

The coroner's role in prevention of death and injury

The Committee endorses the coronial system's growing focus on prevention of future deaths and injury in its report.

The Committee has recommended measures to enhance this role, including by formally recognising it in the Act, improving the operation of the National Coroners Information System (NCIS) and encouraging liaison between coroners and other agencies. The Committee's recommendations also focus on ways to increase the number and quality of coroners' recommendations and support a trial of the informal conferencing model used by coroners in Ontario.

The Committee's report also stresses the need for proper consideration of coroners' recommendations. The Committee has recommended legislative changes that would require formal responses to recommendations, wider publication of both recommendations and responses and give new powers for coroners to call for further information.

Strengthening the prevention and safety role of the coronial system

The Government is committed to building friendly, confident and safe communities in Victoria.[10] The coronial system is in a unique position to contribute to this goal. Coroners obtain valuable information about sudden and accidental deaths during investigations that can be used to identify public health and safety issues. This is well demonstrated by the recall of Mistral cooling fans following the deaths of two young children and the more recent introduction of compulsory life jackets on recreational boats.

The Government has worked with the State Coroner's Office and the Victorian Institute of Forensic Medicine to support the system's contribution to public health and safety. The Government supports the NCIS, a national database of coronial information that is managed by the Victorian Institute of Forensic Medicine. The Government also funds the Clinical Liaison Service and Work Related Liaison Service to help coroners identify prevention issues in health-related and work-related investigations respectively.

Some of the Committee's recommendations for further reform are being addressed. The NCIS's Strategic Plan for 2007-2012, for example, addresses the need to increase coroners' use of the NCIS and to widen access for other agencies and organisations. The NCIS is a joint Commonwealth-state initiative, however, and implementation of the Committee's recommendations about the NCIS will require national consideration (recommendations 71-74, 86 and 123-124).

The Government will also consider ways to incorporate prevention and safety in the objects of the new Act (recommendation 70) and to strengthen the coronial system's ability to contribute to prevention and safety initiatives.

The Government agrees with the Committee's view that care needs to be taken in the way this preventative focus is developed.[11] A prevention focus requires different skills and can involve different timeframes to the coroner's traditional investigative role. Coroners currently make recommendations about prevention and safety in their findings about deaths. In some cases, consideration of these issues has the potential to delay findings, causing additional distress for those involved. In others, the requirement to make findings in individual cases may limit the coroner's ability to examine broader systemic issues.

The Government also agrees that coroners' prevention work requires collaboration with specialist safety agencies (recommendation 75) but notes that this should be carried out in a way that is not seen to compromise the independence of individual investigations.

For these reasons, the Government will work with the State Coroner's Office on prevention and safety issues in the development of the new Act, rather than implementing the Committee's specific recommendations (recommendations 77, 81 and 87-89).

Consideration of coronial recommendations

The Government appreciates that coroners' work to prevent deaths and injuries will not be effective if coronial recommendations are not widely distributed. The Government also appreciates the frustration felt by some families at what appears to be a failure to respond to coronial recommendations.

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10 *Growing Victoria Together: A Vision for Victoria for 2010 and Beyond*, www.dpc.vic.gov.au

11 Victorian Parliament Law Reform Committee, *Coroners Act 1985 – Final Report*, p 382

The Attorney-General currently refers findings provided by the State Coroner's Office to relevant ministers and seeks their advice on implementation. A number of agencies have established systems for monitoring and responding to coronial recommendations. WorkSafe, for example, holds regular meetings with coroners at which it tables and discusses its written responses to recommendations. The Department of Human Services has established a Coroners Inquest Working Group to coordinate the distribution and consideration of coronial findings and responses to the State Coroner.

The Government considers that these existing processes can be improved to meet the concerns of families and the Committee without resort to legislative amendments (recommendations 82-85).

The Government will work with the State Coroner's Office to promote more efficient and timely distribution of coronial findings and better monitoring of responses. The Government will also work with the State Coroner's Office to introduce greater transparency and accountability into these processes through wider publication and distribution of recommendations and responses.

The State Coroner and the State Coroner's Office

The Committee's report suggests a number of ways to improve administration and governance across the coronial system.

The Committee's recommendations include measures to strengthen the offices of the State Coroner and Deputy State Coroner and to reinforce the coronial system's non-adversarial, inquisitorial character. They address the need for coordination of investigations and improvements to case management and services across the state. The Committee has also recommended a new Coronial Council to provide advice and direction to the coronial system as a whole.

Independence and status

Public trust and confidence in the integrity of coronial investigations is critically important. The independence of individual coroners helps to secure that trust.

The Government will consider ways to clarify and strengthen the status of the State Coroner and the State Coroner's Office (recommendations 130-132). The State Coroner's Office already reports through the Magistrates' Court's annual report and the Government will also consider ways to strengthen those reporting arrangements (recommendation 85).

The Government appreciates the Committee's concern that the coronial system has become too adversarial and will look at ways to reinforce the system's inquisitorial character. The Committee's report notes the important role played by the legal profession in this area and the Government has referred the Committee's recommendation on training for lawyers to the Law Institute of Victoria (recommendation 129).

Coordination of coronial services

Public trust and confidence in coronial investigations also depends on the timeliness and quality of coronial services.

The State Coroner's coordinating role in the coronial system helps to promote consistent and effective coronial investigations. Some of the Committee's recommendations are directed to the State Coroner and are matters for his consideration in the independent exercise of his functions (recommendations 30, 78 and 134-135). The Government has appointed a Chief Executive Officer at the State Coroner's Office to drive reform at an administrative level and will explore ways to strengthen the State Coroner's leadership role in the development of the new Act (recommendations 46-48, 98 and 136-137).

The Government notes the Committee's emphasis on case management and supports measures to improve efficiency and timeliness, subject to proper legal processes. As noted earlier, the State Coroner's Office is implementing new case management systems by mid-2007 (recommendation 97). The State Coroner's Practice Manual already addresses the circumstances in which an inquest should be held following a criminal proceeding and the State Coroner's Office has advised that it supports further work on the impact of criminal proceedings on inquests (recommendations 57-58).

The Committee's report also notes the particular challenges involved in providing services in regional areas and recommends that the State Coroner's Office prioritise the improvement of the delivery of coronial services to these areas (recommendation 133).

The Government agrees that, wherever possible, families and communities in regional Victoria should have access to the same standard of coronial services as those in Melbourne.

The Government has provided additional funding to the Victorian Institute of Forensic Medicine from 2006-07 to help increase access to forensic pathology services in regional Victoria. The State Coroner's Office is reviewing its procedures manual and case management systems across the state and, as noted earlier in this response, steps are being taken to make training available to coroners and coronial staff.

The Government will convene a working group with the Magistrates' Court, the State Coroner's Office and the Victorian Institute of Forensic Medicine to provide advice on other ways to improve the availability and quality of coronial services in regional Victoria.

Coronial Council

The Government supports the Committee's proposal for a new Coronial Council to provide advice and guidance to the coronial system as a whole.

Coronial investigations affect families, witnesses, the legal and health professions, industry and community groups. A Council would play a valuable role in keeping the system in touch with these broader community perspectives and relevant research. The Government will work with the State Coroner's Office and other stakeholders to develop this initiative (recommendations 32, 49 and 138).

Conclusion

The Government recognises the contribution made by the many individuals and organisations who participated in the Committee's review, particularly those families who shared their personal experiences with the coronial system.

It also acknowledges the Committee's work towards improving the coronial system so that it meets the needs of Victoria into the 21st century.

The Government and coronial system have already started the process of reform. The Government is committed to continuing this work, in consultation with families and the community, to develop better coronial services and a new Coroners Act.

VICTORIAN PARLIAMENT LAW REFORM COMMITTEE, *CORONERS ACT 1985* – FINAL REPORT
SUMMARY OF RESPONSE TO RECOMMENDATIONS

Recommendation		Government Response	Page Reference
1	That legislation be enacted which requires a doctor, nurse, paramedic or other suitably qualified person to provide a certificate which verifies the fact that a person has died. Such certification must only occur following a clinical assessment of the body (which would include an examination of the body) to establish that death has occurred and must include information in the certificate which details the circumstances of the death including a record of any injuries observed on the body and any information about the death which should be referred to the coroner.	Verification of death procedures supported in principle. Protocol under development pending consideration of legislative reform.	Page 2
2	That the Australian Bureau of Statistics in conjunction with the Registrar of Births, Deaths and Marriages consider including, along with the mortality data it currently collects, statistical information which indicates the type of place where deaths occur.	Collection of mortality statistics to be reviewed.	Page 3
3	That section 13(3)(d) of the *Coroners Act 1985* be amended so that the maximum penalty for doctors who fail to report a notifiable death to the coroner be increased to five years imprisonment and a fine of 600 penalty units.	Alternative accountability measures to be considered in development of new Act.	Page 3
4	That the State Government resource a research project to further investigate incidences of under-reporting of deaths to the coroner and that an analytical report on the data be prepared and published.	Supported in future years following implementation of other initiatives.	Page 3
5	That the Victorian Institute of Forensic Medicine in consultation with the State Coroner's Office review the level of training currently provided to students, interns and overseas trained doctors with a view to developing a consistent training programme that could be used by the Medical Practitioners Board of Victoria and all medical schools in Victoria.	Improved education and information for doctors supported in principle.	Page 3
6	That the *Births, Deaths and Marriages Registration Act 1996* be amended to include a requirement that junior doctors who certify hospital deaths be required, wherever practicable, to have the certification reviewed and endorsed by a more senior doctor who was not responsible for treating the patient before his or her death. If the review does not endorse the certificate, the reviewer must report the death to the coroner.	Alternative quality assurance processes in health system supported.	Page 3
7	That a medical review process for death certification be introduced so that all medical certificates of cause of death are reviewed by medical specialists at the Victorian Institute of Forensic Medicine, following the release of the body to the family, to establish whether further review of the death is required.	Alternative measures to strengthen existing review processes supported.	Page 4

Recommendation		Government Response	Page Reference
8	That where further review is necessary, this is to include the review of the medical case file, discussions with the doctor who certified the death and other medical personnel who were involved in treating the person before s/he died, along with consultation with family members and carers.	See recommendation 7.	Page 4
9	That the medical review process incorporate a triage approach to the review in which medical specialists at the Victorian Institute of Forensic Medicine would recommend which reported cases require further death investigation and which can be completed by a medical death investigation report.	See recommendation 7.	Page 4
10	That legislation be enacted which requires the Registrar of Births, Deaths and Marriages to transmit a copy of the medical cause of death certificate to the Victorian Institute of Forensic Medicine within 24 hours of lodgement of the certificate at the Registry.	See recommendation 7.	Page 4
11	That, in the event that a system is developed which allows doctors to submit certificates online, legislation be developed which permits the Victorian Institute of Forensic Medicine to access the live data in that system.	See recommendation 7.	Page 4
12	That the Victorian Institute of Forensic Medicine establish a computerised auditing system which enables patterns of unusual death rates to be identified and then further investigated, and that the Victorian Institute of Forensic Medicine provide regular reports on auditing outcomes to the State Coroner.	See recommendation 7.	Page 4
13	That the medical specialists at the Victorian Institute of Forensic Medicine be required to promptly report to the State Coroner all incidences in which doctors have failed to notify the coroner of a reportable death.	See recommendation 7.	Page 4
14	That the State Government resource the proposed medical review process and auditing system so that the Victorian Institute of Forensic Medicine is able to recruit, fund and manage a range of general and specialist medical practitioners and to train them in medicolegal work.	See recommendation 7.	Page 4
15	That the *Coroners Act 1985* be amended to require the State Coroner to submit to Parliament an annual report which includes information on the number of reportable deaths which were not reported to the coroner during that year. The report must also include a summary of the action the State Coroner took in relation to each incident, including whether the State Coroner referred the matter to the Medical Practitioners Board of Victoria for possible investigation into a medical practitioner's conduct.	Alternative accountability measures to be reviewed in development of new Act.	Page 3
16	That the *Coroners Act 1985* be amended to remove the word 'unexpected' from the definition of the term 'reportable death'.	Definition of reportable death to be clarified in new Act, subject to further consultation.	Page 5

Recommendation		Government Response	Page Reference
17	That the *Coroners Act 1985* be amended to include, within the definition of reportable death, health procedure deaths which doctors should report to the coroner. The provision should: a) be modelled on the Queensland provision and guidelines; and b) have an additional requirement that the category also include deaths 'where the death from a particular cause was potentially avoidable or preventable had the clinical management had been different'.	Definition of reportable death to be clarified in new Act, subject to further consultation.	Page 5
18	That the *Coroners Act 1985* be amended to remove the words 'that occurs during an anaesthetic' and 'that occurs as a result of an anaesthetic and is not due to natural causes' from the definition of the term 'reportable death'.	Definition of reportable death to be clarified in new Act, subject to further consultation.	Page 5
19	That the *Coroners Act 1985* be amended to extend the definition of a death in custody to include the death wherever occurring of a person: a) who is in prison custody or police custody or detention as a juvenile or detention under a Commonwealth law; b) whose death is caused, or contributed to, by traumatic injuries sustained, or by lack of proper care while in such custody or detention; c) who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and d) who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention or detention under a Commonwealth law.	Amendments to adopt Royal Commission into Aboriginal Deaths in Custody's recommended definition of death in custody supported in principle.	Page 5
20	That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include the following persons: a) all children in the custody or guardianship of the state under the *Children and Young Persons Act 1989* (or the *Children, Youth and Families Act 2005* when this is proclaimed); b) children on interim accommodation orders; c) children whose care was temporarily delegated to a child care facility or educational institution such as a crèche, kindergarten or school; and d) children who at the time of death were residing at a youth or women's refuge which was operated with funding provided by the State or Federal Government for the purposes of providing a refuge.	(a) and (b) – definition of 'person held in care' to be reviewed in context of *Children, Youth and Families Act 2005.* (c) and (d) – not supported at this stage.	Page 5
21	That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person subject to a community treatment order.	Not required. Deaths already reported to the coroner.	Page 5

Recommendation		Government Response	Page Reference
22	That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person who at the time of death was undergoing treatment as a mental health patient at a private hospital.	Not required. Deaths already reported to the coroner.	Page 5
23	That the *Coroners Act 1985* be amended to extend the definition of 'in care' to include a person with a disability as defined under section 3 of the *Disability Act 2006*, who: a) was living in a residential care service or a supported residential service as defined under section 3 of the *Health Services Act 1988*; or b) was receiving residential services operated, or wholly or partly funded, by the Department of Human Services.	Definition of 'person held in care' to be reviewed in context of *Disability Act 2006.*	Page 5
24	That the Coroner's Office, in conjunction with the Office of the Correctional Services Commissioner, implement and develop guidelines to govern a system whereby, within 72 hours of a death being reported to the coroner, a request is made to the Office of the Correctional Services Commissioner to establish whether that person has been released from custody in the preceding 12 months, and where this is the case, that the coroner provide a copy of the findings in the case to the Office of the Correctional Services Commissioner at the completion of the inquiry or inquest.	Deaths of persons on parole or serving orders in the community under the supervision of Community Correctional Services already reported to the coroner.	Page 5
25	That the *Births, Deaths and Marriages Registration Act 1996* be amended so that, as part of the death certification requirements: a) a doctor is required to undertake an external examination of the body when completing the medical certificate of the cause of death (MCCD), wherever this is practicable; and b) where a doctor has not examined the body, the doctor is required to: i) state on the MCCD why s/he is satisfied that s/he can certify the death accurately without examining the body; and ii) indicate on the form that s/he is satisfied that the care and attention afforded to the person who died was reasonable and had no bearing on the death.	(a) and (b)(ii) – alternative quality assurance processes in health system supported. (b)(i) - further consultation with health stakeholders and clarification of reporting obligations under *Coroners Act 1985* supported.	Page 3
26	That the *Births, Deaths and Marriages Registration Act 1996* be amended so that, as part of the death certification requirements, an independent doctor undertakes an external examination of the deceased's body if the person, prior to his or her death, had resided at: a) a high care residential aged care service or accommodation under the Commonwealth Residential Aged Care Programme; or	Alternative quality assurance processes in health system supported.	Page 3

Recommendation		Government Response	Page Reference
	b) a low care residential aged care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; or c) a respite care service where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; or d) supported accommodation provided on a private basis such as Supported Residential Services.		
27	That the State Government raise with the Commonwealth Government the need for death and cremation certificates to be recognised under the Medicare Benefits Schedule as services attracting Medicare benefits.	To be referred to Commonwealth Government.	Page 2
28	That, in relation to reviewable deaths, the *Coroners Act 1985* be amended so that it specifies that the obligation of the Victorian Institute of Forensic Medicine to investigate, assess and instigate responses in relation to: a) the health and safety of a living sibling of a child who has died; and b) the health of a parent of a child who has died ceases when the Victorian Institute of Forensic Medicine provides a report to the State Coroner on the action taken by it in relation to a reviewable death, unless the State Coroner requests that the Victorian Institute of Forensic Medicine undertake further investigations or assessments in relation to the death.	Amendments to be considered in development of new Act.	Page 7
29	That section 22A of the *Coroners Act 1985* be amended to replace the word 'may' with 'shall'.	Amendments to be considered in development of new Act.	Page 7
30	That the State Coroner and the Victorian Institute of Forensic Medicine establish standards for the investigation of reviewable deaths.	Recommendation directed to State Coroner and the Victorian Institute of Forensic Medicine.	Page 12
31	That the Coroner's Office and the Victorian Institute of Forensic Medicine implement a system in which the directors of certain aged care facilities are required to notify the coroner of the deaths of all residents, and that an appropriate agreed number of these notifiable deaths, but not less than 10 percent, be investigated by the State Coroner. The category of institutions required to notify the coroner include: a) high care residential aged care service or accommodation under the Commonwealth Residential Aged Care Programme; b) a low care residential aged care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme;	Not supported at this stage. Commonwealth responsible for monitoring aged care standards.	Page 5

Recommendation		Government Response	Page Reference
	c) respite care services where the person was receiving approved high care services under the Commonwealth Residential Aged Care Programme; or d) supported accommodation provided on a private basis such as Supported Residential Services.		
32	That the proposed coronial council consider the following issues: a) whether particular workplace deaths, such as deaths from industrial diseases or deaths where employment or previous employment may have been connected with the death, should be reported to the coroner; and b) how such deaths should be reported and investigated.	See recommendation 138. Development of coronial council supported in principle, subject to further consultation.	Page 12
33	That the *Coroners Act 1985* be amended to include, as a function of the State Coroner, the responsibility to provide ongoing education of the medical profession and the public, to increase awareness of the obligation to report reviewable and reportable deaths.	Improved education and information for doctors supported in principle.	Page 3
34	That the State Government provide ongoing funds to resource this function.	See recommendation 33.	Page 3
35	That Victoria Police and the Coroner's Office formally develop guidelines for the reporting of missing persons to the coroner.	Supported. Guidelines under development.	Page 6
36	That consideration be given to amending section 59A of the *Coroners Act 1985* to apply the provision retrospectively.	Not required.	Page 6
37	That stillbirths continue to be investigated by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and not the coroner, and that this be clarified in the *Coroners Act 1985*	Supported in principle. Amendments to be considered in development of new Act.	Page 6
38	That the Department of Health review the role, functions and powers of the Consultative Council on Obstetric and Paediatric Mortality and Morbidity to determine whether they are adequate to undertake a comprehensive investigation of stillbirths	Supported in principle. Role, functions and powers already reviewed.	Page 6
39	That section 17(3) of the *Coroners Act 1985* which gives a coroner the discretion not to hold or recommence an inquest where a person has been charged with and convicted or acquitted of certain offences, be amended by removing the words 'child destruction' from the section.	Amendments to be considered in development of new Act.	Page 7
40	That the *Coroners Act 1985* be amended to provide that: a) where it appears to a coroner that a death may be a reportable death, a coroner may undertake a preliminary investigation of the death to establish whether the death is a reportable death;	Amendments to be considered in development of new Act.	Page 7

Recommendation		Government Response	Page Reference
	b) a person may apply to the State Coroner for a review of a coroner's decision, following preliminary investigation, that a death is or is not a reportable death; and c) a person may apply to the Supreme Court for a review of the State Coroner's decision reviewing a coroner's decision that, following preliminary investigation, a death is or is not a reportable death.		
41	That the *Coroners Act 1985* be amended to provide that: a) the Coroner's Office is required to create and maintain a search warrants register and to record the information set out in recommendation 18 of the Victorian Parliament Law Reform Committee report *Warrant Powers and Procedures: Final Report*; b) the Coroner's Office is required to provide information about search warrants and warrant-like powers to persons in the place to be searched, as set out in recommendation 47 of the Victorian Parliament Law Reform Committee report *Warrant Powers and Procedures: Final Report*; and c) on the completion of an inquest or inquiry, a coroner must take all reasonable steps to give anything taken or seized, to the person whom the coroner reasonably believes to be legally entitled to it.	To be considered in context of development on new Warrants Act.	Page 7
42	That the *Coroners Act 1985* be amended to provide that a coroner may give a police officer directions concerning investigations to be carried out for the purposes of an inquest or inquiry into a death or suspected death, whether or not the inquest or inquiry has commenced.	Alternative measures to be considered.	Page 7
43	That the *Coroners Act 1985* be amended to provide that a coroner holding an investigation into a death in custody, a police-related death or a death of an on-duty police officer, must appoint a lawyer or other appropriately qualified person to assist the coroner at an early stage of the investigation and at an inquest, and that the State Government provide funding to the Coroner's Office to enable these appointments.	Appointment of counsel assisting in appropriate cases supported in principle. Amendments to be considered in development of new Act.	Page 7
44	That the duties of the investigator, subject to the direction of the coroner are to: a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and b) ensure that at the inquest all relevant evidence is brought to the coroner and tested.	See recommendation 43	Page 7

Recommendation		Government Response	Page Reference
45	That the *Coroners Act 1985* be amended to provide that a coroner may appoint a specialist investigator to assist with an investigation into a death. The duties of the investigator, subject to the direction of the coroner, are to: a) ensure that a full and adequate investigation is conducted into the cause and circumstances of the death; and b) identify any possible measures which may have prevented the death or similar deaths.	Appointment of specialist advisers in appropriate cases supported in principle. Amendments to be considered in development of new Act.	Page 7
46	That the *Coroners Act 1985* be amended to provide that: a) in order to ensure best practice in the coronial system, the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally; b) when preparing the guidelines, the State Coroner must have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody that relate to the investigation of deaths in custody; c) when investigating a death, a coroner must comply with the guidelines issued to the coroner to the greatest extent practicable.	Amendments to be considered in development of new Act.	Page 12
47	That the guidelines outlined in Recommendation 12 be made available to the public and be available on the Coroner's Office website.	See recommendation 46.	Page 12
48	That the State Coroner's annual report contain all guidelines which were in operation during that year.	Alternative options for publication supported in principle.	Page 12
49	That the proposed Coroner's Advisory Council assist the State Coroner to develop guidelines and standards.	See recommendation 138. Development of council supported in principle, subject to further consultation.	Page 12
50	That the *Coroners Act 1985* be amended to provide that: a) it is a statutory function of the State Coroner to provide training to coroners; b) as part of the State Coroner's annual report, the State Coroner must provide a report indicating the training that coroners have attended.	Training by Judicial College supported in principle. Training package under development.	Page 6
51	That the State Coroner and Chief Magistrate work together to support and encourage coroners, and magistrates who act as coroners, to take advantage of the training opportunities available to them.	See recommendation 50.	Page 6
52	That the *Coroners Act* be amended to provide that the purposes of an inquest are: a) to conduct a public investigation into a death which occurred in contentious circumstances in order to provide public accountability for the death;	Amendments to be considered in development of new Act.	Page 7

Recommendation		Government Response	Page Reference
	b) to provide an effective mechanism for eliciting and challenging evidence; and c) to provide a forum for interested persons to contribute to the development of coronial recommendations for the prevention of similar deaths.		
53	That the *Coroners Act 1985* be amended to include a provision modelled on the Queensland *Coroners Act 2003*, section 34, which allows a coroner to hold, and require attendance at, a pre-inquest conference.	Amendments to be considered in development of new Act.	Page 7
54	That the present categories of death investigations which attract mandatory inquests under the *Coroners Act 1985* be retained.	To be considered in development of new Act.	Page 7
55	That section 17(2) of the *Coroners Act 1985* be amended to provide that, when determining whether an inquest is desirable, a coroner must have regard to the purposes of an inquest.	Amendments to be considered in development of new Act.	Page 7
56	That the *Coroners Act 1985* be amended to provide: a) a set of broad criteria which outline the circumstances in which a multiple-death inquest may be held; b) that a person may ask the State Coroner to hold an inquest into a number of deaths that happened at different times and places but that appear to have happened in similar circumstances; c) that the State Coroner may investigate, or direct a coroner to investigate, at an inquest, a number of deaths that happened at different times and places but that appear to have happened in similar circumstances; and d) that, before deciding whether to convene a multiple-death inquest, the State Coroner must consider the views of persons with sufficient interest regarding the merits of a multiple-death inquest.	Amendments to be considered in development of new Act.	Page 7
57	That the Coroner's Office undertake a research project examining the length of time it takes to complete a coronial death investigation when the investigation is suspended pending the outcome of related criminal proceedings, with a view to taking up this issue with Victorian courts.	Consideration of impact of criminal proceedings on coronial investigations supported in principle.	Page 12
58	That the State Coroner issue guidelines to coroners regarding the circumstances in which a coroner should consider holding an inquest following the completion of related criminal proceedings.	Already implemented through State Coroner's Practice Manual.	Page 12
59	That section 17(3) of the *Coroners Act 1985* be amended to provide that if, in relation to the investigation of a death, a coroner is satisfied that one or more persons have been charged before a court with: a) dangerous driving causing death; or	Amendments to be considered in development of new Act.	Page 7

Recommendation		Government Response	Page Reference
	b) arson causing death; and one or more persons has been found guilty of the offence or acquitted or found not guilty of the offence the coroner may – i) determine not to hold an inquest; or ii) adjourn the holding of an inquest which has already commenced; or iii) if an inquest has been adjourned, determine not to recommence the inquest.		
60	That the *Coroners Act 1985* be amended to provide that, in determining whether a person has a sufficient interest for the purposes of section 45 of the Act, a coroner must consider whether: a) it is in the public interest; and b) it is consistent with the purposes of the Act; for the person to call, examine and cross-examine witnesses and make submissions at an inquest.	Amendments to be considered in development of new Act.	Page 7
61	That the *Coroners Act 1985* be amended to include a provision modelled on section 128 of the Uniform Evidence Act, incorporating recommendation 15-7 of the Uniform Evidence Law Report 2005, which requires that section 128 of the Uniform Evidence Act should apply where – a) a witness objects to giving evidence either to a particular question, or b) a class of questions; on the grounds that the evidence may tend to prove that the witness has committed an offence against or arising under an Australian law or a law of a foreign country or is liable to a civil penalty under such a law.	To be considered in context of Uniform Evidence Act.	Page 7
62	That the section referred to in recommendation 61 is to provide that: a) the coroner is to determine whether or not the claim is based on reasonable grounds; b) if the coroner is so satisfied, the coroner must inform the witness that the witness may choose to give the evidence or the coroner will consider whether the interests of justice require that evidence be given; c) the coroner may require that the witness give the evidence if the interests of justice so require, but the coroner must not do so if the evidence would tend to prove that the witness has committed an offence against or arising under a law of a foreign country or is liable to a civil penalty under a law of a foreign country; and d) if the evidence is given, either voluntarily or under compulsion, a certificate is to be granted preventing the use of that evidence against a person.	See recommendation 61.	Page 7

Recommendation		Government Response	Page Reference
63	That the *Coroners Act 1985* be amended to include a provision which provides that, in considering whether the interests of justice require that the evidence be given, a coroner must consider whether there is a compelling argument that the information is necessary to prevent further harm from occurring.	See recommendation 61.	Page 7
64	That the *Coroners Act 1985* be amended to provide that, where it appears to the coroner that a witness has been asked a question which tends to incriminate the witness, the coroner is required to inform the witness of: a) the right to object to answering a question because the evidence would tend to incriminate the witness but that the coroner may overrule the objection if the coroner considers that it is in the interests of justice for the witness to give evidence; b) the right to obtain independent legal advice; and c) the right to make an application to the coroner that the evidence be heard in camera or that the coroner place a restriction on the reporting of that evidence.	See recommendation 61.	Page 7
65	That the *Coroners Act 1985* be amended to include a provision requiring the State Coroner to issue standard written directions for coroners and witnesses advising witnesses of their rights in relation to giving evidence at an inquest, the section to provide that: a) the directions are to be used by coroners when an issue of self-incrimination arises at an inquest; and b) a copy of the directions is to be provided to all persons summoned to give evidence at an inquest at the same time as the summons is served on the person.	See recommendation 61.	Page 7
66	That section 59A of the *Coroners Act 1985* be amended to provide that a person may apply to the State Coroner for an order that some or all of the findings made without inquest are void.	Amendments to be considered in development of new Act.	Page 7
67	That section 18(3) of the *Coroners Act 1985* be amended so that it states with a greater degree of clarity that, if a coroner refuses a request to hold an inquest and gives reasons in writing for the refusal, a person may apply to the Supreme Court for an order that an inquest be held.	Appeals processes to be considered in development of new Act.	Page 7
68	That the jurisdiction of coroners under the *Coroners Act 1985* to investigate non-fatal fires be retained.	Supported in principle. Amendments to be considered in development of new Act.	Page 6
69	That section 36(1)(c) of the *Coroners Act 1985* be repealed.	See recommendation 68.	Page 6

Recommendation		Government Response	Page Reference
70	That section 1 of the *Coroners Act 1985* be amended to provide that a purpose of the Act is to help prevent deaths or fires in similar circumstances happening in the future by allowing coroners to comment and make recommendations on matters connected with deaths and fires, including matters related to public health and safety or the administration of justice.	Recognition of importance of prevention and safety in objects of Act supported in principle. Amendments to be considered in development of new Act.	Page 10
71	That the *Coroners Act 1985* be amended to recognise the existence of, and authorise the provision of data to and retrieval of data from, the National Coroners Information System, using section 93 of the *Coroners Act 2003* (Qld) as a model.	Requires consideration at national level.	Page 10
72	That increased funding be made available for the National Coroners Information System to enable the search interface and data fields of the database to be improved, and to enable further training initiatives for coroners and other agencies.	Requires consideration at national level.	Page 10
73	That the State Coroner, in conjunction with the Australian State and Chief Coroners, review the rules governing access to the National Coroners Information System database and consider whether access to the database can be made more widely available, in a way that is however consistent with applicable privacy considerations.	Requires consideration at national level.	Page 10
74	That a research unit be established within the Coronial Services Centre with the capacity to properly utilise the National Coroners Information System database, to conduct research relevant to individual cases on behalf of coroners, and to identify trends and clusters of deaths requiring further investigation.	Requires consideration at national level.	Page 10
75	That the *Coroners Act 1985* be amended to provide, using section 5 of the *Coroners Act 2006* (NZ) as a model, that one of the functions of the State Coroner is to help avoid unnecessary duplication and expedite investigation of deaths by liaison and encouragement of coordination (for example, through development of protocols) with other investigating authorities, official bodies or statutory officers.	Supported in principle. Amendments to be considered in development of new Act.	Page 10
76	That as a high priority funds be provided to the Clinical Liaison Service to extend its operation to include psychiatric expertise.	Funding for and structure of Clinical Liaison Service to be reviewed.	Page 7
77	That section 19 of the *Coroners Act 1985* be amended to include a requirement that a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety or the administration of justice.	Alternative measures to be developed in consultation with State Coroner's Office in development of new Act.	Page 10
78	That the State Coroner prepare detailed guidelines for coroners in relation to the formulation of recommendations.	Recommendation directed to State Coroner.	Page 12

Recommendation		Government Response	Page Reference
79	That the State Coroner's Office provide further training for coroners in relation to the formulation of recommendations.	See recommendation 50.	Page 6
80	That the *Coroners Act 1985* be amended to include a requirement, modelled on section 55 of the *Coroners Act 1997* (ACT), that a coroner shall not include in a finding or report under the Act a comment adverse to a person identifiable from the report unless the coroner has, prior to the making of the finding or report, taken all reasonable steps to give to the person a copy of the proposed comment and a written notice advising the person that, within a specified period (being not more than 28 days and not less than 14 days after the date of the notice), the person may: a) make a submission to the coroner in relation to the proposed comment; or b) give to the coroner a written statement in relation to it.	Amendments to be considered in development of new Act.	Page 7
81	That the *Coroners Act 1985* be amended to require that all coronial recommendations be approved by the State Coroner and be made publicly available.	Alternative measures to improve publication of recommendations supported in principle.	Page 10
82	That the *Coroners Act 1985* be amended to: a) empower a coroner to refer findings and/or recommendations to any individual or agency and require that individual or agency to provide, within six calendar months, a written response including a report as to whether any action has been taken or is proposed to be taken in response to the recommendation; b) identify those agencies and individuals to which this section applies, which at a minimum will include government departments or agencies and incorporated companies.	Alternative measures to improve distribution of recommendations and provision of responses supported in principle.	Page 11
83	That the *Coroners Act 1985* be amended to require the coroner to provide a copy of the response referred to in recommendation 82 above to: a) the senior next of kin of the person whose death is mentioned in the coroner's findings or their representative; b) a witness who appeared at an inquest into the death the subject of the findings; and c) any other person who the coroner considers has sufficient interest in the inquest or investigation the subject of the findings.	Alternative measures to improve distribution of responses supported in principle.	Page 11
84	That the *Coroners Act 1985* be amended to empower the State Coroner to call for such further explanations or information as he or she considers necessary, in relation to the implementation of recommendations.	Alternative measures to improve existing processes to be considered.	Page 11

Recommendation		Government Response	Page Reference
85	That the *Coroners Act 1985* be amended to require: a) the State Coroner to include in the Coroner's annual report to Parliament: i) a summary of all coronial investigations in which recommendations have been made; and ii) a summary of responses to the recommendations made in the previous year, including a list of those recommendations which are still awaiting implementation or responses. b) that the State Coroner's annual report be tabled in Parliament; c) that the State Coroner's annual report be published on the website of the State Coroner's Office.	Alternative ways to improve distribution of recommendations and provision of responses, and reporting arrangements, to be considered.	Page 11
86	That the National Coroners Information System, in conjunction with the State Coroner, consider the development of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners.	Requires consideration at national level.	Page 10
87	That the State Coroner's Office undertake a trial of informal conferencing modelled on the Ontario regional coroners' system for cases which the State Coroner considers could be appropriately dealt with in this way.	Alternative measures to be developed in consultation with State Coroner's Office in development of new Act.	Page 10
88	That the features of the informal conferencing model to be trialled include the following: a) any agreement reached in relation to implementing recommendations should be published (with the consent of the organisation and the family) on the State Coroner's Office website and in the State Coroner's annual report; b) where consensus is not forthcoming but the coroner considers his or her recommendations to be feasible, the coroner is to submit draft recommendations to the State Coroner for review prior to their release to the organisation.	See recommendation 87.	Page 10
89	That the trial of informal conferencing be formally evaluated and that this evaluation be reported in the State Coroner's annual report.	See recommendation 87.	Page 10
90	That section 1 of the *Coroners Act 1985* be amended to include, as a purpose of the Act: to accommodate the needs of and provide support for families, friends and others associated with a death which is the subject of a coronial investigation.	Recognition of needs of families in objects of Act supported in principle. Amendments to be considered in development of new Act.	Page 8
91	That the *Coroners Act 1985* be amended to define 'senior next of kin' as the first person who is available from the following persons in the order of priority listed: a) a person who, immediately before the death, was living with the person and	Revision of definition supported in principle. Amendments to be considered in development of new Act following further	Page 9

Recommendation		Government Response	Page Reference
	was either- i) legally married to the person; ii) a domestic partner of the person; b) a person who, immediately before the death, was legally married to the person; c) a son or daughter, who is of or over the age of 18 years, of the person; d) a parent of the person; e) a brother or sister, who is of or over the age of 18 years, of the person; f) a person who had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the person who has died; g) an executor named in the will of the person or a person who, immediately before the death, was a personal representative of the person; or h) any person nominated by the person to be contacted in an emergency; i) where paragraphs (a) to (h) do not apply or a person who would be the senior next of kin under those paragraphs is not available – a person who immediately before the death had a relationship with the person who died that, in the opinion of the coroner, is sufficient for the purpose of being the senior next of kin.	consultation.	
92	That the definition of 'domestic partner' in the Act be amended to 'a person to whom the person is not married but with whom the person is living as a couple on a genuine domestic basis (irrespective of gender)'.	See recommendation 91.	Page 9
93	That the *Coroners Act 1985* be amended to include a definition of 'immediate family' that includes all of the categories of people referred to in the definition of senior next of kin.	See recommendation 91.	Page 9
94	That the *Coroners Act 1985* be amended to include a requirement that, wherever practicable, the coroner permit the immediate family of the person who has died to view and touch the body while the body is under the coroner's control. If the coroner determines not to grant the requested authorisation, the person who made the request should be given written reasons for the refusal.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
95	That the *Coroners Act 1985* be amended to include a provision that, wherever practicable, the coroner must authorise a member of the immediate family of the person who has died, or a representative of that family member, to access the place where the death has occurred and that, if the coroner refuses the request, the person should be given written reasons for the refusal.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8

Recommendation		Government Response	Page Reference
96	That the *Coroners Act 1985* be amended to: a) give family members the right to access witness statements, reports and other evidence and information concerning the death investigation as soon as they become available unless the coroner considers that releasing the material has the potential to compromise a criminal investigation; b) require coroners to inform family members of their right to access such information and, if a request for such information is refused, to provide written reasons for the refusal; c) clarify the scope of 'persons with sufficient interest' in an inquest and the coroner's discretion to determine that question, following the model used in section 40(2) of the *Coroners Act 1993* (NT) and section 52 of the *Coroners Act 1995* (Tas); d) state the timing for release of the statements or other information, if the discretion to release them is exercised; e) establish an avenue for appealing a decision made by the coroner in relation to releasing statements; and f) clarify the extent and nature of the information that can be accessed, following the approach used in section 51 of the *Coroners Act 1997* (ACT); in this regard the *Coroners Act 1985* and the Coroners Regulations 1996 should be consistent.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
97	That the State Coroner's Office investigate the applicability of case management systems used in other jurisdictions and implement an appropriate state-wide case management system.	Supported. New case management system under development.	Page 8 and 12
98	That the *Coroners Act 1985* be amended to include requirements that: a) coroners provide regular updates to family members on the progress of investigations; b) coroners review the progress of each case every six months, commencing from the date that the case is referred to the coroner; c) where an investigation has not been concluded after 12 months have elapsed since the case was referred to a coroner, the investigating coroner give written reasons for the delays to the family of the person who died, along with an estimate of the time required to complete the investigation; d) the State Coroner supervise and monitor progress of cases under consideration by other coroners in Victoria; and e) every coroner must, so far as it is consistent with justice and practicable to do so, perform or exercise his or her functions, powers and duties without delay.	Improved case management procedures supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8 and 12

Recommendation		Government Response	Page Reference
99	That the *Coroners Act 1985* be amended to include a provision modelled on section 20 of the *Coroners Act 1996* (WA) which requires: 1) a coroner who has jurisdiction to investigate a death, as soon as practicable after a death, to provide to any of the immediate family of the person who died the following information: a) that the body is under the control of the coroner investigating the death; b) that an autopsy is likely to be performed; c) that any of the dead person's immediate family may touch the body, where practicable; d) that there is a right to have a representative chosen by the senior next of kin attend the autopsy; e) that if tissue is to be removed in accordance with the written permission of the person who died, there is a right to view such written permission; f) that there is a right to view the body; g) that there is a right to object to the autopsy, and a right to request that an autopsy be performed; h) that tissue may be retained after the completion of the autopsy where it is necessary to do so in order to investigate the death; i) a brief summary stating the manner in which an objection to autopsy may be made; and j) that a free counselling and support service is available. 2) The information provided to be in writing, where practicable, and in a language and form likely to be understood by the person to whom it is provided. The Committee also recommends that, in addition to the matters covered in the WA legislation, provision be included which require that the following information must also be provided to the immediate family: a) whether an investigation or inquest will take place, and that there is a right to request that an inquest be held; b) before conducting an inquest, the time and place of the hearing, where practicable; c) that there is a right to access or request information such as new evidence, witness statements and expert reports in advance of an inquest or finding, as this material becomes available; d) that they are entitled to obtain independent legal advice or representation in relation to the investigation and, if one exists, that there is a free	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8

Recommendation		Government Response	Page Reference
	telephone service that provides advice about objections to autopsies; e) reasons for delays in the investigation or inquest; f) findings made by the coroner and explanations of those findings where requested; and g) details of responses to recommendations received from agencies.		
100	That the *Coroners Act 1985* be amended to require that, before ordering an internal examination of the body, coroners have regard to a list of factors modelled on section 30 of the *Coroners Act 2006* (NZ), including: a) the extent to which matters required by the Act to be established by an investigation are not already disclosed in respect of the death concerned, by information available directly to the coroner or from information arising from investigations or examinations the coroner has made or caused to be made but are likely to be disclosed by an autopsy; b) whether the death appears to have been unnatural or violent; c) if the death appears to have been unnatural or violent, whether it appears to have been due to the action or inaction of other persons; d) the existence and extent of any allegations, rumours, suspicions or public concern about the cause of death; e) the desirability of minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, customarily require bodies to be available to family members as soon as possible after death; f) the desirability or minimising distress to persons who, by reason of their ethnic origins, social attitudes or customs, or spiritual beliefs, find the post-mortem examination of bodies offensive; g) the desire of any member of the immediate family of the person concerned that a post-mortem examination should be performed; and h) any other matters that the coroner thinks relevant.	Principles to guide coroners supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
101	That the *Coroners Act 1985* be amended to give immediate family members other than the senior next of kin the right to object to autopsies but not the right to appeal the coroner's decision, as is the case under the *Coroners Act 1980* (NSW).	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
102	That the Coroner's Office initiate a formal consultation process with the Victorian Aboriginal Legal Service to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs, and the removal and return of the body of the deceased.	Supported in principle. Engagement of cultural diversity officer under consideration.	Page 9

Recommendation		Government Response	Page Reference
103	That a staff member of the Coroner's Office be designated to act as a cultural liaison officer for the purpose of developing knowledge of the cultural requirements of different groups in the community regarding coronial procedures and facilitating effective communication with such groups.	Supported in principle. Engagement of cultural diversity officer under consideration.	Page 9
104	That consideration be given to exempting the senior next of kin from the requirement to pay Supreme Court filing fees when lodging an objection to the decision of a coroner ordering that an autopsy be performed.	Appeals processes to be considered in development of new Act.	Page 8
105	That the current delegation of powers and duties under section 10 of the *Coroners Act 1985* to coroner's clerks be reconsidered by the State Coroner.	Supported. Revised delegations under development.	Page 8
106	That the Act be amended to require a coroner, when determining whether an autopsy is necessary, to consider whether alternatives to internal examination, or whether partial rather than full internal examination, may be appropriate in a particular case.	Principles to guide coroners supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
107	That the *Coroners Act 1985* be amended to contain the following provision: If the senior next of kin asks a coroner to allow a doctor chosen by the senior next of kin to be present at a post-mortem examination, the coroner is to allow that doctor to be present and is to ensure that the doctor is informed as to the time and place of the examination.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
108	That the *Coroners Act 1985* be amended to: a) require a coroner, where practicable, to inform the family of the person who died that tissue will be retained, specify the tissue to be retained, give reasons for its retention and indicate how long the tissue will need to be retained; b) provide that, prior to the retention of any tissue other than minute samples, the written consent of the coroner must be obtained; c) require a coroner to consider the necessity of the retention for the purposes of the investigation despite any concerns raised; d) require a coroner to review at six-monthly intervals the necessity of retaining such tissue; and e) provide for the disposal of the tissue at the end of the retention period, by release to the family or by other arrangements for the respectful disposal by the entity that the tissue.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
109	That the *Coroners Act 1985* be amended to permit the removal of tissue from a body at an autopsy for purposes other than investigating the death only with the prior written permission of the person who died, or with the written informed consent of the senior next of kin specifying the tissue which may be removed and	Currently regulated by the *Human Tissue Act 1982*. Amendments to be considered in development of new Coroners Act following further consultation.	Page 8

Recommendation		Government Response	Page Reference
	the purpose (therapeutic, medical or scientific) for which the tissue may be removed. Consent forms used for this purpose should be expressed in plain English, and a copy should be provided to the senior next of kin.		
110	That the *Human Tissue Act 1982* be amended to ensure its consistency with: a) the recommendations in this report in relation to organ and tissue retention; b) the National Code of Ethical Autopsy Practice.	Requires consideration at national level.	Page 8
111	That the *Coroners Act 1985* be amended to: a) provide that, if a coroner orders an exhumation, the immediate family of a person whose body is to be exhumed or their representative has the right to attend the exhumation; and b) require a coroner who orders an exhumation to direct a person by order to re-inter the body or return the ashes to the person entitled to them, with the costs to be met by the Coroner's Office.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
112	That the *Coroners Act* be amended to incorporate the procedures contained in the existing State Coroner's protocol in relation to the management of Indigenous burial remains, subject to any amendments necessary to achieve consistency with the provisions of Part 2, Division 2, of the *Aboriginal Heritage Act 2006*	Amendments to be considered in development of new Act.	Page 7
113	That the existing Victorian Civil and Administrative Appeals Tribunal telephone service be expanded to provide after-hours legal advice for next of kin on how to object to an autopsy.	Increased support for families supported in principle. To be considered in development of new Act following further consultation.	Pages 7 and 8
114	That the State Coroner's Office, in conjunction with the Victorian Institute of Forensic Medicine: a) develop, in addition to the booklet The Coroners Process: Information for Family and Friends, a separate legal information kit which explains the legal requirements for objections to autopsies, the rights of families in relation to coronial investigations, the rules and procedures relating to inquests, and other legal and practical information relevant to persons affected by a coronial death investigation; b) publish the legal information kit on its website; c) distribute the legal information kit to a wide range of relevant agencies and persons, including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions; d) ensure that the legal information kit includes a hard copy and a downloadable form which can be used by people who wish to object to an autopsy; and e) make the information available in languages other than English.	Increased support for families supported in principle. To be considered in development of new Act following further consultation.	Pages 7 and 8

Recommendation		Government Response	Page Reference
115	That the Government investigate the feasibility of providing legal advice and assistance to families affected by a coronial investigation where this is necessary to enable them to effectively participate in the investigation.	Increased support for families supported in principle. Initiatives to be considered in development of new Act.	Page 8
116	That section 10 of the *Information Privacy Act 2000* and section 14 of the *Health Records Act 2001* be amended so as to clarify the application of the exemptions in those sections to such coronial functions that relate to the conduct of inquests and inquiries under the *Coroners Act 1985*.	Amendments to be considered in development of new Act following further consultation.	Page 8
117	That section 45 of the *Coroners Act 1985* and regulation 24 of the Coroners Regulations 1996 be repealed and that principles be inserted into the Act which regulate the kind of information a coroner may release and to whom s/he may release it, both before and after the completion of an investigation, modelled on the principles contained in Part 3, Division 4, of the *Coroners Act 2003* (Qld).	Amendments to be considered in development of new Act following further consultation.	Page 8
118	That a formal consultation process be established between the State Coroner, the Privacy Commissioner and the Health Services Commissioner to design privacy protocols in relation to the management of sensitive information by coroners and coronial staff.	Supported in principle.	Page 8
119	That the *Coroners Act 1985* be amended to require that medical files delivered to a coroner must: a) be kept physically apart from the coroner's file in a secure place; and b) be accessed only by persons with a sufficient interest and their legal representatives, unless the consent of the senior next of kin is given to other persons to access the medical information.	New records management practices being implemented. Amendments subject to further consideration in development of new Act.	Page 8
120	That the *Coroners Act 1985* be amended to impose on coronial staff who allow public access to confidential information penalties similar to those which apply to hospitals and staff under the *Health Services Act 1988*.	Amendments subject to further consideration in development of new Act.	Page 8
121	That autopsy reports, videos, suicide notes, diary excerpts, letters and other material that is sensitive or likely to cause distress to family members be placed in sealed envelopes within the coronial file to enable its removal prior to the file's being accessed by members of the public in appropriate circumstances.	New records management practices being implemented.	Page 8
122	That provision be made in the *Coroners Act 1985* for the development of clear protocols dealing with the management of coronial inquest data which incorporate privacy safeguards, including notice to persons whose privacy may be affected by the release of records and an opportunity to object to such release. Guiding principles should be included in the Act and more detailed instructions in the protocols.	New records management practices being implemented. Amendments subject to further consideration in development of new Act.	Page 8

Recommendation		Government Response	Page Reference
123	That the National Coroners Information Service (NCIS) be recognised by detailed provisions in the *Coroners Act 1985* that are drafted so that the *Information Privacy Act 2000* applies to the NCIS.	Requires consideration at national level.	Pages 8 and 10
124	That, following the implementation of recommendation 123 above, a code of practice under Part 4 of the *Information Privacy Act 2000* be developed for the NCIS.	Requires consideration at national level.	Pages 8 and 10
125	That section 58(1) of the *Coroners Act 1985* be amended to include a new sub-section (c), as adopted in Tasmania and the Northern Territory, which reads: 1) A coroner must order that no report of an inquest or of any evidence given at an inquest be published if the coroner reasonably believes that it would – ... (c) involve the disclosure of details of sensitive matters including, where the senior next of kin of the deceased has so requested, the name of the deceased.	Amendments subject to further consideration in development of new Act.	Page 7 and 8
126	That increased funding be provided to enhance the operation of the short-term counselling and support program in Melbourne and to enable its implementation across regional Victoria.	Supported in principle. New counselling and support model under development.	Page 8
127	That the *Coroners Act 1985* be amended to include a provision similar to section 16 of the *Coroners Act 1996* (WA) requiring the State Coroner to ensure that a counselling service is attached to the jurisdiction.	Increased support for families supported in principle. Amendments to be considered in development of new Act following further consultation.	Page 8
128	That the information booklet The Coroner's Process: Information for Family and Friends be distributed to a wide range of relevant agencies or persons, including police stations, funeral homes, hospitals, nursing homes, hospices, community legal centres and religious institutions.	Supported. Information booklet published and distributed.	Page 8 and 9
129	That the Law Institute of Victoria: a) consider making coronial law an area of accredited specialisation for its members; and b) continue to provide legal education courses in coronial law.	Recommendation referred to Law Institute of Victoria.	Page 11
130	That references to the 'Coroner's Court' be removed from the building, website and publications of the Coroner's Office, and from the website and publications of the Department of Justice.	Status of State Coroner's Office to be clarified.	Page 11

Recommendation		Government Response	Page Reference
131	That the *Coroners Act 1985* be amended to provide that the State Coroner be appointed for a term of five years, and may be reappointed for one further period of five years.	Amendments to be considered in development of new Act.	Page 11
132	That the Department of Justice determine how the status of the State Coroner and the Deputy State Coroner can be enhanced, whether by equivalent judicial status, salary or other means, to better recognise the complexity and breadth of these roles.	Status of State Coroner and Deputy State Coroner to be clarified.	Page 11
133	That the Coroner's Office prioritise the improvement of the delivery of coronial services to rural areas.	Supported. Initiatives to improve services under development.	Page 12
134	That the State Coroner more actively monitor and supervise the coronial investigations of the state's coroners.	Recommendation directed to State Coroner.	Page 12
135	That the State Coroner set up a formal process for dealing with requests for review of a coronial investigation process, and that the availability of this review process be publicised widely.	Recommendation directed to State Coroner.	Page 12
136	That section 16 of the *Coroners Act 1985* be amended to remove the words '(other than an inquest)'.	Amendments to be considered in development of new Act.	Page 12
137	That the *Coroners Act 1985* be amended to include as a function of the State Coroner: to help, by education, publicity and liaison with the public, to promote understanding of, and co-operation with, the coronial system provided for by this Act.	Non-legislative information and education measures supported in principle.	Page 12
138	That the Department of Justice establish a coronial council.	Development of coronial council supported in principle, subject to further consultation.	Page 12