3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6–40)

The RCIADIC made 35 interrelated Recommendations aimed at reforming the conduct of Indigenous deaths in custody investigations and coronial inquiries.

Significant changes have been made to the coronial system since 1991, with some element of reforming legislation being passed in all States and Territories. Despite this, the structure of the coronial jurisdiction remains largely varied throughout Australia. It is clear there has been no uniform approach to the issue of Indigenous deaths in custody with different State and Territory legislation in operation. This lack of co-ordination has limited the effectiveness of reform.

While the coronial service can, and often does, make a contribution to the prevention of deaths, that input is at risk of being critically undermined by a failure in some jurisdictions:

(a) to effectively legislate for a comprehensive mandatory response to coronial recommendations from government and other bodies; and

(b) to facilitate proper monitoring and analysis to see whether action has been taken to rectify any dangerous practices and systems identified by a Coroner in the course of an inquest.

The recommendations that the RCIADIC made can be categorised as follows:

1. Defining deaths (Recommendation 6);
2. Role of the Coroner (Recommendations 7 – 18);
3. Notification of death and involvement of family (Recommendations 19 – 25);
4. Inquiry of death and roles of officials (Recommendations 26 – 31);
5. Role of the police (Recommendations 32 – 35); and

1. **Defining Deaths (Recommendation 6)**

**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:

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2 For example, the Northern Territory and South Australia have centralised coronial operations to their capital cities, whilst Western Australia, New South Wales, Victoria and Queensland have semi-centralised systems. Uniquely, Tasmania operates a judicial coronial division within the Magistrates Court.
(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 whilst 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.

While deaths in custody are reportable in all States and Territories, full implementation of Recommendation 6 remains varied.

1.1 Victoria

The Victorian legislation provides that a “reportable death” includes the death of a person who immediately before death was a person placed in custody or care, and includes injuries sustained when an authorised person attempts to take the person into custody. It also includes injuries sustained while in the custody of the State, although there is no specific reference to traumatic injuries or lack of proper care whilst in custody or detention. Further, it does not expressly cover a death occurring as a result of a person escaping from custody (whilst other jurisdictions do).

1.2 Western Australia

The Western Australian legislation provides that a “reportable death” includes a death of a person who immediately before death was a person held in care, or that appears to have been caused or contributed to while the person was held in care. The definition of “a person held in care” extends to a person “under, or escaping from, the control, care or custody”. The Western Australian legislation does not expressly deal with a death resulting from an attempt to detain a person or specifically reference a death that is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention, although

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3 Coroners Act 2008 (Vic), s 4; Coroners Regulations 2009 (Vic), reg 7.
4 Coroners Act 2008 (Vic), s 3(1); Coroners Regulations 2009 (Vic), reg 7. The legislation refers to a person who is dying from an injury incurred while in the custody of the State or in the care, control or custody of an authorised person, however this does not clearly extend to traumatic injuries or a lack of proper care.
5 Coroners Act 1993 (NT), ss 12(1)(b), 12(1A)(b); Coroners Act 2003 (Qld), s 10(1)(b); Coroners Act 2009 (NSW), s 23(b); Coroners Act 1996 (WA), s 3 (definition of 'person held in care'); Coroners Act 2003 (SA), s 3(1) (definition of 'death in custody'); Coroners Act 1997 (ACT), s 3C(1)(i); Coroners Act 1995 (Tas), s 3 (definition of 'reportable death').
6 Coroners Act 1996 (WA), s 3.
7 Ibid.
these instances may arguably be covered under a generic provision in the *Coroners Act 1996* (WA). 

**1.3 Queensland**

In Queensland, a “death in custody” expressly includes a death occurring when the person is “escaping, or trying to escape from custody” or when a person is “trying to avoid being put into custody”. However, it does not extend to deaths caused or contributed to by traumatic injuries sustained whilst in custody or detention, or caused by a lack of proper care whilst in detention if the death occurred after the person was released from ‘custody’.

**1.4 Australian Capital Territory**

In the Australian Capital Territory, a “death in custody” includes the death of a person while in, being taken into, or after being taken into, the custody of a custodial officer and while escaping, or attempting to escape, from the custody of a custodial officer. Further, it includes death caused by a fatal injury sustained whilst in custody, which should include fatal injuries incurred in any attempt to detain that person. As noted in other jurisdictions, the definition of a “death in custody” does not specifically extend to deaths caused or contributed to by traumatic injuries sustained whilst in custody or detention, or caused by a lack of proper care whilst in detention if the death occurred after the person was released from custody.

**1.5 New South Wales**

The definition of a “death in custody” in New South Wales includes a death while in the custody of a police officer or in other lawful custody, or escaping or attempting to escape from that custody. The definition also extends to include a death as a result of, or in the course of, police operations, but does not include the actions of prison officers. Further this definition does not extend to include deaths caused or contributed to by traumatic injuries sustained whilst in custody or detention, or caused by a lack of proper care whilst in detention if the death occurred after the person was released from ‘custody’.

**1.6 Tasmania**

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8 Ibid (definition of 'reportable death'). The definition of a 'reportable death' refers to a death “that appears to have been caused or contributed to while the person was held in care”. Note that other jurisdictions expressly include a reference to the detention of a person in the definition of a 'death in custody'. For example, *Coroners Act 1993* (NT), s 12(1A)(a); *Coroners Act 2008* (Vic), s 3(1)(j) (definition of 'person placed in custody or care'); *Coroners Act 2003* (Qld), s 10; *Coroners Act 2009* (NSW), s 23(c); NSW State Coroners Circular No. 24; *Coroners Act 2003* (SA), ss 3(1)(b)-(c) (definition of 'death in custody'); *Coroners Act 1997* (ACT), s 3C(1)(a); *Coroners Act 1995* (Tas), s 3 (definition of 'reportable death').

9 *Coroners Act 2003* (Qld), s 10(1).

10 Ibid, s 10(2).

11 *Coroners Act 1997* (ACT) ss 3C(1)(h), (i).

12 Ibid, s 3C(2).

13 *Coroners Act 2009* (NSW), s 23.

14 Ibid, s 23(c).
The definition of a “reportable death” in Tasmanian legislation includes the death of a person who immediately before death was a person held in custody, the death of a person who was escaping or attempting to escape from custody or detention, or the death of a person that occurred whilst a police officer, correctional officer, mental health officer or prescribed person was attempting to detain that person.\textsuperscript{15} The Tasmanian legislation\textsuperscript{16} does not, however, specifically include the death of a person where the death is contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention.

1.7 South Australia

The definition of “reportable death” in South Australia refers to the death of a person in custody.\textsuperscript{17} The definition of “death in custody” includes the death of a person where there is reason to believe that the death occurred, or a cause of the death, or possible cause of death, arose, or may have arisen, while the person was being detained, was in the process of being apprehended, evading apprehension or escaping or attempting to escape.\textsuperscript{18} This definition arguably covers deaths caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in custody even after release.

1.8 Northern Territory

The definition of a “reportable death” in Northern Territory legislation includes the death of a person who immediately before death was a person held in care or custody, or that was caused or contributed to by injuries sustained whilst the person was held in custody.\textsuperscript{19} There is no specific reference to the death of a person whose death is caused or contributed to by lack of care whilst in custody however this may be still be caught. The definition also includes any person who is in the process of being taken into custody or escaping from custody or detention.\textsuperscript{20}

1.9 Further commentary on Recommendation 6

Only four States (the Northern Territory,\textsuperscript{21} Victoria,\textsuperscript{22} South Australia\textsuperscript{23} and the Australian Capital Territory\textsuperscript{24}) have expanded their definition of a “death in custody” to specifically include a death that has occurred as a result of an injury sustained whilst in custody.\textsuperscript{25}

\textsuperscript{15} Coroners Act 1995 (Tas), s 3 (definition of ‘reportable death’).
\textsuperscript{16} Coroners Act 1995 (Tas).
\textsuperscript{17} Coroners Act 2003 (SA), s 3 (definition of ‘reportable death’).
\textsuperscript{18} Ibid, (definition of ‘death in custody’).
\textsuperscript{19} Coroners Act 1993 (NT), s12.
\textsuperscript{20} Ibid, ss 12(1), (1A).
\textsuperscript{21} Ibid, s 12(1)(a)(viii) (definition of ‘reportable death’).
\textsuperscript{22} Coroners Act 2008 (Vic), s 3(1)(k) (definition of ‘person placed in custody or care’).
\textsuperscript{23} Coroners Act 2003 (SA), s 3(1) (definition of ‘death in custody’).
\textsuperscript{24} Coroners Act 1997 (ACT), s 3C(2).
\textsuperscript{25} In Western Australia, it could be argued that this is covered in section 3 of the Coroners Act 1996 (WA) which provides that a ‘reportable death’ means a death “that appears to have been caused or contributed to while the person was held in care”.
There remains a universal failure to expressly legislate for a death occurring where a person’s death is caused or contributed to by a lack of proper care whilst in custody, although this ‘special duty’ is recognised under common law authority.  

2. Role of Coroners (Recommendations 7 – 18)

The RCIADIC recommended expanding the coronial inquiry from a traditional, narrow determination of the cause of death, to a more comprehensive, modern inquest. It was envisaged that a new approach would increase the likelihood of identifying operative factors contributing to a death in custody. This would enable a Coroner to make constructive remedial recommendations to encourage action to prevent future deaths in similar circumstances.

To ensure a comprehensive post-death investigation has taken place, the RCIADIC made a number of recommendations.

**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.

2.1 Commonwealth

There is no overriding Commonwealth legislation.

2.2 New South Wales

The Coroners Act 2009 (NSW) governs the coronial process in each State and Territory. In New South Wales, a senior Coroner (being a State Coroner or a Deputy State Coroner) has jurisdiction to hold an inquest concerning a death in custody.

2.3 Queensland

In Queensland, a death in custody must be investigated by the State Coroner, the Deputy State Coroner, or an appointed Coroner or local Coroner, approved by the Governor in Council, on the recommendation of the Chief Magistrate in consultation with the State Coroner.

2.4 Australian Capital Territory

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26 Common law authority recognises the special role of an inquest when someone dies in a situation where they are dependent upon or subject to the control of the State. See also Coroners Act 1996 (WA), s 3 (definition of ‘reportable death’).

27 Commonwealth, Royal Commission into Aboriginal Deaths in Custody, National Report (1991), ch 4, [4.2.8-4.2.11].

28 Coroners Act 2009 (NSW), ss 22-23.


3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In the Australian Capital Territory, a Coroner must hold an inquest into the manner and cause of death of a person who dies in custody.\textsuperscript{30}

2.5 Tasmania

In Tasmania, a Coroner has jurisdiction to investigate, and must hold an inquest into, the death of a person held in custody.\textsuperscript{31}

2.6 South Australia

In South Australia, the Coroners Court, constituted of a Coroner, must hold an inquest to ascertain the cause or circumstances of a death in custody.\textsuperscript{32}

2.7 Northern Territory

In the Northern Territory, a Coroner has jurisdiction to investigate, and must hold an inquest into a death in custody.\textsuperscript{33}

2.8 Victoria

In Victoria, a Coroner must investigate reportable deaths,\textsuperscript{34} which include all deaths in custody.\textsuperscript{35} However, the legislation does not provide that the person holding the office of State Coroner is responsible for inquiries into deaths in custody, and there is no publicly available statement of policy in this regard.

2.9 Western Australia

In Western Australia, a Coroner has jurisdiction to investigate, and must hold an inquest into, a death of a person who immediately before death was a person held in care.\textsuperscript{36}

2.10 Further commentary on Recommendation 7

Only the New South Wales and Queensland Governments have taken steps to implement this Recommendation. Although the legislation in the other States and Territories provide a statutory power to direct coronial investigations into deaths in custody, the State Coroner, or in any State or Territory where a similar office does not exist, a Coroner specially designated for the purpose, does not have direct responsibility for the investigation.

\textbf{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.

\textsuperscript{30} Coroners Act 1997 (ACT), s 13(1)(k).
\textsuperscript{31} Coroners Act 1995 (Tas), ss 21, 24.
\textsuperscript{32} Coroners Act 2003 (SA), ss 21, 29.
\textsuperscript{33} Coroners Act 1993 (NT), ss 14-15.
\textsuperscript{34} Coroners Act 2008 (Vic), s 15.
\textsuperscript{35} Ibid, s 4(2)(c).
\textsuperscript{36} Coroners Act 1996 (WA), ss 19, 22.
The RCIADIC recommended that the State Coroner develop a protocol and issue guidelines for coronial inquiries into deaths in custody.\(^{37}\) It is not clear whether this Recommendation has been implemented in each State and Territory, as currently very limited information is publically available.

### 2.11 Queensland

The *Coroners Act 2003* (Qld) requires the State Coroner to issue guidelines to all Coroners about the performance of their functions in relation to investigations generally.\(^{38}\) The guidelines must deal with the investigation of deaths in custody and, when preparing the guidelines, the State Coroner must have regard to the Recommendations of the RCIADIC.\(^{39}\) The State Coroner’s functions also include issuing directions about the investigation of deaths.\(^{40}\) The Queensland Government has made the *State Coroner’s Guidelines 2013* publicly available on the Queensland Coroner’s website.\(^{41}\) The *State Coroner’s Guidelines 2013* are detailed and cover a wide range of coronial issues (including, amongst others, preliminary investigations, autopsies, and the rights of families). It also appears they are current, with updated versions of some chapters being released as recently as 2013.

### 2.12 Victoria

Recommendation 8 has been partially implemented in Victoria where the Coroners Court of Victoria has issued several practice directions pursuant to the *Coroners Act 2008* (Vic), including Practice Direction 4 in relation to ‘police contact deaths’. Practice Direction 4 applies where a death occurs in circumstances involving police custody, which includes a death of a person in police custody or the custody of a protective services officer, the death of a person placed in custody or care who is dying from an injury incurred while in custody and where a member of the police force’s conduct immediately preceding the death requires further investigation by the Coroner.\(^{42}\)

### 2.13 New South Wales

In New South Wales, the functions of the State Coroner include issuing guidelines to Coroners to assist them in the exercise or performance of their functions.\(^{43}\) The State Coroner may also give directions to a Coroner concerning investigations to be

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\(^{38}\) *Coroners Act 2003* (Qld), s 14(1)(b).  
\(^{39}\) Ibid, s 14.  
\(^{40}\) Ibid, s 71(1)(f).  
\(^{43}\) *Coroners Act 2009* (NSW), s 10(d).
carried out for the purposes of any coronial proceedings or proposed coronial proceedings.\textsuperscript{44}

It is not possible to comment on whether the Recommendation has been fully implemented as the New South Wales Government has not made any guidelines publicly available.

\subsection*{2.14 Tasmania}

In Tasmania, the functions of the Chief Magistrate include issuing guidelines to Coroners to assist them to carry out their duties.\textsuperscript{45} The Chief Magistrate may also give directions to a Coroner about an investigation into a death (other than an inquest) and the manner of conducting it.\textsuperscript{46}

It is not possible to comment on whether the Recommendation has been fully implemented as the Tasmanian Government has not made any guidelines publicly available.

\subsection*{2.15 Western Australia}

The \textit{Coroners Act 1996} (WA) requires the State Coroner to issue guidelines with respect to the principles, practices and procedures of the State coronial system, including guidelines relating to the functions of Coroners, Coroner’s clerks and Coroner’s investigators and the manner in which those functions are to be carried out.\textsuperscript{47} With the prior approval of the Chief Magistrate, the State Coroner may also give directions to a Coroner about investigations into deaths generally and the manner in which they are to be conducted.\textsuperscript{48} A discussion paper issued by the Law Reform Commission of Western Australia indicates that the State Coroner issued guidelines for the investigation of deaths of prisoners in the custody of the Ministry of Justice in 1997, however, it is not possible to comment on the adequacy of these guidelines as they have not been made publicly available.\textsuperscript{49}

Legislation in other States and Territories do not impose on Coroners any express obligation to develop a protocol for the conduct of coronial inquiries into deaths in custody.

\subsection*{2.16 Further commentary on Recommendation 8}

Queensland is commended for being the first jurisdiction to publish comprehensive guidelines and it is recommended that all jurisdictions follow this example. Guidelines are crucial to streamline the process, improve understanding of the

\begin{itemize}
\item \textsuperscript{44} Ibid, s 51(1).
\item \textsuperscript{45} \textit{Coroners Act 1995} (Tas), s 7(g).
\item \textsuperscript{46} Ibid, s 22.
\item \textsuperscript{47} \textit{Coroners Act 1996} (WA), s 58.
\item \textsuperscript{48} Ibid, s 21.
\end{itemize}
coronial system\textsuperscript{50} and to facilitate uniformity of approach.\textsuperscript{51} Furthermore, without publishing this material, there is a real risk that people who should be aware of any coronial guidelines (such as families of the deceased, lawyers, police officers and even regional Coroners themselves) may not have knowledge of their existence.\textsuperscript{52}

**Recommendation 9:** That a Coroner inquiring into a death in custody be a Stipendiary Magistrate or a more senior judicial officer.

To ensure a proper legal process takes place and to gain public confidence, the RCIADIC recommended that a death in custody inquiry should be dealt with by a Coroner of at least a stipendiary magistrate level.\textsuperscript{53} Status equivalent to a judge is vital to not only elevate the status and authority of the jurisdiction but also to ensure the process is effectively managed.

This Recommendation has not been consistently implemented by all Australian States and Territories.

2.17 Commonwealth

There is no relevant Commonwealth legislation.

2.18 New South Wales

In New South Wales, a 'senior Coroner', being any Coroner who holds office as the State Coroner or Deputy State Coroner, has exclusive jurisdiction to hold an inquest concerning a death in custody.\textsuperscript{54} A person is qualified to be appointed as the State Coroner or Deputy State Coroner only if they are a Magistrate.\textsuperscript{55}

2.19 Australian Capital Territory

In the Australian Capital Territory, only the Chief Coroner, being the person for the time being occupying the office of Chief Magistrate, can hold an inquest into a death in custody.\textsuperscript{56}

2.20 Queensland

\textsuperscript{50} Coroner's Court of Western Australia, *Inquest Hearings in Western Australia* <http://www.coronerscourt.wa.gov.au/_files/Inquest_Hearings_WA.pdf>.
\textsuperscript{51} The importance of issuing coronial guidelines has been highlighted in England and Wales, where Judge Peter Thornton QC was appointed as the first Chief Coroner in 2012 and has indicated that he will issue guidance to Coroners through practice directions and a set of national standards to provide leadership, clarity and a degree of consistency to the coronial process. See Courts and Tribunals Judiciary, *Appointment of Chief Coroner* <http://www.judiciary.gov.uk/media/media-releases/2012/appt-chief-Coroner/>.\textsuperscript{52}
\textsuperscript{54} *Coroners Act 2009* (NSW), s 23.
\textsuperscript{55} Ibid, ss 7, 22.
\textsuperscript{56} *Coroners Act 1997* (ACT), ss 6, 9(2).

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Queensland, a death in custody must be investigated by the State Coroner, the Deputy State Coroner, or an appointed Coroner or local Coroner. The Governor in Council may appoint a magistrate as the State Coroner or the Deputy State Coroner, and every magistrate is a local Coroner.\(^57\)

2.21 Western Australia

In Western Australia, every magistrate is contemporaneously a Coroner and has jurisdiction to investigate a death in custody.\(^58\) The Attorney-General, on the recommendation of the State Coroner, may also appoint a person to be a Coroner if that person is eligible to be appointed as a magistrate.\(^59\)

2.22 Northern Territory

In the Northern Territory, a Coroner, being a person who is a magistrate, has jurisdiction to investigate a death in custody and this function cannot be delegated under the Coroners Act 1993 (NT).\(^60\)

2.23 South Australia

In South Australia, an inquest into a death in custody is held by the Coroner's Court which is constituted of a Coroner.\(^61\) In addition to each magistrate being a Coroner, the Governor may appoint a legal practitioner of at least 5 years standing to be a Coroner.

Accordingly, the Recommendation has not been implemented in South Australia.\(^62\)

2.24 Tasmania

In Tasmania, all magistrates are Coroners and have jurisdiction to investigate a death in custody. However, “persons” are also eligible for appointment by the Governor as a Coroner and the Coroners Act 1995 (Tas) does not prescribe the skills and experience necessary for appointment.\(^63\) Further, a Coroner may delegate its functions to a Coroner's associate (e.g. a State Service officer or employee appointed by the Secretary of the Department of Justice or a police officer appointed by the Chief Magistrate).\(^64\)

Accordingly, the Recommendation has not been implemented in Tasmania.

\(^{57}\) Coroners Act 2003 (Qld), ss 70, 79, 82.
\(^{58}\) Coroners Act 1996 (WA), s 11.
\(^{59}\) Ibid.
\(^{60}\) Coroners Act 1993 (NT), ss 4, 6(4)(a).
\(^{61}\) Coroners Act 2003 (SA), s 14.
\(^{62}\) Ibid, ss 4-6.
\(^{63}\) Coroners Act 1995 (Tas), s 10.
\(^{64}\) Ibid, s 13.
2.25 Victoria

In Victoria, a death in custody must be investigated by the State Coroner, the Deputy State Coroner, or an Acting Coroner. The State Coroner must be a judge of the County Court and the Deputy State Coroner and Acting Coroner must be a magistrate. The State Coroner and the Chief Magistrate may jointly appoint a magistrate or reserve magistrate to be a Coroner or the Deputy State Coroner.

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.

2.26 Commonwealth

There is no relevant Commonwealth legislation.

2.27 Tasmania and Northern Territory

The relevant legislation in Tasmania and the Northern Territory imposes on the person in whose custody the deceased was held a specific duty to report the death.

2.28 Victoria

The Coroners Act 2008 (Vic) imposes a similar duty on a “responsible person”, being the person who had care, control or custody of the deceased, to report to a Coroner (or the Victorian Institute of Forensic Medicine who must refer such a report to a Coroner as soon as practicable). The Coroners Act 2008 (Vic) does not contain a detailed provision for determining who, for the purposes of the reporting obligation, is the individual that had care, control or custody of the deceased person.

2.29 Australian Capital Territory

The Coroners Act 1997 (ACT) does not impose any express obligation in relation to the reporting of deaths in custody, however, a custodial officer commits an offence under the Act if they fail to report a death without reasonable grounds.

2.30 Queensland, South Australia, Western Australia and New South Wales

The legislation in Queensland, South Australia, Western Australia and New South Wales imposes on “a person” (rather than a custodial authority specifically) an

65 Coroners Act 2008 (Vic), s 52(2)(b).
66 Ibid, ss 91, 92.
67 Coroners Act 2008 (Vic), s 93.
68 Coroners Act 1995 (Tas), s 19; Coroners Act 1993 (NT), s 12(5).
69 Coroners Act 2008 (Vic), s 11.
70 Coroners Act 1997 (ACT), s 78.
express obligation in relation to the reporting of deaths unless the person has reasonable grounds to believe that a death has already been reported. 71

2.31 Further commentary on Recommendation 10

The language used to limit the time to report is not consistent across each jurisdiction. The various legislative provisions provide that a death must be reported as follows:

a. "immediately" (Queensland, South Australia and Western Australia);

b. "as soon as possible" (New South Wales, Northern Territory and Tasmania);

c. "as soon as practicable" (Australian Capital Territory); and

d. "without delay" (Victoria).

In practice, there is little or no difference between the requirement to report "immediately", "as soon as possible", "as soon as practicable" or "without delay". Therefore, each of the States and Territories has taken steps to implement this Recommendation.

Recomendation 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 the 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.

2.32 Commonwealth

Recommendation 11 does not appear to be explicitly legislated by the Commonwealth.

2.33 Australian Capital Territory

In the Australian Capital Territory, a Coroner must hold an inquest into the manner and cause of death of a person who dies in custody. 72 A hearing must 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 or part of it take place in private. 73 This is not as high a standard as referred to in Recommendation 11, which is that "unless there are compelling reasons to justify a different approach, the inquest should be conducted in public hearings". With respect to the Recommendation that "a full record of the evidence should be taken at the inquest and retained", the Registrar must keep a record of the inquest for a period of no less than 7 years after the completion of the inquest. 74 Further, the legislation is not clear as to whether the obligation with respect to keeping a "record of the inquest" includes evidence.

71 Coroners Act 2009 (NSW), s 35; Coroners Act 2003 (Qld), s 7(3); Coroners Act 2003 (SA), s 28; Coroners Act 1996 (WA), s 17.

72 Coroners Act 1997 (ACT), s 13(1)(k).

73 Ibid, s 40.

74 Coroners Act 1997 (ACT), s 73.
Accordingly, the effect of the existing Australian Capital Territory legislation is likely to practically satisfy Recommendation 11.

2.34 New South Wales

In New South Wales, a senior Coroner (being the State Coroner or a Deputy State Coroner) is required to hold an inquest concerning a death in custody.\(^{75}\) Any hearing in coronial proceedings is to be open to the public unless the Coroner is of the opinion that special circumstances make it necessary or desirable not to.\(^{76}\) Further, a Coroner may, if of the opinion that it would be in the public interest to do so, clear the Court and prevent the publication of evidence or submissions.\(^{77}\) This is a different standard than the standard proposed in Recommendation 11, which is that there must be “compelling reasons” to justify a different approach. The Coroner is required to ensure that evidence given by every witness in the proceedings is recorded.\(^{78}\)

Accordingly, the legislation in New South Wales is likely to practically satisfy Recommendation 11, although the Coroner has more discretion than appears to have been anticipated in Recommendation 11.

2.35 Northern Territory

In the Northern Territory, a Coroner must hold an inquest into a death in custody.\(^{79}\) A Coroner must conduct an inquest in open Court, but has broad discretion to exclude all or any persons from an inquest where the Coroner thinks fit for the administration of justice, national security or personal security.\(^{80}\) A Coroner or a Coroner’s clerk must keep a record of findings, evidence and comments in relation to each investigation into a death.\(^{81}\) Similarly, the Coroner’s power to restrict the publication of evidence given at an inquest is broad and includes if a Coroner reasonably believes that to publish the evidence would involve the disclosure of details of sensitive personal matters.\(^{82}\) In this regard, the Northern Territory legislation goes further than the provisions in the New South Wales legislation which only allow non-publication if the death was self-inflicted.\(^{83}\)

Accordingly, Recommendation 11 is only partially implemented in the Northern Territory. Legislative change to remove some of the Coroner’s discretions would be needed for Recommendation 11 to be fully implemented.

2.36 South Australia

\(^{75}\) *Coroners Act 2009 (NSW)*, ss 23, 27(1)(a).

\(^{76}\) Ibid, s 47.

\(^{77}\) Ibid, s 74.

\(^{78}\) Ibid, s 65.

\(^{79}\) *Coroners Act 1993 (NT)*, ss 14, 15.

\(^{80}\) Ibid, s 42.

\(^{81}\) Ibid, s 11.

\(^{82}\) Ibid, s 43.

\(^{83}\) *Coroners Act 2009 (NSW)*, s 75.

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In South Australia, the Coroners Court must hold an inquest to ascertain the cause or circumstances of a death in custody. Inquests held by the Coroners Court must be open to the public, however the Court may also exercise the powers conferred on the Court under Part 8 of the Evidence Act 1929 (SA) relating to clearing Courts and suppressing publication of evidence if it considers it desirable to do so in the interests of national security. Accordingly, this discretion which the Court holds applies a different standard to the standard referred to in Recommendation 11, which is that "unless there are compelling reasons to justify a different approach, the inquest should be conducted in public hearings". With respect to the Recommendation that "a full record of the evidence should be taken at the inquest and retained", we note that the Coroners Court is a 'court of record', and the State Coroner must, on application by a member of the public, allow the applicant to inspect or obtain a transcript of evidence taken by the Court or the written findings and any recommendations of the Court.

Accordingly, Recommendation 11 is implemented in South Australia (with the exception that the Coroners Court holds a discretion with respect to conducting open hearings in certain circumstances).

2.37 Tasmania

In Tasmania, a Coroner has jurisdiction to investigate, and must hold an inquest into, the death of a person held in custody. If a person is charged with an offence, the Coroner must adjourn the inquest until after the conclusion of the proceedings with respect to any of those offences. If the Coroner decides not to resume an inquest at the conclusion of the criminal proceedings the Coroner must inform the Attorney-General in writing. A Coroner is to conduct an inquest in open Court, however, a Coroner may order the exclusion of any or all persons if the Coroner consider that it is in the interests of the administration of justice, national security or personal security. This standard is different to the standard proposed in Recommendation 11, which is that there must be 'compelling reasons' to justify a different approach. A Coroner may also restrict the publication of a report of an inquest or any evidence given at an inquest if the Coroner reasonably believes, amongst other things, that it would involve the disclosure of details of sensitive personal matters. Although a Coroner or the Coroner's associate is required to keep a record of each investigation into a death, the Coroner can make such orders as it thinks fit for the custody of each article tendered in evidence at the inquest.

Accordingly, the discretions held by the Coroner result in Recommendation 11 only being partially implemented in Tasmania.

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84 Coroners Act 2004 (SA), s 21.
85 Ibid, s 19.
86 Ibid, s 11.
87 Ibid, s 37.
88 Coroners Act 1995 (Tas), ss 21, 24.
89 Ibid, s 25.
90 Ibid, s 56.
91 Ibid, s 57.
92 Ibid, ss 29, 61.
2.38 Victoria

In Victoria, a Coroner must hold an inquest into any death that he or she is investigating if the deceased was, immediately before death, in custody.93 An inquest is a public inquiry that is held by the Coroners Court in respect of a death.94 The governing legislation does not contain an express provision empowering the Coroners Court to conduct an inquest otherwise than in public. Assuming that the Coroners Court has an inherent or implied power to do so, the common law test to allow departure from the principle of open justice is a real necessity to secure the proper administration of justice.95 This is likely to overlap significantly with the test set out in the Recommendation. Oral evidence provided at the inquest must be recorded in accordance with section 131 of the Evidence (Miscellaneous provisions) Act 1958 (Vic). There does not appear to be any published rule or policy as to the retention of recorded evidence.

2.39 Western Australia

In Western Australia, a Coroner must hold an inquest into a death in custody.96 Inquests are public hearings and are required to be advertised, although a Coroner may order the exclusion from an inquest of all or any persons if the Coroner reasonably believes it is in the interests of any person, of the public or of justice.97 A Coroner or the Coroner’s registrar must keep a record of each investigation into a death and evidence given at an inquest must be recorded in writing or by sound recording apparatus.98 Accordingly, the legislation in Western Australia is likely to practically satisfy Recommendation 11.

2.40 Queensland

In Queensland, a Coroner must hold an inquest if the Coroner considers the death is a death in custody.99 An inquest must be held by the Coroners Court in open Court, except when the Coroner orders the Court to be closed while particular evidence is given.100 In advance of the inquest, the Coroner must publish details of the hearing date and matters to be investigated in a state-circulated newspaper and on the Coroner’s website.101 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

93 Coroners Act 2008 (Vic), s 52(2)(b).
94 Ibid, s 3.
96 Coroners Act 1996 (WA), s 22.
97 Ibid, ss 39, 45.
98 Coroners Act 1996 (WA), ss 26, 48.
99 Coroners Act 2003 (Qld), s 27.
100 Ibid, s 31.
101 Ibid, s 32.

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Evidence Act 1962 (Qld). Anyone is entitled to obtain a copy of the record under that Act. Accordingly, the legislation in Queensland is likely to practically satisfy Recommendation 11.

**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.

### 2.41 Northern Territory, Western Australia, Tasmania and Australian Capital Territory

Recommendation 12 has only been implemented in full in the Northern Territory\(^\text{103}\), Western Australia\(^\text{104}\), Tasmania and the Australian Capital Territory\(^\text{105}\).

### 2.42 South Australia

In South Australia, there has been partial implementation of Recommendation 12. The State Coroner is simply required to set out the "cause and circumstances of the death".\(^\text{106}\) Consequently, if the quality of care, supervision and treatment are not directly relevant to the cause and circumstances of death, the Coroner has no statutory obligation to examine those subjects.

### 2.43 Victoria, Queensland and New South Wales

In Victoria\(^\text{107}\), Queensland\(^\text{108}\) and New South Wales\(^\text{109}\), the Coroner has the discretion, but not a legal obligation, to review the underlying causes of a death. This leaves it open for the individual Coroner to decide how thoroughly to investigate and, as a result, can allow for inconsistencies to develop in coronial practice.

Death in custody investigations by Queensland's coronial service have, however, been boosted by assistance provided by the Crime and Corruption Commission Queensland ('CCC')\(^\text{110}\) (formerly the Crime and Misconduct Commission).\(^\text{111}\) The CCC currently attends to the initial investigation of all police-related deaths and provides independent oversight regarding the probity and sufficiency of the investigation.\(^\text{112}\)

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\(^{102}\) Ibid, s 38.  
\(^{103}\) Coroners Act 1993 (NT), s 12(1)(A).  
\(^{104}\) Coroners Act 1996 (WA), s 25(3).  
\(^{105}\) Coroners Act 1997 (ACT), s 74.  
\(^{106}\) Coroners Act 2003 (SA), s 25(1).  
\(^{107}\) Coroners Act 2008 (Vic), s 67(3).  
\(^{108}\) Coroners Act 2003 (Qld), s 46(1).  
\(^{109}\) Coroners Act 2009 (NSW), s 82.  
\(^{112}\) Ibid.
**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.

2.44 **Australian Capital Territory**

The Coroner is required to investigate the manner and cause of death of a person who dies in custody and must find, if possible, the person's identity, when and where the death happened, the manner and cause of the death. Accordingly, the Coroner is required to make findings as to a death in custody which it is required to investigate.

However, while the objects of the legislation include allowing a Coroner to make recommendations about the prevention of deaths, the legislation only specifically empowers the Coroner to make recommendations as would improve public safety. Whilst "preventing further custodial deaths" may be read to be fall within "improving public safety", the legislation does not clearly and unambiguously reflect the full desired scope of Recommendation 13.

Further, the legislation does not appear to permit the Coroner to make such recommendations on other matters as he or she deems appropriate. This is because the express power for the Coroner to make recommendations is tied to the improvement of public safety.

2.45 **New South Wales**

A stated object of the legislation is to enable Coroners to investigate certain deaths to determine the identities of deceased persons, times, dates and the manner of deaths in custody. Accordingly, the Coroner is required to investigate such deaths and record in writing its findings. Whilst the Coroner is not required to make any recommendations, the Coroner may make such recommendations as it considers necessary or desirable in relation to any matter connected with the death.

Accordingly, Recommendation 13 is only partially implemented in New South Wales.

2.46 **Northern Territory**

A Coroner must hold an inquest into a death in custody. The Coroner is required (if possible) to make findings regarding the identity of the deceased person, time and

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113 Coroners Act 1997 (ACT), s 13(1).
114 Ibid, s 52(1).
115 Ibid, s 52.
116 Ibid, s 3BA(1)(d)(i).
117 Coroners Act 1997 (ACT), s 57(3)(c).
118 Ibid, ss 3BA(1)(d)(i), 57.
119 Coroners Act 2009 (NSW), ss 3, 23, 27, 81.
120 Ibid, s 82.
121 Coroners Act 1993 (NT), ss 14, 15.

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place of death, cause of death and any relevant circumstances concerning the death. The Coroner, as he or she considers relevant, is required to make recommendations with respect to the prevention of future deaths in similar circumstances. The Coroner is also able to comment on matters including "public health or safety or the administration of justice".

Accordingly, Recommendation 13 is implemented in the Northern Territory.

2.47 South Australia

The Coroners Court is required to hold an inquest as to the cause or circumstance of a death in custody and to give its findings. The Coroners Court is not required to make recommendations, but rather may make recommendations which, in the opinion of the Court, might prevent, or reduce the likelihood of, a recurrence of a similar event that was the subject of the inquest.

Accordingly, Recommendation 13 is only partially implemented in South Australia.

2.48 Tasmania

The Coroner is required to hold an inquest to investigate a death in custody. The Coroner is required to make (if possible) certain findings in respect of the death. The Coroner must make recommendations (where appropriate) with respect to ways of preventing further deaths and on any other matter that the Coroner considers appropriate. In addition, the Coroner must report on the care, supervision or treatment of the person while in custody, and has discretion to comment on any other matter connected with the death.

Accordingly, Recommendation 13 is implemented in Tasmania.

2.49 Western Australia

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.

Accordingly, Recommendation 13 is only partially implemented in Western Australia.

2.50 Victoria

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122 Ibid, s 34(1).
123 Ibid, s 26(2).
124 Ibid, s 34(2).
125 Coroners Act 2003 (SA), ss 21(1)(a), 25.
126 Coroners Act 1995 (Tas), ss 24, 28.
127 Ibid, s 28(2).
128 Ibid, s 28.
129 Coroners Act 1996 (WA), s 25.
130 Ibid, ss 22, 25(2).
131 Ibid, s 25(3).
The obligation on the Coroner is to find, if possible, the identity of the deceased, the cause of death and the circumstances in which the death occurred. The obligation to make findings or recommendations does not extend beyond this. However, a Coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice, and he or she may make recommendations to any Minister, public statutory authority or entity on any such matter. The power to make recommendations can allow a Coroner, within the context of an inquest, to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death. Of particular relevance to the power to make recommendations is the assistance provided to Coroners in Victoria by the Coroners Prevention Unit (‘CPU’). The CPU assists Coroners fulfil their prevention role and contribute to a reduction in preventable deaths, including by assisting to develop coronial recommendations. Details of the activities of the CPU are given in the Annual Report of the Coroners Court of Victoria and in the Coroners Court of Victoria Practice Handbook.

2.51 Queensland

All deaths in custody must undergo an inquest conducted by the State Coroner or the Deputy State Coroner. The Coroner must, if possible, find who the deceased person is, how the deceased person died, when the deceased person died, where the person died and what caused the person to die. 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.

The State Coroner’s Guidelines direct that the breadth of investigations into deaths in custody should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention before determining immediate cause of death and whether it occurred as a result of criminal behaviour. The care, treatment and supervision afforded to the deceased should be examined and a determination should made as to 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.

Accordingly, Recommendation 13 is only partially implemented in Queensland.

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132 Coroners Act 2008 (Vic), s 67(1).
133 Ibid, s 67(3).
134 Ibid, s 72(2).
136 Coroners Act 2003 (Qld), ss 11(2), 27(1).
137 Ibid, s 11(7).
138 Ibid, s 45(2).
139 Ibid, s 46(1).
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.

2.52 South Australia

The Coroner’s Court must, as soon as practicable after the completion of the inquest, forward a copy of its findings and any recommendations to the Attorney-General, to each relevant Minister or other agency or instrumentality of the Crown, 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 matter.141

Accordingly, Recommendation 14 is implemented in South Australia.

2.53 Australian Capital Territory

The Coroner must report the findings to the Attorney-General, the custodial agency in whose custody the death happened, the responsible Minister and any other person who the Coroner considers appropriate.142 The Coroner must also make available a copy of a report of the findings to a witness who appeared at an inquest into the death.143

Accordingly, Recommendation 14 is implemented in the Australian Capital Territory.

2.54 New South Wales

While the Coroner must record in writing the Coroner’s findings,144 there is no requirement to provide a copy of the findings to the persons specified in Recommendation 14. There is also no requirement to provide a copy of the recommendations to all parties who appeared at the inquest.145

2.55 Northern Territory

The Coroner must notify the senior next of kin of the deceased person and may notify any person of the decision, including the reasons.146 The Coroner must also cause a copy of its recommendations to be sent to the Attorney-General147 and may report its findings to the Attorney-General.148

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141 Coroners Act 2003 (SA), s 25(4).
142 Coroner Act 1997 (ACT), s 75(1).
143 Ibid, s 75(2).
144 Coroner Act 2009 (NSW), s 81(1).
145 Ibid, s 82(4).
146 Coroner Act 1993 (NT), s 16.
147 Ibid, s 27.
148 Ibid, s 35(1).
There is a process for the Attorney-General to inform the relevant government authorities of the findings and the recommendations to enable them to respond. The response then informs the report prepared by the Attorney-General, which it may provide to the Coroner. The Coroner may give a copy of the Attorney-General's report to the senior next of kin of the deceased, a witness who appeared at the inquest and any other person who the Coroner considers has a sufficient interest in the matter.\textsuperscript{149}

2.56 Queensland

Recommendation 14 is generally implemented in Queensland, although there is no requirement to give a copy of the findings or recommendations to "other persons as the Coroner deems appropriate".\textsuperscript{150} However, the Coroner must publish its findings and comments on the State Coroner's website.\textsuperscript{151}

2.57 Victoria

In Victoria, coronial findings and recommendations are legally required to be published on the internet, rather than being given to the relevant parties (although this public publication policy does have other benefits, as discussed further below).\textsuperscript{152}

2.58 Tasmania

The Coroner may report to the Attorney-General on a death which the Coroner investigated.\textsuperscript{153} The Chief Magistrate must report annually to the Attorney-General giving details of deaths of persons held in custody, the findings and recommendations made by Coroners and any other matter that the Chief Magistrate considers appropriate.\textsuperscript{154} A Coroner's findings must be given to a senior next of kin.\textsuperscript{155} A coronial authority may give a person access to a coronial record or provide a person with a copy of a coronial record.\textsuperscript{156}

2.59 Western Australia

The legislative notification provisions are generally inadequate and do not reflect current practice.\textsuperscript{157} Legislation only requires the State Coroner to inform the relevant

\begin{itemize}
  \item\textsuperscript{149} Ibid, ss 46A, 46B.
  \item\textsuperscript{150} Coroners Act 2003 (Qld), ss 45(4), 46, 47.
  \item\textsuperscript{151} Ibid, s 46A.
  \item\textsuperscript{152} Coroners Act 2008 (Vic) s 73(1). In practice, the family of the deceased and other interested parties (as determined by the Coroner) will receive a copy of the Coroner's findings. See Coroners Court of Victoria, Practice Handbook: a legal practitioner's guide to the coronial system in Victoria', p 62.
  \item\textsuperscript{153} Coroners Act 1995 (Tas), s 30(1).
  \item\textsuperscript{154} Ibid, s 69.
  \item\textsuperscript{155} Coroners Rules 2006 (Tas), r 25.
  \item\textsuperscript{156} Ibid, r 26.
  \item\textsuperscript{157} In practice, most coronial recommendations are communicated by the Coroners Court to the relevant agency, entity or minister within one month of the delivery of the inquest finding. See Law Reform Commission of Western Australia, Review of Coronial Practice in Western Australia - Discussion Paper - Project No 100 (June 2011), 169 <http://www.lrc.justice.wa.gov.au/_files/P100-}

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agency of the recommendation and report annually to the Attorney-General.\(^{158}\) For example, there is no obligation to provide copies to the Minster responsible for that agency.\(^{159}\) This severely restricts accountability and is currently under review.\(^{160}\)

**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.

### 2.60 Northern Territory

The Attorney-General is required to give a copy of a report or recommendation from a Coroner that contains comments relating to a government agency to that government agency.\(^{161}\) If a government agency receives a copy of a report or recommendation, the government agency must, within 3 months after receiving the report or recommendation, give to the Attorney-General a written response to the findings in the report or to the recommendation.\(^{162}\) The response must include a statement of the action that the agency is taking, has taken or will take with respect to the Coroner’s report or recommendation.\(^{163}\)

Strictly, Recommendation 15 is only partially implemented in the Northern Territory because the time period of 3 months to respond commences when the government agency receives a copy of the report or recommendation from the Attorney-General, rather than at the time of publication of the findings and recommendations.

### 2.61 Australian Capital Territory

A custodial agency must within 3 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.\textsuperscript{164} 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.\textsuperscript{165} Recommendation 15 is implemented in the Australian Capital Territory.

### 2.62 Victoria

Recommendation 15 is partially implemented in Victoria. A public statutory authority or entity must within 3 months after the date of receipt of a report from the Coroner, provide to the Coroner a written response to the findings contained in the report.\textsuperscript{166} 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.\textsuperscript{167}

### 2.63 Tasmania

A Coroner is empowered to report and make recommendations to the Attorney-General on a death which the Coroner investigated, but is under no obligation to do so (except where the Coroner believes that an indictable offence has been committed).\textsuperscript{168} The Chief Magistrate must prepare and submit to the Attorney-General an annual report which must include details of deaths of persons held in custody and findings and recommendations made by Coroners.\textsuperscript{169}

### 2.64 South Australia

The Coroners 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 Minister.\textsuperscript{170} The Minister must, within 8 sitting days of the expiration of 6 months after receiving a copy of the findings and recommendations cause a report to be laid before each House of Parliament giving details of any action taken or proposed to be taken in consequence of those recommendations and forward a copy to the State Coroner.\textsuperscript{171}

### 2.65 New South Wales

A Minister or government agency that receives a coronial recommendation should, within 6 months, write to the Attorney-General outlining any action being taken to implement the recommendation. If it is not proposed to implement a recommendation, reasons should be given, for example, the recommendation will not achieve the intended outcome, the outcome can be achieved in another way, the recommendation is impractical to implement having regard to the cost and potential

\textsuperscript{164} Coroners Act 1997 (ACT), s 76(1).
\textsuperscript{165} Ibid, s 76(2).
\textsuperscript{166} Coroners Act 2008 (Vic), s 72(3).
\textsuperscript{167} Ibid, s 72(4).
\textsuperscript{168} Coroners Act 1995 (Tas) s 30.
\textsuperscript{169} Ibid, s 69.
\textsuperscript{170} Coroners Act 2003 (SA), s 25(4).
\textsuperscript{171} Ibid, s 25(5).
benefits or there are considerations that make implementation of the recommendation not feasible.\textsuperscript{172}

2.66 Western Australia

Within 6 calendar months of the publication of the findings of the Coroner, the Deputy Commissioner Adult Custodial must provide a report to the Minister in response to the findings. The report must include comment as to any action taken or proposed as a result of the findings.\textsuperscript{173}

2.67 Queensland

The Queensland Police Service (‘QPS’) ‘Operational Procedures Manual’\textsuperscript{174} mandates that the investigating officer of a death in custody must provide a report responding to any relevant issues raised by the Coroner. This report is presented to the officer in charge of the region, and the officer in charge of the Health and Safety Section, Organisational Safety and Wellbeing "within a reasonable time and in any event, not later than two months of publication of those findings." The officer in charge of the region must forward the report to the Police Commissioner so a report reflecting the Service’s response to the findings and recommendations, including whether any action has been taken or is proposed to be taken with respect to any person, can be forwarded to the Minister for Police and the Chief Executive Officer of the Department of Justice and Attorney-General within three months of publication of the findings. The report is consolidated by the Department of Justice and Attorney-General with other reports from any other government agency involved to provide a whole-of-government response.

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.

2.68 Northern Territory

After the Attorney-General receives a response from a government agency, the Attorney-General:

\begin{itemize}
  \item a. must report on the Coroner’s report or recommendation and the response to the Coroner’s report or recommendation;
\end{itemize}

\textsuperscript{172} Department of Premier and Cabinet (NSW), Responding to Coronial Recommendations, Policy M2009-12 (June 2009).


b. may give a copy of the report to the Coroner; and

c. must lay a copy of the report before the Legislative Assembly within 3 sitting days after completing the report.\textsuperscript{175}

The Coroner may give a copy of the Attorney-General’s report to the senior next of kin of the deceased, a witness who appeared at the inquest and any other person who the Coroner considers has sufficient interest in the inquest or investigation.\textsuperscript{176}

The Territory Coroner is not expressly empowered to call for further explanations or information.

\textbf{2.69 South Australia}

The relevant Minister is not required to provide copies of responses to the persons specified in Recommendation 16. The Coroners Court is not expressly empowered to call for further explanations of information.

\textbf{2.70 Australian Capital Territory}

The Minister must give a copy of the response to the Coroner in relation to whose findings the report relates.\textsuperscript{177} The Coroner must give a copy of the response to a member of the immediate family of the deceased or a representative of that member and a witness who appeared at an inquest into the death.\textsuperscript{178}

The Chief Coroner is not expressly empowered to call for further explanations or information.

\textbf{2.71 Victoria}

The Coroner must publish responses of a public authority or entity on the internet and provide a copy of the response to any person who has notified the principal registrar that they have an interest in the subject of the recommendations, or who is deemed by the principal registrar to have a sufficient interest in the subject of the recommendations.\textsuperscript{179} However, the relevant Minister is not expressly required to provide copies of responses to the persons specified in Recommendation 16. The State Coroner is not expressly empowered to call for further explanations or information.

\textbf{2.72 Tasmania}

The legislation does not impose any obligations on the Attorney-General to provide copies of any response to the persons specified in Recommendation 16. The Chief Magistrate is not expressly empowered to call for further explanations or information.

\textsuperscript{175} Coroners Act 1993 (NT), s 46B(3).
\textsuperscript{176} Ibid, s 46B(4).
\textsuperscript{177} Coroners Act 1997 (ACT), s 76(3).
\textsuperscript{178} Ibid, s 76(4).
\textsuperscript{179} Coroners Act 2008 (Vic), s 72(5).
2.73 New South Wales

The relevant Ministers are not required to provide copies of any response to the persons specified in Recommendation 16. However, the Attorney-General must maintain a record of all coronial recommendations together with the responses received from Ministers and New South Wales government agencies. The Attorney-General must arrange for a request to be posted on the department’s website in June and December of each year summarising coronial recommendations made and responses received from Ministers and agencies. The Attorney-General must also send a copy of the report to the State Coroner.180

The State Coroner is not expressly empowered to call for further explanations or information.

2.74 Western Australia

There is no obligation on the relevant Ministers to provide copies of any response to the persons specified in Recommendation 16. The State Coroner is not expressly empowered to call for further explanations or information.

2.75 Queensland

The consolidated report prepared by the Department of Justice and Attorney-General must be provided to all other parties appearing at the coronial inquest.181

The State Coroner is not expressly empowered to call for further explanations or information.

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.

2.76 South Australia

On or before 31 October in each year, the State Coroner must make a report to the Attorney-General on the administration of the Coroners Court and the provision of coronial services during the previous financial year. The report must include all recommendations made by the Coroners Court. The Attorney-General must, within 12 sitting days after receiving the report, cause copies of the report to be laid before both Houses of Parliament.182

The legislation does not include an express requirement to include responses to the recommendations in the report.

180 Department of Premier and Cabinet (NSW), Responding to Coronial Recommendations, Policy M2009-12 (June 2009).
182 Coroners Act 2003 (SA), s 39.
2.77 **Queensland**

As soon as practicable after the end of each financial year, the State Coroner must give the Attorney-General a report for the year on the operation of the legislation. The report must also contain a summary of all investigations into deaths in custody. The Attorney-General must table a copy of the report in the Legislative Assembly within 14 sittings days after receiving the report.\(^{183}\)

2.78 **Western Australia**

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 custody. The Attorney-General must cause the report to be laid before each House of Parliament within 12 sittings days after receipt.\(^{184}\)

2.79 **New South Wales**

The State Coroner must make a written report to the Minister containing a summary of the details of the deaths in custody for each calendar year. The report must be made within 4 months after the end of the period to which it relates. The Minister must cause a copy of the report to be tabled in each House of Parliament within 21 days after the request is made.\(^{185}\)

2.80 **Australian Capital Territory**

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 and responses of agencies including correspondence about the responses. 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 6 months after the end of the financial year (subject to extension).

The Attorney-General must present a copy of the report to the Legislative Assembly within 6 sittings days after the day the Attorney-General receives the report.\(^{186}\)

2.81 **Northern Territory**

There is no requirement for the Territory Coroner to report annually in the Northern Territory.

2.82 **Tasmania**

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\(^{183}\) *Coroners Act 2003* (Qld), s 77.

\(^{184}\) *Coroners Act 1996* (WA), s 27.

\(^{185}\) *Coroners Act 2009* (NSW), s 37.

\(^{186}\) *Coroners Act 1997* (ACT), s 102.

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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 the legislation during the preceding financial year. The report must include details of deaths of persons held in custody and findings and recommendations made by the Coroner and may include any other matter the Chief Magistrate considers appropriate. The Attorney-General must cause a copy of the report to be laid on the table of each House of Parliament within 10 sitting days after receiving the report.\(^{187}\)

2.83 Victoria

The State Coroner and the Coronial Council of Victoria must each prepare and submit to the Attorney-General an annual report containing a review of their operations.\(^{188}\) However, there is no express requirement to include details of deaths of persons held in custody. The Attorney-General must cause each annual report submitted to him or her to be laid before each House of Parliament within 7 sitting days after receiving it.\(^{189}\)

**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.

2.84 Northern Territory

A Coroner who holds an inquest into the death of a person held in custody is required to make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers relevant.\(^{190}\) The requirement is therefore a general one and is not specifically related to any reporting requirement.

2.85 Tasmania

There is a general requirement for the Coroner to make recommendations with respect to ways of preventing further deaths.\(^{191}\) A Coroner is also empowered, but not obliged, to make recommendations to the Attorney-General on any matter connected with a death which the Coroner investigated, including public health or safety or the administration of justice.\(^{192}\)

2.86 Australian Capital Territory

There is a general requirement for the Coroner to state whether a matter of public safety is found to arise in connection with an inquest, and if a matter of public safety is found to arise, to comment on the matter.\(^{193}\) In addition, a report by a Coroner to

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\(^{187}\) **Coroners Act 1995** (Tas), s 69.  
\(^{188}\) **Coroners Act 2008** (Vic), ss 102(1), 113(1).  
\(^{189}\) Ibid, ss 102(2), 113(2).  
\(^{190}\) **Coroners Act 1993** (NT), s 26(2).  
\(^{191}\) **Coroners Act 1995** (Tas), s 28(2).  
\(^{192}\) Ibid, s 30(2).  
\(^{193}\) **Coroners Act 1997** (ACT), s 52(4).
the Attorney-General may contain recommendations about matters of public safety.\(^{194}\)

### 2.87 New South Wales

A Coroner is empowered to make such recommendations as the Coroner considers necessary or desirable to make in relation to any matter connected with a death (including a recommendation relating to public health and safety or that a matter be investigated or reviewed by a specified person or body).\(^{195}\) The power is not specifically related to any reporting requirement.

### 2.88 South Australia

The Coroners Court is empowered to make any recommendation that might, in the opinion of the Court, prevent or reduce the likelihood of a recurrence of an event similar to the one that was the subject of the inquest.\(^{196}\) The power is not specifically related to any reporting requirement.

### 2.89 Western Australia

The State Coroner is empowered to make recommendations to the Attorney General on any matter connected with a death, including public health or safety, the death of a person held in custody or the administration of justice.\(^{197}\)

### 2.90 Queensland

A Coroner is empowered to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.\(^{198}\) However, the *State Coroner’s Guidelines 2013* are more emphatic than the legislation as to an onus on Coroners to make preventative recommendations. In relation to deaths in custody, the *State Coroner’s Guidelines 2013* state that “only by ensuring the investigation has such a broad focus as to identify systemic failures will a Coroner be given a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations”.\(^{199}\)

### 2.91 Victoria

A Coroner is empowered to make recommendations to any Minister, public statutory authority or entity on any matter connected with a death which the coroner has investigated, including recommendations relating to public health and safety or the

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\(^{194}\) Ibid, s 57(3).
\(^{195}\) *Coroners Act 2009* (NSW), s 82.
\(^{196}\) *Coroners Act 2003* (SA), s 25(2).
\(^{197}\) *Coroners Act 1996* (WA), s 27(3).
\(^{198}\) *Coroners Act 2003* (Qld), s 46(1).

### 3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
3. Notification of Death and Involvement of Family
(Recommendations 19 - 25)

Recommendaion 19: That immediate notification of death of an Indigenous 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 Indigenous 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.

3.1 Commonwealth and Australian Capital Territory

The Commonwealth does not have an operational role in post-death investigations. The potential for the Commonwealth to take a leadership role in ensuring that Recommendations are implemented has not been realised, leaving it with minimal involvement. However, the Australian Federal Police (‘AFP’) plays a role in policing the laws of the Commonwealth, as well as acting as a regular police service in the Australian Capital Territory. The AFP National Guideline on Persons in Custody and Police Custodial Facilities (‘AFP National Guideline’)\(^{201}\) partially implements Recommendation 19 for the Commonwealth and Australian Capital Territory. The AFP National Guideline provides that if a person dies in custody, next of kin, family or nominated contact persons must be notified as soon as practicable. Notice must be delivered in person if the next of kin lives in the Australian Capital Territory.\(^{202}\) The Children and Young People (Death in Custody) Policy and Procedures 2008 (ACT) provides that in the event of the death of a young (18 - 21 years of age) Aboriginal and/or Torres Strait Islander detainee, the Senior Manager will meet with the family to determine what culturally appropriate arrangements should be made.\(^{203}\) This does not extend to a general requirement for cultural sensitivity for all Indigenous deaths in custody, and there is no provision that notification be preferably given by an Indigenous person, as such Recommendation 19 has not been fully implemented.

At a general level across all States and Territories, the Standard Guidelines for Corrections in Australia (‘Corrections Guidelines’) set out outcomes or goals to be

\(^{200}\) Coroner\,s Act 2008 (Vic), s 72.
\(^{203}\) Children and Young People (Death in Custody) Policy and Procedures 2008 (ACT), s 6.13.
achieved by correctional services. The Corrections Guidelines are a statement of national intent rather than a set of enforceable laws, but still reflect community standards. The Standard Guidelines for Prisons in Australia (‘Prison Guidelines’) is contained within the broader Corrections Guidelines and provides that the next of kin or designated contact person is to be notified as soon as practicable.204

3.2 New South Wales

In New South Wales, Recommendation 19 is not explicitly legislated, but is reflected in the NSW Police Force Handbook and the NSW Coronal Protocol for Deaths in Custody. The NSW Police Force Handbook provides that next of kin are to be advised personally at "the first opportunity",205 with phone calls only in exceptional circumstances and with the approval of the senior officer on duty. The NSW Coronal Protocol states that once notified of a death in custody, the Coroner will check to ensure that relatives have been notified.206

3.3 Tasmania

In Tasmania, the only publicly available soft law guidance is from the AFP National Guideline, the Corrections Guidelines and the Prison Guidelines referred to above. It is unclear whether Recommendation 19 has been implemented further than this.

3.4 Northern Territory

In the Northern Territory, the Police Administration Act 1991 (NT) provides for the appointment of Aboriginal Community Police who have the same roles as police.207 This may extend to notification of the death of an Indigenous person, but it does not clearly implement Recommendation 19. There are no other guidelines publicly available in the Northern Territory.

3.5 South Australia

South Australian soft law guidelines reflect certain aspects of Recommendation 19, with some responsibility given to South Australian Health to liaise with relatives208 and to ensure the notification is in person wherever possible.

3.6 Western Australia

In Western Australia, notification procedures exist in the Department of Corrective Services Adult Custodial Policy Directives in relation to the death of a prisoner in

204 Standard Guidelines for Prisons in Australia, [2.48].
207 Police Administration Act 1991 (NT), s 19.
These procedures mirror the majority of Recommendation 19, and include Indigenous considerations through use of members of the Aboriginal Visitor’s Scheme to assist with notification. There does not appear to be an equivalent policy directive for juvenile custodial services. The *WA Lockup Manual* and *Police Operations Manual* mandates that upon the death of a person held in a police lock-up, members of the police shall promptly inform the next of kin or any other person previously nominated by the person. The Divisional Superintendent in charge of the investigation will, in addition to speaking with relevant welfare services (see below) and where practicable, personally speak with the relatives of the deceased, offer condolences on behalf of the police and if grief counselling is required, refer the relatives to the Coronial Counselling Service.

### 3.7 Queensland

In Queensland, notification to the family of the deceased is given by the police or correctional officer. The notification is to be done in a sensitive manner by someone with knowledge of the facts of the death and notification must also be made to an elder, respected person or Indigenous spiritual healer. Although the *Operational Procedures Manual* requires that notification takes place “immediately”, as proposed by the Recommendation, this requirement is not legislated for in Queensland.

### 3.8 Victoria

In Victoria, the *Victoria Police Handbook* provides ethical guidelines to be followed by police when talking with parents in relation to an infant or child who has died. The guidelines advise that the police should conduct themselves in a caring and sensitive manner. Police are to deliver the news of a death to relatives in person and as a matter of urgency. The handbook provides separate procedures when dealing with the death of an Aboriginal or Torres Strait Islander person. Victorian police are responsible for informing Indigenous communities of the death of an Aboriginal or Torres Strait Islander person and police are advised to seek advice from the Aboriginal Advisory Unit or the Koori Justice Unit, Department of Justice. In the event that a death of an Indigenous person occurs in custody, only the Divisional Patrol

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211 Western Australia Police, *WA Police Operations Manual*, section DC-1.2.2.


213 *Victoria Police Manual*, version as at 26 March 2015 - Procedures and Guidelines Section 11 titled “Sudden unexpected and unexplained deaths in infants and children”.

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Supervisor, Media Unit, State Coroner’s office and PSC can release information about the death.\(^{214}\)

**Recommendation 20:** That the appropriate Aboriginal Legal Service be notified immediately of any Indigenous death in custody.

### 3.9 Commonwealth and Australian Capital Territory

This Recommendation has been partially implemented by the Commonwealth and Australian Capital Territory through the *AFP National Guideline*. The *AFP National Guideline*\(^{215}\) provides that when an Indigenous person dies in custody, the case officer and the AFP Indigenous Community Liaison Officer must, after consultation with the Coroner, notify and provide requested information to the Aboriginal Legal Service. There is no requirement that the notification be made immediately.

The *Prison Guidelines*\(^{216}\) provide that the Aboriginal Legal Service and any Indigenous spiritual advisers are to be notified of the death of an Indigenous person in custody. This influences State and Territory practice but is not binding.

### 3.10 New South Wales and Northern Territory

In New South Wales and the Northern Territory, there is no specific legislative enactment of Recommendation 20.

### 3.11 Tasmania and South Australia

Similarly, Tasmania and South Australia have not explicitly implemented Recommendation 20 but may be influenced by the Corrections Guidelines, the Prison Guidelines or the *AFP National Guideline*.

### 3.12 Western Australia

In Western Australia, there is no specific legislative requirement, however, the *Department of Corrective Service’s Policy Directives* requires the next of kin of the deceased to be advised that the Aboriginal Legal Service can be informed of the death if requested by the next of kin.\(^{217}\) Where the death occurs in police custody, the *WA Lockup Manual and Police Operations Manual* specify that the responsible Divisional Superintendent will, as part of the initial actions and duties of the investigation, carry out all necessary notifications and liaison with relevant statutory or welfare authorities (e.g. the Aboriginal Legal Service, Aboriginal Visitors’ Scheme (24 September 2013) <http://www.correctiveservices.wa.gov.au/_files/prisons/adult-custodial-rules/policy-directives/pd-30.pdf>.

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\(^{214}\) *Victoria Police Manual*, version as at 26 March 2015 - Procedures and Guidelines Section 3 titled “Deceased”, subsection 3.3 titled “Special requirements”.


\(^{216}\) *Standard Guidelines for Prisons in Australia*, [2.50].


### 3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
and Aboriginal Medical Service).\textsuperscript{218} The comments in relation to Recommendation 22 from the Office of State Coroner which are set out below are also relevant to this Recommendation.

### 3.13 Queensland

In Queensland, when an Indigenous person dies in custody, the chief executive of the corrective services facility must notify the Aboriginal or Torres Strait Islander Legal Service representing Indigenous people in the area in which that person died (and if practicable, an elder, respected person or Indigenous spiritual healer relevant to the prisoner).\textsuperscript{219} There is no requirement that the notification be made immediately. The State Coroner’s Guidelines 2013 also set out the indispensable role of the Aboriginal and Torres Strait Islander Legal Services.\textsuperscript{220}

### 3.14 Victoria

In Victoria, there is no specific law or regulation that requires police to notify Aboriginal Legal Services, however, as noted in Recommendation 19, police are advised to seek advice from the Aboriginal Advisory Unit or the Koori Justice Unit, Department of Justice when dealing with the death of an Indigenous person.\textsuperscript{221}

**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.

This Recommendation has not been consistently implemented by the States and Territories. In States and Territories where aspects of this Recommendation are left unlegislated, the AFP National Guideline may still serve to influence the practical implementation of the Recommendation.

### 3.15 Commonwealth

At the Commonwealth level, the AFP National Guideline provides that if an Indigenous person dies in custody, the case officer and the AFP Indigenous Community Liaison Officer must notify and provide requested information (and the time and date of the coronial inquest) to the deceased’s family and the Aboriginal

\textsuperscript{218} WA Lockup Manual; WA Police Operations Manual.
\textsuperscript{219} Corrective Services Act 2006 (Qld), s 24(1)(e).
\textsuperscript{220} Queensland Courts, State Coroner’s Guidelines 2013 Chapter 2 (November 2013), p 5 <http://www.courts.qld.gov.au/__data/assets/pdf_file/0012/206121/osc-state-coroners-guidelines-chapter-2.pdf>. The Guidelines state “If the deceased is an Aborigine or a Torres Strait Islander, contact should be made with the local Indigenous legal service to arrange for a community member to accompany police to advise of the death. Such people will be better equipped to understand the more complicated family structures that exist among some Indigenous people and information they give about the coronial system may be better received or more effectively communicated to other Indigenous people than that supplied by the police. Coronal counsellors regularly engage with community members when communicating with indigenous families about autopsy and other related issues.”
\textsuperscript{221} Victoria Police Manual - Procedures and Guidelines section 3 (Deceased) dated 1 April 2013.
Legal Service. The AFP National Guideline does not require that the date and time be provided "in adequate time" before the inquest.

3.16 Australian Capital Territory

In the Australian Capital Territory, Recommendation 21 has been substantially implemented by section 69 of the Coroners Act 1997 (ACT), which provides that a member of the immediate family of the deceased and the Aboriginal Legal Service must be notified before the hearing is conducted.

3.17 South Australia

South Australian legislation also satisfies most of the requirements of Recommendation 21, with the Coroners Court Rules 2005 (SA) providing that 21 days' notice of the time and place of the inquest must be served on the senior next of kin and any other person who claims to be entitled to appear at the inquest and has provided contact details.

3.18 New South Wales

In New South Wales, the next of kin must be notified of the time and place of the inquest, but there is no requirement that the family be advised as soon as possible, or that the Aboriginal Legal Service be advised at all. The NSW Police Force Handbook provides that next of kin are "personally informed, in ample time before the inquest".

3.19 Tasmania

In Tasmania, the senior next of kin must be informed if the Coroner decides not to hold an inquest, but there is no requirement to inform the next of kin of the particulars of an inquest if it is being held.

3.20 Northern Territory

The Northern Territory requires public notification of the time and date of the inquest to be circulated at least 14 days before the inquest, but does not provide for individual notification to the family.

3.21 Western Australia

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223 Coroners Court Rules 2005 (SA), r 12.
224 Coroners Act 2009 (NSW), s 54(1).
226 Coroners Act 1995 (Tas), s 26.

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Western Australia, there are provisions requiring a Coroner to notify the next of kin regarding investigations and the advertising of inquests. However, there is no legislative requirement to inform the Aboriginal Legal Service. The Office of State Coroner has confirmed that it has adopted a practice of writing to and maintaining close liaison with the Aboriginal Legal Service, but no publicly available guidelines or policy statement to that effect has been located at the time of writing (see Recommendation 22 below for further comments).

3.22 Queensland

In Queensland, Recommendation 21 has been partially enacted to the extent that section 32(1) of the Coroners Act 2003 (Qld) requires notification in the daily newspaper at least 28 days before the inquest is to be held. There is no requirement for specific notification to be given to the deceased's family or other nominated person and the Aboriginal Legal Service. Recommendation 21 has also been included within the State Coroner’s Guidelines 2013, however, there is no requirement that the family be advised "as soon as possible". There is also no timeframe specified for when the notice must be given.

3.23 Victoria

In Victoria, there are provisions under the Coroners Act 2008 (Vic) requiring a Coroner to notify a senior next of kin (which may include a spouse, child, parent or partner) as soon as practicable after the opening of an investigation into a death. The senior next of kin is informed about any medical procedures and will also be provided with updates on the progress of the investigation and any medical reports provided to the Coroner. However, there is no legislative requirement to inform the Victorian Aboriginal Legal Service.

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 [sic] 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.

3.24 Commonwealth

This Recommendation does not appear to be explicitly legislated for at the Commonwealth level.

3.25 Australian Capital Territory

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227 Coroners Act 1996 (WA), ss 20, 39.
229 Coroners Act 2008 (Vic) s 21.

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The Australian Capital Territory has implemented Recommendation 22 through section 69 of the *Coroners Act 1997* (ACT), which provides that the Coroner must not conduct a hearing unless the family has been notified, or reasonable efforts have been made to notify the family.

### 3.26 South Australia

Recommendation 22 is partially implemented in South Australia. In South Australia, inquests are required to be open to the public.\(^{230}\) In combination with the provisions for notification outlined in respect of Recommendation 21, the Coroner should also be satisfied that the family had been notified of the inquest in good time.

### 3.27 New South Wales

Recommendation 22 is partially reflected in the *NSW Coronial Protocol*, which confirms that “the 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 Aboriginal Legal Service is contacted”.\(^{231}\) This implicitly satisfies Recommendation 22 but does not include a requirement that the family be notified with enough time to attend the inquest.

### 3.28 Northern Territory and Tasmania

In the Northern Territory, a person with a sufficient interest is permitted to appear at the inquest\(^ {232}\) but there is nothing to prevent a Coroner proceeding with an inquest where a family representative is not present. This does not satisfy the requirements of Recommendation 22.

The Recommendation is not implemented in Tasmanian coronial legislation.

Further, in both Tasmania and the Northern Territory, a Coroner may exclude a person from an inquest if the Coroner thinks it is appropriate for reasons of personal security or administration of justice.\(^ {233}\) This may include excluding family members from appearing if they have been disruptive or if there is a risk to the personal safety of witnesses.

### 3.29 Western Australia

In Western Australia, there is no legislative requirement that the Coroner must or should not proceed with an enquiry unless satisfied that the deceased’s family and the Aboriginal Legal Service have been notified of the hearing in good time. However, in addition to the matters referred to in Recommendations 19 to 21 above, since December 2013, the Coroners Court has implemented a system of call-overs to, amongst other things, ensure that interested parties receive notice of inquest listings. Call-over lists are advertised and the Listing Manager will write to persons

\(^{230}\) *Coroners Act 2003* (SA), s 19.

\(^{231}\) *NSW Coronial Protocol for Deaths in Custody/Police Operations*.

\(^{232}\) *Coroners Act 1993* (NT), s 40(3).

\(^{233}\) Ibid, s 42(2); *Coroners Act 1995* (Tas), s 56.

**3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)**
who are known to be interested parties to notify them of call-over dates. The
Coroner's Court will take into account the unavailable dates of interested parties.\(^{234}\)
The Office of State Coroner has advised in an e-mail that "[a]s soon as a death is
reported to the Coroner letters are generated to the Aboriginal Legal Service
advising them of the death. At the time of the inquest hearing (and this applies
irrespective of whether the inquest is a death in custody or not) this office will write to
the ALS advising them of the impeding inquest hearing and inviting them to seek
instructions. Throughout this process there is a liaison between our office."

3.30 Queensland

In Queensland, Recommendation 22 has only been implemented via the *State
Coroner's Guidelines 2013* which state that "[c]oroners should ensure steps are
taken to regularly update families about how the Coroner intends to investigate the
death and the progress of his or her investigation. It is important to proactively
manage family expectation with realistic advice about how long each investigate [sic]
phase is likely to take, for example, it can take several months for an independent
expert to review investigation material and provide a report."\(^{235}\) There does not
otherwise appear to be a requirement of the kind contemplated by Recommendation
22.

3.31 Victoria

In Victoria, there is no legislative requirement that the Coroner must or should not
proceed with an enquiry unless satisfied that the deceased’s family and the
Aboriginal Legal Service have been notified of the hearing in good time. The
requirement to notify as discussed in Recommendation 21 above partially satisfies
this Recommendation in that the family will be notified of the inquest and the
procedure going forward, as soon as practicable after an investigation is opened
however, it does not prevent a Coroner from opening an investigation in the absence
of notification. A Coroner will hold an inquest if it is considered mandatory to do so
under the *Coroners Act 2008* (Vic) or if the Coroner decides that an inquest is
necessary.

**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.

Recommendation 23 states that deceased’s family should be entitled to government-
funded legal representation at a death in custody inquest.\(^{236}\) This has not been
legislatively implemented in any jurisdiction\(^{237}\) and although statistical data is not

\(^{234}\) Coroner's Court of Western Australia, *Guideline 1 of 2013: Call-Overs* (2 December 2013), [4]

chapter-2.pdf>.


\(^{237}\) Frances Gibson, 'Legal Aid for Coroners’ Inquests' (2008) 15 *Journal of Law and Medicine* 587,
600. Section 36(1)(c) of the *Coroners Act 2003* (Qld) is partially relevant to this Recommendation in
generally available, it is understood that there is a relatively low incidence of lawyers appearing for the family of a deceased. Families that do not receive legal representation are at a comparative disadvantage in circumstances where other interested persons receive representation.

Each State and Territory has its own system of legal aid and sources of legal assistance for those seeking representation at a coronial inquest. All jurisdictions provide some initial assistance to individuals involved in the coronial process and provide broad information on the general availability of legal assistance. However, that a family member may appear at an inquest, but there are no provisions for family members to be legally represented or any reasonable costs to be paid by the government. Similarly, section 44 of the Coroners Act 1996 (WA) is partially relevant, in that an 'interested person' may be represented by a legal practitioner at an inquest, but the government is not required to pay the reasonable costs of such representation. Section 57 of the Coroners Act 2009 (NSW) provides that the Coroner must grant leave for a family member to appear or be represented, but there is no provision for payment of legal fees. The NSW Legal Aid Policy permits Legal Aid funding to be granted for the purposes of providing representation to the family of the deceased at a coronial inquest, subject to the standard tests of means, merit and availability of funds, but there is no legislated 'entitlement' to such funds. The position is similar in the ACT, but the Legal Aid ACT Legal Assistance Guidelines (at page 6) state that legal assistance will not be granted to a person for representation in proceedings brought under (amongst others) the Coroners Act 1997 (ACT), where the total cost to the Commission of granting assistance in the opinion of the Chief Executive Officer is likely to exceed $20,000 in respect of that person. In both South Australia and Tasmania, it appears that the only assistance available would be through normal legal aid channels, although in Tasmania, Matter Type Guideline 20 on the Legal Aid Commission of Tasmania website states that "assistance will not normally be granted for assistance at inquests unless there is a possibility that the applicant will be charged with a serious offence in relation to the death." At the Commonwealth level, the Service Delivery Directions for the Delivery of Legal Assistance to Indigenous Australians under the Australian Government's Indigenous Legal Assistance and Policy Reform ('LAPR') Program states (at paragraph 2.4) that practitioners participating in the Program must allocate the appropriate level of resources having regard to whether the client is a Priority Client, and also states (at paragraph 3.16) that Priority Clients include a family member of a person who died in custody, and who is seeking representation at an inquiry into the death, unless other appropriate assistance is readily available for that person. However it should be noted that the Australian Government announced cuts to the LAPR in 2013 which would reduce funding to the program by 20% over the following four years.


Frances Gibson, ‘Legal Aid for Coroners’ Inquests’ (2008) 15 Journal of Law and Medicine 587, 594. In Western Australia, a family member of an Indigenous person who died in custody and who is seeking representation at an inquest must be given ‘priority’ to legal services, but he/she may be precluded from receiving the services of the Aboriginal Legal Service if his/her income exceeds the income and asset threshold (i.e. means testing). It is noted that the ‘Key Areas of Service Delivery’ do not include ‘deaths in custody monitoring’ or ‘Coroner’s inquest representation’. However, Coronial and public sector monitoring is listed as a key area. See Aboriginal & Torres Strait Islander Legal

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
the criteria on which funding is allocated is varied. In all States, except Western Australia, legal aid may be granted for an inquest that is in the 'public interest'. In Western Australia, there are very restrictive funding criteria. The Law Reform Commission of Western Australia has acknowledged that under the current legal aid criteria, family members in Western Australia would rarely, if ever, receive legal aid for representation at an inquest. This is currently under review. The Law Reform Commission has recommended that the Western Australia government fund Legal Aid Western Australia, the Aboriginal Legal Service of Western Australia, and community legal centres to provide assistance to families where it is the public interest to do so. This will bring Western Australia more in line with other jurisdictions.

Recommendation 24: That unless the State Coroner or a 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.

3.32 Commonwealth

This Recommendation does not appear to be explicitly legislated for at the Commonwealth level. However, the AFP National Guideline provides that if an Indigenous Australian dies in custody, the case officer and the AFP Indigenous Community Liaison Officer must notify and provide requested information to the deceased's family and the Aboriginal Legal Service.


^243 In a study in 2008, Frances Gibson examined the legal aid funding criteria in each jurisdiction. See Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 Journal of Law and Medicine 587, 595-597, Table 1.

^244 In Western Australia, legal aid is only given for inquests in circumstances where there is a "realistic risk that serious criminal charges may arise against the applicant; where the outcome of the inquest can reasonably be seen to be likely to have a significant impact on civil proceedings involving the applicant; and as a result of such representation, there is a real likelihood of some substantial benefit accruing to the applicant". See Legal Aid Western Australia, Legal Aid Manual: Chapter 6B - State Eligibility Guidelines (July 2006), Guideline 18; Frances Gibson, 'Legal Aid for Coroners' Inquests' (2008) 15 Journal of Law and Medicine 587, 597.


3.33 Australian Capital Territory

Recommendation 24 has been practically implemented in the Australian Capital Territory. In the Australian Capital Territory, the AFP National Guideline is supplemented by the ACT Magistrates Court Service Charter, which provides that the Court will be polite and professional. This accords with the requirement in Recommendation 24 to provide frank and helpful service in a polite and considerate manner. The Australian Capital Territory Coroner’s Court also publishes an information brochure to assist relatives of the deceased. The Coroner’s Act 1997 (ACT) provides that the Coroner must, if requested by a member of the deceased’s immediate family or their representative, authorise an inspection of the scene of death by that member or representative.

3.34 New South Wales

In New South Wales, Recommendation 24 is partially reflected in the NSW Police Force Handbook, which provides that officers should be sensitive and discreet when dealing with relatives of the deceased, and that the Aboriginal Community Liaison Officer will maintain a relationship with all relatives and liaise with them about the movement of the body. Additionally, the Coronial Information and Support Program is available to help family and friends understand the coronial process, and can refer relatives to relevant services such as counselling. The published values of the New South Wales Coroners Court include a commitment to deliver services in a professional and timely manner, and to demonstrate understanding and sensitivity.

3.35 South Australia

Recommendation 24 is partially implemented in South Australia through both legislation and soft law guidance. The Annual Report of the State Coroner for 2011-2012 states that the major responsibilities of counsels assisting (who assist the Coroner and Deputy Coroner) include ensuring that sensitive issues are dealt with in a way that preserves the dignity and rights of those involved. The Coroners Court website and brochure provides information for relatives about the coronial process and what information will be available. The Coroners Act 2003 (SA) provides that a person with sufficient interest will be sent a copy of the Coroner’s findings, and that a member of the public may apply to access various documents relating to process or findings. However, there is no reference to accessing the scene of the

249 Coroner’s Act 1997 (ACT), s 70(1)(b).
253 Coroners Act 2003 (SA), s 25.
254 Ibid, s 37.

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death. There is also no formal requirement that the Aboriginal Legal Service be kept informed.

3.36 Tasmania

In Tasmania, there is no obligation to keep the deceased's family or the Aboriginal Legal Service informed but the rules set out in the Coroners Rules 2006 (Tas) provide a means by which family and representatives might be provided with information. The Coroners Rules 2006 (Tas) allow access to coronial records and findings in certain circumstances, but do not provide for the inspection of the scene of the death. Recommendation 24 is only partially implemented in Tasmania.

3.37 Northern Territory

Recommendation 24 does not appear to be implemented in the Northern Territory.

3.38 Western Australia

There are a number of provisions in the Western Australian legislation that concern the provision of information about and involvement in investigations or inquiries by Coroners or staff to next of kin, or interested persons. These include providing the next of kin of a deceased person with access to the evidence obtained by the Coroner in investigating the death, which could include photographs, police reports and autopsy reports. However, the legislation makes no reference to the inspection of the scene of the death.

3.39 Queensland

In Queensland, the Coroner must give a written copy of any findings and comments she or he has made in relation to a death investigated at an inquest to a family member who accepts the document on behalf of the deceased person's family. The State Coroner’s Guidelines 2013 note the benefits for bereaved families who can view their loved one’s body before burial or cremation and state that families "should be accommodated by the coronial process without compromising the integrity of the Coroner’s investigation." The State Coroner’s Guidelines 2013 also note the importance of the role that Coronial counsellors play in supporting bereaved families. There is also a requirement for Coroners to "strive to progress their matters as expeditiously as possible and ensure families are regularly informed of the progress of the investigation into their loved one’s death, unless doing so could

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256 Coroners Act 1996 (WA), ss 20, 25, 26A, 30, 35, 37, 42.
257 Coroners Act 2003 (Qld), ss 45(4)(a), 46(2)(a).

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compromise the investigation. Families are also entitled to a copy of the brief of evidence.

In relation to the part of Recommendation 24 relating to allowing access to the scene of the death, the Operational Procedures Manual imposes obligations on the investigating officers to "if requested, make all efforts to allow family members or their representative the opportunity to inspect the scene of the death, subject to police operational and security requirements, bearing in mind the cultural needs of the relatives." The QPS policy also emphasises the requirement to assist families wherever possible.

3.40 Victoria

In Victoria, the Coroners Court has a number of protocols and guidelines designed to help family members through the process of an inquest. Coroners try to make inquests less formal than other Court proceedings and try to avoid using unnecessarily complex language in order to assist family members and interested parties to understand what is happening in the proceeding. The Coroner, along with the person assisting the Coroner, will help families understand and participate in the inquest. Information is also provided to family members and interested parties through the Coroners Support Service which provides information and regular updates to families. The legislation makes no reference to providing access to the scene of the death.

Recommendation 25: That unless the State Coroner, or a 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.

The National Report recommended that the family of the deceased should have the right to have the body examined by its own medical practitioner, or, where

necessary, conduct a further post-mortem. This is an important check and balance and is designed to alleviate any fears of bias in the coronial procedure.

Only Queensland and the Australian Capital Territory have implemented this part of Recommendation 25. There has been a total failure to implement this Recommendation in Victoria, New South Wales, South Australia and Tasmania. There has been partial implementation in the Northern Territory and Western Australia, where an independent person can observe (but not partake in) the procedure.

4. Inquiry of Death and Roles of Officials (Recommendation 26 - 31)

**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.

This Recommendation has been implemented, at least in part, in most jurisdictions. However, the relevant legislation does not generally specify the time in which a solicitor or barrister must be appointed, or the stage of the inquest at which the appointment must be made.

4.1 Australian Capital Territory

In the Australian Capital Territory, a lawyer must be appointed as counsel to assist the Coroner in respect of any inquest into a death in custody. However, the legislation does not specify a time in which this appointment must be made.

4.2 Northern Territory

In the Northern Territory, “a person” must be appointed at the inquest stage. However, the legislation does not specify a time in which the appointment must be made.

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264 Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) ch 4, [4.7.4]. It was also recommended that the family have the right to have an independent observer present at any post-mortem, the right to view the body and the scene of the death, and the right to receive a copy of the post-mortem report.


266 *Coroners Act 1997* (ACT), ss 70(1)(c), (d); *Coroners Act 2009* (NSW), s 89. In New South Wales, the Coroner may give certain post-mortem investigation directions which would appear to permit relatives of the deceased to make an application for the matters reflected in Recommendation 25. However, this depends on adequate awareness of the right to make such application, and the availability of legal aid or other assistance.

267 *Coroners Regulations* (NT), reg 8.

268 *Coroners Act 1996* (WA), s 35. In Western Australia, the death of Mr Briscoe at an Alice Springs Watch-house on 4 January 2012 lead to a campaign by the family for the right to conduct an independent autopsy. The request was denied. See Allyson Horn, ABC News, *Aboriginal Death in Custody Inquest Begins* (12 June 2012) <http://www.abc.net.au/news/2012-06-12/briscoe-death-in-custody-inquest-begins/4066476>.

269 *Coroners Act 1997* (ACT), s 72.
4.3 Victoria

In Victoria, there is no requirement that a solicitor or barrister be appointed to assist the Coroner. Rather, the relevant legislation provides that a Coroner 'may' be assisted by a police officer, an Australian lawyer, the Director of Public Prosecutions ('DPP') or another person appointed by the Coroner. This appointment is only made at the inquest stage. The legislation does not specify a time in which the appointment must be made.

4.4 Queensland

In Queensland, there is no requirement that a solicitor or barrister be appointed to assist the Coroner. Rather, the relevant legislation provides that a Coroner may seek the help of a lawyer or other person who the Coroner reasonably believes can help the Coroner investigate the death. This appointment must be made "during the investigation". The State Coroner's Guidelines 2013 provide that the Coroner should obtain whatever expert assistance needed to effectively investigate the matter. Further, if it is anticipated that an inquest may be complex, protracted or contentious, the State Coroner's Guidelines 2013 note that it may be 'desirable' to brief counsel.

4.5 Western Australia and Tasmania

In Western Australia and Tasmania, there is no requirement that a solicitor or barrister be appointed to assist the Coroner. Rather, the relevant legislation provides that a Coroner 'may' be assisted by counsel, or by any other person that the Coroner believes will be of assistance. The legislation does not specify a time in which such appointments must be made.

4.6 New South Wales

In New South Wales, there is no legislative requirement that a solicitor or barrister be appointed to assist the Coroner. However, the State Coroner’s report provides that in circumstances where there is a death in custody or a death in the course of police

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270 Coroners Act 1993 (NT), s 41(2)(b).
271 Coroners Act 2008 (Vic), s 60.
272 Coroners Act 2003 (Qld), s 15.
273 Ibid, s 14(1).
275 Ibid, s 14(1).
276 Coroners Act 1996 (WA), s 46(2).
277 Coroners Act 1995 (Tas), s 53(2).
operations, the State Coroner or the Deputy State Coroner may request the Crown Solicitor to instruct counsel to assist the Coroner with the investigation into the death.\textsuperscript{279} No information is provided with respect to the timeframe in which counsel must be appointed.

4.7 South Australia

In South Australia, there is no legislative requirement that a solicitor or barrister be appointment to assist the Coroner, however, it is noted that the Coroner's Court employs two senior counsel assisting and has an in-house coronial investigation section.\textsuperscript{280} In addition, the State Coroner's Annual Report states that the current trend is for complex matters that involve complicated medical and technical evidence to be reviewed by in-house counsel assisting.\textsuperscript{281} No information is provided regarding the time in which counsel assisting is appointed to review a specific matter.

4.8 Further commentary on Recommendation 26

Although not strictly required by legislation, coronial courts in most jurisdictions do nonetheless (as a matter of practice) appoint counsel to assist the Coroner with certain inquests. Further, some coronial courts employ their own dedicated in-house lawyers. In Victoria, a new operating model was recently implemented which expanded the Coroner's Court's in-house legal services to include a team of solicitors to assist the Coroner (including a support solicitor for each Coroner).\textsuperscript{282} In Queensland, each Coroner is usually supported by a counsel assisting and three administrative officers.\textsuperscript{283} Similarly, in Western Australia (at least in metropolitan areas), each Coroner is assisted by a dedicated legal officer with specialised skills and experience in the jurisdiction.\textsuperscript{284} As regional coronial courts do not have dedicated coronial staff, the registrar typically handles coronial work in addition to the general work of the Court (and there are no in-house legal counsel assisting or other

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inquest management services). If an inquest is handled by a regional magistrate a counsel assisting may be assigned by the Office of the State Coroner.

However, the role played by assisting counsel in each jurisdiction is unclear (i.e. whether they simply assist with inquest preparation and management, or whether they are appointed to a specific case within 48 hours and then actively review and direct the coronial investigation before assisting in the inquest management, as was envisaged by the RCIADIC). For example, in Western Australia, legal counsel typically liaises with investigators at the commencement of an investigation and then monitors the investigation through to the completion of the hearing. However, it is unclear whether such liaison at “the commencement” of the investigation occurs within the 48 hour period recommended by the RCIADIC.

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.

4.9 Commonwealth

This Recommendation has not been implemented at the Commonwealth level.

4.10 Australian Capital Territory

Recommendation 27 has been implemented in the Australian Capital Territory. The Coroners Act 1997 (ACT) provides that the Coroner must appoint counsel assisting when holding an inquest into a death in custody, and that counsel assisting must not have an actual or perceived conflict of interest. The Australian Capital Territory DPP also has a dedicated 'coronial practice'. Furthermore, one of the principal functions of the DPP is to "assist a Coroner in inquests and inquiries".

4.11 Northern Territory

Recommendation 27 has been partially implemented in the Northern Territory. In the Northern Territory, the Coroner may appoint a 'Registrar of the Local Court' to act as a Coroner's clerk. Amongst other things, this appointment assists in preserving

286 Law Reform Commission of Western Australia, Review of Coronial Practice in Western Australia - Background Paper - Project No 100 (September 2010), 26 <http://www.lrc.justice.wa.gov.au/_files/P100-BP.pdf>.
287 Coroners Act 1997 (ACT), s 72(1).
288 Ibid, s 72(3)(b).
289 Director of Public Prosecutions Act 1990 (ACT), s 6(d).
290 Coroners Act 1993 (NT), s 9(2).
independence of the Coroner's clerk from the custodial authorities involved in the
death in custody. However, the Coroner may also appoint 'a person' to assist in an
inquest into a death in custody. The word “person” is very broad and may
encompass custodial authorities and officers (which would not be sufficient to
preserve the independence of the assistant).

4.12 New South Wales

Recommendation 27 has not been expressly implemented in New South Wales. However, guidance documentation sets out the relevant process for coronial
inquests. For example, in cases involving the New South Wales police, the
Deputy State Coroner may request the Crown Solicitor to instruct independent
counsel to assist the Coroner with the investigation. The purpose of this is to "ensure
that justice is done and seen to be done". The Crown Prosecutors Office are
statutory office holders for the purpose of the Crown Prosecutors Act 1986 (NSW) and specialise in the conduct of criminal trials by jury or judge alone in the Supreme
and District Courts, as well as in criminal appeals. The Director of Public
Prosecutions Act 1986 (NSW) further provides that the DPP may assist a Coroner
with any inquest and may be represented by counsel or a solicitor.

4.13 Tasmania

Recommendation 27 has not been expressly implemented in Tasmania. In
Tasmania, the Coroners Act 1995 (Tas) provides for the appointment of several
officers to support the Coroner. The Coroner's Officer has the role of assisting the
Coroner and carrying out all reasonable directions of the Coroner. There is no
express provision to ensure the independence of such an assistant. Rather, the
legislation states that "a police officer is, by virtue of his or her office, a Coroner's
officer and has the same functions and powers as are conferred or imposed on a
Coroner's officer". Police officers can also be appointed to be Coroner's
associates. This is inconsistent with Recommendation 27, which requires
independence from the relevant custodial authorities or officers.

4.14 Victoria

Recommendation 27 has been partially implemented in Victoria. In Victoria, the
Coroner may appoint a principal registrar and as many registrars and deputy

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291 Ibid, s 41(2).
292 New South Wales Office of the State Coroner, Report by the NSW State Coroner into deaths in
custody/police operations for the year 2013 (15 March 2014), 13
293 Ibid.
294 New South Wales Government, Office of the Director of Public Prosecutions, NSW - Annual
295 Director of Public Prosecutions ACT 1986 (NSW), s 12.
296 Ibid, s 21.
297 Coroners Act 1995 (Tas), s 16.
298 Ibid, s 16(2).
299 Ibid, s 15(2).
registrars as are necessary “to assist in the administration of the Coroners Court”. The duties of a registrar include receiving information about a death that a Coroner is investigating, and administering and swearing oaths relating to an investigation by a Coroner. The State Coroner has a broad power to delegate administrative functions to a specified registrar or class of registrar.

A Coroner may also be assisted at an inquest by a member of the police force, an Australian lawyer, the Director of Public Prosecutions or another person appointed by the Coroner. There is no express provision to ensure the independence of a person assisting. However, the Coroner will ensure that independent counsel assisting is appointed where a death has prima facie occurred in circumstances involving police contact, and may appoint an independent lawyer to assist in particularly complicated cases.

4.15 South Australia

Recommendation 27 has not been expressly implemented in South Australia. In South Australia, the Attorney-General has the power to “appoint a person to be an investigator” to assist with enquiries. However, the legislation does not exclude custodial officers from the definition of ‘person’. The Coroner also has a (similarly broad) power to delegate administrative functions to “any other suitable person”.

4.16 Western Australia

Recommendation 27 has not been expressly implemented in Western Australia. The Coroners Act 2003 (WA) does not prescribe the qualifications or duties of counsel assisting the Coroner or Coroner’s assistants. However, it does provide for the appointment of ‘Coroner’s Registrars’ and ‘Coroner’s Investigators’. A Coroner’s Registrar may, on behalf of a Coroner, receive information about a death which a Coroner is investigating, issue a summons requiring a witness to attend an inquest to give oral evidence or to produce documents and carry out any other function authorised under the Act. A Coroner’s Registrar is appointed under Part 3 of the Public Sector Management Act 1994 (WA). A Coroner’s Registrar may (but is not required to) have the requisite independence from the inquest. Alternatively, a registrar of the Magistrates Court may act as a Coroner’s Registrar if an investigation is held at a Court house where the Magistrates Court sits.

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300 Coroners Act 1993 (Vic), s 97(1).
301 Ibid, s 99.
302 Ibid, s 60.
305 Coroners Act 2003 (SA), s 9(1).
306 Ibid, s 8(1)(c).

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Western Australia, the role of the ‘Coroner's Investigator’ is to assist a Coroner in carrying out his or her duties under the Coroners Act 2003 (WA) and carry out all reasonable directions of a Coroner. Coroner’s Investigators are appointed on the Recommendation of the State Coroner. Every member of the police force of the State is contemporaneously a Coroner’s investigator. Accordingly, where the Coroner’s Investigator is a police officer, they are unlikely to have the requisite independence from the inquest. Despite this, the Coroners Court publication Inquest Hearings in Western Australia states that those assisting the Coroner must be independent and impartial.

4.17 Queensland

In Queensland, the Coroner may seek the help of a lawyer or other person who the Coroner reasonably believes can help the Coroner investigate the death, but there is no independence requirement of the kind contemplated by Recommendation 27. The State Coroner's Guidelines 2013 provide that “the role of Counsel Assisting at inquest is to impartially and fairly present the evidence to the Coroner”, however, it does not expressly state that the lawyer is to be independent of the relevant custodial authorities and officers. The CCC’s independent oversight may provide an extra level of assurance regarding the probity and sufficiency of the investigation.

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.

This Recommendation has not been implemented in any Australian jurisdiction. Further, no jurisdiction expressly requires counsel assisting the Coroner to ensure a full and proper inquiry takes place into the cause and circumstances of a death, or empowers counsel assisting the Coroner to review the police investigation.

4.18 Western Australia

In Western Australia, some attempt has been made to articulate the roles and responsibilities of counsel assisting the Coroner. Some examples include ensuring that the police and other investigating officers have conducted adequate

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308 Ibid, s 14.
309 Coroner’s Court of Western Australia, Inquest Hearings in Western Australia 34-36 <http://www.coronerscourt.wa.gov.au/_files/Inquest_Hearings_WA.pdf>.
310 Coroner’s Act 2003 (Qld) s 15(1).
investigations, directing other avenues of inquiry, identifying witnesses and reviewing information obtained. Counsel assisting may also effectively conduct the investigation for the Coroner where important issues are not addressed adequately (including seeking reports and other evidence). \(^\text{313}\)

### 4.19 Queensland

Similarly, in Queensland, guidelines published by the Coroner provide some guidance regarding the role of counsel assisting the Coroner. \(^\text{314}\) However, they do not impose an obligation on counsel to ensure a full and proper inquiry or to review the conduct of the investigation by the police.

### 4.20 Victoria

Similar guidance in relation to the role of a Coroner’s assistant is provided by the Coroners Court of Victoria. The role of a Coroner’s assistant is described as an inherently flexible role that will be adapted in the particular circumstances according to the interests of justice and nature of the investigation. \(^\text{315}\) The role involves providing support to a Coroner in the search for the identity, cause and circumstances of the death which may include discovering, assembling, presenting and testing evidence at the inquest and cross-examining witnesses. In closing submissions, a Coroner’s assistant is expected to present a balanced view of the evidence relevant to the matters that are the subject of the findings.

**Recommendation 29:** That a 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.

### 4.21 Commonwealth

Recommendation 29 has not been implemented at the Commonwealth level. This is because the role and functions of the Coroner are governed by State legislation.

### 4.22 Australian Capital Territory

In the Australian Capital Territory, the Coroner may request the assistance of the chief police officer in an investigation or inquiry. This is likely (by implication) to include the power to give directions as to any additional steps required to be taken in an investigation. The chief police officer must, as far as practicable, comply with any such request. \(^\text{316}\) Any act or thing done by a police officer pursuant to a request is taken to have been done by or on behalf of the Coroner who made the request. The

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\(^\text{313}\) Coroner’s Court of Western Australia, *Inquest Hearings in Western Australia* 35 <http://www.coronerscourt.wa.gov.au/_files/Inquest_Hearings_WA.pdf>.


\(^\text{316}\) Coroners Act 1997 (ACT), s 63(2).

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3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
Coroner also has a broad power to appoint any person to assist in the investigation of any matter relating to an inquest or inquiry.\textsuperscript{317} Any person appointed must report to the Coroner in writing (e.g. in respect of any additional steps directed by the Coroner in that investigation).\textsuperscript{318}

\textbf{4.23 New South Wales}

In New South Wales, the Coroner does not have an express power to require the relevant police officer in charge of the investigation to report to the Coroner. However, the Coroner can require a person to give evidence relevant to the proceedings (under oath or affirmation).\textsuperscript{319} It is noted that this does not strictly fall within the scope or intent of the ‘reporting’ function recommended by the RCIADIC. The Coroner may also give such directions as the Coroner thinks fit for the speedy determination of the issues with which proceedings are concerned, including directing relevant persons in the proceedings to take specified steps (including any additional steps), the time in which such steps must be completed, and any other directions which the Coroner considers appropriate.\textsuperscript{320} The police officer in charge of an investigation would likely fall within the definition of a “relevant person”\textsuperscript{321}, and reporting to the Coroner would constitute a step towards determining the issues in the proceedings.

\textbf{4.24 Northern Territory}

In the Northern Territory, the 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.\textsuperscript{322} A refusal or failure to comply with a lawful direction of the Coroner under this section carries a penalty of up to 6 months imprisonment.\textsuperscript{323} By implication, this would likely include the power to direct a police officer to report to the Coroner, and to take any additional steps required by the Coroner, consistent with the requirements of Recommendation 29.

\textbf{4.25 Tasmania}

Recommendation 29 has been expressly implemented in Tasmania. Specifically, a police officer who has information relevant to an investigation must report to the Coroner.\textsuperscript{324} Further, the Coroner’s officers are required to carry out all reasonable directions\textsuperscript{325} of the Coroner. Police officers are ‘Coroner’s officers’ by virtue of their office.\textsuperscript{326} The Coroner also has broad powers of entry, inspection and possession.

\begin{itemize}
\item \textsuperscript{317} Ibid, s 59.
\item \textsuperscript{318} Ibid, s 59(2)(b).
\item \textsuperscript{319} Coroners Act 2009 (NSW), s 59(1)(b).
\item \textsuperscript{320} Ibid, ss 49(2)(a)-(c).
\item \textsuperscript{321} Ibid, s 49(3)(d).
\item \textsuperscript{322} Coroners Act 1993 (NT), s 25.
\item \textsuperscript{323} Ibid, s 25.
\item \textsuperscript{324} Coroners Act 1995 (Tas), s 20(2).
\item \textsuperscript{325} Ibid, s 16.
\item \textsuperscript{326} Ibid, s 16(2).
\end{itemize}
The Coroner may give directions for an officer to exercise these powers if the Coroner believes it is reasonably necessary for the investigation.327

4.26 South Australia

In South Australia, a police officer must immediately report a death to the Coroner, and must provide any information that the officer has in relation to the matter.328 The Coroner may require the officer in charge to appear before the inquest and answer questions.329 The Coroner also has the ability to direct an investigator (which may include a police officer) to exercise specified powers.330 However, this does not give the Coroner power to direct the investigator as to any additional steps.

4.27 Western Australia

In Western Australia, every member of the police force is contemporaneously a Coroner’s investigator who must assist a Coroner in carrying out his duties and carry out all reasonable directions of a Coroner (except where that is inconsistent with a direction of the Commissioner of Police).331 The Coroner also has broad powers to require a person to attend as a witness at an inquest, produce relevant material or answer any questions.332

4.28 Queensland

In Queensland, police officers are required to assist the Coroner in the performance of its functions or exercise of power, including in respect of the investigation of deaths and the conduct of inquests.333 They are also required to comply with every reasonable and lawful request, or direction, of the Coroner.334 The Coroner has the power to compel “a person” to give the Coroner information that the Coroner believes is relevant to the investigation (including, for example, a police officer). Guidance material also provides that investigating officers must attend an inquest or pre-inquest conference when required by a Coroner.335 Where the investigating officer is unavailable, an officer who has knowledge of the investigation should be nominated to attend.336

4.29 Victoria

In Victoria, there is no specific requirement allowing the Coroner to specify that a police officer must report to the Coroner. However, a police officer who has

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327 Ibid, s 59(3).
328 Coroners Act 2003 (SA), s 28.
329 Ibid, s 23(1).
330 Ibid, s 22(3).
331 Coroners Act 1996 (WA), s 14.
332 Ibid, s 14(1).
333 Coroners Act 2003 (Qld), s 15(2).
334 Police Powers and Responsibilities Act 2000 (Qld), s 794(2).
information that may be relevant to a Coronial investigation is required to give that information to the Coroner to assist in his or her investigation. More broadly, any person, including a police officer, who reports a death to the Coroner must give the Coroner any information or other assistance that the Coroner requests for the purposes of the Coroner's investigation. In addition, the Coroner is empowered to require any person to prepare a document or prepared statement for the purposes of the investigation, attend an inquest as a witness, or to produce documents at an inquest. The Coroner is also entitled to compel a person who appears as a witness in an inquest to answer any questions.

**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.

4.30 Commonwealth

This Recommendation has not been implemented at a Commonwealth level.

4.31 Western Australia

Recommendation 30 has not been implemented in Western Australia. However, guidance material does (at least in part) set out the duties and obligations of counsel assisting the Coroner. For example, counsel assisting is typically required to conduct the procedural steps of the inquest and to introduce evidence for the Coroner. Counsel assisting also plays a role in ensuring that police officers and other investigating officers have conducted adequate investigations so that an inquest brief can be prepared. This may involve directing other avenues of inquiry, identifying witnesses and reviewing information that has been obtained.

4.32 Queensland

Recommendation 30 has not been expressly implemented in Queensland. However, guidance material does (at least in part) set out the duties and obligations of counsel assisting the Coroner. For example, the role of counsel assisting at an 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

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337 Coroners Act 2008 (Vic), s 36.
338 Provided that death is either a "reportable" or "reviewable" death within the meaning of the Coroners Act 2008 (Vic).
339 Ibid, s 32.
340 Ibid, s 42.
341 Ibid, s 55.
342 Ibid, s 55.
343 Coroner's Court of Western Australia, _Inquest Hearings in Western Australia_ 36 <http://www.coronerscourt.wa.gov.au/_files/Inquest_Hearings_WA.pdf>.
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 and outline of relevant legislation and case law. However, it remains the Coroner’s responsibility to weigh the evidence and make appropriate findings and comments. Accordingly, counsel assisting is not strictly responsible for reviewing the conduct of the investigation and advising the Coroner as to the progress of the investigation.

4.33 Other States and Territories

Recommendation 30 has not been implemented in New South Wales, the Australian Capital Territory, the Northern Territory, Tasmania, Victoria or South Australia. The responsibility of the lawyer assisting the Coroner to review the conduct of the investigation is not addressed in any of these jurisdictions.

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.

4.34 Northern Territory, New South Wales and Queensland

Recommendation 31 has been partially implemented (through legislation) in the Northern Territory, New South Wales and Queensland (in particular, in respect of the requirement that the lawyer assisting the Coroner be kept informed by the officer in charge of the police investigation). This is discussed in detail below.

4.35 New South Wales

In New South Wales, the NSW Police Force Handbook requires the officer in charge of the investigation to confer with the Coroner, State Crown Solicitor and any counsel appointed when conducting the investigation. The Coroner also has the power to give a police officer directions, which may include a direction to keep the

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346 Coroners Act 1993 (NT), s 25(1); Coroners Act 2009 (NSW), s 51(2); Coroners Act 2003 (Qld), s 15(2); Police Powers and Responsibilities Act 2000 (Qld), s 794; Coroners Act 1996 (WA), s 14; Coroners Act 2008 (Vic), ss 55(2)(e), 60(a); Coroners Act 1997 (ACT), s 63; Coroners Act 1995 (Tas), s 16.
counsel assisting informed. However, there are no provisions which require the counsel assisting to carry out further investigation.

4.36 Tasmania and Northern Territory

In Tasmania and the Northern Territory, the Coroner has the power to give a police officer directions concerning investigations. However, counsel assisting does not have an equivalent power to give directions.

4.37 South Australia and Australian Capital Territory

In South Australia and the Australian Capital Territory, the Coroner has certain powers to give directions to police officers. However, counsel assisting the Coroner is not granted this power. There are no express provisions in the relevant legislation requiring counsel assisting the Coroner to be kept informed.

4.38 Queensland

In Queensland, guidance material provides that, in some respects the powers of a Coroner exceed that of a police officer investigating a crime. For example, there is no need to suspect that evidence of a crime will be found in order to ground a warrant to search premises and a potential witness cannot refuse to answer questions during the investigation unless they have a reasonable excuse for doing so. In addition, investigating officers must attend an inquest or pre-inquest conference where required by a Coroner.

Investigating officers are required to ensure that:

a. witness statements have been taken;

b. witness expense claims are submitted; and

c. exhibits for a coronial investigation are to be held in compliance with the procedures set out in the Operations and Procedures Manual.

Officers may also be asked to express opinions whilst giving evidence in an inquest “for the purpose of assisting the Coroner in determining the appropriate findings and/or recommendations to prevent deaths in similar circumstances.” In Queensland, there is also a Memorandum of Understanding between the Police

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349 Coroners Act 2009 (NSW), s 51(2).
350 Coroners Act 1993 (NT), s 25; Coroners Act 1995 (Tas), ss 16, 59.
351 Coroners Act 2003 (SA), s 22(3); Coroners Act 1997 (ACT), ss 59, 63.
Commissioner, State Coroner and the Crime and Misconduct Commission (now known as the ‘CCC’) which establishes operational arrangements for the investigation of deaths “arising from police-related incidents”. Under these arrangements, the Ethical Standards Command (‘ESC’) investigates the death, subject to the CCC exercising its power to assume responsibility for the investigation. The Coroner must be consulted about the allocation of police resources during these investigations. This arrangement also limits media releases about these deaths.

4.39 Victoria

In Victoria, the Coroner may be assisted by a police officer or an Australian lawyer. However, there is no requirement that the relevant lawyer must be kept informed by the officer in charge of the police investigation into the death, as to the conduct of the investigation. The absence of a specific power to direct police in investigations was raised by the Law Reform Committee in its review of the Coroners Act 1985 (Vic).

The Coroners Act 1985 (Vic) also does not specify the powers of the lawyer assisting, including whether they are entitled to require the officer in charge of the police investigation to conduct further investigations. Notwithstanding this, it is common practice for police officers to conduct investigations on behalf of the Coroner.

The Office of Police Integrity (‘OPI’) has recommended that specific legislative provisions dealing with investigative and oversight responsibility be implemented in order to “avoid duplication of effort, enhance transparency and most importantly accountability”. Furthermore, Practice Directions issued by the Coroners Court of Victoria provide for a Coroner’s investigator to assist the Coroner with his or her investigation into a reportable death. The Coroner’s investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the Coroner. The Coroner’s investigator takes instructions directly from a Coroner and carries out the role subject to the direction of a Coroner.

4.40 Western Australia

359 The Office of Police Integrity Victoria, Review of the investigation of deaths associated with police contact - Issues paper, (October 2010), 28.
360 The Office of Police Integrity Victoria, Review of the investigative process following a death associated with Police Contact - Final Report, (June 2011), 25.

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Western Australia, whilst every member of the police force (in their capacity as a Coroner's investigator) is required to carry out all reasonable directions of a Coroner, they are not required to do so to the extent that this is inconsistent with a direction of the Commissioner of Police.  

Where there is coronial involvement in a police investigation, research has indicated that clearer directions and guidelines should be provided to the police from the Coroner to ensure a thorough investigation has taken place. For example, the Law Reform Commission of Western Australia has found that:

a. regional Western Australians do not have equality of access to coronial services;

b. there are no coronial counselling services in some regions;

c. the quality of coronial investigations is inconsistent; and

d. the training of regional Coroners and registrars is inadequate.

The Law Reform Commission recommended that coronial regions be established and serviced by dedicated regional Coroners. The importance of coronial guidelines and the need for proper police and coronial training is discussed further in this Report.

5. Coronial Investigations and the Role of the Police
(Recommendations 32 - 35)

Four Recommendations deal specifically with police investigations of deaths in custody in the context of a coronial inquiry. These are, that:

1. the police officer in charge is to be appointed by a Commissioner;

2. the investigating officers should be independent;

3. highly qualified investigators are to head the investigations and report to a senior officer; and

4. police standing orders or instructions must provide specific directions as to the conduct of investigations.

Coroners Act 1996 (WA), ss 14(2), (3)(b), (4).


Ibid.

Ibid.

Ibid. These directions should cover, amongst other things: (a) that suicide should not be presumed; (b) that the investigation should be wide-ranging, covering the general care, treatment and supervision of the deceased prior to death; (c) the circumstances leading up to the incarceration, including the circumstances of the arrest, be examined; (d) whether custodial officers followed all the relevant policies and instructions relating to the care, treatment and supervision of the deceased; (e) an examination of the scene of death, including a seizure of exhibits and photography of the evidence.
It has been difficult to measure the implementation of these Recommendations as this information usually takes the form of police rules, operating manuals, policies, guidelines, codes of practice, general orders and other internal documents which are not always readily accessible to the general public.

For example, only the Queensland, New South Wales and Australian Capital Territory police forces publish police handbooks on their websites. In Queensland, Recommendations 32 to 35 are covered by the *Operational Procedures Manual* under section 16.23 (Deaths in police custody).369

The *Western Australian Police Operations Manual* (which is published on the Western Australian police intranet) is no longer available to be purchased but can be viewed at the Western Australian State Library. The *Police Operations Manual* includes sections pertaining to “Investigations into deaths whilst in police custody or presence” and “Coronial Matters”.370 The *Western Australian Police Code of Conduct* does not contain any express reference to police investigations into deaths in custody or coronial inquests.371 Nonetheless, counsel assisting the Coroner is expected to ensure that adequate investigations are undertaken and to direct and conduct further inquiries if necessary.372

Details of police procedures relating to a death in custody are often only disclosed by way of a coronial finding in which the Coroner has examined and discussed police protocols, or in a subsequent review of police procedure by an independent commission.373 This process is inadequate and there is an urgent need to promote public confidence in the role of the police in the coronial system and transparency is key to achieving this. Some States have acknowledged this issue and are seeking to reform their investigative models and guidelines.

**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.*


370 Western Australian Police Operations Manual. It is noted that the Manual is currently being updated by Western Australian Police (April 2015).


373 Coronal findings have shown that where police procedures are in place, these may often be inadequate or confusing to follow. For example, in a 2010 review of the Doomadgee case in Palm Island, the Crime and Misconduct Commission noted that the information relating to the investigation of a death in police custody in Queensland was spread across six sections of the *Operational Procedures Manual* making it confusing to follow. It was suggested that the *Operational Procedures Manual* be amended to provide for an entirely separate section containing all the relevant policies, procedures and orders relating to a death in custody. See Crime and Corruption Commission, *CMC Review of the Queensland Police Service’s Palm Island Review* (June 2010), 19, 185 <http://www.ccc.qld.gov.au/police/misconduct-by-police/investigations-of-police/palm-island-review/cmc-review-qps-palm-island-review>.

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3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
Recommendation 32 does not appear to have been implemented in legislation across the States and Territories. However, the Commonwealth, Australian Capital Territory, New South Wales, Western Australia and Queensland have publicly available guidelines or manuals which are relevant to this Recommendation.

5.1 Commonwealth and Australian Capital Territory

In the Commonwealth and Australian Capital Territory, Recommendation 32 has been partially implemented. The Australian Capital Territory police is a business unit of the AFP. The *AFP National Guideline* (which is used for the Commonwealth and the Australian Capital Territory) provides that the Manager Professional Standards is responsible for any internal investigation into a death in custody, however, it does not specify that the selection of the officer must be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank.\(^{374}\)

5.2 New South Wales

In New South Wales the *NSW Police Force Handbook* provides that a senior investigating officer (‘SIO’) takes command of the investigation but does not specify who selects that officer. Pursuant to the *NSW Police Force Handbook*, the SIO must confer with the Professional Standards Manager and Commander, Coronial Investigation Team. The SIO must promptly advise the NSWPF Solicitor of the victim’s name, date and place of death, and brief circumstances. The SIO must also supply their name and the names of the review officers to the NSWPF Solicitor.\(^{375}\)

5.3 Western Australia

In Western Australia, Recommendation 32 has been implemented at the policy level. The Western Australian *Police Manuals* provide that the Assistant Commissioner (Professional Standards) has responsibility for investigating all deaths in police custody or in police presence to the Internal Affairs Unit (‘IAU’). The Superintendent IAU will conduct a full investigation into any such incident and must notify the Coroner’s representative. The Superintendent has the responsibility of gathering all evidence and the preparation of a concise report for the Coroner. The Superintendent must regularly liaise with the Coroner during any investigation and carry out any further investigation of any matter associated with the incident which may be required by the Coroner.\(^{376}\) The Western Australian *Police Manuals* provides that the Coronial Investigation Unit shall assist the IAU by undertaking the management of the deceased.\(^{377}\)

5.4 Queensland

\[^{376}\] WA Police Manuals, Operations Manual section DC-1.2.1 (as at April 2015).
\[^{377}\] Ibid.
In Queensland, Recommendation 32 has been partially implemented. The Operational Procedures Manual states that “Deaths in police custody are to be investigated by Ethical Standards Command (‘ESC’), subject to the Crime and Corruption Commission exercising its power to assume responsibility for the investigation.”\(^\text{378}\) According to the QPS website, the ESC’s Internal Investigations Group is responsible for investigating deaths in custody and the group must liaise with the CCC in cases of serious police misconduct.\(^\text{379}\)

An ESC organisational chart indicates that the Internal Investigations Group holds a senior position in the chain of command to that of the Detective Superintendent Deputy Operations Commander. It is headed by (or of equivalent seniority to) the Chief Superintendent Operations Commander and is answerable to the Assistant Commissioner of the ESC.

5.5 Victoria

In Victoria, the Victoria Police Manual provides that responsibility for the investigation of a death in police presence or custody falls to the homicide squad, on behalf of the Coroner under the Coroners Act 2008 (Vic). However, oversight of the investigation is undertaken by the Professional Standards Command or regional investigators, as determined by the Assistant Commissioner. That person is responsible for oversight of the investigation and acts on behalf of the Chief Commissioner and “in the interests of community confidence.”\(^\text{380}\) The oversight role is not to investigate the incident but to oversee the incident in an impartial and objective manner.\(^\text{381}\)

5.6 South Australia, Northern Territory and Tasmania

Relevant police guidelines are not publicly available for South Australia, the Northern Territory and Tasmania. Accordingly, it is not possible to verify whether Recommendation 32 has been addressed in the guidelines. However, pursuant to the Police Administration Act 1991 (NT), the Commander has the power to issue General Orders relevant to Recommendation 32.\(^\text{382}\) Similarly, pursuant to the Police Act 1998 (SA), the Commissioner may make or give general or special orders concerning the manner in which various duties are to be performed.\(^\text{383}\)

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


\(^{380}\) Victoria Police Manual, version as at 26 March 2015, page 2 - Section titled "Death or serious injury incidents involving police".

\(^{381}\) Victoria Police Manual, version as at 26 March 2015, page 5 - Section titled "Death or serious injury incidents involving police – initial action".

\(^{382}\) Police Administration Act 1991 (NT), s 14A.

\(^{383}\) Police Act 1998 (SA), s 11.

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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.

5.7 Commonwealth and Australian Capital Territory

Recommendation 33 has been implemented in the Commonwealth and the Australian Capital Territory in the *AFP National Guideline*, which provides that the Manager Professional Standards, or in their absence, the Duty Commander, must appoint an independent team to investigate the death, and that those involved with the deceased are not to take part in the investigation process, other than as witnesses.\(^{384}\)

5.8 New South Wales

In New South Wales, the *NSW Police Force Handbook* provides that officers connected with the circumstances of, or leading up to, the death must not accompany the body to the mortuary, but this does not sufficiently exclude them from other parts of the investigation. The *NSW Police Force Handbook* also provides for a Professional Standards Command reviewing officer (‘PSC’), who has an independent function and is responsible for ensuring a competent investigation is carried out. The PSC is also responsible for identifying and reporting on deficiencies in established practices and procedures.\(^{385}\) This is a step towards implementing Recommendation 33 but it does not entirely fulfil the requirements of the Recommendation.

5.9 Western Australia

In Western Australia, Recommendation 33 has been implemented at the policy level. The Western Australian *Police Manuals* provide that the Assistant Commissioner (Professional Standards) has responsibility for investigating all deaths in police custody or in police presence to the IAU. The Superintendent IAU must conduct a full investigation into any such incident. The Superintendent has the responsibility of gathering all evidence and the preparation of a concise report for the Coroner. The Superintendent must regularly liaise with the Coroner during any investigation and carry out any further investigation of any matter associated with the incident which may be required by the Coroner.\(^{386}\) The *Police Manuals* also note that the instructions contained within the *Police Manuals* are designed to satisfy the integrity of the investigative process and the need to maintain public confidence in the integrity and accountability of the Western Australian police.

5.10 Victoria

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\(^{386}\) WA Police Manuals, Operations Manual section DC-1.2.1 (as at April 2015).
In Victoria, Recommendation 33 has partly been implemented in policy. The Coroners Court of Victoria has issued a Practice Direction which provides that where a death has, prima facie, occurred in circumstances involving police contact, the Coroner will ensure independent counsel assisting is appointed as permitted by, or in accordance with, sections 60(b)-(d) of the Coroners Act 2008 (Vic).\textsuperscript{387} It appears that this guideline attempts to exclude section 60(a) from deaths that involved contact with police so that where such a death occurs, the Coroner may be assisted at an inquest by an Australian lawyer, the DPP (if the DPP wishes to assist) or another person appointed by the Coroner, but not a police officer.

The Victoria Police Manual requires that where a police officer is involved in a death in custody, they will be separated after the incident and asked not to discuss any issue arising from the incident with any employee other than the designated investigator.\textsuperscript{388} Where possible, employees involved in the oversight or the investigation of the incident are required not to have a substantial connection to police or other parties who are the subject of the incident being investigated and overseen. Also, there should not be any integrity issues that could lead management or a reasonable person to conclude that a conflict of interest may or does exist.\textsuperscript{389}

Further, Victorian police employees involved in the oversight or the investigation are required to complete the oversight/investigation conflict of interest form and conflicts declared may be managed by way of a documented management plan.\textsuperscript{390}

5.11 Queensland

In Queensland, it is clear that impartiality of an investigation is intended to be paramount in the Operating Procedures Manual, however, the manual does not specifically state that officers who were on duty during the time a person died in custody should not take part in the investigation.\textsuperscript{391} Officers who find a person in custody whom they believe to be dead or dying are required to call for assistance and attend to that person, including attempting to resuscitate that person. If the person is confirmed to be dead they are obliged to record information including details of any person who had access to the deceased, any relevant information including the position of the body if the body must be moved for any reason, and must secure all documentation relevant to the particular person.\textsuperscript{392}

5.12 Northern Territory

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\textsuperscript{388} Victoria Police Manual, version as at 26 March 2015, page 6 - Section titled "Death or serious injury incidents involving police – initial action".

\textsuperscript{389} Victoria Police Manual, version as at 26 March 2015, page 2 - Section titled "Oversight of death or serious injury incidents involving police".

\textsuperscript{390} Victoria Police Manual, version as at 26 March 2015, page 4 - Section titled "Oversight of death or serious injury incidents involving police".


\textsuperscript{392} Ibid.

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In the Northern Territory, the police guidelines or manuals are not publicly available. Accordingly, it is not possible to verify whether Recommendation 33 has been implemented. However, it is noted that the Northern Territory police are subject to the *NT Public Sector Principles and Code of Conduct*, and have adopted the *Australasian Police Statement of Ethics*, both of which contain general principles regarding the performance of duties with impartiality and integrity. Pursuant to the *Coroners Act 1993* (NT)\(^{393}\), the Coroner may give directions to a police officer for the purpose of investigating the death of a person held in custody. However, this is not sufficient to ensure the independence of the investigating officers.

### 5.13 Tasmania and South Australia

The police guidelines for Tasmania and South Australia are not available publicly. Accordingly, it is unclear whether Recommendation 33 has been adopted in those States. However, it is noted that in Tasmania, the Department of Police and Emergency Services have released an Aboriginal Strategic Management Plan (2014-2022) (‘the Plan’). The Plan provides that Tasmanian police:

a. will act consistently in a humane, ethical and accountable way;

b. recognise that its use of discretion is central to improving the relationship between Tasmanian police and the community; and

c. recognise and accept its duty of care to all people in custody.

**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.

In most Australian jurisdictions, primary investigative responsibility for a death in custody vests with the police with limited independent oversight by anti-corruption or other such independent bodies. The RCIADIC conceded that the police should retain an investigative role due to their appropriate skills and expertise in death investigations and knowledge of police practice, but recommended that this should be subject to several important safeguards.\(^{394}\) For example, it is crucial that the Coroner controls the investigative process and that officers involved in death investigations are highly qualified and independent. It is noted that police remain involved in many aspects of coronial procedure and this raises questions regarding the impartiality of the police in police-related deaths.\(^{395}\) In particular, there are concerns regarding the:

\(^{393}\) *Coroners Act 1993* (NT), s 25.


\(^{395}\) For example, police usually inform and question close relatives about a family member who died in custody, are present at post-mortem examinations, collect evidence and conduct the investigation, select and interview witnesses and control the dissemination of documents to the relatives of the deceased.
lack of objectivity and independence of police investigations;
- inadequate prioritisation of investigations;
- delays in investigations; and
- poor quality and narrow scope of investigations.

Structural changes have been made to address this criticism in some jurisdictions, although the problem still remains. In 2010, the Western Australian State Coroner outlined his concerns over police led investigations, indicating that the current system is not working.\(^\text{396}\) However, since then several States have acknowledged this and are seeking to reform their investigative models.

### 5.14 Queensland

Queensland was considering introducing a new model which vests sole responsibility for the investigation of a death in police custody with the State Coroner and embedding police investigators in the Coroners Court who report directly to the State Coroner.\(^\text{397}\) The State Coroner's Guidelines 2013 were amended in November 2014. Chapter 11 provides a Memorandum of Understanding between the Police Commissioner, State Coroner and the CCC. It establishes operational arrangements for the investigation of police-related deaths. Under these arrangements the QPS ESC investigates the death, subject to the CCC exercising its power to assume responsibility for the investigation. The Memorandum of Understanding goes some way to supporting Recommendation 34.

### 5.15 New South Wales

In New South Wales, Recommendation 34 has been implemented. Pursuant to the NSW Police Force Handbook, the SIO takes command of the investigation and the PSC has an independent function to ensure a competent investigation is carried out by the team.\(^\text{398}\)

### 5.16 Australian Capital Territory

In the Australian Capital Territory, Recommendation 34 has not been specifically dealt with in the AFP National Guideline. The AFP National Guideline simply

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\(^{396}\) In 2010, the Western Australian State Coroner wrote to the Law Reform Commission of Western Australia outlining his concerns over police led investigations. He noted that the questioning of police in these cases "differs from questioning of other witnesses and very often suggestions are made by the questioner which would provide an explanation for or otherwise reflect well on the conduct of the officers concerned". He suggested that "it is difficult to imagine a system which would favour police officers concerned more than the current one". See Law Reform Commission of Western Australia, Review of Coronial Practice in Western Australia - Discussion Paper - Project No 100 (June 2011), 94 <http://www.lrc.justice.wa.gov.au/_files/P100-DP.pdf>.


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provides that the Manager Professional Standards is responsible for any internal investigation into a death in custody.

5.17 Victoria

In Victoria, a review of the investigative process of police-related deaths was conducted by the OPI and a number of alternative investigative models were considered following the fatal police shooting of 15 year old Tyler Cassidy in December 2008. The final OPI review, tabled in June 2011, highlighted deficiencies in the current system but fell short of outlining an optimal investigative framework for Victoria, deferring responsibility to the Victorian Government "to determine if the current policy and legislative framework requires amendment and, if so, what that amendment should look like". This was a missed opportunity.

5.18 Western Australia

In Western Australia, Recommendation 34 has been implemented. The Western Australian Police Manuals provide that responsibility for investigating all deaths in police custody rest with the IAU. The Superintendent IAU may utilise the resources of the IAU and/or any other area of specialised expertise within the Western Australian police. The Western Australian Police Manuals provide that police officers should bear in mind that every member of the police force is contemporaneously a Coroner’s investigator pursuant to section 14 of the Coroners Act 1996 (WA). The Coroners Act 1996 (WA) also allows for the appointment of independent Coroner’s investigators, however this has never been utilised. The Law Reform Commission of Western Australia recommended that to ensure independent observation or oversight, the Western Australian Corruption and Crime Commission should actively monitor and review police investigations in police-related deaths.

5.19 Tasmania, South Australia and Northern Territory

The police guidelines for Tasmania, South Australia and Northern Territory are not available and therefore it is not clear whether Recommendation 34 has been implemented in those States.

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399 The five models considered were: (a) investigation by another police service model; (b) hybrid civilian/police model; (c) civilian-managed investigation model; (d) embedded civilian observer model; and (d) independent model with an agency separate to the police to carry out the investigation. See The Office of Police Integrity (Victoria), Review of the investigation of deaths associated with police contact - Issues Paper (2010), p44-50.
400 The Office of Police Integrity (Victoria), Review of the investigative process following a death associated with police contact (2011), p 62.
It is suggested that consideration be given to establishing an independent national body to carry out investigations of deaths in custody and police-related deaths. This should consist of highly skilled investigators as well as anti-corruptions bodies.

**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 direction as maybe 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.

5.20 **New South Wales**

In New South Wales, Recommendation 35 has been partially implemented. The *NSW Police Force Handbook* sets out specific instructions as to how investigations are to be conducted. In particular, Recommendation 35(a) and (b) have been implemented in full and Recommendation 35(c), (d) and (e) have been partially implemented.  

5.21 **Australian Capital Territory**

Recommendation 35 has been partially implemented in the Australian Capital Territory. The *AFP National Guideline* sets out specific requirements as to how
investigations into deaths in custody must be carried out, including that all deaths in custody are to be treated as a crime scene, and investigated accordingly, and an independent investigation team must be appointed to investigate the circumstances of the death. The AFP Practical Guide on Deaths also partially addresses Recommendation 35. This guideline outlines general directions as to the conduct of investigations into deaths in the Australian Capital Territory. However, it does not specifically reference deaths in custody or address the requirements of Recommendation 35.

5.22 Queensland

In Queensland, the Operations Procedure Manual provides generally for the manner in which investigations are to be conducted. However, it does not specifically implement Recommendation 35. Appendix 16.3 of the Operational Procedures Manual sets out a “[s]uggested format for reports on deaths in custody or in police company”.

5.23 Western Australia

In Western Australia, Recommendation 35 has been partially implemented. The Western Australian Police Manuals set out directions as to how investigations into deaths in custody are to be carried out by the IAU. It does not specifically address all of the requirements of Recommendation 35. The Police Manuals also refer to the IAU investigation protocols which are not available. These protocols may contain further relevant instructions. The Police Manuals also note that the instructions contained within the Police Manuals are designed to satisfy the integrity of the investigative process and the need to maintain public confidence in the integrity and accountability of the Western Australian police.

5.24 Victoria

In Victoria, the Victoria Police Manual provides generally for the manner in which investigations into incidents of death involving police are to be conducted. This includes instructions for the release of information and notification of relatives where there is a death in custody. However, it does not specifically implement Recommendation 35.

5.25 Tasmania, South Australia and Northern Territory

The police guidelines for Tasmania, South Australia and Northern Territory are not available and therefore it is not clear whether Recommendation 35 has been implemented in those States.

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406 Ibid, [22]. This Guideline is to be read with the ACT Policing Watch-house Operations Manual, which is not publicly available.
408 WA Police Manuals, Operations Manual section DC-1.2.1 and 1.2.2 (April 2015).
6. Inquiry Protocol (Recommendation 36 – 40)

**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.

6.1 New South Wales

In New South Wales, Recommendation 36 has been partially implemented. The **NSW Police Force Handbook** includes specific procedures for investigating deaths in custody. Whilst there is no reference in the New South Wales legislation that the Coroner make specific findings in relation the quality of the care, treatment and supervision of the deceased prior to death, the Coroner has broad powers of investigation and must make a finding (at its conclusion/suspension) about the manner and cause of the person’s death. The Coroner may also make recommendations in relation to public health and safety. The State Coroner has noted that "any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, the reoccurrence of the circumstances of the death in question". These recommendations could, in theory, include reference to the level of care, treatment and supervision of the deceased prior to death.

6.2 Australian Capital Territory

In the Australian Capital Territory, Recommendation 36 has been implemented. The Australian Capital Territory police are a business unit of the AFP. The **AFP National Guideline** sets out specific requirements as to how investigations into deaths in custody must be carried out, including that all deaths in custody are to be treated as a crime scene and investigated accordingly, and an independent investigation team must be appointed to investigate the circumstances of the death. In addition, in the case of a death in custody, the Coroner must make findings "about the quality of

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411 Ibid.
412 Coroners Act 2009 (NSW), ch 5, s 51.
413 Ibid, s 81(1)(c).
414 Ibid, s 82(2)(a).
417 Ibid. This Guideline is to be read with the ACT Policing Watch-house Operations Manual, which is not publicly available.
care, treatment and supervision of the deceased that, in the opinion of the Coroner, contributed to the cause of death".418

6.3 South Australia

In South Australia, Recommendation 36 has been partially implemented. The Coroners Act 2003 (SA) provides that the Coroner has broad investigative powers, and states that in the case of a death in custody, the Coroner must hold an inquest to ascertain the cause or circumstances of the death.419 However, the Act does not require the Coroner to make any findings concerning the quality of care, treatment and supervision of the deceased prior to death.420 Notwithstanding, the Coroner can add to its findings a recommendation that might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.421 This could in theory include reference to the level of care, treatment and supervision of the deceased prior to death. Further relevant information may be contained in the South Australian police guidelines, however, this document is not publically available.

6.4 Tasmania

In Tasmania, Recommendation 36 has been implemented. The Tasmanian Coroners Act 1995 (Tas) provides the Coroner with jurisdiction to investigate a death in custody (being a “reportable death”).422 In circumstances where there is a death in custody, the Act requires the Coroner to report on the care, treatment or supervision of the person while that person was held in custody.423 Further relevant information may be contained in the Tasmanian police guidelines, however, this document is not publically available.

6.5 Northern Territory

In the Northern Territory, Recommendation 36 has been implemented. The Coroner has broad powers to investigate all deaths, and may give directions to police for the purposes of investigating a death in custody.424 In addition, the Coroner must investigate and report on:425

- the care, supervision and treatment of the person who was held in custody; and
- whether the death of the person was caused or contributed to by injuries sustained whilst the person was held in custody.

A Coroner who holds an inquest into a death in custody must also make recommendations with respect to the prevention of future deaths in similar

418 Coroners Act 1997 (ACT), s 74.
419 Coroners Act 2003 (SA), s 21(1)(a).
420 Ibid, ss 22, 23.
421 Ibid, s 25(2).
422 Coroners Act 1995 (Tas), ss 3, 21(1).
423 Ibid, s 28(5).
424 Coroners Act 1993 (NT), div 2, pt 4, s 25(1).
425 Ibid, s 26(1)(a).
circumstances. Further relevant information may be contained in the Northern Territory police manual, however, this document is not publicly available.

6.6 Western Australia

In Western Australia, Recommendation 36 has been implemented. The Recommendation has been implemented at the policy level through detailed procedures in the Police Manuals and in the Policy Directives of the Department of Corrective Services. The Coroner also has broad powers of investigation. In circumstances where there is a death of a person held in care, a Coroner must comment on the quality of the supervision, treatment and care of the person while that person was held in care.

6.7 Queensland

In Queensland, Recommendation 36 has been partially implemented. The State Coroner is required to issue guidelines and directions to all Coroners for investigations, and in doing so the State Coroner must have regard to the Recommendations of the RCIADIC that relate to the investigation of deaths in custody. There are also a number of relevant procedures contained in Chapter 8 of the Operational Procedures Manual. The Coroner is not required to comment on the quality of the care, treatment and supervision of the deceased prior to death as is required in some other jurisdictions. However, the Coroner may, whenever 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. In this regard, the State Coroner’s Guidelines emphasise that there must be a connection to the death investigated.

6.8 Victoria

In Victoria, Recommendation 36 has been partially implemented. The Coroners Act 2008 (Vic) provides that, where it appears to the Coroner that a death is a 'reportable death' (which includes the death of a person who immediately before death was a

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426 Coroners Act 1993 (NT), s 26(2).
427 Police Manuals Operational Manual, Section DC-1.2.2.
430 Ibid, s 25(3).
431 Coroners Act 2003 (Qld), s 14.
432 Ibid, s 14(2).
434 Coroners Act 2003 (Qld), s 46(1).

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person placed in custody or care, or the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer, the Coroner must investigate that death. 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.

A Coroner must, except in certain circumstances including where a death is due to natural causes, hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care. The Coroner has wide powers at inquests, including the power to summon a person to attend as a witness or to produce any document or other material and may give any other directions and do anything else the Coroner believes necessary.

Therefore, it is largely a discretionary matter for the Coroner in investigating and holding an inquest into a death in custody as to how he or she will consider issues such as the cause and circumstances of a death and whether he or she will consider issues such as the quality of the care, treatment and supervision of the deceased prior to death.

In addition, Victorian police report on abusive/offensive language offences and monitor all incidents involving the use of force on persons held in police cells. According to the Victorian Government Response to the Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody, the Victorian Government has acknowledged that provision of this information to other justice agencies raises privacy issues that require further consideration.

**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.**

6.9 New South Wales

The *Coroners Act 2009 (NSW)* provides that a Coroner may direct an “appropriate medical investigator” to conduct (or arrange for another person to conduct) a post-mortem examination. The “appropriate medical investigator” is either a Coronial Medical Officer, a pathologist or any other person that the Coroner considers has appropriate qualifications to conduct (or has the capacity to arrange for another appropriately qualified person to conduct) the examination. Where a post-mortem
investigation direction requires or permits an appropriate medical investigator to arrange for another person to conduct an examination, the investigator may arrange for a person to conduct the examination if the investigator considers that the person has the appropriate qualifications to do so.\textsuperscript{445}

Whilst the legislative provisions do not reflect the terms of Recommendation 37, it has been implemented at a policy level. The State Coroner notes that in respect of all identified deaths in custody, examinations are conducted by post-mortem experienced Forensic Pathologists at Glebe or Newcastle.\textsuperscript{446} In addition, the \textit{NSW Police Force Handbook} states that any person who dies in custody must undergo a post-mortem examination at the Department of Forensic Medicine at Glebe or Newcastle.\textsuperscript{447}

\section*{6.10 Australian Capital Territory}

The \textit{Coroners Act 1997 (ACT)} provides that a Coroner holding an inquest into a death in custody must, whenever practicable, direct a post-mortem examination to be conducted by a pathologist who has not less than 2 years' experience in the conduct of post-mortem examinations.\textsuperscript{448} It is noted that the \textit{Coroners Act 1997 (ACT)} only requires a doctor to carry out post-mortem examinations for deaths other than deaths in custody (i.e. a pathologist is not specified).\textsuperscript{449} However, the Coroner's Court has issued an information brochure which provides that post-mortem examinations are carried out by pathologists.\textsuperscript{450} As such, there appears to be legislative intention to implement Recommendation 37, however, the legislation is not drafted in exactly the same terms.

\section*{6.11 South Australia}

The \textit{Coroners Act 2003 (SA)} gives the Coroners Court 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.\textsuperscript{451} The \textit{Coroners Act 2003 (SA)} does not specify that the pathologist must be a specialist forensic pathologist as Recommendation 37 directs. However, the Coroners Court website provides that "in Adelaide, the post-mortem is performed by a forensic pathologist at the Forensic Science Centre. In country South Australia,}

\begin{footnotesize}
\item[445] Ibid, s 89(5).
\item[446] New South Wales Office of the State Coroner, \textit{Report by the NSW State Coroner into deaths in custody/police operations for the year 2013} (15 March 2014), p 14
\end{verbatim}
\end{verbatim}
\item[448] Coroners Act 1997 (ACT), s 71.
\item[449] Ibid, s 21.
\item[450] ACT Magistrates Court, \textit{Information about the Coroners Court and the Death of a Relative or Friend} (22 September 2010)
\end{verbatim}
\item[451] Coroners Act 2003 (SA), s 22(1)(i).
\end{footnotesize}
the post-mortem may be performed by a pathologist at a hospital in a large regional centre". 452

Accordingly, Recommendation 37 has not been substantively implemented by legislation, however, it appears to have been implemented at a policy level. It is noted that there is some uncertainty as to whether the pathologist in country South Australia will be a specialist pathologist qualified by experience or training to conduct post-mortem examinations.

6.12 Tasmania

The Coroners Act 1995 (Tas) provides that if a Coroner reasonably believes 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.453 An “approved pathologist” is one approved in writing by the State Forensic Pathologist to undertake coronial autopsies, and must either be a pathologist or a medical practitioner.454 Accordingly, Recommendation 37 has been partially implemented, as it is still possible for an autopsy to be conducted by a medical practitioner, rather than a specialist pathologist.

6.13 Northern Territory

Recommendation 37 has been implemented. The Coroners Act 1993 (NT) requires a post-mortem to be conducted by a medical practitioner.455 The Coroners Regulations prescribe the qualifications of a medical practitioner and provide that a medical practitioner who is directed to perform an autopsy shall wherever possible, be a qualified forensic pathologist, or where they are unavailable, be a qualified pathologist who is, in the opinion of the Coroner, suitably experienced to perform an autopsy.456

6.14 Western Australia

In Western Australia, 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.457 Whilst the legislation refers to a ‘pathologist or a doctor’, the Coroners Court website states that in Perth, autopsies are performed by a forensic pathologist and in country Western Australia, autopsies may be performed by a doctor from a local hospital, however in most cases, the post-mortem examinations will be conducted in Perth.458 Based on this information, Recommendation 37 has not been implemented by legislation, but is largely

453 Coroners Act 1995 (Tas), s 36(1).
454 Ibid, s 35(1).
455 Coroners Act 1993 (NT), s 20(1).
456 Coroners Regulations (NT), reg 6(2).
457 Coroners Act 1996 (WA), s 34(1).
implemented by policy (however, this depends on the location of the post-mortem examination).

6.15 Victoria

In Victoria, Recommendation 37 has also been partially implemented. The Coroners Act 2008 (Vic) requires a Coroner to direct a medical investigator to perform an autopsy if the Coroner believes that the autopsy is necessary for the investigation of the death and it is appropriate to give the direction.\(^{459}\) A ‘medical investigator’ is defined to mean the Victorian Institute of Forensic Medicine, a pathologist, or a registered medical practitioner\(^{460}\) under the general supervision of a pathologist.\(^{461}\)

A Coroner may also provide a body to a medical investigator to enable a preliminary examination to be performed on the body.\(^{462}\) Therefore, whilst there is a requirement for an autopsy in certain circumstances, there is no requirement that this is conducted by a specialist forensic pathologist wherever possible or a specialist pathologist qualified by experience or training to conduct such post-mortem examinations.

6.16 Queensland

In Queensland, the Coroner has the power to order that a doctor perform an autopsy as part of the investigation of a death.\(^{463}\) The Coroners Act 2003 (Qld) mandates that the State Coroner's Guidelines 2013 must list the doctors approved by the State Coroner to conduct post-mortem examinations by name or by reference to particular qualifications.\(^{464}\)

The State Coroner's Guidelines 2013 identify forensic pathologists as having the highest level of expertise in the hierarchy of practitioners who can conduct autopsies.\(^{465}\) A table lists the level of expertise required to conduct different categories of autopsy cases, including 'custody deaths'.\(^{466}\) In that table, "almost all deaths in custody" are identified as 'complex' cases and are reserved for forensic pathologists only. Custody deaths which relate to 'expected natural deaths' are identified as 'simple' cases and can be reviewed by 'forensic and other specialist pathologists'.\(^{467}\) Recommendation 37 has largely been implemented, however, it is not clear what the rationale is for using a specialist rather than a forensic pathologist in the case of an expected natural death.

\(^{459}\) Coroners Act 2008 (Vic), s 25(2).
\(^{460}\) Ibid, s 3.
\(^{461}\) Ibid.
\(^{462}\) Ibid, s 23(2).
\(^{463}\) Coroners Act 2003 (Qld), s 19(2).
\(^{464}\) Ibid, s 14(3).
\(^{466}\) Ibid, [Attachment 5B].
\(^{467}\) Ibid.
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.

6.17 Australian Capital Territory

A Coroner may, by order, direct a post-mortem examination to be carried out in any of the circumstances in which the Coroner has jurisdiction to hold an inquest (including where a person dies in custody). There are considerations set out in the legislation which must be taken into account by the Coroner before making such an order. In particular, the 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 distressed or offended by the Coroner's decision to direct a post-mortem examination.

a. The Coroner, holding an inquest into a death in custody must, if requested to do so by a member of the immediate family of the deceased or a family member's representative authorise the member or their representative to:
   b. view the deceased's body;
   c. inspect the scene of the death;
   d. be present at the post-mortem examination; or
   e. have the same or another doctor conduct a further post-mortem,

unless the Coroner believes, on reasonable grounds, that it would not be in the interests of justice to do so.

The term 'member of the immediate family' is defined to include "if the deceased person was an Aboriginal or Torres Strait Islander person - a person who, in accordance with the traditions and customs of Aboriginal or Torres Strait Island community of which the deceased person was a member, had the responsibility for,

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468 Coroners Act 1997 (ACT), s 21(1).
469 Ibid, s 28.
470 Ibid, s 70(1)(d).
or an interest in, the welfare of the deceased person”.\textsuperscript{471} This may be useful, for example, in allowing a family member or representative to determine whether any cultural practices with respect to the deceased's body have been maintained.

If such an authorisation is not given, then the Coroner must give written notice of the decision to the person who made the request, and in the case of an Aboriginal or Torres Strait Islander person, to an appropriate Aboriginal Legal Service.\textsuperscript{472}

In effect, the legislation creates a type of protocol and whilst it does involve some consideration of cultural attitudes and spiritual beliefs, it differs from the requirements of Recommendation 38. Further, based on publicly available information, it is not clear that any separate protocol has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, which is at the heart of the Recommendation. Accordingly, based on this information it is not clear whether Recommendation 38 has been implemented.

6.18 New South Wales

It is noted that following a death in custody, the Coroner will ensure that arrangements have been made to notify relatives, and (if relevant) the deceased's legal representatives. The Aboriginal Legal Service will be contacted where Aboriginality is identified.\textsuperscript{473}

In New South Wales, statute requires that regard must be had to the dignity of the deceased person where a post-mortem examination is conducted.\textsuperscript{474} If more than one procedure is available, then the person conducting the post-mortem is to endeavour to use the least invasive procedure as the circumstances allow.\textsuperscript{475}

The senior next of kin may request that a Coroner or Assistant Coroner not carry out a post-mortem or whole organ retention.\textsuperscript{476} Once such a request is made, a post-mortem must not be carried out unless the Coroner decides that it is necessary or desirable, and must give written notice of this decision to the next of kin.\textsuperscript{477} The senior next of kin may then apply to the Supreme Court for an order that a post-mortem function not be exercised.\textsuperscript{478} The Court may prevent a post-mortem function from being carried out, or may limit the extent of the examination. It is noted that these legislative provisions create a type of protocol, however it does not completely satisfy the requirements of Recommendation 38. Furthermore, it is not a complete solution as it requires knowledge of Supreme Court processes at a time of trauma.

\begin{footnotes}
\item[471] Ibid, Dictionary (definition of 'member of the immediate family').
\item[472] Ibid, s 70(2).
\item[474] \textit{Coroners Act 2009} (NSW), s 88(1).
\item[475] Ibid, s 88(2).
\item[476] Ibid, s 96(1).
\item[477] Ibid, ss 96(2)-(4).
\item[478] Ibid, s 97.
\end{footnotes}

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
and grief for the next of kin. There is also no acknowledgment in the definition of 'senior next of kin' of any special relationships that may exist between Indigenous people.

Furthermore, there is no formal protocol between the Coroner and the Aboriginal Legal Service and Aboriginal Health Service to guide the conduct of inquiries and autopsies with respect to traditional rites. The Report on the NSW Government’s Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody states that "the State Coroner’s Office tries to ensure that relatives of any deceased are dealt with in as sensitive and culturally appropriate a manner as possible. When the death of an Aboriginal person (whether or not a death 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. Burials are permitted as soon as the post-mortem is completed (which is usually within 48 hours of the receipt of the body by the pathologist). The State Coroner does not consider that a formal protocol is necessary in order to implement the substance of this Recommendation".\(^{479}\) The report notes that the Coroner recommended that an Aboriginal Court Liaison Officer (‘ACLO’) attend all coronial proceedings involving Indigenous people, in order to support the family of the deceased as well as to advise the Coroner. The report states that funding restraints restrict this recommendation, so that only sensitive coronial inquiries, such as deaths which occur in custody, should be attended by ACLOs.\(^{480}\)

In summary, there has been an attempt at a legislative and policy level to develop, in effect, protocols dealing with this issue, however they do not cover all of the matters dealt with in Recommendation 38, and there is no formal protocol which lies at the heart of the Recommendation. Accordingly, and whilst acknowledging the existence of the informal protocol, Recommendation 38 has not been fully implemented.

6.19 Northern Territory

In the Northern Territory, where the senior next of kin requests a Coroner not to perform an autopsy, the Coroner must give written notice if it has decided that an autopsy is necessary.\(^{481}\) The autopsy must not be performed until 48 hours after the senior next of kin has been given written notice, and the next of kin may apply within that time to the Supreme Court for an order to prevent the autopsy being carried out.\(^{482}\) The term 'senior next of kin' is defined to include reference to "where a person is an Aborigine – a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person".\(^{483}\) Similar provisions exist where the Coroner reasonably believes that it is necessary for an investigation that a deceased person's body is to be exhumed.\(^{484}\)

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\(^{480}\) Ibid.

\(^{481}\) Coroners Act 1993 (NT), s 23(1).

\(^{482}\) Ibid, ss 23(2)-(3).

\(^{483}\) Ibid, s 3(e).

\(^{484}\) Ibid, s 24.
It is noted that this is not a complete solution as it requires knowledge of how to apply to the Supreme Court, making it difficult for the family of the deceased to object within the relatively short time frame specified in the *Coroners Act 1993 (NT)*.485

In addition, upon request, the Coroner may permit a person who demonstrates sufficient interest in the conduct of the autopsy to attend it.486 This may be useful, for example, in allowing a family member or representative to determine whether any cultural practices with respect to the deceased's body have been maintained.

The Department of Health has issued guidelines for reportable deaths in custody, outlining some cultural practices that may need to be respected.487 However, the Coroner is not required to take them into consideration.

Whilst it is acknowledged that in effect, the legislation creates a type of protocol and does involve some consideration of cultural attitudes and spiritual beliefs, it differs from the requirements of Recommendation 38. Further, based on publicly available information, it is not clear that any separate protocol at a policy level has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, which is at the heart of Recommendation 38. Accordingly, and whilst acknowledging the existence of the legislative protocol, it is not clear whether Recommendation 38 has been implemented.

### 6.20 South Australia

In South Australia, there are no next of kin 'objection' provisions in the legislation similar to those in New South Wales and the Northern Territory. However, the Coroners Court website provides that an informal protocol exists at the policy level. It states 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 whilst the objection is being considered … the State Coroner has to bring down a finding as to the specific cause of death, it is his decision as to whether a post-mortem is conducted. However, the State Coroner will seriously consider objections raised by next of kin".488 This indicates that in practice, some aspects of Recommendation 38 may be implemented.

The 2013-2014 *State Coroner's Report*489 provides that there has been some contact between social workers at the Coroners Court, and officers from Court Services

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485 *Coroners Act 1993 (NT)*, ss 23(2)-(3).
486 *Coroners Regulation (NT)*, reg 8(1).

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Aboriginal Programs. The purpose of the discussion was to create synergies between the Coroners Court and Aboriginal Justice Officers. The future aim is stated as utilising "the specialist knowledge of Aboriginal Justice Officers in understanding and assisting the Aboriginal community during times of grief." 490

However, it is not clear from publicly available information whether there has been any consultation with the Aboriginal Legal Service and Aboriginal Health Service in developing this protocol. Accordingly, and whilst acknowledging that at a policy level there is a form of protocol, it is not clear whether this Recommendation has been implemented as Recommendation 38 is directed towards development of a protocol as between the Coroner, Aboriginal Legal Service and Aboriginal Health Service.

6.21 Tasmania

In Tasmania, it is possible for the senior next of kin of a deceased person to request that an autopsy not be performed.491 If the Coroner decides that an autopsy is necessary, then the Coroner is required to give the senior next of kin notice in writing.492 Unless the Coroner believes that an autopsy needs to be performed immediately, it must not be performed until 48 hours’ notice has been given.493 Within that 48 hour period, the senior next of kin may apply to the Supreme Court for an order that an autopsy not be performed.494 Similar provisions exist in relation to exhumation.495

Similar to the Northern Territory, the term 'senior next of kin' is extended to mean "if the person is an Aborigine, a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person".496

Whilst it is acknowledged that the legislation, in effect, creates a type of protocol, this is not a complete solution as it requires knowledge of how to apply to the Supreme Court, making it difficult for the family of the deceased to object within the relatively short time frame specified in the Coroners Act 1995 (Tas).

In addition, if a Coroner is investigating a 'reportable death'497, and suspects that any human remains relating to that death may be Aboriginal remains (which is defined in the legislation to mean "the remains of an Aboriginal person buried in accordance with Aboriginal custom"),498 the Coroner may refer the matter to an Aboriginal organisation approved by the Attorney-General.499 The Attorney-General has approved the Tasmanian Aboriginal Land Council as the relevant organisation.500

490 Ibid.
491 Coroners Act 1995 (Tas), s 38(1).
492 Ibid.
493 Ibid, s 38(2).
494 Ibid, s 38(3).
495 Ibid, s 39.
496 Ibid, s 3.
497 Ibid.
498 Ibid.
499 Ibid, s 23(2).

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the Coroner refers a matter to an Aboriginal organisation, the Coroner must not carry out any investigations or perform any duties or functions under the Coroner's legislation with respect to the remains, and the Aboriginal organisation must, as soon as practicable after the matter is referred to it, investigate the remains and prepare a report for the Coroner. If the Aboriginal organisation reports to the Coroner that the remains are Aboriginal remains, then the Coroner's jurisdiction ceases and the Coroner's legislation does not apply to the remains.

Whilst it is acknowledged that in effect, the legislation creates a type of protocol and does involve some consideration of cultural attitudes and spiritual beliefs, it differs from the requirements of Recommendation 38. Further, based on publicly available information, it is not clear that any separate protocol at a policy level has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, which is at the heart of Recommendation 38. Accordingly, and whilst acknowledging the existence of the legislative protocol, it is not clear whether Recommendation 38 has been implemented.

6.22 Western Australia

In Western Australia, there is an obligation on the Coroner, as soon as practicable after assuming jurisdiction over a death, to inform the deceased's next of kin of certain prescribed matters, including that there is a legislative regime for objecting to post-mortem examinations. Whilst the body is under the Coroner's control, any of the deceased person's next of kin who wish to view the body are permitted to do so, and are able to touch the body, unless the Coroner determines that it is dangerous or undesirable to do so. The definition of 'senior next of kin' does not include any reference to Aboriginality, as is provided for in some other jurisdictions.

If the senior next of kin asks the Coroner not to direct a post-mortem examination, but the Coroner decides that the post-mortem is necessary, the Coroner must immediately notify the senior next of kin in writing. There is no timeframe given in the legislation during which the senior next of kin must object to the carrying out of the post-mortem. However, the information brochure issued by the Coroner provides that an objection to a post-mortem examination should be made as soon as possible, and that in most country regions and Perth, a period of at least 24 hours will be allowed to enable objections to be made. These timeframes have been the subject of discussion in two Law Reform Commission reports, with the latest report

501 Coroners Act 1995 (Tas), s 23(3).
502 Ibid, s 23(4).
503 Coroners Act 1996 (WA), ss 20, 37.
504 Ibid, s 30(2).
505 Ibid, s 37(5).
506 Coroners Act 1996 (WA) s 37(1).
507 Crown's Court of Western Australia, When a Person Dies Suddenly. Information for families <http://www.coronerscourt.wa.gov.au/_files/When_A_Person_Dies_Suddenly.pdf>. It is noted that the brochure states that for deaths in the Kimberley and Pilbara, internal examinations may not commence for 72 hours after service of the brochure.
508 Law Reform Commission of Western Australia, Review of Coronial Practice in Western Australia - Final Report - Project No 100 (January 2012) <http://www.lrc.justice.wa.gov.au/_files/P100-FR.pdf>
recommending that the time frame for objection be increased to 48 hours. In particular, the Commission heard that “the Aboriginal cultural aspects of grief are so disabling that relatives may fail to register, within the allotted time of 24 hours, an objection to post-mortem based on their genuinely held cultural or spiritual beliefs”. The Western Australian Law Reform Commission recently recommended that the objection be limited to the undertaking of an internal post-mortem examination, but this is not yet reflected in the legislation.

In any event, unless the Coroner believes that the post-mortem needs to be performed immediately, it must not be performed unless 2 clear business days have passed since the notice was given, or until the end of any extension of time granted by the Supreme Court. Within that time period, the senior next of kin may apply to the Supreme Court for an order than no post-mortem be performed. The senior next of kin may also apply to the Supreme Court for an extension of time to apply for such an order.

Although the legislation creates a type of protocol, it differs from the requirements of Recommendation 38. Further, based on publicly available information, it is not clear that any separate protocol has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, as contemplated in the Recommendation. Accordingly, based on this information it is not clear whether Recommendation 38 has been implemented in full in Western Australia.

6.23 Queensland

In Queensland, where the burial of a body has not occurred, the Coroner is required to order an autopsy as part of the investigation of the death. Before ordering an internal examination, the Coroner must, wherever practicable, at least consider:

a. that in some cases a deceased person’s family may be distressed by the making of that type of order, for example, because of cultural traditions or spiritual beliefs; and

b. any concerns raised by a family member, or another person with sufficient interest, in relation to the type of examination to be conducted during the autopsy.

These provisions are mirrored in the State Coroner’s Guidelines. A ‘family member’ is defined in the legislation to include “if the deceased person was an
Aboriginal person or Torres Strait Islander and a spouse, adult child, parent or adult sibling is not reasonably available - and ATSI family member". The term 'ATSI family member' means "for a deceased person who was an Aboriginal person or Torres Strait Islander, means a person who is an appropriate person according to the tradition or custom of the Aboriginal or Torres Strait Islander community to which the deceased person belonged". If after considering any concerns, the Coroner decides that it is still necessary to order the internal examination, the Coroner must give a copy of the order to any person who raised a concern. This enlivens the family member's right to have the decision judicially reviewed. In any event, the State Coroner's Guidelines 2013 states that Coroners "should avoid ordering internal autopsies where this would not compromise the investigation".

In addition, "families now have a right to be informed before the body is released of the Coroner's decision to retain organs or tissue for further examination, and retained organs or tissues must be disposed of according to the family's wishes once no longer required for the Coroner's investigation". The State Coroner's Guidelines 2013 note that Coronial counsellors "regularly engage with community members when communicating with Indigenous families about autopsy and other related issues".

Although the legislation creates a type of protocol, it differs from the requirements of Recommendation 38. Further, based on publicly available information, it is not clear that any separate protocol has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, as contemplated by the Recommendation. Accordingly, based on this information it is not clear whether Recommendation 38 has been implemented in full in Queensland.

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518 Coroners Act 2003 (Qld), sch 2.
519 Ibid.
520 Ibid, s 19(6).
522 Ibid, Chapter 5, at [5.5].
523 Ibid, Chapter 2 at [2.3]; Coroners Act 2003 (Qld), ss 24(4), 24(9).
524 Ibid, at [2.4].

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Victoria, Recommendation 38 has been partially implemented. The Coroners Act 2008 (Vic) provides that a Coroner must direct a medical investigator to perform an autopsy if the Coroner believes that the autopsy is necessary for the investigation of the death and it is appropriate to give the direction. A Coroner may impose conditions on the manner in which an autopsy is performed after consulting with and taking advice from the Victorian Institute of Forensic Medicine or a pathologist.\(^{525}\)

A Coroner must take reasonable steps to notify the next of kin of a direction given by the Coroner that an autopsy be performed. Within 48 hours after receiving notice of the Coroner's direction the senior next of kin may ask the Coroner to reconsider its direction that an autopsy be performed.\(^{526}\) If, after considering such a request, the Coroner determines that the autopsy is necessary for the investigation of the death and it was appropriate to make the direction the Coroner must, without delay, give written notice of the determination to the senior next of kin.\(^{527}\) The next of kin may appeal to the Supreme Court against the Coroner's direction to perform an autopsy and any conditions that may be imposed.\(^{528}\)

Therefore, there are avenues for senior next of kin to object to a decision to perform an autopsy, including appeal rights to the Supreme Court. It is possible for a Coroner to impose conditions on the performance of an autopsy to address specific issues based on cultural grounds but this is a discretionary matter for the Coroner. However, the Coroner should be guided by of the objectives of the Coroners Act 2008 (Vic) which provide that a person exercising a function under the Act should have regard to, amongst other things, that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected.\(^{529}\)

There have been some arguments that Recommendation 38 leads to discrimination against people other than the next of kin. Commissioner Elliott Johnson QC (supported by Justice Beach) stated that "no autopsy should be performed until the Coroner has made every reasonable effort to contact the deceased's family and other interested persons to give them an opportunity to make representations in relation to the conduct of an autopsy". Commissioner Elliott Johnson QC, did not limit standing to the next of kin, but 'other interested persons', which could potentially incorporate Indigenous community members, Indigenous elders and respected persons.\(^{530}\) The Victorian Aboriginal Legal Service Co-operative Limited has recommended that the Coroners Act 2008 (Vic) be amended to reflect the Coroners Act 1993 (NT) which includes the following in the definition of senior next of kin, "where a person is an Aborigine - a person who, according to the customers and

\(^{525}\) Coroners Act 2008 (Vic), s 25.
\(^{526}\) Ibid, s 26(2)(a).
\(^{527}\) Ibid, s 26(3).
\(^{528}\) Ibid, s 79.
\(^{529}\) Ibid, s 8(c).
\(^{530}\) Victorian Aboriginal Legal Service Co-operative Limited Submission to the Implementation Review Team of the Royal Commission into Aboriginal Deaths in Custody.
tradition of the community or group to which the person belongs, is an appropriate person.”

**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.

### 6.25 Australian Capital Territory

As discussed at paragraph 6.17 above, whilst the legislation creates a type of protocol, it differs from the requirements of Recommendation 38. Further, it is not clear from publicly available information whether a specific protocol has been developed with the Aboriginal Legal Service and Aboriginal Health Services as proposed by the Recommendation. Accordingly, it is not clear whether Recommendation 39 has been implemented. However, it is noted that the legislative provisions apply in relation to all deaths.

### 6.26 New South Wales

The legislative provisions discussed at paragraph 6.18 above apply in relation to all deaths, and the informal protocol described in the *Report on the NSW Government’s Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody* is stated to apply "when the death of an Aboriginal person (whether or not a death in custody) is reported to a Coroner”. However, it is also noted that the ACLO is not involved in all coronial proceedings due to funding constraints. However, strictly speaking, the heart of Recommendation 38 was the creation of a formal protocol, rather than the informal protocol that currently exists in New South Wales. On that basis, but acknowledging the existence of the informal protocol, Recommendation 39 has not been implemented.

### 6.27 South Australia

In South Australia, the informal protocol developed by the Coroner (discussed at paragraph 6.20) appears to apply in respect of all deaths and is not specifically directed towards any particular group in the community. However, and whilst acknowledging the informal protocol, it is difficult to say whether Recommendation 39 has been implemented as it is not clear that any separate protocol at a policy level has been developed in consultation with Aboriginal Legal Services and Aboriginal Health Services, as referred to in Recommendations 38 and 39.

### 6.28 Tasmania

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531 Ibid.
533 Ibid.

3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
In Tasmania, the informal protocol developed by the Coroner (discussed at paragraph 6.21) appears to apply in respect of all deaths and is not specifically directed towards any particular group in the community. However, Recommendation 39 is directed to extending the protocol developed in Recommendation 38 as between the Coroner, the Aboriginal Legal Service and the Aboriginal Health Service. It is not clear that any separate protocol at a policy level has been developed in consultation with Aboriginal Legal Services or Aboriginal Health Services which would satisfy Recommendation 38. Accordingly, and whilst acknowledging the existence of the legislative framework, it is difficult to say whether Recommendation 39 has been implemented.

6.29 Northern Territory

The legislative provisions and guidelines discussed at paragraph 6.19 above apply in relation to all deaths. However, Recommendation 39 is directed to extending the protocol developed in Recommendation 38 as between the Coroner, the Aboriginal Legal Service and the Aboriginal Health Service. It is not clear that any separate protocol at a policy level has been developed in consultation with Aboriginal Legal Services or Aboriginal Health Services which would satisfy Recommendation 38. Accordingly, and whilst acknowledging the existence of the legislative framework, it is difficult to say whether Recommendation 39 has been implemented.

6.30 Western Australia

As discussed at paragraph 6.22 above, whilst the legislation creates a type of protocol, it differs from the requirements of Recommendation 38. Further, it is not clear from publicly available information whether a specific protocol has been developed with the Aboriginal Legal Service and Aboriginal Health Services as proposed by the Recommendation. Accordingly, and whilst acknowledging the legislative protocol, it is not clear whether Recommendation 39 has been implemented. However, it is noted that the legislative provisions apply in relation to all deaths.

6.31 Queensland

As discussed at paragraph 6.23 above, whilst the legislation creates a type of protocol, it differs from the requirements of Recommendation 38. Further, it is not clear from publicly available information whether a specific protocol has been developed with the Aboriginal Legal Service and Aboriginal Health Services as proposed by the Recommendation. Accordingly, and whilst acknowledging the legislative protocol, it is not clear whether Recommendation 39 has been implemented. It is however noted that the legislative provisions apply in relation to all deaths.

6.32 Victoria
In Victoria, the Coroner has a broad investigative jurisdiction. The Coroner must investigate a death that:\endnote{534}

a. has a connection with the State;
b. occurred within the last 50 years; and
c. is classified as a 'reportable death'.

Further, the Coroner may investigate the death of a person that is classified as a 'reportable death' which occurred within the last 100 years.\endnote{535} Recommendation 39 appears to have been partially implemented in Victoria. The Coroner may give a direction for a medical practitioner to perform an autopsy\endnote{536} and, if a direction is given, must take reasonable steps to notify the senior next of kin.\endnote{537} The senior next of kin may object to the autopsy.\endnote{538} These provisions are not restricted to deaths in custody. Further, when exercising a function under the Coroners Act 2008 (Vic) a person is to have regard to, amongst other things, that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected.\endnote{539}

**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.

### 6.33 Commonwealth

The National Coronial Information System (‘NCIS’) is a national internet based data storage and retrieval system for Australian coronial cases. The NCIS stores information about every death reported to an Australian Coroner since July 2000. This allows Coroner and research agencies to review previous cases and identify trends or hazards.\endnote{540} In line with Recommendation 40, in 1992 the Commonwealth Government established a deaths in custody monitoring and research program within the Australian Institute of Criminology. The program monitors and regularly reports on the numbers of deaths in custody, and the patterns and trends observed.\endnote{541}

The NCIS website states that each State and Territory has a licence agreement with the Victorian Department of Justice (who administers the NCIS) permitting the transfer, storage and dissemination of coronial information via the NCIS.\endnote{542}

\begin{itemize}
  \item \endnote{534}Coroners Act 2008 (Vic), ss 15, 4 (definition of 'reportable death').
  \item \endnote{535}Ibid, s 14.
  \item \endnote{536}Ibid, s 25(2).
  \item \endnote{537}Ibid, s 26(1).
  \item \endnote{538}Ibid, s 26(2)(b).
  \item \endnote{539}Ibid, s 8(c).
  \item \endnote{540}National Coronial Information System, About the NCIS <http://www.ncis.org.au/data-collection/>.
  \item \endnote{541}Australian Institute of Criminology, Deaths in custody (27 August 2013) <http://www.aic.gov.au/criminal_justice_system/deaths%20in%20custody.html>.
\end{itemize}

### 3. POST-DEATH INVESTIGATIONS (RECOMMENDATIONS 6-40)
Accordingly, the Recommendation to maintain a uniform database has been implemented.

The following subsections discuss the implementation of Recommendation 40 in each State and Territory and, in particular, whether the Coroners Offices in those jurisdictions 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.

6.34 Australian Capital Territory

Recommendation 40 has been implemented in the Australian Capital Territory. In the Australian Capital Territory, after the Coroner has completed an inquest into a death in custody, the Coroner must report the findings in writing to the Attorney-General, the relevant custodial agency, the Australian Institute of Criminology, the appropriate local Aboriginal Legal Service (if the deceased was an Aboriginal or Torres Strait Islander person) and any other person the Coroner considers appropriate.543

6.35 Northern Territory

In the Northern Territory, where there has been an inquest into a death in custody, a copy of each report and the recommendation made must be sent to the Attorney-General.544 If the report makes comments about any agency, Commonwealth department or agency (including the Australian Institute of Criminology), or the Northern Territory police force, the Attorney-General must forward the report to those agencies or the relevant Minister.545 The agencies must provide a written response to the Coroner's report and any recommendations made.546 Consequently the extent to which Recommendation 40 is implemented in the Northern Territory depends on the circumstances, noting that liaison may not necessarily occur with the Australian Institute of Criminology.

6.36 New South Wales

The Coroners Act 2009 (NSW) provides that the State Coroner is to report to the Minister annually on deaths in custody, and that report will be tabled in Parliament.547 The Coroner is to ensure that its recommendations are provided to, amongst others, any person or body to which a recommendation is directed, the Minister, and any other Minister administering legislation relevant to the recommendation.548 Consequently the extent to which Recommendation 40 is implemented depends on the circumstances, noting that liaison may not necessarily occur with the Australian Institute of Criminology.

6.37 South Australia

543 Coroners Act 1997 (ACT), s 75(1).
544 Coroners Act 1993 (NT), s 27.
545 Ibid, s 46A.
546 Ibid, s 46B.
547 Coroners Act 2009 (NSW), s 37.
548 Ibid, s 82(4).

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In South Australia, the Coroner must report to the Attorney-General on the provision of coronial services over the past year, which must be laid before Parliament.\footnote{Coroners Act 2003 (SA), s 39.} In addition, the Coroner must forward a copy of its findings and recommendations after every inquest to the Attorney-General.\footnote{Ibid, s 25(4).} In the case of an inquest into a death in custody, it must forward its findings and recommendations to any Minister or agency to whom a recommendation is directed, to each person who appeared at the inquest, and to any other person, in the opinion of the Coroner, that has a sufficient interest in the matter (which could theoretically include the Australian Institute of Criminology).\footnote{Ibid.} Consequently the extent to which Recommendation 40 is implemented depends on the circumstances, noting that liaison may not necessarily occur with the Australian Institute of Criminology.

6.38 Tasmania

Tasmania requires that the Coroner must keep a record of each investigation into a death and may report to the Attorney-General.\footnote{Coroners Act 1995 (Tas), ss 29(1), 30(1).} The Chief Magistrate must make an annual report to the Attorney-General which includes the details of all deaths in custody and the findings and recommendations made by the Coroner.\footnote{Ibid, s 69(1).} The Attorney-General must table the report in Parliament.\footnote{Ibid, s 69(3).} Consequently, Recommendation 40 is partially implemented as liaison does not occur with the Australian Institute of Criminology as a matter of course.

6.39 Western Australia

In Western Australia, the Coroner must keep a record of each investigation into a death in a prescribed form.\footnote{Coroners Act 1996 (WA), s 26(1).} The Coroner is also required to report annually to the Attorney-General on the deaths that have been investigated in each year, and specifically on the death of each person held in care.\footnote{Ibid, s 27(1).} The State Coroner may make recommendations to the Attorney-General on any matter connected with an investigated death, including of a person held in care.\footnote{Ibid, s 27(3).} If the State Coroner makes recommendations to the Attorney-General regarding a death of a person held in care that is relevant to the operation of an agency, the State Coroner must inform that agency in writing of the recommendation.\footnote{Ibid, s 27(4).} The Western Australian Law Reform Commission notes that "although, in practice, most coronial recommendations are communicated by the Coroners Court to the relevant agency, entity or Minister within one month of the delivery of inquest findings, the Commission felt that the jurisdiction would benefit from legislative entrenchment of notification".\footnote{Law Reform Commission of Western Australia, Review of Coronial Practice in Western Australia - Final Report - Project No 100 (January 2012), 105 <http://www.lrc.justice.wa.gov.au/_files/P100-FR.pdf>.} Consequently,
Recommendation 40 is partially implemented as liaison does not occur with the Australian Institute of Criminology as a matter of course.

6.40 Queensland

In Queensland, the Minister may enter into an arrangement with any entity maintaining a database regarding coronial investigations to include information obtained under the Coroners Act 2003 (Qld) in the database.\(^{560}\) This appears to give effect to the NCIS arrangements.

Coronial findings and comments are published on the Coroner's website (unless the Coroner orders otherwise).\(^{561}\) The Coroner is required to give copies of findings and comments made in relation to any death in custody to the Attorney-General, the appropriate Minister and the Chief Executive.\(^{562}\)

The Operational Procedures Manual directs that officers investigating deaths in police custody "should notify, or cause to be notified, the Australian Institute of Criminology (AIC) of the death as soon as practicable". The phrasing falls short of mandating that officers must make such a notification, but an expectation that such notification would be made is clearly implied.\(^{563}\) Based on this information, Recommendation 40 has been substantially implemented in Queensland.

6.41 Victoria

In Victoria, the Coroner may report to the Attorney-General on a death which the Coroner investigated, including a death of a person placed in custody,\(^{564}\) and make recommendations to a Minister, public statutory authority or entity on any matter connected with the death.\(^{565}\) The findings, comments and recommendations following an inquest must be published on the internet.\(^{566}\) In addition, the Victorian Government provides information on all deaths that occur in custody to the Australian Institute of Criminology.\(^{567}\) Corrections Victoria's Internal Review and Investigations Unit prepares reports for the Coroner's Court in relation to prisoner and offender deaths, while the Corrections Inspectorate reports to the Coroner on prisoner deaths.\(^{568}\) The Report of Death to the Coroner includes the Indigenous status of the deceased, which is entered into the NCIS.\(^{569}\) It appears that in Victoria, Recommendation 40 has been implemented.

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\(^{560}\) Coroners Act 2003 (Qld), s 93(2).
\(^{561}\) Ibid, s 46A.
\(^{562}\) Ibid, s 47.
\(^{564}\) Coroners Act 2008 (Vic), s 52(2)(b).
\(^{565}\) Ibid, ss 72(1), (2).
\(^{566}\) Ibid, s 73(1).
\(^{568}\) Ibid, Part 3.2 p 8.
\(^{569}\) Ibid, Part 3.5 p 12.

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