Deceased persons

Context

Police officers play a number of roles in relation to deceased persons:

- to investigate whether a crime has been committed and, where applicable, charge offenders
- to investigate the death on behalf of the coroner under the *Coroners Act 2008 to* assist in determining how and why a person died
- to assist with identification and coordination of transportation of the body
- to notify relevant authorities about the death and, where applicable, work jointly with such authorities
- to identify the deceased's senior next of kin (SNOK)
- to provide advice and referral information to families.

The coroner, under the *Coroners Act,* has responsibility for investigating reportable and reviewable deaths and is not bound by the normal rules of evidence and therefore is interested in all information that may reduce preventable deaths. A person who reports a death must give the coroner any information or other assistance that the coroner requests for the purposes of the coroner's investigation (s.32, *Coroners Act*).

Policy at a glance

This policy includes:

- clarification regarding when a death must be reported to the coroner
- responsibilities for investigation and preparation of coronial briefs including supervision and welfare support
- investigative and notification requirements relating to specific deaths
- information on the identification of the deceased and SNOK including the role of State Trustees when the SNOK cannot be identified for non-reportable deaths
- the special requirements for notification of specific deaths
- requirements for the management of property and exhibits.

Contents

Scope and application

This policy applies to all police officers.

Responsibilities and procedures

1. Police officers attending deaths – general responsibilities

1.1 *Manage the scene*

When police officers initially attend a death, they must:

- preserve the scene and restrict access if necessary, in accordance with **VPM Scene management.**
- notify:
  - the coroner if it is a reportable or reviewable death (see section 2 of this policy)
  - relevant investigators (see sections 4 and 6 of this policy)
  - external authorities (see section 6 of this policy)
  - relatives.

  (refer to section 9 of this policy for notifications for additional categories of people).
- facilitate the verification of death by a medical practitioner or other health professional, where possible.
- arrange for the removal and identification of the body (see section 10 of this policy). A member must remain with the deceased until transported from the scene.
- care for any property of the deceased (see section 11 of this policy).
- where a crime is involved, comply with the **VPM Crime attendance – initial action.**

2. Deaths that must be reported to the coroner

2.1 *Reportable deaths – overview*

In accordance with s.4, *Coroners Act*, a death of a person is a 'reportable death' where one of the following apply:

- the body is in Victoria
- the death occurred in Victoria
- the cause of death occurred in Victoria
- the person ordinarily resided in Victoria at the time of death

and any of the following applies:

- the death appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury

- the death occurred during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not immediately before the procedure was undertaken, have reasonably expected the death to occur
- the identity of the person is unknown
- a medical practitioner has not signed, and is not likely to sign, a death certificate certifying the cause of death
- a death has occurred at a place outside Victoria and the cause of death is not certified or likely to be certified
- the person, immediately before their death was a person placed in 'custody or care'
- a person, immediately before their death was a patient within the meaning of the *Mental Health and Wellbeing Act 2022*
- the person was under the control, care or custody of the Secretary to the Department of Justice and Community Safety (DJCS) or a police officer
- the person was subject to a non-custodial supervision order under s.26 or s.38ZH, *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

2.2 Reportable deaths

- A person who has reasonable grounds to believe that a reportable death has not been reported, must report it without delay to a coroner, the Victorian Institute of Forensic Medicine (VIFM) or the Officer in Charge of a police station (s.12(1), *Coroners Act*).
- The death of a person may be reported to the coroner because the death was unexpected, even though it is apparent the cause of death is of natural causes. The reporting member must attempt to establish whether a medical practitioner is likely to issue a death certificate as to the cause of death.
- When it is unclear whether a death certificate will be available or if a death is reportable, police officers should contact Coronial Admissions and Enquiries (CAE) Ph: 1300 008 436 (police only telephone number) for advice.
- If it is likely that a death certificate will be issued within 48 hours, the deceased's family are responsible for arranging removal of the body. The reporting member must provide the funeral director with their registered number and station details should the death become a reportable death.
- If a death certificate is not issued, the funeral director will advise the CAE. CAE will arrange collection of the body and notify the original reporting member to submit a Death Report. Where notified by CAE in these circumstances, police officers must ensure the Death Report is submitted as soon as is reasonably practicable.
- Sudden and unexplained deaths of infants and children (SUDI and SUDC) are 'reportable deaths', as these types of deaths are unexpected and generally the doctor will be unable to say how the infant/child died. Note:
  - such deaths may also fall within the 'reviewable deaths' category (see section 2.3 of this policy)
  - deaths that do not fall within the 'SUDI' or 'SUDC' definitions may still require police investigation.
- Refer to section 6 of this policy for investigation and notification responsibilities.

2.3 *Reviewable deaths*

- Under s.5, *Coroners Act*, a deceased child is a reviewable death if the child is the second or subsequent child of the same parent to have died and one of the following applies:
  - the body is in Victoria
  - the death occurred in Victoria
  - the cause of the death occurred in Victoria
  - the child ordinarily resided in Victoria at the time of death.
- A death of a child is not a reviewable death if all of the following apply:
  - the death occurs in a hospital
  - the child was born at a hospital and had always been an inpatient of a hospital
  - the death is not a reportable death.
- A person who has reasonable grounds to believe that a reviewable death has not been reported to the coroner or VIFM as a reviewable death must report the death without delay to the State Coroner or VIFM (s.13(3)).

3. Reporting a death to the coroner

- Police officers (first constable as a minimum, where possible) must notify the coroner of all reportable deaths using a Death Report. Refer to section 2.2 of this policy for the criteria for a reportable death.
- The Death Report must be completed using the Death Reports Application.
- All Death Reports submitted via the Death Reports Application must be approved by a supervisor.
- In circumstances where the Death Reports Application is unavailable, police officers must use the Report of Death [Form 83] and the Statement of Identification [Form 84B].
- All hardcopy Form 83s must be:
  - typed
  - approved by a supervisor before being forwarded to CAE via email: cae@vifm.org
  - entered onto the Death Reports Application as soon as practicable and police officers must notify CAE that a duplicate report has been submitted.
- When a death needs to be reported to the coroner, police officers must:

Step	Action
1	Notify CAE of a reportable or reviewable death. CAE will issue a case number and when the scene investigation is reported as completed, will arrange for transport of the body
2	Complete a Death Report
3	If possible, complete a Statement of identification. The hardcopy Form 84B if completed, must accompany the body to the mortuary. See section 7.2 of this policy for further information
4	Complete an Incident Fact Sheet (IFS) in accordance with **VPM Operational duties and responsibilities** (an IFS is not required for fatal collisions – see **VPM Road policing - general**).

5	Conduct a Traffic Incident System (TIS) search to check involvement of the deceased in vehicle collision: • where it is believed that the deceased recently sustained an injury in a vehicle collision, notify the relevant authorities (see section 4.3 of this policy) • if it is believed the deceased recently sustained an injury in a vehicle collision and a search of the TIS database indicates no TIS report has been made, submit a TIS report (police officers must not upload graphic images of collision scenes or deceased or injured persons to TIS) and notify the relevant authorities (see section 4.3 of this policy).
6	If charges are laid in connection with the death, notify CAE. Record on the Death Report. If charges are laid after the submission of the Death Report, notify the Coroners Court of Victoria (CCoV) Registrar as soon as possible.
7	In case of multiple deaths (more than one at the same incident): • where any reportable or reviewable death relates to an incident involving more than one fatality, the Chemical, Biological and Radiological (CBR)/Disaster Victim Identification (DVI) Unit should be notified in the first instance via the On-Line supervisor at Police Communications • if the CBR/DVI Unit will not be responding, police officers should seek advice from CAE if they require any clarification on 1300 008 436

4. Investigation into death

4.1 *Coronial investigator*

- In accordance with the *Coroners Act*, a coronial investigator is a police officer who is nominated by the Chief Commissioner of Police to assist a coroner in relation to an investigation into a reportable death.
- Section 15A, *Coroners Act* provides for a coroner to issue directions to a coronial investigator in relation to an investigation into a reportable death. Refer to **VPM Inquests and coronial briefs** for more information regarding the role and responsibilities of the coronial investigator.

4.2 *General responsibilities*

- A police officer who has information that may be relevant to an investigation by a coroner into a death or a fire must give that information to the coroner to assist the coroner in their investigation of the death or the fire (s.36, *Coroners Act*).
- A general duties member (as a minimum, a first constable) is responsible for the investigation except:

If . . .	**then . . .**
Suspicious circumstances exist	The relevant Crime Investigation Unit (CIU) must take responsibility for the investigation
Murder or manslaughter is suspected (contact the Homicide Squad for advice)	The Homicide Squad will assume responsibility for the investigation
It is a reportable death with restrictions on which police officers may investigate	See section 6 of this policy
The death occurred in the presence or custody of a Victoria Police employee	See **VPM Death or serious illness/injury incidents involving police**

- The senior member at the scene should provide an appropriate level of supervision of the investigating member.

- The work unit manager should provide ongoing supervision of the member for the duration of the investigation. This should involve welfare support including, welfare management plans, debriefs and recording and appropriate ongoing management of the event on safe-t-net.
- The investigating member should prepare the brief (coronial or prosecution). See **VPMP Briefs of evidence** and **VPM Inquests and coronial briefs**.
- Where a CIU is required to attend a scene, they must provide advice and guidance to uniform members. If they are not preparing the brief, the attending detective must prepare a statement for the coronial brief, which includes their assessment and opinion as to the circumstances of the death, including any preventative/safety issues.
- In situations where only probationary constables are available to investigate reportable deaths, the investigation should be assigned to the most senior member present and the investigation should be overseen by a supervisor.

4.3 *Responsibilities when conducting an investigation*

- Collect any required evidence and exhibits.
- Before removal of the body from the scene, search the body and the surrounding area for any indication of the cause of death. If specialist investigators or the coroner are to attend the scene, consult with them before conducting the search.
- Evidence of medical attention, such as resuscitation tubing, should remain in place so that it can be considered by the pathologist as to the cause of death.
- Clothing or items that may be relevant to the pathologist's investigation must accompany the body.
- When poisoning is suspected and body specimens or other exhibits are required for analysis, consult with CAE.
- Conduct a search of the TIS database to check for recent involvement of the deceased in a vehicle collision. If the deceased has recently sustained an injury in a vehicle collision:
  - add a note in the original TIS report in accordance with the **VPM Road policing - general**
  - notify the TIS Business Support Unit through the PBEA: TIS-ICT SERVICES BUSINESS SUPPORT
  - notify the Road Policing Strategy Division (RPSD), Road Policing Command using the PBEA: RPC-RPSD-MGR and RPSD will consider the circumstances for possible inclusion in the provisional Lives Lost
  - notify PBEA: MAJOR-COLLISION-INVESTIGATION-UNIT-OIC.
- If it is believed the deceased recently sustained an injury in a vehicle collision and a search of the TIS database indicates no TIS report has been made, submit a TIS report in line with **VPM Road policing – general**. In doing so:
  - police officers must not upload graphic images of collision scenes or deceased or injured persons to TIS. See section 4.4 of this policy for management of photographs
  - notify RPSD, Road Policing Command using the PBEA: RPC-RPSD-MGR. RPSD will consider the circumstances and inclusion in the provisional Lives Lost
  - notify PBEA: MAJOR-COLLISION-INVESTIGATION-UNIT-OIC.

- During the investigation of any death or fire, a member may request authority under the *Coroners Act* to enter and search premises, copy documents and seize property. Any requests for the issue of a Coroner's Authority must be made through:
  - Manager, Coronial Support Unit (CSU)
  - if urgent (after hours only) – CAE.

4.4 *Photographs*

- Photographs must be taken of the deceased as found, and of the scene for all reportable and reviewable deaths where reasonable. Where police officers are not required to attend the scene, such as a death following a medical procedure, photographs will not be required.
- Upload the main photographs via the Death Report Application, or forward the main photographs, along with the hardcopy Form 83 (if the Death Report Application is offline) electronically to CAE at cae@vifm.org.
- Only key photographs should be attached initially. Any additional photographs should be included in the coronial brief.
- Take extreme care when addressing emails of this nature to prevent accidental unauthorised release. The email must be immediately deleted from the sent items folder to stop it being incorporated in the email archive system.
- All photographs must be managed in accordance with **VPM Recording devices, CCTV and digital asset management.** A record of all photograph releases must be recorded in the employee's diary/day book or other relevant records.

4.5 *Access to Department of Health records or staff*

Where follow-up statements, access to Department of Health (DoH) records or staff are required:

- prepare a General Report [Form 47] and forward it to CSU, for urgent attention. Include all of the following:
  - the relevant DoH Regional Manager's contact details
  - the required information
  - the reason the information is required.
- CSU will liaise with the relevant coroner on behalf of the coronial investigator.

4.6 *Medical records*

- Either CAE or the CCoV will obtain medical records to assist the medical examination of the deceased to establish a cause of death.
- Coronial investigators should not obtain and hold medical records unless specifically requested by a coroner in the letter of direction to investigate the death and prepare a coronial brief.
- If a coronial investigator believes evidence of medical treatment is relevant, a statement from the identified medical practitioner should be requested and included in the brief.
- CSU maintains a current list of hospital medico-legal contacts on their intranet page. A written request should be forwarded in the first instance to the relevant medico-legal officer or medical practice manager. If statements are not

forthcoming, a Coroner's Authority or coroner's request for prepared statements and documents may be required; contact CSU for assistance.

5. Victoria Police documents and methodology

5.1 *Coronial briefs*

- The coronerial investigator must not attach any documents to the coronial brief, which may be the subject of legal professional privilege or public interest immunity arguments without first consulting the Civil Litigation Unit (CLU) in Legal Services Department. These documents include, but are not limited to:
  - policy and review documents (including internal review documents such as an Operational Safety Critical Incident Review Report, other critical incident debrief reports or a Post Incident Response Report)
  - training documents which may reveal Victoria Police methodology and/or tactics
  - documents pertaining to specialist units of Victoria Police (such as, Special Operations Group, State Surveillance Unit, Technical Surveillance Unit etc.)
  - any documents relating to human source management or registration
  - Professional Standards Command (PSC) files.
- If the CCoV requires a Victoria Police report, the provision will depend on the content of the report. If the report is not sensitive/confidential and is easily accessible (i.e., publicly available), the CCoV should ask the coronial investigator to provide the report.
- If the report is sensitive/confidential and not easily accessible, the CCoV or the coronial investigator should request CLU or the lawyers engaged by the CLU to provide the report to CCoV.
- The CLU will assess any material before it is included in the coronial brief and/or distributed to interested parties by the CCoV. CLU will then notify CCoV whether a claim of public interest immunity or legal professional privilege is made in relation to all or any part of the document or propose redactions to the document.
- The CLU or lawyers engaged by CLU will obtain statements regarding Victoria Police policy and training matters and any statements regarding specialist units or human sources when a request is made by the CCoV or the coronial investigator.

6. Investigation and notification - specific responsibilities

The following table details investigative and notification requirements relating to specific deaths. It should be read in conjunction with section 1 of this policy.

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
Aviation aircraft deaths	• Attending general duties or CIU member • The Australian Transport Safety Bureau (ATSB) investigates some aviation accidents but not all (usually, the ATSB does not investigate sports aviation accidents or those involving amateur built or experimental category aircraft and the ATSB will advise the investigator of the appropriate sporting body and whether or not they are attending) • Even if the ATSB or a safety officer/investigator from the relevant sporting body attends, Victoria Police continues to hold responsibility for the coronial investigation and this responsibility cannot be devolved or delegated to any outside agency or organisation	• Restrict access to area until ATSB advises whether the area is safe, and whether the ATSB will attend • Consider protective clothing and breathing apparatus- if required withdraw to a safe location • Identify toxic substances and hazardous materials • Contact CBR/DVI Unit for advice regarding recording, photographing, sketching and measuring the scene based on risk, i.e., Forensic Services Department (FSD) or Crime Desk to attend • Contact CSU for advice or see its intranet page (if relevant) • Contact appropriate sporting body to arrange attendance of a safety officer/investigator • Co-ordinate the accident investigation • Isolate and secure witnesses for statements on the day • Consider if a line search is necessary to locate fallen or scattered debris • Contact CBR/DVI Unit where there are multiple fatalities, fragmentation or incineration and identification is an issue to assist with scene processing and human remains recovery • Aviation fatalities do not require police escort • If wreckage is to be retained and stored for examination prior approval from the coroner and CEO of the CCoV is required (contact CSU for assistance)	• ATSB • Victorian WorkCover Authority (WorkSafe) • Gliding Australia • Recreation Aviation Australia • Air Sport Australia Confederation • Australian Sports Rotorcraft Association • Australian Ballooning Federation • Sports Aviation Federation of Australia (SAFA) • Model Aeronautical Association of Australia • Australian Parachute Federation • Sports Aircraft Association of Australia

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
Deceased was under the direct control, care or custody of a government department/organisation at the time of death	• CIU must attend		
Deaths following contact with police	• Notify PSC via Police Communications of: - all deaths following: ▪ the discharge of a firearm by a member ▪ any other use of force by a police employee ▪ any action or inaction by any police employee ▪ custody related police operations, which include where police are attempting to detain a person (e.g., pursuits, sieges) ▪ a person escaping or attempting to escape from custody - deaths of people in custody of police whether in cells or otherwise - reportable deaths of current police employees (other than as defined by s.4(2)(b), *Coroners Act*) • Homicide Squad, Major Collison Investigation Unit (MCIU) or the relevant region are responsible for the coronial brief oversighted by PSC or the region or command, depending on the circumstances and the level or nature of the contact	• Comply with **VPM Death or serious injury/illness incidents involving police** • An authority to restrict access may only be issued by the coroner, in accordance with **VPM Scene management** • Contact Major Crime Scene Unit (MCSU) for advice/ assistance with crime scene processing	• WorkSafe in accordance with **VPM OHS incident management** • CCoV – CAE
Disasters	• Contact CBR/DVI Unit to attend where required • Responsibility for the investigation will depend upon the incident and investigation requirements	• If CBR/DVI Unit procedures are required, leave all human remains, clothing, jewellery and property as found • CBR/DVI Unit members will be responsible for developing a property management plan in relation to the deceased's property	
Diving accidents	• Notify the Search and Rescue Squad of an underwater diving accident where death has occurred or is likely to occur	• Police officers first attending the scene must preserve the scene, including the deceased in situ with diving equipment, if possible	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
	• General duties member to complete Death Report • Prior to Search and Rescue attending the scene, police officers must ensure that all possible exhibits are secured (including; scuba equipment of the deceased on the boat or in their vehicle, and dive computers) • Search & Rescue will: - attend diving fatalities, conduct the investigation and compile the coronial brief - take possession of the SCUBA equipment - complete a diving incident report to accompany the Death Report - interview witnesses or obtain details of witnesses for follow-up	• Photograph scene and the deceased and equipment in situ as advised by the Search and Rescue Squad member • Isolate and secure witnesses for statements on the day	
Drug overdoses	CIU must attend drug overdoses and will assume responsibility for the investigation and preparation of the coronial brief	• Seize all drugs and related exhibits regardless of whether charges are contemplated or not • Where the coroner does not initially request analysis of exhibits, store syringes, drugs, tablets, packages etc. and keep them at the station until the coroner's finding (and associated appeal period), exhibits should not be returned to a claimant • If death involves medication, retain medication and packaging for analysis • When an exhibit is requested by CCoV for analysis, obtain a receipt from CCoV and record provision of the exhibit to CCoV on PALM • Dispose of drug exhibits as soon as possible once the coroner's findings have been handed down and the six-month appeal period has expired, according to **VPM Property and exhibit management**	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
		• If death is suspected due to methadone, contact the Drug and Poisons Unit, DoH for patient history and information that may identify the supplier	
Explosions and fires	• CIU must attend • Notify the Arson and Explosives Squad via Police Communications, who will notify FSD as required • As per the Accountability and Resource Model, the region will take primary responsibility for the investigation with the Crime Command providing support in accordance with case priority	• If applicable, manage the scene in accordance with **VPM Scene management** • Contact MCSU for advice/ assistance with crime scene processing	• CCoV must be informed of all deaths and any serious injuries where death is a real possibility
Family violence related deaths	• The Homicide Squad, Arson and Explosive Squad and the MCIU must notify Family Violence Command of a death in the following circumstances: - a suspicious death that is likely to have resulted from a family violence incident - a murder/suicide that is likely to have resulted from a family violence incident - the death of a third party/bystander that is likely to have resulted from a family violence incident (for example, where an Affected Family Member's (AFMs) new partner is killed by the AFM's ex-partner). See **VPM Family violence** for further information	• Contact MCSU for advice/assistance with crime scene processing • If applicable, manage scene in accordance with **VPM Scene management**	
Firearm deaths	• CIU must attend • Ballistics Unit, FSD must be notified (this includes suicide, if the member in attendance is not satisfied with the circumstances) • The Ballistics Unit will provide advice on evidence, safe handling of firearms and attend scenes where necessary	• Firearm residue samples must be collected in all cases where the circumstances are unclear, or some evidentiary value may be gained • Unless otherwise arranged, an authorised FSD member will take samples at the scene • All clothing and property must remain on the body to enable examination for powder residues • Take care not to disturb or contaminate possible residue sites	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
		• A member attending the scene must record details surrounding the firearm, the firearm licence, ammunition storage and any access and safety issues • If an FSD member does not attend the scene, submit an exhibit examination request via the Forensic Portal and, take firearms, fired cartridges and fired bullets to the Forensic Services location for examination as required; see **VPM Forensic services and examinations**	
Hang gliding death	• Attending general duties or CIU member • SAFA may conduct its own investigation parallel to the police investigation • Even if the SAFA Area Safety Officer (ASO) attends, Victoria Police continues to be responsible for the coronial investigation and this responsibility cannot be devolved or delegated to any outside agency or organisation	• Isolate and maintain scene until SAFA ASO arrives • If a harness is involved, if practicable leave attached to the body • Locate ASO if present, who will assist with the investigation. Victoria Police are the lead investigative agency even if an ASO from SAFA attends • Contact CSU for advice or see their intranet page • Isolate and secure witnesses for statements on the day • Liaise with ASO and arrange for inspection of hang glider and equipment • Consider retention and storage of wreckage for examination. • If the wreckage is to be retained and stored, prior approval from the coroner and CEO of CCoV is required (contact CSU for assistance)	• SAFA
Marine accidents	• Notify the Water Police of any marine accident, where death has occurred or is likely to occur • The Water Police will attend all marine fatalities, conduct the investigation and compile the coronial brief	• Preserve scene until the Water Police arrive • Isolate and secure witnesses for statements on the day	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
Parachute deaths	• Attending general duties or CIU member • The Australian Parachute Federation (APF) may conduct its own investigation parallel to the police investigation • Even if the APF attends, Victoria Police continues to be responsible for the coronial investigation. This responsibility cannot be devolved or delegated to any outside agency or organisation	• Isolate and maintain scene until APF Safety and Training Officer (STO) arrives • If a parachute is involved, leave it attached to the body • Contact CSU for advice or see their intranet page • Isolate and secure witnesses for statements on the day • Liaise with STO and arrange for inspection of the parachute at CAE (can be done via CSU)	• APF
Prison deaths (Corrections Victoria)	CIU must attend	• Prison medical records must accompany the body to the Coronial Services Centre • Identify other medical records and note the existence of records on the Death Report. Only obtain the records if directed by the coroner • Information from the Justice Assurance and Review Office (JARO) will be supplied directly to CCoV. The coronial investigator does not contact JARO directly with the request. The coronial investigator should liaise with the relevant CCoV Registry Team in relation to access to the JARO report	
Suicides	• CIU must attend • If the death is a murder/suicide or assisted suicide and a conflict of interest is identified or there is likely to be criticism of Victoria Police's action/inaction regarding its operational response; an independent detective senior sergeant, outside the division where the incident occurred, should take responsibility for the investigation	• Hanging – cut ligature above any tied knot/s and leave attached to the body • See also firearm deaths and drug overdoses • Refer to the Rail Collision Investigative Guidelines for suspected suicides that occur on rail related infrastructure • Contact MCSU for advice/assistance with crime scene processing	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
Sudden unexpected and unexplained deaths of infants or children up to 6 years of age (does not include deaths due to misadventure or transport accidents)	• Police officers must refer to the **Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide** for these incidents • CIU must attend • Sexual Offences and Child Abuse Investigation Team (SOCAT) should attend where possible • Homicide Squad must be notified by the CIU via Police Communications • CIU are responsible for the investigation and coronial brief • If murder or manslaughter is suspected then the Homicide Squad will prepare the coronial brief	• The Investigative Checklist referenced in the **Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide** and located on the Family Violence Command intranet (under SOCAT resources) must be completed and forwarded with the Death Report to the coroner • Police officers must refer to the **Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide** for further best practice advice on how to manage the scene and investigation	• With consent of the parents notify: - Red Nose - Maternal Health Care via central line (see Investigative Checklist and **Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide**)
People: • on parole or pre-release from prison • recently released from prison or remand • currently completing a corrections order or have completed a corrections order within the last 3 months	• Attending general duties members	• Information from the JARO will be supplied directly to CCoV • The coronial investigator does not contact JARO directly with the request. The coronial investigator should liaise with the relevant CCoV Registry Team in relation to access to the JARO report Information from the JARO will be supplied directly to CCoV	

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
Vehicle collisions	• A Highway Patrol member, where available, must attend all fatal collisions except where MCIU criteria applies • If MCIU criteria applies, the senior MCIU member will determine whether the MCIU attend and take on the investigation • The MCIU must be notified and TIS reports submitted as soon as possible after notification of every fatal or life threatening collision following **VPM Road policing - general** • If life threatening injury collision occurs and the person subsequently dies, TIS reports must be updated as soon as possible after the notification of death • PSC must be notified of any serious vehicle collision involving employees on or off duty which may result in questioning or criticism of Victoria Police policies, procedures or practices • All employees must report any act or suspected act of misconduct committed by another Victoria Police employee: - members – obliged under s.167(3), *Victoria Police Act 2013* - Victorian Public Servants – obliged under s. 7(b)(i), *Public Administration Act 2004*	• If applicable, manage the scene in accordance with **VPM Scene management**	• WorkSafe if a workplace accident
Workplace incidents Refer to **VPM Investigation of workplace incidents** for further information	• CIU must attend • Notify MCIU (if appropriate) • CIU or MCIU are responsible for the investigation to determine whether a criminal offence has been committed • Even if a WorkSafe Inspector attends, Victoria Police remains responsible for the coronial investigation	• Contact CSU for advice or see their intranet page. • Secure the scene and wait for the arrival of the WorkSafe Inspector • Victoria Police is the lead agency and has precedence in the initial investigation, including the death of Victoria Police employees (*see below for further considerations	• Immediately notify WorkSafe of a workplace incident where death has occurred or is likely to occur

Police Attendance at Deaths - Investigative Accountabilities and Notifications			
Type of death	**Investigative responsibilities**	**Scene and investigation management**	**External notifications** (can be made via Police Communication)
	and this responsibility cannot be devolved or delegated to any outside agency or organisation	involving employees) even if a WorkSafe Inspector attends the scene • Coordinate the initial response until such time as any handover to WorkSafe can be undertaken if the death will not be subject of a Victoria Police criminal investigation • Isolate and secure witnesses for statements on the day • Photograph the scene, the deceased, and any equipment (if relevant) in situ • A coroner may attend the scene (with or without CSU)	• If there is any doubt about whether a fatality is work-related, the parties will consult with each other to determine the issue as soon as possible • WorkSafe will attend and assist in the investigation

7. Identification of deceased and human remains

7.1 *Overview*

Police officers attending a death must establish the identity of the deceased. Where the person cannot be identified, refer to section 7.3 of this policy.

7.2 *Establishing identification*

- Single deaths:
  - where possible, identification should be done at the scene and the details recorded on the Death Report/Statement of Identification
  - for a sudden unexpected death of an infant, a statement from one of the parents is sufficient (refer to the **Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide**)
  - where identification is to occur at the Coronial Services Centre, or a country mortuary, contact that institution to inform them of the situation
  - consider the reliability of the source used to identify the body (e.g., a new resident in an area may not be a reliable source of identification)
  - requests to the Victorian Clinical Genetic Services (VCGS) for access to records must:
    - only be for the purpose of identifying human remains
    - be submitted via the CSU to the coroner for authorisation – this is the only method that may be used to make a request to VCGS.
- Multiple deaths (more than one death in the same incident where identification is an issue):
  - contact the CBR/DVI Unit and follow its instructions identifications and reconciliation will take place at CAE in Southbank
  - the Death Report should not contain names (the name should read "Unknown" and an accompanying Form 47 should be submitted with the Death Report detailing any information about possible identification)
  - deceased persons (or body parts) should only be given numbers and not identified by actual names (identification and reconciliation will occur at CAE)
  - police officers should seek advice from CAE if they require any clarification on the police only number: 1300 008 436.

7.3 *Where a body cannot be identified*

- Where the identity of a deceased person is unknown after 24 hours and the body is at the Coronial Services Centre, notify the Fingerprint Sciences Group, FSD. Where the body is not at the Coronial Services Centre, contact the Fingerprint Sciences Group to make arrangements for their attendance to take a set of fingerprints from the deceased.
- Where identification of a body is not possible because of severe injury or decomposition, identification may be established by the circumstances surrounding the death. Contact the CAE for assistance. Where there are multiple deaths and identification is an issue, request the attendance of CBR/DVI Unit members from FSD.
- Complete a 'Located Missing Person/Identified Person/Found Remains' [Form L18C] (Part B) immediately upon locating a body or body part where identification is not

made and provide details to Central Data Entry Bureau via telephone or fax (use Case Progress Narrative Update [Form L1A] as a coversheet).

- Where identification is not made or not likely to be made within three days, the CIU must take over the investigation.
- Notify the Missing Persons Squad of any deceased persons that cannot be identified, see **VPM Missing persons investigations**.

7.4 *Unknown human skeletal remains*

- Where human skeletal remains are discovered or handed to police, in addition to criminal considerations, consider whether they are the skeletal remains of one of the following:
  - an Aboriginal/Torres Strait Islander person who died more than 100 years ago
  - a person who has died of natural causes
  - a person who has died by accident or misadventure.
- If information exists that the skeletal remains could be of an Aboriginal/Torres Strait Islander person who died more than 100 years ago, as soon as practicable, notify all of the following:
  - the Manager, CSU
  - CAE
  - the Victorian Aboriginal Heritage Council (VAHC)
  - the Aboriginal Community Portfolio Manager, Priority and Safer Communities Division (PSCD) via email to the PBEA: OFFICE-OF-CMDR-PSCD.
- Note: Failing to notify VAHC is an offence in accordance with s.17, *Aboriginal Heritage Act 1972*.
- If it is confirmed that the skeletal remains are those of an ancestral Aboriginal/Torres Strait Islander person who died more than 100 years ago and can be released, release the remains to a VAHC representative. Otherwise, follow the same procedures as per any other investigation.
- Police officers must:
  - follow the instructions of both the Manager, CSU and CAE
  - take precautions to ensure that the skeletal remains are not further disturbed
  - not allow the media access to the site or remains
  - ensure the skeletal remains are treated with respect and photographed (with a scale) for identification only
  - not forward photographs or pass information on for use by the media.

8. Notification of death

8.1 *Relatives*

- Police officers delivering death notifications must do so in person and as a matter of urgency. The Peer Support Program offers more detailed information about support during and after this work. See the **Fact sheet about delivering death notices** on the Peer Support Program intranet page.
- Police officers should refer relatives to CAE for any information regarding the coronial process.

- Police officers should consider arranging support for relatives by making referrals using Victoria Police e-Referral (VPeR) in LEDR Mk 2 (see **Victoria Police e-Referral (VPeR) System Practice Guide** and **VPM Victim support** regarding information to be provided to victims and people adversely affected by crime).
- For interstate death notifications forward a report to the Police Enquiry Service, Police Enquiry and Data Sharing Department (PEDSD) (PBEA: POLICE ENQUIRIES SERVICE-RSD-MGR).
- For overseas death notifications complete the Interpol Next of Kin Welfare Form located on the Interpol intranet page. The member should then email the completed Form directly to Interpol Canberra.
- For death notifications within the Culturally and Linguistically Diverse (CALD) or Aboriginal/Torres Strait Islander families/next of kin police officers should refer to:
  - the relevant *death, bereavement and mourning* section of the Religious and Spiritual Diversity Guide for Operational Police hosted on the Community Support Hub intranet page
  - the current list of chaplaincy contact's for multi faith denominations on the HRC Chaplaincy intranet page.

8.2 *Release of information*

- Caution should be exercised when communicating information in the immediate wake of any death.
- Every attempt should be made to ensure only accurate information is communicated to any other person.
- Police officers should not provide any opinion on the cause of death or period of suffering.

8.3 *Identifying senior next of kin*

- It is the responsibility of the coronial investigator to attempt to identify the deceased's SNOK (as defined in the *Coroners Act*) and recording their details on the Death Report. Identifying the SNOK is required to allow CAE to release the body in a timely manner.
- Police officers should nominate the SNOK in accordance with the hierarchical order as defined in the *Coroners Act* as follows:
  - spouse or domestic partner
  - adult child
  - parent
  - adult sibling
  - executor of the will
  - personal representative.
- Where the identity of the SNOK is not known at the time the Death Report is submitted to CAE, it remains the responsibility of the coronial investigator:
  - to make reasonable enquiries to identify the SNOK
  - at the earliest opportunity advise CAE with that persons' details or where the SNOK has not been able to be identified, submit a Form 47 to CAE outlining the nature and extent of enquiries conducted.

- The coroner retains ultimate responsibility for the final determination as to who will be appointed the SNOK, in accordance with the *Coroners Act*.

9. Notification of death – requirements for specific categories of people

9.1 *Special requirements*

The following table provides details of notifications for specific deaths:

Notification requirements for specific deaths	
Deaths	**Requirements**
Aboriginal/Torres Strait Islander peoples	• Victoria Police is responsible for informing Aboriginal communities about the death. Attending police officers should liaise with their divisional patrol supervisor, the Aboriginal Community Portfolio Manager, PSCD, Capability Department and/or the Koori Justice Unit, DJCS • Where the death of an Aboriginal/Torres Strait Islander person occurs in police custody, information about that death may only be released by: - divisional patrol supervisor - Media Communications and Engagement Department - CCoV - PSC. • The lead investigator must inform the: - Office of the Commander, PSCD via OFFICE-OF-CMDR-PSCD-MGR - Office of the Deputy Commissioner, Regional Operations via STAFFOFFICER-DC REGIONAL OPERATIONS-OIC and - Koori Justice Unit, DJCS. • The Deputy Commissioner, Regional Operations, should then notify the Deputy Secretary, Aboriginal Justice, DJCS by emailing them directly following receipt of a notification.
Foreign nationals	• To fulfill Australia's obligations under the *Vienna Convention on Consular Relations*, there needs to be timely notification to foreign governments of the death (or detention) of one of their nationals • Notify the divisional patrol supervisor where the death occurred • The divisional patrol supervisor is responsible for notifying the local consulate representative without delay and providing a copy of the death certificate upon request. • To locate the relevant nearest embassy/consulate, see the list on the Department of Foreign Affairs and Trade website • If such a representative is unavailable, contact the Protocol Duty Officer at Department of Foreign Affairs and Trade (DFAT) Canberra on ph: (02) 6361 1111 during office hours or on ph: 0418 167 127 after hours, who will facilitate contact with the appropriate consular officials (if contact cannot be made with this mobile, call the Consular Emergency Centre on 1300 555 135 and have them redirect the call) • Refer to Detention or death of a foreign national in Australia for more information
Student enrolled at a primary or secondary school, including special development school	• With permission from a parent or guardian, notify the Department of Education via the 24-hour phone line (Education Security) 8688 7776 of the death of any school student whether the death occurs on or off school premises • Inform the Department of Education of the student's name, age, school and facts concerning the death

People recorded on LEAP	If police become aware of the death of a person who is recorded on LEAP a Death of Recorded Persons Form [Form 214] must be submitted to PEDSD in both of the following circumstances: • reportable deaths – automatically generated via the Death Reports Application • non-reportable deaths - the reporting member must submit the Form 214

10. Removing the body

10.1 *Supervisor's responsibility*

Unless the coroner directs otherwise, the duty patrol supervisor must ensure that evidence is collected, and the body removed from the scene as soon as possible.

10.2 *Reportable deaths*

- Where a reportable death occurs, contact CAE to organise a funeral director to transport the deceased to the Coronial Services Centre or the appropriate regional centre.
- Where a deceased child is being transported, parents and families must be advised not to accompany the deceased child to the Coronial Services Centre and not to attend there, unless instructed by coronial staff.
- Obtain a case number from CAE and ensure an identifying tag with the case number and the name of the deceased is attached to the body by the funeral director (see instructions on the Death Report for multiple death incidents). Comply with any directions from CAE.
- The deceased's body in a suspicious death investigation or a 'hit and run' vehicle collision should be considered as an exhibit. The deceased's body must be placed in a body bag and sealed by the undertakers from the Coronial Service Centre. The body may still be escorted if the investigating member believes it to be necessary to escort the body or if CAE requires it.
- The investigating member should make a note of the seal number.
- Where the deceased's body has potentially been exposed to, or contaminated with chemical, biological or radiological material, it must be treated as a HAZMAT incident. A clearance check of the body must be conducted by the control agency (either Fire Rescue Victoria or the Country Fire Authority) or the CBR/DVI Unit prior to transportation. CAE must be notified of the potential contamination.
- In accordance with s.26(5), *Coroner's Act*, a coroner may direct that an autopsy be performed immediately if either:
  - the coroner believes it is appropriate in the circumstances
  - there is no SNOK or the next of kin cannot be located.
- In accordance with s.27, *Coroner's Act*, if a coroner has control of a body, any person may ask the coroner to direct that an autopsy be performed on the body.

10.3 *Non-reportable deaths*

- If the death does not need to be reported (a death in which the person has apparently died from natural causes and where a death certificate will be available) the deceased's family is responsible for arranging removal of the body.

- Where it is unclear whether a death certificate will be available, consult CAE for advice.
- Police must not recommend, refer or provide information regarding specific funeral directors to the family.
- Where the next of kin cannot be identified or contacted, police officers should contact the State Trustees, ph: 9667 6129 during office hours or via email: eat@stl.com.au to obtain the details of the funeral director who will be responsible for removal of the body. A Deceased Estate Referral Form available on the CSU intranet page must be completed and forwarded to State Trustees.
- Outside office hours, police officers, in consultation with the divisional patrol supervisor, must only contact one of the funeral directors designated by State Trustees available on the CSU intranet page. In these circumstances, a Deceased Estate Referral Form must also be completed and forwarded to State Trustees.

11. Deceased's property

- Where police are required to provide an escort, the body must remain as found. Do not remove any clothing, property or equipment from the deceased. The attending investigator is responsible for recording property.
- Where police are not escorting the body, the attending member must ensure that any property is removed from the body, unless it cannot be removed or is inappropriate to do so. Removal of property can be undertaken by the funeral directors, providing police supervise the process and immediately take possession of the property with consideration to the following:
  - give the deceased's property to any relatives at the scene and record details (the relative should countersign the record)
  - where property cannot be removed or it may be inappropriate to remove the property, record full details of the property that will be conveyed with the body to the CAE
  - record any property retained in PALM
  - when returning property in relation to deceased persons, thoroughly check the contents and remove any items relating to the death to avoid undue distress to the claimant (for example, the executor of the will or immediate family) and for further instruction refer to **VPM Property and exhibit management** and **VPM Seized property and special property types**. In other cases, State Trustees will give directions as to the disposal of the property.
- Record full details of the funeral director transporting the body in the Patrol Duty Return and day book/diary.

12. Coronial exhibits

12.1 *General*

Police officers may come into possession of property associated with a reportable death in a number of ways, including where:

- a member in attendance at a death scene determines that property should be seized due to its relevance to the death and the coronial investigation, they may seize the property and record and handle it as an exhibit

- a member takes possession of property at a scene as there is no relative or identifiable next of kin at a death scene. If the property has no evidentiary value, it should be dealt with as soon as possible, in accordance with the instructions detailed in section 12.2 of this policy. For example, this may include returning it to a relevant person as soon as they have been identified and located.
- a member seizes property under a Coroner's Authority issued by the CCoV (s.39, *Coroners Act*). The member seizes and retains the property on behalf of the coroner and acts on the instructions of the coroner regarding disposal or return of the seized item/thing or document.

Consider obtaining a Coroner's Authority where the property is not seized by consent, is of significant value or is likely to be the subject of an ownership dispute as per section 4.3 of this policy.

12.2 *Seizure, storage and disposal of coronial exhibits*

The table below outlines the processes involved when property needs to be seized, stored and disposed of in relation to a coronial investigation.

If . . .	**then . . .**
Property is seized and it has evidentiary value to the coronial investigation	• The exhibit should be retained until finalisation of the coronial investigation • Where the coroner does not initially request analysis of exhibits, these should be kept at the station until the coroner's finding (and associated appeal period) and should not be returned to a claimant • A coronial investigation is only considered to be finalised when both: - the coroner's findings have been handed down - the six-month appeal period has expired (commencing from the day of the coroner's findings unless a leave to appeal is granted by the Supreme Court) • When returning property in relation to deceased persons, thoroughly check the contents and remove any items relating to the death to avoid undue distress to the claimant (for example, the executor of the will or immediate family) • instruction refer to **VPM Property and exhibit management** and **VPM Seized property and special property types**
Ownership of the property is disputed	• The individual claimants should make an application to the coroner by submitting the CCoV Form 34 – **Application to Access or Have Released Seized or Received Thing** (available on the CCoV website) • The coroner will then determine who the property is to be released to
Property of evidentiary value is required to be disposed of prior to finalisation of the coronial investigation	• The member should initially contact CSU for advice • In most circumstances an application should only be made once the Medical Examination and Toxicology Reports have been received • The member should then: - complete an **Application to Access or Have Released Seized or Received Thing** – CCoV Form 34 - complete a covering report outlining the circumstances and a list of property sought to be disposed - email the CCoV Form 34 and covering report to the CSU OIC at PBEA: POLICE CORONIAL SUPPORT UNIT-MGR - this process also applies where property has been seized under a Coroner's Authority (s.39 *Coroners Act*) • CSU will then liaise with the investigating coroner and apply for an order from the Court

	• If the application is not granted, Victoria Police must retain the property until finalisation of the coronial investigation
Where property has been seized by police and is retained solely for the coronial investigation at a non-Victoria Police facility (due to size or hazardous nature), and this will incur associated costs	• The investigating coroner approves for property to be retained and stored and the CEO of CCoV approves for the cost to be covered by the CCoV (note: this does not apply to storage costs associated with **motor vehicles** except in limited circumstances for further advice contact CSU) • Approval must be received from the investigating coroner and CEO of CCoV before entering into any agreement with a storage facility and the investigating member should email CSU (POLICE CORONIAL SUPPORT UNIT-MGR) with a written request that includes: - an outline of the circumstances of the death - information detailing the relevance of the property and reason for retention - an estimate of any associated costs - if URGENT, contact CSU via telephone followed by a written request CSU will then seek approval from the investigating coroner • Where approval is not granted by the coroner to retain the property Victoria Police must release the property • Where approval is granted by the coroner to retain the property the investigating member must then: - obtain a written quote detailing the associated storage costs - provide a written report with the quote to PBEA: POLICE CORONIAL SUPPORT UNIT-MGR • CSU will then seek written confirmation from the CEO of CCoV that CCoV will cover the storage costs, and notify the member of approval and any associated conditions • The service provider should make any invoices out to the CCoV (not Victoria Police) • Where the CEO of CCoV does not approve the storage costs the property is not to be retained by Victoria Police and should be released
Parallel criminal and coronial investigations being conducted in relation to a death	The coroner will generally wait for the criminal matter to conclude before progressing their investigation, however, police officers should ensure seized exhibits/property is: • kept following the conclusion of any criminal matter, and • only disposed of or returned once the coronial matter has concluded, unless permission is sought and granted by the investigating coroner to do so earlier

12.3 *Specialist examination of coronial exhibits*

- Where seized property, only required as a coronial exhibit, needs to be examined by an expert not available from Victoria Police, and this examination will incur associated costs, approval must be received from:
  - the investigating coroner who authorises the special examination
  - the CEO of CCoV who approves for the costs to be covered by the CCoV.
- The investigating member must email CSU (POLICE CORONIAL SUPPORT UNIT-MGR) with a written request that includes:
  - an outline of the circumstances of the death
  - information detailing the relevance of the property and need for specialist examination
  - an estimate of any associated costs.

- CSU will then seek approval from the investigating coroner.
- Where approval is granted by the coroner for the property to be examined the investigating member must then:
  - obtain a written quote detailing the examination costs
  - provide a written report with the quote to PBEA: POLICE CORONIAL SUPPORT UNIT-MGR.
- CSU will then seek written confirmation from the CEO of CCoV that CCoV will cover the examination costs and notify the member of approval and any associated conditions.
- The service provider should make any invoices out to the CCoV (not Victoria Police).
- Where the CEO of CCoV does not approve the examination costs the property must not be examined by the external specialist.

Related documents

- VPM Inquests and coronial briefs
- VPM OHS incident management
- VPM Property and exhibit management
- VPM Seized property and specialist property types
- VPM Forensic services and examinations
- VPM Victim support
- Sudden unexpected deaths of infants/Sudden unexpected deaths of children Practice Guide
- Victoria Police e-Referral (VPeR) System Practice Guide
- DoH, 'Guidance Note for Verification of death'
- Further information on the role of the coroner and the CCoV can be found in the brochure 'The Coroner's Process: Information for family and friends', located on the CCoV web page at www.coronerscourt.vic.gov.au

Further advice and information

For further advice and assistance regarding this policy, contact the CSU.

Update history

DATE UPDATED	SUMMARY OF CHANGE	FORCE FILE NUMBER
05/11/18	Consolidation and review of VPMP/VPMG Deceased persons. Inclusion of new section about coronial exhibits and the requirement for independent investigation of murder/suicides.	FF-114639
21/10/19	Instrument names amended to reflect updated property management policies.	FF-116667
10/03/20	Inclusion of requirement to report family violence related deaths	FF-133790

25/01/21	Addition of section 5 re Coronial Briefs, changes regarding transportation for SUDI/SUDC incidents, and minor updates to clarify existing procedures	FF-133624 FF-157579
19/02/21	Policy references updated to reflect review of family violence policies and death or serious injury/illness involving police policies	FF-189857 & FF-186541
19/07/21	Addition of section 8 to include instruction regarding identifying SNOK, clarification that property stored at a non-Victoria Police facility excludes motor vehicles and checking property items to avoid distress to claimants.	FF – 195717 1
30/05/22	Minor update to section 8.1 regarding correct contact for Police Enquiry Service	N/A
22/08/22	Updates to reflect investigation of workplace incidents, notification to MCIU if deceased recently sustained injury in a collision and instruction not to upload graphic images to TIS.	FF – 185332 1 FF-169720 1
01/09/23	Update to reflect new terminology and legislative references under the **VPM Care and control under the *Mental Health and Wellbeing Act 2022***	FF-232451 1
17/07/2024	Administrative amendment as a result of newly published VPM Recording devices, CCTV and digital asset management.	FF-236615
24/12/24	Inclusion of the Death Report Application and advice regarding non-reportable deaths and the role of State Trustees Consequential amendment to include Forensic Portal process for submitting a ballistics exhibit examination request Clarification that Ballistics Unit should be contacted for advice in certain circumstances	FF – 145078 D22/095658 FF- 251261
05/08/2025	Update to include guidance regarding notification of a death of an Aboriginal or Torres Strait Islander person in custody by the Deputy Commissioner, Regional Operations to Deputy Secretary, Aboriginal Justice, DJCS.	FF-273789
22/09/2025	Inclusion of **Victoria Police e-Referral (VPeR) System Practice Guide** for guidance on making referrals for victim support.	FF-266230