Royal Commission into Aboriginal Deaths in Custody Recommendation

34. Police investigations conducted by highly qualified investigators

That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer.[1]

Background[2]	The Royal Commission into Aboriginal Deaths in Custody recognised that police should continue to play a role in investigating deaths that occur in custody and recommended important safeguards to improve the quality and accountability of these investigations. The focus was on making sure investigations are consistent, thorough, and carried out to a high standard. The Commission also supported a more centralised system, with senior oversight and clearer responsibilities, to improve the quality of investigations and ensure that information is collected and reported to coroners in a consistent and reliable way.
Intent	That police investigations into deaths in custody are conducted by highly qualified investigators reporting to one, senior officer.
Responsibility	All state and territory governments.
Key contacts	Victoria Police.
Key action taken	
2005 Review[3]	The State Coroner assessed Recommendation 34 as **partially implemented** and Victoria Police assessed it as **fully implemented**. **State Coroner** The State Coroner advised that police investigations were generally conducted by highly qualified officers. **Victoria Police** Victoria Police advised that all Ethical Standards investigators were Detective Training School qualified. All officers involved in an investigation were responsible to one, identified, senior officer.

[1] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 178 ('*RCIADIC*').

[2] ibid vol 1, 113-123 [4.2.15] [4.2.16].

[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, 468 ('2005 Review').

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2018 Review[4]	Deloitte concluded that Recommendation 34 was **fully implemented** in Victoria as deaths in custody were investigated by the Homicide Squad, with oversight from the Internal Investigations Department.
Since then	**Victoria Police**[5] Victoria Police assessed Recommendation 34 as **fully implemented** in 2023, noting the current practice is that police investigations of deaths in custody are conducted by the Homicide Squad, with oversight provided by the Professional Standards Command (PSC). According to Victoria Police, all police investigators within the Homicide Squad are qualified and highly experienced detectives. Entry into the Homicide Squad is highly competitive and is reserved for detectives with extensive investigatory experience.
Evidence of impact	
Authorising documents	**Victoria Police Manual – Death or Serious Injury/Illness Incidents Involving Police**[6] 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'. *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.* Police with key roles in any investigation are the Senior Investigating Officer (SIO), who is an officer of the rank of inspector or above from the unit responsible for the investigation, and the Senior Oversighting Officer (SOO), who is an officer of the rank of inspector or above from Professional Standards Command in the case of all deaths. The scope and conduct of these investigations are outlined in some detail: • *The member/s appointed to investigate the DSII incident must undertake their role having regard to the principles in VPM Crime attendance and investigation, VPM Deceased persons and VPM Road policing - general.* • *The responsible investigation team will be required to conduct a full investigation of the incident. All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death.* • *In the course of inquiry into the general care, treatment or supervision of the deceased prior to death, particular attention should be given to whether custodial*

[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) 73-74 ('2018 Review').

[5] David Jones and Tyler McRae, 'Victoria Police Review of Recommendations from the Royal Commission into Aboriginal Deaths in Custody' (Response to AJC Request, Tranche Two).

[6] 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').

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	officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased. • *The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand.* • *The SIO is responsible for ensuring appropriate action is taken concerning the prosecution of any person for any identified offence arising from the investigation.*
Outputs	The Victoria Police Manual outlines roles and responsibilities in relation to the investigation of deaths, serious injury or illness incidents involving police. Requirements for the scope and conduct of the investigation are also included.
Outcomes	Victoria Police confirmed that all deaths in custody are investigated by qualified and highly experienced detectives from the Homicide Squad, with oversight provided by the Professional Standards Command. The Senior Investigating Officer is an officer of the rank of inspector or above from the Homicide Squad. Appointed investigators must follow key principles outlined in police procedures related to crime scenes, and deceased persons. The investigation team is responsible for conducting a full and detailed inquiry. This goes beyond simply determining if a crime occurred—it must also examine whether the custody was lawful and whether the person received proper care, treatment, and supervision before their death. Special attention must be given to whether custodial officers followed all relevant policies and procedures regarding the care and supervision of the deceased. In cases involving police watch-houses, investigations must also look into the events leading up to the person being taken into custody, including their arrest and what they were doing beforehand. Finally, if the investigation reveals that someone committed an offence, it is the responsibility of the Senior Investigating Officer to ensure appropriate legal action is taken. Past inquests into Aboriginal deaths in custody have highlighted significant deficiencies with police investigations, and critical gaps between policy, as outlined in the VPM, and practice. While the VPM was updated in 2021 to reflect RCIADIC recommendations and provide specific directions into the conduct of investigations, whether these requirements are consistently complied with remains to be seen.
Community views	**Submission to the Inquest into the Death of Tanya Day**[7] In their submission to the Coroner, Tanya Day's children drew attention to several significant deficiencies in the investigation into their mother's death, including police not following the Coroner's directions in the investigation. Concerns were raised about the scope, thoroughness and timeliness of the police investigation, as well as its independence:

[7] 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.

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> *There are many other examples, like the failure to test the blood found in Mum's cell, to conduct any investigation into the adequacy of her treatment by paramedics, or to establish what else was happening at Castlemaine police station that night. We don't believe that the investigation would be conducted this way if anyone other than police officers were implicated…The solution is to have a truly independent investigator for police contact deaths; not police investigating police.* [8]

Victorian Aboriginal Legal Service[9]

The Victorian Aboriginal Legal Service (VALS) continues to advocate for measures to improve the quality, conduct and independence of coronial investigations into Aboriginal deaths:

> *All coronial investigations into the death of an Aboriginal person should be carried out by an independent Aboriginal-led body, on behalf of the coroner. The body should have:*
>
> - *the powers and training to investigate complaints in a rigorous, timely and effective matter, including the powers to conduct the investigation as a standard criminal investigation and interview police officers, with officers required to co-operate, subject to standard common law rules against self-incrimination*
> - *a statutory basis as an independent statutory body, being properly funded and resourced.*
>
> *Until an independent Aboriginal-led body is established to carry out coronial investigations, this function should be performed by a specialised investigation team at the Coroners Court, that is independent from Victoria Police and any other government authorities:*
>
> - *The team should be adequately resourced and trained and must include Aboriginal investigators.*
> - *They should work closely with the Koori Engagement Unit when investigating Aboriginal deaths.*
> - *This should be an interim model, to ensure independent and culturally appropriate investigations, while longer-term systemic reform is achieved.*

Related recommendations

2005 Review[10]

Recommendation 96

That the State Coroner:

(a) elaborate on the response to Recommendation 34 (i.e. should the Coroner's response be interpreted as meaning that investigating police are not, in all cases, trained investigators)

(b) provide clarification on instances where this has occurred

(c) provide a report to the Aboriginal Justice Forum on (a)-(b).

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[8] Ibid 9.

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

[10] *2005 Review*.

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That the Victorian Government continue to implement Recommendation 34 through any monitoring process established as a consequence of this Review.

Assessment summary[11]

Recommendation 34 intended for police investigations into deaths in custody to be conducted by highly qualified investigators reporting to one, senior officer.

The Victoria Police Manual specifies that the Senior Investigating Officer must hold the rank of inspector or higher within the Homicide Squad and is tasked with leading the investigation. The Homicide Squad comprises skilled and seasoned detectives. Admission to the squad is competitive and reserved for detectives with significant investigative experience.

Past inquests into Aboriginal deaths in custody have highlighted significant deficiencies with police investigations, and critical gaps between policy, as outlined in the Victoria Police Manual, and practice. We know the Victoria Police Manual was updated in 2021 to reflect RCIADIC recommendations and provide specific directions into the conduct of investigations but remain concerned about whether these requirements are met in practice.

> *If directions aren't followed through, what are the consequences for the lack of investigation or failure to perform their duties like they are meant to?* (Chris Harrison, Co-chairperson, AJC)

Recommendation 34 remains relevant until there is an independent body to investigate deaths in custody.

Assessment of Recommendation 34

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)

[11] 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)*').

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.

Accountability for investigations

Ensure disciplinary action or other consequences for failures to adhere to directives or conduct a thorough investigation. Measures should promote accountability and incentivise compliance with established protocols.

Moderate 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 34*	
Low (0–2)			

Bibliography

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