



Royal Commission into Aboriginal Deaths in Custody Recommendation

6. Definition of 'death in custody'

That for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:

- a. The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;
- b. The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care while in such custody or detention;
- c. The death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and
- d. The death wherever occurring of a person 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.¹

Background²	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) called for a broad and inclusive definition of what counts as a death in custody. It stressed that public interest should take priority over narrow legal arguments about whether someone was technically 'in custody.' The Commission recommended that all deaths connected to the actions of police or custodial authorities—whether during detention, while being arrested, due to injuries or neglect while in custody, or during escape attempts—should be thoroughly investigated.
Intent	Ensure that all coronial jurisdictions use a comprehensive definition of 'death in custody'.
Responsibility	The Commonwealth and all state and territory governments.
Key contacts	Coroners Court of Victoria.
Key action taken	
2005 Review³	<p>State Coroner</p> <p>The State Coroner assessed Recommendation 6 as fully implemented and advised that all deaths in custody were reported to the State Coroner's Office and subject to investigation under direction of the coroner in accordance with the <i>Coroners Act 1985</i> (Vic).</p> <p>Review Team</p> <p>The Review Team found several Aboriginal deaths that occurred in the context of interaction with the criminal 'justice' system were not classified as deaths in custody. The review highlighted cases involving deaths that occurred during parole, weekend leave, or day release that were not captured under the definition of 'death in custody' despite these circumstances</p>

¹ *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 171 ('RCIADIC').

² *ibid* vol 1, 141-146 [4.5.39].

³ Aboriginal Justice Forum (Vic), Department of Justice (Vic), *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody* (Review Report, October 2005) 463 ('2005 Review').

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	<p>being directly linked to periods of incarceration. Deaths that occurred while people were on community-based orders, or soon after release from custody were not captured in this definition, nor were deaths of involuntary psychiatric patients, suicides completed in police presence or deaths arising from police pursuits.</p> <p>The Aboriginal community continued to raise concerns, including in the 2005 Review, that the definition of 'death in custody' was too narrow to capture the full scope of relevant cases and opportunities for coroners to investigate these cases and prevent further deaths occurring under similar circumstances, were being missed.⁴</p>
<p>2018 Review⁵</p>	<p>Victorian Government</p> <p>Deloitte assessed Recommendation 6 as being fully implemented in Victoria through legislation and regulations, noting under the Coroners Regulation 2009 a 'reportable death' included deaths occurring while in custody or care, including those caused by injuries sustained during arrest or while in state custody.</p>
<p>Since then</p>	<p>Coroners Court of Victoria⁶</p> <p>The State Coroner issued Practice Direction 6 of 2020 – Indigenous Deaths in Custody (Practice Direction 6) which acknowledged that, despite the RCIADIC recommendations being delivered over 30 years ago, there was still considerable work to be done to improve the investigation of Aboriginal deaths in custody.</p> <p><i>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 Coroners Court on Indigenous families does not perpetuate cycles of grief and loss.</i></p> <p>Under the <i>Coroners Act 2008</i> (Vic) a coroner must investigate any reportable death that occurred in Victoria, including the death of a person who immediately before death was a person placed in custody or care. Elements of the definition of a 'person placed in custody' that most closely align with those in Recommendation 6 include:</p> <ul style="list-style-type: none"> • a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police • a person in the custody of a police officer or a protective services officer • a person who a police officer or prison officer is attempting to take into custody or who is dying from injuries sustained when a police officer or prison officer attempted to take the person into custody • a person in Victoria who is dying from an injury incurred while in the custody of the State

⁴ Ibid 125-7.

⁵ Deloitte Access Economics, Department of Prime Minister and Cabinet, *Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody* (Report, August 2018) 23 ('2018 Review').

⁶ Coroners Court of Victoria, *Practice Direction No 6 of 2020: Indigenous Deaths in Custody*, 22 September 2020,1 ('*Indigenous Deaths in Custody*'); *Coroners Act 2008* (Vic) ('*Coroners Act*').

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Evidence of impact

Authorising documents

Coroners Act 2008 (Vic)⁷

Relevant to this recommendation, a death of a person is a reportable death under this Act if it occurred in Victoria and was:

- (a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or . . .*
- (c) the death of a person who immediately before death was a person placed in custody or care; or . . .*
- (e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer; or . . .*
- (f) the death of a person who is subject to a non-custodial supervision order under section 26 or 38ZH of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997;*
- (g) the death of a person whose identity is unknown.*

Under Section 3(1) of this Act, a 'person placed in custody or care' means:

- (a) a person for whom the Secretary to the Department of Human Services has parental responsibility under the Children, Youth and Families Act 2005; or*
- (b) a child placed in emergency care under the Children, Youth and Families Act 2005; or*
- (c) a person who is deemed to be in the legal custody of the Secretary to the Department of Human Services under section 483 of the Children, Youth and Families Act 2005; or*
- (d) a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health; or*
- (e) a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; or*
- (f) a person in the custody of a police officer; or*
- (g) a person in the custody of a protective services officer; or*
- (h) a person detained in a treatment centre under a detention and treatment order made under section 20 of the Severe Substance Dependence Treatment Act 2010;*
- (i) a patient detained in a designated mental health service within the meaning of the Mental Health and Wellbeing Act 2022; or*
- (j) a person who a police officer or prison officer is attempting to take into custody or who is dying from injuries sustained when a police officer or prison officer attempted to take the person into custody; or*
- (k) a person in Victoria who is dying from an injury incurred while in the custody of the State; or*
- (l) a prescribed person or a person belonging to a prescribed class of person.*

Outputs

The categories outlined in Recommendation 6 are largely reflected in the *Coroners Act 2008 (Vic)* definition of a 'person in custody or care.' While the Act does not explicitly refer to deaths

⁷ s3(1), 4(1) & 4(2) *Coroners Act*.

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	<p>that occur 'in the process of that person escaping or attempting to escape' from custody, deaths in such circumstances would most likely be 'reportable' under the Act on the basis that they were 'unexpected', 'resulted directly or indirectly from an accident or injury' or involved the 'death of a person who immediately before death was a person placed in custody or care'.</p>
Outcomes	<p>Practice Direction 6 specifically addresses Aboriginal deaths in custody. It provides directions regarding cultural considerations and standards in the investigation of deaths of Aboriginal people in custody in Victoria based on the provisions in the <i>Coroners Act 2008 (Vic)</i>.</p> <p>The Coroners Court intend for Practice Direction 6 to be relevant to the coronial processes relating to all reportable deaths of Aboriginal people that fall under the Act⁸ which includes all of those outlined in Recommendation 6.</p>
Community views	<p>Concerns persist that the circumstances of some deaths, including those that occur shortly after release, while people are on community-based orders, or suicides in the presence of police, are not considered to be 'a death in custody' so are not investigated as thoroughly as those that do meet the definition. This limits the information available to families about the circumstances that led to the passing of their loved one, and reduced opportunities to prevent future deaths in similar circumstances. The Aboriginal Justice Caucus (AJC) and Victorian Aboriginal Legal Service continue to advocate for legislative and procedural reforms to expand the definition and ensure that all relevant deaths are investigated thoroughly.</p> <p>Aboriginal Justice Caucus⁹</p> <p>The AJC expressed concerns regarding the 2024 passing of an Aboriginal man on a corrections order. As he was in community rather than custody, his passing was not treated as a 'death in custody' and so a coronial inquest was not automatically required under the <i>Coroners Act 2008 (Vic)</i>. The AJC were concerned that issues raised by his passing in relation to the adequacy of mental health assessments and support within the custodial and court systems, would not be properly investigated. The AJC continue to advocate for changes to the definition of a 'death in custody' and/or legislation so that all deaths that occur where an individual has recently been or is currently involved with the criminal legal system, are thoroughly investigated.</p>
Related recommendations	
Investigation into Deaths and Harm in Custody¹⁰	<p>Recommendation 24</p> <p>That the Department of Justice arrange for an independent research study to be conducted to identify the number and nature of deaths which occur within four weeks of a person leaving prison, and within one year of a person leaving prison.</p>
2005 Review¹¹	<p>Recommendation 1</p>

⁸ *Indigenous Deaths in Custody* 1.

⁹ Aboriginal Justice Caucus, *Aboriginal Justice Caucus Report to Aboriginal Justice Forum 65* (Agenda Paper, July 2023) ('AJC Report to AJF 65'); Aboriginal Justice Caucus, 'Aboriginal Justice Caucus Report to Aboriginal Justice Forum 68' (Agenda Paper).

¹⁰ Victorian Ombudsman, *Investigation into Deaths and Harms in Custody* (March 2014) ('Investigation into Deaths and Harms in Custody').

¹¹ 2005 Review, 496.

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That the Victorian Government expand the definition of an Aboriginal death in custody to incorporate other categories including:

- police pursuits
- community custodial orders, such as Intensive Corrections Orders and Community Custodial Permits
- other custodial arrangements such as day/weekend release and parole
- involuntary psychiatric patients in hospitals.

In expanding the definition of an Aboriginal death in custody the Victorian Government should seek national agreement.

Assessment summary¹²

The intent of Recommendation 6 was to establish a comprehensive definition of 'death in custody' to ensure deaths that occur in a wide range of circumstances across the criminal legal system are reported by police and correctional authorities and subject to thorough coronial investigations.

Actions taken align with the intent of this recommendation as the definition of a 'death in custody' under the *Coroners Act 2008* (Vic) has changed over time and covers the minimum categories outlined in Recommendation 6. However, the 2005 Review revealed the circumstances of Aboriginal deaths that occurred during incarceration or whilst a person was involved with custodial authorities, that did not fit within this definition and weren't investigated in the same way.

That definition is no longer fit for purpose given when the recommendations were made and how long they've been in place. It's time that definition was revisited with a notation from the Victorian perspective that we now see it implies the following situations and whatever else. (Lawrence Moser, Chairperson, Eastern Metropolitan Regional Aboriginal Justice Advisory Committee (EM RAJAC).

Deaths in custody, as defined according to this recommendation, are subject to investigation under the *Coroners Act 2008*, the Coroners Court Practice Direction 6, and Victoria Police and Corrections policies. Cases that fall outside of this definition do occur and may be investigated by the Justice Assurance and Review Office and/or a coroner but are not formally recognised as deaths in custody. This may limit identification of contributing factors and impede efforts to prevent similar incidents. Falling outside this definition of a 'death in custody' are deaths that occur shortly after release from prison, police custody or courts, while under community-based supervision or suicides where police were in attendance based on welfare concerns.

We remain concerned that the current definition is too narrow and limits investigations, oversight and the ability to identify systemic failings. To strengthen prevention and accountability, we advocate for a broader approach in Victoria that requires the investigation of cases outside the existing definition. This could include re-examining deaths of people involved with the justice system that were not previously classified as 'in custody' and ensuring they are subject to full coronial investigations.

There's a lot of grey areas in there that we've got no way to investigate. At least if it's notated in some way that we see that the definition covers these areas, for us as a mob that might enable us to get some more

¹² Meeting with Aboriginal Justice Caucus Working Group (Project Team, In Person 28 August 2024) ('Working Group Meeting (28 August 2024)'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 23 October 2024) ('Aboriginal Justice Caucus (23 October 2024)').

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leverage whether that be through the Attorney General or through Caucus and RAJAC meetings and whatever else. (Lawrence Moser, Chairperson, EM RAJAC).

Assessment of Recommendation 6

Is the intent of the recommendation accurately described?

Yes No

Does the action taken align with the intent of the recommendation?

0 – No action taken

1 – Action taken is of little relevance to the intent of the recommendation

2 – Action taken partially aligns with the intent of the recommendation

3 – Action taken fully aligns with the intent of the recommendation

1.5

(Score out of 3)

Is there evidence of the desired impact or outcome/s?

0 – No evidence

1 – Evidence of output rather than outcome

2 – Some evidence action contributed to outcome/s

3 – Clear link between action and impact or outcome/s

2

(Score out of 3)

How relevant is the recommendation in the current context?

0 – No relevance – refers to practices, agencies or laws that no longer exist

1 – Low – some relevance, but most aspects of the recommendation no longer apply

2 – Moderate – remains relevant, but some aspects of recommendation no longer apply

3 – High – entirely relevant to current context

3

(Score out of 3)

Does full implementation have the potential to reduce incarceration, increase safety in custody and/or progress Aboriginal self-determination?

0 – No potential to improve Aboriginal justice outcomes

1 – Low – potential to improve Aboriginal justice outcomes, but none of the three identified

2 – Moderate – potential to progress one or two of the outcomes identified

3 – High – potential to reduce incarceration AND increase safety in custody AND self-determination

2

(Score out of 3)

Potential actions for further work

Amend the Coroners Act 2008

Change the definition of a 'death in custody' and/or legislative provisions so that all deaths that occur where an individual has recently been or is currently involved with the criminal legal system, are thoroughly investigated. Ensure deaths that occur in such circumstances are subject to coronial inquests.

Re-examine past cases

Reassess past cases that were not recognised as Aboriginal deaths in custody to ensure they receive thorough scrutiny from a coroner.

Justice Assurance and Review Office to review deaths where Corrections Victoria were involved

Justice Assurance and Review Office (JARO) to review and record deaths that occur when the deceased was under corrections supervision or soon after release from prison. JARO to update guidance for these reviews with Aboriginal input to ensure they align with community expectations.

High priority for further work

		Low (0-2)	Moderate (3-4)	High (5-6)
Extent of action taken and evidence of outcomes	High (5-6)			
	Moderate (3-4)			Rec 6
	Low (0-2)			

Bibliography

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- Coroners Act 2008* (Vic)
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