Practice Direction 6 of 2020

Indigenous Deaths in Custody

1. Background

1.1. The final report of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) was published in 1991 and made 339 recommendations across a wide range of areas, including in relation to improvement of coronial processes.

1.2. The Coroners Court of Victoria (**Coroners Court**) recognises that, while the RCIADIC recommendations were handed down almost 30 years ago, there are still significant improvements that can be made to enhance the investigation of Indigenous deaths in custody. The Coroners Court is committed to fully implementing the RCIADIC recommendations as they relate to coronial processes, and recognises the importance of maintaining cultural appropriateness at every stage of the investigation into an Indigenous death in custody, particularly in ensuring that the impact of the work of the Coroner's Court on Indigenous families does not perpetuate cycles of grief and loss.

1.3. The present Practice Direction aims to enhance the implementation, amongst others, Recommendation 8 of the RCIADIC (Recommendation 8):

> **That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.**[1]

1.4. The Coroners Court has previously issued a Practice Direction to address required procedures in the case of police contact deaths,[2] which is considered to 'mostly implement' Recommendation 8.[3] The Coroners Court also recently issued 'Practice

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[1] RCIADIC Recommendations. Available: http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html

[2] Practice Direction 4 of 2014 – 'Police contact deaths' – issued on 9 April 2014 by His Honour Judge Ian Gray, who was then State Coroner. Available: https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/practice%2Bdirection%2B4%2Bof%2B2014%2B-%2Bpolice%2Bcontact%2Bdeaths.pdf (**Practice Direction 4 of 2014**).

[3] *See* Deloitte - Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody - August 2018, pages 26-27. Available: https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-

Direction 5 of 2020 – Directions Hearings in Mandatory Inquests' to provide for the convening of Directions Hearings within 28 days of mandatory inquests.[4]

1.5. However, given the focus of the RCIADIC, it was considered appropriate to implement Recommendation 8 through a Practice Direction that specifically addresses Indigenous deaths in custody, rather than taking a whole-of-population approach. The present Practice Direction will not only provide directions regarding cultural considerations and standards in the investigation of deaths of Indigenous people in custody in Victoria, but, where applicable, will be relevant to the coronial processes relating to all reportable deaths of Indigenous people that fall under the *Coroners Act 2008* (Vic) (**the Act**). The Coroners Court intends this to be the fulfilment of Victorian obligations under RCIADIC Recommendation 8, but will also touch upon obligations under certain other RCIADIC recommendations aimed at improving coronial processes.

2. Definitions

2.1 Coronial brief: This term refers to the brief of evidence compiled by the coroner's investigator and may include an inquest brief as defined in section 115(7) of the Act.

2.2 Coroner's investigator: This term refers to a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his or her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.

2.3 Deaths in custody: The term 'death in custody' is used to refer to deaths that occur in the custody of Victoria Police, Corrections Victoria, or other facilities and circumstances as defined in section 3(1) of the Act.

2.4 Indigenous people: The term 'Indigenous' is used to refer to Aboriginal and Torres Strait Islander people in Australia. It is recognised that the term 'Koori' is used to denote an Aboriginal person from southern NSW or Victoria, and that the majority of the Indigenous Australians dealing with the Coroners Court will be Koori people. However, on the basis that the jurisdiction of the Coroners Court includes deaths occurring in Victoria (including where people may ordinarily reside outside Victoria, and thus may be Indigenous but not be Koori), the term 'Indigenous' is used as inclusive of all Indigenous Australians.

3. Action to be taken immediately after the death of an Indigenous person in custody

3.1 Where practicable, the State Coroner and/or delegate (such as the duty coroner) will always attend the scene of the death in custody of an Indigenous person, **in consultation** with the Coroners Koori Engagement Unit.

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economics-review-implementation-recommendations-royal-commission-aboriginal-deaths-custody-251018.pdf

[4] Practice Direction 5 of 2020 – 'Directions Hearings in Mandatory Inquests' – issued on 17 September 2020 by His Honour Judge John Cain, State Coroner. Available: https://www.coronerscourt.vic.gov.au/sites/default/files/2020-09/2020.09.17%20-%20Practice%20Direction%205%20of%202020%20-%20Mandatory%20inquests.pdf (**Practice Direction 5 of 2020**)

3.2 The investigating coroner will contact the Principal In-House Solicitors or Senior Legal Counsel within 48 hours of the death to allocate the case for legal support and advice (*see RCIADIC Recommendations 26-28 and 30-31*). The Principal In-House Solicitors or Senior Legal Counsel will make contact with the Victorian Aboriginal Legal Service (**VALS**) to facilitate legal advice being provided to senior next of kin on their rights in relation to the coronial process.

3.3 The investigating coroner will convene a meeting within 48 hours (or as soon as is otherwise practicable) with the Coordinator/Manager of the Coroners Koori Engagement Unit to seek advice as to relevant cultural considerations and to determine appropriate next steps. This may include discussion of any issues around media coverage.

3.4 The investigating coroner will ensure the coroner's investigator is contacted at the earliest possible opportunity to determine appropriate arrangements for: (i) obtaining statements (such as to facilitate witness interviews being held in a location other than a police station, or for the presence of support persons at interviews of family members where requested); (ii) the collection of time-critical evidence (such as CCTV footage); and (iii) any other relevant issue that requires early direction.

4. Process around medical examinations and the release of the body

4.1 In accordance with sections 26 and 47 of the Act, the senior next of kin of an Indigenous person who has died in custody will be consulted in relation to any cultural considerations around proposed autopsy and release of the body (*see also RCIADIC Recommendation 38*).

4.2 In general, medical examination reports (**MERs**) are available within 12-16 weeks of all reportable deaths. If there is a delay for an MER relating to an Indigenous death in custody, a member of the Coroners Koori Engagement Unit will engage with the family to keep them informed, recognising that any delays in MERs being available to families in circumstances where a loved one has died in custody may exacerbate and compound their grief.

4.3 The Coroners Koori Engagement Unit will liaise with Coronial Admissions & Enquiries (**CA&E**) to ensure that family who wish to view the body of their loved one are able to do so in a culturally safe manner. This will normally occur once the body of a deceased person has been transported to a funeral home. However, if family do wish to view the body while in the care of the Victorian Institute of Forensic Medicine (**VIFM**), CA&E will ensure they are able to do so in a culturally safe manner, through liaising with the Coroners Koori Engagement Unit in relation to appropriate arrangements (*see RCIADIC Recommendation 25*).

5. Action to be taken in the first four weeks after the death of an Indigenous person in custody

5.1 In accordance with Practice Direction 5 of 2020, where a death in custody of an Indigenous person occurs, and unless reasons exist otherwise, a Directions Hearing will be convened within 28 days of a death being reported to the coroner, in order to:

i) Confirm the coroner's investigator for the coroner;
ii) Fix the date of delivery of the coronial brief; and
iii) Provide any other directions as considered appropriate at that time as relevant to the investigation, including regarding potential witnesses and scope of inquest.

5.2 The Coroners Koori Engagement Unit will engage with the family throughout the coronial process, and hold a family meeting (**Family Meeting**) within four weeks of the death to explain the coronial process, manage expectations about timeframes, and to demonstrate to families that the process will be aimed at being culturally appropriate, including through adherence to this Practice Direction. The timing of the Family Meeting may coincide with the 28-day Directions Hearing if practicable.

5.3 An explanation at the family meeting of the coronial process may include words such as:

- *'Deaths in custody in Victoria result in mandatory inquests.*
- *However, under section 52(3A) of the Coroners Act, if the death is due to natural causes (as determined by a forensic pathologist), a coroner is not required to conduct an inquest.*
- *Notwithstanding, even if the death is due to natural causes, it may be appropriate to examine the medical care and/or other factors to determine whether or not the death was preventable.*
- *In conducting an investigation into a death in custody, the coroner will usually request statements from Victoria Police and/or Corrections Victoria personnel, any relevant medical professionals, and any other relevant witness. Coroners will also obtain statements from any relevant and willing family member'.*

6. Factors to be considered in the investigation into the death of an Indigenous person in custody

6.1 The investigating coroner will direct the preparation of a cultural brief by the Coroners Koori Engagement Unit to ensure awareness of relevant cultural issues specific to the deceased and his or her community.

6.2 Notwithstanding the operation of section 52(3A) of the Act, where an inquest is requested by family, the investigating coroner will have regard to RCIADIC Recommendation 11 even where a death in custody is due to natural causes. Recommendation 11 specifies that '*all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death* […]'.

6.3 The investigating coroner will consider, when investigating the circumstances of the death of an Indigenous person in custody, the quality of care, treatment and supervision of the deceased prior to death (*see RCIADIC Recommendations 12 and 35*). This will entail making specific directions to the appointed coroner's investigator to provide a comprehensive coronial brief that includes statements from persons that can give evidence in relation to these factors.

6.4 In accordance with section 8(d) of the Act, the family of the deceased will be kept apprised of the progress of the investigation, including being consulted on proposed dates of hearings to ensure family is able to attend (*see also RCIADIC Recommendations 21 and 22*).

7. Court hearings – general considerations

7.1 Hearings will be convened in a culturally appropriate manner in consultation with family, including, depending on the nature of the hearing and the wishes of family:

7.1.1. A smoking ceremony (in culturally accepted circumstances);

7.1.2. The display and use in court of the possum skin cloak, didgeridoo and other symbols of cultural significance;

7.1.3 An acknowledgement of country (such as *'I acknowledge the traditional owners of the land where the Court sits, the Wurundjeri people of the Kulin Nation, and I pay my respects to their elders past, present and emerging'*); and

7.1.4 A consideration of the preferred use of names of the deceased, and appropriate warnings about use of those names, including in hearings convened via technological means.

7.2 Where it is anticipated that hearings will be convened via technological means (e.g. audio-visual means), the Coroners Koori Engagement Unit will make arrangements to ensure that family and community can access hearings and participate therein, where required.

7.3 Where there is a preference for the family to attend in person, the Coroners Koori Engagement Unit can assist in facilitating arrangements for families to attend Court, where possible and where required.

7.4 Where supported by family and where it would facilitate attendance at hearings by family and community members, noting section 90(2) of the Act, the coroner may consider convening certain hearings on Country.

8. Dissemination of this Practice Direction

8.1 This Practice Direction is to be disseminated by the State Coroner to all coroners and staff at the Coroners Court, as well as staff at VIFM.

8.2 This Practice Direction will be published on the website of the Coroners Court, in accordance with the usual process.

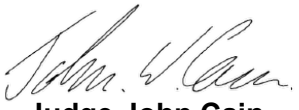
8.3 A one-page fact sheet summarising this Practice Direction will be prepared and distributed to family and community members, so they are aware of the relevant processes under the Practice Direction. This will include the contact details of the Coroners Koori Engagement Unit.

9. Commencement and legal basis of this Practice Direction

9.1 This Practice Direction is made pursuant to section 107 of the Act.

9.2 This Practice Direction is complementary to Practice Direction 4 of 2014 and Practice Direction 5 of 2020.

9.3 This Practice Direction will take effect on 22 September 2020 and will apply from this date to all current and future investigations of deaths in custody of Indigenous people.



Judge John Cain
State Coroner
22 September 2020