Royal Commission into Aboriginal Deaths in Custody Recommendation

25. Family have right to view body and scene of death

That unless the State Coroner, or the coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.[1]

Background[2]	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) emphasised that the family of the deceased or their representative should have the right to view the body, access the scene of death, and have an independent observer present during post-mortem procedures. Cases investigated by the Commission highlighted the distress caused when bodies were swiftly removed for autopsy without allowing the family an opportunity to view them, creating suspicion and uncertainty. Additionally, cultural considerations and concerns relating to autopsies within various Aboriginal communities were outlined. The RCIADIC emphasised the need for timely and explicit communication with bereaved families and relevant Aboriginal organisations, given the importance of their understanding of, and participation in coronial processes.
Intent	Ensure families of those who have died in custody, are able to view the body, access the scene of death, and engage an independent observer in post-mortem procedures if desired.
Responsibility	All state and territory governments.
Key contacts	Coroners Court of Victoria; Victorian Institute of Forensic Medicine; 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 25 as **partially implemented**, noting that it was generally impractical and difficult to organise an inspection by family members of the scene of death. However, with appropriate consideration to the rights of all involved, it could be possible to organise a scene inspection at a later stage. There was no difficulty with a family arranging for an independent pathologist as an observer at postmortem. A copy of the post-mortem report was generally made available to families

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

[2] ibid vol 1, 162 [4.6.18].

[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, 466 ('2005 Review').

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	(subject to appropriate warnings and management to minimise any additional shock or grief from viewing such a document). At the time of the Review, there was a Counselling and Support Unit at the State Coroner's Office, and two counsellors were available to assist all families (and witnesses) to help them with the grieving process and provide information on coronial processes and general support. **Review Team** The Review Team noted the State Coroner's views that inspection by family members of the scene of death was generally impractical, but that families were accorded the right to have an independent pathologist present at the post-mortem.
2018 Review[4]	Deloitte assessed Recommendation 25 as **partially implemented** concluding that the Victorian Government had taken measures to implement this recommendation, but there weren't clear provisions for families to view the scene of death where it was in a police station or prison cell.
Since then	**Victorian Institute of Forensic Medicine**[5] The objectives of the Victorian Institute of Forensic Medicine (VIFM) include overseeing and coordinating the provision of forensic services in Victoria, assisting the Coroners Court with its functions under the *Coroners Act 2008*, contributing to public health and safety, the administration of justice and reducing the number of preventable deaths, and contributing to the development of knowledge, practice and innovation in the provision of forensic services.[6] The new *Victorian Institute of Forensic Medicine Act 2024* (Vic) promotes Aboriginal cultural rights by providing that in performing a function or exercising a power, a person should have regard, as far as possible in the circumstances, to respecting the cultural beliefs of persons affected by the events to which the Institute's services relate, and to recognising the diverse needs of Aboriginal communities, including the importance of self-determination and connection to culture, family, community and Country. This 24-hour Coronial Admissions and Enquiries service is the first point of contact with the coronial system for families of a deceased person. It has been provided by the VIFM since 2013, when the function was transferred from the Coroners Court. Nursing and administrative staff within Coronial Admissions and Enquiries assist in the earliest stages of the death investigation. Staff work closely with families providing them with information and support throughout the initial investigation, particularly for those families who need to attend the VIFM to view the body of their family member for identification and therapeutic purposes.

[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) 57-58 ('2018 Review').

[5] Victorian Institute of Forensic Medicine, 'VIFM Response to AJC RCIADIC Audit - Information' (Response to AJC request).

[6] *Victorian Institute of Forensic Medicine Act 2024* (Vic) 8 ('*VIFM Act*').

25. Family have right to view body and scene of death

When an Aboriginal passing in custody is reported, the State Coroner is immediately notified as is the Aboriginal Medico-Legal Liaison Officer (AMLO) within the Coronial Admissions and Enquiries team and the Yirramboi Murrup Unit (formerly the Coroners Koori Engagement Unit).

The AMLO will be the central point for communication with all Aboriginal families while the person who has passed is in the care of the VIFM. The AMLO works closely with the Yirramboi Murrup Unit to ensure consistent messaging and ongoing continuous support for families. If the AMLO is not available and another staff member must step in to communicate with the family of an Aboriginal person who has passed, they seek to acknowledge cultural practices and give families a choice in the way in which information is communicated. All Coronial Admissions and Enquiries staff receive mandatory Aboriginal Cultural Awareness Training.

Prior to a viewing, the AMLO contacts the family to explain the steps in the process. This includes seeking advice as to whether they would like a possum and/or kangaroo skin cloak placed on the person who has passed at the time of the viewing. The AMLO and/or a member of the Yirramboi Murrup Unit will be present at all viewings of an Aboriginal person who has passed, or where a family member identifies as Aboriginal, if requested. Extended families are often present. This can include Elders and children. Each family is different; the family is given a choice as to whether they would like to view the deceased through glass or be present in the room with the deceased.

Coroners Court of Victoria[7]

The *Coroners Act 2008* (Vic) sets out provisions for investigating reportable deaths, including the release of the deceased's body, the request and conduct of autopsies, and the process for raising objections to autopsies. While these elements are well defined, the Act does not specifically address matters such as viewing the scene of death, the presence of independent observers or medical practitioners at a post-mortem, or the right to request a further post-mortem, as raised in Recommendation 25.

These areas are generally informed by the overarching principles of the Act and further guided by practice directions issued by the State Coroner. In 2020, the State Coroner issued Practice Direction 6, which outlines procedures for investigating Aboriginal deaths in custody. The directive seeks to improve cultural sensitivity in coronial investigations and provides guidance for family involvement, including options to view the body at a funeral home or at the VIFM. It also addresses the facilitation of documentation and court proceedings in a culturally appropriate manner.

Corrections Victoria[8]

In their response, Corrections Victoria noted that the coroner makes determination about who can view the body of the deceased. The scene of a passing at a prison is a crime scene and viewing of the body must occur with the express permission of Victoria Police and the Coroner.

When an Aboriginal person passes in custody, Corrections Victoria provide support to the person's family (if the family wishes and accepts assistance) through the Naalamba Ganbu and Nerrlinggu Yilam (the Yilam) unit which is made up of Aboriginal staff. Support for staff and

[7] *Coroners Act 2008* (Vic) ('*Coroners Act*').

[8] Corrections and Justice Services, 'Corrections and Justice Services response to AJC Project' 13.

	people at the facility is also provided and any culturally significant practices required such as a Smoking Ceremony would be arranged by the Yilam.
Evidence of impact	
Authorising documents	***Coroners Act 2008* (Vic)** Section 21 outlines requirements for providing families with information: *As soon as practicable after a coroner has commenced an investigation into a death, the principal registrar must ensure that the prescribed information in respect of the coronial process is provided to—* *(a) the senior next of kin of the deceased person; and* *(b) any other person—* *(i) who has advised the principal registrar that they have an interest in the investigation of the death; and* *(ii) who the principal registrar considers to have a sufficient interest in the investigation of the death.* Section 115 describes arrangements for access to documents including medical examinations: *(1) Unless otherwise ordered by the coroner, the principal registrar must—* *(a) provide the senior next of kin of a deceased person written notice, in accordance with the rules, specifying—* *(i) that reports have been given to a coroner as a result of a medical examination performed on the deceased; and* *(ii) that the senior next of kin may request copies of those reports; and* *(iii) the manner in which the senior next of kin may request copies of those reports; and* *(b) if an inquest is to be held, provide an interested party with a copy of the coronial brief.* **Practice Direction 6 of 2020-Indigenous Deaths in Custody.**[9] Processes related to autopsy, medical examinations and viewings of loved ones are outlined: *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*

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

do so in a culturally safe manner, through liaising with the Coroners Koori Engagement Unit in relation to appropriate arrangements (see RCIADIC Recommendation 25).

Victorian Institute of Forensic Medicine Act 2024 (Vic)

The Act includes both general principles and ones specific to the needs of Aboriginal families and communities. There principles are to be followed when performing a function or exercising a power under this Act:

(a) meeting professional standards relating to scientific integrity and ethics;

(b) pursuing benefits to the community and to the justice system;

(c) recognising the significant nature of the events to which the Institute's services relate and the need to be sensitive and responsive to persons affected by those events;

(d) promoting public health and safety;

(e) promoting the administration of justice;

(f) respecting the cultural beliefs of persons affected by the events to which the Institute's services relate;

(g) recognising the diverse needs of Aboriginal communities, including the importance of self-determination and connection to culture, family, community and Country.

Section 9 describes VIFM's functions including several relevant to Recommendation 25:

The Institute has the following functions—

(a) to conduct—(i) medical examinations at the direction of a coroner or otherwise in accordance with the Coroners Act 2008 . . .

(d) to take possession of bodies, and where possession of a body is taken on behalf of a coroner, to provide for the release of the body following an order made by a coroner under section 47 of the Coroners Act 2008 . . .

(g) to provide information about the coronial process (whether during the process or after its completion) to, and to discuss that process with, the senior next of kin and family members of a deceased person or to explain to the senior next of kin and family members of a deceased person any forensic medical investigation that is performed on or in relation to the deceased person . . .

(i) to assist the principal registrar of the Coroners Court to provide any information prescribed for the purposes of section 21 of the Coroners Act 2008 as required by that section.

Outputs

The *Coroners Act 2008* (Vic) provides mechanisms for involving families in the coronial process, including decisions about the release of the body, and conduct of autopsies It also allows the senior next of kin to request access to investigation documents, including post-mortem reports. However, the *Coroners Act 2008* does not explicitly grant families the right to view the scene of death, have an independent observer at a post-mortem, or request a second post-mortem. These areas are instead guided by legislative principles and Practice Direction 6, which aims to improve cultural sensitivity in investigations of Aboriginal deaths in custody.

25. Family have right to view body and scene of death

Outcomes	There has been some progress toward addressing Recommendation 25, although key elements are yet to be implemented. The *Coroners Act 2008* (Vic) sets out procedures for investigating deaths and conducting autopsies but does not explicitly cover family access to the death scene, independent observers at post-mortems, or further post-mortems, as outlined in Recommendation 25. These areas are guided by legislative principles in the *Victorian Institute of Forensic Medicine Act 2024* (Vic) and the State Coroner's practice directions. According to VALS, independent medical involvement during post-mortems is uncommon, but families often request independent forensic reviews or expert medical advice as part of the inquest process.
Community views	**Victorian Aboriginal Legal Service**[10] Lawyers within VALS' Wirraway team were not aware of any instances where families had requested an independent observer be present at a post-mortem but believed that families should be informed of this option by the Coroners Court. They also noted that some families may want cultural rituals, such as smoking ceremonies, performed at the scene of death even if they are unable to access the scene. For many families, the priority is to bring their loved one home as soon as possible. Previously, VALS' legal practitioners highlighted delays with the provision of autopsy and other medical reports: > *While the preparation and service of coronial briefs has been particularly problematic, further delays result from the delinquent completion or provision of autopsy reports and other medical reports.*[11] Unnecessarily lengthy coronial investigations may exacerbate the distress of families and others affected by a person's passing. Drawn out proceedings are counter to the aims of the *Coroners Act 2008* for the coronial system to operate in a fair and efficient manner.[12]

Related recommendations

2005 Review[13]	**Recommendation 93** That the State Coroner employ an Aboriginal counsellor to assist family members during an inquest and advise them on their rights. That the Victorian Government continue to implement and monitor Recommendation 25 through any monitoring process established as a consequence of this Review.

[10] Meeting with Wirraway (Project Team, In person, 16 April 2024) ('*Wirraway (16 April 2024)*').

[11] Victorian Aboriginal Legal Service, 'Submission to the Review of Experiences of Bereaved Families Going Through a Coronial Process' 27.

[12] Section 9, *Coroners Act*.

[13] *2005 Review*, 504.

25. Family have right to view body and scene of death

Assessment summary[14]

The intent of Recommendation 25 was to ensure families of those who have passed in custody, are able to view the body, access the scene of death, have an independent observer at autopsy, engage an independent medical practitioner, and receive a copy of the autopsy report.

Actions taken partially align with this recommendation's intent. The *Coroners Act 2008* (Vic) supports the involvement of families in the coronial process, which includes decisions about viewing and releasing the body conducting autopsies, and requesting post-mortem report. Principles in the *Victorian Institute of Forensic Medicine Act 2024* (Vic) and Practice Direction 6 aim to improve cultural sensitivity in practice, as evidenced in arrangements made with families to view the body of their loved one.

Prior to a viewing, the Aboriginal Medico-Legal Liaison Officer (AMLO) within the Coronial Admissions and Enquiries team contacts the family to explain the steps in the process. This includes seeking advice as to whether they would like a possum and/or kangaroo skin cloak placed on the person who has passed at the time of the viewing. The AMLO and/or a member of the Yirramboi Murrup Unit will be present at all viewings of an Aboriginal person who has passed, or where a family member identifies as Aboriginal, if requested.

There is limited evidence on the extent to which other elements of Recommendation 25 are implemented. Existing laws do not explicitly provide families the right to have an independent observer during post-mortems, involve an independent medical practitioner, or arrange additional post-mortems. There aren't any practice directions or commissioner's requirements to support coroners or custodial authorities to respond to requests from families or their representatives to view the scene of their loved one's passing.

Further action is needed to implement this recommendation, including informing Aboriginal families of their rights and supporting them to bring their loved one home and journey through sadness to healing.

> *If we've still got people dying in custody, and the state can't provide them the care that they need to not pass in custody, then the least the state can do is ensure that the families on the outside have got the right apparatuses for healing and moving forward.* (Ebony Hickey, Chairperson, Barwon South West RAJAC)

Assessment of Recommendation 25

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)

[14] Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 12 June 2025) ('*Working Group Meeting (12 June 2025)*'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 16 July 2025) ('*Aboriginal Justice Caucus (16 July 2025)*').

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

Inform Aboriginal families of their rights in coronial processes

Ensure Aboriginal families are informed of their rights in relation to coronial processes, including the right to inspect the scene, have an independent observer at a post-mortem, engage an independent medical practitioner, or conduct a further post-mortem.

Ensure Aboriginal families are supported

Support Aboriginal cultural practices for healing and moving forward (this will differ between families and regions but could include facilitating smoking ceremonies in corrections/police cells, in-community activities, grief counselling, restorative approaches etc).

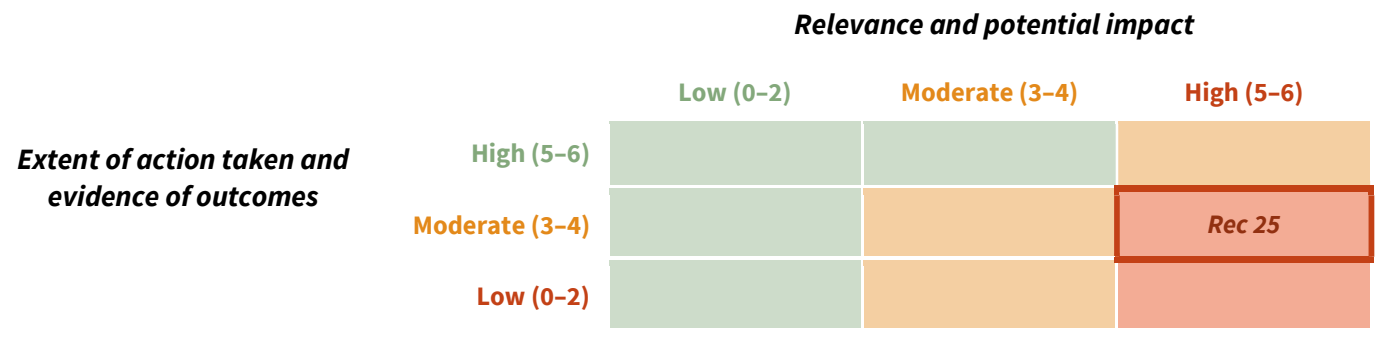
As outlined in response to Recommendation 24:

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.

High priority for further work



Bibliography

Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 12 June 2025)

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)

Meeting with Caucus, Aboriginal Justice (Project Team, In person, 16 July 2025)

Coroners Act 2008 (Vic)

Coroners Court of Victoria, *Practice Direction No 6 of 2020: Indigenous Deaths in Custody*, 22 September 2020

Corrections and Justice Services, Department of Justice and Community Safety 'Corrections and Justice Services response to AJC Project' (31 December 2024)

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)

Royal Commission into Aboriginal Deaths in Custody (Final Report, 1991)

Victorian Aboriginal Legal Service, 'Submission to the Review of Experiences of Bereaved Families Going Through a Coronial Process' (2021)

Victorian Institute of Forensic Medicine, 'VIFM Response to AJC RCIADIC Audit - Information' (Response to AJC request, 29 May 2025)

Victorian Institute of Forensic Medicine Act 2024 (Vic)

Meeting with Wirraway (Project Team, In person, 16 April 2024)