DEATHS IN CUSTODY[1]

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INTRODUCTION

I start this paper with three disavowals. Firstly, it is not a comprehensive or learned review of coronial inquiries into deaths in custody. All that I attempt is to pull together some of the impressions left with me as the result of reviewing coronial inquiries into Aboriginal deaths in custody which occurred between 1 January 1980 and 31 May 1989 in New South Wales, Victoria and Tasmania. Secondly, I am not reviewing or commenting on any particular system at any particular time. The systems vary from state to state and within each state have varied over the period of ten years. I am not concerned to look at the merits of particular systems, but simply to look at some of the points of a general or perennial nature that have emerged. Thirdly, I am not expressing any concluded views on any matter. It would be wrong to pre-empt reports of the Commission by doing this, and in any event all five Royal Commissioners have agreed that except in matters of a purely local nature they will refrain from making recommendations individually and seek to agree on recommendations to be included in the national report.

The deaths that I have reviewed include deaths in police custody, in prison and in a juvenile institution. My commission requires me to inquire not only into each death but into:

> Any subsequent action taken in respect of each of those deaths including, but without limiting the generality of the foregoing, the conduct of coronial, police and other inquiries and any other things that were not done that ought to have been done.

INCIDENCE OF ABORIGINAL DEATHS

The deaths have all been Aboriginal deaths. Although a long campaign going back at least to the death of John Pat at Roebourne, Western Australia, on 28 September 1983, underlay the Royal Commission, its establishment in the second half of 1987 was precipitated by the large numbers of Aboriginal deaths in custody then occurring and receiving great publicity, particularly deaths of young men by hanging in police cells, and by the high degree of suspicion about those deaths, particularly in the Aboriginal community. The rate of such deaths was indeed high and if members of the non-Aboriginal population of Australia had been dying in custody at the same rate as Aboriginals there would have undoubtedly been an enormous outcry. If, as a proportion of the total population of Australia, non-Aboriginal people had died in custody at the same rate as Aboriginal people

1 Paper delivered at a public seminar entitled "Coronial Inquiries", convened by the Institute of Criminology at Sydney University Law School, 10 October 1990.

between 1 January 1980 and 31 December 1988, there would have been something like 7,400 non-Aboriginal deaths rather than the 368 which occurred.

However, statistical studies soon revealed that if one made the comparison on the basis not of the total population in the community but of those in custody, Aboriginal deaths were not occurring at a significantly disproportionate rate. In other words the biggest factor contributing to the large number of deaths in Aboriginal custody was the large number of Aboriginals in custody. The Commission's survey in August 1988 showed that almost 29 per cent of all custodies were of Aboriginal people, although their percentage of the Australian population aged 15 years and above was 1.1 per cent. Similarly, the National Prison Census in June 1987 showed that 14.6 per cent of all prisoners were Aboriginal. Accordingly it has been conservatively calculated that across Australia, Aboriginal people were apprehended and placed in police cells at a rate over 20 times that of non-Aboriginal people and were over-represented in the gaols by a factor of at least 10.

Another factor of a general nature was the very high death rate and low life expectancy among Aboriginal men due to the high incidence of heart disease, diabetes, epilepsy and other life threatening conditions. Given the different health status, one would expect a higher incidence of death from natural causes among Aboriginals in custody as compared with non-Aboriginals in custody. While one must be cautious with what are relatively small numbers for statistical purposes, there seems to be some indication of this in the figures. Of those people who died in custody between 1 January 1980 and 31 December 1988, a higher proportion of Aboriginal people (46 per cent), compared with non-Aboriginal people (33 per cent) died of natural causes. This comparison applies to both police and prison custody groups.

The result is that the focusing of inquiries on the immediate circumstances of death, while providing a lot of valuable information about the causes of death in custody generally, would give only limited insight into the reasons for the high numbers of Aboriginal deaths in custody. To get a real understanding of that issue one must look beyond the circumstances of death to the reasons for the high numbers of Aboriginals in custody and their greater vulnerability. This the Commission has attempted to do.

Having given this general background, I turn to note some particular issues that have arisen relating to coronial inquiries.

ABORIGINAL/POLICE RELATIONS

The fact that the inquiries were confined to the deaths of Aboriginals focused attention on the very significant differences between the relationships of Aboriginals with custodial officers, particularly police, and the relationship of the rest of the community with custodial officers. I think it is fair to say that the rest of the community, while not above suspicion of police or prison officers in particular circumstances, would think it a rare and unusual circumstance if police officers or prison officers were to kill a prisoner or deliberately place the life of a prisoner in jeopardy. Hence such accusations are not

frequently made and are treated with some scepticism. The position is quite different in the Aboriginal community. Many Aboriginals see police in a historic continuity where they started off as the armed agents of invaders who in many areas sought to exterminate them, and everywhere to deprive them of their land and means of livelihood. This is followed by an era in which Aboriginals were segregated with the expectation that they would die out, the police enforcing strict controls over them. Then in relatively recent times there was a high-minded attempt at genocide that went by the name of assimilation. Again the agents in enforcing policy, for example taking away children from their Aboriginal families were either the police or people whose power depended on their ability to call in police. Police have always been called on to do the dirty work associated with aovernment policies in relation to Aboriginals, including the dispersal of camps which offended local residents and even today the suppression of Aboriginal lifestyles that offend middle class propriety, such as drinking in the streets or in parks. Police have also had the role of controlling Aboriginal dissent. I suppose I am showing my age by remembering as if it were yesterday the bitter battles between police and Aboriginals over the tent embassy in Canberra and the Springbok tour shortly before. Police are still the front-line troops who have to confront the bitter expressions of injustice and resentment that often emerge when Aboriginals are highly stressed or under the influence of alcohol.

The significance of all this for the coronial inquiries which have been the subject of inquiry by the Royal Commission is the very high degree of suspicion of foul play that surrounds the deaths. Even in cases which would appear on the face of them to be clear cut cases of deaths by natural causes or by a prisoner taking his or her own life, Aboriginals are often highly suspicious of foul play by police or prison officers, which they regard as just as likely and sometimes more likely than other explanations. It has been a major problem in relation to many coronial inquiries and the police investigations which preceded them that there has been little or no sensitivity to the feelings of Aboriginal relatives and the Aboriginal community.

Both police and Aboriginals bring a great deal of historical baggage to their relationships, which is a great impediment to those who seek to alter the situation for the better. Many of these, let me hasten to say, are in the Police Forces. It is the unhappy historical side of Aboriginal/police relations that is relevant to my present theme. In a more general review of relationships I would be the first to acknowledge the goodwill and hard work at senior levels, and some local levels, in the Police Forces of New South Wales and Victoria, which are slowly starting to impact on the attitudes and beliefs embedded in police culture. What their efforts are coming up against is the fact that while Police Forces can present a more human face, they cannot resolve the basic injustices and frustrations that are at the root of conflict between black and white in this country. That is a task for all of us.

CUSTODIAL DEATHS

The special character required of an investigation and inquiry into a death in custody has long been recognised. Waller's *Coronial Law and Practice* (2nd edition, 1982), which has

been widely used in Australia, cites the *Coroner's Manual* (4th edition, p45) which summarises in measured terms the aim of holding inquests into deaths in custody:

> It is very desirable that no suspicion should arise in the public mind that deaths in Government Institutions such as gaols are made the subject merely of investigation by Government officers, and that therefore, when deaths occur, it is not likely that everything which reflects on the management of the institution will be allowed to come into the public view. The public should be satisfied that the prisoner or confinee came to his death by the common cause of nature, and not by some unlawful violence or unreasonable hardship put upon him by those under whose power he was while confined. There should not be given an opportunity for asserting that matters with regard to deaths in public institutions are 'hushed up'.

What goes on inside a gaol or police cell is hidden from public view, and after a death very frequently the only surviving witnesses are the custodial officers. From a relative's point of view a live son, daughter, husband, wife or other relative goes into custody and a body is returned. There are no independent witnesses. Relatives and the public are entitled to be suspicious unless there is a full, open and impartial inquiry and the greatest possible access given to all information on the part of those representing the family. The issues go far beyond questions of homicide or deliberate infliction of physical harm; they extend to the care taken of a prisoner, often one who is intoxicated or under the influence of drugs, and to the psychological treatment of the prisoner.

In the *Interim Report* of Royal Commissioner Muirhead at the end of 1988 he said:

> The anguish of many relatives of those who die in custody, i.e., in the 'care' of Government agencies, and the fear and suspicions which follow are not generally comprehended. The situation demands the most thorough investigation of facts and circumstances by skilled investigators who hopefully may be regarded as impartial, autopsies performed by expert forensic pathologists followed by thorough coronial inquiries conducted by legally trained Coroners under modern legislation which enables such Coroners to make remedial recommendations. In all these processes there must be sensitivity to the situation of the families of the deceased.
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> If this degree of thoroughness, the implementation of such expertise, had been current in Australia over past years, it is arguable that the necessity for establishment of this Royal Commission would not have arisen. It is for this reason, which appears to be widely misunderstood, that the Terms of Reference require investigation into inquiries made subsequent to death.

There is a very great temptation on the part of custodial authorities to be secretive about a death in custody. Instead of regarding relatives and their representatives, such as the Aboriginal Legal Services, as genuinely concerned people who want to know what happened, there is a tendency to treat them as trouble makers to be denied knowledge in case they misuse it, or (patronizingly) as people who should not be told things that might upset them.

A particularly undesirable practice is the use of the coroner and the pending coronial inquiry as a shield behind which custodial and investigative officers hide — the body cannot be seen because it is in the charge of the coroner; the site cannot be visited because it is the subject of coronial investigation; information cannot be given out because

the matter is in the hands of the coroner; nothing can be said until the coronial investigation is complete and the inquest over. Much of this use of the coroner's name has taken place without any reference to the coroner, who may well have been quite unaware of the frustration being suffered by relatives and their representatives.

TREATMENT OF RELATIVES

The initial notification of a death to relatives is of critical importance. It is a time of great anguish and shock for the relatives, particularly if the prisoner is said to have taken his own life. This is likely to be received with incredulity by relatives who are sure that he or she would never commit suicide. It is common too that relatives will be further disturbed by feeling some, perhaps unconscious, guilt about their past treatment of the deceased. Breaking the news requires skill and sensitivity and openness. In the case of Aboriginal deaths it is extremely desirable that there should be an Aboriginal person involved, who will have much more chance of understanding and responding to the reactions and concerns of relatives than a non-Aboriginal. Too often notification is treated as a painful chore of the persons who have to perform it, for which they have no training and which makes them very uncomfortable, a feeling which will soon be picked up and possibly misinterpreted by the relatives. There is need for great openness at this stage in giving all information, and in particular not hiding behind notions such as the coroner's control of the matter. Otherwise the whole investigation will be poisoned from the start with the suspicion of a cover-up.

There should be an opportunity if the relatives wish to see the body at a very early stage or have their representatives see it. One matter which gave very great concern to the relatives of Lloyd Boney, who died in a police cell in Brewarrina in 1987, was that the body was whisked out of town within an hour of being discovered and before any attempt was made to notify a relative. Sometimes the sight of the body may be very distressing, but the choice whether it is seen or not should be that of the relatives. They may well nominate someone else to look at it on their behalf, but there should be an opportunity to see whether the body bears any marks of violence or whether there are other suspicious circumstances. Obviously restrictions may have to be placed on the viewing for the purpose of ensuring that there is no disturbance of possible evidence, but this does not justify a blanket refusal of access.

There should also be the earliest possible access on the part of the family, usually through their legal representatives, to documentary material, witnesses' statements, and where witnesses are in confinement to the witnesses themselves. Obviously the investigations of police and coroner should take priority in the sense that they should have the opportunity to carry out their interviews of witnesses before others speak to them. However once that is completed witnesses should be available, just as they would be if they were not in confinement.

In some cases the family will wish to have someone present at the autopsy, perhaps their own forensic pathologist or perhaps a lay person who will be able to see the

state of the body and what is done. Again this should be facilitated, subject to not allowing any interference with the work of the forensic pathologist.

The family should be involved in the preparation for the inquest. The most satisfactory inquests that the Commission has investigated have been those where there was collaboration from an early stage between those assisting the coroner and the representatives of the family. This has ensured that all the witnesses whom the family consider relevant are interviewed and if necessary called and any tests or other steps desired by the family are attended to.

Apart from the demands of humanity, there are practical reasons for treating relatives in this open way. If there has been foul play or neglect, the more critical eyes of the sceptical relatives may help expose it. If there has not, this may become obvious. In any event openness will be of value in reducing suspicion and disputation.

POLICE INVESTIGATION

In most of the cases which the Commission has investigated the coronial inquiry has been largely shaped by the preceding police investigation, although there have been recent exceptions. Often the inquest has consisted of no more than a perfunctory running through a brief supplied by police. Unsatisfactory coronial inquiries have usually been the prisoner of inadequate police inquiries. If we are to continue with the system whereby deaths are investigated for the coroner by police the quality of police investigation is of tremendous importance.

In my experience as a Royal Commissioner I have become very conscious of the existence of a "police culture" — a set of ingrained attitudes and ideas that are widespread in the police force and are very resistant to change. There is a very great blindness in that culture to the problems of police investigating police, and a very great reluctance to acknowledge the possibility of wrong-doing by police. Again and again deaths in custody have been subjected to no really independent investigation and the brief for the coroner has been prepared by the very officer who was in charge of the prisoner and whose conduct should have been subject of scrutiny. Even when investigation is under the control of a separate unit like the Internal Affairs Branch, the officers who come in often act as though their function is to defend the local police and demonstrate their innocence rather than to carry out an independent investigation.

There can be great façades of independent supervision which in practice mean absolutely nothing. In one Victorian inquiry, counsel for the police argued that the fact that the officer preparing the coronial brief was the officer who had been in charge of the prisoner was not objectionable, because he was under the scrutiny of a host of independent eyes — a doctor who came to examine the body, a CIB detective, the inspector in charge and the Internal Investigation Branch. One by one the relevant witnesses were called. The doctor said that he only certified death and was not concerned to examine the body; the detective said that his only function was to take photographs; the inspector said that his task was purely administrative and not investigative; and the Internal Investigation Branch

representative said that his function was to "oversight", which turned out to mean that he had just accepted what he was told by the officer in charge. It is almost comical at times to see how everybody passes the buck for such investigations.

It is remarkable how in police investigations of police the need is not seen for the same scrutiny of evidence as in other cases. It is elementary in general crime investigation that a suspect is interviewed quickly, and that if there are a number of people involved steps are taken to prevent them conferring and putting together an agreed version. I doubt that this has been done in any of the deaths in custody which I have investigated. In most cases police were not even interviewed but allowed to write their own statements at leisure, the leisure being any time up to a week or a fortnight before the inquest. Even where police have been interviewed, no steps have been taken to prevent prior discussion and agreement between them, and what they say has not been tested or probed.

PREVENTION OF SUICIDE

A remarkably resilient idea is that "a suicide is a suicide"; once it appears that the person has taken his or her own life, there is nothing further to investigate except to get evidence that the person was unhinged or depressed. Coupled with this notion is the proposition, which I have seen enunciated even by coroners, that if persons are really determined to commit suicide, there is nothing you can do to stop them. The corollary is seen to be that it is not very important to ask what was done to stop the person committing suicide, because it would have made no difference anyway. The fact is that very few cases where people take their own lives in custody are the acts of determined suicides, who are set on finding a way to end their life, no matter what. All the self-inflicted deaths that I have come across in the Commission have been impulsive actions, often under the influence of very temporary conditions, such as the anger or frustration at the effect of arrest on other activities, the depression that comes with declining blood alcohol levels, or the disturbance associated with withdrawal symptoms. Such deaths can be prevented by adequate care and supervision. Some deaths can be prevented simply by a little sympathetic human interaction. A short or kind sympathetic chat by a custodial officer may not alter the prisoner's view of life, but it may weaken resolve or delay action until an opportunity or impulse for suicide has passed.

Such issues are often excluded by the very narrow focus of police and this applies to deaths in prison as well as in police custody. In the case of a self-inflicted death there is concentration on showing that the actual death was self-inflicted and not a failure to inquire into surrounding circumstances of care and supervision and safety, such as, for example the gaol classification of a prisoner as not requiring observation.

This is important not only for establishing responsibility for the death, but to see whether, similar situations of risk can be avoided in the future. Some recent statements of law may have some salutary effect both on the conduct of custodial officers and the approach of investigators. In *R v Tak Tak*[2] the New South Wales Court of Criminal Appeal

2 *R v Tak Tak* (1988) 14 NSWLR 227.

reviewed the law of manslaughter by neglect. In *Rirkham v Chief Constable of Manchester* (1990)[3] the English Court of Appeal removed any doubt that the duty of custodial officers to take all reasonable steps to avoid acts or omissions which they could reasonably foresee would be likely to harm a prisoner extends to harm self-inflicted by the prisoner, including suicide.

HARD EVIDENCE

Where the only witnesses are those whose conduct is under scrutiny, it is very important to collect as much "hard" evidence as possible, that is evidence that remains in durable form for examination after the death. The impounding of all relevant documentation is most important, as is the taking of early and good quality photographs.

Independent physical examination of the scene, including a search for fingerprints, may also be important.

In relation to a death, the most important hard evidence is often the body itself, and its clothing. Hence the central importance of the autopsy.

AUTOPSIES

There is a surprising lack of agreement as to the function of an autopsy in a death in custody. At one extreme is the pathologist who sees the function of the autopsy as simply to establish a cause of death which can be entered on a death certificate. Next is the pathologist who sees his or her function as to take the police report, assuming it to be *prima facie* correct, and see if a cause of death can be found consistent with the police report. It is essential that in a case of a death in custody the forensic pathologist should proceed in a completely independent way, and among other things see whether there is anything consistent with foul play or ill-treatment. The investigation should not be limited in any way by the police report.

Professor Cordner, the Director of the Victorian Institute of Forensic Pathology, has reviewed numerous autopsies for the Royal Commission. He has said that the fundamental purpose of all autopsies is to discover and describe all the pathological processes (including injuries) present in the deceased. This enables:

(i) the provision of an accurate cause of death,

(ii) the identification of pathology contributing to death, and

(iii) correlation with the clinical observations made in life.

A forensic autopsy has an additional purpose — contributing to the reconstruction of the events leading to the death. It is in this area that forensic pathologists have their particular expertise. The contribution to the reconstruction of the events is made by a combination of:

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3 *Rirkham v Chief Constable of Manchester* (1990) 2 WLR 987.

(i) an assessment of the scene of death,

(ii) the autopsy findings.

The third major purpose is to record the findings in such a way as to put another pathologist at a later date in the same position as the one who conducted the autopsy. Achieving this involves detailed description, retention of relevant organs and tissues, and photography.

One problem is that the more exhaustive the investigation by the pathologist, the more mutilation there will be of the body. This may be offensive to relatives and is a consideration that has to be taken into account by the pathologist. However in most deaths in custody it is desirable that there should be very extensive investigation for the purpose of establishing whether the prisoner has been bruised or man-handled. This may be very important in apparent suicides or natural causes deaths. In hangings, for example, such examinations may go a long way to eliminate the suggestion that the person was forcibly hung, or hung after being killed in some other way in order to conceal the original cause of death.

Ideally the pathologist (and for that matter the coroner) would visit the scene of death and see the body in place before it is removed or at all events see the remainder of the scene undisturbed. However, there are judgments to be made as to how practicable this is and whether it is worth the time and expense. In the case of deaths in custody, it is desirable that such judgments should be made by the coroner or the pathologist rather than by the police.

The body is very frequently the most important piece of "hard" evidence which survives the circumstances of death and is not dependent on human truthfulness and recollection. This not only makes the autopsy very important in itself, but makes important the preservation of information about it in case controversy resumes at some later time or new issues are raised. Extensive and good quality colour photographs are most important, and the preservation of samples, for example, of blood and stomach contents for further examination if required. Tissue samples are often taken for histological examination and can be kept.

One problem that has arisen in some of the cases dealt with by the Commission has been concern on the part of the family that major organs such as the brain or heart are buried with the deceased. In some cases it appears that they are removed for further examination and disposed of separately and not returned to the body. This is capable of causing very considerable anguish to some relatives and is to be avoided unless there are strong forensic reasons necessitating it.

THE INQUEST

These days coroners usually have reasonable facilities for recording and reproducing the evidence, and it is important that this position should be maintained.

An issue in regard to a number inquests has been the treatment of the family and its representatives. Regrettably there is sometimes a tendency for the person assisting the coroner, and sometimes the coroner himself or herself, to fall into the lawyer's habit of treating the inquiry as an adversary situation. The family should not be treated in any way as an adversary, but as a group of people who have a right to know what happened and are trying to find out what happened. Thus, if the family wants a witness with relevant information to be called, it is quite wrong for the representative to be asked whether foul play is alleged and to be called on to formulate an allegation. Families obviously have not had the resources and access to make the investigations which have been made, or should have been made by police and are entitled to test the police investigation and to explore possibilities without being compelled to assume the role of adversaries or to make allegations.

The most successful coronial inquiries I have seen are those in which those assisting the coroner have worked in close co-operation with the family to ensure that all relevant issues are ventilated and all relevant material put before the inquiry.

Very often the significance of the inquest goes far beyond the particular death. The death may be illustrative of widespread problems. In these circumstances it is appropriate that public interests groups and other appropriate persons should have an opportunity to participate in a coronial inquiry. This does not mean that they should have open slather, and be entitled to go over circumstances of the particular death which are being covered by representatives of the family. But it is desirable that they should have opportunities to ventilate the matters of general concern that arise out of the death.

COUNSEL ASSISTING THE CORONER

The position of officer or counsel assisting the coroner is very important. It has been traditional in Australia for assistance of a coroner to come in most cases from a member of the police force. In some cases into which the Commission has inquired the officer who was in charge of the prisoner, and whose conduct should have been subject to scrutiny, was not only the officer in charge of the investigation and the preparation of the police brief for the coroner, but the officer assisting the coroner. This makes a mockery of any notion of independent investigation.

It is increasingly common today for independent counsel to be briefed in relation to deaths in custody. There is a very strong case for the coroner to be assisted by someone who is quite independent of the police force. Often this is a member of the private bar. This can be very successful if the member of the bar takes an active role in the preparation and conduct of the case and sees himself or herself as having responsibility to ensure that all the facts come out. I have, however, seen inquiries in which a member of the private bar was briefed and did no more than a police prosecutor would have done, that is simply called the witnesses nominated by the police and ran through their statements. In that case nothing except expense is added to the inquiry. On the other hand I have seen cases where the counsel assisting has been a person with prior experience and understanding of the Aboriginal point of view, and has so prepared and conducted the inquiry as to ensure that,

so far as possible, all avenues of concern are thoroughly explored and all evidence is thoroughly tested.

I do not myself regard all forensic skill and independence as being located at the private bar, although that is certainly a place where it can be located, and is also a place where, because of the high remuneration available, a lot of the most able people congregate. The latter consideration becomes a problem if very high counsel's fees have to be built into the general running of coronial inquiries. It may be that there are many cases which could appropriately be handled by salaried legal officers of the Crown, provided that adequate care is taken to ensure that they are not persons identified with police or prisons. A suggestion has been made that there should be an independent coronial staff, with legal officers responsible for investigations or the oversighting of investigations and available to assist the coroner. There are various possibilities that may be worthy of consideration.

Some of the coronial inquiries that have been held into Aboriginal deaths in custody in recent times have been extremely long and expensive. I would not see this as something which needs to or should become the norm. I think that it reflects the lack of trust in police investigations, and often the complete inadequacy of police investigations, and the current general concerns about Aboriginal deaths in custody. Hopefully, if machinery is worked out to have truly independent and thorough investigation, with frank and open involvement of families, the need for such lengthy and expensive inquiries will rapidly decline.

RECOMMENDATIONS BY CORONERS

In several of the recent inquiries into Aboriginal deaths in custody the coronial inquiry has been not only wide-ranging but has resulted in some quite extensive recommendations. These have been very valuable and it is important that coroners should make explicit recommendations. In some cases coroners have proceeded on the basis that the situation is apparent from their findings and there is no need for recommendations, but all too often police or public authorities take no notice of anything except explicit recommendations.

Even very explicit recommendations can be ignored. In a number of cases they have not even come to the notice of relevant authorities. It is essential that there be proper machinery for conveying all coronial recommendations to the relevant authorities, and for monitoring what happens. One suggestion is that the coroner should have some continued jurisdiction for a period after he delivers his findings, during which he could if necessary have a further hearing to follow up the issues which emerged from the inquest.

STATUS OF CORONERS

There has been a steady increase in the status of coroners. The days of lay coroners are largely gone and coronial inquiries are in the hands of magistrates and increasingly of specialist magistrates, or at all events under the supervision of a specialist magistrate. A hangover in New South Wales is the situation where a Clerk of Court acts as coroner.

There may be value in a Clerk of Court being able to perform some of the administrative functions of coroner, particularly where there is no resident coroner, but I have suggested in my *Report of the Inquiry into the Death of Mark Wayne Revell* that such officers should not exercise the judicial or quasi-judicial functions of coroners. I referred in that report to:

> a system which prostituted the precious tradition of judicial independence and competence to rubber-stamp inadequate police investigations on the cheap. If certain inquests are to be formalities to be carried out by administrative officers, they should be presented as administrative acts, not passed off as judicial.

This is particularly important in relation to deaths in custody, as Clerks of Court inevitably have close contact with the local police and are seen by many people as part of a closely knit establishment. It is essential that judicial functions, including coronial hearings and making findings, should be carried out by somebody with a clearly independent status, with some degree of remoteness from police, and capable of commanding public confidence, and in particular, in the case of Aboriginal deaths in custody, the confidence of the relatives and of the Aboriginal community.

In his *Interim Report* Commissioner Muirhead wrote:

> The value of the Coroner's role must now be recognised, the responsibilities of that office require recognition of the Coroner's true status, the provision of adequate and coordinated facilities. In my view the Coroner should be the person basically in charge of investigation of deaths within his or her jurisdiction and those responsibilities should be recognised. The terms and conditions attaching to Senior Coroner or State Coroner's office should certainly not be less than that of a Judge of a District or County Court. The office represents the only tribunal which can investigate circumstances fairly and quickly, before memories fade or perhaps before reconstruction rather than memory influences the minds of witnesses.

We have not yet reached the stage suggested by Commissioner Muirhead, but in several States there has been an enhancement of the status and resources of a State Coroner. This has resulted in considerably more specialisation in coronial functions, and in specialist supervision of inquests carried out by others. This is to be commended. However the experience of the Commission shows that the establishment of new procedures and institutions does not easily change ingrained practices and attitudes. I have discussed some of the problems that have come up in Commission inquiries without regard to particular systems operating at the time. They are problems which must be recognised whatever system operates, and it should not be too easily assumed that they will automatically be overcome by the revamping of institutions. Constant monitoring will always be required to ensure that the new institution works with the quality, confidence and independence that is necessary.