36. Thoroughness of investigations into deaths in custody

Investigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner on inquest into the cause and circumstances of the death and the quality of the care, treatment and supervision of the deceased prior to death.[1]

Background[2]	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) emphasised the need for greater investigative processes surrounding deaths that occur in custody. The RCIADIC shed light on significant shortcomings in various police investigations, particularly highlighting cases where the focus was narrowly confined to determining the cause of death without adequately examining broader systemic issues. The Commission underlined the importance of moving beyond a mere search for criminal misconduct, urging an extended approach that scrutinised the care, treatment, and supervision of individuals inside and outside of custodial settings leading up to their death. This perspective sought to rectify recurring problems identified by the RCIADIC, including biases, inadequate consideration of systemic failures, and a lack of attention to broader contextual and systemic factors.
Intent	Ensure investigations into deaths in custody include thorough examination of the cause and circumstances of the death and quality of care and treatment prior to death.
Responsibility	All state and territory governments.
Key contacts	Coroners Court of Victoria; Victorian Institute of Forensic Medicine; Victoria Police.
Key action taken	
2005 Review[3]	**State Coroner** The State Coroner assessed Recommendation 36 as **partially implemented** and advised that this generally occurred. Under the *Coroners Act 1985* (Vic) the investigating Coroner was required to find identity, cause of death and how death occurred. **Victoria Police** Victoria Police assessed Recommendation 36 as **fully implemented** and referred the Review Team to the Victoria Police Manual – Investigative Criteria of the State Crime Squads.

[1] *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) vol 1, 179 ('*RCIADIC*').

[2] Ibid vol 1.

[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, 504 ('2005 Review').

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2018 Review[4]	Deloitte concluded that Recommendation 36 was **partially implemented** in Victoria through the *Coroners Act 2008* (Vic), but the legislation did not explicitly require that the care, treatment and supervision of the deceased be considered in all cases.
Since then	**Coroners Court of Victoria** The *Coroners Act 2008* (Vic) provides the legal framework and requirements that guide the conduct of coronial investigations into deaths in custody. In 2020 the State Coroner issued Practice Direction 6 – Indigenous Deaths in Custody (Practice Direction 6) which outlines the expectation that the investigating coroner will consider, when investigating the death of an Aboriginal person in custody, the quality of their care, treatment and supervision. **Victorian Institute of Forensic Medicine** Since its establishment in 1985, the Victorian Institute of Forensic Medicine (VIFM) has served the State Coroner and the justice system with forensic services. The objectives of 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.[5] 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.[6] **Victoria Police**[7] In 2023 Victoria Police assessed this recommendation as **fully implemented**, and advised: • The 1994 Victorian Implementation Report noted that the Homicide Squad and Internal Investigations Department (now called Professional Standards Command) had standard operating procedures, which addressed this recommendation. • Victoria Police Manual (VPM) policies provide sufficient guidance in the investigation of coronial matters within the investigation. Crime Command and Professional Standards Command rely on several parts of the VPM to address these issues: • VPM - Policy Rules: Persons in police care or custody • VPM - Guidelines: Safe management of persons in police care or custody • VPM - Deceased Persons

[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) 78-79 ('2018 Review').

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

[6] Victoria, *Parliamentary Debates*, Legislative Assembly, 15 May 2024, vol 60th Parliament, (Anthony Carbines, Minister for Police, Minister for Crime Prevention, Minister for Racing).

[7] 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).

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	• VPM - Death or serious injury/illness incidents involving police. Read in conjunction with each other, they cover the elements in Recommendation 36.

Evidence of impact

Authorising documents	***Coroners Act 2008*** **(Vic)**[8] The *Coroners Act 2008* (Vic) provides the legal framework and requirements that guide the conduct of coronial investigations into deaths in custody. Section 15 of the Act outlines deaths that a coroner must investigate: *A coroner must investigate the death of a person if—* *(a) it appears to the coroner that the death, or the cause of death, occurred in Victoria; and* *(b) it appears to the coroner that the death is a reportable death; and* *(c) it appears to the coroner that the death occurred within 50 years before the death was reported to a coroner; and* *(d) an interstate coroner has not investigated, is not investigating, and does not intend to investigate, the death.* Section 67 of the Act outlines the findings a coroner investigating a death must make: *(1) A coroner investigating a death must find, if possible—* *(a) the identity of the deceased; and* *(b) the cause of death; and* *(c) unless subsection (2) applies, the circumstances in which the death occurred; and* *(d) any other prescribed particulars.* *(2) Whether it is possible or not, a coroner need not make a finding with respect to the circumstances in which a death occurred if—* *(a) an inquest into the death was not held; and* *(b) the coroner finds that—* *(i) the deceased was not, immediately before the person died, a person placed in custody or care; and* *(ii) there is no public interest to be served in making a finding regarding those circumstances.* *(3) A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.* **Practice Direction 6 – Indigenous deaths in custody**[9] The Coroner's Court of Victoria issued Practice Direction 6 – Indigenous deaths in custody in 2020. It confirms factors to be considered in the investigation into the death of an Aboriginal person in custody:

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

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

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	The investigating coroner will consider, when investigating the circumstances of the death of an Indigenous person in custody, the quality of care, treatment, and supervision of the deceased prior to death. This will entail making specific directions to the appointed coroner's investigator to provide a comprehensive coronial brief that includes statements from persons that can give evidence in relation to these factors. **Coroners Court Bench Book** The Coroners Court Bench Book highlights that the *Coroners Act 2008* (Vic) does not require a more extensive investigation for deaths in custody than for other deaths. However, Practice Direction 6 of 2020 specifies procedures for investigating the death of Aboriginal or Torres Strait Islander person in custody.[10] These procedures include visiting the scene, notifying the Victorian Aboriginal Legal Service, and evaluating the quality of care, treatment, and supervision, consistent with RCIADIC Recommendations 12 and 35. Furthermore, the Bench Book points out that in the Inquest into the Passing of Veronica Nelson, Coroner McGregor emphasised that the *Charter of Human Rights and Responsibilities Act 2006* (Vic) obligates coroners to examine deaths rigorously. This includes scrutinising the actions of state agents and the circumstances surrounding the death to identify potential human rights violations.[11] The recommendation that investigations into deaths in custody should provide a thorough evidentiary base aligns with the need for comprehensive inquiries into the cause and circumstances of death and the quality of care, treatment, and supervision prior to death. The Bench Book commented that under previous legislation, the focus was on 'how death occurred,' leading to a narrow approach.[12] The *Coroners Act 2008* reinforced a broader perspective, requiring coroners to identify facts and actions causally related to the death, including identifying contributors. However, the Bench Book noted that coroners must keep investigations within reasonable limits, focusing on relevant circumstances rather than the deceased's entire life or sociological factors, adhering to the principle of remoteness to ensure statutory findings.[13]
Outputs	The *Coroners Act 2008* (Vic) provides the legal framework for coronial investigations, including those involving deaths in custody. The Act outlines requirements of coroners when investigating reportable deaths, obtaining assistance from police, and determining the circumstances of death. Practice Direction 6 (2020) aims to improve investigations of Aboriginal deaths in custody and ensure that investigating coroners consider the quality of care, treatment, and supervision before death and that the coroner's police investigator provides a thorough coronial brief.

[10] Ibid.

[11] Judicial College of Victoria, *Coroners Bench Book Victoria* (2023) 26.

[12] Ibid 28.

[13] Ibid.

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	Victoria Police implemented various policies within the Victoria Police Manual (VPM), including guidelines for managing incidents involving deaths in custody, ensuring that the necessary investigators and support services are involved in such cases.
Outcomes	The Victorian Aboriginal Legal Service (VALS) found there were inconsistent outcomes from coronial investigations of Aboriginal deaths in custody. Families can struggle to obtain basic information about how their loved ones died, with critical details sometimes missing from initial coronial briefs. For example, in Veronica Nelson's case, a crucial statement from a nurse was only provided two weeks before the hearing despite being essential to the inquest. Coronial investigations were perceived to be less thorough than homicide investigations, with police handling them in a way that often fails to uncover critical information. VALS must frequently push for broader investigations, highlighting systemic racism and other crucial issues that might otherwise be overlooked. Limited funding for expert witnesses at the Coroners Court means that VALS often has to fund experts to ensure comprehensive analysis, further indicating gaps in the system's ability to deliver thorough investigations in the absence of external advocacy on behalf of affected families.
Community views	**Victorian Aboriginal Legal Service**[14] VALS emphasised the importance of acknowledging Australia's colonial history and its ongoing impact on current legal structures, which often fail to deliver justice for Aboriginal people. This colonial legacy, characterised by violence, dispossession, and denial of sovereignty, continues through contemporary policies. VALS urged the Coroners Court of Victoria to recognise this history by acknowledging that these aspects are vital for guiding necessary reforms toward an equitable legal system. *[A]cknowledging how this country's colonial history has created and shaped structures and institutions characterised by racism, which so often fail to deliver true justice for Aboriginal people, is crucial. The legal system is built on a foundation of violence and dispossession, denial of sovereignty (and of course, humanity), with the colonial project continuing through policies of protection and assimilation. Today's injustices are inextricably linked to the injustices of the past, and achieving a collective understanding of Victoria's colonial legacy can help guide the reforms necessary for realising a truly equitable legal system.* VALS highlighted that the Tanya Day Inquest is the only coronial inquest in Australia that has explicitly considered systemic racism, finding that unconscious bias influenced the V/Line train conductor's decisions. In Raymond Noel's inquest, while systemic racism was not directly investigated, Coroner Olle acknowledged the disproportionate impact of police pursuits on Aboriginal people and the adverse interactions with police that many Aboriginal individuals experience. VALS acknowledged that Practice Direction 6 of 2020 expanded the scope of coronial inquests involving Aboriginal individuals in custody by requiring consideration of the quality of their

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

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care, treatment, and supervision prior to death. However, VALS and the families it represents believe that the role of systemic racism should also be explicitly included in these investigations to ensure comprehensive examination of causes and circumstances of death.

> *Practice Direction 6 of 2020 has provided further guidance on the scope of coronial inquests into the passing of an Aboriginal person in custody, by requiring the coroner to consider, "the quality of care, treatment and supervision of the deceased prior to death." This is a direct implementation of Recommendations 12 and 35 of RCIADIC and is a welcome development. However, VALS and the families that we represent, strongly believe that Practice Direction 6 of 2020 should also require the investigating coroner to consider the role of systemic racism in relation to both the cause and circumstances of death.*

Consequently, VALS recommended enhancing the efficiency and effectiveness of the coronial inquest process to maximise its preventative benefits, such as preventing future tragedies by implementing inquest recommendations. They also suggested amending Practice Direction 6 of 2020 to allow investigating coroners to consider systemic racism or racial bias if requested by the family and to be open to expert evidence on these issues. Additionally, VALS proposed the creation of a sub-unit within the Coronial Prevention Unit to collect data on systemic racism.

Related recommendations

2005 Review[15]

Recommendation 74

That the Victorian Government continue to implement and monitor Recommendation 36.

Recommendation 97

That the State Coroner:

(a) elaborate on the response to Recommendation 36 (i.e. should the response be interpreted as meaning that there are exceptions to the rule of providing satisfactory evidentiary information)

(b) provide clarification on instances where this has occurred, and

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

Assessment summary[16]

Recommendation 36 aimed to establish structured investigations into deaths in custody, ensuring thorough inquiries into the cause and circumstances of death, as well as the quality of care, treatment, and supervision provided before death.

A coroner investigating a death must find, if possible, the identity of the deceased, cause of death, circumstances in which the death occurred and any other prescribed particulars. A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.

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[15] *2005 Review*.

[16] Meeting with Aboriginal Justice Caucus Working Group (Project Team, Online, 17 June 2025) ('*Working Group Meeting (17 June 2025)*'); Meeting with Aboriginal Justice Caucus (Project Team, Online, 16 July 2025) ('*Aboriginal Justice Caucus Meeting (16 July 2025)*').

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The *Coroners Act 2008* (Vic) does not require a more extensive investigation for deaths in custody than for other deaths. However, Practice Direction 6 requires the investigating coroner to consider, when investigating the circumstances of the death of an Aboriginal person in custody, the quality of care, treatment, and supervision of the deceased prior to death. This will entail making specific directions to the appointed coroner's investigator to provide a comprehensive coronial brief that includes statements from persons that can give evidence in relation to these factors. The extent of the investigation is subject to the discretion of individual coroners, who are not obligated to explore beyond the immediate circumstances of death and its location.

In the Inquest into the Passing of Veronica Nelson, Coroner McGregor emphasised that the *Charter of Human Rights and Responsibilities Act 2006* (Vic) obligates coroners to examine deaths rigorously. This includes scrutinising the actions of state agents and the circumstances surrounding the death to identify potential human rights violations.

Under previous legislation, the focus was on 'how death occurred,' leading to a narrow approach. The *Coroners Act 2008* reinforced a broader perspective, requiring coroners to identify facts and actions causally related to the death, including identifying contributors. However, coroners are required to keep investigations within reasonable limits, focusing on relevant circumstances rather than the deceased's entire life or sociological factors, adhering to the principle of remoteness to ensure statutory findings.

'Reasonable limits' are determined by individual coroners upon consideration of legal requests relating to the scope of inquest.

> *I think we, the Justice Caucus, need to look at the Coroner's Act and scrutinise it. . . pull it apart, and push the boundaries to seek change… We haven't been at the table when they've written this stuff, so I think it's incumbent on us to scrutinise it.* (Lawrence Moser, Chairperson, Eastern Metropolitan RAJAC)

Community concerns persist around issues like systemic racism, that are rarely addressed in investigations.

> *VALS and the families that we represent, strongly believe that Practice Direction 6 of 2020 should also require the investigating coroner to consider the role of systemic racism in relation to both the cause and circumstances of death.* (Victorian Aboriginal Legal Service)

Assessment of Recommendation 36

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

2.5
(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
(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

Review of the *Coroners Act 2008*

Ensure a comprehensive review of the *Coroners Act 2008* that seeks to strengthen it in terms of recognising and reflecting Aboriginal human, cultural and other rights in the conduct of coronial processes.

Amend the *Coroners Act 2008* *(in line with AJC endorsed actions for RCIADIC Recommendations 5-40)*

- Legally require a coronial inquiry culminating in a formal inquest for all Aboriginal deaths in custody, regardless of whether the cause of death is considered to be ‘natural causes’.
- Change the definition of a ‘death in custody’ and/or legislative provisions so that all deaths that occur where an individual has recently been or is currently involved with the criminal legal system, are thoroughly investigated. Ensure deaths that occur in such circumstances are subject to coronial inquests.
- Require coronial inquests into Aboriginal deaths in custody to be completed within two years.
- Mandate that a coroner must consider, when investigating the circumstances of the death of an Aboriginal person in custody, the quality of care, treatment and supervision prior to death.
- Empower coroners to make recommendations on other matters they deem appropriate.
- Amend Section 15A (2) to specify that the coronial investigator must comply with a reasonable and lawful direction within a reasonable timeframe. This addition would ensure that directives from the coroner are followed promptly and efficiently, enhancing the effectiveness and timeliness of investigations.
- Remove Section 15A (3)(a) so that coronial investigators must always comply with written directions from the coroner.
- Specify minimum requirements for the scope of inquiry into an Aboriginal death in custody that include the examination of potential breaches of human rights and impact of systemic racism.

Dedicated resources in Coronial Prevention Unit to collect data on systemic racism

Creation of a sub-unit within the Coronial Prevention Unit to collect data on systemic racism to support its inclusion in the scope of coronial investigations.

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)			*Rec 36*
	Moderate (3–4)			
	Low (0–2)			

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