Practice Direction 6 of 2020

Aboriginal Passings 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 over 30 years ago, there are still significant improvements that can be made to enhance the investigation of Aboriginal passings in custody. The Coroners Court is committed to fully implementing the RCIADIC recommendations as they relate to coronial processes and recognises the importance of striving for cultural appropriateness at every stage of the investigation into an Aboriginal passing in custody, particularly in ensuring that the impact of the work of the Coroners Court on Aboriginal families does not perpetuate cycles of grief and loss.

1.3. The present Practice Direction aims to enhance the implementation, amongst others, of 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 has previously been considered to 'mostly implement' Recommendation 8.[3] The Coroners Court also issued 'Practice Direction 5 of 2020 – Directions Hearings in Mandatory Inquests' to provide for the convening of Directions Hearings within 28 days of mandatory inquests.[4]

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[1] RCIADIC Recommendations. Available here.

[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. This was rescinded and replaced by an updated Practice Direction 3 of 2021 – 'Police contact deaths' – issued on 26 May 2021 by his Honour Judge John Cain, State Coroner. Available here.

[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 here.

[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 here ('**Practice Direction 5 of 2020**').

1.5. However, given the focus of the RCIADIC, it was considered appropriate to implement Recommendation 8 through a Practice Direction that specifically addresses Aboriginal passings 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 passings of Aboriginal people in custody in Victoria, but, where applicable, will be relevant to the coronial processes relating to all reportable passings of Aboriginal 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 coronial investigator and may include an inquest brief as defined in section 115(7) of the Act.

2.2 Coronial investigator: This term means a police officer who is nominated by the Chief Commissioner of Police to assist a coroner in relation to an investigation into a reportable death as defined in section 3(1) of the Act.

2.3 Passings in custody: The term 'passing in custody' is used to refer to passings that occur in the custody of Victoria Police, Corrections Victoria, or other facilities and circumstances as defined in section 3(1) of the Act. The term 'passing' is used as it is generally more accepted and sensitive terminology when discussing the death of Aboriginal person, due to the spiritual belief around the life cycle. The term 'passing' is used throughout this Practice Direction unless the statutory language of the Act or a reference to a formal document requires otherwise.

2.4 Aboriginal people: For readability, and in consultation with the Coroners Aboriginal Engagement Unit (**Aboriginal Engagement Unit**), the term 'Aboriginal' is used to refer to people who are: (i) Aboriginal; (ii) Torres Strait Islander; and (iii) Aboriginal and Torres Strait Islander. 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 Aboriginal people dealing with the Coroners Court will be Koori people. However, on the basis that the jurisdiction of the Coroners Court includes passings occurring in Victoria (including where people may ordinarily reside outside Victoria, and thus may be Aboriginal but not be Koori), the term 'Aboriginal' is used as inclusive of all First Peoples.

3. Action to be taken immediately after the passing of an Aboriginal 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 passing in custody of an Aboriginal person, in consultation with the Aboriginal Engagement Unit.

3.2 The investigating coroner will contact the Principal In-House Solicitors or Senior Legal Counsel within 48 hours of the passing 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 contact the Victorian Aboriginal Legal Service (**VALS**) to provide notification of an Aboriginal passing in custody.

3.3 The investigating coroner will convene a meeting within 48 hours (or as soon as is otherwise practicable) with the Manager of the Aboriginal 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 coronial 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 Aboriginal person who has passed 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 passings. If there is a delay for an MER relating to an Aboriginal passing in custody, a member of the Aboriginal 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 passed in custody may exacerbate and compound their grief.

4.3 The Aboriginal Engagement Unit will liaise with Coronial Admissions and 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 Aboriginal Engagement Unit in relation to appropriate arrangements (*see RCIADIC Recommendation 25*).

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

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

i) Confirm the coronial 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 Aboriginal 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:

- *'Passings in custody in Victoria result in mandatory inquests.*

- *However, under section 52(3A) of the Coroners Act, if the passing is due to natural causes (as determined by a forensic pathologist), a coroner is not required to conduct an inquest.*

- *Notwithstanding, even if the passing is due to natural causes, it may be appropriate to examine the medical care and/or other factors to determine whether or not the passing was preventable.*

- *In conducting an investigation into a passing 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 passing of an Aboriginal person in custody

6.1 The investigating coroner will direct the preparation of a cultural brief by the Aboriginal 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 passing 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 the coroner into the circumstances of the death* […]'.

6.3 The investigating coroner will consider, when investigating the circumstances of the passing of an Aboriginal person in custody, the quality of care, treatment and supervision of the deceased prior to passing (*see RCIADIC Recommendation 12 and 35*). This will entail making specific directions to the appointed coronial 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 that we meet today on the lands of the Wurundjeri and Boon Wurrung Peoples of the Kulin Nation. I acknowledge them as Traditional Custodians of this land. I pay my respects to their Ancestors and Elders past and present'*); and

7.1.4 A consideration of the preferred use of names of the deceased, and appropriate warnings about use of those names and images depicting the deceased, 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 Aboriginal 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 Aboriginal 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 Aboriginal 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 5 of 2020 and Practice 3 of Direction 2021.

9.3 The first version of this Practice Direction took effect on 22 September 2020. The current version of this Practice Direction supersedes the previous version and takes effect on 14 May 2024. It applies to all current and future investigations of passings in custody of Aboriginal people.

Judge John Cain
State Coroner
14 May 2024

ANNEXURE I - AMENDMENT HISTORY

This Practice Direction was first issued on 22 September 2020 and is replaced by the current version issued on 14 May 2024. The amendments made include:

1. Changing the word ‘death’ to ‘passing’ unless otherwise required by the language of the *Coroners Act 2008* or as otherwise referred to in a formal document.

2. Changing the word ‘Indigenous’ to ‘Aboriginal’ to refer to (i) Aboriginal; (ii) Torres Strait Islander; and (iii) Aboriginal and Torres Strait Islander people.

3. Changing references to the ‘Coroners Koori Engagement Unit’ to the ‘Aboriginal Engagement Unit’.

4. Replacing the definition of ‘coroner’s investigator’ to reflect the recently-inserted definition of ‘coronial investigator’ in section 3(1) of the *Coroners Act 2008*.

5. Including references to ‘Practice Direction 3 of 2021 – Police contact deaths’ in lieu of the rescinded ‘Practice Direction 4 of 2014 – Police Contact Deaths’.

6. An update to the Acknowledgement of Country and reference to cultural warnings.

7. Minor grammatical amendments to reflect the timing of the re-issued Practice Direction.

8. An update to paragraph 3.2.