Victorian Aboriginal Legal Service Submission to the Department of Health on the Victorian Suicide Prevention and Response Strategy

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Background to the Victorian Aboriginal Legal Service

The Victorian Aboriginal Legal Service (**VALS**) is an Aboriginal Community Controlled Organisation (**ACCO**). VALS was established in 1973 to provide culturally safe legal and community justice services to Aboriginal and/or Torres Strait Islander people across Victoria. VALS' vision is to ensure that Aboriginal people in Victoria are treated equally before the law; our human rights are respected; and we have the choice to live a life of the quality we wish.

Legal Services

Our legal practice serves Aboriginal people of all ages and genders in the areas of criminal, family and civil law. We have also relaunched a dedicated youth justice service, Balit Ngulu. Our 24-hour criminal law service is backed up by the strong community-based role of our Client Service Officers (**CSO**s). CSOs are the first point of contact when an Aboriginal person is taken into custody, through to the finalisation of legal proceedings.

Our Criminal Law Practice provides legal assistance and representation for Aboriginal people involved in court proceedings. This includes bail applications; representation for legal defence; and assisting clients with pleading to charges and sentencing. We represent clients in matters in the generalist and Koori courts. Most clients have been exposed to family violence, poor mental health, homelessness and poverty. We aim to understand the underlying reasons that have led to the offending behaviour and equip prosecutors, magistrates and legal officers with knowledge of this. We support our clients to access support that can help to address the underlying reasons for offending, and so reduce recidivism.

Our Civil and Human Rights Practice provides advice and casework to Aboriginal people in areas including infringements; tenancy; victims of crime; discrimination and human rights; Personal Safety Intervention Orders (**PSIO**) matters; coronial inquests; consumer law issues; and Working With Children Check suspension or cancellation.

Our Aboriginal Families Practice provides legal advice and representation to clients in family law and child protection matters. We aim to ensure that families can remain together and children are kept safe. We are consistent advocates for compliance with the Aboriginal Child Placement Principle in situations where children are removed from their parents' care.

Our Specialist Legal and Litigation Practice (Wirraway) provides legal advice and representation in civil litigation matters against government authorities. This includes for claims involving excessive force or unlawful detention; police complaints; prisoners' rights issues; and coronial inquests (including deaths in custody).

Community Justice Programs

VALS operates a Custody Notification System (**CNS**). The *Crimes Act 1958* requires that Victoria Police notify VALS within 1 hour of an Aboriginal person being taken into police custody in Victoria. Once a notification is received, VALS contacts the relevant police station to conduct a welfare check and facilitate access to legal advice if required.

The Community Justice Team also run the following programs:

- Family Violence Client Support Program[1]
- Community Legal Education
- Victoria Police Electronic Referral System (**V-PeR**)[2]
- Regional Client Service Officers
- Baggarrook Women's Transitional Housing program[3]
- Aboriginal Community Justice Reports[4]

Policy, Research and Advocacy

VALS informs and drives system change initiatives to improve justice outcomes for Aboriginal people in Victoria. VALS works closely with fellow members of the Aboriginal Justice Caucus and ACCOs in Victoria, as well as other key stakeholders within the justice and human rights sectors.

Acknowledgements

VALS pays our deepest respect to traditional owners across Victoria, in particular, to all Elders past, present and future. We also acknowledge all Aboriginal and Torres Strait Islander people in Victoria and pay respect to the knowledge, cultures and continued history of all Aboriginal and Torres Strait Islander Nations.

We also acknowledge the following staff members who collaborated to prepare this submission:

- Isabel Robinson, Senior Policy Adviser
- Andreea Lachsz, Head of Policy, Strategy and Communications
- Alex Walters, Principal Managing Lawyer, Civil and Human Rights Practice
- Juergen Kaehne, Principal Managing Lawyer, Aboriginal Families Practice
- Sarah Schwartz, Senior Lawyer / Advocate, Wirraway - Specialist Legal and Litigation Practice

Aboriginal and/or Torres Strait Islander people should be aware that this submission may contain the names of and/or reference to deceased Aboriginal persons.

[1] VALS has three Family Violence Client Support Officers (FVCSOs) who support clients throughout their family law or civil law matter, providing holistic support to limit re-traumatisation of our clients and provide appropriate referrals to access local community support programs and emergency relief monies.
[2] The Victoria Police Electronic Referral (V-PeR) program involves a partnership between VALS and Victoria Police to support Aboriginal people across Victoria to access culturally appropriate services. Individuals are referred to VALS once they are in contact with police, and VALS provides support to that person to access appropriate services, including in relation to drug and alcohol, housing and homelessness, disability support, mental health support.
[3] The Baggarrook Women's Transitional Housing program provides post-release support and culturally safe housing for six Aboriginal women to support their transition back to the community. The program is a partnership between VALS, Aboriginal Housing Victoria and Corrections Victoria.
[4] See https://www.vals.org.au/aboriginal-community-justice-reports/

SUMMARY OF RECOMMENDATIONS

Priority Populations

Recommendation 1. The new Suicide Prevention and Response Strategy for Victoria should prioritise the following additional population groups:

- People in contact with the criminal legal system, particularly people in custody and people who have just left custody;
- Children and young people in contact with the Child Protection system, particularly those in Out-of-home care (**OOHC**), including residential care facilities.

Guiding Principles

Recommendation 2. Include the following additional principles to guide the development of the strategy:

- Culture as a protective factor;
- Cultural safety and cultural competency;
- Equivalency of mental health care in custody;
- Detention as a last resort;
- Health responses to mental health crises;
- Accountability.

Suicide Prevention and Response Initiatives and Actions

Recommendation 3. The Government should work with Aboriginal communities to identify suicide prevention and response initiatives for the following population groups:

- Aboriginal people in custody;
- Aboriginal people who have recently left custody;
- Aboriginal children and young people in out-of-home-care (**OOHC**).

Recommendation 4. In relation to people in custody and people who have recently left custody, initiatives included in the new Strategy should:

- Reduce Aboriginal incarceration rates and ensure that detention is a last resort;[1]
- Ensure that all Aboriginal people in custody can access mental health care that is equivalent to the care available in the community;
- Ensure that Aboriginal people in custody are able to maintain their connection to culture as a significant protective factor;
- Invest in culturally safe transitional support and housing for Aboriginal people leaving custody.

Recommendation 5. The Government must provide long-term and sustainable funding for suicide prevention and response initiatives that respond to Aboriginal people in custody, those who have recently left custody, and Aboriginal children and young people in OOHC.

Recommendation 6. The new Suicide Prevention and Response Strategy must include a robust monitoring and evaluation framework which ensures Government accountability for implementing the initiatives identified in the Strategy, that respond to Aboriginal people in custody, those who have recently left custody, and Aboriginal children and young people in OOHC.

Recommendation 7. All staff in prisons, police custody, child protection (including residential care workers) must complete mandatory and regular training in cultrual awareness, anti-racism (including training on systemic racism), unconscious bias.

Recommendation 8. Cultural awareness training must be developed by Aboriginal organisations and communities, and delivered by Aboriginal people.

Responses for Bereaved Families

Recommendation 9. As set out at recommendations 10 to 36 (below), the Suicide Prevention and Response Strategy should prioritise measures to improve the experience of bereaved Aboriginal families who are involved in coronial processes.

Recommendation 10. The Koori Engagement Unit (**KEU**) should be further embedded into the Court, to ensure visibility over the coronial investigation and access to all information that is relevant to Aboriginal families in a timely manner.

Recommendation 11. The Victorian Government should provide additional funding and resources to the KEU, to ensure that they are able to provide support to all Aboriginal families going through coronial processes.

Recommendation 12. Coronial investigations into Aboriginal deaths by suicide must not be carried out by police. They should be carried out by a specialist civilian investigation team that is independent from police and developed by Aboriginal communities.

Recommendation 13. Family members should be notified of the death of their loved one by an Aboriginal person and, where possible, that person should be known to the family. Where appropriate, Aboriginal Community Controlled Organisations can play a key role in the notification. Notification should occur immediately, and in person where possible. Notification should not be by Victoria Police.

Recommendation 14. All authorities that are responsible for the care or custody of individuals (including Corrections Victoria, Victoria Police, Youth Justice, Child Protection and health facilities) must develop protocols for culturally safe notification of the death of an Aboriginal person in their care or custody.

Recommendation 15. At the time of being notified about the death of their loved one in custody, Aboriginal family members should be informed about culturally safe counselling and support services and access to these services should be funded by the Coroners Court.

Recommendation 16. When an Aboriginal family member is in custody at the time that their loved one passes away, they should be provided with culturally safe counselling and support, including

through Aboriginal Community Controlled Health Services. Special dispensation through compassionate leave should be granted, if the service needs to be accessed on a supervised basis away from the custodial institution.

Recommendation 17. In addition to Commonwealth funding for culturally safe legal assistance and representation for Aboriginal families in coronial processes, the Victorian Government should provide funding to VALS to:

(a) provide culturally safe and competent bereavement supports to Aboriginal families; and
(b) provide community legal education to Aboriginal communities regarding coronial processes and senior next of kin arrangements.

Recommendation 18. The Coroners Court should provide funding to families to cover the costs associated with participating in the investigation and inquest (travel, accommodation, incidental costs etc.).

Recommendation 19. *Practice Direction 6 of 2020* should be amended to explicitly provide that the requirement of a Directions Hearing within 28 days of a death being reported to the coroner (Direction 5.1) applies to all coronial investigations into the death of an Aboriginal person, where the coroner believes that an inquest will take place.

Recommendation 20. The Victorian Government should amend the *Coroners Act 2008* to include a duty of candour on all interested parties. The duty would require parties to assist the coronial process, and should include the following elements:

(a) A requirement to make full disclosure of relevant documents, materials and facts;
(b) A requirement for parties to set out their position on relevant matters at the outset of the investigation/inquest.

Recommendation 21. Without undermining the discretion of coroners to manage each investigation/inquest on a case-by-case basis, there should be further standardisation of coronial processes. This will assist in providing clarity for families and their legal representatives about the process.

Recommendation 22. In coronial investigations that will not proceed to inquest, the Coroners Court should consider options for family conferencing, to provide a culturally appropriate forum for regular updates from the Court during the investigation.

Recommendation 23. The Coroners Court should establish a monthly call-over list for all matters being dealt with by the Court when an Aboriginal person has passed away. The purpose of this list would be to provide regular updates to bereaved families and other interested parties about the progress of the investigation/inquest. The list should be established though a new Practice Direction.

Recommendation 24. The State Coroner should adopt Practice Directions establishing timeframes for key aspects of coronial inquiries, including distribution of materials to families within a specified timeframe once they have been received by the coroner. The Practice Direction should include a requirement to provide medical reports to families within one month.

Recommendation 25. *Practice Direction 7 of 2014* ("Coronial Briefs") should be amended to require coroners to set a deadline for preparation of the coronial brief. Additionally, the coronial investigator should provide written reasons to the family and interested parties if the deadline is not met.

Recommendation 26. Families who have lost a loved one to suicide must be treated with respect and provided with all relevant information in a timely and appropriate manner, prior to this information being revealed in the court room.

Recommendation 27. The Coroners Court should explore innovative ways of empowering bereaved family members to share their stories in a culturally safe space, such as private sessions (currently used in WA), yarning circles, restorative justice conferencing, and therapeutic jurisprudence within the coronial process.

Recommendation 28. In consultation with the Koori Engagement Unit, the State Coroner should work with Corrections Victoria, Youth Justice and Victoria Police (including Aboriginal Liaison Officers at these agencies) to develop protocols to facilitate the participation of family members who are in custody whilst a coronial investigation and inquest are proceeding. This should include issues such as viewing of the body, participating in sorry business, and access to culturally safe counselling and support provided by Aboriginal organisations.

Recommendation 29. Legal counsel who engage with and question Aboriginal family members during a coronial inquest must be trained in cultural awareness, anti-racism, systemic racism, unconscious bias, and therapeutic and trauma-informed approaches.

Recommendation 30. The State Coroner should enhance the timeliness, efficiency and efficacy of the coronial inquest process to the greatest degree possible, to ensure that the therapeutic benefits of coronial inquests for bereaved families are realised to their fullest potential.

Recommendation 31. *Practice Direction 6 of 2020* should be amended to provide that, if requested by the family, the investigating coroner should include within the scope of the inquest whether systemic racism or racial bias contributed to the cause or circumstances of the person's death. The coroner must be open to receiving expert evidence regarding systemic racism and racial bias.

Recommendation 32. Government responses to coronial recommendations should provide detail on the action being taken to implement the recommendation and the response should be tabled in Parliament.

Recommendation 33. The State Coroner should also be empowered to call for further explanations or information from public authorities or entities that have received coronial recommendations, including reports as to further action taken in relation to the recommendations.

Recommendation 34. The Department of Premier and Cabinet should have overall responsibility for implementation of coronial recommendations by relevant departments and agencies.

Recommendation 35. The Victorian Government should establish an independent, statutory office of the Aboriginal and Torres Strait Islander Social Justice Commissioner. This office should report directly

to the Parliament and be mandated to monitor the implementation of recommendations from coronial inquests into Aboriginal deaths.

Recommendation 36. The Commonwealth Government should work with State and Territory Governments to establish a central database of publicly available coronial recommendations.

DETAILED SUBMISSIONS

Introduction

VALS welcomes the opportunity to provide feedback on the new Suicide Prevention and Response Strategy for Victoria. Our feedback is based on our experience providing legal and community justice services to Aboriginal communities in Victoria for nearly 50 years. In particular, this submission draws on our experience providing assistance to Aboriginal families involved in coronial investigations and inquests relating to the death by suicide of their loved one.

Aboriginal communities in Victoria are disproportionality impacted by suicide, with devastating and wide-reaching impacts. Data published by the Coroners Court in January 2022 showed that Aboriginal people pass away by suicide at a rate that is three and a half times higher than non-Aboriginal people.[5] In 2021, the number of suicides of Aboriginal people in Victoria increased by 75%.[6]

Experiences from VALS' Coronial Practice highlight particular concerns relating to suicide prevention and responses for children and young people in Out-of-home-care (**OOHC**), particularly in residential care. In addition, we have significant concerns about suicide prevention and responses for Aboriginal people in contact with the criminal legal and youth justice systems, particularly those in custody and those leaving, or who have recently left custody.

Our overarching feedback in relation to the new Suicide Prevention Strategy is that it must prioritise suicide prevention and responses for Aboriginal people in OOHC and in contact with the criminal legal and young justice systems. For both of these priority populations, as well as children and young people who are in OOHC and in contact with the youth justice system, ("crossover kids"), initiatives that support connection to culture, Country, community and kinship as a protective factor are paramount.

Our submission responds to the following consultation questions:

- Question 2a: In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)
- Question 2b: If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?

[5] Coroners Koori Engagement Unit and Coroners Prevention Unit, *Suicides of Aboriginal and Torres Strait Islander people: Victoria 2018-2021* (2022), p. 8.
[6] Ibid., p. 4.

- Question 3: What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?
- Question 4: What principles should guide the development and implementation of the strategy?
- Question 5a: In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?
- Question 5c: In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?
- Question 5f: For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

Policy Framework

We note the following documents, which form part of the broader policy framework for suicide prevention and response at both the Victorian and National level.

Victoria

- *Victorian suicide prevention framework 2016–2025* (2016)
- *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–2015* (2015)
- *Victorian Closing the Gap Implementation Plan (2021-2023*), Target 14
- *Correctional Suicide Prevention Framework: Working to prevent prisoner and offender suicides in Victorian correctional settings* (2015)
- Justice Health and Corrections, *Aboriginal Social and Emotional Wellbeing Plan* (2015)
- *Youth Justice Strategic Plan 2020-2030* (2020)
- *Wirkara Kulpa – Aboriginal Youth Justice Strategy 2022-2032* (2022)
- *Victorian Child Protection Manual*

National

- Closing the Gap National Agreement (2020) - Target 14
- *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (2017)
- *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* (2013)
- *Fifth National Mental Health and Suicide Prevention Plan* (2017-2022)

- *The Gayaa Dhuwi (Proud Spirit) Declaration* (2015)[7]
- *The Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* (2017)[8]

Additionally, we note the following inquiries and reports, which have resulted in numerous recommendations in relation to mental health care and suicide prevention and response for individuals in custody and in contact with the child protection system:

- Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), Final Report (1991)
- Victorian Ombudsman and Office of Police Integrity, *Conditions for Persons in Custody* (2006)
- Victorian Ombudsman, *Investigation into Deaths and Harms in Custody* (2014)
- Victorian Ombudsman, *Investigation into Rehabilitation and Reintegration of Prisoners in Victoria* (2015)
- Victorian Ombudsman, *Implementing OPCAT in Victoria: Report and Inspection of the Dame Phyllis Frost Centre* (2017)
- Victorian Ombudsman, *OPCAT Report: Investigation of Practices Related to Solitary Confinement* (2019)
- Commission for Children and Young People (**CCYP**), *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection* (2019)
- CCYP, *Keep caring: Systemic inquiry into services for young people transitioning from out-of-home care* (2020)
- CCYP, *Our Youth, Our Way: Inquiry into overrepresentation of Aboriginal Children and Young People in the Youth Justice System*.

Priority Populations and Areas

Consultation Questions

- **Question 2a**: In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate? (Yes/No)
- **Question 2b**: If not, which other higher risk groups do we need to prioritise for targeted and comprehensive action now?
- **Question 3**: What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?

The discussion paper identifies the following priority groups:

[7] *National Aboriginal and Torres Strait Islander Leadership in Mental Health (**NATSILMH**), The Gayya Dhuwi (Proud Spirit) Declaration* (2015)
[8] NATSILMH, *The Gayaa Dhuwi (Proud Spirit) Declaration Implementation Guide* (2017).

- Aboriginal people;
- Children and young people;
- Culturally diverse people;
- LGBTIQ+ communities;
- People in remote and rural communities;
- People living with mental illness;
- People living with substance abuse/addictions;
- People with lived experience of suicide;
- People with disability
- People working in high risk industries;
- Veterans and ex-armed services
- Women.

We strongly support the focus on Aboriginal people in the new Suicide Prevention and Response Strategy. In addition, we strongly support the emphasis on intersectionality, and the need to consider a range of contributing and compounding risk factors for suicide.

In this regard, the Strategy should adopt a more sophisticated and meaningful approach to intersectionality. In addition to recognising the way that an individual may be impacted by multiple and compounding factors, the Strategy must include appropriate responses and support for individuals, based on their intersectional risk and protective factors.

Additionally, the Discussion Paper does not identify the following priority populations, which should be included:

- People in contact with the criminal legal system, including people in custody, people who have recently been released from custody, people on parole and people on Community Corrections Orders (**CCO**s);
- Children and young people in OOHC, including residential care.

Although the discussion paper notes "contact with the justice system" and "contact with social services and child custody issues" as contributing/risk factors for suicidal thoughts and behaviour, prevention and support for these cohorts should be explicitly prioritised in the strategy.

People in Contact with the Criminal Legal System

People in contact with the criminal legal system must be included as a priority population within the new Strategy. In particular, this includes people in custody, people on parole and/or recently released from custody, children and young people in contact with both child protection and youth justice

(sometimes referred to as "cross over kids") and people on parole or Community Corrections Orders (**CCO**s).

The most recent report of the Coroners Court on Aboriginal suicides indicated that engagement with police and justice system proximal to passing was a theme arising from the 92 Aboriginal deaths by suicide, that took place between 2018 and 2021.[9] This was particularly relevant for people aged 18-24 years at the time of their passing.

People in Prisons

Recent data relating to deaths by suicide in Victorian prisons is not easily accessible.[10] However, data published in 2015 indicates that over the 30 year period from 1983–2013, 76 incarcerated people died by apparent or actual suicide in Victorian private and public prisons.[11] Both nationally and internationally, the data indicates that self-inflicted deaths in the prison population greatly exceeds that of self-inflicted deaths in the community.[12] Other key trends include higher rates of suicide amongst unsentenced than sentenced incarcerated people,[13] and a greater suicide risk during the early stages of detention.[14]

Currently, suicide prevention and response for Aboriginal people in prisons in Victoria is governed by the following policy framework:

- *Correctional Suicide Prevention Framework: Working to prevent prisoner and offender suicides in Victorian correctional settings* (2015)[15]
- *Aboriginal Social and Emotional Wellbeing Plan* (2015)
- *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–2015*[16]
- Additional documents: Commissioner's Requirements, Deputy Commissioner's Instructions, Local Operating Procedures and Justice Health Standards.[17]

Many of these documents are dated and it is unclear if they are still applicable or have been replaced. Some of these, including the *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010–*

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[9] Coroners Koori Engagement Unit and Coroners Prevention Unit, *Suicides of Aboriginal and Torres Strait Islander people: Victoria 2018-2021* (2022), p. 10.
[10] The Productivity Commission's Report on Government Services includes data on the number of Aboriginal deaths from apparent unnatural causes, but this does not identify deaths by suicide.
[11] Justice Health, *Correctional Suicide Prevention Framework: Working to prevent prisoner and offender suicides in Victorian correctional settings* ("hereafter "*Correctional Suicide Prevention Framework* ") (2015), p.4.
[12] M. Willis, A. Baker, T. Cusssen and E. Patterson, "Self-inflicted deaths in Australian prisons," *Trends and Issues in Crime and Criminal Justice,* Australian Institute of Criminology (2016).
[13] According to Willis, Baker, Cussen and Patterson, "Studies in both NSW and South Australia found more than 50 percent of suicide victims were on remand at the time of their death." Ibid., p. 3.
[14] According to According to Willis, Baker, Cussen and Patterson, "in South Australia, 26 percent of suicides were found to occur in the first week of custody and 39 percent in the first month." Ibid.
[15] The *Correctional Suicide Prevention Framework* serves as "a single overarching whole-of-system prevention framework to complement existing standards and procedures." Justice Health, Correctional *Suicide Prevention Framework* (2015), p.4.
[16] This document is referred to in the *Correctional Suicide Prevention Framework* (2015) and the *Aboriginal Social and Emotional Wellbeing Plan (20105),* however it is not available publicly.
[17] Cited in Correctional Suicide Prevention Framework (2015) p. 4.

2015, are not publicly available. There is a clear need to revise and update the existing policy framework relevant to prisons, in coordination with Aboriginal communities.

Even when policies and procedures exist, there is often a lack of accountability for implementing these strategies. For example, the *Aboriginal Social and Emotional Wellbeing Plan* (2015) includes a range of measures to build a culturally capable workforce, improve access to culturally safe and responsive services and improve continuity of care for Aboriginal people as they are leaving custody.

The plan was due to be implemented by 2018, yet VALS has ongoing concerns about the lack of implementation of many of the actions identified in the Plan. Although the Plan is now outdated, the Discussion Paper lists this document as a "current or upcoming" policy document that can inform the new Strategy.[18]

Lack of accountability has also been an ongoing concern for VALS in relation to RCIADIC which made numerous recommendations relating to custodial health and safety in 1991.[19] Despite a 2005 review of the status of implementation of these recommendations in Victoria,[20] many of these recommendations have not been implemented. In this regard, the Aboriginal Justice Caucus (**AJC**) is currently undertaking an Aboriginal-led review of the Government's progress in implementing RCIADIC recommendations in Victoria.

There are significant needs amongst the Aboriginal prison population, and a clear need to prioritise this population group in the new *Suicide Prevention and Response Strategy.*

Children and Young People in Youth Justice Centres

Data from 2018 and 2019 indicates that Aboriginal children and young people are substantially over-represented in incidents involving attempted suicide and self-harm in Victoria's youth justice centres.[21] Despite accounting for 16% of the monthly average youth justice population, 42% of all reported suicide attempts and 34% of all reported self-harm incidents involved Aboriginal children and young people.[22]

The current policy framework for suicide prevention and response in youth justice includes the *Youth Justice Strategic Plan 2020-2030,*[23] *Wirkara Kulpa: Aboriginal Youth Justice Strategy 2022-2032,*[24] and two Director's instructions relating to suicide and self-harm: *Safety and security: immediate response to suicidal and self-harming behaviour* and *Safety and security framework for the prevention of suicidal and self-harming behaviour*.[25]

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[18] Department of Health, *Suicide Prevention and Response Strategy: Discussion Paper* (2020), p. 18.
[19] See Recommendations 122 – 167, Royal Commission into Aboriginal Deaths in Custody (RCIADIC), *National Volume 5* (1991).
[20] *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody* (2005)
[21] CCYP, *Our Youth, Our Way* (2021), p. 530.
[22] Ibid.
[23] *Youth Justice Strategic Plan 2020-2030* (2020).
[24] *Wirkara Kulpa: Aboriginal Youth Justice Strategy 2022-2032* (2022).
[25] Cited in CCYP, *Our Youth, Our Way* (2021), p. 533.

The CCYP has been advocating for urgent reforms for many years, including in its 2021 report, *Our Youth, Our Way: Inquiry into overrepresentation of Aboriginal Children and Young People in the Youth Justice System*.[26] Recommendation 72 from this report is that the Department of Justice and Community Safety (**DJCS**) should "urgently develop a strategy to provide improved, consistent and therapeutic responses to children and young people at risk of suicide or self-harm in youth justice centres. The strategy should include specific elements to ensure a culturally safe and improved response to Aboriginal children and young.[27]

We note that the new Suicide Prevention and Response Strategy will address key recommendations from the CCYP 2019 Inquiry, *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection* (discussed further below). Similarly, the new Strategy should respond to recommendations from the CCYP Inquiry into Aboriginal Children in Youth Justice.

People in Police Custody

Data is not publicly available in relation to self-harm incidents and death by suicide of people in police custody. Despite this, data above on the high suicide risk during the early stages of detention indicates that suicide prevention during police custody is critical.

Currently, the policy framework for suicide prevention and response for people in police custody is governed by the Victoria Police Manual (**VPM**), *Safe Management of Persons in Police care or custody* (July 2022) and the VPMP,[28] *Persons in Police Care or Custody* (July 2022).[29]

People Recently Released from Custody

According to the *Correctional Suicide Prevention Framework*, "the first few weeks immediately following release from prison is a time of high risk of suicide with this group at greater risk than the general population."[30] Similarly, *Balit Marrup* states that Aboriginal people released from prison are particularly at risk of suicide immediately after release.[31]

VALS continues to have concerns about the lack of support for Aboriginal people exiting custody, particularly in relation to lack of stable housing and supports. Existing supports/programs for Aboriginal people leaving custody include:

- The Baggarrook Women's Transitional Housing program: Baggarrook combines transitional housing and holistic support for six Aboriginal women to support their transition back to the community. Housing is provided by Aboriginal Housing Victoria and holistic support is

[26] CCYP, *Our Youth, Our Way* (2021), pp. 530 – 537.
[27] See Recommendation 72: That DJCS urgently develop a strategy to provide improved, consistent and therapeutic responses to children and young people at risk of suicide or self harm in youth justice centres. The strategy should include specific elements to ensure a culturally safe and improved response to Aboriginal children and young people. CCYP, *Our Youth, Our Way*, p. 537.
[28] The VPMP are Policy Rules setting out mandatory requirements for employees.
[29] Both of these documents are available publicly at the State Library of Victoria.
[30] Justice Health, *Correctional Suicide Prevention Framework,* p. 9.
[31] Department of Health and Human Services (DHHS), *Balit Marrup: Aboriginal social and emotional wellbeing framework 2017-2027* (2017), p. 17.

provided by VALS and allied organisations, as well as DHHS and Corrections Victoria. The program is funded by Corrections Victoria.

- VACCA's Through-care project for Aboriginal children and young people: the project was initially implemented as a pilot for Aboriginal young people aged 10-17 years who had been detained for more than a week, and focuses on cultural strengthening and cultural mentoring. The program is no longer a pilot as VACCA has received three years of additional funding.

In addition to the limited number of programs in Victoria, there are important examples of culturally safe through-care from other jurisdictions in Australia, including the Throughcare Service run by the Northern Australian Aboriginal Justice Agency (**NAAJA**) (see below).

Good Practice Model: NAAJA Throughcare Service

The North Australian Aboriginal Justice Agency's (**NAAJA**) Throughcare service begins working with people in prison and youth detention six months prior to their release, with the aim of supporting people's transition back into the community. The support is provided in recognition of the various issues that might present challenges to a successful transition, including "Homelessness or marginal accommodation; No income, disengagement from Centrelink, or unstable income; Literacy and numeracy issues, and/or English as second, third or fourth language; Problematic family relationships, Involvement with welfare agencies, history of family violence; Cultural/payback issues; Lack of community supports; Substance misuse issues; and Health, including mental health issues, and/or physical disabilities."[1] Support can come in the form of "Ongoing rehabilitation, Accommodation, Employment, Education and training, Health, Life and problem solving skills, and Reconnection to family and community."[1]

In its 2018-2019 Annual Report, NAAJA reported that, "since commencing in February 2010, case management support has been provided to 1102 clients. Only 143 of which (approximately 13.3%) have been returned to prison for re-offending or a conditional breach while participating in the Program. This figure continues to compare favourably with the NT recidivism rate of 60%, notwithstanding the measures are not directly comparable."[1]

We strongly recommend that the Strategy includes a specific focus on people immediately following their release from prison, including a commitment to provide long-term and stable funding to ACCOs to deliver pre-and post-release programs, including transitional housing programs run by ACCOs, to provide support to Aboriginal adults, children and young people leaving prison.

Aboriginal Children and Young People in OOHC

In 2019, the CCYP carried out an Inquiry into the deaths of 35 children who had died from suicide between 2007 and 2019, and who were Child Protection clients at the time of their death or in the 12 months prior to their death.[32] The Inquiry was initiated by the CCYP based on identified patterns

[32] CCYP, *Lost, not forgotten* (2019).

arising from these deaths, and built on findings and recommendations from an unpublished report in 2018 on *Inquiry into issues of cumulative harm and suicide in child deaths.*

Of the 35 children whose deaths were examined by the CCYP, six children (17%) identified as Aboriginal.[33] Recent experiences of the VALS Coronial Practice also highlight concerns arising from the death of children and young people in OOHC, including residential care.

As noted above, we support the commitment in the Discussion Paper to address recommendations from the 2019 Inquiry by CCYP. Key recommendations are highlighted in the text box below.

Key recommendations from the CCYP Inquiry, Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection (2019)

- ***Recommendation 1:*** Recommendation In line with Roadmap to Reform, the Victorian Government develop, resource and implement an integrated and whole-of-system investment model and strategy for the child and family system, focussed on:
    - Earlier intervention and prevention services to reduce risks to children and build child and family wellbeing
    - reducing the rate of entry to care
    - meeting the distinct needs of children who need to live away from the family home.
- ***Recommendation 3:*** That the Department of Health and Human Services (**DHHS**) review and revise all foundational practice guidance, training and tools to embed children's participation in decision making during the investigation, protective intervention and protection order phases of Child Protection intervention.
- ***Recommendation 4:*** That the DHHS develop practice advice in relation to children involved with Child Protection who are identified as at risk of suicide.
- ***Recommendation 6:*** That the DHHS develop and implement a suicide prevention strategy for children known to Child Protection that incorporates any relevant findings and recommendations made by the Royal Commission into the Victorian Mental Health System.

Additionally, in 2020, the CCYP carried out an Inquiry into services for young people transitioning from out-of-home-care, which identified "a high incidence of mental health, trauma and drug use among young people about to leave care or who have recently left care," including a high incidence of self-harm and attempted suicide.[34] Key recommendations from this Inquiry are highlighted in the text box below.

[33] Ibid., p. 8
[34] CCYP, *Keep caring: Systemic inquiry into services for young people transitioning from out-of-home care* (2020), p. 18.

Key recommendations from CCYP Systemic inquiry into services for young people transitioning from out-of-home care (2020)

- **Recommendation 8:** That the Victorian Government ensure that all Aboriginal young people have the opportunity to access culturally safe supports based on their level of need as they transition from care, by:
    - at a minimum, allocating a proportion of funding to ACCOs to deliver Better Futures proportionate to Aboriginal young people's representation in the leaving care cohort
    - working with ACCOs and Aboriginal young people with a lived experience of care to design a culturally safe Better Futures model
    - reporting annually on the proportion of Better Futures funding which is allocated to ACCOs
    - giving ACCOs direct access to and control over Better Futures flexible funding
    - funding ACCOs, who are delivering Better Futures, to also deliver the Community Connections service.

- **Recommendation 11:** That the Victorian Government increase investment in the Home Stretch program to ensure that all care leavers have the option of remaining in their kinship or foster care placements, or transitioning to independent living, with support, until 21 years.

- **Recommendation 12:** That the Victorian Government:
    - increase investment in post-care housing options for care leavers to a level sufficient to guarantee a secure, stable and safe home for all young people upon leaving care
    - ensure housing investment for Aboriginal care leavers is proportionate to their over-representation among young people leaving care
    - report annually through the Aboriginal Children's Forum on housing investment for Aboriginal care leavers as a proportion of funding allocated to all care leavers
    - develop and implement an integrated and demand-driven suite of housing options – which includes housing stock and support services – tailored to the diverse needs of young people leaving care.
    - The suite of options should include:
        - social and public housing stock
        - a range of supported and step-down accommodation options for young people up to the age of 21 years, who are not yet ready to live independently
        - a range of culturally safe housing for Aboriginal young people leaving care, including tailored supports.

Given that the new Suicide Prevention and Response Strategy intends to respond to recommendations from both of the CCYP Inquiries, it is unclear why children in contact with the Child Protection System, or children in OOHC are not identified as a priority population. This should be rectified.

RECOMMENDATIONS

Recommendation 1. The new Suicide Prevention and Response Strategy for Victoria should prioritise the following additional population groups:

- People in contact with the criminal legal system, particularly people in custody and those who are about to or have just left custody;
- Children and young people in contact with the Child Protection system, particularly those in Out-of-home care (**OOHC**), including residential care facilities.

Principles

Consultation Questions

- **Question 4**: What principles should guide the development and implementation of the strategy?

The discussion paper identifies the following principles to guide the development and implementation of the strategy:

- Valuing lived experience
- Supporting equity and taking an intersectional approach
- Supporting Aboriginal self-determination
- Being adaptable and evidence-informed
- Taking a person-centred approach.

We believe that the following additional principles should be included:

- Culture as a protective factor
- Cultural competency and cultural safety
- Detention as a last resort
- Equivalency of mental health care
- Health responses to health issues (not law enforcement responses)
- Accountability

Culture as a Protective Factor

As identified in the Discussion Paper, "culture can have a very strong protective factor in supporting social and emotional wellbeing, including connection to: spirit, spirituality and ancestors; land; culture; community; family and kinship; mind and emotions; and body."[35]

As referenced in the Inquest into the suicide of 13 Aboriginal children and young people in the Kimberley region in Western Australia in 2017,[36] a study of 197 communities in British Columbia identified the following 8 protective factors:

- Achievement of a measure of self-government
- Have litigated for Aboriginal title to traditional lands
- Accomplished a measure of local control over health
- Accomplished a measure of local control over education
- Accomplished a measure of local control over policing services
- Have accomplished a measure of control over child welfare services
- Have created community facilities for the preservation of culture
- Characterised as having elected councils composed of more than 50% women[37]

In communities where all 8 protective factors were present, there were no cases of suicide; in communities where none of the protective factors were present, youth suicide rates were many times higher than the national average.

VALS strongly supports the importance of culture as a protective factor, and recommends that it should be prioritised as an additional principle in the Strategy. The role of Aboriginal community-controlled organisations in promoting culture as a protective factor should also be highlighted.

Cultural Safety and Cultural Competency

In addition to Aboriginal self-determined responses, it is critical that the strategy prioritises cultural competency of generalist services, including mental health services.

According to the National Safety and Quality Health Service Standards, cultural awareness and cultural competency are on a continuum, and contribute to a culturally safe environment, that is respectful of Aboriginal and Torres Strait Islander patients and workforce: "Cultural awareness is a basic understanding that there is diversity in cultures across the population. Cultural competency extends beyond individual skills or knowledge to influence the way that a system or services operate across

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[35] Department of Health, Discussion Paper, p. 12.
[36] Coroners Court of Western Australia, *Inquest into the Deaths of Thirteen Children and Young persons in the Kimberley Region, Western Australia*, 25/2017.
[37] Chandler, M. and Lalonde, C. (2008) "Cultural Continuity as a Protective Factor Against Suicide in First Nations Youth" Horizons 10(1), 68 – 72, cited in Coroners Court of Western Australia, *Inquest into the Deaths of Thirteen Children and Young persons in the Kimberley Region, Western Australia*, 25/2017, [149].

cultures."[38] Importantly, "One-off training does not create a culturally competent workforce, but could increase cultural awareness."

Additionally, the Australian Health Practitioner Regulation Authority defines cultural safety as follows:

> Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.[39]

As noted in our submission regarding the *Mental Health and Wellbeing Bill*, Aboriginal self-determination must be prioritised, but parallel and ongoing efforts to improve cultural competency across generalist services is critical. Strategies that could be utilised:

- Include Aboriginal mental health workers, Aboriginal family members and Elders in decisions regarding treatment and care of Aboriginal people
- Ensure that services provided by generalist service providers are culturally appropriate and free of racism
- Provide strengths-based treatment and care that supports connection to culture, family, community and Country, as protective factors for Aboriginal people.

Detention as a Last Resort

In 1991, the RCIADIC recommended that detention of Aboriginal people should be a last resort. The Royal Commission investigated 30 deaths by suicide of Aboriginal people in custody,[40] and made recommendations in relation to suicide prevention within prisons and police custody. However, one of the overarching themes arising from the RCIADIC was that many of the Aboriginal people whose deaths were investigated by the Commission, should not have been in custody in the first place.

Given that involvement with the legal system is a risk factor for suicide, as well as the particular vulnerabilities associated with detention (including disconnection from Country and culture) the Strategy should prioritise measures to reduce incarceration of Aboriginal people (see further below).

Health Responses to Mental Health Crises

As highlighted by the Royal Commission into Victoria's Mental Health System, health responses to mental health crises should be led by health personnel, not law enforcement.[41] In our view, health responses to mental health crises are a critical way to ensure that individuals are provided with appropriate and culturally safe support and services, rather than being criminalised.

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[38] Australian Commission on Safety and Quality in Health Care (2017). *National Safety and Quality Health Service Standards: User Guide for Aboriginal and Torres Strait Islander Health*, p. 22.
[39] Australian Health Practitioner Regulation Authority (AHPRA), *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.*
[40] RCIADIC, National Volume 1, para 2.6.4.
[41] Royal Commission into Victoria's Mental Health System, *Final Report*, Recommendation 10.

Despite Recommendation 10 of the Royal Commission, Victorian Police and Protective Service Officers (**PSO**s) will continue to play a prominent role in mental health crisis responses under the *Mental Health and Wellbeing Bill 2022,* included through expanded powers for PSOs.

In addition to the power to apprehend someone where the relevant threshold is met, the Bill also expands PSO powers to include the power to detain for the purposes of transporting someone, enter premises for the purposes of apprehending someone, search a person, seize and secure items found after searching a person and use bodily restraints on someone after apprehending them.

The 2016 report by the Independent Broad-based Anti-corruption Commission (**IBAC**) on Transit Protective Officers highlights a number of allegations of assault and excessive use of force, predatory behaviour and unauthorised access to or disclosure of information by PSOs.[42] In addition to the fact that PSOs receive more limited training than police officers, these allegations indicate that there are serious risks in giving police powers to PSOs.

Contrary to the *Mental Health and Wellbeing Bill* 2022, the Suicide Prevention and Response Strategy must prioritise health responses, not law enforcement responses.

Equivalency of Mental Health Care

In relation to suicide prevention and response for people in custody, the new Strategy should include an Equivalency of Mental Health Care Principle, requiring that individuals in custody receive mental health care that is equivalent to that which is available in the community.

Healthcare in prisons and police custody in Victoria is both inadequate and culturally unsafe, with significant detrimental effects for Aboriginal people who are incarcerated. Over thirty years ago, RCIADIC (Recommendation 150) stated that healthcare in prisons must be equivalent to what is available in the community. This recommendation has not been implemented.

In 2021, an analysis of deaths in custody across Australia found that Aboriginal people who died in custody were three times more likely not to receive all necessary medical care, compared to non-Aboriginal people, and that less than half of the Aboriginal women who died in custody received all required medical care prior to death.[43]

Mental health care provided to individuals who are in custodial settings must be equivalent to the level of care that is available in the community.

Accountability

There are a multitude of government policies and strategies in Victoria that commit to Aboriginal self-determination, and closing the gap between Aboriginal and non-Aboriginal communities in a range of areas. Yet, many of these remain unimplemented, with weak mechanisms for accountability.

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[42] IBAC (2016), *Transit Protective Services Officers: An exploration of corruption and misconduct risks*.
[43] Allam, L. et al. (2021). The facts about Australia's rising toll of Indigenous deaths in custody.

As noted above, lack of accountability has been a key concern for VALS and the Aboriginal Justice Caucus (**AJC**) for many years, in relation to recommendations from RCIADIC and coronial recommendations. In this regard, it is encouraging to see that the Suicide Prevention and Response Strategy will address relevant coronial recommendations (see further below).

Similarly, our experiences from coronial inquests indicate that there may often be policies and procedures in place that are not, in fact, implemented or adhered to, and there is no system for addressing these failures until someone has passed away and there is a coronial inquest.

Against this backdrop, accountability – including both organisational and individual – must be a core principle in the development and implementation of the Suicide Prevention and Response Strategy.

RECOMMENDATIONS

Recommendation 2. Include the following additional principles to guide the development of the strategy:

- Culture as a protective factor
- Cultural safety and cultural competency
- Equivalency of mental health care in custody
- Detention as a last resort
- Health responses to mental health crises
- Accountability

Suicide Prevention and Response Initiatives and Actions

Consultation Questions

- **Question 5a:** In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?
- **Question 5c**: In addition to training, what else is needed to support frontline workforces and other social and health services workforces to respond compassionately to: people experiencing suicidal thoughts and behaviour; suicide attempt survivors; and families and carers?

Initiatives

The new Suicide Prevention and Response Strategy must include initiatives that respond to individuals' intersecting protective and risk factors, including Aboriginal people in custody and those who have just left custody, as well as Aboriginal children and young people in out-of-home care.

In line with the commitment to Aboriginal self-determination, the process for developing the new Strategy should prioritise the expertise of Aboriginal communities in identifying initiatives to support these population groups. Suicide prevention and response initiatives targeting Aboriginal people in custody and those in OOHC must be backed up by long-term and sustainable funding.

The following key themes should be addressed in future processes to identify relevant suicide prevention and response initiatives for these population groups.

People in custody and people who have recently left prison or youth justice centres

- Reduce Aboriginal incarceration rates and ensure that detention is a last resort[44]
- Ensure that all Aboriginal people in custody can access mental health care that is equivalent to the care available in the community
- Ensure that Aboriginal people in custody are able to maintain their connection to culture as a significant protective factor
- Implement relevant recommendations from the CCYP Inquiry, *Our Youth Our Way*: *Inquiry into overrepresentation of Aboriginal Children and Young People in the Youth Justice System*
- Invest in culturally safe transitional support and housing for Aboriginal people leaving custody

Children and young people in OOHC

- Implement relevant recommendations from the CCYP Inquiry, *Lost, not forgotten: Inquiry into children who died by suicide and were known to Child Protection* (2019)
- Implement relevant recommendations from the CCYP Inquiry, *Keep Caring: Systemic Inquiry into services for young people transitioning from out-of-home care* (2020)

[44] This includes: raising the age of criminal responsibility to at least 14 years; raising the minimum age of detention to 16 years; reforming the punitive bail system to create a presumption in favour of bail for all offences, with the onus on the prosecution to prove otherwise; repealing bail offences, which re-criminalise people who are already criminalised; expanding Koori Courts to include culturally appropriate bail hearings; ensuring that a strengths-based approach to Aboriginality is incorporated into all bail and sentencing decisions; decriminalising public intoxication and ensuring that the "health response" to public intoxication does not include detention of individuals in police cells, police vehicles or police stations; decriminalising the use of cannabis and the possession of cannabis for personal use should be decriminalized. For additional legislative and policy reforms aimed at reducing Aboriginal incarceration rates, see: VALS, *Submission to the Inquiry into Victoria's Criminal Justice System* (2021).

RECOMMENDATIONS

Recommendation 3. The Government should work with Aboriginal communities to identify suicide prevention and response initiatives for the following population groups:

- Aboriginal people in custody
- Aboriginal people who have recently left custody
- Aboriginal children and young people in out-of-home-care (**OOHC**).

Recommendation 4. In relation to people in custody and people who have recently left custody, initiatives included in the new Strategy should:

- Reduce Aboriginal incarceration rates and ensure that detention is a last resort[1]
- Ensure that all Aboriginal people in custody can access mental health care that is equivalent to the care available in the community
- Ensure that Aboriginal people in custody are able to maintain their connection to culture as a significant protective factor
- Invest in culturally safe transitional support and housing for Aboriginal people leaving custody.

Recommendation 5. The Government must provide long-term and sustainable funding for suicide prevention and response initiatives that respond to Aboriginal people in custody, those who have recently left custody, and Aboriginal children and young people in OOHC.

Recommendation 6. The new Suicide Prevention and Response Strategy must include a robust monitoring and evaluation framework which ensures Government accountability for implementing the initiatives identified in the Strategy, that respond to Aboriginal people in custody, those who have recently left custody, and Aboriginal children and young people in OOHC.

Training

Although training is not a panacea, mandatory and regular training for all frontline authorities in Victoria is a critical step towards culturally appropriate suicide prevention and responses. In our view, training must be mandatory and regular for all staff in prisons, police custody, residential care providers and Child Protection.

Training for frontline workers must include training on cultural awareness, anti-racism (including training on systemic racism) and unconscious bias. Aboriginal cultural awareness training must be developed by Aboriginal organisations and communities, and delivered by Aboriginal people.

Training commitments must be backed up by clear strategies to achieve these commitments, with targets, impacts, evaluation and public reporting for transparency. Where possible, training requirements should be connected to annual performance reviews.

In relation to training, we take this opportunity to highlight the following key findings and recommendations from the Inquest into the death of proud Palawa and Nunga man, Harley Larkin,[45] who died in 2016 at the age of 23 years. At the time of his death, Harley was an involuntary patient at the North Western Mental Health Service.

In his findings, the coroner highlighted the clear risk in generalist services that the expertise of Aboriginal mental health workers will not be adequately incorporated into treatment and care decisions.[46] Additionally, the coroner emphasised that the cultural competency of the entire treatment team is critical; it is not enough just to have an Aboriginal Liaison Officer, or senior staff who are "culturally competent." Indeed, the Inquest highlighted that the lack of cultural competency of nurses and other support staff contributed to an environment where Aboriginal mental health workers were intermittently refused access to Harley Larking, and their advice and recommendations were not given adequate weight.[47] For this reason, the Coroner recommended that all inpatient psychiatric staff at the North Western Mental Health Service must undertake regular training in cultural competence in mental health clinical practice.[48]

RECOMMENDATIONS

Recommendation 7. All staff in prisons, police custody, child protection (including residential care workers) must complete mandatory and regular training in cultrual awareness, anti-racism (including training on systemic racism), unconscious bias.

Recommendation 8. Cultural awareness training must be developed by Aboriginal organisations and communities, and delivered by Aboriginal people.

Responses for Bereaved Aboriginal Families

Consultation Question

- **Question 5f:** For people who have been bereaved by suicide, what are the most compassionate and practical responses we can implement? How might this differ across various communities/groups?

All suicides in Victoria must be reported to the Coroners Court, which maintains the Victorian Suicide Register and is responsible for investigating cause and circumstances of the death. If a suicide occurs

[45] Findings into Death with Inquest, *Inquest into the death of Harley Robert Larking*, COR 2016 2137.
[46] Coroners Court (2020). *Finding into Death with Inquest: Inquest into the Death of Harley Robert Larking*, Doc. 2016 2037, paras 199 – 226.
[47] Ibid., paras. 199-227.
[48] Coroners Court (2020). *Finding into Death with Inquest: Inquest into the Death of Harley Robert Larking*, Doc. 2016 2037, para 225 and Recommendation 7.

in custody or care,[49] the authority responsible for the care or custody of the person at the time of their death is obliged to report the death to the coroner,[50] and the death is subject to a mandatory coronial inquest.[51]

As noted above, VALS provides assistance and representation for Aboriginal families involved in coronial investigations and inquests, including those arising from death by suicide. If an Aboriginal person dies in custody in Victoria, including as a result of suicide, VALS must be notified within 48 hours.[52]

In all coronial matters, VALS works closely with the Koori Engagement Unit (**KEU**) at the Coroners Court, and we strongly support the work of this Unit. We have seen first-hand the significant improvements in court processes and approaches since the Koori Family Engagement Coordinator was appointed in 2018, and with the creation of the KEU.

In particular, the introduction of *Practice Direction 6 of 2020 (Indigenous Deaths in Custody)*[53] has had a significant impact for Aboriginal families involved with the Coroners Court. This Practice Direction applies specifically to Aboriginal Deaths in Custody, however, coroners are encouraged to apply *Practice Direction 6 of 2020* to all Aboriginal deaths investigated by the Court, including all Aboriginal deaths by suicide.[54] The Koori Engagement Unit was critical in the development of this Practice Direction.

Despite the creation of the KEU and the development of *Practice Direction 6 of 2020*, VALS clients continue to experience challenges with coronial processes, which further exacerbate their grief and trauma. Additionally, *Practice Direction 6 of 2020* failed to include a requirement for coroners, if requested by the family, to investigate the role of systemic racism in relation to the death.

There are opportunities for change and improvement within the coronial process, to ensure that Aboriginal families are treated with dignity and respect.

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[49] Under s. 3 of the *Corners Act 2008* (Vic), "custody or care" means: (a) a person for whom the Secretary to the Department of Human Services has parental responsibility under the *Children, Youth and Families Act 2005*; (b) a child placed in emergency care under the *Children, Youth and Families Act 2005*; (c) a person who is deemed to be in the legal custody of the Secretary to the Department of Human Services under the *Children, Youth and Families Act 2005*; (d) a person under the control, care or custody of the Secretary to the Department of Human Services or the Secretary to the Department of Health; (e) a person in the legal custody of the Secretary to the Department of Justice or the Chief Commissioner of Police; (f) a person in the custody of a police officer; (g) a person in the custody of a protective services officer; (h) a person detained in a treatment centre under a detention and treatment order made under the *Severe Substance Dependence Treatment Act 2010*; (i) a person detained in a treatment centre under a detention and treatment order made under the *Severe Substance Dependence Treatment Act 2010*; (j) a person detained in a treatment centre under a detention and treatment order made under the *Severe Substance Dependence Treatment Act 2010*; (k) a person in Victoria who is dying from an injury incurred while in the custody of the State; or (l) a prescribed person or a person belonging to a prescribed class of person.

[50] S. 11, *Coroners Act 2008* (Vic).

[51] S. 52(2)(b), *Coroners Act 2008* (Vic).

[52] Practice Direction 6 of 2020: Indigenous Deaths in Custody, at 1.1 - 1.5. See also Royal Commission into Aboriginal Deaths in Custody ("RCIADIC") (1991), *National Report Volume 5*, Recommendation 20.

[53] Victorian State Coroner, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (2020).

[54] Ibid., para 1.5.

Key Issues

- Culturally inappropriate notification of deaths to Aboriginal family members – this includes: insensitive and inappropriate notification by Victoria Police; lack of notification and family members finding out about the death of their loved one via media or social media;[55] inappropriate notification to Aboriginal family members.
- Lack of compassion and support services for Aboriginal family members who are notified of the death of their loved one whilst in custody.
- Lack of independent coronial investigation of police-contact deaths (including death by suicide of individuals who are in police custody), as investigations are carried out by police on behalf of the coroner.
- Inadequate and deficient investigations by Victoria Police, including failure to preserve critical evidence, poor exercise of discretion regarding the investigation, and an "alarming lack of rigour." [56]
- Insensitive and culturally inappropriate responses from Victoria Police, including when taking statements from Aboriginal family members who have lost a loved one.
- Aboriginal communities do not trust police investigations into the death of an Aboriginal person, particularly if death has occurred whilst the person was in the custody or care of a government authority.
- Frequent delays with coronial investigations and inquests, including up to 3 or 4 years.
- Lack of information provided to family members and their legal representatives regarding the processes and timeline for the investigation and inquest: the lack of information can further exacerbate the distrust that Aboriginal families may have with regard to the investigation.
- Lack of standardisation of coronial processes: this means that there is inconsistency between coronial processes and a lack of clarity for Aboriginal family members and their legal representatives about how the process will proceed.
- Significant delays in providing critical documents and information to Aboriginal family members and their legal representatives, including medical reports and the coronial brief.
- In some cases, poor communication by the court with family members and their legal representatives, including lack of response by the court to requests from the family, and decisions made by the coroner are sometimes not communicated to family members of their legal representatives.
- Lack of culturally appropriate avenues for family members to participate in the inquest, including to provide evidence.

[55] See for example, Statement from Patricia Lamont

[56] Finding into Death with Inquest, *Inquest into the Death of Raymond Noel Lindsay Thomas*, COR 2017 003012, 20 September 2021. The coroner criticised the independent police investigation for an "alarming lack of internal rigour," however, he said that it had not impacted the coronial investigation, para 148.

- Lack of funding for culturally safe assistance and representation for Aboriginal senior next of kin during coronial investigations and inquests.

RECOMMENDATIONS

Recommendation 9. As set out at recommendations 10 to 36 (below), the Suicide Prevention and Response Strategy should prioritise measures to improve the experience of bereaved Aboriginal families who are involved in coronial processes.

Koori Engagement Unit

Recommendation 10. The Koori Engagement Unit (**KEU**) should be further embedded into the Court, to ensure visibility over the coronial investigation and access to all information that is relevant to Aboriginal families in a timely manner.

Recommendation 11. The Victorian Government should provide additional funding and resources to the KEU, to ensure that they are able to provide support to all Aboriginal families going through coronial processes.

Independent Coronial Investigations

Recommendation 12. Coronial investigations into Aboriginal deaths by suicide must not be carried out by police. They should be carried out by a specialist civilian investigation team that is independent from police and developed by Aboriginal communities.

Notification of the Death to Aboriginal Family Members

Recommendation 13. Family members should be notified of the death of their loved one by an Aboriginal person and where possible, that person should be known to the family. Where appropriate, Aboriginal Community Controlled Organisations can play a key role in the notification. Notification should occur immediately, and in person where possible. Notification should not be by Victoria Police.

Recommendation 14. All authorities that are responsible for the care or custody of individuals (including Corrections Victoria, Victoria Police, Youth Justice, Child Protection and health facilities) must develop protocols for culturally safe notification of the death of an Aboriginal person in their care or custody.

Support for Aboriginal Family Members

Recommendation 15. At the time of being notified about the death of their loved one in custody, Aboriginal family members should be informed about culturally safe counselling and support services and access to these services should be funded by the Coroners Court.

Recommendation 16. When an Aboriginal family member is in custody at the time that their loved one passes away, they should be provided with culturally safe counselling and support, including through Aboriginal Community Controlled Health Services. Special dispensation through

compassionate leave should be granted, if the service needs to be accessed on a supervised basis away from the custodial institution.

Recommendation 17. In addition to Commonwealth funding for culturally safe legal assistance and representation for Aboriginal families in coronial processes, the Victorian Government should provide funding to VALS to:

(c) provide culturally safe and competent bereavement supports to Aboriginal families; and
(d) provide community legal education to Aboriginal communities regarding coronial processes and senior next of kin arrangements.

Recommendation 18. The Coroners Court should provide funding to families to cover the costs associated with participating in the investigation and inquest (travel, accommodation, incidental costs etc.).

Efficiency and Timeliness of Coronial Processes

Recommendation 19. *Practice Direction 6 of 2020* should be amended to explicitly provide that the requirement of a Directions Hearing within 28 days of a death being reported to the coroner (Direction 5.1) applies to all coronial investigations into the death of an Aboriginal person, where the coroner believes that an inquest will take place.[57]

Recommendation 20. The Victorian Government should amend the *Coroners Act 2008* to include a duty of candour on all interested parties. The duty would require parties to assist the coronial process, and should include the following elements:

(c) A requirement to make full disclosure of relevant documents, materials and facts;
(d) A requirement for parties to set out their position on relevant matters at the outset of the investigation/inquest.

Participation of Aboriginal Family Members in Coronial Processes

Recommendation 21. Without undermining the discretion of coroners to manage each investigation/inquest on a case-by-case basis, there should be further standardisation of coronial processes. This will assist in providing clarity for families and their legal representatives about the process.

Recommendation 22. In coronial investigations that will not proceed to inquest, the Coroners Court should consider options for family conferencing, to provide a culturally appropriate forum for regular updates from the Court during the investigation.

Recommendation 23. The Coroners Court should establish a monthly call-over list for all matters being dealt with by the Court when an Aboriginal person has passed away. The purpose of this list would be to provide regular updates to bereaved families and other interested parties about the

[57] Direction 1.5 of *Practice Direction 6 of 2020* notes that the Direction should apply, where relevant, to all reportable deaths of Indigenous people that fall under the Coroners Act 20018. Nevertheless, the Practice Direction should be amended to make it explicitly clear that this requirement applies to all investigations, not just investigations into deaths in custody.

progress of the investigation/inquest. The list should be established though a new Practice Direction.

Recommendation 24. The State Coroner should adopt Practice Directions establishing timeframes for key aspects of coronial inquiries, including distribution of materials to families within a specified timeframe once they have been received by the coroner. The Practice Direction should include a requirement to provide medical reports to families within one month.

Recommendation 25. *Practice Direction 7 of 2014* ("Coronial Briefs") should be amended to require coroners to set a deadline for preparation of the coronial brief. Additionally, the coronial investigator should provide written reasons to the family and interested parties if the deadline is not met.

Recommendation 26. Families who have lost a loved one to suicide must be treated with respect and provided with all relevant information in a timely and appropriate manner, prior to this information being revealed in the court room.

Recommendation 27. The Coroners Court should explore innovative ways of empowering bereaved family members to share their stories in a culturally safe space, such as private sessions (currently used in WA), yarning circles, restorative justice conferencing, and therapeutic jurisprudence within the coronial process.

Recommendation 28. In consultation with the Koori Engagement Unit, the State Coroner should work with Corrections Victoria, Youth Justice and Victoria Police (including Aboriginal Liaison Officers at these agencies) to develop protocols to facilitate the participation of family members who are in custody whilst a coronial investigation and inquest are proceeding. This should include issues such as viewing of the body, participating in sorry business, and access to culturally safe counselling and support provided by Aboriginal organisations.

Recommendation 29. Legal counsel who engage with and question Aboriginal family members during a coronial inquest must be trained in cultural awareness, anti-racism, systemic racism, unconscious bias, and therapeutic and trauma-informed approaches.

Recommendation 30. The State Coroner should enhance the timeliness, efficiency and efficacy of the coronial inquest process to the greatest degree possible, to ensure that the therapeutic benefits of coronial inquests for bereaved families are realised to their fullest potential.

Recommendation 31. *Practice Direction 6 of 2020* should be amended to provide that, if requested by the family, the investigating coroner should include within the scope of the inquest whether systemic racism or racial bias contributed to the cause or circumstances of the person's death. The coroner must be open to receiving expert evidence regarding systemic racism and racial bias.

Accountability for Implementing Coronial Recommendations

Recommendation 32. Government responses to coronial recommendations should provide detail on the action being taken to implement the recommendation and the response should be tabled in Parliament.

Recommendation 33. The State Coroner should also be empowered to call for further explanations or information from public authorities or entities that have received coronial recommendations, including reports as to further action taken in relation to the recommendations.

Recommendation 34. The Department of Premier and Cabinet should have overall responsibility for implementation of coronial recommendations by relevant departments and agencies.

Recommendation 35. The Victorian Government should establish an independent, statutory office of the Aboriginal and Torres Strait Islander Social Justice Commissioner. This office should report directly to the Parliament and be mandated to monitor the implementation of recommendations from coronial inquests into Aboriginal deaths.

Recommendation 36. The Commonwealth Government should work with State and Territory Governments to establish a central database of publicly available coronial recommendations.