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Health Insights

Coroners Court Directions Hearings now required within 28 days for mandatory inquest deaths

The Victorian State Coroner recently issued Practice Direction 5 of 2020 – 'Directions Hearings in Mandatory Inquests', requiring that in all cases where an inquest must be held, and unless reasons exist otherwise, a Directions Hearing will be convened within 28 days of the death being reported to the Coroner.

A mandatory inquest is required if:

(a) the Coroner suspects the death was a result of homicide; or

(b) the deceased was, immediately before death, a person placed in custody or care; or

(c) the identity of the deceased is unknown; or

(d) the death occurred in prescribed circumstances.[1]

The new Practice Direction takes its lead from Practice Direction 4 of 2014 which outlined the same Directions Hearing requirement, but for police contact deaths only. The State Coroner has directed that the procedure of convening a Directions Hearing within 28 days promotes efficiency and ensures that interested parties are aware of proceedings and the timeline of the investigation. As such, it constitutes best practice and ought to apply to all deaths for which holding an inquest will be mandatory.

Practice Direction 5 of 2020 specifies that in all cases where an inquest must be held, and unless reasons exist otherwise, a Directions Hearing will be convened within 28 days in order to:

(a) confirm the Coroner's investigator for the Coroner;

(b) fix the date of delivery of the coronial brief; and

(c) provide any other directions as considered appropriate at that time as relevant to the investigation, including regarding potential witnesses and scope of inquest.

Importantly, the 28 day Directions Hearing procedure may still apply to deaths where a Coroner ultimately determines that an inquest is not required to be held on the basis that the death was due to natural causes[2] (where such determination has not yet been made). This may be because the evidence that the death was due to natural causes is not yet be available by the 28 day point, or because even if the death was due to

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[1] *Coroners Act 2008* (Vic), section 52(2)
[2] As per *Coroners Act 2008* (Vic), section 52(3A).

natural causes, it may be appropriate to examine by way of inquest, certain issues such as medical care, to determine whether or not the death was preventable. [3]

For completeness, we note that on 22 September 2020 the Victorian State Coroner also issued Practice Direction 6 of 2020 - 'Indigenous Deaths in Custody'. The aim of Practice Direction 6 of 2020 is to enhance the implementation of Recommendation 8 of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC):

That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.

Although Indigenous deaths in custody are captured by Practice Direction 5 of 2020, given the focus of RCIADIC it was considered appropriate to implement the Recommendation through a separate Practice Direction that specifically addresses Indigenous deaths in custody, rather than taking a whole of population approach. [4]

Practice Direction 6 of 2020 provides a number of different directions relevant to Indigenous deaths in custody, including cultural considerations and standards in the investigation of deaths, and is also relevant to the coronial processes relating to all reportable deaths of Indigenous people that fall under the *Coroners Act 2008* (Vic).[5] Matters addressed by Practice Direction 6 of 2020 include:

(a) action to be taken immediately after the death of an Indigenous person in custody;

(b) process around medical examinations and the release of the body;

(c) action to be taken in the first four weeks after the death of an Indigenous person in custody (which includes convening a Directions Hearing within 28 days of a death being reported to the Coroner, in accordance with Practice Direction 5 of 2020);

(d) factors to be considered in the investigation into the death of an Indigenous person in custody, and general considerations for Court hearings (for example, that hearings will be convened in a culturally appropriate manner in consultation with family).

This article was written by Principal Kellie Dell'Oro and Associate Anna Martin. Please contact us if you have any questions or would like more information.

Kellie Dell'Oro, Principal
T: +61 3 9810 6775
E: kdelloro@meridianlawyers.com.au

Anna Martin, Associate
E: amartin@meridianlawyers.com.au

[3] Practice Direction 5 of 2020 – 'Directions Hearings in Mandatory Inquests', paragraph 7.
[4] Practice Direction 6 of 2020 – 'Indigenous Deaths in Custody', paragraph 1.5.
[5] Ibid.

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