



Royal Commission into Aboriginal Deaths in Custody Recommendation

28. Duties of the lawyer assisting a coroner

That the duties of the lawyer assisting the Coroner be, subject to direction of the Coroner, to take responsibility, in the first instance, for ensuring that full and adequate inquiry is conducted into the cause and circumstances of the death and into such other matters as the Coroner is bound to investigate. Upon the hearing of the inquest the duties of the lawyer assisting at the inquest, whether solicitor or barrister, should be to ensure that all relevant evidence is brought to the attention of the Coroner and appropriately tested, so as to enable the Coroner to make such findings and recommendations as are appropriate to be made.¹

Background²	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) highlighted the crucial role of lawyers in assisting coroners during inquiries into deaths in custody, particularly in gathering and presenting relevant evidence. Lawyers play a key role in ensuring thorough investigations by presenting all pertinent information and rigorously testing the evidence to uncover any potential misconduct or concealment. Their involvement helps ensure that the inquiry process is transparent and comprehensive.
Intent	Ensure that the lawyer assisting the coroner is responsible for ensuring a full and adequate investigation and all relevant evidence is presented and tested during inquest hearings.
Responsibility	All state and territory governments.
Key contacts	Coroners Court of Victoria.
Key action taken	
2005 Review³	The State Coroner assessed Recommendation 28 as partially implemented and referred to their responses to Recommendations 26 and 27.
2018 Review⁴	Deloitte concluded that Recommendation 28 was fully implemented in Victoria through the <i>Coroners Act 1985</i> (Vic), and the Coroners Court Bench Book.
Since then	Coroners Court of Victoria⁵ The role of a coroner’s assistant is comparable to that of counsel assisting in a Royal Commission. They help to uncover the facts by organising and presenting material clearly and conducting witness questioning on the coroner’s behalf. They may guide the direction of

¹ *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 176 ('RCIADIC').

² *Ibid* vol 1, 149-152 [4.5.72].

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) 467 ('2005 Review').

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) 62-63 ('2018 Review').

⁵ Judicial College of Victoria, *Coroners Bench Book Victoria* (2023) 56-57.

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inquiries and assist witnesses in preparing their statements—without altering or censoring the content. They may also prepare evidence summaries, highlight relevant legal provisions and identify applicable authorities. This division of responsibilities allows the coroner to remain impartial and focused on assessing the evidence presented.

Evidence of impact

Authorising documents

Coroners Act 2008 (Vic)⁶

Section 60 of the *Coroners Act 2008 (Vic)* outlines the types of individuals authorised to support coronial proceedings which include: a police officer, Australian lawyer, the Director of Public Prosecutions, or another person appointed by the coroner.

Coroners Court Bench Book (Vic)⁷

Section 5.4 summarises the role and duties of the coroner’s assistant during an inquest:

They assist in the discovery of facts by presenting material in an orderly fashion and questioning witnesses in place of the coroner. They may direct inquiries along lines and may help witnesses in preparing their statements, though not to the point of censoring the evidence. They may also produce summaries of the evidence and outlines of relevant statutory provisions and may identify relevant authorities.

Key requirements of the conduct of the coroner’s assistant:

... The assistant must be impartial and independent and must not struggle unduly for a particular result.

Outputs

The *Coroners Act 2008 (Vic)* has a greater focus on the powers and functions of coroners in relation to inquiries into deaths in custody, than the duties of other parties. The Act outlines the types of people who could be appointed to assist the coroner but does not provide further detail on their roles and responsibilities. The Coroners Court Bench Book details the duties of the coroner’s assistant at inquest.

Outcomes

Under the *Coroners Act 2008 (Vic)* a coroner has a broad power to shape and direct an investigation. It is their responsibility for ensuring that a full and adequate inquiry is conducted into the cause and circumstances of the death and into such other matters as the they are bound to investigate.

The Coroners Court Bench Book details the duties of the coroner’s assistant at inquest which include questioning witnesses, directing lines of inquiry, and outlining relevant statutory provisions and may identify relevant authorities. Their role is to ensure the coroner is presented with all necessary information to make informed findings regarding the cause of death and surrounding circumstances.

⁶ *Coroners Act 2008 (Vic)* 51-52 ('Coroners Act').

⁷ Judicial College of Victoria, *Coroners Bench Book Victoria* 57 [5.9].

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While the coroner should not work with the assistant in a way that is unfair to any interested parties, the coroner must confer with the assistant on day-to-day inquest management issues, to ensure the inquest proceeds in a way that is fair, effective and efficient.

Community views

Inquest into the passing of Tanya Day

In their submission to then Deputy State Coroner English, the children of Tanya Day raised concerns about the management of the case by the coroner's assistant. They challenged elements of submissions made by Counsel Assisting, highlighting that the adoption of certain narratives resulted in systemic problems such as racism and bias not being adequately addressed in the investigation.⁸ Additionally, they urged the Coroner and Counsel Assisting to conduct a comprehensive review of evidence and address systemic issues more directly rather than relying on the existing arrangements with Victoria Police for coronial investigations.

Related recommendations

2005 Review⁹

Recommendation 94

That the Victorian Government provide adequate resources to the State Coroner to appoint counsel to assist the coroner's investigation of an Aboriginal death in custody.

That the Victorian Government continue to implement and monitor Recommendations 28.

Assessment summary¹⁰

Recommendation 28 intended for the lawyer assisting a coroner to ensure a full and adequate inquiry, bringing all relevant evidence to the coroner's attention and ensuring it is properly tested.

Actions taken partially aligned with the intent of this recommendation. The *Coroners Act 2008* (Vic) provides for lawyers to assist the coroner but provides little detail on their responsibilities. The Coroners Court Bench Book offers more guidance, outlining duties such as presenting evidence, questioning witnesses, and assisting in inquiry direction—emphasising impartiality and independence. Whether the efforts of coroner's assistants 'ensure a complete and adequate inquiry' depends on their skills, experience and in the case of inquests into Aboriginal passings, their understanding of Aboriginal culture, history and community.

Caucus members noted cases where Aboriginal families had challenged submissions made by Counsel Assisting which highlighted ways in which presenting information in a particular way, can potentially undermine the adequacy of the inquiry, and limit the findings and recommendations a coroner can make.

Recommendation 28 remains relevant given its potential to help build community trust in coronial processes.

Not only is it about instilling confidence in families and the Coroners Court, but also instilling confidence in our communities, because once a person passes, you know...we all grieve for them and their families.
(Bobby Nicholls, Chairperson, Hume Regional Aboriginal Justice Advisory Committee (RAJAC).

⁸ Belinda Day/Stevens et al, 'Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberley Watson, the Children of Tanya Day', Submission in *Inquest into the Death of Tanya Louise Day*, COR 2017 6424, 15 October 2019, 8-9.

⁹ 2005 Review.

¹⁰ Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 24 April 2024) ('Working Group Meeting (24 April 2024)'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 12 June 2024) ('Aboriginal Justice Caucus (12 June 2024)').

Assessment of Recommendation 28

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

1.5

(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

Cultural audit of training and experience

Coroners Court to conduct a cultural audit to verify individuals working with Aboriginal families have the necessary training and experience including awareness of the relevant recommendations of the Royal Commission into Aboriginal Deaths in Custody, unconscious bias and systemic and structural racism in the 'justice' system.

Moderate priority for further work

Relevance and potential impact

		Low (0-2)	Moderate (3-4)	High (5-6)
Extent of action taken and evidence of outcomes	High (5-6)			
	Moderate (3-4)		Rec 28	
	Low (0-2)			

Bibliography

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Coroners Act 2008 (Vic)

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Day/Stevens, Belinda et al, 'Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberley Watson, the Children of Tanya Day', Submission in *Inquest into the Death of Tanya Louise Day*, COR 2017 6424, 15 October 2019

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