THE CENTRALITY OF THE ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY WHEN DISCUSSING POTENTIAL REFORM TO THE VICTORIAN CORONIAL SYSTEM

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I Introduction

At the outset the Victorian Aboriginal Legal Service Co-operative Limited ('VALS') pays its respects to past Indigenous Australians.

The *Coroners Act 1985* (Vic) is likely to be reformed by the end of 2008 as an outcome of a Victorian Parliament Law Reform Committee Review of the Act. In this paper VALS highlights the centrality of the Royal Commission into Aboriginal Deaths in Custody ('RCIADIC') in the context of reform to the coronial system in Victoria. Although the amendments to the Act are confidential at this stage, this paper will endeavour to provide reasons as to why one may have an optimistic or pessimistic view in relation to what those amendments might be. It is argued that the Victorian Parliament Law Reform Committee's ('LRC') *Coroners Act 1985* Discussion Paper[1] and Report,[2] and the Victorian Government's response[3] to the Report, each have a positive regard to the RCIADIC in varying degrees. However, there are barriers to the full realisation and implementation of those recommendations of the LRC's Report that are sourced from the RCIADIC. VALS makes some suggestions about how to overcome barriers to achieving positive reform to the Victorian coronial system and about how to view the RCIADIC in the context of 2008.

II Centrality of the RCIADIC

It has been almost two decades since the RCIADIC concluded and some have questioned the relevance of the RCIADIC in 2008. Indeed, while the prevention of Indigenous deaths in custody remains essential, it is often overlooked, with funding tending to be committed to other areas such as early intervention. However, it is clear that the RCIADIC and its recommendations are still live and relevant and should be given centrality. Indigenous Australians continue to be over-represented in the criminal justice system and remain at a relatively high risk of dying in custody. In addition, the rate of implementation of the RCIADIC recommendations applicable to the State Coroner of Victoria is inadequate and in need of improvement. Of the 33 RCIADIC recommendations applicable to the State Coroner of Victoria, only 14 have been fully implemented; 12 have been partially implemented and no progress has been made on seven.[4] Two case scenarios illustrate the continuing relevance and importance of the RCIADIC findings:

1. In March 2004, a VALS client attempted to hang himself in a cell at the Swan Hill police station using his belt. The placement of the client in a cell with his belt was in breach of police operating procedures and ignored the RCIADIC findings that belts are an object used by people to hang themselves, and that hanging points in cells need to be eliminated.[5] VALS argues that the fact that VALS' client is alive today is not a result of the effective implementation of the RCIADIC recommendations but is due to the quick actions of another prisoner.
2. In August 2006, two police officers drove an Aboriginal person 15 kilometres from the town centre to a location on the Sturt Highway. The person was left at this location and shortly thereafter was struck by a heavy transport vehicle and killed instantly. VALS argues that the death is a death in custody, however the police are denying this. VALS contends that the actions of the police expose both an inadequate assessment of risk and possible negligence in relation to the duty of

care. The findings of the Coroner are yet to be handed down.

The RCIADIC represents best practice for taking into account the needs of Indigenous Australians in custody, and it should therefore be given centrality in reforming the Victorian coronial system. VALS is committed to the full realisation of the recommendations of the RCIADIC.

III Reasons for Optimism

A Within the Review

In the documentation relating to the reform of the *Coroners Act 1985* (Vic), there is a welcome engagement with the RCIADIC, though the level of engagement does vary between documents. The LRC's Discussion Paper and Report are impressive and unique documents that give consideration to the RCIADIC rather than overlook it or refer to it in a tokenistic manner. The Victorian Government's response to the LRC's Report is positive in that it expresses commitment to some of the Report recommendations which happen to originate from the RCIADIC. However, it needs to be acknowledged that the Report and the Government response could go further in their recognition of the RCIADIC. The capacity of the Government to effectively respond to the RCIADIC is limited by the fact that some of the Report recommendations, the Government has at its disposal, do not go at far as they should. Beyond this, there is reason to doubt the commitment of the Government to the Report's RCIADIC-related recommendations concerning death prevention (discussed further below).

The manner in which the Discussion Paper lent itself to a discussion of the RCIADIC, and in turn enabled those writing a response to the Discussion Paper to do the same, is a factor behind the Report repeating RCIADIC recommendations within its own recommendations. The Discussion Paper contained 28 questions and four of them directly related to the RCIADIC. An example of a question is as follows: 'Do you have any comments regarding the implementation of the 1991 RCIADIC Recommendations relating to coronial investigations?'[6] Questions such as this enabled VALS' submission, in response to the Discussion Paper, to adopt a RCIADIC framework. Other Discussion Paper questions did not explicitly mention the RCIADIC but did prompt discussion of sentiments expressed in the RCIADIC.

Both the Discussion Paper and Report recognise the importance of the RCIADIC by incorporating 37 RCIADIC recommendations relevant to the coronial system, including their implementation status, as an appendix. To the eye unfamiliar with the RCIADIC, the Report appears to place a much lesser emphasis on the RCIADIC than the Discussion Paper, with the RCIADIC not mentioned in the body of the Report. However, despite the fact that the RCIADIC is not attributed as a source of recommendations in the Report, RCIADIC recommendations are repeated in the Report. The Discussion Paper and the Report are documents that have different purposes, and there is more opportunity to mention sources of suggestions in the Discussion Paper. However, in VALS' opinion, it would have been preferable for the Report to be more open about its reliance on the RCIADIC in order to boost recognition of the importance of the RCIADIC (discussed further below).

While it is the nature of the law review process, such as that engaged in by the LRC's Discussion Paper and Report, to provide a broad range of advice to government, it is in the nature of a government response to pick and choose elements of that review that are safe to express a commitment to. This is to ensure that the government is not seen to renege on a commitment. In the Government response to the LRC Report on the *Coroners Act 1985* (Vic), the language used to discuss the Report's recommendations regarding deaths in custody, next of kin and consultation aligns with the language of the Report and contains no contradictions. However, see the discussion of death prevention below for a contrasting situation. As such, there is a strong chance that the recommendations relating to these definitions will be implemented.

Recommendation 19 of the LRC Report provides for the amendment of the *Coroners Act 1985* (Vic) to define 'death in custody'. The Report recommends:

> That the Coroners Act 1985 be amended to extend the definition of a death in custody to include the death wherever occurring of a person:
>
> (a) who is in prison custody or police custody or detention as a juvenile or detention under a Commonwealth law;
> (b) whose death is caused, or contributed to, by traumatic injuries sustained, or by lack of proper care while in such custody or detention;

(c) who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and

(d) 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 or detention under a Commonwealth law.[7]

The source of this Report recommendation is the RCIADIC.[8] The Government response to this recommendation suggests an awareness of the need for such reform:

> The Government will ... examine ways to bring the Act into line with the Royal Commission into Aboriginal Deaths in Custody's definition of 'death in custody' ... . Coroners have construed their powers widely in this area and the Government will give a clearer legislative basis to this practice in the new Act.[9]

VALS supports the inclusion in the *Coroners Act 1985* (Vic) of the definition of 'death in custody' as defined under the RCIADIC and the LRC Report. The current Act provides no definition of 'death in custody'; it merely defines 'person held in care' to include a person in the custody of a member of the police force.[10]

Two recommendations of the LRC Report provide for the definition of 'next of kin' and 'immediate family' under the *Coroners Act 1985* (Vic). Recommendation 91 recommends:

> That the Coroners Act 1985 be amended to define 'senior next of kin' as the first person who is available from the following persons in the order of priority listed:
>
> ...
>
> (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. [11]

Recommendation 93 recommends: 'That the Coroners Act 1985 be amended to include a definition of "immediate family" that includes all of the categories of people referred to in the definition of senior next of kin.'[12] The source of these recommendations is the RCIADIC, which contains a recognition in the words of Commissioner Elliott Johnston QC 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.[13]

Similar sentiments were expressed by Justice Beach in *Green v Johnstone*[14]. Justice Beach ordered that no autopsy be performed in recognition of the fact that it was contrary to Aboriginal cultural and religious law. He said:

> great weight should be given to the cultural and spiritual laws and practices of the various cultural groups forming our society and that great care should be taken to ensure that their laws and practices, assuming they are otherwise lawful, are not disregarded or abused.[15]

The Government response to the LRC Report's recommendations in relation to the definition of family appears to recognise the specific needs of Indigenous Australians. It states: 'The Government will consider the need for modern and culturally relevant definitions of family (recommendations 91–93).'[16]

The need for the Government to engage in consultation with VALS is recognised in LRC Report recommendation 102, which recommends:

> That the [State] Coroner's Office initiate a formal consultation process with the Victorian Aboriginal Legal Service 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.[17]

The sources of this recommendation are RCIADIC recommendations 38 and 39, which pertain to the development of such a protocol in consultation with VALS and the Victorian Aboriginal Health Service.[18] VALS is pleased by LRC Report's recommendation as, despite the RCIADIC recommendations in relation to consultation for the development a protocol, VALS has not to date been approached about developing a protocol. Encouragingly, the Government response states:

> In light of the recent review of the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody, the Government will also take the opportunity to review the Commission's recommendations on coronial investigations in consultation with the indigenous community.[19]

VALS is hopeful that this will finally result in the Government developing a protocol in consultation with VALS. However, despite LRC Report recommendation 102 only recommending consultation with VALS for devising a protocol, the Victorian Aboriginal Health Service should also be included in the consultation process, as was envisaged in the RCIADIC recommendations.

B Beyond the Review

The reasons for optimism about Victorian coronial reform go beyond the review of the *Coroners Act 1995* (Vic) and relate to the broader Victorian policy climate. Evident in Victoria is a willingness on the behalf of government to engage with the RCIADIC in a manner perhaps more progressive than in other States and Territories. This willingness is apparent in the fact that the Victorian Government commissioned an independent community-led review of the implementation of the RCIADIC.[20] The Victorian review is arguably more candid than reviews in other jurisdictions where self-evaluations occur. In addition, Victoria also has a fairly comprehensive Aboriginal Justice Agreement which, amongst other things, is an attempt to address the RCIADIC. Victoria is the only State to have two phases to the agreement – the first beginning in 2000 and the second in 2006.[21] Related to the Agreement is a mechanism that enables Indigenous Australians to communicate effectively with the Government about their justice-related issues.

IV Barriers and Reasons for Pessimism

As details about the reform of the Victorian coronial system are confidential at this stage, VALS has only been able to glean a general sense about the Bill from the public documentation. Nevertheless, elements of such documentation give rise to pessimism about some elements of the outcome of the reform process. VALS urges the Government to ensure the issues raised below do not become a reality when the new Coroners Bill is released. VALS is particularly concerned about the barriers to reforming the coronial system in relation to the prevention of deaths. VALS urges the Government to ensure that any reform to the Act reflects the LRC Report recommendation 70 of making prevention of deaths a purpose of the Act, which in turn reflects the sentiment in RCIADIC recommendations relating to prevention.

A Review

1 Prevention

A barrier to achieving positive reform of the coronial system in relation to prevention is the failure of the LRC Report recommendations to go as far as the RCIADIC recommendations. LRC Report recommendation 77 states that

> a coroner must, whenever appropriate, 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 or the administration of justice.[22]

This LRC recommendation would be stronger if the words 'whenever appropriate' were deleted. Also, LRC Report recommendation 82 only requires that parties who have received coronial findings provide a written response (ie, about whether any action has been taken or is proposed to be taken in response to the recommendation) within six months,[23] but RCIADIC recommendation 15 requires the provision of a written response within three months.[24]

A further barrier to achieving positive coronial reform is a lack of government commitment to prevention-related LRC Report recommendations. VALS is concerned that the Government response's failure to address some LRC Report recommendations relating to prevention indicates a lack of commitment, especially when viewed in comparison to areas of the Report which are supported in their entirety by the Government. It appears that the Government response to the Report has weakened elements of the aim of prevention expressed in Report recommendation 70:

> That section 1 of the Coroners Act 1985 be amended to provide that a 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.[25]

This Recommendation should not be weakened because it corresponds positively with RCIADIC 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.[26]

At first glance, the aspirational language of the LRC's Discussion Paper and Report about prevention is used by the Government in its formal response to the Report. For instance, the Government states it will

> consider ways to incorporate prevention and safety in the objects of the new Act (recommendation 70) and to strengthen the coronial system's ability to contribute to prevention and safety initiatives.[27]

However, upon a closer look the Government response is mixed; whilst the Government recognises the importance of prevention, it desires to devise its own response rather than implementing the Report recommendations. The Government's aspirational sentiment about incorporating prevention in the objects of the new Act is weakened by its statement that:

> the Government will work with the State Coroner's office on prevention and safety issues in the development of the new Act, rather than implementing the Committee's specific recommendations.[28]

The importance of the aim of prevention is downplayed by other statements in the Government response as well; for instance: 'in some cases consideration of these [prevention] issues has the potential to delay findings, causing additional distress for those involved.'[29]

Another indication that the Government's great aspiration for death prevention may not be followed through with is evident in relation to the post-inquest distribution of coronial recommendations. The Government states in its response to the LRC Report: 'coroners' work to prevent deaths and injuries will not be effective if coronial recommendations are not widely distributed.'[30] However, as the following subsequent quote from the Government response makes clear, there is no governmental intention to go beyond the status quo under the current legislation: 'existing processes can be improved to meet the concerns of families and the Committee without resort to legislative amendments.'[31] This in effect means that Report recommendations such as recommendation 82[32] are unlikely to be legislated. Instead, the Government reiterated its commitment to existing processes; that is, the referral of coronial findings by the Attorney-General to relevant Ministers for their advice on implementation, and the practice of a number of agencies, such as WorkSafe, monitoring and responding to coronial recommendations.[33] Whilst these existing processes are positive, there is potential to go beyond the status quo through an adherence to the aspirational recommendations of both the LRC Report and RCIADIC. VALS is not satisfied with the status quo; the current coronial system is not effective in preventing death because the potential of the coronial process to prevent avoidable deaths is not fully realised. In its submissions relating to the review of the coronial system, VALS highlighted that the coroner is in a position to prevent Indigenous deaths because of the coroner's awareness of the causes of deaths. That information should be shared widely with others. At present, however, the information the coroner has is a resource that is not being used effectively, and the inability to capitalise on it, coupled with the failure to implement the RCIAIDC recommendations, means that avoidable deaths are occurring.

The preventive role of the coroner should be facilitated through the following:

- the lifetime appointment of State Coroners. This would provide security of tenure, meaning that State Coroners could be critical of the Government without fear of losing their position. It would also mean that there is a greater chance of addressing systemic issues and preventing avoidable deaths;
- annual written reporting by the State Coroner in relation to prevention and the level of follow-up of prevention-related recommendations. The report would be provided to the Attorney-General or Minister for Justice and also tabled in State Parliament. This is in line with RCIADIC recommendations 17 and 18[34] and LRC Report recommendation 85;[35]
- the provision of powers to the State Coroner for the enforcement of recommendations; and
- making the State Coroner responsible for monitoring the implementation of coronial recommendations.

2 Report Recommendations not Mentioned in the Government Response

Unlike the LRC Report recommendations pertaining to deaths in custody, next of kin and consultation, there are a number of LRC recommendations which give centrality

to the RCIADIC that are not repeated or referred to in the Government response. One example is recommendation 46, which recommends:

> That the Coroners Act 1985 be amended to provide that:
>
> (a) in order to ensure best practice in the coronial system, the State Coroner must issue 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 Royal Commission into Aboriginal Deaths in Custody that relate to the investigation of deaths in custody;
> (c) when investigating a death, a coroner must comply with the guidelines issued to the coroner to the greatest extent practicable.[36]

VALS supports LRC Report recommendations, such as recommendation 46, which give centrality to the RCIADIC. However, due to the fact that some of these recommendations are not repeated in the Government response, the chances of change occurring in line with those Report recommendations are slim.

B Beyond the Review

Outside the specific elements of the review of the *Coroners Act 1995* (Vic) and its documentation, there are broader reasons to be pessimistic about whether reform to the Victorian coronial system will adequately reflect the RCIADIC. Various social and political factors, no doubt formative forces in the review of the *Coroners Act 1995* (Vic) itself, represent further barriers to achieving effective reform of the coronial system. There have been substantial changes to the social and political landscape since 1991 when the RCIADIC concluded, which have resulted in an increase in the scale of problems facing Indigenous Australians. It appears to be a common if erroneous sentiment that reports such those that came out of the RCIADIC have a use-by date and become redundant. In addition, there has been a lack of resources to implement the RCIADIC recommendations and a lack of consultation as to the best means of implementing the RCIADIC recommendations. There has also been a commitment to policies which work against the successful implementation of the RCIADIC recommendations. Macro policies over the last decade have consisted of:

- campaigns of intolerance against Indigenous Australians;
- a 'tough on crime' approach, facilitated by consistent media coverage and premised on the assumption that if enough people are locked up for long enough crime problems will be solved; and
- a government mindset that lacks recognition of the fact that effective programs and policies require a willingness to be flexible, and to recognise and respond to difference.

V Moving Forward

Despite the fact that the RCIADIC recommendations are now 17 years old, they have retained their potency as a means to move forward in addressing Indigenous Australian disadvantage. The relevance of the RCIADIC has been demonstrated by the LRC's Discussion Paper and Report and the Government response, as each of these give some consideration to the RCIADIC. In terms of coronial reform, the centrality of the RCIADIC is essential in moving forward in the State of Victoria, and the Indigenous Victorian community will be disappointed if the Government fails to have proper regard for the RCIADIC in reforming the Victorian coronial system. The RCIADIC recommendations are a pertinent, viable currency with which to address the needs of the Indigenous Australian community.

VALS has some suggestions on how to move forward with a RCIADIC framework in the context of 2008:

- creativity: be creative in conveying the spirit of the RCIADIC (ie, represent the proposals of the RCIADIC in a different way);
- awareness of barriers: be aware of the barriers outlined above;
- awareness of tools: highlight the value of the 2005 Victorian implementation review of the RCIADIC as a tool that should not be ignored and make an independent review of the implementation of the RCIADIC recommendations an ongoing process, rather than an occasional process;
- consultation: consult with Indigenous Australians about the RCIADIC; and
- improve the policy climate: reaffirm the importance of working in partnership with the Indigenous Australian community. For instance, ensure that any new proposal is, prior to development, subject to an analysis by

Indigenous Australians about the impact of the proposal on Indigenous Australians.

VI Conclusion

It has been nearly two decades since the RCIADIC concluded but even in the context of 2008 the RCIADIC recommendations and findings still remain relevant and represent best practice. As the independent review of the implementation of RCIADIC recommendations in Victoria shows, the rate of the implementation of RCIADIC recommendations pertaining to the coronial system in Victoria needs improvement.

Following the process of review of the *Coroners Act 1995* (Vic), Victoria has the chance to improve its coronial system. Although the legislative amendments remain confidential at this stage, there are some reasons to be optimistic about the reforms. All of the documentation of the review respond, albeit to varying extents, to the RCIADIC, with the LRC's Discussion Paper and Report most impressive in terms of their regard to the RCIADIC.

The Government response to the LRC Report is positive in its commitment to some of the Report recommendations sourced from the RCIADIC, including those pertaining to consultation and the definitions of 'death in custody' and 'next of kin'. That being said, the Report and the Government response could go further in their recognition of the RCIADIC. In particular, there is reason to doubt the commitment of the Government to RCIADIC-sourced Report recommendations relating to prevention of deaths, given that the Government response weakens the LRC Report's language. VALS urges the Government to ensure that reform to the *Coroners Act 1985* (Vic) reflects the Report recommendation of making prevention an aim of the Act, which in turn reflects the sentiment in RCIADIC recommendations relating to prevention. There are also a number of important considerations the Government should adhere to in seeking to move forward with a RCIADIC framework, which involve creativity in the use of the RCIADIC, an awareness of barriers and tools for effective reform, consultation with Indigenous communities, and an improvement of the policy climate.

Postscript

The Coroners Bill 2008 (Vic) was released to the public in October 2008.[37] The purpose of this postscript is to outline whether the reasons for optimism or pessimism discussed in the article above about reform of the Victorian coronial system have been realised with the release of the Bill. The primary focus in the postscript is on those topics mentioned above, as these are the priorities of Indigenous Victorians in reform of the Victorian coronial system. It is not a one-sided story: there are some positive elements to the Bill, but there are also many areas where the Bill does not go far enough. Also, this postscript judges the Bill in relation to the level of centrality it gives the RCIADIC. VALS argues that the Victorian LRC's Discussion Paper and Report gave more regard to the RCIADIC than the Bill and that this should be rectified by the Bill giving a greater recognition of the RCIADIC.

VALS' expectations in relation to the definition of 'death in custody' have not been met by the Bill. The provision of a definition of 'person held in custody or care' in s 3 of the Bill has partially implemented the relevant recommendations of both the RCIADIC and the LRC Report in respect of the 'death in custody' definition. It is positive that the Bill's definition appears to incorporate parts (a) and (d) of recommendation 19 of the LRC Report, which was based on the near-identical recommendation 6 of the RCIADIC (discussed in article above). However, parts (b) and (c) of the same recommendation have been excluded from the definition, with the consequence that the RCIADIC recommendation, regarding the definition of 'death in custody', will only be partially implemented through the operation of the Bill.

On the topic of prevention, it is positive that the Bill includes the goal of prevention as a purpose in the long title, preamble and 'purposes' section (s 1). However, there are also negative aspects to the Bill's treatment of prevention, with the result that the RCIADIC provisions relating to prevention can only be partially implemented through the operation of the Bill. While VALS is pleased to see that some means are provided to meet the purpose of prevention – s 73(1), for instance, requires the publication of findings and reports of coroners on the internet, unless a coroner orders otherwise – it is a concern that such means are limited. Additionally, it is disappointing that the Bill has not made it mandatory for parties subject to coronial recommendations to report on the implementation status of those recommendations. As mentioned in the original article, the provision of mandatory responses to coronial recommendations was a key recommendation of the RCIADIC and the LRC Report.

VALS supports the Bill's establishment of a Coronial Council that provides advice to the Attorney-General in relation to

the prevention of deaths (see pt 9 of the Bill). However, the content of the Council's Annual Report to Parliament is not broad enough, as it only relates to operations of the Council (s 113). As the LRC Report recommended, the Council's Annual Report should include:

> a summary of all investigations in which recommendations were made, and ... a summary of responses to the recommendations made, including a list of those still awaiting implementation.[38]

In relation to the Bill's definition of 'senior next of kin', a crucial measure of the Bill's cultural appropriateness, VALS is disappointed. There appears to be less progress on this issue than in respect of the topics of prevention and the definition of 'death in custody'. It is unsatisfactory that LRC recommendation 91(f), which recommended defining 'next of kin' in a culturally inclusive manner and which VALS supports, has been overlooked, and it raises questions about the cultural appropriateness of the Bill. It appears that no attempt has been made to resolve the complexities associated with a Western legal system taking into account Indigenous Australian culture. VALS endorses the proactive approach taken in the Northern Territory where a hierarchy of senior next of kin that is specifically inclusive of Indigenous Australian culture has been implemented. Under s 3 of the *Coroners Act* (NT), where the deceased person is Aboriginal, 'senior next of kin' includes 'a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person.' By contrast, and against VALS' expectations from the Government response to the LRC Report, the Government has taken a stance of inaction by failing to be inclusive of Aboriginal culture in defining 'senior next of kin' in the Bill.

The Government's inaction is even more evident – and even more damning – in light of the fact that VALS has not been approached by the Government to develop a protocol about 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 disappointing that RCIADIC recommendations 38 and 39 and LRC Report recommendation 102, relating to development of such a protocol, have been overlooked.

VALS' disappointment about the Bill's handling of the issue of prevention is less of a surprise than its handling of the definitions of 'death in custody' and 'next of kin', and inaction in relation to the protocol. In the original article, written before the release of the Bill, VALS placed the former under the heading 'pessimism' and the latter three under the heading 'optimism'. VALS takes this opportunity to once again reiterate to the Government the need to take into account VALS concerns before the Bill becomes legislation.

* The Victorian Aboriginal Legal Service Co-Operative Limited ('VALS') is a community-owned and -controlled organisation that was established in 1973. VALS provides legal assistance to Aboriginal and Torres Strait Islander people in Victoria, and is also actively engaged in research, policy and law reform initiatives aimed at promoting social justice for Indigenous Australians.

1 LRC, Parliament of Victoria, *Coroners Act 1985: Discussion Paper* (2005) <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/disc%20paper.pdf> at 21 November 2008.

2 LRC, Parliament of Victoria, *Coroners Act 1985: Report* (2006) <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/final%20report.pdf> at 21 November 2008.

3 Victorian Government, *Government Response to the Victorian Parliament Law Reform Committee's* Coroners Act 1985 – *Final Report* <http://www.parliament.vic.gov.au/LAWREFORM/inquiries/Coroners%20Act/govt%20resp.pdf> at 21 November 2008.

4 Victorian Department of Justice, *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody: Review Report* (2005) vol 1, 458–62 <http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/Home/Your+Rights/Research+and+Statistics/> at 21 November 2008.

5 Commonwealth, RCIADIC, *National Report* (1991) vol 1, [3.2.4].

6 LRC, Parliament of Victoria, *Coroners Act 1985: Discussion Paper*, above n 1, xix (question 28).

7 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, xix.

8 Commonwealth, RCIADIC, above n 5, [4.5.45].

9 Victorian Government, above n 3, 5.

10 *Coroners Act 1985* (Vic), s 3.

11 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, xxxii.

12 Ibid 446.

13 Commonwealth, RCIADIC, above n 5, [4.6.22].

14 [1995] 2 VR 176.

15 Ibid.

16 Victorian Government, above n 3, 9.

17 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, 500.

18 Commonwealth, RCIADIC, above n 5, [4.7.4].

19 Victorian Government, above n 3, 7 (citations omitted).

20 Victorian Department of Justice, *Review Report*, above n 4.

21 See Victorian Department of Justice, *Victorian Aboriginal Justice Agreement* (2000) <http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/resources/file/eb0d4b0ad85e729/Vic_Aboriginal_Justice_Agreement_2004.pdf> at 21 November 2008; Victorian Department of Justice, *Victorian Aboriginal Justice Agreement Phase 2* (2006) <http://www.justice.vic.gov.au/wps/wcm/connect/DOJ+Internet/resources/file/eb0d5a0ad8850c7/Aboriginal%20Justice%20Agreement%20%28Phase%202%29.pdf> at 21 November 2008.

22 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, 385.

23 Ibid 409.

24 Commonwealth, RCIADIC, above n 5, [4.7.4].

25 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, 330.

26 Commonwealth, RCIADIC, above n 5, [4.7.4].

27 Victorian Government, above n 3, 10.

28 Ibid.

29 Ibid.

30 Ibid.

31 Ibid 11.

32 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, 409.

33 Victorian Government, above n 3, 10.

34 Commonwealth, RCIADIC, above n 5, [4.7.4].

35 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, 409.

36 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, xxiv.

37 The Bill can be viewed at Victorian Government, *Victorian Legislation and Parliamentary Documents* <http://www.dms.dpc.vic.gov.au/> at 21 November 2008.

38 LRC, Parliament of Victoria, *Coroners Act 1985: Report*, above n 2, xxxi.