3 Coronial matters

The recommendations in this chapter relate to: Overview (1-3); the Findings of the Commissioners as to the Deaths (4-5); Post-Death Investigations (6-40); and Adequacy of Information (41-47).

Key themes from recommendations (47 recommendations)

- The adoption and implementation of the recommendations should be done in a public manner and in consultation with Aboriginal and Torres Strait Islander people and organisations. There should be ongoing reporting on the implementation of the recommendations to allow for monitoring of progress.
- The RCIADIC found that many deaths in custody were poorly reported at the time of death and families and next of kin were ill informed about the details of the death, which caused additional distress. The processes for post-death investigations, notification of deaths to families and next of kin, and coronial inquests should be improved and detailed recommendations on how to do so are provided.
- National databases should be established to collect data on deaths in custody, incarceration rates, the flows in and out of police cells and the demographics of detainees. This should be accompanied by a national harmonisation of data collection and reporting standards.

Legend: Complete | Mostly Complete | Partially Complete | Not Implemented | Out of Scope

Commonwealth | Key actions: The Commonwealth produced annual implementation reports from 1992-93 to 1996-97, and continues to publish data on Aboriginal and Torres Strait Islander people in the prison population. The AFP's National Guideline on persons in custody and police custodial facilities, and the AFP Commissioner's Order on Professional Standards were developed to improve process of reporting and investigating deaths in custody.

Remaining gaps: The intensity of reporting on the progress of implementation has reduced over time. The AIC has undertaken to establish and report on data on police custody. This remains an ongoing issue for the AIC. A review of the first data collection using electronic custody data has been completed internally. The next stage is for the AIC to engage with States and Territories to develop the next iteration of data collection.

New South Wales | Key actions: New South Wales produced implementation reports between 1992 and 2000, and monitored the implementation of the RCIADIC through an AJAC Committee. Coronial recommendations have been incorporated into police procedures and policies, and the *Coroners Act 2009* (NSW). The NSW Government contributes to ongoing data publication.

Remaining gaps: In New South Wales, there is no provision that an inquest not proceed should the deceased's family or their representatives not be in attendance. Further efforts are required in relation to notifying family members and the Aboriginal Legal Service surrounding the details of an inquest.

Victoria | Key actions: The Victorian Government produced implementation reports and established an AJAC to monitor the implementation of recommendations. Aboriginal Justice Agreements have continued to monitor progress, and set strategic policy priorities. Coronial recommendations have been addressed through the *Coroners Act 2008* (Vic), and ongoing data publication of Aboriginal and Torres Strait Islander people in the prison population occurs.

Remaining gaps: The Victorian Government has not fully addressed recommendations relating to the selection or appointment of officers to conduct post-death investigation. It does not appear that the protocol called for between the Aboriginal Legal Services and Aboriginal Health Services has been extended to cover all Aboriginal and Torres Strait Islander deaths notified to the coroner. Further action is also required to address the provision and publication of information on persons in custody.

Queensland | Key actions: In Queensland, the government produced implementation reports between 1993 and 1997 and established an AJAC and the ATSIAB to monitor progress. Coronial inquest and reporting processes were addressed through legislation and procedural guidelines. The Queensland Corrective Services publishes annual reports and other data.

Remaining gaps: The Queensland Government has not established a protocol between the Aboriginal Legal Services and Aboriginal Health services to cover all Aboriginal and Torres Strait Islander deaths notified to the coroner. Further action is also required to address the settlement of claims via negotiation, and the publication of data profiling persons in police cells.

South Australia | Key actions: The South Australian Government produced implementation reports and established an AJAC and the South Australian AAC to monitor the progress of implementation. Recommendations relating to coronial inquest, and investigation and reporting procedures were addressed through the Coroners Act 2003 (SA) and procedural guidelines. Ongoing data publication occurs as called for by the RCIADIC.

Remaining gaps: While the South Australian Government has at least partially addressed nearly all recommendations, further implementation is required in relation to continued monitoring and reporting on progress. Coronial recommendations which deal with autopsy procedures, and the responsibilities and powers of the lawyer assisting the coroner, are also not fully met.

Western Australia | Key actions: The Western Australian Government has produced five public implementation reports and continues to consult with Aboriginal and Torres Strait Islander communities in relation to the RCIADIC. The *Coroners Act 1996* (WA) significantly addresses recommendations relating to the process of post-death investigation and coronial conduct. Western Australia cooperates with the Commonwealth Government on the publication of relevant data.

Remaining gaps: The Western Australian Government has not fully met the requirements of recommendations related to the settlement of claims made in respect of deaths in custody, or the Coroner's reporting and recommendation requirements to the Attorney-General. There is also a lack of legislation requiring the Aboriginal Legal Service to be notified of a death in custody.

Tasmania | Key actions: The Tasmanian Government produced implementation reports in 1993 and 1995. The process of coronial inquest, and investigation and reporting procedures were addressed through amendments to the Coroners Act 1995 (Tas), and the Tasmania Police Manual. Ongoing data publication occurs in cooperation with the Commonwealth.

Remaining gaps: The Tasmanian Government has not fully met recommendations related to the monitoring of progress, or the establishment of an AJAC or similar body. Procedures governing the departmental response to coronial findings, notification of the family of the deceased, and post-mortem examinations are also not fully addressed.

Northern Territory | Key actions: The Northern Territory Government produced implementation reports and monitored the progress of implementation through an AJAC and AJU. The *Coroners Act 1993* (NT) and other legislation and policy has been introduced to address coronial matters. Ongoing data collection and reporting occurs through the function of the NTCS, and cooperation with the Commonwealth.

Remaining gaps: The Northern Territory Government has not fully addressed principles attached to the provision of legal aid, or the duties of the lawyer assisting the coroner. Police, Corrections and Health have protocols in place for Aboriginal and Torres Strait Islander people that die in their care, custody or fall under the provisions of the *Coroners Act 1993* (NT), however protocols don't exist for Aboriginal and Torres Strait Islander people that die outside of the care/custody of these agencies or fall outside the provisions of the *Coroners Act 1993* (NT).

Australian Capital Territory | Key actions: The Australian Capital Territory Government produced implementation reports, and continually monitored implementation through the Advisory Council and the Aboriginal Justice Centre. The Coroners Act 1997 (ACT), and the AFP National Guideline on persons in custody and police custodial facilities, were introduced in response to coronial recommendations. The ACT continues to publish data as called for by the RCIADIC.

Remaining gaps: The Australian Capital Territory has not addressed the requirement that coronial authorities notify the Coroner's Office of all deaths in custody immediately. It does not appear that a protocol exists between Aboriginal Legal Services and Aboriginal Health Services to cover all Aboriginal or Torres Strait Islander deaths reported to the coroner.

3.1 Overview (1-3)

Recommendation 1

That having regard to the great input which has been made to the work of the Commission, not only by governments and departments of government but also by Aboriginal communities, organisations and individuals, on the one hand, and non-Aboriginal organisations and individuals, on the other, it is highly desirable that the attitude of governments to the recommendations and the implementation of those adopted be carried out in a public way as part of the process of education and reconciliation of the whole society. To this end the Commission recommends:

a. *That the Commonwealth Government and State and Territory Governments, in consultation with ATSIC, agree upon a process which ensures that the adoption or otherwise of recommendations and the implementation of the adopted recommendations will be reported upon on a regular basis with respect to progress on a Commonwealth, State and Territory basis;*

b. *That such reports should be made not less than annually and that, subject to the agreement of its Commissioners so to do, ATSIC be given special responsibility and funding to enable it to monitor the progress of the implementation of the adopted recommendations and to report thereon to the Aboriginal and Torres Strait Islander community;*

c. *That governments consult with appropriate Aboriginal organisations in the consideration and implementation of the various recommendations in this report;*

d. *That, wherever appropriate, governments make use of the services of Aboriginal organisations in implementing such recommendations; and*

e. *Ensure that local Aboriginal organisations are consulted about the local implementation of recommendations, and their services be used wherever feasible.*

Background information

The RCIADIC Report represented the first comprehensive review of factors impacting the incarceration of Aboriginal and Torres Strait Islander people and was influential in terms of setting policy direction for governments. Recommendation 1 is for the findings of this Report to be incorporated into Australia's public policy discussion.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **Commonwealth** Government produced five annual implementation reports over the period 1992-93 to 1996-97. Following that, ATSIC was responsible for ongoing monitoring until disbanded in 2005. The Commonwealth also cooperated with ATSIC to ensure the involvement of Aboriginal and Torres Strait Islander organisations in the implementation of Recommendation 1. However, ATSIC was disbanded in 2005. The extent and nature of all deaths that occur in gaols, juvenile justice centres and in police custody have been monitored and publicly reported by the AIC through the National Deaths in Custody Program since 1992. Currently, the Commonwealth does not formally monitor the implementation of the RCIADIC recommendations.

◑ *The Commonwealth has only partially completed Recommendation 1. While initial progress following the RCIADIC was made in the monitoring and implementation of recommendations, this has ceased. After ATSIC was disbanded, cooperation with Aboriginal and Torres Strait Islander organisations on the implementation of the recommendations does not appear to have continued.*

The **New South Wales** Government produced five reports between 1992 and 2000 outlining its implementation of the recommendations. In 1992, NSW established an Inter Departmental Committee to monitor the implementation of the recommendations and to coordinate state funding arrangements. The then Department of Aboriginal Affairs (currently Aboriginal Affairs NSW) received funding from ATSIC to ensure the involvement of Aboriginal people in monitoring the implementation of the recommendations. In respect to part d), in 1994-95, the-then Department of Aboriginal Affairs contracted the Western Aboriginal Legal Service and Tranby Aboriginal Cooperative to undertake a series of community workshops specifically dealing with the implementation of the recommendations.

In 2004, the former Aboriginal Justice Advisory Committee (AJAC) made the decision to suspend state reporting in light of the implementation of the Aboriginal Justice Plan in 2004 and the Department of Aboriginal Affairs' *Two ways together: New South Wales Aboriginal Affairs Plan (2003-2012)*. The intent of the Royal Commission's work continues to inform the work of NSW Government agencies today. This includes a commitment to ongoing consultation and engagement with Aboriginal communities to inform the development and implementation of new policies, programs and services in a broad range of areas including education, employment, child protection and family wellbeing, health and the recognition and preservation of Aboriginal culture and heritage.

The NSW Government conducts annual reporting on progress on OCHRE[3] and also has a 10-year evaluation plan. OCHRE is the NSW Government's plan for Aboriginal affairs. The plan invests in language and culture, healing, Aboriginal governance, education and employment. Implementation and evaluation takes place using a genuine co-design approach with Aboriginal communities at the centre of decision making.

Corrections Research, Evaluation and Statistics (part of Corrective Services NSW (CSNSW)) collects, analyses, interprets and disseminates information to inform CSNSW planning, policy formulation and operational management including initiatives relating to Aboriginal offenders. Under the Strategy for supporting Aboriginal offenders to desist from re-offending CSNSW actively seeks the formal involvement of Aboriginal community representatives in devising policies and programs as well as CSNSW responses to new legislative initiatives. CSNSW collaborates with regional non-government agencies including Aboriginal organisations to deliver rehabilitation and community based integration programs and services.

NSW Government funding supports Aboriginal Community Controlled Health Services to deliver services in the areas of chronic care, oral health, domestic and family violence, mental health, vascular health, preventive health care and drug and alcohol misuse. This important work is taking place through the NSW *Aboriginal Health Plan 2013-2023,* which was developed in partnership with the Aboriginal Health and Medical Research Council of NSW to ensure that the voices of Aboriginal people inform the NSW Government's decision-making processes.

The New South Wales Government has mostly implemented Recommendation 1 through the publication of implementation reports, the development of plans, and continued engagement with Aboriginal organisations. However, it doesn't appear that the ongoing monitoring of all these plans occurs.

The **Victorian** Government produced Royal Commission Implementation Reports in 1992, 1993, 1995-96 and 2005. In 1994, the-then Victorian Minister for Aboriginal Affairs, the Hon. Michael John, MP, was responsible for coordinating the Victorian Government's implementation and response to the recommendations of the RCIADIC. Through Aboriginal Affairs Victoria, a system of monitoring and reporting on initiatives to implement the Commission's recommendations was established. Phase 1 of the Victorian Aboriginal Justice Agreement (AJA) was produced in direct response to the 1997 National Ministerial Summit into Indigenous Deaths in Custody, which was held to review the implementation of the RCIADIC recommendations. Phase 1 ran from 2000 to 2006 and Phase 2 from 2006 to 2012. The current phase is Phase 3, which commenced in 2013. An independent evaluation of AJA Phase 2

[3] Opportunity, Choice, Healing, Responsibility, Empowerment.

was undertaken in 2011-12 and AJA Phase 3 specifies benchmarks, performance indicators, targets and timelines that all AJA initiatives are measured against.

In respect to parts c) and e), the AJAs are a formal agreement between the Victorian Government and Koori Community for working together to improve justice outcomes for the Koori community, and had its origins are on implementing the RCIADIC recommendations. In respect to part d), it is Victorian Government policy to use Aboriginal community organisations, wherever possible, to deliver services to Aboriginal people.

● *The Victorian Government has implemented Recommendation 1 through the publication of implementation reports, the development of AJAs as part of the response to the RCIADIC, and continued engagement with Aboriginal and Torres Strait Islander organisations.*

The **Queensland** Government produced four RCIADIC Implementation Reports between 1993 and 1997. The Queensland Government noted that current government policies, programs and practices that implement the recommendations are now considered 'business as usual'. Reporting on relevant activity that implements the recommendations forms part of the regular reporting process of government. In December 1992, the Queensland Government appointed a 12-member Aboriginal and Torres Strait Islander Overview Committee. The Committee's terms of reference included ensuring meaningful consultation with the Aboriginal and Torres Strait Islander community, monitoring and advising government on the implementation of the RCIADIC recommendations, and keeping the Aboriginal and Torres Strait Islander community informed of the processes and progress of implementation.

● *The Queensland Government has implemented Recommendation 1 through the publication of implementation reports, the appointment of an Aboriginal and Torres Strait Islander Overview Committee, and the incorporation of implementation updates into regular government reporting processes.*

The **South Australian** Government produced two RCIADIC Implementation Reports in 1993 and 1994. The 1994 Implementation Report highlighted that the Aboriginal Justice Advisory Committee, with representatives drawn from local committees or organisations, would assist in improving consultation about the local implementation of recommendations. It is the South Australian Government's current position that government policy and practices must place emphasis on consultation and collaboration. The South Australian Government also noted there has been progress in the spirit of the recommendations through implementation of services through approaches that include holistic, place-based, community development practice and empowered decision making with Aboriginal nations, organisations and communities.

◑ *The South Australian Government has partially implemented Recommendation 1 through the publication of implementation reports, and continued consultation and collaboration with Aboriginal and Torres Strait Islander organisations. However, it does not appear that ongoing monitoring of the RCIADIC recommendations occurs.*

Since the Royal Commission, the **Western Australian** Government has produced five public implementation reports (1993, 1994, 1995, 1997, 2000) against the Recommendations. The first report set out the Aboriginal community-based initiatives and established a detailed outcomes-based reporting process in line with the Aboriginal community response.

The Western Australian Government has consulted with Aboriginal organisations when previously implementing the Recommendations. Presently, the Western Australia Government is undertaking significant consultations with Aboriginal communities across the State for the refreshed Closing the Gap agenda.

In terms of the specific issue of Aboriginal deaths in custody, the Western Australian Government reports such occurrences to the Productivity Commission annually, for their production of the Report on Government Services ('Volume C: Justice' refers).

More strategically, in meeting the needs of Aboriginal people, the Western Australian Government conducted a review of the public sector in 2017, titled the Service Priority Review (SPR). The first

direction from the SPR is to ensure the public sector is focused on community needs, Aboriginal or otherwise. Machinery of Government changes have seen the creation of the Aboriginal Policy Unit (APU) within the Department of the Premier and Cabinet. The APU's primary aim is to transform the relationship between Aboriginal people and government in Western Australia to deliver mutual and enduring benefits. Location-based solutions, including across regional and remote communities, is another key focus of the APU.

The Western Australian Government has also approved further funding for the Regional Services Reform Unit. The Unit is focused on remote communities in the Pilbara and Kimberley regions with a dedicated focus on working with Aboriginal communities to achieve better outcomes. The Unit has published details of its extensive consultation with communities in its report 'Resilient Families, Strong Communities'.

The Western Australian Government has implemented Recommendation 1 through the publication of implementation reports, the incorporation of implementation updates into regular government reporting processes and continued engagement with Aboriginal and Torres Strait Islander organisations.

The **Tasmanian** Government produced two RCIADIC Implementation Reports in 1993 and 1995. The 1993 Implementation Report highlighted that the Department of Premier and Cabinet was responsible for overseeing the implementation process and had secured funding from ATSIC to ensure that Aboriginal organisations were consulted about the local implementation of the recommendations. Further to this, in 1995, the Tasmanian Government stated that a RCIADIC Monitoring Committee had been established to oversee the implementation of the recommendations.

The Department of Police, Fire and Emergency Management's *Aboriginal Strategic Plan 2014-2022* acknowledges the importance of Aboriginal and Torres Strait Islander communities within the context of the broader community, and supports strategies to develop and maintain appropriate and culturally respectful relationships between the Tasmanian Government and these communities. Additionally, the Tasmania Police State Aboriginal Liaison Coordinator establishes a framework for regular meetings between Tasmania Police and local Aboriginal and Torres Strait Islander organisations.

The Tasmanian Government has mostly implemented Recommendation 1 through the publication of implementation reports, the establishment of a RCIADIC Monitoring Committee, and the Department of Police, Fire and Emergency Management's Aboriginal Strategic Plan 2014-2022. However, it does not appear that ongoing monitoring of the RCIADIC recommendations occurs.

The **Northern Territory** Government produced four RCIADIC Implementation Reports in 1993, 1994, 1996 and 1997. The 1994-95 Implementation Report stated that the Northern Territory Government had appointed an Aboriginal RCIADIC Project Officer and an Assistant Project Officer within the Office of Aboriginal Development to enhance involvement of the Northern Territory Aboriginal community in the monitoring and implementation process. According to the 1996-97 Implementation Report, funding for the project officers ceased in 1996-97.

The Northern Territory Government has partially implemented Recommendation 1 through the publication of implementation reports, the appointment of Project Officers to assist with the implementation of the RCIADIC, and continued community engagement and monitoring activities. However, it does not appear that ongoing monitoring of the RCIADIC recommendations occurs.

The **Australian Capital Territory** Government produced four RCIADIC Implementation Reports between 1992 and 1998. By 1994, the ACT Government had formed the Aboriginal and Torres Strait Islander Advisory Council and the Council was working with the ACT Government to implement the recommendations. The 1997 Implementation Report noted that the ACT Government was consulting with the Aboriginal and Torres Strait Islander Consultative Council and other Aboriginal and Torres Strait Islander organisations when implementing the RCIADIC recommendations.

The ACT Aboriginal and Torres Strait Islander Agreement 2015-2018 expires at the end of 2018. The next Agreement (ACT Aboriginal and Torres Strait Islander Agreement 2019-2024) will commence in

2019 to align with the Aboriginal and Torres Strait Islander Justice Partnership 2019-2024. The Agreement is being developed in partnership with the ACT Aboriginal and Torres Strait Islander Elected Body (the Elected Body[4]). The Elected Body will be a signatory to the Agreement, along with the ACT Government and ACT Public Service.

The Agreement is a commitment by the ACT Government, the Elected Body, the ACT Public Service and its service partners to work with the community to meet the vision of equitable outcomes for individuals and members of the ACT Aboriginal and Torres Strait Islander community. The Agreement is a whole-of-government agreement, therefore it is expected that all ACT Government Directorates will use the policy framework to ensure that the self-determination principle is applied in the design and implementation of any policy or program or the substantial modification of any policy or program which will particularly affect Aboriginal and Torres Strait Islander members of the community.

◑ *The Australian Capital Territory Government has partially implemented Recommendation 1 through the publication of implementation reports, and continued consultation and collaboration with Aboriginal and Torres Strait Islander organisations. However, it does not appear that ongoing monitoring of the RCIADIC recommendations occurs.*

Recommendation 2

That subject to the adoption by governments of this recommendation and the concurrence of Aboriginal communities and appropriate organisations, there be established in each State and Territory an independent Aboriginal Justice Advisory Committee to provide each Government with advice on Aboriginal perceptions of criminal justice matters, and on the implementation of the recommendations of this report. The Aboriginal Justice Advisory Committee in each State should be drawn from, and represent, a network of similar local or regionally based committees which can provide the State Advisory Committee with information of the views of Aboriginal people. It is most important that the views of people living outside the urban centres be incorporated. The terms of reference of each State, local or regional Advisory Committee is a matter to be negotiated between governments and Aboriginal people. The Commission suggests however that matters which might appropriately be considered include, inter alia:

a. *The implementation of the recommendations of this report, or such of them as receive the endorsement of the Government;*

b. *Proposals for changes to policies which affect the operation of the criminal justice system;*

c. *Programs for crime prevention and social control which enhance Aboriginal self-management and autonomy;*

d. *Programs which increase the recruitment of Aboriginal people to the staff of criminal justice agencies; and*

e. *The dissemination of information on policies and programs between different agencies, and between parallel bodies in different States.*

[4] The Elected Body consist of seven members. Each member is elected by the ACT Aboriginal and Torres Strait Islander community for three years and hold office on a part-time basis. The Chair and Deputy Chair are elected by majority vote of the members. The purpose of the Elected Body is to provide a strong, respected and democratically elected voice for Aboriginal and Torres Strait Islander people living in the ACT by: Understanding and representing community needs and priorities; Supporting development of government policy and services that meet community needs; and Advocating for accountability, transparency and effectiveness in achieving social and economic outcomes for the ACT Aboriginal and Torres Strait Islander community. The Elected Body has been established by the ACT Government as an innovative and unique model underpinning Aboriginal and Torres Strait Islander community development and self-determination in Canberra.

Background information

To implement successfully the RCIADIC recommendations, the RCIADIC recommended the establishments of an independent Aboriginal Justice Advisory Committee (AJAC) to capture the views of Aboriginal and Torres Strait Islander people. In order to reflect accurately the opinions of all Aboriginal and Torres Strait Islander people, the Advisory Committee should include a group of regionally based members to reflect the views of those Aboriginal and Torres Strait Islander people who live in regional areas.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the Attorney-General approved the formation of an AJAC in 1993. The AJAC Committee held its first meeting on 10 June 1993 and their role involved advising the Attorney-General on a range of matters within its Terms of Reference. In 1998, the AJAC became the Aboriginal Justice Advisory Council, which operated until 2009.

Currently, the New South Wales Government receives advice in relation to justice policy, including from the Corrective Services NSW AAC and the Juvenile Justice Aboriginal Strategic Advisory Committee, and at a local level from a range of Aboriginal advisory communities. There are also a number of Aboriginal Consultative Committees with representatives from local Aboriginal organisations and services programs advising Juvenile Detention Centres on relevant local issues to support Aboriginal young people.

Consultation is also occurring at the local level under the NSW Government's Aboriginal Affairs policy, OCHRE. As a part of Local Decision Making, negotiations in the Illawarra Wingecarribee region, the regional Aboriginal governance body, and relevant NSW Government agencies have negotiated the establishment of a Community Police and Justice Committee. The Committee's role is to discuss local policy matters and to resolve local contentious issues. The inter-jurisdictional Corrective Services Administrators Council is an effective forum to disseminate information and best practice on policies and programs for Aboriginal offenders. The Council have established the National Indigenous Working Group comprising representatives of Aboriginal policy advisors around Australia to share best practice approaches and ensure the currency and relevance of policies and programs impacted by Aboriginal offenders.

The New South Wales Government implemented Recommendation 2 through the establishment of an AJAC, which provided advice on the implementation of the RCIADIC. Aboriginal perspectives on criminal justice issues continue to be provided through a number of advisory committees.

In 1993, the **Victorian** Government established an Aboriginal Justice Advisory Committee. The Committee acted as the primary source of advice and direction to the Victorian and Commonwealth Governments on the implementation of the RCIADIC recommendations. The *Victorian Government Indigenous Affairs Report 2004-05* detailed that Regional Aboriginal Justice Advisory Committees were a key link in the partnership between the Government and Aboriginal and Torres Strait Islander community. To date, there are nine Regional Aboriginal Justice Advisory Committees throughout Victoria.[5]

The Victorian Government implemented Recommendation 2 through the establishment of AJACs which were tasked with providing advice on the RCIADIC, and continue to provide advice to the Victorian Government.

In 1993, the **Queensland** AJAC was established to provide the-then Minister for Justice and Attorney-General with independent and informed advice about Aboriginal and Torres Strait Islander perspectives on criminal justice issues that affect Aboriginal and Torres Strait Islander people. In

5 http://www.justice.vic.gov.au/home/your+rights/aboriginal+justice+agreement/regional+aboriginal+justice+advisory+committee.shtml, accessed September 2017.

1997, the AJAC was replaced by the Indigenous Advisory Council, which in turn was replaced by the Aboriginal and Torres Strait Islander Advisory Board (ATSIAB). The ATSIAB's terms of reference included the provision of advice on the implementation of this recommendation of the RCIADIC. The ATSIAB was disbanded when the Aboriginal and Torres Strait Islander Justice Agreement expired in 2011. The Department of Justice and Attorney-General has initiated strategies aimed at recruiting and training Aboriginal and Torres Strait Islander departmental officers. In relation to sentencing matters, the Queensland Sentencing Advisory Council is able to provide advice to the Attorney-General on matters relating to sentencing. A recent reference of issues affecting parole and community based orders requires the Council to consider Indigenous over-representation in the criminal justice system.

The Queensland Government mostly implemented Recommendation 2 through the establishment of an AJAC, and later ATSIAB, which provided advice on the RCIADIC. However, it is not clear which mechanisms currently exist to promote the intent of this recommendation.

An AJAC was formed in **South Australia** in 1989. To ensure that the Committee was truly independent, it was re-established as a community-based committee in 1994. The Committee worked closely with the Aboriginal Legal Rights Movements Inc. and the Department of State Aboriginal Affairs. In November 2005, the Premier established the South Australian AAC (SAAAC). In May 2007, the interim SAAAC recommended that an ongoing AAC be convened as a key engagement mechanism between South Australian Aboriginal people and the State Government. The South Australian Government formally adopted these recommendations in December 2007.

The AAC has the role of providing the Government with advice on existing programs and policies as they affect Aboriginal people. The Attorney General's Department established the time-limited Port Adelaide Justice Reinvestment Advisory Group with an independent Aboriginal and Torres Strait Islander chairperson to oversee consultations on justice reinvestment in 2015. The SA Government's strategy to reduce reoffending by 10% by 2020 was underpinned by an Aboriginal and Torres Strait Islander advisory panel.

The South Australian Government has implemented Recommendation 2 through the establishment of an AJAC, the SAAAC, and the AAC.

In 1992, the **Western Australian** Government established the Aboriginal Advisory Council (AAC) as the interim AJAC. The role of the AAC was to provide Aboriginal perspectives on criminal justice matters, and to monitor the implementation of the Recommendations of the RCIADIC. In 1994, the Aboriginal Justice Council (AJC) was formally established and replaced the AAC. The State Government funded the AJC until 2002.

Although, the Western Australian Government does not currently have an advisory council dedicated solely to Aboriginal justice matters the functions in the Recommendation are addressed as follows:

- the Western Australia Aboriginal Advisory Council (WAAAC) is a legislated body that considers a wide range of strategic policies and programs affecting the lives of Aboriginal people. Members are drawn from regions in Western Australia, including regional and remote locations;
- the Justice Planning and Reform Committee (JPRC) has been established to lead a coordinated approach to criminal justice system reform. The JPRC is chaired by the Director General of the Department of the Premier and Cabinet and membership is comprised of senior officers from justice agencies; and
- justice agencies develop Reconciliation Action Plans (RAPs) that include strategies to recruit and retain Aboriginal staff.

The Western Australian Government implemented Recommendation 2 through the establishment of the AAC and the AJC, which provided advice on the implementation of the RCIADIC. Aboriginal perspectives on justice issues continue to be provided through a number of advisory bodies.

According to the 1993 Implementation Report, the **Tasmanian** Government would only support this recommendation if the Aboriginal community, represented through Aboriginal Legal Service, agreed to the proposal. The Aboriginal Legal Service and the Department of Police did not give their support to

implement the recommendation and by the time of the 1995 Implementation Report, an AJAC was still under consideration. No further information on more recent actions taken towards implementation could be located.

The Tasmanian Government has not implemented Recommendation 2. The establishment of an AJAC did not occur in Tasmania.

The 1994-95 **Northern Territory** Implementation Report stated that an AJAC had been established comprising representatives from Aboriginal organisations and communities. However, the 1996-97 Implementation Report noted that the Northern Territory AJAC had been dormant for some months and was expected to be revitalised during the 1998-99 financial year. In 2017, the Northern Territory's Attorney-General's Department established an Aboriginal Justice Unit which commenced development of an Aboriginal Justice Agreement through extensive consultation with communities and stakeholders. A key objective of the Unit is to develop strategies and actions aimed at reducing the high levels of Aboriginal and Torres Strait Islander recidivism rates in the Northern Territory justice system.

The Northern Territory Government mostly implemented Recommendation 2 through the establishment of an AJAC. Whilst there was a gap in the implementation of this recommendation, the Northern Territory has now established an Aboriginal Justice Unit for ongoing implementation.

In the **Australian Capital Territory**, the Chief Minister had established an Advisory Council by 1993 to advise and monitor the implementation of the RCIADIC recommendations, which fulfilled the role of an AJAC. In 2006, the Aboriginal Justice Centre replaced the Advisory Council to assist the ACT Government in implementing the RCIADIC recommendations. In 2015, the Aboriginal Justice Centre was placed into administration after the ACT Government withdrew funding for the service due to lack of proper financial management in the previous financial year.[6] Through extensive community consultation with the Elected Body it was agreed that the ACT Government seek tenders from existing local Aboriginal and Torres Strait Islander organisations to provide community justice programs. Since 2015 the Canberra Office of the Aboriginal Legal Service has been the lead agency to deliver these programs and services.

The ACT Government has also entered into an Aboriginal and Torres Strait Islander Justice Partnership with the Elected Body, which seeks to reduce Aboriginal and Torres Strait Islander over-representation in the ACT justice system, as both victims and offenders. This Partnership aims to improve justice outcomes for Aboriginal and Torres Strait Islander people in the ACT through the development and implementation of policies and programs that have long-term benefits for the local community.

The Australian Capital Territory Government implemented Recommendation 2 through the establishment of the Advisory Council, and subsequent bodies. Currently, Aboriginal and Torres Strait Islander perspectives on justice issues are sought through the Justice Partnership.

Recommendation 3

The Commission notes that some of the recommendations of this report, particularly those relating to the custodial environment, are particularly detailed. The monitoring of the implementation of recommendations could only be carried out in close liaison with the authorities responsible for implementing them. In order to ensure that the State Aboriginal Justice Advisory Committee is able to give informed advice to the Attorney-General or Minister for Justice, it should be assisted by a small Secretariat, staffed by people with knowledge of Aboriginal interactions with the criminal justice system. The role of the Secretariat should be to provide information to the Advisory Committee, assist it in the development of policy proposals, and liaise on behalf (and at the direction of) the Committee with other agencies. The Secretariat should be located within the Department of Attorney-General or Minister for Justice but be accountable to the Advisory Committee on terms to be negotiated between

[6] http://www.canberratimes.com.au/act-news/liquidator-appointed-for-aboriginal-justice-centre-20150406-1mf6jy, accessed September 2017.

government and Aboriginal people but with the maximum degree of autonomy from government as may be consistent with it fulfilling its function to assist the Advisory Committee to give informed, independent advice to government.

Background information

The purpose of forming the Secretariat was to create a strong connection between the AJAC and the Attorney-General or Minister for Justice or their equivalent in each jurisdiction. By forming this connection, the Commission intended for the Secretariat to act as a negotiator between the two bodies and to monitor the implementation of recommendations.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In 1994, the **New South Wales** Government appointed an Executive Officer to support the NSW AJAC. The Officer was located within the Attorney-General's Department but is accountable to the Advisory Committee. The Executive Officer was able to use the support staff in the Legislation and Policy Division of the Department. Currently, the various Aboriginal advisory groups within Justice do not have a specific secretariat budget. Catering is provided and in some limited cases travel costs for some committees or advisory groups. The NSW Sentencing Council pays a sitting fee and has an Aboriginal representative.

The New South Wales Government has implemented Recommendation 3 through the function performed by the Executive Officer to the AJAC.

In 1994, the **Victorian** secretariat to the AJAC was based in Aboriginal Affairs Victoria, within the Department of Health and Community Services. Aboriginal Affairs Victoria was responsible for monitoring the implementation of the recommendations of the RCIADIC and serving the AJAC.

Currently, the Aboriginal Justice Forum brings together leaders in the Aboriginal community and the most senior representatives of the Justice, Health and Human Services, and Education government departments. It operates as the peak coordinating body responsible for overseeing the development, implementation and direction of the AJA. Aboriginal community representation at the Forum includes each of the nine Regional Aboriginal Justice Advisory Committee (RAJAC) chairs as well as senior representatives from a number of key Aboriginal community organisations and peak bodies (for example, Victorian Aboriginal Legal Service, Victorian Aboriginal Childcare Agency, Victorian Aboriginal Education Association, etc.). The Koori Caucus comprises the Aboriginal community members of the Aboriginal Justice Forum. In addition to the nine Chairs of the Regional Aboriginal Justice Advisory Committee, the Koori Caucus also includes Aboriginal representatives of Aboriginal peak bodies and some Aboriginal Community Controlled organisations.

The Koori Justice Unit within the Department of Justice and Regulation is responsible for coordinating the development and delivery of Aboriginal justice policies and programs across the Victorian Government and justice agencies. The Unit builds capacity in the department and the Aboriginal community, to develop and deliver effective and efficient justice services in partnership; provides advice to the Justice executive, ministers and staff across the department on issues impacting on Aboriginal communities across Victoria, advocates for ongoing improvement in the design and delivery of Aboriginal justice initiatives; monitors and evaluates Aboriginal justice initiatives; maintains a robust evidence base detailing Aboriginal involvement with criminal justice institutions; provides executive services to Justice ministers and the Justice executive and secretariat support and program implementation on behalf of the Aboriginal Justice Forum. As a part of the Department of Justice and Regulation the Koori Justice unit briefs up to the Attorney-General but also takes direction from and reports to the Koori Caucus.

The Victorian Government has implemented Recommendation 3 through the function performed by the secretariat to the AJAC and ongoing arrangements to support the Aboriginal community to provide input into Aboriginal justice policies and programs.

By 1994, the **Queensland** AJAC Secretariat had been formed and was located within the Department of Justice and Attorney-General. In 1997, the Secretariat was staffed by a policy co-ordinator, a senior research officer and two administrative assistants, providing policy advice and research support to the AJAC in its role as an independent Ministerial advisory committee.

The Queensland Government has implemented Recommendation 3 through the establishment of the AJAC Secretariat to provide police advice and research support to the AJAC. The Secretariat was located within the Department of Justice and Attorney-General.

An AJAC was established in **South Australia** in 1989 to provide advice and monitor government implementation of the RCIADIC recommendations. In 2002, this was replaced by the Aboriginal Justice Consultative Committee with the role of creating partnerships between the Aboriginal community and the justice agencies.

The South Australian Government has partially implemented Recommendation 3. While an AJAC was established, it is not clear what level of Secretariat support was provided.

The 2000 Implementation Report noted that an Aboriginal Justice Council was formed in **Western Australia** in 1994 and was funded on a recurrent basis from 1995-96. The State Government provided a secretariat to support the State Aboriginal Justice Council through the Aboriginal Affairs Department. The Aboriginal Justice Council's role widened in 1996-97 to monitor progress relating to the underlying and social issues identified in the RCIADIC report in addition to the criminal justice recommendations.

The present WAAAC is supported by the secretariat at the Department of the Premier and Cabinet to facilitate the WAAAC's input on matters across a spectrum of social issues. This wide focus places the Council in the best position to consider justice issues in context, given its appreciation of commonalities between seemingly disparate policy issues.

The Western Australian Government has implemented Recommendation 3 through the provision of a secretariat support to the Aboriginal Justice Council and now the WAAAC.

As mentioned in the 1993 Implementation Report, **Tasmania** believed that the establishment of a secretariat would have significant resource implications for the Department of Justice and could not be justified for Tasmania. Given no AJAC has been established in Tasmania (see Recommendation 2), this recommendation does not apply to Tasmania.

Recommendation 3 is out of scope for the Tasmanian Government because the establishment of the secretariat was irrelevant given no AJAC has been established in Tasmania.

The 1994-95 **Northern Territory** Implementation Report highlighted that a Secretariat to the Law and Justice Forum had been provided by the Office of Aboriginal Development. The Secretariat for the AJAC was located within the North Australian Aboriginal Legal Aid Service.

The Northern Territory Government has implemented Recommendation 3 through the provision of a Secretariat to the Law and Justice Forum.

In the **Australian Capital Territory**, the 1995-96 Annual Report recorded that the ACT Aboriginal and Torres Strait Islander Consultative Council monitored the ACT Government's implementation of the Commission's recommendations. The ACT Government had received funding from the Aboriginal and Torres Strait Islander Commissioner (ATSIC) to assist the council in its monitoring role. The Aboriginal and Torres Strait Islander Issues Unit of the Chief Minister's Department provided secretariat support for the Consultative Council.

Currently, a caucus of Aboriginal and Torres Strait Islander representatives from justice and related sectors is embedded into the advisory framework to monitor and provide advice on the implementation of the Justice Partnership and related initiatives. The caucus group meet on a quarterly basis and provides advice up to the executive level justice partnership advisory group established to monitor the progress in achieving the key objectives in the partnership.

The Australian Capital Territory Government has implemented Recommendation 3 through the ACT Aboriginal and Torres Strait Islander Consultative Council, and the provision of secretariat support by the Chief Minister's Department.

3.2 The findings of the Commissioners as to the deaths (4-5)

Recommendation 4

That if and where claims are made in respect of the deaths based on the findings of Commissioners:

a. Governments should not, in all the circumstances, take the point that a claim is out of time as prescribed by the relevant Statute of Limitations; and

b. Governments should, whenever appropriate, make the effort to settle claims by negotiation so as to avoid further distress to families by litigation.

Background information

The RCIADIC realised that some facts relating to deaths in custody may not be known until after the Commission's hearings and the reports were made available. For this reason, some contemplated claims may be out of time for reasons beyond the families' control. The RCIADIC also noted that ligation can bring additional stress to families and should be avoided where possible.

Responsibility

States and Territories. The States and Territories are responsible for the criminal justice system and providing related support to the relatives of detainees in the event of a death in custody.

Key actions taken and status of implementation

In **New South Wales,** the Crown Solicitor's Office was instructed to forward all relevant papers to the Attorney-General should such a claim arise. The most recent State Government report noted that as of 1996, no such claim had been made as a result of the finding of the RCIADIC. The NSW Government Model Litigant Policy for Civil Claims now contains a statement of principles requiring that NSW agencies act with complete propriety, fairness and in accordance with the highest professional standards. The expectation that the State will act as a model litigant is recognised by the courts. The policy creates an expectation that agencies will deal with claims properly, avoid unnecessary delay and pay legitimate claims without litigation.

The New South Wales Government has partially implemented Recommendation 4, noting that all relevant papers would be forwarded to the Attorney-General for consideration. However, it does not appear that all further specific actions have been taken to address the requirements of this recommendation.

In the 1993 Implementation report, the **Victorian** Government noted that the Statute of Limitations should not be invoked to prevent the hearing of claims for compensation cases where the hearing of such claims has been delayed by the length of the RCIADIC. The implementation report highlighted that it is in the interests of all litigants for claims to be settled by negotiation whenever possible.

The Victorian Government has implemented Recommendation 4, noting that the Statute of Limitations would not be invoked to prevent hearing of cases delayed by the RCIADIC. Additionally, negotiation has been stated as the preferred claim resolution mechanism.

In the 1996-97 Implementation Report, the **Queensland** Government stated that Crown Law is fully aware of the responsibilities in custodial death matters. However, the conduct of Crown Law is governed by the instructing agency. The conduct of litigation on behalf of the State of Queensland is undertaken in accordance with model litigant principles. The principles require the State to act in a manner that adheres to the principles of fairness, including the requirement to handle claims in a consistent and prompt manner and to endeavour to avoid the scope of legal proceedings where possible.

The Queensland Government has partially implemented Recommendation 4. While the Queensland Government upholds model litigant principles, it does not appear that any further specific actions have been taken to address the requirements of this recommendation.

In the 1993 Implementation Report, the **South Australian** Government stated that the Statute of Limitations should not generally be invoked to prevent the hearing of claims for compensation cases where the hearing of such claims has been delayed by the length of the RCIADIC. However, there may be special cases where a departure of this principle is warranted. The Report also highlighted that it is in the best interests of all litigants for claims to be settled by negotiation whenever possible.

The South Australian Government noted in their 1993 implementation report that the Statute of Limitations should not be invoked to prevent the hearing of claims for compensation cases where such cases have been delayed by the RCIADIC. Additionally, negotiation has been noted as the preferred method of claim settlement where possible.

In **Western Australia**, the *Limitation Act 2005* (WA) contains no provision specifically regulating claims arising from deaths in custody, but some of the Act's provisions may be relevant to such claims. There have been no other legislative changes since the release of the Royal Commission's report that are relevant to claims arising from deaths in custody and, more particularly, Recommendation 4.

The Western Australian Government has not implemented Recommendation 4.

As discussed in the 1995 Implementation Report, the **Tasmanian** Government's decision of whether or not to plead the statute of limitations would depend upon the circumstances of each particular case. However, the Tasmanian Government generally tries to settle litigation if reasonable settlement can be obtained.

The Tasmanian Government has partially implemented Recommendation 4, noting that reference would be given to the details of individual cases. However, the Tasmanian Government generally tries to settle litigation if reasonable settlement can be obtained.

In the **Northern Territory**, even if the limitation period is pleaded, the person making the claim is entitled to apply to the Courts under Section 44 of the *Limitation Act 1981* (NT) to extend the limitation. As stated in the 1994-95 Implementation Report, it is the practice of the Solicitor for the Northern Territory to settle claims by negotiation whenever possible.

The Northern Territory Government has implemented Recommendation 4 through section 44 of the Limitation Act 1981 (NT), and has noted that claims would be settled by negotiation where possible.

The 1995-96 Implementation Report noted that the **Australian Capital Territory** was not aware of any claims arising from Aboriginal deaths in custody in the ACT. The Report also stated that if a claim were to be received, it would be settled by negotiation where possible and it is unlikely the *Limitation Act 1985* would be invoked.

The ACT Government acts as a model litigant in all legal proceedings it is involved in. The *Law Officer (Model Litigant) Guidelines 2010* (No 1) set out the government's obligation in the conduct of litigation. This includes paying legitimate claims without litigation, and using methods that it considers appropriate to resolve the litigation including alternative dispute resolution.

The Australian Capital Territory Government has implemented Recommendation 4 through the model litigant provisions, noting that the ACT Government is not aware of any deaths in custody in the ACT that were considered as part of the RCIADIC.

Recommendation 5

That governments, recognising the trauma and pain suffered by relatives, kin and friends of those who died in custody, give sympathetic support to requests to provide funds or services to enable counselling to be offered to these people.

Background information

The RCIADIC realised that the Commission hearings were a stressful experience for many families, heightened by the grieving associated with the death.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, $130,000 was provided to Aboriginal controlled organisations by the Commonwealth government via ATSIC between 1992-93 and 1996-97. Funds were granted to Tranby Aboriginal Co-operative College for the purpose of conducting nine community workshops throughout the state. Additionally, the Western Aboriginal Legal Service conducted 19 smaller workshops in the western area of NSW.

Currently, the families of Aboriginal people who have died in prison are contacted and offered support through the CSNSW Chaplaincy service and the Aboriginal Strategy and Policy Unit in Department of Justice. Local assistance and family support is provided through CSNSW Regional Aboriginal Program Officers. Family members of the deceased who are in custody are offered counselling and support from CSNSW counselling staff. CSNSW can also provide financial support to families for funeral arrangements. NSW Police Force Aboriginal Community Liaison Officers (ACLO), of which there are fifty-five across the state, offer support to the family and community of a person who has died in custody. ACLO's also assist police in engaging with the family as well as in the referral of the family and kin to services such as the Aboriginal Medical Services, Justice's Victim Access Line or other appropriate services.

The New South Wales Government has completed Recommendation 5 through the provision of counselling and support to family members of Aboriginal people who died in custody.

In December 1991, the **Victorian** Government received $60,000 from the Commonwealth Government for the provision of counselling and support services to the families of people who died in custody.

The Victorian Government has completed Recommendation 5 through the provision of counselling and support to family members of Aboriginal and Torres Strait Islander people who died in custody.

In 1994, the-then **Queensland** Department of Family Services and Aboriginal and Islander Affairs received a one-off grant of $500,000 from ATSIC to enable the Department to develop a family counselling and support program. Further, the Queensland Government notes that organisations continue to operate around the state to provide counselling and other support services to Aboriginal and Torres Strait Islander people.

The Queensland Government has implemented Recommendation 5 through the provision of funding through ATSIC to facilitate the development of a family counselling and support program.

In the 1993 Implementation Report, the **South Australian** Government noted that the Commonwealth provided funds specifically for this purpose. This assistance was directly provided to the Aboriginal Health Council for provision to relatives and friends of those who had died in custody. Additionally, the South Australian Department for Correctional Services (DCS) has established a de-briefing process for family members affected by the death of an Aboriginal and Torres Strait Islander relative in custody. This process complements DCS's Standard Operating Procedure in relation to prisoner deaths in custody, and DCS cooperates with the Aboriginal Legal Rights Movement to assist family through the difficult time.

The South Australian Government has implemented Recommendation 5 through the administration of Commonwealth funding and the provision of support for family and members affected by the death of an Aboriginal and Torres Strait Islander relative in custody.

In 1993, the **Western Australian** Aboriginal Affairs Department received $465,000 in grant funding totalling from ATSIC for the purposes of providing community counselling and support services to people who had family members that had died in custody.

Currently, when a death occurs in prison, the Aboriginal Visitors Scheme is available to provide support and counselling to family members. Family members in Western Australian prisons also have access to peer support officers. The Office of the State Coroner has the Coronial Counselling Service, which provides grief counselling and liaison services for families in need following a sudden death. Friends of the deceased may also be eligible for counselling services depending upon individual cases.

The Western Australian Government has implemented Recommendation 5 through the administration of Commonwealth funding and the ongoing provision of support for family and members affected by the death of an Aboriginal and Torres Strait Islander relative in custody.

The 1992-93 Commonwealth Implementation Report noted that **Tasmania** received $20,000 from the Commonwealth for the purpose of addressing Recommendation 5 which funded a 'Prison and Police Officer' cross-cultural project. As mentioned in the 1995 Tasmanian implementation Report, should a death in custody occur at the Ashley Youth Detention Centre, the Child, Family and Community Support program of the Department of Community and Health Services would purchase appropriate counselling services. In 2016, the Coroner's Court released *A Guide for Families and Friends* that includes details of relevant support services and information that can help individuals to cope with grief and loss.

The Tasmanian Government has implemented Recommendation 5 through the administration of Commonwealth funding to provide counselling services, and the Child, Family and Community Support program.

The 1994-95 Implementation Report highlighted that the Commonwealth Government provided funds to the **Northern Territory** for the provision of counselling services. Consultation with the relatives of people who had died in custody indicated a desire for compensation and not counselling. Following this, the funding of $166,497was provided to three Aboriginal and Torres Strait Islander organisations to pilot community based Aboriginal and Torres Strait Islander mental health worker projects.

The Northern Territory Government has implemented Recommendation 5 through the administration of Commonwealth funding to provide counselling services, and by funding Aboriginal and Torres Strait Islander organisations to pilot community-based Aboriginal and Torres Strait Islander mental health workers.

The **Australian Capital Territory** Government currently funds a Coronial Counselling Service through Relationships Australia. This service provides support to bereaved family, friends and community members immediately following a death, through all stages of the coronial process and up to three months after an inquest process has finalised. This service can also provide specialist support including: liaison with the coronial office and staff; support at coronial hearings; trauma, grief and bereavement counselling services; family therapy; information about the impact of grief, bereavement and trauma; and referrals and links to appropriate support.

The Australian Capital Territory Government has implemented Recommendation 5 through the provision of funds for the ACT Coronial Support Services.

3.3 Post-death investigations (6-40)

Recommendation 6

That for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:

a. The death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

b. *The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care while in such custody or detention;*

c. *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*

d. *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.*

Background information

Prior to 1991, there was not a uniform approach to the issue of deaths in custody with different state and territory legislation in operation. The RCIADIC recognised this issue and recommended the adoption of a consistent definition of a 'death in custody' across the States and Territories.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the *Coroners (Amendment) Act 1993* (NSW) included a provision to extend the definition of a death in custody in accordance with the provisions of Recommendation 6. The Act was passed by parliament in November 1993 (section 13A of the *Coroners Act 1980* (NSW)). The provision in the current legislation is section 23 of the *Coroners Act 2009* (NSW), which also requires deaths of offenders who are in home detention to be considered as deaths in lawful custody.

The New South Wales Government has implemented Recommendation 6 through the Coroners (Amendment) Act 1993 (NSW) and the Coroners Act 2009 (NSW) which set out the definition of deaths in custody in accordance with the principles of this recommendation.

In **Victoria,** under the *Coroners Regulation 2009 – Regulation 7*, a 'reportable death' includes the death of a person who died while in custody or care, and includes cases where the death was caused by injuries sustained when an authorised person takes the person into custody. It also includes injuries sustained while in the custody of the State.

Paragraphs (j) & (k) of the definition of a person placed in custody or care in section 3 of the *Coroners Act 2008* (Vic) include a person "who is dying from injuries sustained when a police officer or prison officer attempted to take the person into custody" and "a person in Victoria who is dying from an injury incurred while in the custody of the State". Since paragraph (k) refers to "an injury incurred while in custody", traumatic injuries would be captured by paragraph (k). If a person dies from injuries as a result of an attempted escape from custody, they will have died from an injury incurred while in the custody of the State and it would also be covered by paragraph (j) or (k).

Since the definition covers a death in custody and a death from injuries incurred in custody, the definitions would cover most deaths that were caused or contributed to by a lack of proper care. However, there is no specific reference to traumatic injuries or lack of proper care while in custody, or to a death occurring as a result of a person escaping from custody.

The Victorian Government has implemented Recommendation 6 through legislation and regulations.

The **Queensland** *Coroners Act 2003* (Qld) defines a death in custody as cases when the person who died was in custody, or escaping, trying to escape from, or trying to avoid being put into custody. The definition of a 'reportable death' also accounts for a death that was violent or otherwise unnatural or deaths that arise from an injury that either caused or contributed to the death.

The Queensland Government has implemented Recommendation 6 through the Coroners Act 2003 (Qld), which sets out the definition of deaths in custody in accordance with the principles of this recommendation.

In **South Australia**, under section 3(1) of the *Coroners Act 2003* (SA) a death in custody includes the death of a person while detained in care, in the process of being apprehended, evading apprehension or escaping/attempting to escape. A 'reportable death' also includes the death of a person by an unexpected, unnatural, unusual, violent or unknown cause.

The South Australian Government has mostly implemented Recommendation 6 through the Coroners Act 2003 (SA). However, no reference is made to lack of care while in custody as contributory factors to death.

In **Western Australia**, the definitions of "persons held in care" and "reportable deaths" contained in section 3 of the *Coroners Act 1996* (WA) encompass the circumstances outlined in Recommendation 6. The Act addresses all circumstances of a death, including those resulting from an attempt to detain a person, those caused or contributed to by traumatic injuries sustained, and those caused by lack of proper care while in, or escaping from, custody or detention.

The Western Australian Government has implemented Recommendation 6 through the Coroners Act 1996 (WA).

Under Section 3 of the **Tasmanian** *Coroners Act 1995* (Tas), a 'reportable death' includes the death of a person held in custody, the death of a person escaping or attempting to escape from custody or detention, or a death that occurred while a police officer, correctional officer, mental health officer or prescribed person was attempting to detain that person. Additionally, a 'reportable death' also includes a death where it appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury. While lack of proper care is not specifically stated in the legislation it is provided for in the *Coroners Act 1995* (Tas) under section 3(a) (i), (ii), (iii) and (iv) and under section 28 (5), which state that 'the coroner must report of the care, supervision or treatment' of a person who dies while in custody.

The Tasmanian Government has implemented Recommendation 6 through the Coroners Act 1995 (Tas).

In the **Northern Territory**, the definition of a 'reportable death' is set out in the *Coroners Act 1993* (NT). The definition includes the death of a person who immediately before death was held in care or custody, cases where the death was caused or contributed to by injuries sustained while the person was held in custody, and any deaths of a person who is in the process of being taken into custody or escaping from custody or care. Additionally, a reportable death also covers those deaths that have been unexpected, unnatural or violent or have to have resulted, directly or indirectly, from an accident or injury.

The Northern Territory Government has implemented the principles of Recommendation 6 in the Coroners Act 1993 (NT).

The definition of a 'death in custody' in the **Australian Capital Territory** is included in the *Coroners Act 1997* (ACT). The definition includes the death of a person in the custody of a police officer or in other lawful custody, the death of a person escaping or attempting to escape from custody, and the death of a person while being taken into custody. A 'death in custody' includes the death of a person due to a fatal injury sustained in custody.

Section 13(1) (i) of the *Coroners Act 1997* (ACT) directs mandatory inquests in relation to all deaths in custody irrespective of the age of the deceased person. Moreover, section 34A (2) creates a mandatory hearing requirement for these deaths. While there is no explicit, specific reference to deaths occurring outside a place of detention, as a result of injury or quality of care provided in a place of detention, section 3C would likely cover these situations where the death is because of fatal injury sustained in a place or in circumstances relating to being in, or taken to, a place of detention.

The Australian Capital Territory Government has implemented the principles of Recommendation 6 in the Coroners Act 1997 (ACT).

Recommendation 7

That the State Coroner or, in any State or Territory where a similar office does not exist, a Coroner specially designated for the purpose, be generally responsible for inquiry into all deaths in custody.

Background information

The RCIADIC recommended expanding the coronial inquiry from a traditional investigation to a broader and more comprehensive inquest. This would enable a Coroner to give constructive feedback to try to prevent future deaths in similar situations.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the *Coroners (Amendment) Act 1993* (NSW) included a provision to make the State Coroner or Deputy State Coroner solely responsible for the investigation and conduct of inquests in the case of deaths in custody (section 13A of the *Coroners Act 1980* (NSW)). The current relevant provision is section 23 of the *Coroners Act 2009* (NSW).

● *The New South Wales Government has implemented Recommendation 7 through the Coroners (Amendment) Act 1993 (NSW) and the Coroners Act 2009 (NSW) which include a provision to make the State Coroner or Deputy State Coroner solely responsible for inquests into deaths in custody.*

In **Victoria**, sections 7(b), &(c) and 17 of the *Coroners Act 1985* (Vic) require that an investigation and inquest be held where the deceased was held in care immediately before death. In the event of a juvenile death in custody, the State Coroner and the Department of Health and Community Services must investigate the case.

● *The Victorian Government has implemented Recommendation 7 through the Coroners Act 1985 (Vic) which requires an investigation and inquest to be held where the deceased was held in custody immediately before death.*

In **Queensland**, the State Coroner, Deputy State Coroner, or an appointed coroner or local coroner approved by the Governor in Council must investigate a death in custody as per section 7 of the *Coroners Act 2003* (Qld). A death in custody must be subject to an inquest.

● *The Queensland Government has implemented Recommendation 7 through the Coroners Act 2003 (Qld). The State Coroner, Deputy State Coroner, or an appointed coroner or local coroner approved by the Governor in Council must investigate a death in custody.*

In **South Australia**, under the *Coroners Act 2003* (SA) the State Coroner has the role of administering the Coroner's Court. The Coroner's Court must hold an inquest to determine the cause or circumstance of a death in custody. While the State Coroner does not directly have to hold the inquest, they are in charge of the operation of the Coroner's Court, which undertakes the inquest.

● *The South Australian Government has implemented Recommendation 7 through the Coroners Act 2003 (SA) in which the State Coroner is given responsibility for administering the Coroner's Court and holding an inquiry to determine the cause of circumstance of a death in custody.*

In **Western Australia**, the requirements of Recommendation 7 are met by Part 2 of the *Coroners Act 1996* (WA). Section 8 of the *Coroners Act 1996* (WA), sets out the functions of the State Coroner, which requires the investigation of all reportable deaths, including all deaths of persons in custody.

● *The Western Australian Government has implemented Recommendation 7 through the Coroners Act 1996 (WA).*

In **Tasmania**, under sections 21 and 24 of the *Coroners Act 1995* (Tas), a coroner has jurisdiction to investigate a death if it appears to the coroner that the death is or may be a reportable death – which includes a death in custody. The Chief Magistrate in Tasmania oversees the operation of the State coronial system.

The Tasmanian Government has implemented Recommendation 7 through the Coroners Act 1995 (Tas).

In the **Northern Territory**, the Territory Coroner has jurisdiction to investigate and must hold an inquest into a death in custody. The Territory Coroner must hold an inquest if immediately before death, the deceased was in custody or care or the death was caused or contributed to by injuries sustained while the deceased in custody.

The Northern Territory Government has implemented Recommendation 7. The Territory Coroner must hold an inquest if immediately before death, the deceased was in custody or care or the death was caused or contributed to by injuries sustained while the deceased in custody.

The 1995-96 Implementation Report noted that the **Australian Capital Territory** does not have a State Coroner. However, the Chief Coroner, who is also the Chief Magistrate in the ACT, is responsible for the business of the Coroner's Court including holding inquests into deaths in custody. In the ACT, under section 13(1) of the *Coroners Act 1997* (ACT), a coroner must hold an inquest into the manner and cause of death of a person who dies in custody. Under Section 9(2) of the Act, the Chief Coroner must not direct a deputy coroner to hold an inquest into a death in custody.

The ACT Government noted that in the ACT all resident magistrates have a coronial case load. Consideration could be given as part of an upcoming coronial system review to designating a Magistrate to work as a dedicated Coroner, who may handle all deaths in custody.

The Australian Capital Territory Government has implemented Recommendation 7 through the Coroners Act 1997 (ACT) and the function of the Chief Coroner.

Recommendation 8

That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.

Background information

The RCIADIC realised the importance of having a set of streamlined guidelines to improve the coronial process and system. By creating such guidelines, all coroners required to undertake inquiries into deaths in custody would be able to follow the correct procedures.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **New South Wales** *Coronial Protocol for Deaths in Custody/Police Operations* for the conduct of coronial inquiries into deaths in custody was developed in 1994 and is still applicable. It is contained within the Report by the NSW State Coroner into deaths in custody/police operations.

The New South Wales Government has implemented Recommendation 8 through the development of the Coronial Protocol for Deaths in Custody/Police Operations which deals with coronial inquiries into deaths in custody.

As highlighted in the 1993 **Victorian** implementation report, under section 7(e) of the *Coroners Act 1986* (Vic), the State Coroner was able to issue guidelines to coroners to help them carry out their duties. Further to this, under section 16, the State Coroner was able to give directions to coroners about an investigation into a death.

Currently, Section 107 of the *Coroners Act 2008* (Vic) permits the State Coroner to issue practice directions, statements or notes for the Coroners Court in relation to investigations and hearings of the Court. *Practice Direction 4 of 2014 - Police contact deaths* requires, subject to a direction of a coroner, that a directions hearing will be conducted within 28 days of a police contact death, including a death in police custody. The purpose of the directions hearing is to identify the Coroner's Investigator, fix a date for the delivery of the coronial brief and make any other orders or directions required for the

purpose of the investigation. The senior next of kin is advised of this hearing. However, there is no set protocol for coronial inquiries into deaths in custody.

Recommendation 8 is mostly implemented. While the Victorian State Coroner has power to make orders or directions for the conduct of coronial inquiries into deaths in custody, the State Coroner has not developed a protocol as specified in the recommendation.

Under section 14 of the **Queensland** *Coroners Act 2003* (Qld), the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally. Section 14(2) of the *Coroners Act 2003* specifically states that when preparing the guidelines, the State Coroner must have regard to the recommendation of the RCIADIC that relate to investigation of deaths in custody. Further to this, the Queensland Government has made the *State Coroner's Guidelines 2013* publicly available on the Queensland Coroner website.

The Queensland Government has implemented Recommendation 8 through the Coroners Act 2003 (Qld) and the publication of the State Coroner's Guidelines 2013.

The **South Australian** Government noted that a protocol for the conduct of coronial inquiries into deaths in custody exists in South Australia.

The South Australian Government has implemented Recommendation 8 through the development of a protocol for the conduct of coronial inquiries into deaths in custody.

In **Western Australia**, the requirements of the Recommendation have been met through compliance with section 25 of the *Coroners Act 1996* (WA), which provides that where a person is held in care, a Coroner must comment on the quality of the supervision, treatment and care of the person while in care. Guidelines developed for Coroners have been issued pursuant to section 58 of the Act, which provide guidance to coroners addressing matters raised in the Recommendation. While not publicly available, these guidelines have been provided to the Western Australia Police Force and to custodial services in the Department of Justice to assist with understanding the requirements of undertaking inquests.

The Western Australian Government has implemented Recommendation 8 through the Coroners Act 1996 (WA) and the publication of Guidelines.

Under section 7(g) of the *Coroners Act 1995* (Tas), a function of the **Tasmanian** Chief Magistrate is to issue guidelines to coroners to assist them to carry out their duties. Section 22 of the Act also allows the Chief Magistrate to give directions to a coroner about an investigation into a death and the manner of conducting it.

The Tasmanian Government has partially implemented Recommendation 8 under the Coroners Act 1995 (Tas). However, it does not appear that an overarching guideline has been developed for the conduct of coronial inquiry.

The 1996-97 **Northern Territory** Implementation Report noted that a draft Protocol containing guidelines for the conduct of inquests and autopsies had been prepared. The guidelines were to be finalised after consultation with relevant government and non-government bodies, including Aboriginal organisations. However, we were unable to locate the final guidelines for coronial inquiries into deaths in custody.

The Northern Territory Government has mostly implemented Recommendation 8 through the development of a Protocol containing guidelines for the conduct of inquests and autopsies. However, it is unclear whether the draft protocol was finalised and implemented.

Under section 51(A) of the *Coroners Act 1997* (ACT), in the **Australian Capital Territory** an inquest must be conducted in accordance with any practice or procedure prescribed under the Act. However, if a practice or procedure for an inquest of inquiry is not prescribed under the Act, the Chief Coroner may give directions for the practice or procedure in the inquest or inquiry.

The Australian Capital Territory Government has partially implemented Recommendation 8 through provisions made by the Coroners Act 1997 (ACT). However, there does not appear to have been explicit protocols established.

Recommendation 9

That a Coroner inquiring into a death in custody be a Stipendiary Magistrate or a more senior judicial officer.

Background information

The RCIADIC suggested that having a judicial officer with a status equivalent to a judge would increase the status and authority of the investigation and ensure the process was managed effectively.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the *Coroners Act 1980* (NSW) was amended in 1993 to provide that appointment as a magistrate is a prerequisite for appointment as a State Coroner or as a Deputy State Coroner. These are the only coroners allowed to conduct inquests into deaths in custody. Currently, the provisions of this recommendation are set out in section 23 of the *Coroners Act 2009* (NSW) and provide that only a Senior Coroner can conduct an inquest into a death in custody or within a Police Operation.

The New South Wales Government has completely implemented Recommendation 9 through the Coroners Act 1980 (NSW) and the Coroners Act 2009 (NSW).

In **Victoria**, under the *Coroners Act 1985* (Vic), the State Coroner or Deputy State Coroner is required to have been a County Court Judge, a magistrate, or a barrister or solicitor.

The Victorian Government has completely implemented Recommendation 9 through the Coroners Act 1985 (Vic).

In **Queensland**, Section 11(7) of the Coroners Act 2003 (Qld) states that an inquest held in relation to a death in custody or a death which occurs as a result of police operations must be investigated by the State Coroner or the Deputy State Coroner or another coroner approved by the Governor-in-Council on the recommendation of the Chief Magistrate in consultation with the State Coroner. Under Part 4 of the *Coroners Act 2003* (Qld), the State Coroner and the Deputy Coroner must be a Magistrate. All local Coroners are Magistrates. Lawyers of at least five years standing may be appointed Coroners by the Governor-in-Council.

The Queensland Government has completely implemented Recommendation 9 through the Coroners Act 2003 (Qld).

In **South Australia**, under section 4(3) of the *Coroners Act 2003* (SA), a person is not eligible for appointment as the State Coroner unless he or she is a magistrate.

The South Australian Government has completely implemented Recommendation 9 through the Coroners Act 2003 (SA).

In **Western Australia**, the State Coroner conducts all investigations into deaths in custody. According to Section 6 of the *Coroners Act 1996* (WA), the State Coroner is the equivalent in status to the Chief Magistrate. Section 11 of the Act also provides that all magistrates are contemporaneously considered to be coroners, and that the State Coroner may only appoint a person as coroner who is eligible to be appointed as a magistrate.

The Western Australian Government has completely implemented Recommendation 9 through the Coroners Act 1996 (WA).

It is standard practice in **Tasmania** for a magistrate to conduct all inquests, according to the 1995 Implementation Report. The Chief Magistrate will determine which magistrate will undertake the inquest. However, section 13 of the *Coroners Act 1995* (Tas) provides that, subject to any direction given by the Chief Magistrate, a coroner may delegate to a coroner's associate any function or power of a coroner other than the power of delegation or a power prescribed by regulations.

The Tasmanian Government has partially implemented Recommendation 9 through the Coroners Act 1995 (Tas). However, a coroner may delegate to a coroner's associate any function or power of a coroner other than the power of delegation.

In the **Northern Territory**, under the *Coroners Act*, which came into force on 1 September 2017, the Administrator may appoint a Local Court Judge to be the Territory Coroner, and a person who is a Local Court Judge is a coroner. The investigation of the person who dies in custody must be undertaken by a coroner and cannot be delegated to a deputy coroner.

The Northern Territory Government has completely implemented Recommendation 9 through the Coroners Act.

In the **Australian Capital Territory**, the Chief Magistrate is the Chief Coroner for the Territory. Under section 9(2) of the *Coroners Act 1997* (ACT), the Chief Coroner must not direct a deputy coroner to hold an inquest into a death in custody.

The Australian Capital Territory Government has completely implemented Recommendation 9 through the Coroners Act 1997 (ACT).

Recommendation 10

That custodial authorities be required by law to immediately notify the Coroner's Office of all deaths in custody, in addition to any other appropriate notification.

Background information

The RCIADIC highlighted the importance of notifying the Coroner's Office immediately of all deaths in custody so that the family and friends of the deceased are informed in a timely and sensitive manner.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, a death in custody or within a police operation is regarded as a death within section 23 of the *Coroners Act 2009*. A mandatory inquest must therefore be conducted by a senior Coroner under the legislation. The New South Wales State Coroner's protocol for deaths in custody includes a requirement that the State Coroner or Deputy State Coroner be immediately notified of any death in custody.

The New South Wales Government has implemented Recommendation 10 through the Coroners Act 2009 (NSW).

In **Victoria**, under section 13(5) of the *Coroners Act 1985* (Vic), all deaths in custody must be reported to the Coroner as soon as possible. According to the 1994 implementation report, police instructions also state the Coroner must be immediately notified of all reportable deaths.

The Victorian Government has implemented Recommendation 10 through the Coroners Act 1985 (Vic).

In **Queensland,** Section 7(3) of *Coroners Act 2003* (Qld) states that the person that becomes aware of the death must immediately report the death to the State Coroner or Deputy State Coroner if the death happened in the course of, or as a result of, police operation or if the death was a death in custody. This is also provided in the Queensland Police Service *Operational Procedures Manual*.

The Queensland Government has implemented Recommendation 10 through the Coroner's Act 2003 (Qld).

In **South Australia**, under section 28(1) of the *Coroners Act 2003* (SA) a person must, immediately after becoming aware of a death that is, or may be a reportable death, notify the State Coroner. This is built into standard operating procedures for South Australia's custodial officers.

- *The South Australian Government has implemented Recommendation 10 through the Coroners Act 2003 (SA).*

In **Western Australia**, the *Coroners Act 1996* (WA) imposes on "a person" (rather than a custodial authority specifically) an express obligation to report deaths, unless the person has reasonable grounds to believe that a death has already been reported. The Department of Justice guidance documents for prisons include the policy directive, *Death of a Prisoner – Procedures*. This directive lists the category of persons required to be notified immediately in the event of a death in custody, including the Coroner. The Youth Justice Services Standing Order 29 – *Death of a Detainee* – identifies required notifications, including the Coroner.

- *The Western Australian Government has implemented Recommendation 10 through the Coroners Act 1996 (WA), the Department of Justice policy directive and the Youth Justice Services Standing Order 29.*

In **Tasmania,** Section 19 of the *Coroners Act 1995* (Tas) requires a person who has reasonable grounds to believe that a reportable death has not been reported must report it as soon as possible to a coroner or police officer. The coroner or police officer must inform the Chief Magistrate of the reportable death as soon as possible.

- *The Tasmanian Government has completely implemented Recommendation 10 through the Coroners Act 1995 (Tas).*

In the **Northern Territory**, Section 91 of the *Correctional Services Act 2014* (NT) requires the Commissioner to be notified of a prisoner death. Under the *Coroners Act 1993* (NT), the Commissioner is required to report the death of a prisoner to the Coroner and the Coroner's staff must notify the prisoner's next of kin.

- *The Northern Territory Government has completely implemented Recommendation 10 through the Prisons (Correctional Services) Act (NT) and the Coroners Act 1993 (NT).*

In the **Australian Capital Territory**, section 78 of the *Coroners Act 1997* (ACT) stipulates a specific offence creating an obligation on custodial officers to report deaths in custody as soon as practicable after becoming aware of it and having reasonable grounds to believe that the death has not been reported to a coroner, which sits over and above the general obligation in section 77.

ACTCS currently operates under the Code Black Operating Procedure in relation to a death in custody. This operating procedure is currently under review and will include the requirement for notifying the Coroner's Office, as well as ACT Policing of a death in custody.

Custodial facilities advise ACT Policing Operations of any deaths at custodial facilities that would be considered deaths in custody. This is a requirement under the ACTCS Operating Procedure 'Death in Custody' which is to become operational imminently. This requires the Officer in Charge to notify ACT Policing of a death in custody as soon as practicable and in all instances within 30 minutes of the death being confirmed.

ACT Policing Operations advise on-call Coroners Team members of all deaths as standard procedure as soon as they are notified. On-call Coroners Team members advise the duty coroner of deaths, as appropriate. A death in custody (in a custodial facility, as opposed to a person under a Mental Health order) would be notified to the duty coroner immediately.

- *The Australian Capital Territory Government has implemented Recommendation 10 through the Coroners Act 1997 (ACT) and the operational procedures followed by ACTCS and ACT Policing.*

Recommendation 11

That all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death. Unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings. A full record of the evidence should be taken at the inquest and retained.

Background information

The RCIADIC suggested that having a formal coronial inquiry into all deaths in custody would ensure a thorough and impartial investigation. By retaining a full record of all evidence from the coronial inquest, the RCIADIC anticipates that this may help prevent future deaths in similar circumstances.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under Section 12B(1)(b) of the *Coroners Act 1980* (NSW), an inquest must be held in respect of a suspected death in custody. Currently, a death in custody or within a police operation is regarded as a death within section 23 of the *Coroners Act 2009* (NSW). A mandatory inquest must therefore be conducted by a senior Coroner under the legislation.

The New South Wales Government has partially implemented Recommendation 11 through the Coroners Act 1980 (NSW) and the Coroner's Act 2009 (NSW). However, it does not appear that the inquest must be conducted in public hearings or a full record of evidence must be retained.

In **Victoria,** as cited in the 1994 implementation report, section 17 of the *Coroners Act 1985* (Vic) provides that a Coroner must investigate a death if immediately before or at the time of death the deceased was held in care. Inquests are normally held in public, unless the Coroner orders that all or some persons be excluded from the court, if they believe it is in the interest of any person, the public or of justice to do so. Under Section 57 of the *Coroners Act 1985* (Vic) all evidence must be recorded.

The Victorian Government has completely implemented Recommendation 11 through the Coroners Act 1985 (Vic).

In **Queensland**, under section 27 of the *Coroners Act 2003* (Qld), a Coroner must hold an inquest if the coroner believes the death is a death in custody. Section 31 of the *Coroners Act 2003* (Qld) requires an inquest to be held by the Coroners Court in open court, except when the coroner orders the court be closed while particular evidence is given. With some exceptions regarding pre-inquest conferences and prohibited publications relating to inquests and pre-inquest conferences, any other proceedings in the Coroners Court must be recorded under the *Recording of Evidence Act 1962* (Qld). Under this Act, anyone is entitled to obtain a copy or these recordings.

The Queensland Government has completely implemented Recommendation 11 through the Coroners Act 2003 (Qld) and the Recording of Evidence Act 1962 (Qld).

Under section 21 of **South Australia's** *Coroners Act 2003* (SA), the Coroner's Court must hold an inquest to determine the cause of all deaths in custody. Inquests held in the Coroner's Court must be open to the public. However, the Court may withhold publication of evidence if it considers it desirable to do so in the interests of national security. As the Coroner's Court is a court of record, all proceedings are therefore recorded and available as evidence of fact.

The South Australian Government has completely implemented Recommendation 11 through the Coroners Act 2003 (SA).

In **Western Australia**, section 22(1) of the *Coroners Act 1996* (WA) makes it mandatory for an inquest to be held into the death of a person in care. The practice is that the State Coroner undertakes all inquests into deaths in custody. All inquests are public hearings unless there are compelling reasons to justify a different approach and full records are kept of proceedings.

The Western Australian Government has completely implemented Recommendation 11 through the Coroners Act 1996 (WA).

Section 24 of the **Tasmanian** *Coroners Act 1995* (Tas) requires a coroner who has jurisdiction to investigate a death, if the person died in custody. Section 56 of the Act requires the coroner to conduct an inquest in open court. However, a coroner may exclude any or all persons from an inquest if they consider it in the interests of the administration of justice, national security or personal security. Further to this, section 29 of the Act requires that a coroner or a coroner's associate must keep a record of each investigation into a death.

The Tasmanian Government has completely implemented Recommendation 11 through the Coroners Act 1995 (Tas).

In the **Northern Territory**, under section 15 of the *Coroners Act 1993* (NT), a coroner is required to hold an inquest if the body of the deceased person was held in care or custody immediately before death or if the death was caused or contributed to by injuries sustained while the deceased was held in custody. Section 42 of the Act requires inquests to be held in open court unless a coroner thinks it necessary to order persons outside for the safety of others. Finally, section 11 of the Act requires the coroner or coroner's clerk to keep a record of findings, evidence and comments in relation to each investigation into death or disaster.

The Northern Territory Government has completely implemented Recommendation 11 through the Coroners Act 1993 (NT).

In the **Australian Capital Territory**, under section 13 of the *Coroners Act 1997* (ACT), a coroner must hold an inquest into the manner and cause of death of a person who dies in custody. Section 40 of the Act requires the hearing to be held in public, unless a Coroner is of the opinion that it is desirable in the public interest or in the interests of justice to direct that a hearing take place in private. In the ACT, the registrar must keep a record of the inquest into a death in custody for a period of no less than seven years after the completion of the inquest under section 73 of the Act.

The Australian Capital Territory Government has completely implemented Recommendation 11 through the Coroners Act 1997 (ACT).

Recommendation 12

That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.

Background information

The RCIADIC recommended that all investigations should extend beyond an inquiry into whether a death occurred as a result of criminal behaviour and should include an inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, quality of care, treatment and supervision of the deceased were already examined by the State Coroner prior to the RCIAIDIC, to establish whether they contributed to the death of a person. Therefore, it was not considered necessary to amend the *Coroners Act 1980* (NSW) to specify that these matters should be specifically examined in any inquest. However, while current and past practice when conducting inquests has been consistent with the specific principles in Recommendation 12, the New South Wales Government has not given legislative or legal effect to this recommendation.

The New South Wales Government has partially implemented Recommendation 12, as the recommendation is adhered to in practice but it is not specified in legislation.

In **Victoria**, under the *Coroners Act 2008* (Vic), a coroner must find, if possible, the cause of death and determine how the death occurred. The coroner is also required to report on the circumstances of the death. The coroner may also comment on any matter connected with the death including public

health or safety, or the administration of justice, which includes the quality of care, treatment and supervision.

The Coroners Court has a prevention unit that provides advice to the coroner, including the provision of advice from medical specialists regarding the quality of treatment and care provided to those in custody. The coroner would look at the care, treatment and supervision of the deceased, if it were relevant to the circumstances of the death and/or it were an issue regarding public health and safety.

The Victorian Government has mostly completed Recommendation 12 through the Coroners Act 1985 (Vic), however there is no legal requirement for the Coroner to comment on the quality of care, treatment or supervision of the deceased.

In **Queensland**, under section 45(2) of the *Coroners Act 2003* (Qld), the coroner must, if possible, find how, when and where the person died as well as what caused the person to die. Section 14 of the *Coroners Act 2003* (Qld) provides that the State Coroner must issue guidelines that deal with the investigation of deaths in custody and that coroners must comply with the guidelines to the greatest practicable extent. The State Coroners Guidelines require coroners to direct their attention to the general care, treatment and supervision of the deceased and to determine whether custodial officers complied with their common law duty of care and all departmental policies and procedures, and whether these were best suited to preserving the prisoner's welfare. Coroners are directed to consider the possibility of any systemic failure relating to a death.

The Queensland Government has implemented Recommendation 12 through the requirements set out in the Coroner's Act 2003 (Qld) and the State Coroners Guidelines.

In **South Australia**, the *Coroners Act 2003* (SA) requires that the cause and circumstances of a death in custody be investigated. However, does not specifically provide that the quality of the care, treatment and supervision of the deceased prior to death be investigated. Those areas of investigation generally feature in death in custody investigations, although not a requirement of the law.

The South Australian Government has mostly implemented Recommendation 12 through the Coroners Act 2003 (SA). It is current practice to take evidence as to the care, treatment and supervision during the time of incarceration and prior to death. However, this is not required by law.

In **Western Australia**, the *Coroners Act 1996* (WA), section 25(1) (b) requires the Coroner to determine how the death occurred. Under section 25(3) of the *Coroners Act 1996* (WA), where a death has occurred in custody, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

The Western Australian Government has implemented Recommendation 12 through the Coroners Act 1996 (WA).

In **Tasmania**, under section 28(5) of the *Coroners Act 1995* (Tas), if a coroner holds an inquest into the death of a person who died while that person was in custody, held in care, or escaping or attempting to escape from prison, a secure mental health unit, a detention unit or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or care.

The Tasmanian Government has implemented Recommendation 12 through the Coroners Act 1995 (Tas).

In the **Northern Territory**, section 15 of the *Coroners Act 1993* (NT) requires that where a death occurs in custody that an inquiry must be held. Section 26 of the Act provides that where the coroner holds an inquest into the death of a person held in custody or where the death was caused or contributed to by injuries sustained while being held in custody, the coroner must investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody.

The Northern Territory Government has implemented Recommendation 12 through the Coroners Act 1993 (NT).

In the **Australian Capital Territory**, under section 74 of the *Coroners Act 1997* (ACT), the coroner holding an inquest into a death in custody must include in a record of proceedings of the inquest, findings about the quality of care, treatment and supervision of the deceased where, in the opinion of the coroner, these contributed to the cause of death.

The Australian Capital Territory Government has implemented Recommendation 12 through the Coroners Act 1997 (ACT).

Recommendation 13

That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate.

Background information

As the State Coroner may be able to identify general, persistent problems, which may not be apparent from an individual examination, the RCIADIC recommended that the Coroner be given the right to make recommendations to prevent future deaths in custody.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the *Coroners Act 1980* (NSW) was amended in 1993 to include a provision that the State Coroner may make recommendation to prevent further deaths in custody. This provision is set out in section 22A of the *Coroners Act 1980* (NSW). Currently, the New South Wales Government notes that a formal written finding must be handed down by the Coroner outlining the circumstances, reasons, and findings related to the death in custody.

The New South Wales Government has implemented Recommendation 13 through the Coroner's Act 1980 (NSW), which provides the Coroner with the right to make recommendations to prevent further deaths in custody.

As noted in the 1993 **Victorian** Implementation Report, while there is no statutory duty to do so, the Coroner has the discretion under section 19 of the *Coroners Act 1985* (Vic) to comment on any matter connected with the death including public health or safety, or the administration of justice.

The Victorian Government has implemented Recommendation 13 through the Coroner's Act 1985 (Vic), which provides the Coroner with the right to comment and make recommendations on deaths in custody.

In **Queensland**, under Section 46 of the *Coroners Act 2003* (Qld), the Coroner may comment on anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Further under this legislation, a written copy of any comment must, if the comment relates to matters with which a government entity deals, be given to the Attorney-General, the relevant Minister and the chief executive officer of the entity.

The Queensland Government has implemented Recommendation 13 through the Coroners Act 2003 (Qld) which permits the Coroner to comment on anything connected with a death investigated at an inquest.

In **South Australia**, under section 25(2) of the *Coroners Act 2003* (SA), the Coroner's Court may add to its findings any recommendations that may prevent, or reduce the likelihood or reoccurrence, of a similar event occurring.

The South Australian Government has implemented Recommendation 13 through the Coroner's Act 2003 (SA), which provides the Coroner with the right to comment and make recommendations on deaths in custody.

In **Western Australia**, under sections 25(2) and 27(3) of the *Coroners Act 1996* (WA), the Coroner is required to investigate and must find (if possible) the identity of the deceased, how the death occurred and the cause of death. The Coroner may also comment on any matter connected with the death including public health or safety, or the administration of justice. The Coroner must comment on the quality of the supervision, treatment and care of the deceased.

- *The Western Australian Government has implemented Recommendation 13 through the Coroner's Act 1996 (WA).*

Under section 28(2) of the **Tasmanian** *Coroners Act 1995* (Tas), a coroner must, where appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers relevant.

- *The Tasmanian Government has implemented Recommendation 13 through the Coroner's Act 1995 (Tas).*

In the **Northern Territory**, under section 26(2) of the *Coroners Act 1993* (NT), a coroner who holds an inquest into a death in custody must make recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant. The Coroner must report on the care, supervision, and treatment of the person held in prison; and may report on matters in connection with public health, safety, or the administration of justice as it relates to the death. The Coroner must report to the Attorney-General.

- *The Northern Territory Government has implemented Recommendation 13 through the Coroner's Act 1993 (NT), which requires the Coroner to make recommendations to prevent future deaths in custody. The Coroner must also report on the care, supervision, and treatment of the person held in prison.*

In the **Australian Capital Territory**, section 74 of the *Coroners Act 1997* (ACT) requires a Coroner to make additional findings into deaths in custody as to the quality of care, treatment and supervision that contributed to the cause of death. The objects of the Act in section 3BA provide a very broad discretion in relation to coronial recommendations including the prevention of deaths. While section 57 creates a process in relation to certain recommendations in reports to the ACT Attorney-General, as the Act is not a Code, ACT Coroners retain their common law powers and functions and regularly make recommendations under common law.

- *The Australian Capital Territory Government has implemented Recommendation 13 through the Coroner's Act 1997 (ACT).*

Recommendation 14

That copies of the findings and recommendations of the Coroner be provided by the Coroner's Office to all parties who appeared at the inquest, to the Attorney-General or Minister for Justice of the State or Territory in which the inquest was conducted, to the Minister of the Crown with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.

Background information

The RCIADIC recognised the importance of establishing a formal means to ensure proper public accountability and to provide a system of review, which is able to draw from the general experience gained from all inquests into deaths in custody.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under the NSW Premier's Memorandum M2009-12 Responding to Coronial Recommendation, findings must be provided to Departments and Ministers. The *Coroners Act 1980* (NSW) was amended in 1993 to include a provision to require the State Coroner to report to the Attorney-General on all deaths in custody. This requirement is set out in section 12A(4) of the Act. All

persons with an interest in the death are entitled to a copy of findings. Findings are also published on the NSW State Coroners website and in the State Coroner Annual Report on Deaths in Custody.

The New South Wales Government has mostly implemented Recommendation 14 through the Coroner's Act 1980 (NSW) and current coronial practice. It does not appear to be a requirement that relevant departments or Minister for the Crown be given a copy of the Coronial findings.

In **Victoria,** under section 72 of the *Coroners Act 2008* (Vic), a Coroner may report to the Attorney-General on a death, and may make recommendations accordingly. Further to this, under section 73 of the Act, it is required that all inquest findings, with recommendations, be published on the internet. The findings and recommendations of the coroner are provided to all interested parties, who have a right to appeal against the findings. This gives the interested parties an implied right to receive the findings.

The Victorian Government has implemented Recommendation 14 through the Coroner's Act 1985 (Vic).

In **Queensland**, under section 45 of the *Coroners Act 2003* (Qld), the Coroner must give a written copy of the findings to a family member of the deceased person, any person who appeared at the inquest when the deceased was a child, and to the State Coroner, if they did not conduct the inquiry themselves. Further to this, under section 46 of the *Coroners Act 2003* (Qld), the Coroner must publish the findings and coroner comments on the State Coroner's website. A written copy of any Coroner's comment must, if the comment relates to matters with which a government entity deals, be given to the Attorney-General, the relevant Minister and the chief executive officer of the entity.

The Queensland Government has mostly implemented Recommendation 14 through the Coroner's Act 2003 (Qld), however no express requirement is made that in all cases the Attorney-General or Minister for Justice are provided with the Coroner's inquest findings and recommendations.

In **South Australia**, under section 25 of the *Coroners Act 2003* (SA), the Coroner's Court must, as soon as practicable, forward a copy of its findings and any recommendations to the Attorney-General, to each relevant minister or other agency that was instrumental to the Crown during the inquest, to each person who appeared personally or by counsel at the inquest, and to any other person who, in the opinion of the court, has a sufficient interest in the manner.

The South Australian Government has implemented Recommendation 14 through the Coroners Act 2003 (SA).

In **Western Australia**, it is current practice that findings and recommendations are provided to the Western Australian Attorney-General, the responsible minister, interested parties and all agencies listed in the Coroner's findings. Guideline 33 of the Guidelines for Coroners provides for the identification of any person or body whose action would be required for the implementation of recommendations and for reports to the Coroner. Details of the Coroner's findings and recommendations, and information as to their implementation, are included in the State Coroner's Annual Report, which is laid before both Houses of Parliament (s27 of the *Coroners Act 1996* (WA)). Section 26(3) of the Act requires that a copy of any part of the record of the death investigation be provided to the senior next of kin on request. Furthermore, the findings and recommendations of an inquest are published on the website of the Coroner's Court of Western Australia.

The Western Australian Government has implemented Recommendation 14 through current practice, Guideline 33 and the Coroners Act 1996 (WA).

In the 1995 Implementation Report, the Tasmanian Government noted that in **Tasmania** the Coroner's Office provides copies of findings and recommendations of the Coroner to all parties who appeared at the inquest, to the Attorney-General and to the Minister of the Crown with responsibility for the relevant custodial agency or department. Rule 25 of the *Coroners Rules 2006* provides that at the conclusion of an investigation into a death, a copy of the coroner's findings is to be provided to the deceased person's senior next of kin, parties who appeared at the inquest, and government departments.

The Tasmanian Government has implemented Recommendation 14 as noted in the 1995 implementation report and through the Coroner's Rules 2006.

In the **Northern Territory**, under section 27 of the *Coroners Act 1993* (NT), the coroner is required to send a copy of each report and recommendations relating to an inquest into the death in custody to the Attorney-General without delay. As highlighted in the 1994-95 Implementation Report, the Attorney-General must then provide the relevant agency or department with the report or recommendations. The Attorney-General must also table a copy of the report or recommendations before the Legislative Assembly within six days of receiving it.

The Northern Territory Government has mostly implemented Recommendation 14 through the Coroner's Act 1993 (NT), however it does not appear that there exists a requirement to provide all parties who appeared at the inquest with a copy of the findings and recommendations.

In the **Australian Capital Territory,** under section 75 of the *Coroners Act 1997* (ACT), the Coroner must make available a copy of the findings to a member of the immediate family, plus any witness who appeared at the inquest into the death in custody, along with the Attorney-General, the custodial agency, the Australian Institute of Criminology, the appropriate Aboriginal Legal Service (if the deceased was Aboriginal and Torres Strait Islander) and any other person the Coroner considers appropriate.

The Australian Capital Territory Government has implemented Recommendation 14 through the Coroner's Act 1997 (ACT).

Recommendation 15

That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person.

Background information

The RCIADIC Report noted that it is necessary to establish a formal means to ensure proper public accountability and to provide a system of review, which is able to draw from the general experience gained from all inquests held into deaths in custody.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under the NSW Premier's Memorandum M2009-12 Responding to Coronial Recommendation, findings must be provided to Departments and Ministers. The relevant Minister or NSW Government agency is required to write to the Attorney-General outlining any action being taken to implement the coronial recommendation within six months of receiving a recommendation from the Coroner.[7]

The New South Wales Government has mostly implemented Recommendation 15 through the NSW Premier's Memorandum M2009-12 Responding to Coronial Recommendation. However, the time period is set as six months as opposed to the three months required in this recommendation.

Under section 72 of the **Victorian** *Coroners Act 2008* (Vic), a public statutory authority or entity must within three months after the date of receipt of a report from a Coroner, provide to the Coroner a written response to the findings contained in the report. The response must include a statement of the action (if any) that has been, or is being taken in relation to any aspect of the findings contained in the report.

[7] http://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations, accessed September 2017.

The Victorian Government has implemented Recommendation 15 through the Coroner's Act 2008 (Vic).

In **Queensland**, an administrative scheme operates to facilitate the compilation of a government response to coronial recommendations. In the case of a death in custody, such a response would be compiled. The arrangement is administrative, as opposed to legislative. Under the arrangement, the relevant government entities must respond within six months from the date of the delivery of the recommendation. Any response will advise whether the recommendation has been implemented. If any recommendation is still under consideration at the conclusion of that period, an implementation update must be provided. Government responses and implementation updates are publicly available on the Coroners Court section of the Queensland Courts website. Following a Coroner's inquest into a death in custody, Queensland Corrective Services (QCS) notifies the Minister for Corrective Services of the findings of the inquest and any action that has been taken or is proposed to be taken as a result of the inquest.

The Queensland Government has mostly implemented Recommendation 15 through the Operational Procedures Manual. However, current practice is for six months rather than the three months required in this recommendation.

According to section 25 of **South Australia's** *Coroners Act 2003* (SA), the Coroner's Court must, as soon as practicable after the completion of the inquest, forward a copy of its findings and recommendations to the Attorney-General and the relevant Minster. Section 25(5) of the Act requires that the Minister must cause a report to be laid before each House of Parliament, within eight sitting days once six months has passed since receiving a copy of the findings and recommendations. The report must detail any actions taken, or proposed to be taken, in response to the recommendations. A copy of the report must also be forwarded to the State Coroner.

The South Australian Government has mostly implemented Recommendation 15 through the Coroner's Act 2003 (SA). However, the time period is set as six months as opposed to the three months required in this recommendation.

There is currently no legislative requirement to compel a **Western Australian** Government agency or department to respond to findings or recommendations made by the Coroner. Despite the absence of legislative obligations, however, the Western Australian Government stated that it remains committed in its support for the Coroner.

The Western Australian Government has not implemented Recommendation 15 and there is no requirement for government agencies or departments to respond to the Coroner's recommendations.

In **Tasmania**, under section 30 of the *Coroners Act 1995* (Tas), a Coroner is empowered to report and make recommendation to the Attorney-General on a death in which the Coroner investigated. Section 69 of the Act states that the Chief Magistrate must, on or before 30 November in each year, prepare and submit to the Attorney-General a report in relation to the operation of this Act during the preceding financial year. Currently, it is normal practice for government agencies to provide a response to any findings or recommendations to the relevant Minister.

The Tasmanian Government has not implemented Recommendation 15. While it is current practice for government agencies to provide a response to Coronial findings, this does not appear to be a requirement.

In the **Northern Territory**, under section 46B(1) of the *Coroners Act 1993* (NT), if a Chief Executive Officer of a government agency or department, or the Commissioner of Police receives a copy of a report or recommendations, they must, within three months after receiving the report or recommendations, give the Attorney-General a written response to the findings in the report or to the recommendations. The Northern Territory Correction Services (NTCS) *Incident Reporting and Recording Policy* provides that a response to the Coroner's findings will be provided within three months.

The Northern Territory Government has implemented Recommendation 15 through the Coroner's Act 1993 (NT). This recommendation is also addressed through the NTCS Incident Reporting and Recording Policy.

In the **Australian Capital Territory**, under section 76 of the *Coroners Act 1997* (ACT), the custodial agency must, within three months after the date of receipt of a report from the Coroner, give to the responsible Minister a written response to the findings contained in the report. A written response must include a statement of the action (if any) that has been, or is being, taken in relation to any aspect of the findings contained in the report.

The Australian Capital Territory Government has implemented Recommendation 15 for the custodial agency through the Coroner's Act 1997 (ACT).

Recommendation 16

That the relevant Ministers of the Crown to whom responses are delivered by agencies or departments, as provided for in Recommendation 15, provide copies of each such response to all parties who appeared before the Coroner at the inquest, to the Coroner who conducted the inquest and to the State Coroner. That the State Coroner be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations.

Background information

With the aim of ensuring public accountability, the RCIADIC Report hoped that by enforcing such measures as discussed in Recommendations 15 and 16 this would help to identify general, persistent problems which may not be apparent from an examination of the circumstances of an individual death.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

According to the **New South Wales** 1994-95 Implementation Report, the State Coroner had implemented a protocol which provides for the distribution of responses to all parties at the inquest. The 1994-95 Implementation Report noted that it was more administratively efficient for the State Coroner's Office to arrange for the distribution of responses to all parties at the inquest. The actions taken towards the implementation of Recommendation 14 also address this recommendation.

The New South Wales Government has partially implemented Recommendation 16. However, it does not appear that the State Coroner is empowered to call for further explanations or information.

In **Victoria**, under section 72(5) of the *Coroners Act 2008* (Vic), the coroner must publish the response of a public authority or entity on the Internet. The Coroner must also provide a copy of the response to any person who has advised the principal registrar that they have an interest of the subject of the recommendation and who that principal registrar considers to have sufficient interest in the subject of the recommendations. The relevant Minister is not explicitly required to provide copies of responses to the persons specified in Recommendation 16, however a copy is available on the internet. The State Coroner is not specifically empowered to call for further explanations or information.

The Victorian Government has mostly completed Recommendation 16 through the Coroner's Act 2008 (Vic), however the State Coroner is not empowered to call for further explanations or information.

As noted in Recommendation 15, in **Queensland** responses to coronial recommendations are publicly available. Any implementation reports which arise subsequent to the initial response are also made public. Under section 16.23.6 of the *Operational Procedures Manual* (Issue 59), a consolidated report prepared by the Department of Justice and Attorney-General is provided to all other parties appearing at the coronial inquest including the Coroner, other Government agencies, next of kin and legal

services. No further information has been found suggesting that the State Coroner is empowered to call for further explanations or information. Under section 50A of the *Coroners Act 2003* (Qld), a coroner who held an inquest may reopen an inquest if satisfied that it is in the public interest.

The Queensland Government has mostly implemented Recommendation 16 through a range of initiatives including the reporting requirements, and the Operational Procedures Manual for police. While under the Coroner's Act 2003 (Qld), a coroner may reopen an inquest if it is deemed to be in the public interest, there is no explicit power granted to the Coroner to call for further explanations or evidence.

Under section 39 of the **South Australian** *Coroners Act 2003* (SA), the State Coroner must, on or before 31 October each year, make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under this Act during the previous financial year. The report most include all recommendations made by the Coroner's Court. Additionally, the Attorney-General must, within 12 sitting days after receiving a report cause copies of the report to be laid before both Houses of Parliament. South Australian legislation does not explicitly require the State Coroner to include responses to the recommendations in the report, and the South Australian Government notes that the Coroner should not assume a policing role.

The South Australian Government has partially implemented Recommendation 16 through the Coroner's Act 2003 (SA), however there does not appear to be a provision empowering the Coroner to call for further explanations or evidence or to reopen an inquest.

The 2000 Implementation Report noted that within **Western Australia** a copy of the report provided to the Minister is forwarded to the Coroner. Under section 27(1) of the *Coroners Act 1996* (WA), the State Coroner is required to report annually to the Attorney-General on the deaths which have been investigated in each year, including a specific report on the death of each person held in care. Section 27(3) of the Act allows for the State Coroner to make recommendations to the Attorney-General on any matter connected with a death in care. The Western Australian Government notes that there is currently no legislative requirement to compel a Western Australia government agency or department to respond to findings or recommendations made by the Coroner.

The Western Australia Government has not implemented Recommendation 16. There is currently no legislative response which implements the principles of this recommendation.

In **Tasmania**, the Coronial Practice Handbook recommends that organisations consider forwarding correspondence to the coroner's office outlining the measures taken to implement the recommendations, the measures that are intended to be taken in the future or, if alternative measures are employed, details and the reasons for implementing those measures.

The Tasmanian Government has not implemented Recommendation 16.

In the **Northern Territory**, under section 46B(3) of the *Coroners Act 1993* (NT), after receiving the response of the Chief Executive Officer or the Commissioner of Police, the Attorney-General must, without delay, report on the coroner's report or recommendation and respond to the coroner's report or recommendation. The Attorney-General must table a copy of their report before the Legislative Assembly within three sitting days of completing the report. Additionally, the coroner may give a copy of the Attorney-General's report to the senior next of kin of a deceased person mentioned in the report, a witness who appeared at the inquest and any other person who the coroner considers has sufficient interest in the inquest or investigation. The Territory Coroner is not expressly empowered to call for further explanations or information.

The Northern Territory has partially implemented Recommendation 16 through the Coroners Act 1993 (NT), however there is no express power granted to the Coroner enabling them to call for further explanations or information.

The 1995-96 Annual Report states that within the **Australian Capital Territory**, Ministers who receive a response from an agency concerning a coronial report are required under the *Coroners Act 1997* (ACT) to provide a copy of that response to the Coroner. The Coroner is then required to deliver

a copy to any person who received a copy of the report. The Coroner, without the need for a statutory provision, may seek additional information from an agency about a response made by that agency.

Under s.76 of the *Coroners Act 1997* (ACT), the custodial agency must give a response to the responsible Minister that details the action being taken in relation to any aspect of the findings in the inquest report. That response must then be provided to the Coroner, family members, other witnesses presenting at an inquest, and all stakeholders listed in s.75 of the *Act*.

The Australian Territory has implemented Recommendation 16 through the Coroners Act 1997 (ACT).

Recommendation 17

That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above.

Background information

The RCIADIC Report suggested that the State Coroner should report to the Attorney-General or Minister for Justice annually as a further precaution to ensure proper public accountability for all deaths in custody.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales** under section 37 of the *Coroners Act 2009* (NSW), the State Coroner is required to make a written report to the Minister containing a summary of the details of all deaths in custody on an annual basis. Section 27(3) of the Act states that the Minister is to cause a copy of the report that is then to be tabled in each House of Parliament within 21 days after the request is made. The report is also published on the State Coroner's website.

The New South Wales Government has implemented Recommendation 17 through the Coroners Act 2009 (NSW) and annual reporting processes.

Under sections 102 and 113 of the *Coroners Act 2008* (Vic), the **Victorian** State Coroner must submit to the Attorney-General, by 31 October, a report containing a review of the operation of the Coroner's Court during the 12 months ending on the preceding 30 June. The Attorney-General must provide the annual report to each House of Parliament within seven sitting days after receipt of the report.

The Victorian Government has implemented Recommendation 17 through the Coroners Act 2008 (Vic) and annual reporting to the Attorney-General and Victorian Parliament on the operation of the Coroner's Court.

In **Queensland**, under section 77 of the *Coroners Act 2003* (Qld), the State Coroner must give the Attorney-General a report on the operation of the legislation for the year as soon as practicable after the end of financial year. Section 72(2) (c) of the Act requires that a summary of the investigation, including the inquest, must contain all deaths in custody. The Attorney General must table a copy of the report in the Legislative Assembly within 14 sitting days after receiving the report.

The Queensland Government has implemented Recommendation 17 through the Coroners Act 2003 (Qld) and reporting practices between the State Coroner and the Attorney-General's Department.

Section 39 of the **South Australian** *Coroners Act 2003* (SA) requires that the State Coroner must, on or before 31 October in each year, make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under this Act during the previous financial

year. The Attorney-General must, within 12 sitting days after receiving a report, cause copies of the report to be laid before Houses of Parliament.

The South Australian Government has implemented Recommendation 17 through the Coroners Act 2003 (SA) and annual reporting to the Attorney-General on the operation of the Coroner's Court.

In **Western Australia**, section 27(1) of the *Coroners Act 1996* (WA), requires that the State Coroner must report annually to the Attorney-General on the deaths that have been investigated in each year, including a specific report on the death of each person held in care. The Attorney-General must table the report before each House of Parliament within 12 sitting days after receiving the report.

The Western Australian Government has implemented Recommendation 17 through the Coroners Act 1996 (WA).

In **Tasmania**, under section 69 of the *Coroners Act 1995* (Tas), the Chief Magistrate must, on or before 30 November in each year, prepare and submit to the Attorney-General a report of the operations of the Act during the preceding financial year. The report must include details of deaths of persons held in custody and findings and recommendations made by coroners, and may also include any other matter that the Chief Magistrate considers appropriate. The Attorney-General must table a copy of the report in each House of Parliament within ten sitting days after receiving the report.

The Tasmanian Government has implemented Recommendation 17 through the Coroners Act 1995 (Tas) and annual reporting to the Attorney-General on the operation of the Coroner's Court.

In the **Northern Territory**, under section 27 of the *Coroners Act 1993* (NT), the coroner must provide a copy of each report and recommendations into all deaths in custody to the Attorney-General without delay. There is no requirement for the Territory Coroner to report annually in the Northern Territory.

The Northern Territory Government has partially implemented Recommendation 17 through the Coroners Act 1993 (NT). However, there is no requirement for the Territory Coroner to report annually in the Northern Territory.

In the **Australian Capital Territory,** under section 102 of the *Coroners Act 1997* (ACT), the Chief Coroner must give a report relating to the activities of the court during each financial year to the Attorney-General for presentation to the Legislative Assembly. The report must include particulars of reports prepared by coroners into deaths in custody and findings contained in the reports. The Chief Coroner must give the report to the Attorney-General as soon as practicable after the end of the financial year and, in any event, within six months after the end of financial year. The Attorney-General must present a copy of a report to the Legislative Assembly within six sittings days after the day the Attorney-General receives the report.

The Australian Capital Territory Government has implemented Recommendation 17 through the Coroners Act 1997 (ACT) and annual reporting processes to the Attorney-General.

Recommendation 18

That the State Coroner, in reporting to the Attorney-General or Minister for Justice, be empowered to make such recommendations as the State Coroner deems fit with respect to the prevention of deaths in custody.

Background information

The RCIAIDIC Report recommended that the State Coroner be empowered to make such general recommendations as he or she sees fit to prevent future deaths in custody. It is anticipated that the State Coroner may be able to identify general, persistent problems which may not be apparent from examining individual deaths.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under section 82 of the *Coroners Act 2009* (NSW), the State Coroner is empowered to make such recommendations as the Coroner considers necessary or desirable to make in relation to any matter connected with the death.

- *The New South Wales Government has implemented Recommendation 18 through the Coroners Act 2009 (NSW).*

Under section 72(2) of the **Victorian** *Coroners Act* 2008 (Vic), a coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death that the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.

- *The Victorian Government has implemented Recommendation 18 through the Coroners Act 2008 (Vic), under which the State Coroner may make recommendations to Ministers and public statutory authorities on matters relating to deaths in custody.*

In **Queensland**, section 46(1) of the *Coroners Act 2003* (Qld) provides that a coroner may, wherever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening on similar circumstances in the future. Section 46(2) requires those written comments to be provided to certain people including family members and Ministers responsible for government entities. Additionally, the State Coroner must give the Attorney-General a report after the end of the financial year on the operation of the *Coroners Act 2003* (Qld) which includes a summary of the investigation, including the inquest, into each death in custody.

- *The Queensland Government has implemented Recommendation 18 through the Coroners Act 2003 (Qld), under which the State Coroner may make recommendations to Ministers and the Attorney-General.*

Under section 25(2) of the *Coroners Act 2003* (SA), within **South Australia** the Coroner's Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

- *The South Australian Government has implemented Recommendation 18 through the Coroners Act 2003 (SA), under which the State Coroner may add to its findings any recommendation that might prevent or reduce the likelihood of a future death in custody.*

In **Western Australia**, under section 27(3) of the *Coroners Act 1996* (WA), the State Coroner may make recommendations to the Attorney-General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice. Further, under section 25 of the *Act*, the State Coroner and other Coroners make public the findings and recommendations on the circumstances of any death. The findings and recommendations are published on the website of the Coroner's Court of Western Australia.

- *The Western Australian Government has implemented Recommendation 18 through the Coroners Act 1996 (WA), under which Coroners are empowered to make recommendations and recommendations and findings are made public.*

Section 29(2) of the **Tasmanian** *Coroners Act 1995* (Tas), defines that a coroner must, wherever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

- *The Tasmanian Government has implemented Recommendation 18 through the Coroners Act 1995 (Tas).*

In the **Northern Territory**, under section 26(2) of the *Coroners Act 1993* (NT), a coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody must make recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

The Northern Territory Government has implemented Recommendation 18 through the Coroners Act 1993 (NT), under which the State Coroner must make recommendations with respect to the prevention of future deaths in similar circumstances.

In the **Australian Capital Territory**, under section 52(4) of the *Coroners Act 1997* (ACT), the coroner, in the coroner's findings, must state whether a matter of public safety is found to arise – comment on the matter. Further to this, section 57(3) if the Act requires that a report to the Attorney-General by the coroner may make recommendation about matters of public safety if the recommendations relate to the coroner's findings about a cause of death or, in the opinion of the coroner, improve public safety.

The Australian Capital Territory Government has implemented Recommendation 18 through the Coroners Act 1997 (ACT), under which the Coroner is required to comment on matters relating to public safety.

Recommendation 19

That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known.

Background information

The RCIADIC Report found that many deaths in custody were poorly reported at the time of death due to a lack of knowledge about the circumstances of the death. This may be seen as an attempt to hide the truth or a lack of understanding of the complex family obligations and responsibilities that exist in Aboriginal and Torres Strait Islander society.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **Commonwealth** and the **Australian Capital Territory** Governments have responsibility for the AFP, which provides community policing in the ACT. This Recommendation 19 has been addressed through the *AFP National Guideline* on persons in custody and police custodial facilities (hereafter referred to as the National Guideline) which provides that if a person dies in custody, next of kin, family, or nominated contact persons must be notified as soon as practicable (paragraph 21). If the person's next of kin lives in the ACT, the notice must be delivered in person. The procedures relating to deaths in custody are set out in the 1995-96 Australian Capital Territory Implementation Report, the Australian Federal Police ACT Regional Guidelines 4/96 (Care of Persons in Police Custody) and 5/96 (Watch House), and ACT Regional Instruction 8/92 (Deaths). These provide that, where an Aboriginal and Torres Strait Islander dies in custody, the officer in charge of the investigation will notify the family and the Aboriginal Legal Service. This was to be done in conjunction with the Officer in Charge, who has been designated liaison officer with ACT Aboriginal and Torres Strait Islander communities. Each detention centre must also notify the AFP with details of the detainee's family or next of kin and request that the police notify the family of the death in custody. Further to this, ACT Youth Justice Services are also required to contact the immediate family of the deceased and Aboriginal Legal Services are also to be notified.

Additionally, the Corrections Management (Next of Kin) Policy 2012 outlines the policy and procedure to notify a detainee's next of kin of any unexpected injury/illness, death or other urgent circumstances. Policy in the Australian Capital Territory's Alexander Maconochie Centre requires that ACT Policing, in the event of a death in custody, are contacted and informed of the death and provided with the contact details of the next of kin or another nominated person for notification. However, currently there exists no requirement to engage an Aboriginal and Torres Strait Islander person to make the notification.

The Commonwealth and the Australian Capital Territory Governments have mostly completed Recommendation 19 through the introduction of the AFP National Guideline. However, it does not appear to be a requirement to engage an Aboriginal and Torres Strait Islander person for the notification.

In **New South Wales**, the NSW Police Force and CSNSW procedures are consistent with this recommendation. The NSW Police Force Critical Incident Guidelines 4.2.3 state that the Local Area Commander is to personally notify relatives of any deceased person, or to delegate the responsibility to a fully briefed senior officer. Arrangements should be made for other family members to be in attendance as a support mechanism particularly if the deceased is Aboriginal and that it is important to consider local Aboriginal protocols. This role would be supported by the ACLO and requisite notifications would also be made to the Aboriginal Legal Service and Aboriginal Regional Coordinator.

The Policy for the Prevention, Detection, Intervention and Management of Suicide and Self-Harm Behaviour in Juvenile Justice Centres establishes that the family of the deceased must be notified as soon as possible by officers of Juvenile Justice NSW. The Department of Corrective Services incorporated this recommendation into the Custodial Operations Policy and Procedures (COPP). The NSW Police Force have responsibility for notifying the inmate's emergency contact person of the inmate's death. To ensure a sensitive and culturally appropriate response, the CSNSW ASPU is notified if an Aboriginal inmate dies in custody and follows formal documented processes. The Regional Aboriginal Programs Officer provides local assistance to family and friends of the deceased. These and all ASPU positions are Aboriginal identified positions. The Head of the CSNSW Chaplaincy Services is notified and makes contact with the family of the deceased to offer care and support. The COPP also sets out the process for assisting the deceased inmate's emergency contact person or family member.

The New South Wales Government has mostly implemented Recommendation 19 through the introduction of processes consistent with Recommendation 19. These are set out in NSW Police Force and CSNSW procedures. However, it does not appear that an Aboriginal that is known to the family must be used.

The **Victorian** 1994 Annual Report cited that the Correctional Services Division within the Department of Justice utilises the Division's Aboriginal Welfare staff to notify family and others in the event of the death of an Aboriginal person in custody. The Annual Report noted that in respect to the Victoria Police, in the event where an Aboriginal person dies in custody, the Homicide Squad was to notify the Victorian Aboriginal Legal Service Co-operative Ltd and the Aboriginal/Police Liaison Officer of such death and relevant factors. The Victorian Aboriginal Legal Service was then responsible for informing the Aboriginal community of such a death. Further to this, when notifying relatives of the death, police were to be accompanied, where practicable, by an Aboriginal person known to those being notified. The Victorian Government also noted in AJA 3 that a protocol was developed between the State Coroner's Office and the Aboriginal Funeral Service regarding the release of information about the deceased, including notification of the deceased's relatives.

The Victorian Government has introduced measures to ensure that the notification of the deceased's relatives in the event of death in custody is conducted in a manner that is consistent with Recommendation 19.

The **Queensland** *Operational Procedures Manual Issue 59 Public Edition* sets out under sections 16.23.3(vi), (vii) and (viii), that investigating officers as part of their investigation should immediately arrange for the next of kin or person previously nominated by the deceased to be notified. Where the deceased is an Aboriginal and Torres Strait Islander person, notification should preferably be assisted

by an Aboriginal and Torres Strait Islander person known to those being notified. Further to this, if the deceased is an Aboriginal and Torres Strait Islander person, the investigating officer is to notify Aboriginal and Torres Strait Islander Legal Service or another Aboriginal and Torres Strait Islander community organisation with responsibility for that area, as soon as possible, whether or not the relatives have been located. This recommendation is also implemented under the *Corrective Services Act 2006* (Qld) which sets out notification requirements for the chief executive officer in the event of a death in custody.

The Queensland Government has implemented Recommendation 20 through the Operational Procedures Manual Issue 59 Public Edition and the Corrective Services Act 2006 (Qld).

As discussed in the 1994 **South Australian** Annual Report, in principle it is desired that correctional staff should accompany the police when the notification of next of kin occurs. However, this may not always be practicable because of location of next of kin and under these circumstances notification will be made by Police. In these circumstances, correctional staff will be involved with the family as appropriate. In the case of a death in custody, Department of Human Services (DHS) staff refer to the DHS Coronial Policy and DHS Coronial Guidelines and Mandatory Procedures. As soon as confirmation has been received by Department of Correctional Services that the family is aware of the Death, the Director Department for Correctional Services Aboriginal Services Unit (DCS-ASU) contacts the family to provide support. Refer to recommendation 5 for further information. There is a requirement to provide training for correctional personnel who may be called upon to be a notifier. Currently, the South Australian Government notes that this recommendation has been addressed and implemented through *Police General Orders* and the practices of Family and Community Services.

The South Australian Government has implemented Recommendation 19 through Police General Orders and the practices of Family and Community Services.

The **Western Australian** 2000 Annual Report noted that Director General's Rule 2M and Juvenile Custodial Rule 410 apply to Recommendation 19. In general, notification is provided by the Western Australia Police Service, who, because of their greater distribution across the state, are better placed to provide personal notification, with a requirement that the Superintendent of the Prison or Detention Centre verify the notification. The Department of Justice also have procedures in place in the event of a death in custody, and in conjunction with the WA Police Service, seek to ensure that cultural protocols are adhered to in the notification process.

The Western Australian Government has mostly implemented Recommendation 19 through policy documents and procedures. However, the custodial institution is not responsible for the notification.

In **Tasmania**, the 1995 Implementation Report noted that Police Policy Document 8/92 states that there should be sensitive notification of the death of a person in custody. While it may not always be practicable to have an Aboriginal and Torres Strait Islander person present to notify the family, the Department of Community and Health Services recognised that it is preferred to have an Aboriginal person known to the family to deliver the notification of death. The Department of Community and Health Services also fully supported the immediate notification of Aboriginal Legal Services of any Aboriginal and Torres Strait Islander death in custody. Currently, the Aboriginal Liaison Officer must be notified under the *Tasmania Prison Service Emergency Operating Procedure*.

The Tasmanian Government has mostly implemented Recommendation 19 through policy documents and procedures. However, it does not appear to specify that the custodial institution is responsible for the notification.

In the **Northern Territory**, under section 91 of the *Correctional Services Act 2014* (NT), the General Manager of the custodial facility must notify the Commissioner as soon as practicable after a prisoner becomes critically ill or dies. The Commissioner must then notify the next of kin or a decision making authority if a prisoner is critically ill or injured.

The Northern Territory Government has mostly implemented Recommendation 19 through the Correctional Services Act 2014 (NT). However, it does not appear that an Aboriginal and Torres Strait Islander that is known to the family be used.

Additional commentary

In the Australian Capital Territory under existing legislation and governance, all deaths in custody are investigated by ACT Policing who reports directly to the Coroner. The ACT Coroner directs how ACT Policing members notify families of the deceased. The Chief Coroner has stated that consideration should be given to having these notifications made by a staff member of the Coroners Court with appropriate skills or training. The Chief Coroner considers that ideally, this would be the preferable course for notifications of these deaths in the ACT. However, in the absence of sufficient court resources to facilitate this, she believes that the ACT Policing Coroners Officers are the next most appropriate to give death notifications for Aboriginal and Torres Strait Islander deaths in custody.

Recommendation 20

That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody.

Background information

To be effective, the right of appearance at coronial inquests is dependent on appropriate steps being taken to arrange for legal advice and representation. The RCIADIC Report noted that there were shortcomings in the Aboriginal Legal Services, as they were called at the time, receiving notification and making the necessary arrangements for representation on instructions from the deceased's family or next of kin.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **Commonwealth** and the **Australian Capital Territory** Governments have responsibility for the AFP, which provides community policing in the ACT. The AFP *National Guideline on persons in custody and police custodial facilities* provides that when an Aboriginal and Torres Strait Islander person dies in custody, the case officer and the ACT Policing Aboriginal and Torres Strait Islander Community Liaison Officer must, after consultation with the Coroner, notify and provide requested information to the ATSILS (paragraph 22). Additionally, section 69 of the *Coroners Act 1997* (ACT) requires that notification be given to the deceased's family as well as the appropriate Aboriginal Legal Service. Under section 38 of the *Act*, the Coroner is required to give public notice of an inquest at least 14 days prior to the hearing. However, there is no requirement that the notification be made immediately. The Remand Centres Standing Orders number 4.4.8 (Deaths in Custody) ensures that the AFP, Coroner's Office and Aboriginal Legal Services are notified.

As discussed in the 1995-96 Implementation Report, the Australian Capital Territory have addressed Recommendation 20 through Australian Federal Police ACT Regional Guidelines 4/96 (Care of Persons in Police Custody) and 5/96 (Watch House), and ACT Regional Instruction 8/92 (Deaths) which include procedures in relation to all deaths in custody. Additionally, in the event of a death, ACT Youth Justice Services would contact the immediate family of the deceased. If the deceased was an Aboriginal and Torres Strait Islander person, the Aboriginal Legal Service would also be notified.

Significant progress has been made by the Commonwealth and Australian Capital Territory Governments on Recommendation 20 through the introduction of the AFP National Guideline, but the Guideline does not currently require that notification is immediate.

Recommendation 20 is addressed in the '**New South Wales** coronial protocol for deaths in custody/police operations' section of the *Report by the NSW State Coroner into deaths in custody/police operations 2006*. The report notes that upon notification of death, the State Coroner is required to ensure that arrangements have been made to notify the relatives of the deceased and, if necessary, the deceased's legal representatives. Where Aboriginality is identified, the Aboriginal Legal

Service is contacted. As part of the formal processes that CSNSW follows in the event of an Aboriginal death in custody, the Principal Manager of the Aboriginal Strategy and Policy Unit contacts the Chief Legal Officer of the Aboriginal Legal Service to advise of the death. The head of NSW Aboriginal Affairs is also notified of the death. The Head of the CSNSW Chaplaincy Services is notified and makes contact with the family of the deceased to offer care and support. As part of the formal processes that CSNSW follows in the event of an Aboriginal death in custody, the Principal Manager of the Aboriginal Strategy and Policy Unit in Department of Justice contacts the Chief Legal Officer of the Aboriginal Legal Service to advise of the death. The head of NSW Aboriginal Affairs is also notified of the death.

● *The New South Wales Government has implemented Recommendation 20, with the appropriate Aboriginal Legal Service and NSW Aboriginal Affairs notified in the event of an Aboriginal death in custody.*

The 1994 **Victorian** Implementation Report noted that the Victorian Aboriginal Services Service Co-operative Ltd, the Aborigines Advancement League Inc. and the Victorian Aboriginal Health Service Co-operative Ltd were to be notified immediately by the Correctional Service Division Aboriginal Welfare Officer in the event of an Aboriginal death in custody. Further to this, when an Aboriginal person dies in custody, the Homicide Squad were to notify the Victorian Aboriginal Legal Service of the death and relevant information.

● *The Victorian Government has implemented Recommendation 20, with the appropriate Aboriginal Legal Service and associated agencies immediately notified of any Aboriginal and Torres Strait Islander death in custody.*

In **Queensland**, under section 24(e) of the *Corrective Services Act 2006* (Qld), if an Aboriginal and Torres Strait Islander person dies in custody, the chief executive officer must notify an Aboriginal and Torres Strait Islander legal service representing Aboriginal and Torres Strait Islander persons in the area in which the prisoner died. Additionally, if practicable, the chief executive officer should also notify an elder, respected person or Aboriginal and Torres Strait Islander spiritual healer who was relevant to the prisoner.

● *The Queensland Government has implemented Recommendation 20, under the Corrective Services Act 2006 (Qld) the chief executive officer must notify an Aboriginal and Torres Strait Islander legal service in the event of an Aboriginal and Torres Strait Islander death in custody.*

The 1994 Implementation Report noted that within **South Australia**, Recommendation 20 had been incorporated into Correctional Services Departmental procedures and Instructions as well as Police General Orders. The Aboriginal Legal Rights Movement is contacted when the death of an Aboriginal person in custody has occurred.

● *The South Australia Government notes that Recommendation 20 had been incorporated into Correctional Services Departmental procedures and Instructions as well as Police General Orders.*

In **Western Australia**, the 2000 Implementation Report highlighted that Prison Services and Juvenile Custodial Services were to advise the Aboriginal Legal Service if approved by the family. This is also provided for in Juvenile Custodial Services Outstanding Orders and Director General Rule 2M, as well as in the policy and procedures of the Western Australia Police Services. However, there is currently no specific legislative provision for the Department of Justice to notify the Aboriginal Legal Service of a death in custody.

◐ *The Western Australia Government has partially completed Recommendation 20, as there is currently no express legislative provision for the Aboriginal Legal Service to be notified of a death in custody.*

The 1995 **Tasmanian** Implementation Report noted that the Department of Community and Health services fully supported the immediate notification of the Aboriginal Legal Service of any Aboriginal death in custody. Additionally, an instruction of the Tasmania Police, contained in *Police Gazette Notice 13, 1993* required that the Aboriginal Legal Service were appropriately notified when a death in custody occurred. The Gazette notice also applied to the notification of the progress of the

investigation to the family of the deceased, Aboriginal Legal Service and/or lawyers representing the family. Actions taken towards the implementation of Recommendation 16 also apply to this recommendation.

The Tasmanian Government notes that Recommendation 20 has been incorporated among the Department of Community and Health Services, and Tasmania Police.

Under section 80 of the **Northern Territory's** *Prisons (Correctional Services) Act 1980* (NT), the Director of Correctional Services shall notify a prisoner's next of kin, close relative, legal representative or such other person as requested by a prisoner to be notified, when the prisoner is seriously ill or dies. This provision is also set out in the NTCS *Directive 2.8.2 Death of a Prisoner* which states that Executive Director Correctional Operations will notify the nearest Aboriginal Legal Office of the death unless the next of kin requests otherwise.

The Northern Territory Government has implemented Recommendation 20 through NTCS Directive 2.8.2 Death of a Prisoner. Additionally, the Prisons (Correctional Services) Act 1980 (NT) provides that Correctional Services shall notify a prisoner's legal representative.

Recommendation 21

That the deceased's family or other nominated person and the Aboriginal Legal Service be advised as soon as possible and, in any event, in adequate time, as to the date and time of the coronial inquest.

Background information

The historical background of Aboriginal-police relations has resulted in custodial deaths being regarded with a high degree of suspicion by Aboriginal people, even in cases which are ultimately found to be straightforward deaths by natural causes. The RCIADIC recommended openness, frankness and sensitivity towards to family of the deceased.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

Under 21 of the *Coroners Act 2009* (NSW), within **New South Wales** if an inquest or inquiry is held into a death, the coroner must give particulars of the time and place to the person's next of kin if the coroner has been informed of the name and address of the next of kin. Further to this, the coroner may also give the particulars of time and place to any person who has, in the opinion of the coroner, a sufficient interest in the subject matter of the inquest or inquiry. It is unclear whether the ATSILS is notified.

The New South Wales Government has partially implemented Recommendation 21 through the Coroners Act 2009 (NSW), however it does not appear that measures have been taken to ensure that ATSILS is notified of the date and time of inquest.

In **Victoria**, section 21 of the *Coroners Act 2008* (Vic) specifies that as soon as possible after a coroner has commenced an investigation into a death, the principal registrar must ensure that the prescribed information in respect of the coronial process, including dates of the inquest, is provided to the senior next of kin and family parties of the deceased and any other person who the principal registrar considers to have sufficient interest in the investigation of the death. It is unclear whether the ATSILS is notified.

The Victorian Government has partially completed Recommendation 21 through the Coroners Act 2008 (Vic), however it does not appear that measures have been taken to ensure that ATSILS is notified of the date and time of inquest.

Under section 32 of the *Coroners Act 2003* (Qld), within **Queensland**, the Coroner's Court must publish, in a daily newspaper circulating generally in the State, a notice of the matters and issues to be investigated at the inquest, along with the date, time and place of the inquest set by the coroner. Such notice must be published at least 28 days before the inquest is to be held. Additionally, Chapter 9 (9.6) of the *State Coroner's Guidelines 2013*, specifies that all people with a legitimate interest in an

inquest must be notified of the date, time and place it will commence. The Guidelines also require that notice of commencement of an inquest be given to the ATSILS, unless another legal practitioner acts on behalf of the family or the family has indicated that they do not wish to participate in the inquest.

In Queensland, the State Coroner's Guidelines 2013, specifies that all people with a legitimate interest in an inquest, including the ATSILS, must be notified of the date, time and place it will commence. Recommendation 21 is also implemented through the Coroner's Act 2003 (Qld). However, it does not appear that there is a requirement that notification occur as soon as is possible.

The ***South Australian*** *Government Gazette No.63*, under section '12 – Notice to be given of intention to hold inquest', requires that the Manager must, not less than 21 days before the commencement of an inquest or reopening of an inquest, publish a notice of the date, time and place of the inquest in a newspaper circulating generally throughout the state. Also, the Manager must serve a copy of the notice on the senior available next of kin of the person who is deceased and any other person who claims to be entitled to appear at the inquest and has notified the Manager of their details. The Aboriginal Legal Rights Movement is also contacted.

The South Australian Government has implemented Recommendation 21 through the provisions made in the South Australian Government Gazette No.63 which deals with 'notice to be given of intention to hold inquest', and the function of the ALRM. However it does not appear that there is a requirement that notification occur as soon as is possible.

Discussed within the **Western Australian** 2000 Implementation Report, under section 39 of the *Coroners Act 1996* (WA), the State Coroner must, at least 14 days before an inquest, publish in a daily newspaper circulating generally in the State, the date, time, place and subject of the inquest. The Report also noted that Guideline 23 of the *Guidelines for Coroners* provides for Coroners to notify the family of the deceased in writing of the date, time, place and subject of the inquest and in the case of an Aboriginal person, the Aboriginal Legal Service is to be advised in writing.

The Western Australia Government has implemented Recommendation 21 into Coronial practice through the Coroners Act 1996 (WA) and the Guidelines for Coroners.

The **Tasmanian** Government noted that all efforts are made by investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office to provide frank and helpful advice to the family of the deceased in a polite and considerate manner at all times. However, it is unclear what the procedures are for notifying the family and the ATSILS of the time and place of the inquiry.

It does not appear that the Tasmanian Government has taken actions to implement Recommendation 21.

Within the **Northern Territory**, the 1996-97 Implementation Report specified that the Coroner's Regulations provide that the inquest into the death of a person in custody shall not commence in the absence of the senior next of kin or representative of the family of the deceased person nominated by the senior next of kin, unless the Coroner has been advised by that person or his/her legal representative that he or she does not wish to attend the inquest. The Northern Territory Government also notes that the ATSILS are notified of all deaths at the time of the death, and subsequently of the inquest time and date upon listing. The Northern Territory Government has advised that the next of kin are always notified.

The Northern Territory Government has implemented Recommendation 21 into Coronial practice.

Under section 69 of the **Australian Capital Territory's** *Coroners Act 1997*, a coroner must not conduct a hearing into a death in custody unless satisfied that either (a) a member of the deceased's family has been notified, or (b) reasonable attempts to notify a family member have been unsuccessful. The Coroner must also ensure that the appropriate Aboriginal Legal Service has been notified prior to conducting a hearing.

The Australian Capital Territory Government has mostly implemented Recommendation 21 through the Coroners Act 1997 (ACT). However, it does not appear that there is a requirement that notification occur as soon as is possible.

Recommendation 22

That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family's intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family.

Background information

The RCIADIC noted that it is important for there to be an opportunity to view the body of the deceased and for the family, or their nominated representative, to satisfy themselves that there are no suspicious marks or indications of violence.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

Similar to that of Recommendations 20 and 21, within **New South Wales** the State Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified, the ATSILS is contacted. If this has not occurred the inquest may be adjourned until those steps have been taken.

It does not appear that the New South Wales Government has taken steps to implement Recommendation 22. While the Coroner checks that the family of the deceased has been notified, there does not appear to be a requirement that the inquest not go ahead in their absence or upon advice the family does not wish to appear.

In **Victoria**, Section 8(d) of the *Coroners Act 2008* (Vic) provides for family members who are affected by a death being investigated to be kept informed of an investigation. The Act specifies that as soon as possible after a coroner has commenced an investigation into a death, the principal registrar must ensure that the prescribed information in respect of the coronial process is provided to the senior next of kin of the deceased and any other person who the principal registrar considers to have sufficient interest in the investigation of the death. In practice, various people would try to engage with the senior next of kin, including the coroner's investigator, registry and counsel assisting.

The Victorian Government has mostly implemented Recommendation 22 through the Coroners Act 2008 (Vic), however there is no express requirement that the advice of ATSILS is sought before the inquest in the event that clear advice is not available from the family.

Chapter 2 (2.11) of the **Queensland** *State Coroner's Guidelines* 2013, states that families must always be notified of a coroner's decision to hold an inquest. Paragraph 2.7 of the *Guidelines* states that families should be regularly informed as to the progress of an inquest. Chapter 9.6 of the Guidelines states that 'written notice of the commencement date should be given to the senior family member and the inquest should not commence unless the coroner is satisfied that the family member has been notified.'

The Queensland Government has completed Recommendation 22 through the State Coroner's Guidelines 2013, which provides that families must be notified and kept regularly informed on matters relating to inquest.

The actions taken by the **South Australian** Government to Recommendation 21 also apply to Recommendation 22. Additionally, the 1994 Implementation Report included that the State Coroner adopts the practice described in Recommendation 22. This recommendation has been implemented through a combination of the *Coroners Act 2003* (SA) and the practices of the Coroners Court.

The South Australian Government has mostly implemented Recommendation 22 through their response to Recommendation 21, the Coroners Act 2003 (SA), and the practices of the Coroners Court.

The 2000 Implementation Report noted that within **Western Australia**, section 44(1) of the *Coroners Act 1996* (WA) specifies that an interested person may appear, or be represented by an Australian legal practitioner, at an inquest and examine or cross-examine witnesses. The actions taken by the WA Government in Recommendation 21 also apply to Recommendation 22. There is no legislative requirement that the Coroner must not proceed with an inquest unless satisfied that the deceased's family and the Aboriginal Legal Service have been notified of the hearing in good time. In order to ensure that an inquest does not proceed until such time as every avenue has been exhausted to discover the family's interest in the proceeding, the Coroner's Court has implemented a system of call-overs to notify interested parties of inquest listings.

The Western Australian Government has partially implemented Recommendation 22 through the Coroners Act 1996 (WA) and the implementation of call-overs. However, there is no requirement that the Coroner must not proceed with the inquest unless satisfied that the deceased's family and the Aboriginal Legal Service have been notified of the hearing in good time.

According to the 1995 **Tasmanian** Implementation Report, inquests do not proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing and does not wish to be represented. If an inquest is to proceed without family or legal representation, the Coroners Clerk must obtain advice from the family, the Aboriginal Legal Service, or legal representatives that the family does not wish to appear of be represented. If no such advice is forthcoming, the Clerk must demonstrate that all reasonable efforts were made to obtain that advice.

The Tasmanian Government has implemented Recommendation 22 as noted in their 1995 implementation report and exemplified in current court processes.

As discussed in the 1994-95 Implementation Report, the **Northern Territory's** Coroners Regulations provided that an inquest into the death of a person held in custody may not begin without the presence of the senior next of kin, unless the coroner is satisfied that the senior next of kin does not wish to attend. The next of kin, nominated representative or legal representative must advise the coroner if this is the case. Permission is also granted for a person with sufficient interest to appear at the inquest.

The Northern Territory Government has implemented Recommendation 22 through the Coroners Regulations which provided that an inquest into the death of a person held in custody may not begin without the presence of the senior next of kin.

Under section 69 of the *Coroners Act 1997* (ACT), within the **Australian Capital Territory** the Coroner must not commence an inquest into the death of a person held in custody unless a member of the immediate family has been notified of the time and place of hearing. The appropriate Aboriginal Legal Service must also be notified. However, these requirements do not apply if the Coroner believes on reasonable grounds that it would be in public interest or the interests of justice to proceed with a hearing despite these requirements.

The Australian Capital Territory Government has mostly implemented Recommendation 22 through the Coroners Act 1997 (ACT).

Recommendation 23

That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise.

Background information

In most cases, Aboriginal and Torres Strait Islander people did not have legal representation due to a lack of funds. Lack of representation placed Aboriginal and Torres Strait Islander people at a

disadvantage, and this was a significant factor impacting the rates of offending, violence and incarceration.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

Immediately following the RCIADIC, the **Commonwealth** Government agreed to provide funding for legal representation for families at inquests relating to deaths in custody and ATSIC provided $9.7 million to ATSILS to expand their services (*1992-93 Annual Report*).

Through the Indigenous Legal Assistance Program, the Commonwealth funds eight ATSILS to deliver culturally appropriate, accessible legal assistance and related services to Aboriginal and Torres Strait Islander people so that they can fully exercise their legal rights as Australian citizens. From 2015 to 2020, the Australian Government is investing over $370 million into the Indigenous Legal Assistance Program. It is a matter for legal service providers to target services to the greatest need to ensure they maximise the benefit to disadvantaged and vulnerable clients.

The Commonwealth has implemented Recommendation 23 by providing ongoing funds to ATSILS for legal assistance services. These services may include, where applicants meet eligibility requirements, legal assistance to the family of the deceased at inquests.

The 1995-96 Implementation Report noted that Legal Aid was available in **New South Wales** for inquests into deaths where the public interest would be advanced by representation of the applicant. The Legal Aid Commission altered its guidelines in 1992 to provide that where the death occurred in the custody of police, a juvenile detention centre or a prison, questions of public interest will generally be considered to have arisen. Currently, Legal Aid NSW has a dedicated Coronial Inquest Unit which provides free legal advice, assistance and representation to people at coronial inquests where the matter involves some 'public interest'.

The New South Wales Government has implemented Recommendation 23 through the provision of legal services through Legal Aid.

The **Victorian** 1994 Implementation Report suggested that the Commonwealth Government had funding responsibility for Aboriginal Legal Services, while the Victorian Government shared responsibility for the Legal Aid Commission of Victoria.

The Victorian Government has implemented Recommendation 23 through the administration of Commonwealth funds provided for Aboriginal Legal Aid Commissions.

In **Queensland**, grants of legal assistance are available through Legal Aid Queensland for legal representation to the families of an Aboriginal and Torres Strait Islander person who died in custody.

The Queensland Government has implemented Recommendation 23. Grants of legal assistance are available through Legal Aid Queensland for legal representation to the families of an Aboriginal and Torres Strait Islander person who died in custody.

The 1994 Implementation Report highlighted that within **South Australia,** Aboriginal and Torres Strait Islander people are entitled to legal representation free of charge either through the Legal Services Commission or the Aboriginal Legal Service, provided they qualify for support through a means test. The South Australian Government notes that the Legal Services Commission does not receive a specific allocation to provide funding for legal representation at coronial inquiries. Applications for legal assistance are assessed against normal funding criteria, which comprise a means test, a merits test and guidelines. Coronial inquiries may fall outside these criteria. Legal Aid may also be granted for an inquest that is in the 'public interest'.

In South Australia, past practice has been that Aboriginal and Torres Strait Islander people are entitled to means-tested legal representation free of charge either through the Legal Services

Commission or the Aboriginal Legal Service. Legal assistance is available for coronial inquiries through an application to ATSILS however is assessed against normal funding criteria and is not guaranteed.

In **Western Australia**, s 44(1) of the *Coroners Act 1996* (WA) allows the family of the deceased to be represented at an inquest. Legal Aid Western Australia is funded by the Western Australian Government, and provides representation at inquests in limited, means-tested circumstances where the applicant meets the Legal Aid Western Australia State eligibility guidelines. Aid may be granted for representation at inquests where there is a realistic risk that serious criminal charges may arise against the applicant, or where the outcome of the inquest can reasonably seen to have a significant impact on civil proceedings involving the applicant.

In Western Australia, Recommendation 23 has been mostly implemented. While legal representation is provided by the Aboriginal Legal Service, Legal Aid Western Australia offers limited access to services.

Under section 52(4) of the **Tasmanian** *Coroners Act 1995* (Tas), a person who the coroner considers has a sufficient interest may appear or be represented by an Australian legal practitioner. The 1993 Implementation Report highlighted that such persons may apply for legal aid in the normal manner, either through the Legal Aid Commission or the Aboriginal Legal Service.

In Tasmania, past practice has been that Aboriginal and Torres Strait Islander people are entitled to means-tested legal representation, which upon qualifying is free of charge. Legal assistance is available for coronial inquiries through ATSIL but is assessed against normal funding criteria and is not guaranteed.

The **Northern Territory** considered that Recommendation 23 fell under the Commonwealth Government's responsibility.

It does not appear that the Northern Territory Government has taken actions towards the implementation of Recommendation 23, noting that they consider implementation of this recommendation to be a matter for the Commonwealth Government.

The 1993-94 Implementation Report noted that the **Australian Capital Territory** Government considers that the most appropriate source for legal representation of Aboriginal and Torres Strait Islander people at inquests is through the Aboriginal Legal Service, noting that this is funded by the Commonwealth. The Report also highlighted that the ACT Government would consider additional funding for legal representation at coronial inquests relating to deaths in custody on a case-by-case basis. Currently, there is no guaranteed right to funded legal representation for family members. The Australian Capital Territory Government note that funded representation will be considered as part of an upcoming review into the operation of the *Coroners Act 1997* (ACT).

The Australian Capital Territory Government has partially completed Recommendation 23 as some funding is provided for legal representation.

Recommendation 24

That unless the State Coroner or the Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.

Background information

Notification of death and the provision of information into the circumstances of the death is crucial for the relatives of the deceased. Additionally, notification is important in allowing relatives to organise proceedings for the inquest.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **Commonwealth** and **Australian Capital Territory** governments have addressed Recommendation 24 through the AFP *National Guideline* which provide that if an Aboriginal and Torres Strait Islander person dies in custody, the case officer and the ACT Policing Aboriginal and Torres Strait Islander Community Liaison Officer must notify and provide requested information to the deceased's family and the ATSILS (paragraph 22). Current AFP procedure for the ACT and Jervis Bay Territory is set by the *ACT Coroners Act 1997* which provides families or their representatives the opportunity to inspect the scene of death; to view the body; to have a representative present at any post-mortem examination; and to have another medical practitioner conduct a further post-mortem. Additionally, the Act provides for the deceased's immediate family to have all reasonable questions about the circumstances of the death answered; and to be kept informed of all important developments throughout the inquest. It is also standard practice in the ACT that the Coroners Court is polite and professional.

The Commonwealth and Australian Capital Territory governments have implemented Recommendation 24 through the AFP National Guideline and the ACT Coroners Act.

The **New South Wales** *Police Force Handbook* sets out that officers are to be sensitive and discreet when dealing with relatives of deceased people. The Handbook notes that if an Aboriginal person dies in police custody, officers are to secure and preserve the scene and to notify their regional commander. If available, officers are to use Aboriginal Community Liaison Officers to maintain a relationship with the relatives. Under existing protocols for Aboriginal deaths in custody, the Aboriginal Strategy and Policy Unit provides a contact for families seeking advice on prison protocols and the status of relevant investigations conducted by CSNSW. Information such as briefs of evidence and post mortem reports are provided upon request to the court. Information about coronial processes are contained on the website and brochures given to families. Police Officers were instructed by the Police Commissioner, pursuant to Instruction 55, to ensure that all reasonable requests by the family were complied with, which may include viewing the body or the scene of the death.

The New South Wales Government has implemented Recommendation 24. The Aboriginal Strategy and Policy Unit provides a contact for families seeking advice on prison protocols and the status of relevant investigations conducted by CSNSW.

Within **Victoria**, coroners try to make inquests less formal than other court proceedings, according to *The Coroners Process Information for family and friends*. The document notes that the coroner will try to avoid using unnecessarily complex language as the coroner wants family members and interested parties to understand what is happening in the proceeding. Further to this, the Coroners Support Service provides information and updates to families through letters and phone calls so that they are up to date with key findings of a coroner's investigation. The Victorian Government also provided in AJA 3 that a protocol would be developed between the State Coroner's Office and the Aboriginal Funeral Service, to authorise release of information regarding the deceased.

The Victorian Government has implemented Recommendation 24 through The Coroners Process Information for Family and Friends, and the initiatives undertaken by the Coroners Support Service in providing information and updates to families.

In **Queensland**, under section 45(4) of the *Coroners Act 2003* (Qld), the coroner must give a copy of the findings to a family member of the deceased person who has indicated that he or she will accept the document for the deceased person's family. Chapter 2(2.7) of the *Guidelines* reminds coroners that steps are to be taken to ensure that families are provided with regular updates about how the investigation into a death is to be conducted and the progress of that investigation. The Guidelines also highlight the importance of the role that Coronial counsellors play in supporting grieving families. Further to this, Section 16.23.3(xii) of the *Operational Procedures Manual Issue 59 Public Edition*, notes that if requested, investigation officers should make all efforts to allow family members or their

representatives the opportunity to inspect the scene of death, subject to police operational and security requirements, bearing in mind the cultural needs of the relatives.

The Queensland Government has implemented Recommendation 24 through the Coroner's Act 2003 (Qld), Guidelines, and the police Operational Procedures Manual Issue 59 Public Edition.

In the 1994 **South Australian** Implementation Report, the South Australian Government explained that the processes described in Recommendation 24 were already practised by the Coroner's Court. Documentary evidence was made available to members of the family in a managed way through a social worker employed by the court. If convenient, family members were given the opportunity to inspect the scene of the death. Additionally, under section 25 of the *Coroners Act 2003* (SA), the Coroner is required to send a copy of the Coroner's findings to any person with sufficient interest. Section 37 of the Act notes that a member of the public may apply to access various documents relating to coronial process or findings.

The South Australian Government has noted that Recommendation 24 was incorporated into practices prior to the RCIADIC, and implementation is further strengthened by the Coroners Act 2003 (SA). However, this does not appear to necessarily require all reasonable measures to be taken.

The 2000 **Western Australian** Implementation Report noted that Guideline 33 of the *Guidelines for Police* provided that throughout any inquiry all efforts should be made to provide frank and helpful advice to the relatives of the deceased and to do so in a polite and considerate manner. If requested, all efforts were to be made to allow family members or their appointed representatives to inspect the scene of death. The opportunity to inspect the scene of death will only be permitted after the initial investigations are completed on behalf of the Coroner. Where the death occurs in a prison or the Banksia Hill Detention Centre, permission to view the scene of death must be authorised by the designated superintendent. Additionally, section 42 of the *Coroners Act 1996* (WA) provides that the Coroner may make available statements arising from the inquiry to any person with a sufficient interest - including the family of the deceased. Section 26(a) of the *Act* allows access to the evidence by the senior next of kin.

The Western Australian Government has implemented Recommendation 24 through the Guidelines for Police and the Coroners Act 1996 (WA).

The actions taken by the **Tasmanian** Government in Recommendation 20 are also relevant to Recommendation 24. Additionally, section 25 of the *Coroners Rules 2006* (Tas) requires that at the conclusion of an investigation into a death, the coroner is to ensure the senior next of kin of the deceased person is provided with a copy of the coroner's findings. If family members wish to access a public place where a death occurred, family can attend at any time unless police or the coroner are still conducting investigations at the scene. If the scene is still an active part of the investigation, the police will deny access until all evidence is gathered and it is safe for the public. Staff at the Coroner's Court can notify family once access to the scene is open. If the scene family wish to access is a private residence, building or on private property then there are restrictions on accessing the scene.

The Tasmanian Government has implemented Recommendation 24 through the Coroners Rules 2006 (Tas).

The 1994-95 Implementation Report noted that in the **Northern Territory**, Code C9 had been added to the Police General Order Coroners and Inquests. Paragraph 41.2.10 under Code C9 specified that unless the coroner conducting the inquest otherwise directs, any information that is sought by the deceased's family, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of the investigation is to be supplied. Further to this, paragraph 41.2.11 of Code C9 requires that unless the coroner conducting the inquiry otherwise directs and providing the viewing does not prejudice the conduct of the investigation, members of the deceased's immediate family or a representative thereof, shall be permitted to view the body or scene of death as soon as practicable.

The Northern Territory Government has implemented Recommendation 24 through Code C9.

Recommendation 25

That unless the State Coroner, or the Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.

Background information

The RCIADIC Report noted that in several cases, the deceased's body was removed from the place of death prior to the relatives being given an opportunity of viewing it. This aroused concern and suspicion amongst the deceased's family. It is important that the family's right to view the body should be recognised.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **Commonwealth** and **Australian Capital Territory** governments note in the 1995-96 Implementation Report that the Coroner's Act empowers the Coroner, on request, to allow a member of the immediate family of the deceased, or a representative of that family member, to view the body, inspect the scene of death, be present at any post mortem and order a further post mortem. If the coroner believes, on reasonable grounds, that it would not be in the interests of justice to do this, the coroner must notify the person making the request and the Aboriginal Legal Service in writing and provide the reasons for the decision. These provisions are also made under section 70 of the *Coroners Act 1997* (ACT), including that if requested the Coroner must authorise the viewing of the body, inspection of the scene of death and presence of family members at any post-mortem except where it is not in the interests of justice. Additionally, section 32(b) provides for the report of the post-mortem to be given to the representative of the deceased.

The Commonwealth and Australian Capital Territory governments have implemented Recommendation 25 through the AFP National Guideline and the Coroners Act 1997 (ACT).

The 1995-96 Implementation Report noted that in **New South Wales** the protocol of the State Coroner's Officer specified that the family of the deceased was entitled to have an independent representative attend the post mortem. The Aboriginal Legal Service were to liaise with the State Coroner's Office for this purpose. Police Officers were instructed by the Police Commissioner, pursuant to Instruction 55, to ensure that all reasonable requests by the family were complied with, which may include viewing the body or the scene of the death. The Report highlighted that in relation to an 'independent' observer or medical practitioner, it was the responsibility of the family of the deceased or the Aboriginal Legal Service to make such arrangements. Further to this, the Department of Corrective Services had incorporated Recommendation 25 in Section 13.2.7 of the Operations Procedure Manual.

The New South Wales Government has implemented Recommendation 25 through Section 13.2.7 of the Operations Procedure Manual. Procedures exist for families to arrange to be present at the post-mortem and to view the body.

The **Victorian** Implementation Report of 1994 specified that the family of the deceased or their representative were able to view the body of the deceased on request. The family could view the scene of death as part of the arrangements for the inquest. It was also noted that the Coroner could not provide a right for the family to view the scene of death when it was within a police station or prison. Additionally, independent observers were allowed at post-mortems if suitable arrangements were made with the Coroner. A copy of the post-mortem report was normally available as part of the court file and was provided on request. The Victorian Government also noted in the AJA 3 that in the event of a death in custody that relatives would be notified in accordance with privacy and legal considerations.

While the Victorian Government has taken measures to implement Recommendation 25, there is no provision for families of the deceased to view the scene of death where it is in within a police station or prison cells.

In **Queensland**, this is provided for in the *Coroners Act 2003* (Qld). Chapter 2(2.5) of the *State Coroner's Guidelines* emphasises the benefits that can be gained for grieving families to view their loved one's body from burial or cremation. Chapter 4 of the *Guidelines* establish the processes in place for viewing the remains of a deceased person, arrangements are made for the family to view the body and in some cases ritual cleansing of cells has occurred. Chapter 5 of the *Guidelines* permit a medical practitioner engaged by the family to attend an autopsy. A coroner's order for an autopsy will usually permit a family to be told of the results of an autopsy by a counsellor or other person. A family is also entitled to access the brief of evidence.

The Queensland Government has implemented Recommendation 25 through the Coroners Act 2003 (Qld).

The 1994 Implementation Report noted that the **South Australian** Government was advised that this process detailed in Recommendation 25 was then current practice of the Coroner's Court. A 'viewing room' was available at the court and the family were able to view the body where possible. An independent observer and medical practitioner were possible in certain circumstances and upon request. A copy of the post mortem report was available was available to members of the family through a social worker.

The South Australian Government has incorporated Recommendation 25 into current practice concerning families viewing the scene of death.

In **Western Australia**, section 30(2) of the *Coroners Act 1996* (WA) provides that while a body is under the control of the coroner investigating the death, the coroner is to ensure that any of the deceased person's next of kin who wish to view or touch the body are permitted to do so. Section 35 of the Act specifies that if the senior next of kin of the deceased asks a coroner to allow a doctor to be present at a post mortem examination, the coroner is to allow that doctor to be present. Additionally, the 2000 Implementation Report noted that an independent observer may be permitted at post mortem examination and the Coroner can consider a request for additional post mortem examination. The opportunity to inspect the scene of death will only be permitted after the initial investigations at the scene of death are completed on behalf of the Coroner. Where the death occurs in a prison, authorisation by the designed Superintendent must be approved before the family can view the scene of death. The Western Australian Government notes that it is current practice for an independent medical practitioner nominated by the next of kin to receive a copy of the post-mortem report on request.

The Western Australian Government has incorporated Recommendation 25 into current practice concerning families viewing the scene of death.

In **Tasmania**, as highlighted in the 1993 Implementation Report, the family of the deceased or their representative may view the body and/or the scene of death. The family may also request a further post mortem (at their own cost) and are entitled to receive a copy of the examining pathologist's report. The Report also noted that as post mortems in Tasmania are conducted by qualified and independent pathologists, the presence of an independent medical practitioner or observer at post mortems is unnecessary. The Tasmanian Government comments that determination as to whether family members would have the opportunity to inspect the scene of death would be subject to police operational and security requirements, but the cultural needs of the relatives would be acknowledged.

The Tasmanian Government has incorporated Recommendation 25 into current practice concerning families viewing the scene of death.

The actions taken in Recommendation 24 in the **Northern Territory** also apply to this recommendation. It is unclear whether an independent medical practitioner is able to be present at the post mortem and will receive a copy of the post-mortem report, or if a copy of the direction is sent to the family and the ATSILS. The Northern Territory Government notes that in practice, while

regulations to this effect do not exist, there is no issue with an independent medical practitioner being present at the post-mortem. Additionally, the NTCS Directive 2.1.19 *Sorry Business/Body Viewing and Smoking Ceremonies* allows for the rest of kin and other relatives to make arrangements to see the body and the place of death, should they wish to.

The Northern Territory has mostly implemented Recommendation 25 through the Coroners Act 1993 (NT). However, it does not appear that regulatory provisions allowing an independent medical practitioner to be present at the post-mortem exist. It is not clear whether the independent medical practitioner will receive a copy of the post-mortem report, or if a copy of the direction is sent to the family and the ATSILS.

Recommendation 26

That as soon as practicable, and not later than forty-eight hours after receiving advice of a death in custody the State Coroner should appoint a solicitor or barrister to assist the Coroner who will conduct the inquiry into the death.

Background information

The RCIADIC recommended that a legal practitioner should be immediately appointed to assist the Coroner to ensure that a full and adequate inquiry is conducted into the cause and circumstances of death.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

As discussed in the 1995-96 **New South Wales** Implementation Report, where a death occurs in police custody or there is alleged to be police involvement in the death, the Crown Solicitor or the Office of General Counsel is requested at the earliest opportunity to instruct suitable Counsel to assist. Where the death occurs in non-police custody, a Police Advocate may be instructed to assist the Coroner. Under the State Coroner's protocol for deaths in custody, when informed of a death in police custody, the State Coroner will ask the Attorney-General to appoint a barrister to assist the coroner on that day.

In New South Wales, Recommendation 26 has been mostly implemented. There is no requirement that appointment of a counsel occur within 48-hours.

In **Victoria,** under section 60 of the *Coroners Act 2008* (Vic), a coroner may be assisted at an inquest by an Australian lawyer. The 1994 Implementation Report highlighted that this is a discretionary, not mandatory, requirement. The Report noted that in practice, counsel is usually appointed for an inquest into a death in custody, however, this is done at the inquest stage, not at the beginning of the investigation. The Victorian Government noted that in practice, if the death in custody is related to the police, the Coroner will generally attend the scene and appoint a solicitor within 48 hours.

While the Victorian Government has responded to Recommendation 26 through the Coroners Act 2008 (Vic) and current practices, the appointment of a barrister or solicitor is not mandatory and does not always occur at the beginning of the inquiry.

In **Queensland,** each coroner is already assisted by a lawyer (counsel assisting), so the option to appoint further legal assistance is in addition to the assistance provided by the counsel assisting positions. The State Coroner is supported by a dedicated and independent Counsel Assisting attached to the court who assists in the investigation of all deaths in custody from the time the death is reported. External counsel can be briefed in more complex matters.

The Queensland Government has implemented Recommendation 26, as all coroners are already assisted by a lawyer in their inquiries.

In **South Australia**, there is no legislative requirement to meet a 48-hour time frame, however the Coroner's Court has two full time legal practitioners who assist with inquests. Additionally, the State Coroner may request appointment of additional Counsel from the responsible government office.

There have, however, been occasions where requests made by the Coroner for the appointment of additional counsel have not been met.

The South Australian Government has mostly implemented Recommendation 26 by the employment of 'in-house' practitioners within the Coroner's Court. There have, however, been occasions where requests made by the Coroner for the appointment of additional counsel have not been met.

Under section 46(2) of the *Coroners Act 1996* (WA), in **Western Australia** a coroner may be assisted by counsel, or by any other person that the coroner believes will be of assistance. Highlighted in the 2000 Implementation Report, as of 10 March 1997, a solicitor had been attached to the Coroners Court. Currently, the Coroner's Court employs three people as counsel to assist in inquests. Additionally, an arrangement had been entered into with the Director of Public Prosecutions whereby officers from that office were seconded to the Office of State Coroner for a period on a rotational basis.

The Western Australian Government has partially implemented Recommendation 26 through the Coroners Act 1996 (WA). However, it appears that no timeframe is provided for the Director of Public prosecutions to provide counsel to assist the coroner.

The 1993 Implementation Report noted that in **Tasmania** a Crown Counsel from the Director of Public Prosecutions Office is appointed to assist the Coroner in all cases dealing with a death in custody in Tasmania. Section 53(3) of the *Coroners Act 1995* (Tas) provides that a coroner must request the Director of Public Prosecutions to provide counsel to assist the coroner, however no timeframe is provided for this to occur.

The Tasmanian Government has partially implemented Recommendation 26 through the Coroners Act 1995 (Tas). However, no timeframe is provided for the Director of Public prosecutions to provide counsel to assist the coroner.

In the **Northern Territory**, under section 41(2)(b) of the *Coroners Act 1993* (NT), a coroner must appoint a person to assist the coroner for the purpose of an inquest into a death in custody. The Coroners Regulations stipulates that the person shall be a legal practitioner and, if practicable, shall be experienced in coronial matters. The Northern Territory Government noted in their 1996-97 annual report that Coroners Regulations were proposed to be amended to ensure that the legal practitioner was appointed as soon as possible after the advice of a death in custody was received, although it is unclear if this occurred.

The Northern Territory Government has mostly implemented Recommendation 26. Under the Coroners Act 1993 (NT), a coroner must appoint a person to assist the coroner for the purpose of an inquest into a death in custody. However, there is no requirement for this to occur within 48 hours.

In the **Australian Capital Territory**, under section 72 of the *Coroners Act 1997* (ACT), the coroner holding an inquest into a death in custody must appoint a lawyer as counsel to assist the coroner. It is unclear whether such appointment must be made within 48 hours. The Australian Capital Territory Government notes that time limits for the appointment of counsel assisting the Coroner will be considered as part of an upcoming review of the *Act*.

The Australian Capital Territory Government has mostly implemented Recommendation 26. Under the Coroners Act 1997 (ACT), a coroner must appoint a lawyer or counsel to assist the coroner for the purpose of an inquest into a death in custody. However, there does not appear to be a requirement for this to occur within 48 hours.

Recommendation 27

That the person appointed to assist the Coroner in the conduct of the inquiry may be a salaried officer of the Crown Law Office or the equivalent office in each State and Territory, provided that the officer so appointed is independent of relevant custodial authorities and officers. Where, in the opinion of the

State Coroner, the complexity of the inquiry or other factors, necessitates the engaging of counsel then the responsible government office should ensure that counsel is so engaged.

Background information

The RCIADIC proposed that the lawyer assisting the coroner may be a salaried officer of the Crown Law Department, or equivalent office, provided that the lawyer is not engaged in the consideration or preparation of any criminal proceedings which may arise from any inquest in which that legal officer has assisted.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The **New South Wales** 1995-96 Implementation Report noted that the Attorney-General instructs the Crown Solicitor to assist the coroner where the coroner so requests. The Crown Solicitor and Office of General Counsel are completely independent of all custodial authorities in these matters. Counsel is engaged if the complexity of the case demands it. The Report highlighted that this is the rule, rather than the exception, in the case of Aboriginal deaths in custody.

The New South Wales Government has implemented Recommendation 27. In all deaths in custody, the Attorney-General instructs the Crown Solicitor to assist the Coroner.

The 1994 **Victorian** Implementation Report stated that in all deaths in custody the Coroner seeks assistance from the Office of Public Prosecutions staff so they may brief independent counsel to assist the Coroner.

The Victorian Government has implemented Recommendation 27. In all deaths in custody, the Coroner seeks assistance from the Office of Public Prosecutions staff.

In **Queensland**, the counsel assisting the coroners, who provide legal assistance in the first instance, are employed by the Coroners Court of Queensland and are therefore independent of custodial authorities. The State Coroner is supported by a dedicated and independent Counsel Assisting attached to the court who assists in the investigation of all deaths in custody from the time the death is reported. External counsel can be briefed in more complex matters.

The Queensland Government has implemented Recommendation 27 through the use of independent counsel from the Coroners Court.

In **South Australia**, the Coroner's Court has two full time legal practitioners who assist with inquests. The State Coroner may request appointment of additional Counsel from the responsible government office. There have, however, been occasions where requests made by the Coroner for the appointment of additional counsel have not been met.

The South Australian Government has mostly implemented Recommendation 26 by the employment of 'in-house' practitioners within the Coroner's Court. There have, however, been occasions where requests made by the Coroner for the appointment of additional counsel have not been met.

The 2000 **Western Australia** Implementation Report highlighted that the State Coroner had entered into an arrangement with the Office of the Director of Public Prosecutions whereby officers from that office would be seconded to the Office of the State Coroner for a period of one year on a rotational basis. The Coroner's Court 2012 publication 'Inquest Hearings in Western Australia' requires that those assisting the Coroner be independent and impartial. Coroner's Investigators are appointed on the recommendation of the State Coroner and every member of the Western Australia Police Force is contemporaneously a Coroner's Investigator.

The Western Australian Government has mostly implemented Recommendation 27. However, it is not clear that current practice is for the Assistant to the Coroner to be a salaried officer of the Crown Law Office.

The 1993 **Tasmanian** Implementation Report noted that the process described in Recommendation 27 was the current practice in Tasmania.

The Tasmanian Government noted in their 1993 implementation report that Recommendation 27 had been incorporated into current practice. However, no evidence of these actions taken could be identified.

As discussed in the 1994-95 Implementation Report, in the **Northern Territory** the-then current regulations specified that the person appointed to assist the coroner must be a legal practitioner. The 1996-97 Report noted that the Coroners Regulations were to be amended to give effect to this recommendation. The updated *Coroner's Act 1993* (NT) provides that the coroner's clerk may perform functions including witnessing an affidavit, receive information about a death or disaster, and may issue a summons.

The Northern Territory Government has partially implemented Recommendation 27 by amending the Coroners Regulations to give effect to the principles contained in this recommendation. It does not appear to be an explicit requirement that legal advice be independent.

In the **Australian Capital Territory,** under section 72 of the *Coroners Act 1997* (ACT), a lawyer appointed to assist the coroner holding an inquest into a death in custody must not have an actual or perceived conflict of interest (based on lawyer's personal or professional circumstances) that would prevent the lawyer from properly carrying out the functions of counsel.

The Australian Capital Territory Government has implemented Recommendation 27 through the Coroners Act 1997 (ACT), which provides that the appointed lawyer to assist in inquest must not have a conflict of interest.

Recommendation 28

That the duties of the lawyer assisting the Coroner be, subject to direction of the Coroner, to take responsibility, in the first instance, for ensuring that full and adequate inquiry is conducted into the cause and circumstances of the death and into such other matters as the Coroner is bound to investigate. Upon the hearing of the inquest the duties of the lawyer assisting at the inquest, whether solicitor or barrister, should be to ensure that all relevant evidence is brought to the attention of the Coroner and appropriately tested, so as to enable the Coroner to make such findings and recommendations as are appropriate to be made.

Background information

The RCIADIC suggested that upon the hearing of the inquest that services of that lawyer should be retained to assist the coroner to ensure that all relevant factors are brought to the attention of the coroner to enable the making of all findings and recommendations which are appropriate to be made.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

Discussed in the 1995-96 Implementation Report, within **New South Wales** it is the duty of the legal officer assisting the coroner to ensure that all relevant evidence is brought to the coroner's attention and is appropriately tested during the course of an inquest. Additionally, this duty applies to both police prosecutors and independent lawyers engaged to assist in specific cases.

The New South Wales Government has implemented Recommendation 28, and provides that it is the duty of the legal officer assisting the coroner to ensure that all relevant evidence is brought to the coroner's attention and accurately tested.

The 1994 **Victorian** Implementation Report noted that under section 46 of the *Coroners Act 1985* (Vic), the Coroner normally appoints counsel whose role is confined to assisting the Coroner during the inquest to ensure that relevant matters are raised. Under the amended *Coroners Act 2008* (Vic), provision is made for the appointment of a lawyer to assist the Coroner with their duties at inquest. However, no specific reference is made to the duties.

The Victorian Government has also addressed the principles of Recommendation 28 through the Coroners Court Bench Book. The Coroners Court Bench Book provides that the role and involvement of an assistant will depend on the wishes of the presiding coroner. In general, the coronial assistant will conduct the procedural steps at the inquest, and will adduce evidence on behalf of the coroner. This allows the coroner to focus on listening to and evaluating the evidence. The coronial assistant must be independent and impartial, and must not struggle unduly for a particular result.

The Victorian Government has addressed Recommendation 28 through the Coroners Act 1985 (Vic), and the Coroners Court Bench Book.

According to the 1997 Implementation Report, the **Queensland** Government highlighted that the responsibilities imposed on Counsel assisting Coroners in regard to Recommendation 28 were fully complied with. The Queensland *State Coroner's Guidelines 2013* sets out the role of counsel assisting the coroner, which includes impartially and fairly presenting the evidence to the coroner, identifying issues for examination, calling and examining witnesses, exploring the range of possibilities open on the available evidence, exploring possible options for preventative recommendations and making submissions about the findings and comments open to the coroner.

The Queensland Government has implemented Recommendation 28 through the State Coroner's Guidelines 2013.

In **South Australia**, the Coroner's Court has two full time legal practitioners who assist with inquests. The State Coroner may request appointment of additional Counsel from the responsible government office. The State Coroner has noted that if requests for the appointment of Counsel are not met, the Coroner's Court may not be in a position to carry out its Inquiry within the words of this recommendation.

The South Australia Government has partially implemented Recommendation 28. However, where a request made by the State Coroner for the appointment of additional Counsel to assist is not met, this has the potential to impact upon the Coroner's Court's Inquiry.

Within **Western Australia**, as discussed in the 2000 Implementation Report, the counsel appointed to assist Coroners is able to ensure that full and adequate inquiry is conducted from a very early stage through to completion of each inquiry.

As discussed in the 2000 Implementation Report, Recommendation 28 has been implemented in Western Australia.

The 1995 Implementation Report noted that within **Tasmania**, the responsibility of a Crown Counsel is to ensure that a full and detailed inquiry has been conducted and that all evidence that might reasonably be collected has in fact been collected and will be presented to the Coroner.

The Tasmanian Government has implemented Recommendation 28 through the responsibilities of the Crown Counsel.

Within the **Northern Territory**, as highlighted within the 1996-97 Implementation Report, amendments to the Coroners Regulations were proposed to give effect to Recommendation 28. The amended regulations were unable to be located.

Within the Northern Territory, Recommendation 28 has been implemented through revised Coroners Regulations.

The 1995-96 Implementation Report noted that in the **Australian Capital Territory**, Recommendation 28 was the current practice in the ACT. Section 39(a) of the *Coroners Act 1997* (ACT) sets out the functions of counsel assisting which include: assisting the Coroner as required by the Coroner in the inquest or inquiry; appearing at the hearing and presenting evidence and examining witnesses at the hearing; making submissions to the Coroner on any matter relevant to the inquest or inquiry; and acting in the public interest and the interests of justice to assist the Coroner in deciding matters of fact or law.

Within the Australian Capital Territory, Recommendation 28 has been implemented as noted in the 1995-96 implementation report and under the Coroners Act 1997 (ACT).

Recommendation 29

That the Coroner in charge of a coronial inquiry into a death in custody have legal power to require the officer in charge of the police investigation to report to the Coroner. The Coroner should have power to give directions as to any additional steps he or she desires to be taken in the investigation.

Background information

The RCIADIC stressed the importance of ensuring the independence of the coroner in addition to the independence of the officer in charge of the police investigation from outside influence.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

Under the **New South Wales** *Coroners Act 2009* (NSW), section 51(2) specifies that a coroner in coronial proceedings may give such directions as the coroner thinks fit. In particular, the coroner may direct relevant persons in the proceedings to take specified steps in relation to the proceedings, time frames in which the specified steps must be completed and give directions with respect to the conduct of proceedings as the coroner considers appropriate. Section 49(3)(d) of the Act specifies that a relevant person means any person assisting the coroner in conducting the proceedings.

The New South Wales Government has implemented Recommendation 29 through the Coroners Act 2009 (NSW), under which Coroners may make any directions they deem fit.

In **Victoria**, under section 36 of the *Coroners Act 2008* (Vic), a police officer who has information that may be relevant to an investigation by a coroner into a death must give that information to the coroner to assist the coroner in his or her investigation of the death. Under section 32 of the Act, a person who reported a reportable death or a reviewable death must give the coroner any information or other assistance that the coroner requests for the purposes of the coroner's investigation. Additionally, section 42 of the Act highlights that if a coroner is of the opinion that a document or prepared statement is required for the purposes of the investigation, the coroner may require a person to give the document to the coroner.

The Victorian Government has implemented Recommendation 29 through the Coroners Act 2008 (Vic), under which a police officer with relevant information is required to present it to the coroner during the investigation into death.

As discussed in the **Queensland** *Police Powers and Responsibilities Act 2000* (Qld), section 794 stipulates that it is the duty of police officers to help coroners in the performance of a function, or exercise of a power, under the *Coroners Act 2003* (Qld), section 15. This provides for the investigation of deaths and the conduct of inquests. Further to this, it is the duty of police officers to comply with every reasonable and lawful request, or direction, of a coroner.

The Queensland Government has implemented Recommendation 29 through the Police Powers and Responsibilities Act 2000 (Qld), under which police officers are required to help coroners in the performance of a function, or exercise of a power.

In **South Australia**, Section 28(3) of the *Coroners Act 2003* (SA) requires that a police officer must, on being notified of a reportable death, immediately notify the State Coroner of the death and any information that the police officer has or has been given in relation to the matter. The police officer in charge of the investigation does not report solely to the Coroner. Section 23(1) of the Act specifies that the Coroner's Court may, by summons, require the appearance of any person before a Coronial inquest.

The South Australian Government has partially implemented Recommendation 29 through the Coroners Act 2003 (SA). However, police in charge of the investigation are not required to report solely to the Coroner.

In **Western Australia**, under section 14 of the *Coroners Act 1996* (WA), every member of the Police Force of the State is at the same time a coroner's investigator. Under s.14(3) of the *Act*, a coroner's investigator must assist the coroner in carrying out his or her duties under the Coroners Act and carry out all reasonable directions of the coroner.

The Western Australian Government has implemented Recommendation 29 through the Coroners Act 1996 (WA).

Under section 20(2) of the *Coroners Act 1995* (Tas), in **Tasmania**, a police officer who has information relevant to an investigation must report to the Coroner. Section 16(b) of the Act specifies that that a police officer is, by virtue of his or her office, a coroner's officer and has the same functions and power as are conferred or imposed on a coroner's officer by the Act. Further to this, section 59(3) of the Act provides that the Coroner may give directions for an officer to exercise their powers of entry, inspection and possession if the Coroner believes it is reasonably necessary for the investigation.

The Tasmanian Government has implemented Recommendation 29 through the Coroners Act 1995 (Tas).

In the **Northern Territory**, under section 25 of the *Coroners Act 1993* (NT), a coroner may give directions to a police officer for the purpose of investigating the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody. A police officer must not refuse or fail to comply with a lawful direction by a coroner as per this section of the *Coroners Act 1993*.

The Northern Territory Government has implemented Recommendation 29 through the Coroners Act 1993 (NT), which provides that a police officer must not refuse or fail to comply with a lawful direction by a coroner.

In the **Australian Capital Territory**, as per section 63 of the *Coroners Act 1997* (ACT), a coroner may, in writing, request the chief police officer for the assistance of a police officer in an investigation for an inquest or inquiry. The chief of police must, as far as practicable, comply with the coroner's request. Further to this, section 59(1) of the Act provides that a coroner may appoint a person to assist the coroner in the investigation of any matter relating to an inquest or inquiry. Such a person must report in writing to the coroner on any matter referred to by the coroner by the investigator's instrument of appointment.

The Australian Capital Territory Government has implemented Recommendation 29 through the Coroners Act 1997 (ACT), which provides that the chief of police must comply with the Coroner's request.

Recommendation 30

That subject to direction, generally or specifically given, by the Coroner, the lawyer assisting the Coroner should have responsibility for reviewing the conduct of the investigation and advising the Coroner as to the progress of the investigation.

Background information

The RCIADIC suggested that to ensure all investigations are carried out with thoroughness and vigour, the lawyer assisting the coroner should advise and assist the coroner in his or her investigation.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

The 1995-96 Implementation Report noted that within **New South Wales**, the lawyer assisting the coroner was able to provide a direction for certain inquires where considered necessary. If a lawyer assisting an inquiry had concerns with any aspect of the investigation, he or she would advise the coroner. Additionally, the counsel assisting the coroner were to liaise with the Coronial Investigation

Unit of the NSW Police Service. Further to this, the Report highlighted that paragraph 8 of the State Coroner's protocol for deaths in custody provided that upon appointment of counsel, instructed by the Crown Solicitor of NSW, investigations into the death were supervised and checked by counsel and the instructing solicitor.

The New South Wales Government has implemented Recommendation 30. The 1995-96 implementation report noted that the lawyer assisting the Coroner was able to advise a direction for certain inquiries, and advise the coroner, where considered necessary.

Addressed in the 1994 **Victorian** Implementation Report, during the inquest, counsel are able to attempt to review the conduct of the investigation and advise the Coroner. In addition, prior to an inquest, counsel could raise defects or other matters, which were then investigated prior to and during the inquest by the Victoria Police in conjunction with the Coroner.

The Victorian Government has implemented Recommendation 30. The 1994 implementation report noted that counsel were able to review the conduct of the investigation and advise the coroner during the inquest.

The **Queensland** *State Coroner's Guidelines 2013*, details in chapter 9.5 that each coroner is supported by in-house lawyers whose role is to assist the coroner to manage complex investigations and inquests and appear as Counsel Assisting at inquest. The role of Counsel Assisting at inquest is to impartially and fairly present the evidence to the coroner, identify issues for examination, call and examine witnesses, explore the range of possibilities open on the available evidence, explore possible options for preventative recommendations and make submissions about the findings and comments open to the coroner. Coroners may ask Counsel Assisting to assist in the preparation of findings by providing a summary of the evidence, outline of relevant legislation and case law.

The Queensland Government has implemented Recommendation 30 through the State Coroner's Guidelines 2013 which provide the Counsel Assisting with the authority outlined in this recommendation.

Although the 1994 **South Australian** Implementation Report stated that the procedure specified in Recommendation 30 was current practice, today there are no express powers for counsel assisting the Coroner to be kept informed. However, there is a "Protocol for Investigation into Deaths in Custody" drafted by the State Coroner's Office which SAPOL Investigators comply with. This protocol details the role of the investigating officer and counsel assisting, and provides guidelines on providing regular updates to counsel assisting.

The South Australian Government has partially implemented Recommendation 30. There are no express powers for counsel to be kept informed, however, there is a "Protocol for Investigation into Deaths in Custody" drafted by the State Coroner's Office which SAPOL Investigators comply with.

As per the 2000 Implementation Report, within **Western Australia** police officers are ex officio Coroner's Investigators. Under section 14(3) of the *Coroners Act 1996* (WA), a coroner's investigator must assist a coroner is carrying out his or her duties and carry out all reasonable directions of a coroner. Under the Coroner's guidelines, counsel assisting is required to conduct the procedural steps of the inquest, to introduce evidence, and to play a role in ensuring that police officers and other investigating officers have conducted adequate investigations for a brief to be prepared.

The Western Australian Government has implemented Recommendation 30 through Coronial guidelines and legislation.

The 1995 **Tasmanian** Implementation Report highlighted that it was the-then current practice of Tasmania Police that the officer in charge of the police investigation into a death in custody informs the lawyer assisting the Coroner about the conduct of the investigation.

The Tasmanian Government has implemented Recommendation 30 and the requirements of the recommendations have been incorporated into current practice.

Within the **Northern Territory**, as discussed in the 1994-95 Implementation Report, section 41(2) of the *Coroners Act 1993* (NT) provides that the coroner must appoint a person to assist the coroner for the purpose of an inquest into a death in custody. Regulation 11 stipulates that person shall be a legal practitioner who, if practicable, is experienced in coronial matters. Further to this, the Report noted that the Coroner's Office advised that, as a matter or practice, the Deputy Coroner or the lawyer assisting, reviews the conduct of the investigation and advises the Coroner as to the progress of the investigation.

The Northern Territory Government has implemented Recommendation 30 through the Coroners Act 1993 (NT).

The **Australian Capital Territory** Government noted within the 1995-96 Implementation Report that the coroner holding an inquest into a death in custody is responsible for the investigation into the death, including providing directions to the lawyer assisting the coroner. Under the-then current procedures, the coroner could delegate responsibility for an investigation or part of an investigation to the lawyer assisting the coroner. The assisting lawyer was required to keep the coroner informed of the progress of the investigation.

The Australian Capital Territory Government has implemented Recommendation 30 through the ability of the coroner to delegate powers to the lawyer assisting the coroner.

Recommendation 31

That in performing the duties as lawyer assisting the Coroner in the inquiry into a death the lawyer assisting the Coroner be kept informed at all times by the officer in charge of the police investigation into the death as to the conduct of the investigation and the lawyer assisting the Coroner should be entitled to require the officer in charge of the police investigation to conduct such further investigation as may be deemed appropriate. Where dispute arises between the officer in charge of the police investigation and the lawyer assisting the Coroner as to the appropriateness of such further investigation the matter should be resolved by the Coroner.

Background information

The ability for lawyers to carry out a thorough and unhindered coronial investigation into the circumstances of death is crucial in identifying systemic and individual failures of care. The RCIADIC Report noted deficiencies in the post-death investigative processes, and found that these partly stemmed from the inquiry being conducted by local police officers.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In relation to the **Commonwealth** and **Australian Capital Territory** governments' actions taken to address this recommendation, the AFP commented that ACT Policing works effectively with Counsel Assisting the Coroner to inform the Coroner of the circumstances of a death in custody, and in a practical sense, this recommendation has been implemented. However, there is no requirement that the Counsel Assisting is kept informed of the conduct of the investigation at all times, nor is the Counsel Assisting entitled to require Police to conduct further investigation they deem appropriate.

Actions taken towards the implementation of Recommendation 29 are also relevant to this recommendation. Additionally, the 1995-96 Implementation Report noted that in the ACT, the Director of Public Prosecutions assists the coroners.

The Commonwealth and Australian Capital Territory Government have partially implemented Recommendation 31. The AFP assists the Counsel Assisting and conducts investigations at direction of the Coroner. However, the Counsel Assisting does not have the full powers set out in the recommendation for example there is no provision made in respect to mechanisms for dispute resolution.

As set out in the **New South Wales** *Police Force Handbook*, when conducting an investigation, an officer must confer with the Coroner, State Crown Solicitor and the appointed counsel to help the investigation and presentation of evidence at the inquest. The Coroner will in most cases conduct a directions hearing for all legal representatives prior to the inquest commencing. Under section 51(2) of the *Coroners Act 2009* (NSW), a coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings. Such directions may include a direction to keep to Counsel Assisting informed.

The New South Wales Government has mostly implemented Recommendation 31, through the Police Force Handbook and the Coroners Act 2009 (NSW). However, it does not appear that specific provisions are made for dispute resolution between a lawyer supporting with the inquest and the police officer in charge.

As per the 1994 **Victorian** Implementation Report, the actions taken by the Victorian Government in Recommendation 30 are the same as those actions taken in Recommendation 31. Additionally, the Victorian Government noted that, in practice, the Coroner's Investigator will keep Counsel Assisting appraised of the progress of the investigation and at the direction of the coroner will conduct further investigations. In the case of a dispute between the Counsel Assisting and the Coroner's Investigator, the appropriateness of further investigations will be resolved by the Coroner who is given ultimate charge over the investigation under the *Coroners Act 2009* (Vic).

The Victorian Government has incorporated Recommendation 31 into current practice, with the Coroner given ultimate responsibility including over dispute resolution under the Coroners Act 2009 (Vic).

In the 1997 Implementation Report, the **Queensland** Government noted that where the lawyer assisting the Coroner is of the view that further investigation is required, this is brought to the attention of the Coroner who may ask the police to investigate further.

Currently, section 794 (Helping coroner investigate a death) of the *Police Powers and Responsibilities Act 2000* (Qld) and section 15 (Help in investigation) of the *Coroners Act 2003* (Qld) require police officers to help coroners in the performance of a function, or exercise of a power. There is therefore no requirement for dispute resolution as police are required to assist the coroner in their investigation. This recommendation is also addressed in the Queensland Government's response to Recommendation 29.

The Queensland Government has implemented Recommendation 31 through the Police Powers and Responsibilities Act 2000 (Qld) and the Coroners Act 2003 (Qld).

The **South Australian** Government noted in the 1994 Implementation Report the process outlined in Recommendation 31 was then current practice in SA. Today there are no express powers for Counsel assisting to require that they be kept informed by the officer in charge of an investigation into a death in custody. However, there is a "Protocol for Investigation into Deaths in Custody" drafted by the State Coroner's Office which SAPOL Investigators comply with. This protocol details the role of the investigating officer and counsel assisting, and provides guidelines on providing regular updates to counsel assisting. It is not practice in South Australia to refer disputes between Counsel assisting and the officer in charge of the police investigation to the Coroner.

The South Australian Government has partially implemented Recommendation 31. There is no express provision for counsel assisting the Coroner to be kept informed, however, there is a "Protocol for Investigation into Deaths in Custody" drafted by the State Coroner's Office which SAPOL Investigators comply with. There are no specific provisions made for dispute resolution between counsel supporting the inquest and the police officer in charge.

The actions taken by the **Western Australian** Government in Recommendation 29 are relevant to this recommendation. Section 14(2) of the *Coroners Act 1996* (WA) provides that every existing member of the WA Police Force is a Coroner's Investigator. The 2000 Implementation Report noted that these actions give Coroners sufficient power to ensure compliance with this recommendation. When a police officer is working as the Coroner's Investigator, he or she must follow the Coroner's

instructions. The Western Australian Government notes that the Commissioner of the Western Australia Police Force may not direct the work of a police officer who is working in this capacity for the Coroner.

● *The Western Australian Government has implemented Recommendation 31 through the Coroners Act 1996 (WA).*

In **Tasmania**, the *Coroners Act 1995* (Tas) addresses this recommendation, as discussed in relation to Recommendation 29 and the relationship between the Coroner and police officers.

○ *The Tasmanian Government does not appear to have taken actions in relation to Recommendation 31. There is no express provision for Counsel assisting the Coroner to be kept informed or covering dispute resolution.*

The actions taken by the **Northern Territory** Government in Recommendation 29 are relevant to this recommendation. Further, under the General Order Deaths in Custody, the Commissioned Officer in charge of an investigation into a death is required to: liaise with Counsel Assisting the Coroner; carry out any directions given by the Coroner in regard to the investigation; keep Counsel Assisting the Coroner informed of the progress and conduct; and in case of a dispute refer to the Coroner for resolution.

● *The Northern Territory Government has implemented Recommendation 31 through the Coroners Act 1993 (NT) and the General Order Deaths in Custody.*

Recommendation 32

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.

Background information

The RCIADIC Report noted that in many cases local police officers, despite having a close relation to the particular custodial incident, conducted the inquiry into the death. In ensuring a fair and thorough investigation occurs following a death in custody, it is important that there is input from more highly-ranked police officers.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In relation to the **Commonwealth** and **Australian Capital Territory** governments' actions taken towards this recommendation, the *1992-93 Annual Report* noted that the procedures for the AFP (Jervis Bay and nationally) were reviewed and partially amended in accordance with Recommendation 32.

In the Australian Capital Territory, the *Commissioner's Order on Profession Standards* provides that in the ACT, all deaths in custody are investigated by Criminal Investigations within ACT Policing. The selection of investigating officers and the Officer in Charge is a matter for the Superintendent of Criminal Investigations. The Chief Police Officer, at the rank of Assistant Commissioner, does not currently have the responsibility for selecting investigating officers, but has the ability to select officers if required.

The AFP National Guideline provides that a death in custody classifies as a critical incident. As a result, the Deputy Chief Police Officer – Crime has overall responsibility for the investigation into a death in custody. Where the death occurred in police custody, the Manager Professional Standards is responsible for any internal investigation.

● *The Commonwealth and Australian Capital Territory governments have implemented Recommendation 32 through the AFP's policies and procedures for investigating a death in custody.*

The 1995-96 **New South Wales** Implementation Report noted that the NSW Police Service had incorporated Recommendation 32 in Commissioner's Instructions 155.8.01. Additionally, the *NSW Police Force Handbook* specifies that a Senior Investigating Officer takes command of the investigation team. It is unclear who selects the Senior Investigating Officer. The NSW Police Force Critical Incident Guidelines provides that a death in custody is to be deemed a "critical incident". 4.1.3 of NSW Police Force Critical Incident Guidelines indicate that the Region Commander (Assistant Commissioner) must direct a Critical Incident Investigation Team to be formed once he or she has decided that an incident will be investigated as a critical incident. A suitably experience Senior Critical Incident Investigator should be appointed to ted the Critical Incident Investigation Team until the investigation has concluded.

The New South Wales Government has implemented Recommendation 32 through the Commissioner's Instructions 155.8.01 and the NSW Police Force Handbook.

The **Victorian** Government discussed in the 1994 Implementation Report that the Chief Commissioner of Police had directed that deaths in custody were to be investigated by the Homicide Squad with active oversighting by the Internal Investigations Department of the Victoria Police. Currently as per the VPMG Deceased Persons, the Homicide Squad is responsible for the Coronial brief oversighted by the Professional Standards Command. Given this current policy, the Victorian Government noted that implementation of Recommendation 32 is considered unnecessary.

The Victorian Government has not implemented Recommendation 32. There is no requirement that the officer in charge of an investigation be appointed by the Chief Commissioner, or a Deputy Commissioner or Assistant Commissioner.

Under section 16.23.1 of the **Queensland** *Operational Procedures Manual, Issue 59 Public Edition*, deaths in custody are to be investigated by Ethical Standards Command, subject to the Crime and Corruption Commission exercising its power to assume responsibility for the investigation.

The Queensland Government has mostly implemented Recommendation 32. While Ethical Standards Command is headed by an Assistant Commissioner, the Manual does not specifically require that the Assistant Commissioner appoint the officer.

Discussed in the 1994 Implementation Report, the **South Australian** Government noted that the Superintendent of the Major Crime Squad selects this officer on delegated authority from an Assistant Commissioner. South Australia Police (SAPOL) *General Orders* state to ensure investigations are independent and impartial Major Crime Investigation Section will fully investigate deaths in police custody. Investigations will be overseen by the Officer in Charge, Internal Investigation Branch, who will assume command and control of the investigation if instructed by the Commissioner of Police.

The South Australian Government has mostly implemented Recommendation 32. While the Superintendent of the Major Crime Squad selected the officer, this function is performed on delegated authority from an Assistant Commissioner.

The 2000 **Western Australian** Implementation Report highlighted that responsibility for the conduct and supervision of investigations were delegated through the chain of command on the receipt of notification of death in police custody. Firstly, the Assistant Commissioner instructs a senior investigator of the substantive rank of Superintendent to conduct a full investigation and report directly to the coroner. Fully qualified Senior Investigating Officers are responsible for ensuring the investigation is being conducted under the provisions of the Criminal Investigation Act 2006 or the Coroners Act 1996. Secondly, the Assistant Commissioner thereafter notifies the Deputy Commissioner of the circumstances surrounding the death.

The Western Australian Government has incorporated Recommendation 32 into police procedures in regard to the conduct and supervision of investigations.

In **Tasmania**, the 1995 Implementation Report explained that the Commissioner of Police made the appointment of the officer in charge of the police investigations into a death in custody, as such cases were treated as major crime investigations. It was then current practice of Tasmania Police that all officers involved in the investigation of a death in police custody were in every respect as independent

as possible from police officers concerned with matters under investigation. At the time of the report, the Coroner had the power to direct which Police Branch were to investigate a death. The Tasmania Police Manual states that where a person dies or receives life-threatening injuries while in police custody, the Deputy Commissioner is to assume control of the investigation, which will be conducted by Professional Standards.

The Tasmanian Government has implemented Recommendation 32. As noted in their 1995 implementation report, the Commissioner of Police makes the appointment of the officer in charge of the police investigation into a death in custody.

The **Northern Territory** 1994-95 Implementation Report specified that an amendment had been made to *Police General Order Coroners and Inquests – Code C9*, at paragraph 39, providing that the member in charge of an investigation into a death in custody was to be appointed by the Assistant Commissioner of the appropriate Command. The *Police General Order – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public* provides that the Deputy Commissioner is notified and appoints an investigative head and team. In the interim until the team is appointed, the Commissioned Officer responsible is the Divisional Officer for the location where the incident occurred.

The Northern Territory Government has implemented Recommendation 32. Under the Police General Order Coroners and Inquests – Code C9 the member in charge of an investigation into a death in custody must be appointed by the Assistant Commissioner of the appropriate Command.

Recommendation 33

That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.

Background information

The RCIADIC Report noted that post-death coronial processes were inadequate and a cause of concern and suspicion for families of the deceased. This is largely due to a lack of transparency and independence in the post-death investigation. In many cases, the inquiry into the circumstances of the deceased's death was conducted by local police officers who had a close relation to the particular custodial incident.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

For the **Commonwealth** and **Australian Capital Territory** responses to this recommendation**,** the AFP *National Guideline* provides that the Manager Professional Standards, or in their absence, the Deputy Commander, must appoint an independent team to investigate the death (paragraph 22). Those that are involved with the deceased are not to take part in the post-death inquiry, except as witnesses.

The Commissioner's Order on Professional Standards provides that an independent investigation team from Criminal Investigations will be appointed to investigate the circumstances of the death. It is standard AFP practice that investigators for such an incident would be drawn from the most qualified business area of the AFP rather than from the internal affairs unit. AFP Professional Standards provide a critical oversight role, sitting over all aspects of the investigation including the appropriateness and independence of the allocated investigators. The members involved with the person while in police custody which include the informant, the Watch-house staff and other members directly involved with the deceased, are not to take part in the investigation process, other than as witnesses.

The Coroner may only refuse a request if they believe, on reasonable grounds, that it would not be in the interests of justice to allow access to a member of the immediate family of the deceased, or a representative of that member. All deaths in custody must be treated as a crime scene and investigated accordingly. The *1992-93 Annual Report* noted that the procedures for the AFP (Jervis Bay and nationally) were reviewed and amended in accordance with Recommendation 33.

The Commonwealth and Australian Capital Territory governments have implemented Recommendation 33 through the AFP's policies and procedures for investigating a death in custody.

The 1995-96 **New South Wales** Implementation Report noted that the NSW Police Force had incorporated Recommendation 33 in Commissioner's Instruction 155.18.01. Under the NSW Police Force Critical Incident Guidelines, a Death in Custody would be deemed a "Critical Incident". 4.1.3 of NSW Police Force Critical Incident Guidelines states that Critical Incident Investigation Team (CIIT) must comprise police officers who are not involved in the incident and who do not appear likely from the outset to have a conflict of interest. It follows that members of the CIIT should be drawn from a different local area command (LAC) to the one in which the incident occurred, and a different command to that of the directly involved officer/s. The *NSW Police Force Handbook* also sets out that the Senior Investigating Officer must ensure that the officer who accompanies the body to the mortuary is not connected with the circumstances of, or leading up to, the death. The Handbook further provides that the Professional Standards Command reviewing officer has an independent function and is responsible for ensuring a competent investigation is carried out by their team. They are also responsible for identifying and reporting on deficiencies in established practices and procedures.

The New South Wales Government has implemented Recommendation 33 through Commissioner's Instruction 155.18.01 and the NSW Police Force Handbook.

The **Victorian** Government specified in the 1994 Implementation Report that deaths in custody, as well as deaths arising from police investigation, were investigated by the Homicide Squad. The investigation was actively oversighted by the Internal Investigations Department of the Victoria Police.

The Victorian Government has implemented Recommendation 33 as noted in the Victorian 2005 implementation review, by updating processes and practice.

Under section 16.23.1 of the **Queensland** Police Services *Operational Procedures Manual,* deaths in police custody are to be investigated by the Queensland Police Service (QPS) Ethical Standards Command, subject to the Crime and Corruption Commission exercising its power to assume responsibility for the investigation. Further to this, under section 16.23.3(xiv), investigating officers are required to ensure that officers involved in the incident are not given access to investigation documents without the consent of the Coroner who is investigating the matter. Under section 16.23.2, a police officer or watch-house officer who finds a person whom they considered to be dead or dying is required to call for assistance and attend to that person – including attempting to resuscitate that person. When a death in police custody has occurred, first response officers should record any relevant information including the position of the body, if the body must be moved for any reason, and secure all documentation relevant to the particular person.

The Queensland Government has implemented Recommendation 33 through the QPS Operational Procedures Manual.

The 1994 **South Australian** Implementation Report noted that the procedure specified in Recommendation 33 was the current practice within SA. It is a requirement under SAPOL *General Orders* that the Major Crime Investigation Branch must investigate the death ensuring compliance with the State Coroner's *Protocol for Investigation into Deaths in Custody*. This recommendation is also implemented through the South Australian Government's response to Recommendation 32.

The South Australian Government noted in their 1994 implementation report that Recommendation 33 had been incorporated into police practice. Current practice continues to implement the principles of this recommendation through SAPOL General Orders.

As highlighted in the 2000 **Western Australian** Implementation Report, a Superintendent from the Internal Investigation Unit was to investigate the death in police custody. An alternative to this was that the Deputy Commissioner in his discretion could appoint the local Detectives Office to handle the investigation, depending on the circumstances. The officer delegated to the task must be independent of the incident under investigation, this contributes to an open and equitable process for the investigation of a death in custody. Current practice, as noted by the Western Australian Government, is for the Police Major Crime Division to take responsibility for investigating incidents including deaths in custody. The Major Crime Division is independent of the police officers concerned under the investigation.

The Western Australian Government has implemented Recommendation 33 through police policies and procedures.

In **Tasmania**, the actions taken in Recommendation 32 are relevant to this recommendation.

The Tasmanian Government has implemented Recommendation 33 through their actions taken towards Recommendation 32.

Under section 25 of the **Northern Territory** *Coroners Act 1993* (NT), a coroner may give directions to a police officer for the purpose of investigating the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody. A police officer must not refuse or fail to comply with a lawful direction by a coroner given under this Act. Under the *Police General Order – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public*, members of the investigation team are required to be, as far as practicable, independent and not directly involved in the incident. It is further provided that the senior police member will ensure that the scene is secured and that only essential personnel involved in the preservation of life are allowed access. The senior member will also ensure that witnesses are not able to communicate to each other. There is no requirement that members of the investigative team be selected from an Internal Affairs Unit. This recommendation is also dealt with in the Northern Territory Government's response to Recommendation 32.

The Northern Territory Government has mostly implemented Recommendation 33. There is no requirement that officers be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred.

Recommendation 34

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.

Background information

The RCIADIC Report noted that police should retain an investigative role in post-death coronial investigations, but also seeks to implement some important safeguards. Recommendation 34 seeks to provide one such safeguard.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In relation to the **Commonwealth** and **Australian Capital Territory** responses to this recommendation, the AFP has confirmed that all deaths in custody (whether police custody or other custodial setting) are investigated by trained criminal investigators from Criminal Investigations. A Detective Superintendent has overall command of Criminal Investigations, with the area further supervised by the Deputy Chief Police Officer – Crime.

The Commissioner's Order on Professional Standards states that all deaths in custody will be referred to the Criminal Investigations Reception Officer, and that all non-natural deaths will be investigated by a member of ACT Policing Criminal Investigations.

- *The Commonwealth and Australian Capital Territory governments have implemented Recommendation 34 through the AFP's policies and procedures for investigating a death in custody.*

In **New South Wales**, the *NSW Police Force Handbook*, provides that the Senior Investigating Officer is required to take command of the investigation and the Professional Standards Manager has an independent function to ensure a competent investigation is carried out by the team. This recommendation has been incorporated into the Commissioner's Instruction 155.18.01 – Deaths in Custody. Current practice is that for a death in custody, the Region Commander and the SCC Homicide Squad Commander must agree within 48 hours of the incident what level of involvement the Homicide Squad will have in the Critical Incident Investigation Team. Whatever agreement is reached, the Homicide Squad must provide specialist investigative advice for the duration of the investigation. The (SCII) will lead a team in the investigation of all critical incidents. The primary role of the SCII is to ensure critical incidents are rigorously and thoroughly investigated in a timely manner.

- *The New South Wales Government has implemented Recommendation 34. Under the NSW Police Force Handbook the Senior Investigating Officer is required to take command of the investigation.*

The 1994 **Victorian** Implementation Report specified that police investigations of deaths in custody were conducted by the Homicide Squad and oversighted by the Internal Investigations Department.

- *The Victorian Government has implemented Recommendation 34. Deaths in custody are investigated by the Homicide Squad, with oversight from the Internal Investigations Department.*

In **Queensland**, a Memorandum of Understanding (MOU) was signed in 2008 between the Police Commissioner, State Coroner and the Crime and Misconduct Commission – now known as the Crime and Corruption Commission (CCC). The MOU establishes operational arrangements for the investigation of police related deaths. Under these arrangements, the Queensland Police Service Ethical Standards Command investigates the death, subject to the CCC exercising its power to assume responsibility for the investigation. The MOU requires consultation with the State Coroner about the allocation of appropriate police resources to these investigations.

- *The Queensland Government has implemented Recommendation 34. A MOU was signed between the Police Commissioner, State Coroner and the Crime and Misconduct Commission to establish operational arrangements for the investigation of police-related deaths.*

The 1994 **South Australian** Implementation Report noted that the-then current practice was that the Major Crime Squad were required to investigate the death of any person in police custody. The nature of the work undertaken by this squad required that any officer attached were to be a highly experienced investigator. Current practice per South Australia Police *General Orders* is that the Major Crime Investigation investigates the death of all persons in police custody. All investigating officers in the Major Crime Investigation Branch are highly experienced and directly responsible to the Officer in Charge, Major Crime Investigation Branch.

- *The South Australian Government has implemented Recommendation 34. Deaths in custody are investigated by the Major Crime Investigation Branch, comprised of highly experienced members.*

The actions taken by the **Western Australian** Government in Recommendation 33 are also relevant to this recommendation. Additionally, under section 14 of the *Coroners Act 1996* (WA), every member of the Police Force of the State is contemporaneously a coroner's investigator. Further, as stipulated by the Police Force Manual *Critical Incidents Involving Police* and legislation, all Senior Investigating Officers are fully qualified.

- The Western Australian Government has implemented Recommendation 34 through police manuals and legislation, which provide that all Senior Investigating Officers be fully qualified.

The **Tasmanian** Government noted within the 1993 Implementation Report that a Tasmanian Police Policy document was being drafted to reflect this recommendation. The Report also highlighted that appropriate arrangements were largely in place in regard to this recommendation. This recommendation is also dealt with in the Tasmanian Government's response to Recommendation 32.

The Tasmanian Government has implemented Recommendation 34 through the development of guidelines discussed in their 1993 implementation report.

The 1994-95 **Northern Territory** Implementation Report specified that there are a number of highly qualified investigators available in the NT Police. Suitably qualified and experienced members conduct investigations into major incidents. Actions taken by the Northern Territory Government in response to Recommendation 33 are also relevant to this recommendation.

The Northern Territory Government has partially implemented Recommendation 34. Suitably qualified and experienced members conduct investigations into major incidents. It does not appear that a chain of command has been established, as required by this recommendation.

Recommendation 35

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.*

Background information

In order to ensure the conduct of a thorough enquiry and to avoid long, drawn-out processes which add to the stress experienced by families of the deceased, clear police standing orders and instructions as to the conduct of post-death investigations are required.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In the **Commonwealth** and **Australian Capital Territory**, the AFP *National Guideline* establishes consistent procedures for the conduct of post-death investigations. Included in the Guideline are the requirements that all deaths in custody are to be treated as a crime scene, and that an independent investigation team must be appointed to investigate the circumstances of the death (paragraph 22). The AFP guidelines do not specifically state the requirement for colour photography as per part e) of the recommendation.

This recommendation is also addressed through the Commissioner's Order on Professional Standards, the ACT Policing Watch House Policy, and the ACT Coroner's Act 1997. These measures incorporate Recommendation 35 into standard investigative and oversight practices. In the event of a death in custody, the experienced investigators from ACT Policing will work at the direction of the Coroner.

The AFP confirmed that AFP Forensic Services adopt industry standards, best practice and Court accepted methodology which includes colour photography However, the AFP's guidelines do not specifically state the requirement for colour photography as per part (e) of the recommendation.

The Australian Capital Territory Government has noted that ACT Policing will progress an amendment to the *National Guideline* to stipulate the requirement for colour photography.

The Commonwealth and Australian Capital Territory governments have mostly implemented Recommendation 35 through the AFP's policies and procedures for investigating a death in custody. However, these do not specifically address all the requirements of Recommendation 35, as there is no requirement for colour photography of the scene of death.

The **New South Wales** *Police Force Handbook* specifies on page 40 that officers are not to presume suicide and to consider that evidence presented to the Coroner must be sufficient to conclusively prove it. The Handbook also specifies under the chapter *Deceased Persons - Death in Custody* that the Senior Critical Incident Investigator is to consider the lawfulness of the custody and the general care, treatment and supervision of the prisoner before death. It further states that the first officer at the scene of a Death in Custody is to preserve the scene and exhibits (including, where relevant, any/all police appointments and possible forensic evidence relating to gunshot residue) for examination by representatives of the Forensic Services Group (FSG). If practical, any deceased person is to remain in situ for the purpose of examination by FSG and other relevant personnel.

This recommendation has also been incorporated into the *Commissioner's Instruction 155.18.01 – Deaths in Custody*, and the NSW Police Force Critical Incident Guidelines which provide detailed information for those officers involved in the management, investigation and review of critical incidents so they can be dealt with consistently and effectively when they arise.

The New South Wales Government has implemented Recommendation 35 through the NSW Police Force Handbook and through directions to the Region Commanders (Assistant Commissioner) within Commissioner's instructions: 155.18.01 - Deaths in Custody.

The 1994 **Victorian** Implementation Report noted that both the Homicide Squad and the Internal Investigations Department of the Victoria Police had standard operating procedures, which addressed this recommendation. No evidence of more recent actions taken towards implementation could be located.

The Victorian Government has implemented Recommendation 35 in the standard operating procedures of the Homicide Squad and the Internal Investigations Department.

Under section 16.23.3 of the **Queensland** Police Services *Operational Procedures Manual*, officers investigating a death in custody should treat the death in custody as a homicide until otherwise determined and are not to presume suicide or natural death regardless of whether it appears likely. Appendix 16.3 of the *Operational Procedures Manual* provides a suggested format for reports on deaths in custody or in police company. The suggested format requires that an officer should comment on the general care and treatment of the deceased, the watch-house routine for accepting the prisoner and photographs of scene and body 'in situ'. The suggested format does not specifically require officers to assume the death may be a homicide.

The Queensland Government has implemented Recommendation 35 through the requirements set out in in the Operational Procedures Manual.

The **South Australian** Government noted within the 1994 Implementation Report that the procedures outlined in Recommendation 35 were then current practice for all deaths and attempted suicides in police custody in SA. Additionally, while the matters referred to in this recommendation were addressed during the investigation into a death in custody, the complete file was then subjected

to review by the Internal Investigations Branch. At that time, particular attention was provided to the nominated custodial aspects. The South Australian Government notes that the provisions set out in this recommendation are complied with in all investigations into deaths and attempted deaths in police custody. This recommendation has been implemented through South Australia Police *General Orders*, South Australia Police's *Operational Guidelines for Investigators and Managers for Deaths*, and the State Coroner's Office *Protocol for Investigation into Deaths in Custody*. Additionally, the complete investigation file is then subjected to review by the Internal Investigations Branch to ensure implementation of provisions contained in this recommendation.

In South Australia, this recommendation has been implemented through South Australia Police General Orders, South Australia Police's Operational Guidelines for Investigators and Managers for Deaths, and the State Coroner's Office Protocol for Investigation into Deaths in Custody.

The **Western Australian** Government highlighted within the 1994 Implementation Report that all deaths in custody were treated as a homicide in regards to evidence collection and scene examination by forensic staff. In relation to part e), the Report noted that high quality Agfa film was to be used in either 35mm or 120mm format. The 2000 Implementation Report emphasised that the investigative policy in process then in place provided for an open and equitable process for investigating deaths in custody. The Western Australian Government notes that Recommendation 35 has been met by the enactment of the *Criminal Investigation Act 2006* (WA) and the *Coroners Act 1996* (WA).

In Western Australia, Recommendation 35 has been completed through the enactment of the Criminal Investigation Act 2006 (WA) and the Coroners Act 1996 (WA).

The **Tasmanian** Government noted within the 1995 Implementation Report that a Procedures Manual *Guidelines for Investigation of Complaints Against Police Officers* had been issued which specified directions as to how officers should conduct such investigations. The Report highlighted that Police Policy Document and 6/94 were also relevant to this recommendation. This recommendation is incorporated under the Tasmania Police Manual section 7.4 *Death or Life Threatening Injury in Custody*.

The Tasmanian Government has mostly implemented Recommendation 35 in the Tasmania Police Manual section 7.4 Death or Life Threatening Injury in Custody. However, specific details of implementation could not be located such as provisions related to colour photography.

The 1994-95 **Northern Territory** Implementation Report highlighted that the actions taken by the NT Government in Recommendation 12 are relevant to this recommendation. The actions taken in Recommendation 12 have direct implications for the police in relation to all custodial deaths. Accordingly, Police General Order Coroners and Inquests – Code C9 was amended. An addition was made to the General Order to include the precise requirements of part d) and e) of this recommendation. Additionally, parts a) to d) of Recommendation 35 have been addressed the Northern Territory's *Police General Order - Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public.*

The Northern Territory Government has implemented Recommendation 35 in the Police General Order - Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public.

Recommendation 36

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.

Background information

The RCIADIC Report noted that post-death investigations were inadequate, and often lacked thoroughness. This added further stress and inspired suspicion among the families of the deceased. In order to improve the Coronial inquest, greater evidence into the cause and circumstances of death must be collected and provided to the Coroner.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In the **Commonwealth** and **Australian Capital Territory,** the AFP National Guidelines established rules for the conduct of post-death investigations, including that all deaths in custody are to be treated as a crime scene and investigated accordingly, that an independent investigation team must be appointed, and that the Coroner must make findings in relation to factors that contributed to the cause of death. Additionally, under section 74 of the *Coroners Act 1997* (ACT), the coroner holding an inquest into a death in custody must include a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.

The Commonwealth and Australian Capital Territory governments have implemented Recommendation 36 through the AFP National Guideline and the ACT Coroners Act.

As discussed in the 1995-96 **New South Wales** Implementation Report, the NSW Police had incorporated this recommendation in the Commissioner's Instructions 62.25, 155.18.01 and 155.18.02. Relevant agencies have a range of practices and procedures to ensure a thorough evidence-base informs the coronial inquest. Additionally, the Internal Investigation Unit of the Department of Corrective Services conducted investigations following a death in custody. Such investigations addressed the conduct of staff in terms of compliance with Departmental policies and procedures. Further to this, section 23 of the *Coroners Act 2009* (NSW) also addresses this recommendation.

The New South Wales Government has implemented Recommendation 36 through the Coroners Act 2009 (NSW) and Commissioner's Instructions 62.65, 155.18.01 and 155.18.02. Agencies in NSW have a range of practices to ensure a thorough evidence-base informs the coronial inquest.

In **Victoria**, as specified under section 15 of the *Coroners Act 2008* (Vic), a coroner must investigate the death of a person if it appears to the coroner that the death is a reportable death. Section 36 of the Act explicates that a police officer who has information that may be relevant to an investigation by a coroner into a death must give that information to the coroner to assist in his or her investigation. Additionally, section 52 of the Act requires that a coroner must hold an inquest into a death if the deceased was, immediately before death, a person placed in custody. Further, the Coroner is required to determine the circumstances of the death under section 67 of the Act, including the quality of care, treatment and supervision of the deceased where relevant.

The Victorian Government has mostly implemented Recommendation 36 through the Coroner's Act 2008 (Vic). There is no explicit legislative requirement that in all cases the care, treatment and supervision of the deceased be considered.

In **Queensland**, under section 14 of the *Coroners Act 2003* (Qld), the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally. When preparing guidelines, the State Coroner must have regard to the recommendations of the RCIADIC that relate to the investigation of deaths in custody. Additionally, section 46(1) provides that the coroner may, wherever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. The State Coroners Guidelines require coroners to direct their attention to the general care, treatment and supervision of the deceased and to determine whether custodial officers complied with their common law duty of care and all departmental policies and procedures and whether these were best suited to preserving the prisoner's welfare. Coroners are directed to consider the possibility of any systemic failure relating to a death.

The Queensland Government has implemented Recommendation 36 through the Coroner's Act 2003 (Qld) and the State Coroners Guidelines.

In **South Australia**, under section 21 of the *Coroners Act 2003* (SA), the Coroner's Court must hold an inquest to ascertain the cause or circumstances of a death in custody. As a matter of public record the Coroner hears evidence concerning the care, treatment and supervision of deaths in custody and in hospitals. In addition, the Coroner requires police investigators to include within their evidence of the cause or circumstances of the death that consideration is given to the care, treatment and supervision of the deceased prior to death. Section 25(3) of the Act specifies that the Coroner's Court may add to its findings any recommendation that might, in the opinion of the Court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

The South Australian Government has fully met the requirements of Recommendation 36 through the Coroner's Act 2003 (SA).

Western Australia has implemented this recommendation at a policy level which includes detailed procedures in the *Police Manuals Operational Manual* and in the *Policy Directives* of the Department of Corrective Services. Under section 25(3) of the *Coroners Act 1996* (WA), where there is a death in custody, the coroner must comment on the quality of supervision, treatment and care of the person while in that care. The Western Australian Government notes that Recommendation 35 has been met by the enactment of the *Criminal Investigation Act 2006* (WA) and the *Coroners Act 1996* (WA).

In Western Australia, Recommendation 36 has been completed through the enactment of the Criminal Investigation Act 2006 (WA) and the Coroners Act 1996 (WA).

In **Tasmania**, under section 21 of the *Coroners Act 1995* (Tas), a coroner has jurisdiction to investigate a death if it appears that the death is or may be a reportable death. Section 28(5) of the Act provides that if a coroner holds an inquest into a death in custody, the coroner must report on the care, supervision or treatment of that person while that person was held in custody.

The Tasmanian Government has fully met the requirements of Recommendation 36 through the Coroner's Act 1995 (Tas).

In the **Northern Territory**, section 25(1) of the *Coroners Act 1993* (NT), a coroner may give directions to a police officer for the purpose of investigating the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody. Section 26(1) of the Act provides that where a coroner holds an inquest into a death in custody, the coroner must investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed by injuries sustained while being in custody. Additionally, the coroner may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

The Northern Territory Government has fully implemented Recommendation 36 through the Coroner's Act 1993 (NT), which requires that the Coroner investigate and report on the care, supervision and treatment of the person while being held in custody.

Recommendation 37

That all post-mortem examinations of the deceased be conducted by a specialist forensic pathologist wherever possible or, if a specialist forensic pathologist is not available, by a specialist pathologist qualified by experience or training to conduct such post-mortems.

Background information

The RCIAIDC noted that autopsies were being inadequately performed and that forensic pathologists should undertake the autopsies to ensure that they are conducted at a high standard.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under section 89 of the *Coroners Act 2009* (NSW), a coroner may, by written order, give directions to an appropriate medical investigator to undertake a post mortem examination.

Under section 89(3) of the Act, an 'appropriate medical investigator' is classified as a Coronial Medical Officer, a pathologist or anyone else the coroner considers to have appropriate qualifications. Further to this, the *NSW Police Force Manual* explicates that anyone who dies in custody is to undergo a post mortem examination at the Department of Forensic Medicine in Glebe or Newcastle. The New South Wales Government notes that it is practice that only a qualified Forensic Pathologist can conduct a post-mortem examination.

The New South Wales Government has implemented Recommendation 37, and notes that it is practice that only a qualified Forensic Pathologist can conduct a post-mortem examination.

In **Victoria**, under section 25 of the *Coroners Act 2008* (Vic), a coroner must direct a medical investigator to perform an autopsy on a body under the control of the coroner if the coroner believes that that autopsy is necessary for the investigation of the death and it is appropriate to give the direction. Section 3 of the Act defines a medical investigator to be the Institute, a pathologist or a registered medical practitioner under the general supervision of a registered medical practitioner.

The Victorian Government has implemented Recommendation 37 through the Coroners Act 2008 (Vic) which provides that a medical investigator must perform an autopsy in the event of an investigation into death.

In **Queensland**, under section 19(2) of the *Coroners Act 2003* (Qld), as part of the investigation of a death, a coroner may order a doctor to perform an autopsy. In the *State Coroner's Guidelines 2013*, forensic pathologists are identified as the highest qualified practitioner to undertake an autopsy. Attachment 5B of the Guidelines classifies all deaths in custody as complex and are reserved for forensic pathologists only.

The Queensland Government has implemented Recommendation 37 through the State Coroner's Guidelines 2013 which reserves all deaths in custody for forensic pathologists only.

In **South Australia**, under section 21(1)(i) of the *Coroners Act 2003* (SA), the Coroner's Court has the power to direct a medical practitioner who is a pathologist, or some other person or body considered by the State Coroner or the Court to be suitably qualified, to perform a post-mortem examination of the body of the deceased person. The South Australian Government additionally notes that in Adelaide, post-mortems are performed by a specialist forensic pathologist (this is not necessarily the case in regional centres).

The South Australian Government has partially implemented Recommendation 37 through the Coroners Act 2003 (SA), however there is no recognition provided that a forensic pathologist is best qualified to conduct autopsy.

In **Western Australia,** as outlined in section 34 of the *Coroners Act 1996* (WA), if a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a pathologist or a doctor to perform a post mortem examination on the body. Further to this, the Coroner's Court of Western Australia website specifies that in Perth, the autopsy is performed by a forensic pathologist.[8] The Western Australian Government notes that it is established practice with the State Coroner's Office that all post-mortem examinations are conducted at the State Mortuary by fully qualified forensic pathologists.

In Western Australia, Recommendation 37 has been completed through the Coroners Act 1996 (WA).

Section 36 of the **Tasmanian** *Coroners Act 1995* (Tas), provides that if a coroner reasonably believes that it is necessary for the investigation of a death, the coroner may direct the State Forensic Pathologist or an approved pathologist, or a medical practitioner under the direct supervision of the State Forensic Pathologist or an approved pathologist, to perform an autopsy on the body.

[8] http://www.coronerscourt.wa.gov.au/W/who_does_the_autopsy.aspx?uid=9011-9553-1679-9690, accessed September 2017

The Tasmanian Government does not appear to have implemented Recommendation 37. While there is the possibility to appoint the State Forensic Pathologist or an approved pathologist to conduct autopsy, there is no provision that all autopsies should be conducted by these parties.

In the **Northern Territory**, as specified under section 20 of the *Coroners Act 1993* (NT), if a coroner reasonably believes that it is necessary for an investigation of a death, the coroner may direct a medical practitioner to perform an autopsy on the body of the deceased person. Additionally, section 6(2) of the *Coroners Regulations 2010*, provides that the medical practitioner who is directed to perform the autopsy shall wherever possible, be a qualified forensic pathologist, or be a qualified pathologist who is, in the opinion of the coroner, suitably experienced to perform the autopsy. The *Police General Order - Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public* provides that an autopsy be carried out by a specialist forensic pathologist, or by a specialist pathologist qualified by experience or training to conduct autopsies.

The Northern Territory Government has implemented Recommendation 37 through the Coroners Regulations 2010 which provides that the medical practitioner who is directed to perform the autopsy shall wherever possible, be a qualified forensic pathologist.

As discussed in the **Australian Capital Territory** *Coroners Act 1997* (ACT), section 71 provides that the coroner holding the inquest into a death in custody must, wherever practicable, direct a post-mortem examination to be made of the body by a pathologist who has not less than two years' experience in conducting post-mortem examinations. Additionally, the Magistrates Court of the Australian Capital Territory website explains that a post-mortem examination is a thorough medical examination performed by a Pathologist to establish the medical cause of death.[9] In the 2018-19 Australian Capital Territory, $1.9 million of funding over four years was announced to fund a full-time resident forensic pathologist to oversee all post-mortems.

The Australian Capital Territory Government has implemented Recommendation 37 through the Coroners Act 1997 (ACT) and funding made available in the 2018-19 to ensure that all post-mortems are conducted by a resident forensic pathologist.

Recommendation 38

The Commission notes that whilst the conduct of a thorough autopsy is generally a prerequisite for an adequate coronial inquiry some Aboriginal people object, on cultural grounds, to the conduct of an autopsy. The Commission recognises that there are occasions where as a matter of urgency and in the public interest the Coroner may feel obligated to order that an autopsy be conducted notwithstanding the fact that there may be objections to that course from members of the family or community of the deceased. The Commission recommends that in order to minimise and to resolve difficulties in this area the State Coroner or the representative of the State Coroner should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rites and that relatives of a deceased Aboriginal person be spared further grief. The Commission further recommends that the Coroner conducting an inquiry into a death in custody should be guided by such protocol and should make all reasonable efforts to obtain advice from the family and community of the deceased in consultation with relevant Aboriginal organisations.

Background information

The RCIADIC found that it is highly desirable that, as far as possible, no obstacle be placed in the way of carrying out traditional rites and that relatives of a deceased Aboriginal person be spared further grief.

[9] https://www.courts.act.gov.au/magistrates/courts/coroners_court/information-about-the-coroners-court, accessed September 2017

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, under section 88 of the *Coroners Act 2009* (NSW), when a post mortem examination or other examination or test is conducted on the remains of a deceased person, regard is to be had to the dignity of the deceased person. Further, if more than one procedure is available to a person conducting a post-mortem examination to determine the cause and manner of a deceased person's death, the person conducting the examination is to endeavour to use the least invasive procedures that are appropriate in the manner. A Coronial Information and Support team is in place which includes three social worker positions. In the event of an objection or organ retention, a social worker will talk one-on-one with the family or nominated next of kin explaining the procedures and options for the family. Section 96 of the Act provides that a senior next of kin may, by notice in writing, request a coroner or an assistant coroner not to exercise a relevant post-mortem investigative function in relation to the deceased person.

The New South Wales Government has partially implemented Recommendation 38 through the function of the Coronial Information and Support team. However, no provision is made for traditional rites to be performed by family members, and it does not appear that Aboriginal Legal Services and Aboriginal Health Services have been consulted.

The **Victorian** *Coroners Act 2008* (Vic), specifies under section 26 that a coroner must take reasonable steps to notify the senior next of kin of the deceased that an autopsy is to be performed. Within 48 hours after receiving notice, the senior next of kin may ask the coroner to reconsider the direction that an autopsy be performed. Section 26(3) of the Act specifies that if, after reconsidering the autopsy, the coroner determines that the autopsy is necessary for the investigation, the coroner must, without delay, give written notice to the senior next of kin.

The Victorian Government has mostly implemented Recommendation 38 through the Coroner's Act 2008 (Vic) which provides for a consultative process between the Coroner and the deceased's next of kin in the event that an autopsy must be performed. It does not appear that a protocol has been developed as called for in this recommendation.

In **Queensland**, under section 19 of the *Coroners Act 2003* (Qld), as part of the investigation of a death a coroner, if burial of the body has not happened, must order a doctor to perform an autopsy. Before ordering an internal examination of the body, the coroner must, wherever practicable, consider that in some cases a deceased person's family may be distressed by the making of this type of order. Additionally, the coroner must consider any issues are raised by a family member, or another person with sufficient interest, in relation to the type of examination to be conducted during the autopsy. A coroner may still order an internal examination despite objections from a family member.

The State Coroner's Guidelines state that occasionally families may wish to observe cultural or religious rites before the body is removed from the scene. Coroners should allow this to occur for non-suspicious deaths once the scene has been forensically examined, provided the ritual does not involve physical contact with or contamination of the body. Care needs to be taken to ensure these observances do not unduly delay transportation and consequently it is reasonable to impose timeframes on when and for how long the ritual can be performed. Families should generally be allowed to observe religious or cultural rites during a post-autopsy viewing provided the ritual is not unduly disruptive to the mortuary environment.

The Queensland Government has mostly implemented Recommendation 38 through the Coroner's Act 2003 (Qld) and the State Coroner's Guidelines. However, it does not appear that Aboriginal Legal Services and Aboriginal Health Services have been consulted.

The **South Australian** Government notes that the State Coroner should be advised immediately in writing of any objection to a post-mortem being conducted so that the post-mortem can be delayed while the objection is being considered. In the South Australian *Annual Report of the State Coroner for 2013-14*, it was reported that Social Workers had met with officers from Court Services Aboriginal Programs to discuss synergies between the Coroners Court and Aboriginal Justice Officers. The aim of

this was to gain a greater understanding of how to assist the Aboriginal and Torres Strait Islander community during times of grief and loss. The South Australian Government has cooperated with pathologists from Forensic Science South Australia in implementing this recommendation.

◑ *The South Australian Government has partially implemented Recommendation 38, permitting objections to autopsy to be considered and adopting initiatives to consider the cultural sensitivities of Aboriginal and Torres Strait Islander communities as they concern autopsy. However, it does not appear that the Aboriginal Legal Service (ALS) has been consulted or that a protocol has been developed as called for in this recommendation.*

In **Western Australia**, as per section 20 of the *Coroners Act 1996* (WA), a coroner who has jurisdiction to investigate a death must, as soon as practicable after assuming jurisdiction, provide to any of the deceased person's next of kin that a port-mortem examination is likely to be performed on that body. Section 37 of the Act provides that is the senior next of kin of the deceased asks a coroner not to direct a post mortem examination but the coroner decides that a post mortem examination is necessary, the coroner must immediately provide, in writing, a notice to the senior next of kin and to the State Coroner. The Office of State Coroner deals with objections to post-mortem with due respect and Office counsellors take a lead role in dealing with the family and their concerns. Within two clear working days after receiving notice of the decision, or before the end of any extension of time granted by the Supreme Court, the senior next of kin may apply to the Supreme Court for an order that no post mortem examination be performed. Alternatives to physically invasive post-mortem examinations have been announced by the Western Australian Government and a Computed Tomography Scanner has been purchased by the Office of the State Coroner to facilitate less invasive examinations. There is currently no protocol between the Office of the State Coroner and the Aboriginal Legal Service and Aboriginal Health Services.

◑ *The Western Australian Government has partially implemented Recommendation 38, permitting objections to autopsy to be considered. However, there is no protocol between the Office of the State Coroner and the Aboriginal Legal Service and Aboriginal Health Services.*

Within **Tasmania**, under section 38 of the *Coroners Act 1995* (Tas), where the senior next of kin of the deceased person requests a coroner not to direct that an autopsy be performed but the coroner decides that an autopsy in necessary, the coroner must immediately give notice in writing of the decision to the senior next of kin. Within 48 hours after receiving notice of the coroner's decision to perform an autopsy, the senior next of kin of the deceased person may apply to the Supreme Court for an order that an autopsy not be performed.

◑ *The Tasmanian Government has partially implemented Recommendation 38, since there is no provision for traditional rites to be performed by family members and it does not appear that Aboriginal Legal Services and Aboriginal Health Services have been consulted.*

Section 23 of the **Northern Territory** *Coroners Report 1993* (NT) provides that where the senior next of kin of the deceased person asks a coroner not to direct that an autopsy be performed but the coroner decides that the autopsy is necessary, the coroner must immediately give notice in writing of the decision to the senior next of kin. The autopsy must not be performed until 48 hours after the senior next of kin has been given notice, and the next of kin may apply within that time to the Supreme Court for an order that the autopsy not be performed. Under the NT *Coroners Regulations*, section 8(1) specifies that a coroner may allow a person with sufficient interest to attend the conduct of the autopsy.

◑ *The Northern Territory Government has partially implemented Recommendation 38, and allow for a consultative process between the Coroner and the deceased's next of kin in the event that an autopsy must be performed. However, it does not appear that the ALS has been consulted or that a protocol has been developed as called for in this recommendation.*

In the **Australian Capital Territory**, under section 21 of the *Coroners Act 1997* (ACT), a coroner may direct a doctor to conduct a post-mortem examination of the body of a person, in which the coroner has conducted an inquest. Section 17(a) of the *Act* emphasises that a coroner must have regard to the desirability of minimising the causing of distress or offence to people who, because of

their cultural attitudes or spiritual beliefs, could reasonably be expected to be distressed or offended by the decision. Under section 70(2), if a coroner does not give authorisation for an immediate family member or representative to be present at the post-mortem examination conducted on the body, the coroner must give written notice of the decision and the reasons for the decision to the person whom the request was made and, if the deceased was an Aboriginal and Torres Strait Islander person, to an appropriate local Aboriginal Legal Service. The Australian Capital Territory Government notes that families are always advised of their rights to formally object to post-mortem examination, and within operational limitations the examination of Aboriginal and Torres Strait Islander people is undertaken as expeditiously and prioritised wherever possible.

The Australian Capital Territory Government has mostly implemented Recommendation 38 through the Coroners Act 1997 (ACT) and consultative process in the event that an autopsy must be performed. It does not appear that a protocol has been developed as called for in this recommendation.

Recommendation 39

That in developing a protocol with Aboriginal Legal Services and Aboriginal Health Services as proposed in Recommendation 38, the State Coroner might consider whether it is appropriate to extend the terms of the protocol to deal with any and all cases of Aboriginal deaths notified to the Coroner and not just to those deaths which occur in custody.

Background information

The RCIADIC suggested that the State Coroner should extend the scope of the protocol so that the Aboriginal Legal Service and Aboriginal Health Services could be notified to assist in investigations of all Aboriginal deaths brought to the Coroner's attention.

Responsibility

All State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, as discussed within the *Report on the NSW Government's Implementation of the Recommendation of the Royal Commission into Aboriginal deaths in custody*[10], when the death of an Aboriginal person (whether or not in custody) is reported to a Coroner it is usual for the Aboriginal Legal Service to make contact and discuss the matter with the Coroner. While the NSW Attorney-General's Department noted that it supported this recommendation, it was highlighted that due to funding restraints, Aboriginal Court Liaison Officers were only to attend particularly sensitive coronial inquiries into Aboriginal deaths, for example, those which occur in custody.

It does not appear that the New South Wales Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

In **Victoria**, under section 15 of the *Coroners Act 2008* (Vic), a coroner must investigate the death of a person if it appears to the coroner that the death occurred in Victoria, is a reportable death, occurred within 50 years before the death was reported to a coroner or if an interstate coroner does not intend to investigate the death. Section 25 of the Act specifies that a coroner must direct a medical investigator to perform an autopsy on a body under the control of the coroner if the coroner believes that the autopsy is necessary for the investigation of the death and it is appropriate to give the direction. Section 16 of the Act provides that a coroner must take reasonable steps to notify the senior next of kin in which they are given 48 hours, after receiving notification of death, to object the autopsy. Further section 8(c) of the Act highlights that coroners should have regard to the fact that different cultures have different beliefs and practices. These provisions are not restricted to deaths in custody.

[10] http://www.lawlink.nsw.gov.au/report%5Clpd_reports.nsf/pages/rc99_investigating, accessed September 2017

It does not appear that the Victorian Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

The actions taken by the **Queensland** Government in Recommendation 38 are relevant to this recommendation. Additionally, the 1997 Implementation Report noted that consideration will be given to this recommendation as part of the development of a new Coroner's Act. There does not appear to be any legislation in the *Coroners Act 2003* (Qld) that addresses this recommendation. Further, it is unclear whether a specific protocol has been formed with the Aboriginal Legal Service and Aboriginal Health Services as projected by this recommendation.

It does not appear that the Queensland Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

Within **South Australia**, the action taken by the SA Government to address the issues faced in Recommendation 38 also apply to this recommendation. It is unclear whether a separate protocol has been developed in consultation with the Aboriginal Legal Service and Aboriginal Health Services. Additionally, the South Australian Government notes in their response to this recommendation that action has been taken to accommodate the sensitivities of Aboriginal and Torres Strait Islander families and communities in relation to the retention of organs.

It does not appear that the South Australian Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

The **Western Australian** Government noted within the 2000 Implementation Report, that all known facts relating to the deceased will be given due consideration before a Post Mortem Examination is carried out. Sections 36 and 37 of the *Coroners Act 1996* (WA) provide a right to object and a right to appeal to the Supreme Court to have or not to have a post-mortem examination. The Western Australian Government comments that there is no protocol as the Act's provisions are considered to meet these requirements.

It does not appear that the Western Australian Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

The actions taken by the **Tasmania** Government in response to Recommendation 38 also applies to this recommendation, as it does not appear to specifically apply to deaths in custody. It is unclear whether a separate protocol has been formed in consultation with the Aboriginal Legal Service and Aboriginal Health Services to address this recommendation.

It does not appear that the Tasmanian Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

The actions taken by the **Northern Territory** Government to address Recommendation 38 also apply to this recommendation as it applies to all deaths. It is unclear whether a separate protocol has been developed in consultation with the Aboriginal Legal Service and Aboriginal Health Services to satisfy this recommendation.

It does not appear that the Northern Territory Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

The actions taken by the **Australian Capital Territory** Government to address Recommendation 38 are also relevant to this recommendation, as it is not specifically targeted towards deaths in custody. Further, it is unclear whether a separate protocol has been developed in consultation with the Aboriginal Legal Service and Aboriginal Health Services.

It does not appear that the Australian Capital Territory Government has developed a specific protocol with the Aboriginal Legal Service and Aboriginal Health Services, and as such the requirements of Recommendation 39 are not met.

Recommendation 40

That Coroners Offices in all States and Territories establish and maintain a uniform data base to record details of Aboriginal and non-Aboriginal deaths in custody and liaise with the Australian Institute of Criminology and such other bodies as may be authorised to compile and maintain records of Aboriginal deaths in custody in Australia.

Background information

The RCIADIC Report found that data collection and reporting are important in identifying systemic failures in custodial practices and thus preventing future deaths in similar circumstances.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

In its initial response, the **Commonwealth** supported the establishment of a Monitoring Unit in the AIC which was tasked with monitoring and research into cases of deaths in custody. This Monitoring Unit contributed to the formation of a national database on deaths and custody, and the publication of several monitoring reports.

The National Coronial Information System (NCIS) – launched in July 2000 and now administered by the Victorian Department of Justice – is an internet based data storage and retrieval system for Australian coronial cases. It stores information about every death reported to an Australian Coroner since July 2000 and thereby enables Coroners and research agencies to review previous cases and identify trends. The Commonwealth provides funding for the NCIS.

The Commonwealth has implemented Recommendation 40. The NCIS provides the AIC with access to relevant information on deaths in custody.

In **New South Wales**, under section 37 of the *Coroners Act 2009* (NSW), the State Coroner is required to make a written report to the Minister containing a summary of all deaths, or suspected, deaths in custody. The report is then to be tabled in each House of Parliament within 21 days of the report being made. Further, section 82(4) of the Act provides that the coroner is to ensure that a copy is provided of a record to the State Coroner, any person or body to which a recommendation included in the record is directed, the Minister and any other Minister that administers legislation to which a recommendation in the record relates. Other key agencies also have processes for tracking or reporting relevant deaths. Corrective Services NSW records and reports on all deaths in custody; the Justice Health and Forensic Mental Health Network maintains an annual Death in Custody register that identifies Aboriginal status; and all NSW coronial data are additionally stored in the National Coronial and Information System with that of other jurisdictions.

The New South Wales Government has implemented Recommendation 40 through several initiatives: CSNSW records and reports on all deaths in custody; the JH&FMHN maintains an annual Death in Custody register that identifies Aboriginal status; and all NSW coronial data are additionally stored in the National Coronial and Information System with that of other jurisdictions.

Section 72 of the **Victorian** *Coroners Act 2008* (Vic), specifies that a coroner may report to the Attorney-General on a death which the coroner has investigated. A Coroner may make recommendation to any Minister, public statutory authority or entity on any matter connected with a death which the coroner has investigated. Section 73 of the Act provides that unless otherwise ordered by a coroner, the findings, comments and recommendations made following an inquest must be published on the Internet. Further, the 2005 Implementation Report noted that the Victorian Government would continue to provide information on all deaths in custody to the Australian Institute of Criminology, which maintains a national database. Section 3.5 of the 2005 Implementation Report

highlighted that the State Coroner, in conjunction with the Victorian Police, had developed a revised 'Report of Death to the Coroner', which includes the Aboriginal and Torres Strait Islander status of the deceased.

The Victorian Government has implemented Recommendation 40 through several cooperative initiatives with the Commonwealth. These include the provision of Coronial information to the Australian Institute of Criminology, the publication of findings on the internet, and reporting requirements.

In **Queensland**, section 93 of the *Coroners Act 2003* (Qld) provides that the Minister may enter into an arrangement with the entity for stated information obtained under the Act to be included in the database. Section 46A of the Act specifies that if a coroner investigates a death at an inquest, the coroner must publish the findings and comments of the investigation on the State Coroner's website, unless the coroner orders otherwise. The coroner must also give a written copy of the findings and comments to the Attorney-General, the appropriate chief executive and Minister. Further to this, section 16.23.5 of the *Operational Procedures Manual, Issue 59, Public Edition*, provides that Investigating Officers, as part of their investigation, should notify the Australian Institute of Criminology of the death as soon as practicable.

The Queensland Government has implemented Recommendation 40 through the provision of Coronial information to the Australian Institute of Criminology, the publication of findings on the internet, and cooperation with the Minister in maintaining the database.

Within **South Australia**, under section 39 of the *Coroners Act 2003* (SA), the State Coroner must make a report to the Attorney-General on the administration of the Coroner's Court and the provision of coronial services under the Act during the previous financial year. The report must include all recommendation made by the Court's Court. The Attorney-General must cause copies of the report to be laid before both Houses of Parliament. Further, section 25(4) of the Act provides that the Coroner's Court must forward a copy of its findings and recommendations to the Attorney-General, a Minister or other agency, to each person who appeared personally or by counsel at the inquest and any other person, who in the opinion of the Court, has sufficient interest in the matter. The National Coronial Information Service also helps to implement this recommendation throughout Australia.

The South Australian Government has implemented Recommendation 40 through reporting processes and cooperation with the National Coronial Information Service.

As discussed in the **Western Australian** *Coroners Act 1996* (WA), section 26 provides that a coroner, or the coroner's registrar must keep a record of each investigation into a death in a prescribed form. 27(1) of the Act specifies that the State Coroner must report annually to the Attorney-General on the deaths which have been investigated in each year, including a specific report on the death of each person held in care. The Attorney General is to cause a report to be laid before each House of Parliament within 12 sitting days of such House. The State Coroner may make recommendations to the Attorney-General on any matter connected with a death which a coroner investigated. Where recommendations are made regarding a death of a person in care is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation. Additionally, the Office of the State Coroner maintains a localised database as part of the National Coronial Information System.

The Western Australian Government has implemented Recommendation 40 through the Coroners Act 1996 (WA) and participation in the National Coronial Information System.

In **Tasmania**, as outlined in sections 29 and 30 of the *Coroners Act 1995* (Tas), a coroner or the coroner's associate must keep a record of each investigation into a death and a coroner may report to the Attorney-General on a death which the coroner investigated. Section 69 of the Act provides that the Chief Magistrate must prepare and submit to the Attorney-General a report in relation to the operation of the Act during the preceding financial year. The report must include details of persons held in custody and findings and recommendations made by coroners. The Attorney-General must also cause a copy of the report to be laid on the table of each House of Parliament. It is unclear whether the Australian Institute of Criminology is notified of all deaths in custody.

The Tasmanian Government has partially implemented Recommendation 40 through reporting processes under the Coroners Act 1995 (Tas). However, it does not appear that the AIC is notified of all deaths in custody.

In the **Northern Territory**, as per section 26 of the *Coroners Act 1993* (NT), where a coroner holds an inquest into the death of a person held in custody, the coroner must report on the care, supervision and treatment of the person. Section 27 of the Act provides that the coroner must cause a copy of the report and recommendations to the Attorney-General without delay. As highlighted in section 46A of the Act, where the Attorney-General receives a report or recommendations from the coroner that contains comments relating to an agency or the Police Force of the Northern Territory, the Attorney-General must give a copy of the report or recommendations to the Chief Executive Officer of the Agency or the Commissioner of the Police, as the case requires. Further, section 46B provides that if the Chief Executive Officer or the Commissioner of Police receives a copy of a report or recommendations, they must give the Attorney-General a written response to the findings in the report or to the recommendations. The *Police General Order - Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public* also provides that Divisional Officers will assist the AIC in the monitoring of deaths in custody.

The Northern Territory Government has implemented Recommendation 40 through the provision of Coronial information to the Australian Institute of Criminology, and reporting requirements.

In the **Australian Capital Territory**, under section 75(1) of the *Coroners Act 1997* (ACT), after the coroner has completed an inquest into a death in custody, the coroner must, in writing, report the findings to the Attorney-General, the custodial agency in who custody the death occurred and the Minister responsible for that agency, the Australian Institute of Criminology, an appropriate Aboriginal Legal Service (if the deceased was Aboriginal and Torres Strait Islander) and any person whom the coroner considers appropriate.

The Australian Capital Territory Government has implemented Recommendation 40 through the provision of Coronial information to the Australian Institute of Criminology, and reporting requirements contained under the Coroners Act 1997 (ACT).

3.4 Adequacy of information (41-47)

Recommendation 41

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) 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) *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) *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.*

Background information

The RCIADIC Report recognised the importance of publicly available, accurate information about deaths in custody in allaying suspicion and inspiring greater confidence in various administrations.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

As part of the **Commonwealth's** initial response, the National Deaths in Custody Program database was started in 1992 to collect and disseminate data on all deaths that occur in police, correctional, and youth justice services – including the number of deaths, and the trends observed in those deaths. At the inception of the National Deaths in Custody Program, five annual reports were tabled for Commonwealth Parliament. However, following the *1996-97 Annual Report*, no further reports have been tabled for Parliament.

The AIC and police services agreed to monitor and report on deaths in custody. The Consensus Statement, reached in 1994, provides that this collaborative approach will ensure that this recommendation is implemented in a manner which enhances community understanding of deaths in custody, and also minimises the scope for misinterpretation of the data emanating from the monitoring process. The database currently holds information from 1979-80 to 2014-15. Data from the National Deaths in Custody Program are published on a biennial basis in the AIC's Statistical Report.

The Commonwealth has mostly implemented Recommendation 41 through the work of the AIC. However, annual reporting to the Parliament has ceased and there is no clear indication of monitoring by the Parliament.

The **New South Wales** Police Service, Department of Corrective Services, Juvenile Justice NSW and State Coroner's Office all contribute data to the database. A separate database which could identify the deceased on the basis of Aboriginality is maintained for all deaths in custody. This information is regularly provided to the ABS. In relation to part c) of the recommendation, the *1995-96 Implementation Report* also noted that the Commonwealth and the NSW Government had agreed to a uniform definition of deaths in custody, which covered the requirements of this recommendation. The NSW Government commented that the AIC has completed a series of monitoring reports informed by NSW data and that of other jurisdictions.

The New South Wales Government has implemented Recommendation 41 through cooperating with the Commonwealth, and the ongoing data collection and associated initiatives of relevant agencies.

In **Victoria**, as noted in the 1997 Implementation Report, the Correctional Services Division and Victoria Police provide statistical data to the AIC on all Victorian Deaths in Custody. The Report noted that Victoria Police – Internal Investigations Department – is responsible for recording particulars of all deaths in custody.

The Victorian Government also noted in AJA 3 a commitment to collaborating with Victoria Police, Corrections Victoria, the Department of Human Services, and the courts to develop a detailed database which described Aboriginal and Torres Strait Islander over-representation in the justice system. This serves as part of a broader data improvement strategy introduced as part of AJA 3.

The Victorian Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data, and initiatives by the Victorian Police under the AJA 3.

The 1997 **Queensland** Implementation Report specified that Recommendation 41 has been implemented. Specifically, statistics are provided to the AIC in two standard categories; deaths in institutional settings and other deaths during custody-related police operations. Queensland Corrective Services also annually reports on deaths from apparent unnatural causes in the Department of Justice and Attorney-General Annual Report, through Service Delivery Statements and the Report on Government Services (ROGS). The definition of a death in custody used in Queensland (as described in Recommendation 6) addresses part c) of this recommendation.

The Queensland Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data, and the annual reporting initiative of Queensland Corrective Services.

In **South Australia**, the 1994 Implementation Report highlighted that State Agencies were cooperating with the AIC is relation to this recommendation. For example, DCS keeps a record of all Aboriginal and non-Aboriginal deaths in prison and within 30 days a Death in Custody Notification form is provided to the AIC of a death in custody for the National Deaths in Custody Program. The definition of a death in custody used in South Australia (as described in Recommendation 6) addresses part c) of this recommendation.

The South Australian Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data, and through their response to Recommendation 6.

In **Western Australia**, the Office of the State Coroner participates in the NCIS, which allows for collection, analysis and reporting of coronial data from across Australia as part of the National Monitoring of Deaths in Custody. The Department of Justice is currently developing a memorandum of understanding with the AIC for the provision of data on all reportable deaths to the AIC. On a broader scale, the Department of Justice collects ongoing data relating to Aboriginal deaths in custody. This information is sensitive to cause of death, whether from unnatural or natural causes. The definition of a death in custody used in Western Australia (as described in Recommendation 6) addresses part c) of this recommendation.

The Western Australian Government has implemented Recommendation 41 through cooperating with the Commonwealth with the collection and provision of data, and through their response to Recommendation 6.

Within **Tasmania**, as discussed in the 1995 Implementation Report, the Department of Community and Health Services fully supports the national monitoring of statistics and other information on Aboriginal and non-Aboriginal deaths in custody, police custody and juvenile detention centres and related matters. The Tasmanian Government provided that state authorities comply with the requests of the AIC in relation to the establishment of uniform national procedures and methodologies. The Report also noted that Tasmania Police co-operate with the AIC by the provision of statistics and other information. They regularly provide and publish detailed information on the numbers and details of the people passing through their cells. In 2017, the Tasmania Prison Service signed a Memorandum of Understanding with the AIC regarding the Deaths in Custody Program.

The Tasmanian Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data.

The 1996-97 **Northern Territory** Implementation Report specified that the NT Government is co-operating with the AIC in line with this recommendation. Further, as per the actions taken by the NT Government for Recommendation 6, the NT definition of a death in custody addresses part c) of this recommendation. This is also supported by the *Police General Order - Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public*, as discussed in Recommendation 40.

The NT Government also noted that deaths in custody by Aboriginal and Torres Strait Islander status are reported to the Productivity Commission and reported as part of the Report on Government Services. Deaths in Police custody are reported separately to apparent unnatural deaths in correctional services custody. The definitions used are standardised across jurisdictions. For Correctional Services, 'apparent unnatural deaths' is defined as the number of deaths where the likely cause of death is suicide, drug overdose, accidental injury or homicide.

A register relating specifically to deaths in NTCS custody is maintained within NTCS.

The Northern Territory Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data, and has responded to part c) in their response to Recommendation 6.

The **Australian Capital Territory** Corrective Services and ACT Youth Justice Services provide the necessary details to the AIC of any deaths in custody. The definition of a death in custody used in the ACT (as described in Recommendation 6) addresses part c) of this recommendation.

The Australian Capital Territory Government has implemented Recommendation 41 through cooperating with the Australian Institute of Criminology with the collection and provision of data, and has responded to part c) in their response to Recommendation 6.

Additional commentary

The Commonwealth's National Deaths in Custody Program is Australia's only national data collection with the capacity to collect information on deaths in custody and communicate it to key stakeholders including law enforcement and other government, non-government organisations, academia and the general public. The AIC has maintained a strong commitment to the administration of the National Deaths in Custody Program and the collection and storage of comprehensive trend data on deaths in custody.

Through their administration of the Juvenile Justice National Minimum Data Set, the AIHW also collects information on all young people under youth justice supervision on an annual basis, including their status as an Aboriginal and Torres Strait Islander.

Recommendation 42

That governments require the provision of and publish, on a regular and frequent basis, detailed information on the numbers and details of the people passing through their police cells.

Background information

The RCIADIC Report noted a paucity of information at the national level concerning the demographic characteristics of Aboriginal and Torres Strait Islander people at risk of death in custody.

Responsibility

The Commonwealth, and all State and Territory governments have responsibility for this recommendation.

Key actions taken and status of implementation

At the **Commonwealth** level, the AIC has published annual data on all deaths in custody in all Australian jurisdictions since the inception of the National Deaths in Custody Program, this also includes the numbers and details of Aboriginal and Torres Strait Islander detainees.

The AIC conducted National Police Custody Surveys in 1992, 1995 and 2002, which provided information on the numbers of people in custody, the types of offences for which they are held, their details, and trends in those numbers over the period 1988-2002. The survey was also conducted in 2007, however the results were not available for public release due to issues with data validity and reliability. The AIC undertook a review of the *National Police Custody Survey* in 2011, which concluded that previous data issues may be alleviated by collation of data from electronic custody management systems operating in each jurisdiction. In 2011, the AIC collaborated with the States and Territories through the National Police Custody Monitoring Program to establish electronic custody management systems within each jurisdiction. Data were collected for the period 1 July 2011 to 30 June 2014.

However, these data were also affected by reliability and validity issues and the survey was suspended in 2016. The AIC has undertaken to report on police custody data. This remains an ongoing issue for the AIC. A review of the first data collection using electronic custody data has been completed internally. The next stage will be for the AIC to engage with state and territory data providers to develop the next iteration of data collection.

The ABS conducts the annual National Prison Census (NPC) on persons held in custody in Australian prisons, which is typically published each year through the *Prisoners in Australia* publication. The quarterly ABS publication *Corrective Services in Australia* also contains information on persons in corrective services, including their numbers, gender, demographic information, and Aboriginal and Torres Strait Islander status.

The Commonwealth has implemented Recommendation 42 since the AIC has published annual data on all deaths in custody since 1992. While the National Police Custody Survey is not conducted at the moment, the NPC performs a similar function.

The 1995-96 **New South Wales** Implementation Report stated that the Department of Corrective Services provides relevant information sourced from the NSW Prison Census to the NSW Attorney-General and Bureau of Crime Statistics and Research. Further, the NSW Police Service publishes data on the number and details of all persons passing through police cells, including Aboriginal status. The data are published in the monthly and Annual Activity Reports produced by the Statistical Service Branch, Strategy and Review Command and provided to the Police Ministry.

The New South Wales Government has implemented Recommendation 42. NSW Police Service publishes data on the number and details of all persons passing through police cells. There are a number of other initiatives which also support the implementation of this recommendation in New South Wales.

In **Victoria**, data on the number and details of people in police cells are not routinely published or made publicly available, although this information has been produced for specific reports and inquiries as required. While statistics relating to people held in prisons are routinely produced, the scope of these collections does not generally include people held in police cells.

The Victorian Government has not implemented Recommendation 42. Data on the number and details of people in police cells are not routinely published or made publicly available.

The **Queensland** 1996-97 Implementation Report highlighted that the-then Queensland Police Services Indepol recording system could not provide all of the required data. It was anticipated that the integrated Queensland Police Services Polaris Computer System would facilitate provision of detailed custody information when stage 3 was to be completed. There is currently no ability to extract data from the QPS Queensland Police Records and Information Management Exchange (QPRIME).

The Queensland Government has partially implemented Recommendation 42, while the data are collected it is not possible to extract all of the data from the QPRIME system for publication.

The **South Australian** Government notes that South Australia Police collects and collates the number of people arrested, for which offence, gender, and whether the offender is a juvenile or an adult. These data are detailed in the South Australian Police Annual Report.

The South Australian Government has implemented Recommendation 42 through the collection and collation of statistics on the number of people arrested, for which offence, gender, and status as a juvenile or adult. These statistics are provided in an annual report.

In **Western Australia**, as noted by the 2000 Implementation Report, the process for data collection had been put in place, however, further examination of the data collected prior to the publication of the annual report revealed variances and inconsistencies in that data that would not present an accurate representation of the information. For this reason, the information was not included in the annual report. Prior to this, for the preceding five years the Western Australian Police Services (WAPS) published in its annual report lock up admission for drunken detainees and comparative

figures for sobering up shelters. WAPS noted that it was improving its information system through the development of a major information system infrastructure and software upgrade.

The Western Australian Government noted that it captures data relating to people passing through police cells. A broad range of custodial data continues to be published regularly. This includes State Government Annual Reports, statistics pages on justice departments' websites, and Western Australian data published in the Productivity Commission's Report on Government Services.

The Western Australian Government has mostly implemented Recommendation 42 through the collection of data on the number of people passing through police cells. It is not clear that these data are published regularly.

The 1993 **Tasmanian** Implementation Report noted that the process described in this recommendation was current practice within the state. Further, the 1995 Implementation Report noted that the Tasmanian Police regularly provided and published details on the numbers and details of the people passing through their cells. This requirement was formalised in Tasmania Police Policy Document No, 9/92 issued in November 1992. Currently, the Tasmania Prison Service does not publish this information for watch-house cells.

The Tasmanian Government has mostly implemented Recommendation 42 through the publication of statistics on the number of people, as provided for in Tasmania Police Policy Document No 9/92. However, these statistics are not published currently for watch-house cells.

Within the **Northern Territory**, as specified in the 1994-95 Implementation Report, information on the number of people by race and gender for Protective Custody is published in the Northern Territory Police, Fire and Emergency Services Annual Reports. Further statistical information comparing Aboriginal and non-Aboriginal arrest rates was included in the Annual Implementation Report. Care was taken to protect the privacy of individuals, and information which could identify individuals was not published.

The Northern Territory Government has mostly implemented Recommendation 42 through the publication of statistics on the number of people in Protective Custody separated by race and gender immediately following RCIADIC. It is not clear if these arrangements remain current.

The 1995-96 **Australian Capital Territory** Implementation Report noted that the information required in Recommendation 42 was readily available from the Regional Watch House Online Charging System and was published in the Australian Federal Police annual report to the ACT Government. However, this information was not published in the most recent ACT Policing Annual Report.[11]

The ACT Government responded that ACT Policing will make amendments to ensure this information is included in the ACT Policing Annual Report.

The Australian Capital Territory Government has mostly implemented Recommendation 42 through the publication of statistics in the Regional Watch House Online Charging System. However, annual reporting has ceased.

Recommendation 43

That a survey such as the 1988 National Police Custody Survey be conducted at regular intervals of, say, two to five years, with the aim of systematically monitoring and evaluating the degree to which needed improvements in legislation, attitudes, policies and procedures that affect police custody are implemented.

Background information

The 1988 National Police Custody Survey provided information including the timing and reasons for the detainee's incarceration, and details relating to the number of detainees and trends observed. The

[11] https://www.police.act.gov.au/sites/default/files/PDF/ACT%20Policing%20Annual%20Report%202015-2016.PDF

establishment of a regular monitoring program would increase the volume of information available about Aboriginal and Torres Strait Islander people in detention at the national level.

Responsibility
This Recommendation is solely the responsibility of the Commonwealth Government.

Key actions taken and status of implementation
The **Commonwealth** Government has addressed this recommendation through data collection, discussed in relation to the implementation of Recommendation 42.

The Commonwealth has implemented Recommendation 43. While the National Police Custody Survey is not conducted at the moment, the NPC performs a similar function. The data collected by through the NPC could be used for evaluating legislation, attitudes, policies and procedures.

Recommendation 44
That the Australian Institute of Criminology co-ordinate and implement the recommended series of national surveys. The experience of the first national survey points to the fact that careful planning with all the relevant authorities will be needed to ensure that the maximum amount of useful information is derived from the surveys.

Background information
The RCIADIC Report noted a paucity of information at the national level concerning the demographic characteristics of Aboriginal and Torres Strait Islander people at risk of death in custody. It further notes the importance of data collection in the identification of trends, monitoring of detainees, and the prevention of future deaths in custody.

Responsibility
This recommendation is solely the responsibility of the Commonwealth Government.

Key actions taken and status of implementation
The **Commonwealth** Government has addressed this recommendation through data collection, discussed in relation to the implementation of Recommendation 42.

The Commonwealth has implemented Recommendation 44. The National Police Custody Survey is temporarily suspended while data issues are resolved. However, the NPC performs a similar function, noting it is run by the ABS.

Recommendation 45
That the appropriate Ministerial Councils strive to achieve a commonality of approach in data collections concerning both police and prison custody.

Background information
It is important that information on people in custody be comparable across the States and Territories, and be in a form that enables data to be aggregated to produce a national overview, in order to identify systematic failures and thereby reduce the occurrence of future deaths in custody.

Responsibility
The Commonwealth, and all State and Territory governments are responsible for this recommendation.

Key actions taken and status of implementation
The **Commonwealth's** AIC contributed to the implementation of this recommendation through the National Deaths in Custody reports and the National Deaths in Custody Program (see Recommendation 41).

Currently, the ABS and the AIHW are responsible for the development of nationally consistent police and corrections data. The ABS produces nationally consistent comparable adult corrections statistics. The ABS continues to further refine data in collaboration with States and Territories, in ensuring that

the comparability of statistics across jurisdictions is maintained. The ABS noted that their collections do not include information on deaths in custody and do not include data relating to police custody (police cells are currently out of scope of the ABS collections). The AIHW's Juvenile Justice National Minimum Data Set provides information on the number of young people supervised by youth justice agencies in each State and Territory.

The Commonwealth has implemented Recommendation 45. Significant progress has been made by the AIC, ABS and AIHW in the collection of nationally-consistent data. Data provided by the Northern Territory do not meet the nationally agreed minimum data standards for inclusion in the Juvenile Justice National Minimum Data Set, which is outside of the Commonwealth's responsibility.

The **New South Wales** Government highlighted in the 1995-96 Implementation Report that a commonality of approach exists in the censuses of persons held in police and prison custody sponsored by the AIC, which are conducted annually. Standardised reporting on a range of prison metrics are included in the annual ROGS, and the NPC.

The New South Wales Government has implemented Recommendation 45 through cooperation with national initiatives.

The 1994 **Victorian** Implementation Report provided that both the Victoria Police and the Correctional Services Division participate in national statistical collection processes in which agreement on the commonality of data generally occurs. Additionally, the Report highlighted all corrections jurisdictions participate in the National Corrections Statistics Committee, which is a committee under the National Corrections Administrators Conference. Similarly, the Victoria Police participates in the AIC sponsored census of person held in police custody, which involves all States and Territories.

The Victorian Government has implemented Recommendation 45 through participation in national initiatives which are focused on achieving a standard approach to data collection.

In **Queensland**, as noted within the 1996-97 Implementation Report, the Queensland Police Service provides standardised custody information to the AIC. The Queensland Corrective Services Commission has consulted and cooperated with the AIC in data collection. It has met all requests for data from that organisation. Further to this, the Department of Families, Youth and Community Care Client Information System had incorporated relevant data requirements to ensure compatibility with other Queensland Government systems.

The Queensland Government has implemented Recommendation 45 through the provision of standardised data to the AIC, and the adoption of state-wide consistent data reporting practices.

The 1994 **South Australian** Implementation Report noted that the Australian correctional agencies had already achieved a commonality of approach in data collections.

The South Australian Government has implemented Recommendation 45 through cooperation with national initiatives.

The **Western Australian** Government continues to participate in the national data collection of prison data in accordance with the agreed national approach. The State also produces data on the rate of adult recidivism for return to prison, return to community corrections and return to corrections (i.e. prison or community corrections).

The Western Australian Government has implemented Recommendation 45 through cooperation with national initiatives.

In **Tasmania**, as highlighted in the 1995 Implementation Report, Tasmania Police contributed to the development of existing data collection system. The Tasmanian Department of Justice currently participates in the collection of national correctional statistics through the National Corrections Statistics Group.

The Tasmanian Government has implemented Recommendation 45 through cooperation with national initiatives.

The 1994-95 **Northern Territory** Implementation Report provided that both the Department of Correctional Services and the Northern Territory Police cooperate with the AIC on a continuing basis, and both endeavour to comply with the requirements of their Ministerial Councils. The NTCS records of offenders are maintained within an Integrated Offender Management System which has information from the Police Integrated Justice Information System.

The Northern Territory Government has implemented Recommendation 45 through the provision of standardised data to the AIC on a continuing basis, and the development of an Integrated Offender Management System.

The **Australian Capital Territory** Government noted that ACT Corrective Services works with the Commonwealth and other jurisdictions to achieve a common approach.

The Australian Capital Territory Government has implemented Recommendation 45 through cooperation with the Commonwealth and other jurisdictions to achieve a common approach.

Recommendation 46

That the national deaths in custody surveys which I have recommended be undertaken by the Australian Institute of Criminology include the establishment of uniform procedures and methodologies which would not only enhance the state of knowledge in this area but also facilitate the making of comparisons between Australian and other jurisdictions, and facilitate communication of research findings.

Background information

The RCIADIC Report identified the attaining of comparable data as a significant problem in criminological research conducted across jurisdictions.

Responsibility

This recommendation is solely the responsibility of the Commonwealth Government.

Key actions taken and status of implementation

The **Commonwealth** Government's National Deaths in Custody Program records information on deaths in prison and police custody based on definitions developed specifically for the collection and in response to the Recommendations of RCIADIC. The definition of a death occurring in police custody is based on a resolution of the Australasian Police Ministers' Council in 1994 and captures Category 1 deaths (1a. deaths in institutional settings and 1b. other deaths in police operations where officers were in close contact with the deceased) and Category 2 deaths (other deaths during custody-related police operations).

Information held in the National Deaths in Custody Program database is based on two main data sources: completed data collection forms from state and territory police and corrective services; and coronial reports including toxicology, police reports, post-mortem accounts and proceeding and findings transcripts. At the commencement of the National Deaths in Custody Program a data collection template was developed in consultation with police and correctional custodial agencies in each jurisdiction. The template includes standardised data items that are consistently collected across jurisdictional custodial agencies, thus allowing for comparisons between States and Territories and the preparation of national data. The National Deaths in Custody Program uses the NCIS (see recommendation 40) as a confirmatory measure of the primary data provided by police and corrective services. To ensure accuracy of data, the AIC maintains a strict verification process whereby data on deaths in custody are sent to each data provider at the end of a financial year for confirmation. Before releasing any data on deaths in custody the AIC confirms findings with data providers to ensure they match.

The Commonwealth Government has implemented Recommendation 46. The AIC continues to operate National Deaths in Custody Program with strict adherence to the methodology and processes outlined above.

Recommendation 47

That relevant Ministers report annually to their State and Territory Parliaments as to the numbers of persons held in police, prison and juvenile centre custody with statistical details as to the legal status of the persons so held (for example, on arrest; on remand for trial; on remand for sentence; sentenced; for fine default or on other warrant; for breach of non-custodial court orders; protective custody or as the case may be), including whether the persons detained were or were not Aboriginal and Torres Strait Islander people.

Background information

The RCIADIC highlighted that a significant deficiency had been the fact that for some jurisdictions, there had been a relatively high number of cases for which the Aboriginality or non-Aboriginality of the prisoners was not stated.

Responsibility

All State and Territory governments are responsible for this recommendation.

Key actions taken and status of implementation

In **New South Wales**, the NSW Department of Justice Corrective Services division conducts and publishes an annual Inmate Census as part of the NPC conducted by the ABS. The annual Inmate Census contains statistics on inmates held in full-time prison, police and juvenile centre custody and includes statistical details as to the legal and Aboriginal status of all persons held. The results of the annual Inmate Census are published on the Corrective Services website.

Further to this, the Minister of the NSW Department of Justice is required to table to State Parliament the operations of that financial year in accordance with the *Annual Report (Departments) Act 1985* (NSW). The published Bureau of Crime Statistics and Research quarterly custody statistics provide reception, discharge and custody population data and information on age, gender, Aboriginal status, most serious offence and the average length of stay. Separate figures are presented for juveniles and adults.

The New South Wales Government has implemented Recommendation 47 through the Department of Justice Annual Report which is tabled to State Parliament annually by the relevant Minister. A range of other data publications are also published annually, and contain the data referred to in this recommendation.

In **Victoria**, the Department of Justice Annual Report includes prison service statistics which includes the total annual daily average number of prisoners, the total number of deaths in custody and the total number of Aboriginal and Torres Strait Islander deaths in custody. The Annual Report also comprises of statistics of those persons who identify as being of Aboriginal and Torres Strait Islander background. These annual reports are tabled to State Parliament annually by the relevant Minister in accordance with this recommendation. This is also supported by initiatives introduced under AJA 3 in response to Recommendation 42.

The Victorian Government has implemented Recommendation 47 through the Department of Justice Annual Report which is tabled to State Parliament annually by the relevant Minister.

Queensland Corrective Services produces annual reports containing statistical data on offending persons. The annual reports include statistics on the proportion of Aboriginal and Torres Strait Islander prisoners (custodial) and proportion of prisoners who are Aboriginal and Torres Strait Islander (probation and parole). It is unclear whether the Minister is required to table the report to State Parliament. The Department of Justice and Attorney-General also provides an annual report to Parliament supplying the statistical data required in this recommendation.

The Queensland Government has implemented Recommendation 47 through the Department of Justice and Attorney-General annual reporting requirements, and the reports from Queensland Corrective Services.

In **South Australia**, the Department of Correctional Services Annual Report provided detailed statistics on persons in custody for that year including whether or not the persons detained are of

Aboriginal and Torres Strait Islander background. Appendix 4 of the 2015-16 Annual Report details Prisoner Statistical Information, which includes whether the prisoner is sentenced, un-sentenced or unknown and Aboriginal and Torres Strait Islander, non-Aboriginal and Torres Strait Islander or unknown. Further to this, under section 9 of the *Correctional Service Act 1982* (SA), the Chief Executive of the Department must submit to the Minister the annual report which must be tabled in each House of Parliament. However, the South Australian Government notes that these statistics are no longer provided in the Department of Correction Services Annual Report. Instead, statistics are provided through ROGS which is publicly available but does not have a formal requirement to be reported to Parliament.

The South Australian Government has mostly implemented Recommendation 47 through the Department of Corrective Services Annual Report which was tabled to State Parliament annually by the relevant Minister. However, this is no longer current practice, and while data are published they do not have to be tabled in Parliament.

In **Western Australia**, a broad range of custodial data continues to be published regularly. This includes State Government Annual Reports, statistics pages on justice departments' websites, and Western Australian data published in the Productivity Commission's Report on Government Services. The Western Australia Police Force is currently taking action to commence publishing data on the number of persons held in police custody to supplement the data already available.

The Western Australian Government has mostly implemented Recommendation 47 through the publication of custodial data. However, the data made public currently does not identify the number of persons held in police custody.

The **Tasmanian** Justice Department produces an annual report with a chapter on Corrective Services. The Corrective Services chapter includes detailed statistics on those persons in custody, including whether they are Aboriginal and Torres Strait Islander or non-Aboriginal and Torres Strait Islander. However, the annual report does not include information relating to the legal status of those persons in custody. In accordance with section 36 of the *State Service Act 2000* (Tas), the annual reports are required to be tabled before the State Parliament. The 2016-17 Department of Justice Annual Report does not include the information referred to by this recommendation. Tasmania also contributes to the ABS Prisoners in Australia (prisoner census as at 30 June each year) which does contain State and Territory data and specific information regarding the prisoner population including legal status, Aboriginal and Torres Strait Islander status and most serious offence or charge.

The Tasmanian Government has mostly implemented Recommendation 47 through the Justice Department's annual report and provisions made under the State Service Act 2000 (Tas). However, the 2016-17 Department of Justice Annual Report does not include all of the data specified in the recommendation.

The **Northern Territory** Police, Fire and Emergency Services annual report includes statistics on the type and number of offences the number of persons held in police protective custody by Indigenous status. For prison and juvenile centre custody, these data are reported through the Productivity Commission, ABS and AIHW data collections. In particular, the ABS National Prisoner Census presents information about adult prisoners held in custody in Australian prisons (in the NT this includes gazetted police prisons administered and controlled by the Director of Corrective Services). Statistics are derived from information collected by the ABS from administrative records held by corrective service agencies in each state and territory. A range of information is presented on the demographic and legal characteristics of prisoners such as age, sex, country of birth, Indigenous status, legal status, prior imprisonment, most serious offence/charge, aggregate sentence and length of sentence being served, as well as time on remand.

Currently, the NTCS has a system in place that requires daily information that includes the number of Aboriginal and Torres Strait Islander people in custody to be emailed to the Minister. The Research and Statistics Unit of the NTCS supports the implementation of this recommendation through the collection and dissemination of statistics, including the NTCS Annual Statistics.

The Northern Territory Government has implemented Recommendation 47 through the Police, Fire and Emergency Services annual report, national data collections and the Research and Statistics Unit of the NTCS. Regular updates are also provided to the Minister.

In the **Australian Capital Territory**, the Justice and Community Safety Directorate of the ACT publishes the ACT Criminal Justice Statistical Profile which contains information relating to persons held in prisons and youth justice centres. The Profile contains statistical details of the Aboriginal and Torres Strait Islander status, gender, offence and legal status (including on remand or sentenced) of those held in custody. ACT Policing provide data on the number of apprehensions (persons taken into police custody) for inclusion in the Profile. The Profile data are compiled quarterly and then tabled in the ACT Parliament. ACT Corrective Services also provides data annually to the Elected Body.

The Australian Capital Territory Government has implemented Recommendation 47 through the ACT Criminal Justice Statistical Profile.