Practice Direction 3 of 2021

Police Contact Deaths

1. Background

1.1 A proportion of the *reportable deaths* investigated by the Coroners Court of Victoria are those that occur in circumstances involving interaction or contact with a Police Officer (normally members of Victoria Police although the definition includes members of interstate or federal Police Forces where the relevant criteria under the legislation are satisfied).

2. Definitions

2.1 A p*olice contact death* is *not* defined within the *Coroners Act 2008* and is a case management term used within the Coroners Court.

2.2 A *police contact death* includes:

2.2.1 Deaths pursuant to the definition in section 3 of the *Coroners Act 2008* of a *person placed in custody or care:*

(e) Deceased was in the legal custody of the Chief Commissioner of Police; or

(f) Deceased was in the custody of a Police Officer; or

(g) Deceased was in the custody of a Protective Services Officer; or

(j) A Police Officer was attempting to take the deceased into custody, or the deceased died from injuries sustained when a Police Officer attempted to take the deceased into custody.

2.2.2 For the purposes of this Practice Direction, a *police contact death* also includes:

(a) circumstances where a Police Officer's conduct *immediately preceding the death* requires further investigation by the coroner under the Act (as determined by the investigating coroner).

2.3 A *police contact death* does *not* include any reportable death where the *post-death* conduct of the coroner's investigator and/or any member of the police force are not directly relevant to establishing the identity of the deceased, the medical cause of death and the circumstances in which the death occurred.

3. Investigation of a police contact or police conflict death

3.1 In circumstances where a *police contact death* has occurred, the investigating coroner as soon as reasonably practicable will refer the matter to the In-House Legal Service (IHLS) to take carriage of and assist the investigating coroner at all stages of the investigation (from inception to closure).

3.2 Under no circumstances are the Police Coronial Support Unit (PCSU) to take carriage of or have any substantive involvement in the investigation of a *police contact death*.

3.3 Circumstances may arise where PCSU may be *conflicted* in assisting the investigating coroner (for example the *reportable death* of a serving Police member/employee or where concerns arise in respect of the adequacy of the Police coronial investigation of a death). The conflict arising may be either actual or perceived, however it is *not* possible to be prescriptive in identifying what constitutes such a conflict, and each matter is to be assessed on a case-by-case basis. Where a potential conflict arises, a determination is to be made by the investigating coroner in consultation with the Director, Legal Services and Officer-in-Charge, PCSU as to the appropriate Unit to take carriage.

4. Mandatory Inquests

4.1 It is *not* mandatory for a coroner to hold an inquest into every *police contact death*.

4.2 Section 52(2) *Coroners Act 2008* and related sections define when an inquest is mandatory in respect of a death. The coroner will determine whether it is necessary to hold an inquest depending upon the specific circumstances of each death and in accordance with the legislation.

5. 28-day Directions Hearing

5.1 Practice Direction 5 of 2020 applies in respect of *police contact deaths* and whether a 28-day Directions Hearing is to be convened (ie. a 28-day Directions Hearing is required in all cases where an inquest is mandatory, and unless reasons exist otherwise).

6. Commencement and legal basis of this Practice Direction

6.1 This Practice Direction is made pursuant to section 107 *Coroners Act 2008*.

6.2 Practice Direction 4 of 2014 is rescinded. References to Practice Direction 4 of 2014 in any other Practice Direction (including Practice Direction 5 of 2020 and Practice Direction 6 of 2020) will be interpreted as referencing the current Practice Direction.

6.3 This Practice Direction will take effect on 26 May 2021.

Judge John Cain
State Coroner
26 May 2021