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VALS' submission to the Victorian Parliament Law Reform Committee in response to the Coroners Act 1985 Final Report – sent 15th November 2006

Introduction

The Victorian Aboriginal Legal Service Co-operative Limited (VALS) pays respect to Indigenous Australians past and present and particularly those who died as a result of contact with Europeans and who have died while in custody. VALS acknowledges that its offices in Victoria are situated on Aboriginal land. Also, Aboriginal cultural practices in relation to death continue to be practiced today.

VALS is appreciative of the opportunities it has had to provide input on the review of the Coroners Act 1985. VALS has divided discussion of the Coroners Act 1985 Report Recommendations (Report Recommendations) under the following headings:

1. Report Recommendations specifically in line with the Royal Commission into Aboriginal Deaths in Custody 1991 (RCIADIC).
2. Report Recommendations that would be improved if they were brought in line with the RCIADIC Recommendations.
3. Other Report Recommendations that will benefit Indigenous Australians.
4. Other Report Recommendations that can be improved.

VALS argues that it is positive that some of the Report Recommendations take into account the RCIADIC and the Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody 2005 (RCIADIC Implementation Review). The RCIADIC is an authority of Aboriginal deaths in custody and coronial investigations that should not be overlooked. However, some of the Report Recommendations do overlook the RCIADIC and this must be rectified in order to improve Indigenous Australian's experience of the coronial process. It is positive that the Report recommends measures other than those included in the RCIADIC which will have the effect of improving Indigenous and non-Indigenous Australian's experience of the coronial process. However, some improvements can still be made in this area.

Update

Below is a list of recent events relevant to Indigenous Australians and coronial investigations:

- The Queensland Coroner found that Senior Sergeant Chris Hurley landed the blows which killed Mr. Doomadgee on Palm Island in 2004. The need for Coroners Reports to be taken seriously and given weight is highlighted by the disappointing approach of State and Federal Government following the release of the Coronial Report. Premier Beattie is supportive of the Police Minister, Judy Spence, who has not suspended Sergeant Hurley, while the Director of Public Prosecutions decides what is to be done.¹
- Despite the Coronial Report calling for a major overhaul of how the justice system deals with Indigenous Australians, the Senate passed the Crimes Amendment (Bail and Sentencing) Bill 2006 on 8 November 2006. The Bill is yet to be introduced in the House of Representatives. If the Bill is enacted the potential for injustice in sentencing decisions affecting Indigenous Australian people (ie: remove cultural background as a factor in sentencing) will increase.²
- The Western Australian Law Reform Commission Report on Aboriginal Customary Laws was released on 30th October 2006. The Report contains recommendations about coronial investigations and is available at <http://www.lrc.justice.wa.gov.au/Aboriginal/Final%20Report/Recommendations.pdf> (see recommendations 75-77).
- The Victorian Government met the request of the Victorian Indigenous Australian community that the Aboriginal Heritage Council include Traditional Owners only.

1. Report Recommendations in line with the RCIADIC

VALS is encouraged to see that the RCIADIC is treated as an authority and influences some of the Report Recommendations. For instance,

- **Definition of death in custody** - The RCIADIC definition of death in custody (volume 1 para 4.5.45) was adopted in Recommendation 19 of the Report.
- **Lawyer assistance** - RCIADIC Recommendation 26 (ie: a lawyer be appointed to assist a coronial investigation within 48 hours after advice regarding a death in custody was adopted) in Report Recommendations 43 & 44. This is important given that according to the State Coroner in response to the Victorian Implementation Review of the RCIADIC the RCIADIC Recommendation is generally not practiced.³

¹ 'Injustice Rolls On' Editorial - The Sydney Morning Herald, September 30 2006 as at <http://www.smh.com.au/text/articles/2006/09/29/1159337334345.html>.

² Quinlan Frank, 'Sentencing Laws will Further Alienate Indigenous Australians' Eureka Street, Tuesday, 3rd October, 2006 as at <http://www.eurekastreet.com.au/article.aspx?aeid=1788>.

³ Victorian Parliament Law Reform Committee 'Coroners Act 1985 Final Report' September 2006, p.208

- **Guidelines** - Report Recommendation 46 that the Coroner's Act 1985 be amended to provide that:
 - a) in order to ensure best practice in the coronial system, the State Coroner must issues guidelines to all coroners about the performance of their functions in relation to investigations generally;
 - b) when preparing the guidelines, the State Coroner must have regard to the recommendations of the RCIADIC that relate to the investigation of deaths in custody.

- **Mandatory inquest** - Report Recommendation 54 that the present categories of death investigations which attract mandatory inquests under the Coroners Act 1958 be retained (including where it appears the death was due to natural causes).⁴ VALS also agrees with Professor Stephen Cordner that not investigating natural deaths in custody is a direct contradiction of recommendations 11 and 12 of the RCIADIC and statement that "[f]or those who die in custody from whatever cause there will be at least one relative who thinks the person was murdered".⁵

- **Independent Doctor** - Report Recommendation 107 which is in line with Recommendation 25 of the RCIADIC.

- **Autopsies** - Report Recommendation 102 (ie: the State Coroner's office initiate a formal consultation process with VALS to develop a protocol for the resolution of questions involving the conduct of inquires and autopsies, the removal and burial or organs, and the removal and return of the body of the deceased) is positive. This is in line with RCIADIC 8 and VALS is disappointed such a consultation process has not happened to date.

- **Prevention:** Report Recommendation 70 that the stated purpose of the Act is to help to prevent deaths or fires in similar circumstances happening in the future by allowing coroners to comment and make recommendations on matters connected with deaths or fires, including matters related to public health and safety or the administration of justice. This is in line with RCIADIC 18 about prevention.

2. **Report Recommendations that would be improved if they were brought in line with the RCIADIC Recommendations**

VALS has the following suggested improvements to bring other Report Recommendations in line with the RCIADIC Recommendations:

- **Implementation/monitoring** - Report Recommendations 82-85 should be more reflective of RCIADIC Recommendations 15-17. The two sets of Recommendations differ as follows about:

⁴ Op cit 236

⁵ Op cit 237

- The timeframe for Departments/Agencies to report on their response to a Coronial Report (ie' RCIADIC - within 3 months & Report - within 6 months).
- The process of reporting on the response outlined above (ie: RCIADIC - Department/Agency report to relevant Minister who then reports to Coroner & Report - report directly to Coroner).
- **Autopsies** - Report Recommendation 102 should not only require that the State Coroner's office initiate a formal consultation process with VALS, but also the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). This would bring the Report Recommendation in line with RCIADIC Implementation Review Recommendation 99.

3. **Other Report Recommendations that will benefit Indigenous Australians**

VALS is encouraged to see the following recommendations that will benefit Indigenous Australians in light of the over-representation of Indigenous Australians in the criminal justice and child protection systems, such as:

- **Definition of death in care** - Report Recommendation 20 extending the definition of deaths in care.
- **Post release deaths** - Report Recommendation 24 requiring the investigation of deaths 12 months preceding custody in a systematic way.
- **Cultural Liaison Officer** - Report Recommendation 103 that the Coroner's office have a Cultural Liaison Officer.
- **Definition of Next of Kin/immediate family** - The amended definition of senior next of kin in Report Recommendation 91 & 93 is welcomed as it is inclusive of an Aboriginal concept of next of kin in part f: a person who had, in accordance with the customs or traditions of the community of which the person was part, responsibility for, or an interest in, the welfare of the person who has died.
- **Right to information** – Report Recommendation 99 which is modeled on Western Australian legislation.
- **Legal Advice**- Report Recommendation 113 extending access to legal advice out of office hours. However, this is on the provision that the legal advice is culturally sensitive funding for legal advice does not detract from assistance in other areas of the law.

4. **Other Report Recommendations that can be improved**

VALS has the following suggestions for improvement:

- **Definition of Next of Kin/immediate family** - The State Coroner should receive adequate training to deal with cases that involve a collective nature of decision making in a sensitive manner (ie: cultural sensitivity).⁶
- **Right to information** – Report Recommendation 99 should also include learnings from s 69 of the Coroner’s Act 1997 (Act), such as:
 - Requirement of notification of the local Aboriginal Legal Service if the deceased is Aboriginal.⁷
 - Coroner giving consideration as to whether there has been reasonable efforts to notify the relevant people.
- **Indigenous burial remains:** Report Recommendation 112 should follow the Tasmanian approach (ie: inspection of suspected Indigenous remains is passed directly to the Aboriginal community as early as possible) rather than Aboriginal Affairs Victoria protocol.
- **Kit:** The kit mentioned in Report Recommendation 114 should be made available in an accessible format for Indigenous Australians.
- **Prevention:** Report Recommendation 77 could be strengthened by deleting the words ‘where appropriate’. Alternatively the matters where it is considered ‘appropriate’ for the Coroner to make recommendations with respect to ways of preventing further deaths in similar circumstances and on any matter connected with the death including public health and safety and the administration of justice should be broad.

Conclusion

VALS is pleased to see that some Report Recommendations are in line with the RCIADIC. Also, some Report Recommendations are in line with other recommendations from different sources that discuss how to meet the needs of Indigenous Australians. However, the Report Recommendations can be improved by incorporating the RCIADIC Recommendations and RCIADIC Implementation Review Recommendations to a greater extent and some of VALS’ general suggestions.

⁶ Op cit 445

⁷ Op cit 475

Bibliography

Injustice Rolls On' Editorial - The Sydney Morning Herald, September 30 2006 as at <http://www.smh.com.au/text/articles/2006/09/29/1159337334345.html>.

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