Australian National Preventive Mechanism (NPM) Members' Joint Submission to the UN Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions' Call for Input on Deaths in Custody

March 2023

Contents

We acknowledge the traditional custodians of the lands where we work and live, and Elders both past and present. We recognise Aboriginal and Torres Strait Islander Peoples' ongoing connection to Country and Culture.

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1. Members of the Australian National Preventive Mechanism (NPM)

In 2017, Australia ratified the UN *Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**). The coordinating body for the Australian National Preventive Mechanism (**NPM**) is the Commonwealth Ombudsman, and a number of bodies have been designated members of the NPM by Federal, State and Territory Governments. Not all governments have nominated or established bodies as an NPM member.

This submission has been prepared and endorsed by the following NPM members:

- Commonwealth Ombudsman
- Australian Capital Territory (**ACT**) Inspector of Correctional Services
- ACT Ombudsman
- Northern Territory (**NT**) Office of the Children's Commissioner
- NT Community Visitor Program
- NT Office of the Ombudsman
- South Australia (**SA**) Training Centre Visitor

Although visiting places where people are, or may be, deprived of their liberty is the core function of the NPM bodies, their functions also include "submit[ting] proposals and observations concerning existing or draft legislation" (Article 19(c) OPCAT). Additionally, the UN Subcommittee on Prevention of Torture has identified the following as being within an NPM's mandate:

> Either contributing to the reports that States parties are required to submit to United Nations bodies and committees and to regional institutions, pursuant to their treaty obligations, or presenting its own reports and, where necessary, expressing an opinion on the subject, in accordance with its independent status.

And while there is no obligation on the Australian Government to make a submission to this Call for Input, the NPM bodies that have prepared this submission have undertaken to do so, recognising the opportunity to contribute their experience and expertise to the work of the Special Rapporteur.

The prevention of torture and ill-treatment of detained people being the fundamental objective of the NPM, and noting that the Special Rapporteur's aim with this report is "to raise awareness about deaths in custody globally and to contribute to the protection of the right to life of those deprived of liberty, including with practical recommendations and best practices on the effective investigation, documentation and prevention of custodial deaths", we would particularly bring your attention to the findings of Carver and Handley's seminal report, "Yes, torture prevention works" - a global research study

> The key finding of the research is that torture prevention works. The statistical analysis shows that, among the four clusters identified by the researchers in law and practice (detention, prosecution, monitoring and complaints), and independently of the broader political factors, *detention safeguards in practice have the highest torture prevention impact, followed by prosecution and monitoring mechanisms*. With regard to complaints mechanisms, the study found no measurable impact on torture prevention. (emphasis added)

2. Focus of the Submission

The purpose of the Call to Input is "to collect information on practices for the investigation, documentation and prevention of deaths in custody in the criminal justice context; Report to be presented to the Human Rights Council in June 2023."

The Special Rapporteur's "report will focus primarily on deaths in custody of persons deprived of liberty in the criminal justice context, occurring from the moment of their arrest, and its immediate aftermath; during law enforcement custody; during pre-trial up to post-conviction detention… The report aims to raise awareness about deaths in custody globally and to contribute to the protection of the right to life of those deprived of liberty, including with practical recommendations and best practices on the effective investigation, documentation and prevention of custodial deaths."

This NPM members' submission focuses on:

- The role of the UN *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* and National Preventive Mechanisms in the prevention of deaths in custody.
- The Australian Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), particularly recommendations relating to post-death investigations.
- Legislation prohibiting torture and ill-treatment.
- An example of existing accountability mechanisms in Australia.
- The *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ("Istanbul Protocol")."

3. Summary of Recommendations

Recommendation 1:

That the Special Rapporteur emphasise that properly funded and legislated National Preventive Mechanisms under the UN *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* play a crucial role in the prevention of torture, ill-treatment and deaths in custody. Encouraging States to ratify the Protocol and comply with obligations is a means by which to prevent deaths in custody around the world.

At the domestic level, Australia should implement the recommendation of the UN Committee against Torture, and

> (a) Take all necessary measures to promptly establish its network of national preventive mechanisms across all states and territories and ensure that each of its member bodies has the necessary resources and functional and operational independence to fulfil its preventive mandate in accordance with the Optional Protocol, including access to all places of deprivation of liberty as prioritised by the bodies themselves;
>
> (b) Intensify its efforts to build the capacities of the Commonwealth Ombudsman in coordinating the network of national preventive mechanisms with a view to ensuring effective

and independent monitoring of all places of deprivation of liberty across all states and territories.

Recommendation 2: That the Special Rapporteur consider the Australian Royal Commission into Aboriginal Deaths in Custody recommendations, particularly those relating to post-death investigations. Investigations of deaths in custody should be both independent and culturally appropriate for Aboriginal and/or Torres Strait Islander people.

Recommendation 3: That the Special Rapporteur emphasise the importance of ratifying international human rights instruments, particularly the CAT, OPCAT and ICCPR and incorporating these obligations in domestic legislation, with a particular focus on the non-derogable prohibition on torture.

Recommendation 4: While the Special Rapporteur's Report will focus on deaths in custody, we recommend that the Special Rapporteur also emphasise the importance of adherence to the Istanbul Protocol, as accountability for and prevention of torture and ill-treatment can contribute to efforts to prevent deaths in custody.

4. Responses to Questionnaire

(1) Existing practices for data gathering, analysis and reporting of deaths in custody

The Australian Institute of Criminology's National Deaths in Custody Program

The Australian Institute of Criminology's "National Deaths in Custody Program (NDICP) has monitored the extent and nature of deaths occurring in prison, police custody and youth detention... The NDICP was established at the Australian Institute of Criminology in 1992 in response to recommendation 41 by the Royal Commission into Aboriginal Deaths in Custody."

It has recorded 527 deaths of Aboriginal and/or Torres Strait Islander people since the Royal Commission into Aboriginal Deaths in Custody (discussed in further detail below).

Its most recent report, Deaths in custody in Australia 2021-22, noted the following limitations of its reporting:

> The purpose of the NDICP is to monitor annual and trend information on the nature and extent of deaths in Australian prison and police custody. This function is performed through the collation and cross-referencing of quantitative data from police services, correctional departments and the NCIS [National Coronial Information System] on the characteristics of the deceased and the circumstances of the death. Compiling qualitative data from coronial findings sits outside the scope of the NDICP and these data are not routinely reported in the Deaths in custody in Australia series. These contextual data are instead collated for individual studies examining specific population groups or categories of deaths. The publication time frame also affects contextual information available to this series of reports. Some contextual information, such as the nature of health care and medical intervention for natural cause deaths, is largely derived from coronial investigations which have either not concluded or whose

findings are not released until after the reporting cycle. As such, this material is not captured in the NDICP for annual reporting but examined in separate studies.

The National Coronial Information System

National Coronial Information System

The National Coronial Information System is

> a secure database of information on deaths reported to a coroner in Australia and New Zealand. The NCIS contains data on over 450,000 cases investigated by a coroner. Data includes demographic information on the deceased, contextual details on the nature of the fatality and searchable medico-legal case reports including the coronial finding, autopsy and toxicology report and police notification of death. The database is available to coroners to assist investigations and appropriate access is available on application for research or monitoring projects.

Data fields listed include

- Birthplace
- Cause of death
- Drugs
- Employment status
- Geocoding
- Aboriginal and Torres Strait Islander identification/ethnicity
- Intent type
- Location
- Marital status
- Objects/mechanisms as contributory factors (Contextual or environmental factors that cause or contribute to death are coded as the object and mechanism causing death).
- Perpetrator relationship to deceased
- Sex
- Sudden unexpected death in infancy
- Usual occupation

Access is limited as follows:

> Data contained in the NCIS is available for direct system access to authorised users, allowing them to view coronial case information via an online interface.
>
> Access is available to two categories of users and both categories must complete an approval process. The user categories are:
>
> > Death Investigators – those with responsibilities to assist in coronial investigation such as Coroners, Registrars, Court Staff, Police.
> >
> > Third Party Researchers – those with an ethically approved research project.
>
> Each user category requires approval for access. Death Investigators require approval from the State or Chief Coroner. Third Party Researchers requesting access to the NCIS must obtain approval through the Victorian Department of Justice and Community Safety ethics committee for Australian data and through the New Zealand Chief Coroner for New Zealand data.

Anyone wishing to access the NCIS must have a bona fide interest or professional role in public health and safety or a statutory requirement to collect and publish data. Members of the media and private organisations or individuals are not permitted direct access to the NCIS but can make a request for data.

Fatal Facts Tool

Separately, there is a publicly available 'Fatal Facts' tool

A coroner may make recommendations that relate to public health and safety following an investigation to help prevent similar deaths in the future. Fatal facts is a unique NCIS tool providing access to case summaries where coronial recommendations were made by Australian coroners from 2013. Cases are added to the tool quarterly by the NCIS Unit.

Scope and limitations are as follows:

Only cases where coronial recommendations have been made and with a Coroner closed date in the NCIS within the relevant period are included in Fatal facts. Fatal facts contains cases closed by an Australian coroner from 2013.

Fatal facts is based on information available in the NCIS at the time of reporting. Fatal facts is distinct from the secure NCIS database which requires authorisation to access. Fatal facts contents are publicly available through the tool and do not require a user login. Not all cases in the NCIS have a corresponding Fatal facts summary.

Fatal facts case summaries are produced by the NCIS Unit. Best efforts have been made to accurately summarise the circumstances, findings and recommendations made by the coroner in each case. Despite this, it should be noted that they are not exact replications of coronial findings.

Cases included in Fatal facts have received coronial approval from the relevant State or Chief Coroner for publication.

(2) Measures in place, including policies and good practices for investigating, documenting and preventing deaths in custody

(a) The Australian NPM

The role of the NPM focuses on *prevention*, as opposed to corrective mechanisms. Mechanisms which *respond* to allegations of torture or ill-treatment and deaths in custodial settings include:

- investigations, audits and complaints adjudication by independent statutory bodies, such as ombudsman;
- civil litigation, including pursuing compensation or injunctions;
- coronial inquests following a death in custody;
- systemic inquiries and royal commissions;
- criminal prosecutions for alleged wrongdoing by staff who work in places of detention or who have powers to detain, like police;
- regulatory bodies, such as those focusing on workplace health and safety for staff, that have coercive and enforcement powers, such as issuing fines.

Of course, effective corrective mechanisms can contribute to prevention of deaths in custody, in both their ability to educate detaining authorities and providing guidance on how to improve legislation, policies and practices, and to deter detaining authorities from engaging in conduct that might amount to torture or ill-treatment, or lead to a death in custody.

However, the NPM is unique in that it is forward-looking, rather than reactive. An NPM focuses on:

- finding root causes of torture and ill-treatment in places of deprivation of liberty;
- identifying risks of torture, ill-treatment and deaths in custody; and
- making expert recommendations on how to mitigate those risks.

Australia ratified OPCAT in 2017, postponed meeting its obligations by three years, and then sought a further one year extension. The deadline to have an operational NPM across the country was 20 January 2023. On that date, members of the Australian NPM released a joint statement:

> Today marks the deadline for Australia to establish its NPM, across the country, under OPCAT. Australia voluntarily agreed to meet the obligations outlined in OPCAT, and yet 5 years later, there is still much work that needs to be done. Progress towards designating and operationalising NPM bodies varies across different states and territories… Where they have not yet done so, we call on all Australian governments to appoint NPMs, to legislate their role and powers, and to resource them to fully discharge their mandate to carry out preventive visits to places of detention.

In its Concluding Observations last year, the UN Committee Against Torture (**CAT**) made the following recommendations with regard to the Australian NPM:

> 42. The State party should:
>
> (a) Take all necessary measures to promptly establish its network of national preventive mechanisms across all states and territories and ensure that each of its member bodies has the necessary resources and functional and operational independence to fulfil its preventive mandate in accordance with the Optional Protocol, including access to all places of deprivation of liberty as prioritized by the bodies themselves;
>
> (b) Intensify its efforts to build the capacities of the Commonwealth Ombudsman in coordinating the network of national preventive mechanisms with a view to ensuring effective and independent monitoring of all places of deprivation of liberty across all states and territories.

We echo the UN CAT's recommendations, noting the UN Subcommittee on Prevention of Torture's guidance that the NPM's mandate includes the following:

> Following up on the process of implementation of recommendations made by United Nations and regional bodies to the States parties with regard to torture and related issues, providing advice at the national level and providing the recommending bodies with information, as appropriate.

Recommendation 1:

That the Special Rapporteur emphasise that properly funded and legislated National Preventive Mechanisms under the UN *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* play a crucial role in the prevention of torture, ill-treatment and deaths in custody. Encouraging States to ratify the Protocol and comply with obligations is a means by which to prevent deaths in custody around the world.

At the domestic level, Australia should implement the recommendation of the UN Committee against Torture, and

> (a) Take all necessary measures to promptly establish its network of national preventive mechanisms across all states and territories and ensure that each of its member bodies has the necessary resources and functional and operational independence to fulfil its preventive mandate in accordance with the Optional Protocol, including access to all places of deprivation of liberty as prioritised by the bodies themselves;
>
> (b) Intensify its efforts to build the capacities of the Commonwealth Ombudsman in coordinating the network of national preventive mechanisms with a view to ensuring effective and independent monitoring of all places of deprivation of liberty across all states and territories.

(b) The Royal Commission into Aboriginal Deaths in Custody

Over 30 years ago, the watershed Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) made 339 recommendations, many of which have still not been implemented today.

The RCAIDIC report opens as follows:

> Between 1 January 1980 and 31 May 1989, ninety-nine Aboriginal and Torres Strait Islander people died in the custody of prison, police or juvenile detention institutions. They were eighty-eight males and eleven females. Their approximate average age at death was thirty-two years, the median age-the point above and below which half the cases fell--was twenty-nine years and the range was fourteen to sixty-two years. Their deaths were premature. The circumstances of their deaths were extremely varied. One cannot point to a common thread of abuse, neglect or racism that is common to these deaths. However, an examination of the lives of the ninety-nine shows that facts associated in every case with their Aboriginality played a significant and in most cases dominant role in their being in custody and dying in custody.

The RCIADIC found that "a major reason for Aboriginal deaths in custody remains: the grossly disproportionate rates at which Aboriginal people are taken into custody, of the order of more than twenty times the rate for [non-Aboriginal people]. Something can be done to reduce this rate by law reform and changes in policing strategies."

This finding reflects the UN Special Rapporteur on Torture's conclusion that "avoiding depriving a person of [their] liberty is one of the most effective safeguards against torture and ill-treatment".

While the entirety of the RCIADIC report is of relevance to preventing deaths in custody, for ease of reference, we have included the recommendations relating to post-death investigations in the appendix.

Recommendation 2:
That the Special Rapporteur consider the Australian Royal Commission into Aboriginal Deaths in Custody recommendations, particularly those relating to post-death investigations. Investigations of deaths in custody should be both independent and culturally appropriate for Aboriginal and/or Torres Strait Islander people.

(c) Legislation prohibiting torture and ill-treatment

The prohibition of, and the obligation to prevent, torture and other cruel, inhuman or degrading treatment or punishment can be found in a number of UN instruments, including:

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

- Article 2(1). Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.
- Article 2(2). No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.
- Article 2(3). An order from a superior officer or a public authority may not be invoked as a justification of torture.
- Article 16(1): Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

International Covenant on Civil and Political Rights

- Article 7: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Convention on the Rights of the Child

- Article 37(a): No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age.

Universal Declaration of Human Rights

- Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

- Article 2: Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.
- Article 3: No State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Standard Minimum Rules for the Treatment of Prisoners

- Rule 1: All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.

Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment

- Principle 6: No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. No circumstance whatever may be invoked as a justification for torture or other cruel, inhuman or degrading treatment or punishment.

Code of Conduct for Law Enforcement Officials

- Article 5: No law enforcement official may inflict, instigate or tolerate any act of torture or other cruel, inhuman or degrading treatment or punishment, nor may any law enforcement official invoke superior orders or exceptional circumstances such as a state of war or a threat of war, a threat to national security, internal political instability or any other public emergency as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

However, even where there are binding obligations on States, human rights are not always reflected in domestic legislation. Given the evidence that detention safeguards are effective in preventing torture, having those safeguards in place should be a priority in strategies aiming to prevent deaths in custody.

Human Rights Acts in Australia

The Australian Capital Territory (**ACT**) *Human Rights Act 2004* states the following:

> s10 Protection from torture and cruel, inhuman or degrading treatment etc
> (1) No-one may be—
> (a) tortured; or
> (b) treated or punished in a cruel, inhuman or degrading way.

(2) No-one may be subjected to medical or scientific experimentation or treatment without his or her free consent.

The Victorian *Human Rights and Responsibilities Act 2006* states the following:

s10 Protection from torture and cruel, inhuman or degrading treatment

A person must not be—

(a) subjected to torture; or

(b) treated or punished in a cruel, inhuman or degrading way; or

(c) subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

The *Queensland Human Rights Act 2019* states the following:

s17 Protection from torture and cruel, inhuman or degrading treatment

A person must not be—

(a)subjected to torture; or

(b)treated or punished in a cruel, inhuman or degrading way; or

(c)subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent.

We draw your attention to the recent launch of the Australian Human Rights Commission's Position Paper on A National Human Rights Act for Australia. The Commission proposed the following right for inclusion in an Australian Human Rights Act:

Protection from torture and cruel, inhuman or degrading treatment

(1) A person must not be—

(a) subjected to torture; or

(b) treated or punished in a cruel, inhuman or degrading way; or

(c) subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent.

The Position Paper makes clear that this prohibition should not be subject to any limitations.

Recommendation 3:
That the Special Rapporteur emphasise the importance of ratifying international human rights instruments, particularly the CAT, OPCAT and ICCPR, and incorporating those obligations in domestic legislation, with a particular focus on the non-derogable prohibition on torture.

(d) Additional - Accountability mechanisms for deaths in custody

ACT Office of the Inspector of Correctional Services (OICS) – Critical Review Function

The ACT Office of the Inspector of Correctional Services (**OICS**) is an independent body established under the *Inspector of Correctional Services Act 2017* to conduct preventive style reviews of adult corrections and youth justice to reduce risks of ill-treatment. It also has a 'critical incident' review function, enabling it to conduct external reviews of the most serious incidents that occur in an adult

or youth justice setting including 'the death of a person'. The Explanatory Statement to the establishing legislation states that this 'aims to ensure accountability and public transparency of events that may cause significant impact or harm in a custodial setting'.

The OICS has completed one death in custody review to date, since the office was established in 2018. This review was publicly tabled in the Legislative Assembly six months after the incident. The Critical Incident review function is an opportunity for an independent body specialising in corrections and youth justice oversight to identify any issues or concern or risks in a relatively timely way, make recommendations aimed at reducing risk, and provide transparency for family and the community.

(e) Additional - Availability and use of national or international protocols

The UN OHCHR has identified one of the roles of the NPM being "advocat[ing] for the establishment of an independent body with the capacity to assess allegations of torture and ill-treatment in accordance with the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ("Istanbul Protocol")."

The Istanbul Protocol describes the principles of effective investigation and documentation, which are, in large part, applicable also in the context of investigations into deaths in custody:

> States should establish, preferably on a statutory basis, mechanisms with full investigatory powers that are institutionally and functionally independent, such as independent police complaints commissions or ombudspersons, to ensure impartiality.
>
> Investigative bodies should reflect the diversity of the communities that they serve.
>
> States must ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated.
>
> A prompt investigation is essential in order to ensure the protection of the victim and to avoid the risk that any traces of torture or ill-treatment might disappear. Investigations need to be commenced without any delay, taking place within hours or, at the most, a few days after the suspicion of torture or ill-treatment has arisen, and to be conducted expeditiously throughout.
>
> Investigations must be carried out in an impartial manner, taking into account potential conflicts of interest, hierarchical relationships with potential suspects and the specific conduct of the investigators.
>
> An impartial investigation must be thorough and include several essential investigatory steps, including a forensic medical investigation.
>
> The investigators, who should be independent of the suspected perpetrators and the agency that they serve, must be competent and impartial.
>
> They must have access to or be empowered to commission investigations by impartial medical or other experts.
>
> The methods used to carry out these investigations must meet the highest professional standards. The investigation should be conducted transparently and the victims, their lawyers and the judicial authority should have access to the findings.
>
> Authorities should systematically collect and regularly publish disaggregated data on the number, content and outcome of complaints and investigations relating to torture or ill-treatment.
>
> An independent review body should be tasked with reviewing the handling of specific complaints and investigations relating to torture or ill-treatment upon request and with examining, and annually reporting on, the effectiveness of relevant complaints procedures and investigations.

The investigative authority should have the power and obligation to obtain all the information necessary for the inquiry.

The persons conducting the investigation must have at their disposal all the necessary budgetary and technical resources for effective investigation.

The investigative body must also have the authority to oblige all those acting in an official capacity who were allegedly involved in torture or ill-treatment to appear and testify. The same applies to any witness. To this end, the investigative authority is entitled to issue summonses to witnesses, including any officials allegedly involved and to demand the production of evidence.

Recommendation 4:

While the Special Rapporteur's Report will focus on deaths in custody, we recommend that the Special Rapporteur also emphasise the importance of adherence to the Istanbul Protocol, as accountability for and prevention of torture and ill-treatment can contribute to efforts to prevent deaths in custody.

5. Appendix

(1) Royal Commission into Aboriginal Deaths in Custody - Recommendations related to Post-Death Investigations

(a) Definition of death in custody

Rec 6. That for the purpose of all recommendations relating to post-death investigations the definition of deaths should include at least the following categories:

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

b. The death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care 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.

(b) Establishing the Coroner's Office

Rec 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. (In all recommendations in this report the words 'State Coroner' should be taken to mean and include the Coroner so specially designated.)

Rec 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.

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

(c) Notifying the Coroner

Rec 10. That custodial authorities be required by law to immediately notify the Coroners Office of all deaths in custody, in addition to any other appropriate notification.

(d) Legal requirements to have a Coronial Inquest

Rec 11. That all deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a Coroner into the circumstances of the death. Unless there are compelling reasons to justify a different approach the inquest should be conducted in public hearings. A full record of the evidence should be taken at the inquest and retained.

Rec 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.

(e) Findings and recommendations

Rec 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.

Rec 14. That copies of the findings and recommendations of the Coroner be provided by the Coroners 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.

Rec 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.

Rec 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.

(f) Responses to findings and recommendations

Rec 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.

Rec 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.

(g) Notifying the family and legal service

Rec 19. That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known.

Rec 20. That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody.

Rec 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.

(h) Rights of the family

Rec 22. That no inquest should proceed in the absence of appearance for or on behalf of the family of the deceased unless the Coroner is satisfied that the family has been notified of the hearing in good time and that the family does not wish to appear in person or by a representative. In the event that no clear advice is available to the Coroner as to the family' s intention to be appear or be represented no inquest should proceed unless the Coroner is satisfied that all reasonable efforts have been made to obtain such advice from the family, the Aboriginal Legal Service and/or from lawyers representing the family.

Rec 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.

Rec 24. That unless the State Coroner or the Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroners 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.

Rec 25. That unless the State Coroner, or the Coroner appointed to conduct the inquiry, directs otherwise, and in writing, the family of the deceased or their representative should have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the Coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report. If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.

(i) Counsel Assisting

Rec 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.

Rec 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.

Rec 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.

(j) Investigation

Rec 29. That the Coroner in charge of a coronial inquiry into a death in custody have legal power to require the officer in charge of the police investigation to report to the Coroner. The Coroner should have power to give directions as to any additional steps he or she desires to be taken in the investigation.

Rec 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.

Rec 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.

Rec 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.

Rec 33. That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.

Rec 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.

Rec 35. That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:

a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;

b. All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;

c. The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;

d. In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and

e. The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography.

Rec 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.

(k) Cultural considerations for post-mortem examinations

Rec 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.

Rec 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.

Rec 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.

(l) Uniform database recording deaths in custody

Rec 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.