Royal Commission into Aboriginal Deaths in Custody Recommendation

24. Inform family of progress of investigation and brief

That unless the State Coroner or the Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.[1]

Background[2]	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) stressed the importance of clear, respectful, and transparent communication throughout the investigation of deaths in custody. It underscored the need for investigators and Coroner's Office staff to respond appropriately to requests from the deceased's family or their representatives. This included providing updates on the progress of the coronial investigation, offering courteous and supportive guidance, and allowing the family or their representatives to view the scene of death to help address any concerns about the circumstances surrounding their loved one's passing.
Intent	Provide information about coronial investigations and their progress to the family of the deceased and their legal representatives.
Responsibility	All state and territory governments.
Key contact	Coroners Court of Victoria; Corrections Victoria, Department of Justice and Community Safety and Victoria Police (in relation to family members being able to view the scene of death); Victorian Aboriginal Legal Service.
Key Action Taken	
2005 Review[3]	The state Coroner assessed Recommendation 24 as **partially implemented** and advised that it was generally followed, except if an investigation needed to be undertaken with limited information distributed to a range of parties. Upon completion of the coronial brief, the full brief and all other documents were made available to the family (and other parties) prior to the inquest. If further investigation of any issue was requested, it was generally followed up before the case was listed for inquest. Families were entitled to be kept up to date with the progress of the investigation, and general information was provided throughout the

[1] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 175 ('*RCIADIC*').

[2] ibid vol 1, 158-161 [4.6.5].

[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) vol 1, 465-466 ('2005 Review').

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	management and progress of a case. There was also a guide booklet for families explaining how the coronial system works in Victoria. The State Coroner noted that inspection by family members or their representative of the scene of death was generally impractical and difficult to organise. However, with appropriate consideration to the rights of all involved, it could be possible to organise a scene inspection at a later stage.
2018 Review[4]	Deloitte assessed Recommendation 23 as being **fully implemented** through provision of the Coroners Process Information for Family and Friends, and efforts of the Coroners Support Service to provide information and updates to families.
Since then	**Coroners Court of Victoria** Since its establishment in 2019, the Coroners Koori Engagement Unit (now the Yirramboi Murrup Unit) has assisted Aboriginal families navigating the coronial process by providing culturally responsive support and improving the cultural sensitivity of investigations and court proceedings.[5] The Unit consists of Aboriginal people employed by the Coroners Court to provide cultural support and communicate directly with Aboriginal families throughout the coronial process.[6] They facilitate family meetings and access to hearings, including participation via technological means, and assist with arrangements for families to attend court when needed.[7] The State Coroner issued a new practice direction in 2020 outlining protocols for the conduct of coronial investigations into Aboriginal deaths in custody. Under this practice direction, the family of the deceased are to be kept informed of the progress of the investigation, including being consulted on proposed hearing and inquest dates.[8] *This practice direction gives Aboriginal people a voice in investigations into deaths in custody and ensures the Court is equipped with the cultural competency to support them.*[9] **Victoria Police**[10] In the Victoria Police Manual sections on 'Deceased Persons' and 'Death or Serious Injury Incidents Involving Police, there is no mention of family members or their legal

[4] 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) 55 ('2018 Review').

[5] Victorian Aboriginal Legal Service, 'Submission to the Review of Experiences of Bereaved Families Going Through a Coronial Process' 10.

[6] Thirrili, 'VIC Coroners Court Fact Sheet 7 ', *Thirrili* (Fact Sheet, December 2024) <https://thirrili.com.au/coroners-toolkits/> ('VIC Coroners Court Fact Sheet 7 ').

[7] Victorian Aboriginal Legal Service, 'Submission to the Review of Experiences of Bereaved Families Going Through a Coronial Process'.

[8] Coroners Court of Victoria, *Practice Direction No 6 of 2020: Indigenous Deaths in Custody*, 22 September 2020 ('*Practice Direction 6*').

[9] Troy Williamson, Manager Coroners Koori Engagement Unit, quoted in Coroners Court of Victoria, 'New Protocol for Coronial Investigations into Indigenous Deaths in Custody', *Coroners Court of Victoria* (Media release, 22 September 2020) <https://www.coronerscourt.vic.gov.au/new-protocol-coronial-investigations-indigenous-deaths-custody> ('New Protocol for Coronial Investigations into Indigenous Deaths in Custody').

[10] Victoria Police, *Victoria Police Manual Guidelines - Deceased persons* (Guidelines rev ed, January 2024, ('VPMG - Deceased persons'); Victoria Police, *Vicotria Police Manual - Death or Serious Injury Incidents Involving Police* (Guidelines rev ed, April 2024, ('VPMG- Death or Serious Injury Incidents Involving Police').

24. Inform family of progress of investigation and brief

	representatives being given the opportunity to inspect the scene of death as outlined in this recommendation.
Evidence of impact	
Authorising Document	***Coroners Act 2008* (Vic)** [11] Section 21 of this Act states that as soon as possible after an investigation into a death has commenced, the principal registrar must provide the prescribed information about the coronial process to the senior next of kin and any other person who has shown an interest in the investigation and is deemed by the principal registrar to have a sufficient interest in it. In addition, the Act considers that family members affected by a death being investigated should, where appropriate, be kept informed of the progress of the investigation. **Practice Direction 6 of 2020-Indigenous Deaths in Custody**[12] As outlined for recommendations 20 and 21, this practice direction requires notification of the Victorian Aboriginal Legal Service 'within 48 hours of the death'. *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.*[13] Requirements for keeping families updated on the progress of the investigation are clear: *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).*[14] The Coroners Koori Engagement Unit holds a family meeting within four weeks to explain the coronial process, manage expectations, and ensure the process is culturally appropriate. This may align with the 28-day Directions Hearing.
Outputs	The *Coroners Act 2008* (Vic) and Practice Direction 6 of 2020 support the intent of keeping families updated on the progress of investigations and preparation of the coronial brief. The Act requires families to be kept informed about the progress of the investigation, while Practice Direction 6 supports ongoing engagement and regular communication with families.
Outcomes	The requirements of the *Coroners Act 2008* (Vic), Practice Direction 6, and the practice of the Coroners Koori Engagement Unit suggest that families are routinely contacted and engaged throughout the coronial process. However, community concerns expressed by VALS highlight that limited information is provided to family members during the investigation, which can take several years. *A lack of information during this time further exacerbates the distrust that Aboriginal families may have in the process.*

[11] *Coroners Act 2008* (Vic) ss 8, 21 ('*Coroners Act*').

[12] *Practice Direction 6* 3.2-3.3, 4.1-4.3, 5.2-5.3, 6.1.

[13] Ibid.

[14] Ibid.

24. Inform family of progress of investigation and brief

	Where matters proceed to inquest, families are often not provided with clear information about the timeframes for the inquest and when the coronial brief will be provided. These information barriers may impact families' ability to attend hearings, remain informed, and fully engage with the investigation into their loved one's passing. There are no Coroners Court, Corrections Victoria or Victoria Police directives or procedures to assist with facilitating family requests to inspect the scene of death.
Community Views	**Victorian Aboriginal Legal Service**[15] The Coronial Council of Victoria completed a Review into Improving the Experiences of Bereaved Families with the Coronial Process. In their 2021 submission to this review, VALS acknowledged the importance of the Coroners Koori Engagement Unit (KEU): *The support provided by KEU has been instrumental for Aboriginal families. The KEU has also enhanced the capacity of VALS to represent our clients, by liaising closely with VALS lawyers in relation to all aspects of the coronial process. We strongly support the KEU being further embedded in the Court, with increased visibility over the coronial investigation and access to all information that is relevant for families in a timely manner.* Clear communication and timely access to information throughout the coronial process are essential to ensure that Aboriginal families who have lost a loved one are treated with dignity, respect, and cultural sensitivity. Early and consistent information helps alleviate grief and distress, allowing families to participate meaningfully in investigation and inquest processes. *Although the KEU plays a critical role in explaining the coronial process to Aboriginal families and providing information and updates throughout the process, there is a clear need for better processes to ensure that families and their legal representatives are provided with detailed information throughout the entire coronial process.* While recognising that the *Coroners Act 2008* and Practice Direction 6 seek to uphold RCIADIC recommendations 21, 22 and 24 (among others), VALS noted that in practice Aboriginal families often face communication gaps and serious delays. Investigations can take years, with little information shared during this time, deepening existing distrust in the coronial system. If a case does not go to inquest, families are usually notified only via written correspondence. For those that do proceed, families frequently lack clarity on timeframes and do not receive timely access to the coronial brief. Further challenges arise during the inquest process itself. Families and their legal representatives, such as those from VALS, report delays in receiving critical information, poor communication about key procedural steps, and insufficient responses from the Court. In some cases, decisions by the coroner are not communicated to the family or their representatives, adding to their distress and frustration. To address these issues, VALS recommend that the Coroners Court: • Consider options for family conferencing, to provide a culturally appropriate forum for providing regular updates during investigations.

[15] Victorian Aboriginal Legal Service, 'Submission to the Review of Experiences of Bereaved Families Going Through a Coronial Process' 21-23.

24. Inform family of progress of investigation and brief

- Establish a monthly call-over list for all matters being dealt with by the Court when an Aboriginal person has passed away. The purpose of this list would be to provide regular updates to bereaved families and other interested parties about the progress of the investigation/inquest.
- Amend Practice Direction 7 of 2014 ('Coronial Briefs') to require coroners to set a deadline for preparation of the coronial brief and require the coronial investigator to provide written reasons to the family and interested parties if the deadline is not met.

Related recommendations

2005 Review[16]	**Recommendation 92** That the Departments of Justice (Corrections Victoria) and Human Services (Juvenile Justice) and Victoria Police provide access to the scene of a death to family members (or their representatives) if requested. That the Victorian Government continue to implement and monitor Recommendation 24.

Assessment Summary[17]

The intent of Recommendation 24 was to provide information surrounding inquests, investigations, and their progress to families or their legal representatives.

The Coroners Court of Victoria has implemented measures under the *Coroners Act 2008* (Vic) and Practice Direction 6 of 2020 to keep families and their legal representatives informed and engaged throughout the coronial process. Coroners and court staff are encouraged to provide information to, and update families on the progress of investigations and facilitate contact with legal services like the Victorian Aboriginal Legal Service (VALS) that may also assist in this regard.

Community feedback and insights from VALS indicate that families continue to encounter challenges with receiving timely information updates, particularly on the status and content of coronial briefs. If the brief is delayed, families are not informed and must request their legal representative follow up with the Coroners Court to receive an update.

> *There is a clear need for better processes to ensure that families and their legal representatives are provided with detailed information throughout the entire coronial process.* (VALS)

There are no Coroners Court, Corrections Victoria or Victoria Police directives or procedures to assist with facilitating family requests to inspect the scene of death.

[16] *2005 Review*, 504.

[17] Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 6 December 2024) ('*Working Group Meeting (6 December 2024)*'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 11 June 2025) ('*Aboriginal Justice Caucus (11 June 2025)*').

Assessment of RCIADIC Recommendation 24

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

2

(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

1

(Score out of 3)

Potential actions for further work

Timeline for coronial processes

Coroners Court of Victoria to set timeframes for coronial processes in practice directions to provide better support for families and timeliness in the process. Update procedures to ensure that families and their legal representatives receive regular updates about the coronial brief.

Amend Practice Direction 7 of 2014 ('Coronial Briefs')

Require coroners to set a deadline for preparation of the coronial brief and require the coronial investigator to provide written reasons to the family and interested parties if the deadline is not met.

Enable families or their legal representatives to inspect the scene of death

Introduce explicit legal provisions for families or their legal representative to inspect the scene of death.

Coroners Court, Corrections Victoria and Victoria Police to update their respective directives and procedures to assist with facilitating family requests to inspect the scene of death.

As outlined for recommendations 21 and 22:

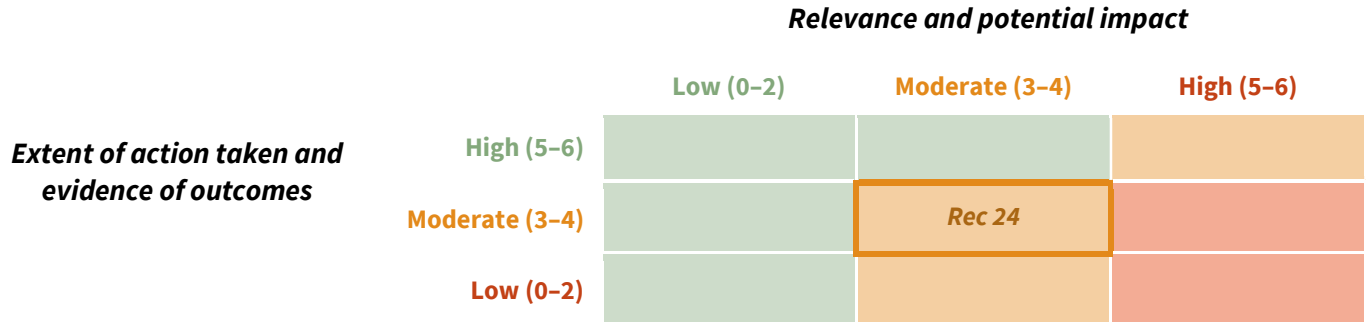
Additional resourcing for Aboriginal Engagement Unit within the Coroners Court

Provide additional resources to the Yirramboi Murrup Unit to better support families with coronial processes.

Coroners Court call-over list for Aboriginal passings

Establish a monthly call-over list for all matters being dealt with by the Court when an Aboriginal person has passed away. The purpose of this list would be to provide regular updates to bereaved families and other interested parties about the progress of the investigation/inquest.

Moderate priority for further work



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