**Royal Commission into Aboriginal Deaths in Custody Recommendation**

## 32. Selection of officer in charge of the police investigation

*That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank.*[1]

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| **Background**[2] | The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended a standardised approach for appointing an officer to lead investigations into deaths in custody, specifying that the role should be assigned to someone of at least Chief Commissioner, Deputy Commissioner, or Assistant Commissioner rank. This measure aimed to ensure greater oversight, accountability, and expertise in managing such sensitive cases. By restricting the role to senior officers, the recommendation sought to enhance the credibility and impartiality of investigations, addressing concerns about conflicts of interest and both structural and individual bias. |
| **Intent** | Ensure high-ranking officials are responsible for selecting the officer in charge of a police investigation into a death in custody. |
| **Responsibility** | All state and territory governments. |
| **Key contacts** | Victoria Police. |
| **Key action taken** | |
| **2005 Review**[3] | **State Coroner**<br>The State Coroner advised that this did not generally occur, and Recommendation 32 was **not implemented.**<br>**Victoria Police**<br>Victoria Police assessed Recommendation 32 as being **fully implemented** at the time of the 2005 Review and advised that the Homicide Squad investigated all deaths in custody where there had been contact with police. The officer in charge of the Homicide Squad would select an officer to handle an investigation of a suspicious death or death in police custody, with oversight by the Ethical Standards Department.<br>In the case of a death in custody at the Melbourne Custody Centre, the Prison Squad would assist in the inquiry along with the Homicide Squad. A Memorandum of Agreement existed between the Homicide Squad and Ethical Standards Department in relation to these investigations. |

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[1] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 177 ('*RCIADIC*').

[2] ibid vol 1, 113-123 [4.2].

[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) 403-404 [6.3] ('2005 Review').

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| **2018 Review**[4] | Deloitte concluded that Recommendation 32 was **not implemented** in Victoria as the Homicide Squad was responsible for the coronial brief oversighted by the Professional Standards Command. Deloitte noted the Victorian Government considered implementation of Recommendation 32 unnecessary given the arrangements already in place. |
| **Since then** | **Victoria Police**[5]<br>In 2023, Victoria Police assessed Recommendation 32 as **partially implemented,** noting:<br>The Victoria Police Manual (VPM) was updated regarding the inclusion of Recommendation 35 of the RCIADIC to provide specific directions for the conduct of investigations. Specifically, the VPM stipulates that the Senior Investigating Officer (SIO) for a death occurring in police custody is an officer of the rank of Inspector or above from the Homicide Squad who is responsible for the investigation. The VPM further stipulates that the Senior Oversighting Officer (SOO) for a death occurring in police custody is an officer of the rank of Inspector or above from Professional Standards Command who is responsible for oversight of the investigation.<br>**Coroners Court of Victoria**<br>The Coroners Court Bench Book suggests that the Chief Commissioner of Police nominates a police officer to assist a coroner with their investigation of a death in custody:<br>*Where a reportable or reviewable death requires a coronial brief, a coroner relies upon the Chief Commissioner of Police to nominate a member of the force to assist them with their investigation.*[6] |

### Evidence of impact

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| **Authorising documents** | **Victoria Police Manual – Deaths or serious injury/illness incidents involving police**[7]<br>*Death or serious injury/illness incidents (DSII incidents) involving police must be subject to investigation, oversight and review to ensure all appropriate actions are taken and to maintain public trust and confidence in police. These incidents may be investigated by the Independent Broad-based Anti-corruption Commission or Victoria Police. This policy aims to ensure that where DSII incidents are investigated by police, they are investigated thoroughly and transparently, and to ensure that the interests of all parties are appropriately represented and supported.*<br>The Victoria Police Manual (VPM) is issued under the authority of the Chief Commissioner of Police in s.60, *Victoria Police Act 2013.* On this basis, the Chief Commissioner of Police has assigned responsibility for the investigation of deaths that occur in police presence or custody to the Homicide Squad, or the Major Collision Investigation Unit in the case of fatal collisions. |

[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) 69-70 ('2018 Review').

[5] Victoria Police, *Victoria Police Manual - Death or serious injury/illness incidents involving police* (Internal Policy, January 2024) rev ed January 2024, ('VPMP - Death or serious injury/illness incidents involving police').

[6] Judicial College of Victoria, *Coroners Bench Book Victoria* (2023).

[7] *VPMP - Death or serious injury/illness incidents involving police*, rev ed January 2024.

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Deaths that occur before or following police contact are to be investigated by a squad or unit nominated by the Deputy Commissioner, Public Safety and Security. Oversight of all DSII incidents is the responsibility of Professional Standards Command.

The VPM summarises roles, responsibilities and functions in relation to DSII incidents:

<table>
<tr><th>Role</th><th>Responsibility</th><th>Functions</th></tr>
<tr><td>Investigation of death or serious injury/illness in police presence or custody<br>Note: Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed.</td><td>• Deaths – Homicide Squad<br>• Fatal collisions – Major Collision Investigation Unit<br>• Non-fatal incidents – Crime squad or unit nominated by Deputy Commissioner (Public Safety and Security)</td><td rowspan="2">• To identify how and why the death or serious injury/illness occurred<br>• To determine if an offence has been committed by any person involved in the DSII incident.<br>• If a death, this investigation is on behalf of the Coroner under the Coroners Act 2008.</td></tr>
<tr><td>Death or serious injury/illness before or following police contact</td><td>Squad or unit nominated by Deputy Commissioner (Public Safety and Security)</td></tr>
<tr><td>Oversight</td><td>PSC (all deaths) or regional investigator/s (serious injury/ illness), if determined by the Assistant Commissioner, PSC to be appropriate in the circumstances</td><td>To ensure the integrity of the investigation of the DSII incident</td></tr>
<tr><td>Debrief and review</td><td>The appointed Review Officer</td><td>• To attend the debrief of the incident and assess the strategy and tactics of the incident or operation<br>• To identify and recommend opportunities for improvement in police systems, process, practice, policy and training</td></tr>
</table>

The senior investigating officer (SIO) is an officer of the rank of inspector or above from the unit responsible for the investigation.

The senior oversighting officer (SOO) is an officer of the rank of inspector or above from the unit responsible for oversight of the investigation.

**Coroners Court Bench Book**[8]

The role of the coroner in directing the coronial investigator is described:

> *Where a reportable or reviewable death requires a coronial brief, a coroner relies upon the Chief Commissioner of Police to nominate a member of the force to assist … with their investigation.*[9] *This person is the 'coroner's investigator' and 'takes instructions directly from a coroner and carries out the role subject to the direction of a coroner'. The*

[8] Judicial College of Victoria, *Coroners Bench Book Victoria* 38.

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| | *coroner's investigator is usually the police officer who first attended the scene of death. This reflects the fact that police are regarded as experts, through their training and experience, in the conduct of investigations and evidence-gathering, including for death investigations.* |
| **Outputs** | The Victoria Police Manual outlines roles and responsibilities in relation to the investigation of deaths, serious injury or illness incidents involving police. |
| **Outcomes** | The Chief Commissioner of Police has assigned responsibility for the investigation of deaths that occur in police presence or custody to the Homicide Squad, and the Major Collision Investigation Unit in the case of fatal collisions. Deaths that occur before or following police contact are to be investigated by a squad or unit nominated by the Deputy Commissioner, Public Safety and Security. Oversight of all DSII incidents is the responsibility of Professional Standards Command, with the Assistant Commissioner to determine the most appropriate investigator. The senior investigating officer is an officer of the rank of inspector or above from the unit responsible for the investigation. The senior oversighting officer is an officer of the rank of inspector or above from the unit responsible for oversight of the investigation. |
| **Community views** | **Victorian Aboriginal Legal Service**[10]<br>*Appointing police to carry out coronial investigations into the death of Aboriginal people is deeply problematic for multiple reasons. It is particularly concerning for police contact deaths, as police should not investigate police. However, given systemic racism within the police force and historical and contemporary distrust of police by Aboriginal families, the fundamental problems with police investigating Aboriginal deaths on behalf of the coroner apply to all Aboriginal deaths being investigated under the Coroners Act.*<br>**Victoria needs a Police Ombudsman – Open letter from community sector to the Premier**[11]<br>*The systemic failings of Victoria Police have seriously diminished the Victorian community's confidence in the organisation. These failures include the…death of Yorta Yorta woman Tanya Day. We are gravely concerned that maintaining the status quo will allow these systemic failings to continue unchecked.*<br>*Aboriginal people are more likely to experience serious police misconduct, but less likely to make a complaint. They do not trust the system.* |

[10] Victorian Aboriginal Legal Service, 'Review of Experiences of Bereaved Families going through a Coronial Process' 17.

[11] Open letter from Police Accountability Project and Victorian Aboriginal Legal Service to Premier Daniel Andrews, 7 October 2022. Signatories included: Aborigines Advancement League; Australian Lawyers Alliance; Centre for Crime, Law and Justice UNSW; Djirra; Federation of Community Legal Centres; Fitzroy Legal Service; Harm Reduction Victoria; Humanist Victoria; Human Rights Law Centre; Inner Melbourne Community Legal; Justice Connect; Justice-involved Young People network; Liberty Victoria; Media, Entertainment & Arts Alliance – Victorian branch; Mental Health Legal Centre; Moonee Valley Legal Service; Police Accountability Project; Northern Community Legal Centre; Robinson Gill Lawyers; Uniting Church in Australia, Synod of Victoria and Tasmania; Victorian Aboriginal Community Services Association Limited; Victorian Aboriginal Community Controlled Health Organisation; Victorian Aboriginal Education Association Incorporated; Victorian Aboriginal Executive Council; Victorian Aboriginal Legal Service; Victoria Mental Illness Awareness Council; WEstJustice; Women's Legal Service; YouthLaw

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### Related recommendations

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| **2005 Review**[12] | **Recommendation 71**<br>That Victoria Police provide a report to the Aboriginal Justice Forum in relation to the implementation of Recommendation 32, with reference to how existing arrangements fit in with the requirements of this recommendation.<br>That the Victorian Government continue to implement and monitor Recommendation 32. |

### Assessment summary[13]

Recommendation 32 aimed to ensure that investigations into deaths in custody were led by officers appointed by a senior official of at least Chief Commissioner, Deputy Commissioner, or Assistant Commissioner rank.

The Victoria Police Manual outlines the areas responsible for the investigation of deaths that occur in police presence or custody, or before or following police contact. The senior investigating officer is an officer of the rank of inspector or above from the unit responsible for the investigation. The senior oversighting officer is an officer of the rank of inspector or above from the unit responsible for oversight of the investigation, usually Professional Standards Command. Assigning specific officers for these roles involves the Deputy or Assistant Commissioner with responsibility for the relevant police squad or unit.

The Aboriginal Justice Caucus echo community concerns about police investigating police where an Aboriginal person has passed in police custody. We continue to advocate for independent investigators. Implementation of Recommendation 32 is insufficient to meet community expectations of credible and impartial investigations.

> *Even if it's implemented…it's still police and doesn't have the potential to provide the Aboriginal community with what we want.* (Marion Hansen, Co-chairperson, AJC)

### Assessment of Recommendation 32

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| ***Is the intent of the recommendation accurately described?*** | Yes ☑ No ☐ |
| ***Does the action taken align with the intent of the recommendation?***<br>*0 – No action taken*<br>*1 – Action taken is of little relevance to the intent of the recommendation*<br>*2 – Action taken partially aligns with the intent of the recommendation*<br>*3 – Action taken fully aligns with the intent of the recommendation* | **2**<br>(Score out of 3) |
| ***Is there evidence of the desired impact or outcome/s?***<br>*0 – No evidence*<br>*1 – Evidence of output rather than outcome*<br>*2 – Some evidence action contributed to outcome/s*<br>*3 – Clear link between action and impact or outcome/s* | **1**<br>(Score out of 3) |

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[12] *2005 Review*.

[13] Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 9 May 2024) ('*Working Group Meeting (9 May 2024)*'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 12 June 2024) ('*Aboriginal Justice Caucus Meeting (12 June 2024)*').

***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*

**2**

(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

**Establish an independent coronial investigation unit**

Establish an independent investigation unit, and until it is established, create a specialised investigation team within the Coroners Court.

Explore international benchmarking models such as the Police Ombudsman for Northern Ireland to identify best practices for independent investigation units in custodial matters. Evaluate the feasibility of adapting similar models to the Victorian context to enhance investigative integrity and transparency.

## Low priority for further work

***Relevance and potential impact***

| ***Extent of action taken and evidence of outcomes*** | Low (0–2) | Moderate (3–4) | High (5–6) |
|---|---|---|---|
| High (5–6) | | | |
| Moderate (3–4) | *Rec 32* | | |
| Low (0–2) | | | |

# Bibliography


Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 9 May 2024)

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