



## Royal Commission into Aboriginal Deaths in Custody Recommendation

### 41. National monitoring of deaths in custody

*That statistics and other information on Aboriginal and non-Aboriginal deaths in prison, police custody and juvenile detention centres, and related matters, be monitored nationally on an ongoing basis. I suggest that responsibility for this be established within the Australian Institute of Criminology and that all custodial agencies co-operate with the Institute to enable it to carry out the responsibility. The responsibility should include at least the following functions:*

- a) *Maintain a statistical data base relating to deaths in custody of Aboriginal and non-Aboriginal persons (distinguishing Aboriginal people from Torres Strait Islanders).*
- b) *Report annually to the Commonwealth Parliament; and*
- c) *Negotiate with all custodial agencies with a view to formulating a nationally agreed standard form of statistical input and a standard definition of deaths in custody. Such definition should include at least the following categories:*
  - i. *the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;*
  - ii. *the death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention;*
  - iii. *the death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and*
  - iv. *the death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.<sup>1</sup>*

<b>Background<sup>2</sup></b>	The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) found that national data collection and reporting were critically important in identifying systemic failures in custodial practices that could be addressed to prevent further deaths in similar circumstances. The Commission emphasised the importance of, and urgent need to collect and maintain accurate information about deaths in custody that distinguished Aboriginal people from Torres Strait Islanders and non-Aboriginal people. Publicly available, accurate information was essential for transparency and accountability of custodial agencies and governments.
<b>Intent</b>	Maintain a database of deaths in custody based on a standard definition of deaths in custody and standard statistical input, with annual reports to the Commonwealth Parliament.
<b>Responsibility</b>	The Commonwealth and all state and territory governments.

<sup>1</sup> *Royal Commission into Aboriginal Deaths in Custody* (Final Report, 1991) 613 ('RCIADIC').

<sup>2</sup> *Ibid* vol 1, 187-9.

## 41. National monitoring of deaths in custody

### Key contacts

Australian Institute of Criminology (AIC); Corrections Victoria, Justice Assurance and Review Office, National Coronial Information System (NCIS), Youth Justice, Department of Justice and Community Safety; Victoria Police

### Key action taken

#### 2005 Review<sup>3</sup>

Recommendation 41 was assessed by Victoria Police, the Department of Human Services and the Department of Justice as **fully implemented** with part b) of the recommendation deemed the sole responsibility of the Commonwealth Government.

#### Victoria Police

Victoria Police advised that it maintained data relating to deaths in custody, and the statistical input definitions aligned with those outlined in this recommendation.

#### Department of Human Services

Child Protection and Juvenile Justice advised that their database, the Juvenile Justice Client Information System, identified young people on custodial and non-custodial supervised dispositions and distinguished Aboriginal young people from Torres Strait Islander young people. At the time of the review, the Department of Human Services were developing an integrated information system across Child Protection, Juvenile Justice, Specialist Children's Services and Disability Services with the aim of enhancing case management within and across these programs. The Juvenile Justice Branch also contributed information to the AIC Deaths in Custody Unit.

#### Department of Justice

Corrections Victoria advised that it provided information to the AIC on all deaths that occurred in Victorian prisons. This included identifying the death as relating to an Aboriginal or Torres Strait Islander person where relevant. Corrections Victoria reported to the AIC according to the established proforma and the definition of deaths in custody as established by the AIC in accordance with the RCIADIC.

#### 2018 Review<sup>4</sup>

#### Commonwealth Government

Deloitte concluded that the Commonwealth Government had **mostly implemented** Recommendation 41 through the work of the AIC. However, annual reporting to the Parliament had ceased and there was no clear indication of monitoring by the Parliament.

As part of the initial response in 1992, the National Deaths in Custody Program (NDICP) started to collect and disseminate data on all deaths that occurred in the custody of police, correctional, and youth justice services – including trends observed in those deaths. Five annual reports were tabled for Commonwealth Parliament. Following the 1996-97 Annual Report, no further reports were tabled for Parliament.

<sup>3</sup> 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) 462 ('2005 Review').

<sup>4</sup> 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) 88-90 ('2018 Review').

## 41. National monitoring of deaths in custody

The AIC and police services agreed to monitor and report on deaths in custody. The Consensus Statement, reached in 1994, supported a collaborative approach to ensure Recommendation 41 was implemented in a manner which enhanced community understanding of deaths in custody, and minimised the scope for misinterpretation of monitoring data. Data from the NDICP was published on a biennial basis in the AIC's Statistical Report.

### **Victorian Government**

Deloitte concluded that Recommendation 41 was **fully implemented** in Victoria through cooperation with the AIC in the collection and provision of data, and initiatives by Victoria Police under the third Aboriginal Justice Agreement (AJA3). Deloitte noted that:

- Corrections Victoria and Victoria Police provided data to the AIC on all Victorian deaths in custody.
- Victoria Police were responsible for recording particulars of all deaths in custody.
- The State Coroner developed with Victoria Police a revised 'Report of Death to the Coroner', which included the Aboriginal status of the deceased.
- The Victorian Government would continue to provide information on all deaths in custody to the AIC, which maintained the national database.

Under AJA3, as part of broader data improvement efforts, Victoria Police, Corrections Victoria, the Department of Human Services, and Courts committed to collaborate on development of a detailed database describing Aboriginal over-representation in the justice system.

### **Since then**

#### **National Coronial Information System<sup>5</sup>**

The NCIS, established in 2000 in response to recommendations from the RCIADIC, is a secure database of information on over 450,000 cases investigated by coroners in Australia and New Zealand. Data includes demographic information on the deceased, contextual details on the nature of the fatality, and searchable case reports. While jurisdictional differences affect the information available in the NCIS, as far as possible the data is nationally standardised.

Funding for the NCIS is provided by all Australian states and territories, New Zealand and select Commonwealth Government agencies including the AIC. Administration of the NCIS is carried out by a team in the Victorian Department of Justice and Community Safety.

Coroners have access to the NCIS to assist investigations, and appropriate access is available on application for research or monitoring projects. NCIS data also supports AIC monitoring.

#### **National Deaths in Custody Program – Real-time reporting<sup>6</sup>**

The National Deaths in Custody Program (NDICP) database is maintained by the AIC as a direct outcome of the RCIADIC. The AIC produce regular reports to track trends in relation to Aboriginal deaths in custody and make comparisons between jurisdictions.

<sup>5</sup> 'About NCIS', *National Coronial Information System* (Web Page, 27 June 2023) <<https://www.ncis.org.au/about-us/>> ('About NCIS').

<sup>6</sup> Australian Institute of Criminology, 'Explanatory Notes', *Australian Institute of Criminology*, 21 June 2023 <<https://www.aic.gov.au/explanatory-notes>> ('Explanatory Notes'). Australian Institute of Criminology, 'Deaths in custody real-time reporting', *Australian Institute of Criminology* (Web page, 21 June 2023) <<https://www.aic.gov.au/media-centre/news/deaths-custody-real-time-reporting>> ('Deaths in custody real-time reporting').

## 41. National monitoring of deaths in custody

In June 2023, the AIC introduced real-time reporting of deaths in custody. Data published on the real-time dashboard are drawn from NDICP data collection forms provided by state and territory police services, correctional departments and youth justice agencies. This data includes deaths that fall clearly within the scope of the NDICP and accord with the definition outlined in part c) of this recommendation.

When real-time reporting was introduced the Attorney-General noted it was part of a broader \$99 million Commonwealth Government investment in Aboriginal justice initiatives:

*We want to end deaths in custody. We want to grapple with systemic problems that are there in the system . . . This is only part of the solution but it's an important part.*<sup>7</sup>

Data provided by state and territory police services, correctional departments and youth justice agencies are cross-referenced with coronial records sourced from the NCIS.

The AIC confirms deaths in custody data with data providers at the end of each quarter, prior to preparation of the Deaths in Custody in Australia Quarterly Dashboard, and again prior to preparation of the Deaths in Custody in Australia Annual Report. Following the quarterly and annual verification processes, data may be revised on the real-time dashboard.

### Evidence of impact

#### Authorising documents

#### **Australian Institute of Criminology National Deaths in Custody Program<sup>8</sup>**

After Recommendation 6 was made, states and territories agreed to this 'minimum' definition of a death in custody, and it became the basis for the National Deaths in Custody Program (NDICP) and reporting by police and corrective services.

*The NDICP uses the definition of a death in custody recommended by the RCIADIC in determining whether cases should or should not be included in the NDICP database.*

In response to this recommendation the Australian Institute of Criminology (AIC) broadened its definition in 2001 to improve the classification of custodial deaths. This expanded scope included deaths resulting from police or correctional efforts to detain individuals or during escape attempts.<sup>9</sup>

The NDICP generally deals with cases that are clearly deaths in custody, but each year, some instances arise that are less straightforward. These cases create uncertainty about whether they meet the official definition of a death in custody. According to the NDICP, a person is considered to be in custody when they are under arrest or detention by police or corrections officers and not free to leave. This definition extends to individuals who die in hospital, provided that the cause of death was linked to injuries or illnesses sustained while in custody. Similarly, if someone dies during a police operation — such as a shooting, pursuit, raid, or siege

<sup>7</sup> Attorney-General quoted in Nicole Hegarty, 'Real-Time Deaths in Custody Reporting to Address 'National Shame' of Indigenous Incarceration', *Indigenous Policy*, ABC News (online, 21 June 2023) <<https://www.abc.net.au/news/2023-06-21/federal-gov-introduces-real-time-reporting-of-deaths-in-custody/102503106>>.

<sup>8</sup> Australian Institute of Criminology, 'Explanatory notes- Definitions of deaths in custody', *Australian Government- Australian Institute of Criminology*, (Explanatory notes) <<https://www.aic.gov.au/explanatory-notes>> ('Definitions of deaths in custody').

<sup>9</sup> Australian Institute of Criminology, *Deaths in Custody in Australia to 30 June 2011: Twenty Years of Monitoring the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody* (Monitoring Report No 20, May 2013) ('Deaths in Custody in Australia').

## 41. National monitoring of deaths in custody

— while police are clearly attempting to detain them, they are considered to be in custody at the time of death.

When there is ambiguity surrounding a case, it is excluded from analysis until a coronial inquest is completed. These inquests can take months or even years, delaying the inclusion of such cases in NDICP reports. Waiting for the coronial outcome 'ensures the integrity and reliability of the NDICP over the longer term'.

The Australian Institute of Criminology recognises that there are differences between the scope of the NDICP and coronial legislation in various jurisdictions:

*There are several key differences between the scope of the NDICP and legislated definitions of deaths in custody for coronial purposes. Thus, deaths that may require notification to the coroner under state or territory legislation may not fall within the scope of the NDICP.<sup>10</sup>*

The NDICP strictly limits its scope to deaths involving individuals who are in custody, in the process of being detained, or actively escaping detention. It does not track deaths of people who are assisted by police services during search, rescue or evacuation; deaths during operations to prevent a suicide; or innocent bystanders who die during police operations.

### Box 1: Definitions of deaths in custody

#### Deaths in prison custody

Deaths in prison custody include deaths that occur in prison or youth detention facilities. This also includes the deaths that occur during transfer to or from prison or youth detention centres, or in medical facilities following transfer from adult or youth detention centres (RCIADIC 1991).

#### Deaths in police custody

Deaths in police custody are divided into two main categories:<sup>a</sup>

##### Category 1

1. Deaths in institutional settings (eg police stations or lock-ups, police vehicles, during transfer to or from such an institution, or in hospitals following transfer from an institution).
2. Other deaths in police operations where officers were in close contact with the deceased. This would include most raids and shootings by police. However, it would not include most sieges where a perimeter was established around a premises but officers did not have such close contact with the person to be able to significantly influence or control the person's behaviour.

##### Category 2

Other deaths during custody-related police operations. This would cover situations where officers did not have such close contact with the person to be able to significantly influence or control the person's behaviour. It would include most sieges, as described above, and most cases where officers were attempting to detain a person—for example, a pursuit.

a: This definition of a 'death in police custody' is based on a 1994 resolution of the Australasian Police Ministers' Council. Category 1(a) deaths have been included in the NDICP since 1980, whereas data on police operational deaths (category 1(b) and category 2 deaths) have been collected by the NDICP since 1990

### National Deaths in Custody Program Steering Group<sup>11</sup>

This Steering Group, formed in 2021, provides advice on matters associated with ongoing program implementation including program design, definitions, data collection, analysis and reporting. The Steering Group helps to ensure that the NDICP is responsive to emerging issues associated with the monitoring of deaths in custody in Australia.

Most jurisdictions have two representatives on the Steering Group drawn from agencies responsible for police, corrections, youth justice or coronial services. Victoria is represented

<sup>10</sup> Australian Institute of Criminology, 'Definitions of deaths in custody'.

<sup>11</sup> Australian Institute of Criminology, 'National Deaths in Custody Program Steering Group Terms of Reference', *Australian Institute of Criminology* (Terms of Reference, 21 June 2023) <<https://www.aic.gov.au/national-deaths-custody-program-steering-group>> ('National Deaths in Custody Program Steering Group Terms of Reference').

## 41. National monitoring of deaths in custody

	<p>by Victoria Police and Corrections Victoria. The National Aboriginal and Torres Strait Islander Legal Services is the only group representing the Aboriginal community invited to be on the Steering Group.</p> <p><b>National Coronial Information System<sup>12</sup></b></p> <p>The provision and use of coronial data is governed by a licence agreement held between the NCIS and each coronial jurisdiction in Australia and New Zealand and a memorandum of understanding between the NCIS and Victoria.</p>
<p><b>Outputs</b></p>	<p><b>National Coronial Information System<sup>13</sup></b></p> <p>The NCIS core data set was agreed upon by all participating jurisdictions upon its establishment in 2000. The NCIS Unit monitors the provision of information from coroners courts against the core data set.</p> <p><b>Aboriginal and Torres Strait Islander identification<sup>14</sup></b></p> <p>The NCIS contains two fields which indicate whether an individual identified as an Aboriginal or Torres Strait Islander person. Coronial information is supplemented with Indigenous status information from each state/territory Births, Deaths and Marriages registry. The latter data originates from the death registration process and/or medical certificate cause of death.</p> <p>Collecting two data sources for Aboriginal and Torres Strait Islander identification in the NCIS recognises the importance of this information for death and injury prevention work. It acknowledges the difficulty of collecting comprehensive and accurate data about Aboriginal and Torres Strait Islander identification in administrative data sets. Two data sources provide greater coverage and a reduced reliance on one administrative process to capture this characteristic. It supplements Australian coronial data for these variables which are not always consistently collected.</p>
<p><b>Outcomes</b></p>	<p><b>National Deaths in Custody Program<sup>15</sup></b></p> <p>The NDICP has monitored the extent and nature of deaths occurring in prison, police custody and youth detention since 1980. The NDICP was established at the AIC in 1992 in response to this recommendation.</p> <p>The NDICP provides real-time and quarterly data dashboards on deaths in custody in Australia and annual reports of the same name. On 1 July 2025, the real-time dashboard indicated there had been 598 Aboriginal deaths in custody since the RCIADIC.</p>

<sup>12</sup> 'About NCIS'.

<sup>13</sup> Ibid.

<sup>14</sup> National Coronial Information System, *Identification of Aboriginal and Torres Strait Islander people in the NCIS* (Data Quality Statement, October 2021) ('Aboriginal People in the NCIS').

<sup>15</sup> Australian Institute of Criminology, 'Deaths in custody in Australia', *Australian Institute of Criminology* (Web page, 21 June 2023) <<https://www.aic.gov.au/statistics/deaths-custody-australia>> ('Deaths in custody in Australia'). Last accessed 1 July 2025.

## 41. National monitoring of deaths in custody

### Community views

#### Hannah McGlade, Associate Professor, Curtin Law School

*We've been calling for real-time reporting because otherwise people really aren't aware there's been another death in custody and the circumstances of that death.<sup>16</sup>*

#### Apryl Day, Executive Officer, Dhadjowa Foundation

*For myself as a family member I haven't been asked to contribute to this and I know as the executive officer of the Dhadjowa Foundation, which is a national grassroots organisation that supports Aboriginal deaths in custody families, we also have not been consulted on this...*

*As an individual tool, I don't think it's going to achieve a lot on its own. If this was to come alongside preventative and accountability measures, I think that could make a difference. . .It's the things that are causing these deaths that need to actually be addressed.<sup>17</sup>*

### Related recommendations

#### 2005 Review<sup>18</sup>

#### Recommendation 67

That the Victorian Government continue to implement and monitor Recommendation 41 through any monitoring process established as a consequence of this Review.

#### Recommendation 149

That the Department of Justice (Corrections Victoria) provide a report to the Aboriginal Justice Forum on progress of the implementation of recommendations from the National Corrective Services Statistics Unit of the Australian Bureau of Statistics and the AIC.

### Assessment summary<sup>19</sup>

The intent of Recommendation 41 was for the Australian Institute of Criminology (AIC) to maintain a database based on a standard definition of deaths in custody and standard form of statistical input, with annual reports to the Commonwealth Parliament.

Several actions have been taken in line with the intent of this recommendation, but some, like reporting annually to Parliament have not continued over time. We continue to be concerned about the definition of a death in custody and fatalities that may be missed based on the current definition. We raised this earlier in Recommendation 6.

It's important for states and territories to maintain consistent records of Aboriginal deaths in custody to support identification of systemic issues and failures that contribute to such passings. Recommendation 41 remains relevant, as the data produced is crucial to supporting Aboriginal self-determination and advocacy for reforms to prevent further deaths.

<sup>16</sup> Hannah McGlade quoted in Hegarty, 'Real-Time Deaths in Custody Reporting to Address 'National Shame' of Indigenous Incarceration'.

<sup>17</sup> Apryl Day quoted in *ibid*.

<sup>18</sup> 2005 Review, vol 1, 52, 72-73.

<sup>19</sup> Meeting with Aboriginal Justice Caucus Working Group (Project Team, In Person, 7 June 2023) ('Working Group Meeting (7 June 2023)'); Meeting with Aboriginal Justice Caucus (Project Team, In person, 19 July 2023) ('Aboriginal Justice Caucus Meeting (19 July 2023)').

## 41. National monitoring of deaths in custody

While there is a clear link between the establishment of the National Deaths in Custody Program by the AIC, the National Coronial Information System and the changes intended by Recommendation 41, there needs to be greater Aboriginal involvement in their oversight.

### Assessment of Recommendation 41

**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

**2.5**

(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

#### **Increase Aboriginal involvement in the oversight of coronial databases**

Increase Aboriginal community representation on the National Deaths in Custody Program Steering Group and oversight of the National Coronial Information System.

#### **Advocate for national reporting on a broader range of deaths involving police/correctional authorities**

Advocate for the National Deaths in Custody Program to collect and report information on deaths that occur soon after people leave custody, while on community-based orders and suicides that occur in the presence of police.

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 41	
	Moderate (3-4)			
	Low (0-2)			

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