



Royal Commission into Aboriginal Deaths in Custody Recommendation

35. Police directions to conduct investigations into a death in custody

That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:

- a) Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;*
- b) 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;*
- c) 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;*
- d) 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 officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and*
- e) The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography.¹*

Background²	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) highlighted the importance of clear police procedures when investigating deaths in custody. It stressed that all such deaths should be treated seriously, with investigations starting from the assumption that a crime may have occurred. This means looking closely not only at whether there was any criminal behaviour, but also at the conditions of custody and the care provided to the person who died. The Commission found that in many cases, poor investigation practices—like assuming a suicide too quickly, missing key steps, or failing to gather proper evidence—led to serious gaps in understanding what really happened.
Intent	Police instructions clearly outline directions for thoroughly investigating the circumstances of a death in custody.
Responsibility	All state and territory governments.
Key contacts	Victoria Police.

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

² RCIADIC, (Final Report, 1991) vol 1, 115 [4.2.4] ('RCIADIC').

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Key action taken

<p>2005 Review³</p>	<p>The State Coroner and Victoria Police assessed Recommendation 35 as fully implemented.</p> <p>State Coroner</p> <p>The State Coroner advised that these investigations were overseen by a coroner, and covered issues associated with identity, cause of death and how the death occurred. The scene of death was examined in detail by specialists. Generally, the State Coroner (and a forensic pathologist) attended all deaths in custody scenes within a short time of the report of death. The State Coroner also noted the Prison Squad’s Charter of Operations and Standard Operating Procedures was under review by Police Command (as the unit had been reformed).</p> <p>Victoria Police</p> <p>Victoria Police advised that the procedures, policy, and Standing Orders were described in the Victoria Police Manual. Additionally, high quality colour photographs were taken at each scene, which received the same amount of attention as any prescribed crime scene and investigation. There was strict adherence to this policy in the event of a death in custody.</p>
<p>2018 Review⁴</p>	<p>Deloitte concluded that Recommendation 35 was fully implemented in Victoria on the basis that the 1994 Victorian Implementation Report noted both the Homicide Squad and Internal Investigations Department of Victoria Police had relevant standard operating procedures. No evidence of more recent actions taken towards implementation could be found.</p>
<p>Since then</p>	<p>Victoria Police⁵</p> <p>In 2023, Victoria Police assessed Recommendation 35 fully implemented, noting that the Victoria Police Manual (VPM) ‘Death or serious injury/illness incidents involving police’ was updated in 2021 to acquit the five parts (a, b, c, d, e) of Recommendation 35.</p>

Evidence of impact

<p>Authorising documents</p>	<p>Victoria Police Manual – Death or Serious Injury/Illness Incidents Involving Police⁶</p> <p>The framework for the investigation, oversight and review notes that:</p> <p style="text-align: center;"><i>Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed.</i></p> <p>The section on scene and incident management states that the scene of a death in custody should be video recorded and subject to thorough examination:</p>
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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, 503-504 ('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) 76-77 ('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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The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography.

Police officer appointed to investigate a death in custody must undertake their role 'having regard to the principles' in the Crime Attendance and Investigation and Deceased Persons sections of the VPM. The investigation team is 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 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 Senior Investigating Officer (SIO) is responsible for ensuring appropriate action is taken concerning the prosecution of any person for any identified offence arising from the investigation.*

The VPM also outlines the use of Operational Safety Critical Incident Reviews for continual improvement in Victoria Police responses to a death or serious injury/illness incident involving police. Their specific purpose is to:

Examine the effectiveness of police policies, procedures, guidelines, training, practices, and culture. This includes consideration of the actions and decision making of police employees.

Outputs

Updates made to the Victoria Police Manual in 2021.

Outcomes

The Victoria Police Manual - Death or serious injury/illness incidents involving police was updated in 2021 to acquit the five parts (a, b, c, d, e) of this recommendation. The wording in the VPM is identical to that in Recommendation 35.

Community views

Submission to the Inquest into the Death of Tanya Day⁷

In their submission to the Coroner, Tanya Day's children highlighted several significant deficiencies in the investigations into their mother's death. Concerns were raised about the scope and adequacy of the police investigation, as well as its independence. This included allegations of withholding crucial CCTV footage, overlooking critical inconsistencies in witness

⁷ Belinda Day/Stevens et al, 'Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberly 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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statements, neglecting to re-interview witnesses for clarification, and failing to inquire into the lawfulness of the deceased's treatment.

Moreover, the failure to test blood found in the cell and to investigate the adequacy of paramedic treatment raised alarming concerns about the thoroughness and effectiveness of the inquiry, further amplifying concerns about police investigating police.

Riley was supposed to be conducting an investigation to determine whether a criminal offence had been committed, at least until some unspecified time in early January 2018 when it became a coroner's investigation. Yet...his investigation was totally inadequate. He never followed up on glaring inconsistencies or apparently false statements made by police. He never even tried to conduct a suspect record of interview with Wolters or Neale. He certainly didn't approach his investigation "on the basis that the death may be a homicide". In those circumstances, you should be slow to decide you do not believe that an offence "may have been committed". Without a proper investigation, it remains a real possibility.⁸

Related recommendations

2005 Review⁹

Recommendation 73

That Victoria Police provide a report to the Aboriginal Justice Forum on the review of its Prison Squads Charter of Operations and Standard Operating Procedures.

That the Victorian Government continue to implement and monitor Recommendation 35 through any monitoring process established as a consequence of this Review.

Assessment summary¹⁰

Recommendation 35 intended for police instructions to clearly outline directions for thoroughly investigating the circumstances of a death in custody, including treating each case as a potential homicide, examining the circumstances of arrest, scrutinising custodial care, and thoroughly documenting the scene.

Previous inquests into Aboriginal deaths in custody in Victoria, highlighted significant inadequacies in police investigations:

[H]is investigation was totally inadequate. He never followed up on glaring inconsistencies or apparently false statements made by police...He certainly didn't approach his investigation "on the basis that the death may be a homicide". In those circumstances, you should be slow to decide you do not believe that an offence "may have been committed". Without a proper investigation, it remains a real possibility. (Day family submission)¹¹

⁸ Ibid [138].

⁹ 2005 Review.

¹⁰ 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)').

¹¹ Day/Stevens et al, 'Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberly Watson, the Children of Tanya Day'.

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The Victoria Police Manual - Death or Serious Injury/Illness Incidents Involving Police was updated in 2021 to align with the five components of Recommendation 35. The wording in the Victoria Police Manual is identical to the wording in this recommendation. However, we are concerned that these updates are guidelines rather than mandated policy rules and may not be followed in practice.

We need it to be thoroughly investigated and if it's not complied with, they are not doing their job. (Merle Miller, Victorian Aboriginal Education Association Incorporated)

Recommendation 35 remains relevant until there is an independent body to investigate deaths in custody.

Assessment of Recommendation 35

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

3

(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

2.5

(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

1.5

(Score out of 3)

Potential actions for further work

Mandate Victoria Police Manual guidelines for conducting investigations

Upgrade the existing guidelines for conducting investigations into a death in custody to be a mandated policy in the Victoria Police Manual.

Low 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)		Rec 35	
	Moderate (3-4)			
	Low (0-2)			

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