AUSTRALIAN DEATHS IN CUSTODY

No. 10 Coroners' Recommendations and the Prevention of Deaths in Custody: A Victorian Case Study

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Coroners have much to contribute to the prevention of deaths in custody. The coronial process gives a direct insight into the causes of a particular death, and their unique role allows them to highlight preventive measures which logically form a part of coronial findings.

This issue of Deaths in Custody Australia is a timely study of the extent to which coronial inquests into deaths in custody in Victoria have made recommendations which could assist in the prevention of deaths in custody. It would appear that this potential has not yet been fully realised in Australia and there are a number of reasons for this.

The study examines the range of factors which inhibit the full development of the preventive potential of coronial processes, including historical inertia, legalistic models of practice and an accompanying preoccupation with retrospective blame rather than prospective prevention.

Proactive strategies are needed to change coronial practice. These strategies could include coroner-specific training in preventive approaches to the analysis of unnatural deaths; the development of consistent coronial standards of custodial care; the development of appropriate databases through which patterns of death and injury can be detected; and the development of prevention-focussed legislative frameworks.

The Deaths in Custody Australia series has documented the significant number of deaths in custody. Although progress has been made in reducing this number in some circumstances, it is clear that we need to explore every avenue to promote preventive strategies. Coroners have a leading role to play in this effort.

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INTRODUCTION

The critical role of the coroner in the investigation of deaths in custody was commented upon at length in the *National Report* of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC 1991).

The Report specifically referred to the need to ensure that appropriate recommendations were made by coroners and that these recommendations and the resulting responses were made available to the interested parties. This paves the way for remedial action to be implemented by all those concerned.

Each unnatural death examined by coroners represents the tip of an iceberg of injuries and other high-risk circumstances. A proactive strategy therefore has the potential to prevent many deaths as well as to make a significant reduction in risks to health and safety more generally.

Coronial investigations into deaths in custody are a potential monitoring tool of standards of custodial care and thus provide a window into the practical implementation of the RCIADIC recommendations. The momentum for reform initiated by the Royal Commission could be sustained through a more proactive coronial role. This potential is apparently not recognised by coroners themselves, as the cases under study will show.

The extent to which the coronial process actually functions in this way depends on the extent of coroners' awareness of the issues raised by the Royal Commission. It depends also upon whether appropriate recommendations are in fact made by coroners. The practical and policy impact of coroners' recommendations will then depend on the extent of their implementation.

The Royal Commission made recommendations which have application for the custodial care of both Aboriginal and non-Aboriginal detainees, recognising that the best way of improving the custodial circumstances of Aboriginal detainees is to improve custodial standards and processes overall.

Matters of public interest in coronial proceedings should be reflected in the content of coronial findings, since this is the output of the inquest, and the document which is most likely to be conveyed to other agencies and individuals with an interest in proceedings. It is reasonable to expect that a summary of these matters should be included in the findings, or at least such matters as are pertinent to the particular case under consideration. Only in this way can the public interest be protected and transparency and accountability be assured.

The public interest in coronial proceedings has been described thus:

> *. . . the coroner can and should enquire into the circumstances giving rise to the condition which caused the death, and ascertain whether they disclose a preventable hazard, or errors and weaknesses in systems or in administration affecting public safety . . .*

Further:

> *. . . to place on record all relevant evidence as to the facts and circumstances of the death; . . . to inform the public through an impartial inquirer of the broad facts of the matter, and to inform all concerned, in appropriate cases, of the precautions desirable to avoid repetitions* (New South Wales 1975, p. 98).

In relation to deaths in custody, the matters which are relevant in this context are identified in RCIADIC Recommendation 35, which reads, in part:

> *b. All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of custody and the general care, treatment and supervision of the deceased prior to death;*
>
> *c. The investigations into deaths in police watch-houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;*
>
> *d. In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instruction relating to the care, treatment and supervision of the deceased* (RCIADIC 1991, Vol. 1, p. 178).

The definition of a death in custody used is that recommended by the Royal Commission in Recommendations 6 and 41, which includes not only deaths in institutional settings, such as cells and police vans, but also:

> *c) the death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person;*
>
> *d) the death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention* (RCIADIC 1991, Vol. 1, p. 190).

Thus, police shootings are included in such a definition, as would deaths which occurred in the course of a siege or a motor vehicle pursuit involving police officers.

Victoria was selected as the site for this study because, at the time of release of the RCIADIC *National Report* in 1991, the Victorian model of coronial process was acknowledged to be "the most innovative and efficient within Australia" and recommended as a model for adaptation in other Australian States (RCIADIC 1991, Vol. 1, p. 136). The exemplary features included a centrally administered coronial service under the control of a State Coroner and a coronial service integrated with the Victorian Institute of Pathology. In the process of legislative reform sparked by the Royal Commission, the Victorian model has in fact been adapted or is being considered by a number of other jurisdictions, including Tasmania, the Northern Territory and Western Australia. Queensland is in the process of reviewing coronial legislation, but no Bill has been developed as yet.

Case studies of sixteen deaths in custody in Victoria from the years 1990-1992 were used to test the extent to which the concerns raised by the Royal Commission were echoed in the coronial processing of deaths in custody cases, and whether appropriate recommendations to initiate preventive action were made. Both Aboriginal and non-Aboriginal cases of deaths in prison and police custody were examined.

The case studies show that the recommendations of the Royal Commission relating to custodial health and safety are frequently ignored by coroners and custodial officers alike. Moreover, they reveal the application of widely varying standards of acceptable custodial care from coroner to coroner. The use of this variable standard, coupled with an apparent reluctance to make recommendations, blunts the effectiveness of the coronial process as a reliable means of identifying risk factors and developing remedial strategies.

In this context, it is useful to consider possible reasons why there might be some reluctance by coroners to make recommendations before moving to a closer examination of the cases themselves. The reasons stem from the historical background to the role of the coroner; the narrow focus of coronial investigations into deaths in custody; possible conflicts of interest in the preparation of evidence for presentation at an inquest; the weakness of the legislative context; and legalistic smokescreens which obscure the development of preventive and consistent standards of custodial care. As will be shown, these factors skew the coronial process and draw attention away from a forward-looking systemic focus which could lead to useful remedial action.

Historical burdens

The heart of the coronial process has been to gather facts about the who, what, when, where and why of unexpected deaths. Some commentators have viewed with suspicion any deviation from the realm of fact into the realm of opinion. This is partly a response to the fact that coronial processes are inquisitorial rather than accusatorial, and that the formal rules of evidence do not apply. Brodrick expressed anxiety that in drawing attention to omissions or the blameworthiness of individuals for a death "he may be doing an injustice to the person criticised". Furthermore:

> *Comments on the morals, ethics or professional standards of those who have no opportunity to answer back made by someone who speaks from a position of privilege are reprehensible and we should like to see them discontinued* (Law Reform Commission [England] 1971, para. 16.54, p. 193).

Moreover, it was considered that the "decision whether any further action is required may depend on many factors of which the coroner will know nothing and we think these matters would be best left to the expert authorities concerned" (Law Reform Commission [England] 1971, para. 16.52, p. 193).

Thus, there has been vigorous debate about the authority of coroners to make recommendations and their appropriate status. Jervis, in the 8th edition of *On the Office and Duties of Coroners*, was clear about his view of the significance of recommendations (which are sometimes known as riders):

> *the addition is no part of the verdict, but is mere surplusage. A recommendation is no part of the verdict and the coroner may refrain from recording it, or, he may allow it to be written in the margin of the inquisition, of which it is not part* (Jervis 1946, p. 110 cited in Johnstone 1992, p. 153).

These comments were echoed in Pilling's review of the Brodrick Report, endorsing the proposed removal of "the irritation of riders and animadversions" (Pilling 1972, p. 75).

In summary, there were fears that the coroner might inadvertently make suggestions which could have the potential to make a bad situation worse. The Brodrick Committee recommended that the right to attach a recommendation should be abolished and that, in order to prevent recurrence of the fatality, the coroner should have "the right to refer the matter to the appropriate body or public authority, and he should announce he is doing so" (Law Reform Commission [England] paras. 16.52 and 16.53, p. 193). Following the release of the Brodrick Report, the power of the coroner to attach a recommendation to the verdict was abolished in England and Wales in 1980.

Waller, in his text on *Coronial Law and Practice in New South Wales* echoes a similar concern when he cautions that "there are dangers that coroners will make definite recommendations without being fully aware of the ramifications, or of competing priorities in a Government department" (Waller 1994, p. 95).

As Johnstone points out, however, these arguments do not take account of the fact that the coroner can call experts to provide testimony on the details of any relevant matter; that coroners' suggestions are frequently very general in nature; and that, most importantly, "there is never likely to be a better time" to make a recommendation (Johnstone 1992, p. 156). Moreover, the coroner has no power to require formally that any suggested action be carried out. It is always open to the agency to ignore or reject coronial recommendations, either explicitly or implicitly, and with or without communicating the reason for choosing such a course of action.

Johnstone (1992, p. 140) points out that as far back as 1907, the potential role of the coroner in the prevention of deaths and injury was acknowledged. He cites the early writings of William Brend, who argued that the Coroners' Court was poorly adapted for the detection of crime; that claims for compensation were settled in other courts and that the only valuable role left to the coroner was a preventive role.

This potentially preventive role has been marginalised in some coronial practice through the emphasis on unpacking the facts of individual cases, rather than the systematic identification of patterns of death and injury. This emphasis reflects the over-riding modus operandi of the legal profession as a whole, which has concerned itself solely with dealing with events on a case by case basis, closing the file at the conclusion of each. A preventive focus requires additional steps: identifying patterns; identifying remedial responses; making recommendations to implement the response; ensuring that problematic situations are remedied.

The tension between the fact finding/warning provision role and the active initiation of remedial action role is highlighted in the subtle, yet highly significant differences of emphasis between the Brodrick Committee which reviewed the coronial system in England and Wales and the Ontario Law Reform Commission (OLRC 1971) Report on the role of the coroner in Ontario, Canada. According to the Brodrick Committee Report, the public interest served by a coronial enquiry requires the coroner to:

> *draw attention to a possible fatal hazard so that an adequate warning can be given to the public and precautions taken, whether by individuals or by a responsible authority, against any new fatality* (Ontario Law Reform Commission 1971, para. 14.22, p. 161).

The Ontario Law Reform Commission went further, and stated that the coronial inquest should not only focus community attention on preventable deaths, but should also have the function of "initiating community response to preventable deaths" (OLRC 1971, p. xi). The Norris Review of the *Victorian Coroners Act 1958* drew attention to the capacity of the Ontario coronial system to take "direct action to implement jury recommendations when possible" by sending a copy of the verdict and recommendations "with a covering letter asking how it is intended to remedy the situation" (Norris 1980, p. 135). It also acknowledged the importance of the data generated by the coronial process for the prevention of future deaths and the need to make recommendations (Norris 1980, recommendation 30).

Investigatory skills and training

The Public Interest Advocacy Centre (PIAC) in New South Wales has drawn attention to the influence that the skills base of the individual coronial and police officers has on the conduct of coronial processes. There is no specialist coronial training currently available in Australia to provide the additional preventive investigatory skills required in coronial work, which must, by default, be acquired "on the job". Most coroners have previously been employed as magistrates, and PIAC asserts that they are likely to be influenced in their coronial role by the traditional role of judicial officers in courts of law:

> *. . . as removed and passive arbiters in proceedings between parties whose legal rights are directly affected by the proceedings[. This] has not only tended also to be used in coronial inquests, but it has contributed to coroners (largely) vacating the investigative functions of their office. In the resulting hiatus the police have dominated in investigative aspects of the coronial system* (PIAC 1988, p. 5).

PIAC argues further that the focus of the police investigators upon whom coronial processes depend is likely to reflect their training also, and thus be concerned with issues of criminal responsibility rather than systemic or procedural risk factors. In Victoria, a team of nine police officers make up the State Coroner's Assistants Office, which gathers evidence for presentation at coronial inquests. This team is assisted by police officers from the Homicide Squad and the Internal Investigations Division of the Victoria Police. When a death occurs in a non-metropolitan custodial facility, local police officers are likely to undertake investigations. There is thus usually some stability in the personnel undertaking investigations on behalf of the coroner from case to case, which enhances the possibility of developing a preventive investigatory skills base over time.

The narrow focus of coronial investigations received extensive comment in the RCIADIC *National Report*. It was noted that the focus upon "suspicious circumstances" from a criminal liability perspective frequently obscured the need to consider wider systems issues, such as custodial practices and procedures, hospital and emergency procedures, and this narrow focus was necessarily reflected in the findings and ultimately in the recommendations accompanying the findings (RCIADIC 1991, Vol. 1, p. 132).

Possible conflicts of interest

In the case of the police role in coronial investigations into deaths in police custody (and possibly prison custody when police and corrections belong to the same portfolio), there is likely to be either a perceived or actual conflict of interest which might interfere with either the public confidence in the investigatory process, or the actual conduct of the investigatory process. This question was specifically raised by a family member in one of the cases under discussion here, who directly challenged the credibility of the coronial process because she had no confidence in the capacity of police officers to investigate fellow officers impartially. It is noteworthy in this context that the Victorian Deputy Ombudsman (Police Complaints) has the discretion to investigate complaints directly, without the involvement of police officers:

> *if the conduct complained of is of such a nature that he considers it in the public interest that he investigate it or if the conduct complained of is in accordance with established practices and procedures of the Force and the Deputy Ombudsman considers that the practices or procedures should be reviewed* (Victoria 1990).

The Deputy Ombudsman (Police Complaints) investigates, among other things, complaints which involve injuries sustained in police custody, including police pursuits and police assaults. Thus, in two similar investigatory contexts, those of the Ombudsman and the coroner, there are clearly quite different responses to the potential conflict of interest which might arise from police officers investigating police officers and procedures. Cases which the coroner investigates are arguably more serious, in as much as fatalities are more serious than non-fatal injuries. The case for a coronial discretion not to engage police officers in such investigations is at least as strong as the case for the Police Complaints Ombudsman.

The perceived conflict of interest is not assisted by the fact that the same police officers conduct investigations on behalf of both the Victoria Police and the State Coroner simultaneously. It would appear that there is no legal obstacle in Victoria to the coroner choosing not to use police officers, and that the present convention has arisen because of custom and the fact that police officers have access to resources, such as forensic photographers and specialist forensic equipment, which are not readily available elsewhere.

The dependence of coroners on the quality of police investigations received extensive attention in the RCIADIC *National Report*. The breadth and quality of the coronial inquest often "reflected the inadequacies of perfunctory police investigations and did little more than formalise the conclusions of police investigators". The Report emphasised the "general inability of coroners to control the quality of preliminary police investigations which lay the foundation for the subsequent coronial inquest" (RCIADIC 1991, Vol. 1, p. 130). In this context, it is important to note that under existing legislation, the Victorian State Coroner does not have the power to direct Victoria Police, although police are required to report relevant information to the coroner.

Royal Commission Recommendations 26, 27, 28, 30 and 31 all emphasise the need for a solicitor or barrister to be appointed within 48 hours of a death to ensure that "all relevant evidence is brought to the attention of the coroner and appropriately tested" (Rec. 28); and that person "should have responsibility for reviewing the conduct of the investigation and advising the coroner as to the progress of the investigation" (Rec. 30). This does not occur in Victoria, and counsel are appointed only to assist the coroner during the inquest to ensure that relevant matters are raised then. In police shootings cases, barristers have been appointed at an earlier stage in recent years. Barristers may "raise defects or other matters which are then investigated prior to and during the inquest by the Victoria Police" (Victoria 1994, p. 66). In view of the fact that there is usually a delay of around nine months between a death in custody and the time of inquest (and sometimes years elapse), the scope to remedy deficiencies in the investigation of a death after such a long period of time would be dramatically reduced. Indeed, it is highly likely that any person who became involved in a case at such a late stage would have a very limited awareness of any possible deficiencies, particularly if such curiosity is not welcomed by the agency under scrutiny.

Whether or not a barrister would have any more skills in preventive investigation than police officers is a moot point. At least such an individual would be able to provide independent guidance on the conduct of police investigations when conflict of interest considerations arose, as they might in deaths in police custody cases.

The inquest into the 1989 deaths of five prisoners in a fire at Pentridge and the subsequent *Murray Report* (1990) which reported on alleged corruption within the Victorian Office of Corrections testifies to the recent reality of an agency attempting to conceal evidence from the coroner, and the scope for attempted regulatory capture of the coroner by agencies under investigation. Many lessons were learned from this case, and the internal investigatory processes within the Victorian Office of Corrections now appear to be very thorough and feed into a systemic remedial action strategy. Nevertheless, no matter how comprehensive such internal processes are, structural relationships between the coroner and other agencies would ideally ensure independent investigation of all deaths, to avoid real or perceived conflicts of interest in the information gathering process. Of course the extent to which this can actually occur is dependent upon available resources.

The legislative framework

In the initiation of preventive action there is a critical difference between what might be termed a coronial "power" and what might be termed a coronial "responsibility". The difference between "power to comment" and "responsibility to make recommendations" has ramifications for the information collection process in coronial hearings. What is found depends largely upon what is sought. If individual "contribution" has an overwhelming priority in the inquisitorial process, and preventive potential is not so actively pursued, questions which could have a preventive focus are less likely to be asked, and expert or other witnesses with a relevant background are less likely to be called upon to flesh out the preventive picture.

RCIADIC Recommendation 13 not only requires the empowerment of coroners to make recommendations but that the making of recommendations be mandatory rather than discretionary, where the circumstances of a particular death warrant such a response. The *Victorian Government Response to the Royal Commission into Aboriginal Deaths in Custody 1992* stated that Recommendation 13 had been implemented, although the "Action" comment stated that while "there is no statutory duty to do so, the coroner has a discretion under section 19 of the *Coroners Act 1985* to comment on any matter connected with the death including public health or safety or the administration of justice" (Victoria 1994, p. 12). Similarly, under section 21(2), the coroner has a discretionary power to "make recommendations to the Attorney General on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice."

An overseas example of a more explicit and less discretionary statement of responsibility to initiate preventive action can be found in the *Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976* which states in section 6(1) that:

> *. . . the sheriff shall make a determination setting out the following circumstances of the death . . .*
>
> *c) the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided;*
>
> *d) the defects, if any, in any system of working which contributed to the death or any accident resulting in the death.*

In Australia, as in many common law countries, Coroners' recommendations are not enforceable. This is probably not surprising in view of the perceived lack of insider and/or specialist knowledge on the part of coroners about technical matters relating to the wide range of incidents which come before them, including bus crashes, swimming pool drownings, poisonings and deaths in custody. However, investigations which include the testimony of expert witnesses and involve a cooperative approach to hazard reduction are more likely to lead to a mutual understanding of the need for preventive action which ideally would lessen the need for a coercive response.

Prevention and blame¾ legalistic smokescreens

In the subsequent discussion of case studies, it is important to distinguish between the notion of a civil standard of "duty of care" and a preventive approach to the development of acceptable standards of care. The civil notion carries a burden of "blame" and liability. There is an associated emphasis upon whether or not an individual or an agency complied with a given regime of statutory or regulatory requirements, rather than upon the adequacy of these requirements. However, as Johnstone, speaking of coronial investigations generally, points out:

> *. . . "accident" causes are multi-faceted, of which the "contribution", "lack of care" or "negligence" of the individual or corporation is only one aspect.*

Moreover, he notes the comment of Dr Eric Wigglesworth that continuing investigation of individual fault provides:

> *. . . a very effective conceptual smokescreen to prevent the identification and introduction of effective countermeasures* (cited in Johnstone 1992, p. 146).

Indeed, a "blaming" framework of investigation is likely to lead not only to a limitation on the types of evidence sought, but also to a more defensive response on the part of the agency involved and thus a less cooperative approach to the provision of relevant information and the ultimate elimination of hazards.

The quest for a preventive response to problems is likely to move beyond "blame" and look towards a critical assessment of the adequacy of systemic responses to problems, to actively seek out ways in which this response can be improved and refined, to look for patterns of problems and linkages between types of problems which might have common application.

Nevertheless, a consistent notion of an acceptable standard of care and acceptable level of risk in custodial circumstances must form the basis of any coherent and effective preventive strategy. This is particularly relevant to deaths in custody cases in which the individual is often deprived of the means to protect him/herself from risk as well as being placed in a highly stressful environment.

THE CASE STUDIES

Sixteen cases of deaths in custody were selected for study. Fifteen were non-Aboriginal detainees and one was Aboriginal; all were males. Twelve of the deaths occurred in police custody, including three deaths from police gunshot. The remaining four individuals died in prison custody.

The causes of death in the cases selected were self-inflicted hanging (six cases); police gunshot (three cases); aspiration of stomach contents while unconscious (two cases); homicide (two cases); head injuries (one case); combined drugs toxicity (one case); combined alcohol and drugs toxicity (one case). The findings from each of these categories of deaths are summarised in Table 1.

The cases studies were drawn from deaths in custody in Victoria in 1990, 1991 and 1992. Over this time, a total of thirty-one people died in custody in Victoria, twenty-nine of whom were non-Aboriginal and two were Aboriginal. Cases were excluded from the study if the findings did not describe circumstances from which preventive lessons could be learned; for example, cases in which the deceased committed suicide and all reasonable steps were taken by custodial officers to prevent such an outcome, or deaths in custody from natural causes which appeared to have been inevitable. Cases were selected if they contained recommendations or raised standard of care questions which had the potential to generate recommendations. Cases without recommendations were included in the selection to determine whether the issues raised may have been addressed by other formal or informal processes.

The cases were analysed according to the range of custodial health and safety elements which arise from case to case. The elements include the quality of supervision; care of "at risk" detainees (for example management of alcohol affected detainees); cell design; adequacy of existing custodial health and safety guidelines. These elements were assessed according to whether or not the coroner demonstrated an awareness of the relevant standard of care, including awareness of the Royal Commission's coverage of custodial health and safety issues; whether or not the coroner drew attention to inadequacies in custodial health and safety policy and practice; and whether or not the coroner initiated appropriate action to remedy perceived inadequacies in these matters.

In the following discussion, reference is made only to the facts as presented by the coroner in the finding for each case. The findings are the section of the transcript of the coronial hearing which is most likely to be made generally available to the public and forwarded to relevant agencies. The finding is thus the key vehicle through which the public interest in the coronial process is conveyed.

Earlier in this paper, the specific matters which should be investigated in coronial enquiries into deaths in custody were identified. Logically, findings should explicitly relate to the matters investigated and should reflect the themes which are of general public interest in deaths in custody cases. An assessment of the extent to which the duty of care of custodial officers was discharged is assumed to be an essential component of a finding, both to minimise groundless suspicion and to ensure that appropriate remedial action is taken. For example, if the death in custody was associated with intoxication of the detainee, the public has a right to be informed of whether or not the duty of care to the "at risk" detainee was fully discharged. Ideally, the finding would explicitly refer to such key indicators of care as the interval of inspection; whether or not the person received medical care; whether custodial officers checked that the detainee was sleeping in a coma position and was observed to be breathing normally at the time of inspection. Without specific assessment of these matters against an informed "reasonable standard" the public is entitled to be suspicious and the confidence of the community in both the coronial office and the care of custodial officers will be diminished accordingly.

If it is concluded that there were deficiencies in the care of those in custody, these deficiencies should be explicitly addressed through appropriate recommendations thereby maximising the preventive potential of the coronial process.

The decision to take into custody

The findings need to identify whether or not the decision to take someone into custody was the best decision in all the circumstances. If the person was believed to be intoxicated, what was the level of impairment of that person? Would a medical response have been more appropriate? Were alternative facilities available? Was the legal framework within which custodial officers operated conducive to preserving the health and safety of such detainees?

Eight of the cases selected died in police custody after consuming large amounts of alcohol and/or other drugs or were mistakenly suspected of having done so. These cases are summarised in Table 2. While all were, in fact, arrested for drunkenness, in three of these cases no information is provided in the finding about the reason for arrest, although the suspected intoxicated state of the deceased was stated. In one of the eight cases, the person was arrested for drunkenness but died later from head injuries sustained prior to arrest. Although he was known to be a vagrant alcoholic, at the time of admission to hospital some eight hours after arrest, no alcohol was present in his blood. In two of the cases, the detainees died from aspiration of stomach contents after lapsing into unconsciousness having consumed large amounts of alcohol — one died in a police cell and one in the back of a police van. One person died from combined alcohol/drugs toxicity and another detainee died from combined drug toxicity in a police cell, although at the time of death no alcohol was detected in his blood. The last four cases were potentially avoidable deaths and the outcome of the head injuries case may have been different if the detainee had received prompt, appropriate medical care.

In only one of the cases did the coroner mention the issue of decriminalising drunkenness as an alternative response to police custody. However, in none of these eight cases was any recommendation made about the inappropriateness of taking persons into police custody for drunkenness or any acknowledgment of the failure of the Victorian Government to effect legislative reform in this area. In the *Justice Under Scrutiny*

TABLE 1
Summary of Cases

Detainee Case No.	Coroner	Recs	Alcohol	Indig-enous	Cause of death	Date of death	Interval Inspection	Place of Death	Place of Inquest
R.F. 743/90	Phil Byrne	0	Yes	No	Choking on vomit	February 1990	35 mins	Horsham Police Station	Horsham
S.K. 850/90	Clive McPherson	0	Yes	No	Hanging	March 1990	9 mins	Kyneton Police Station	State Coroner's Office
P.C. 1659/90	Peter Couzens	0	No	No	Stab wounds	May 1990	No info	Pentridge	Brunswick
A.W. 2490/90	Iain West	0	No	No	Police gunshot	July 1990	N/A	Melbourne Private House	State Coroner's Office
B.F. 3115/90	Wendy Wilmoth	0	No	No	Hanging	August 1990	No info	Oakleigh Police Station	State Coroner's Office
R.L. 4161/90	Barbara Cotterell	0 Comment	Yes	No	Choking on vomit	November 1990	No info	Police van en route Geelong	State Coroner's Office
P.C. 2022/91	Wendy Wilmoth	0	Yes	No	Combined drugs/ alcohol	June 1991	No info	Frankston Police Station	State Coroner's Office
T.W. 2736/91	Phil Byrne	0	Yes	No	Police gunshot	August 1991	N/A	Ararat Caravan Park	Ballarat/State Coroner's Office
J.W. 2844/91	Wendy Wilmoth	4	Yes	Yes	Hanging	August 1991	35 mins	Bendigo Police Station	Bendigo Magistrates Court
D.S. 3359/91	Wendy Wilmoth	1	Yes	No	Hanging	October 1991	2 hrs 30 mins	Sale Police Station	Sale Coroners Court
G.W. 3950/91	Wendy Wilmoth	4	Other drugs	No	Combined drugs toxicity	December 1991	45 mins	Melbourne Police Station	State Coroner's Office
A.D. 4144/91	Iain West	0	Suspect Yes Deceased No	No	Police gunshot	December 1991	N/A	Kew, Melbourne Private House	State Coroner's Office
M.P. 708/92	Jacinta Heffey	0	No	No	Head & chest injury	March 1992	No info	Bendigo Prison	State Coroner's Office
D.T. 3116/92	Tim McDonald	1	No	No	Hanging	September 1992	No info	Ararat Prison	Ararat
P.J. 3566/92	Jacinta Heffey	1	Suspected	No	Head injuries	November 1992	No info	Melbourne Police Station	State Coroner's Office
R.G. 3826/92	Anne MacDonald	0	No	No	Hanging	November 1992	14 hrs 50 mins	Pentridge Prison	State Coroner's Office

Report of the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, it was noted that as of August 1994, Victoria, along with Queensland and Tasmania, had not decriminalised public drunkenness.

The specific recommendations of the Royal Commission which relate to public drunkenness are Recommendations 79 to 81 and 84, 85 and 135. These recommendations highlight the need for the decriminalisation of public drunkenness and the concomitant need for the provision of alternative non-custodial facilities for the care and treatment of intoxicated persons. Also recommended was the recognition of a statutory duty for police officers to consider and utilise alternative facilities. No comment or recommendations were made in any of the cases on the need for alternative facilities for intoxicated persons in which appropriate supervision can be provided, although in one case, the coroner acknowledged that: "With decriminalisation might come the provision of resources which might enable drunken persons to be dealt with outside police custody" (Case No. 2022/91).

Brain damage symptoms are often indistinguishable from the symptoms of drunkenness to the lay person, particularly if the detained person has sustained a head injury and has also been drinking. Consequently, it is essential that these symptoms should be treated as a medical problem and appropriate steps taken to eliminate the possibility of inadvertent misdiagnosis by custodial officers. Recommendation 135 specifically requires that persons who are unconscious or not easily roused not be transported by police to a watch-house and that he/she be transported to a hospital or medical practitioner. In none of the cases of suspected heavy intoxication was there any acknowledgment of this requirement.

Information on blood alcohol levels at the time of death was provided in six of the eight cases of suspected intoxication. The decision to treat a person as either a policing case or a medical case should depend in part upon observations of the level of impairment at the time of arrest. The quality of this decision has critical ramifications for the risk of death or injury to the detainee. The observations made by custodial officers in making a decision to detain could reasonably be expected to be contained in coroners' findings. However, in only three of the eight cases was information provided about the observed level of impairment of the deceased at the time of arrest. In one of these cases, the deceased was described as requiring assistance to walk and exhibiting signs of extreme intoxication (Case No. 4161/90). In spite of this high level of impairment, the deceased was placed in the back of a police van where he died from aspiration of stomach contents. While the coroner highlighted the need for extremely intoxicated persons to be placed in a supervised coma position, the propriety of a policing response to the situation compared with a medical response was not discussed, nor was the feasibility of providing the required level of supervision in the rear of a police van.

Assessment of risk status

Prisoner medical checklists and/or other guidelines

The Royal Commission (in Recommendations 125 and 126) recommended the development and utilisation of screening forms with which to undertake a risk assessment of detainees prior to placement in a cell. In both the 1992 and 1993 Victorian Government (RCIADIC) Implementation Reports, it was stated that prisoner checklists have been distributed to and are located in all watch-houses. It also stated that it has introduced a "Register of Prisoners" form to be used in conjunction with the checklist, to record medication dispensed, apparent injury or illness and any abnormal behaviour observed (Victoria 1992, p. 78; 1994, pp. 134-5).

According to the Victorian Police Prisoner Medical Checklist, custodial officers should check for suggestions of suicidal ideas or behaviour and also for signs of alcohol/drug withdrawal. As can be seen from Table 2, the checklist was not used in any of the five cases to which it was relevant, and coroners were critical of the failure to use the checklist in all of these cases except one in which it was not mentioned at all. However, recommendations relating to its use were made in only one of the cases. In none of the cases which occurred before the introduction of the checklist was there mention of the need for such an assessment tool and none of the cases referred to the Royal Commission's recommendations or discussion of this matter.

TABLE 2
Alcohol or Suspected Alcohol-Related Cases

Date of Death Detainee	Name Coroner	Recs	Cause of death	Arrested drunk	Blood Alcohol Level at Autopsy	Medical Check-list relevant	Medical Check-list mentioned	Medical Check-list used	Criticism failure to use	Other guide-lines mentioned	Interval inspect-ion	Place of cus-tody	Indig-enous
February 1990 R.F.	Byrne	0	Choke vomit	(Yes) No info	(0.272) No info	No	N/A	N/A	N/A	No	35 mins	Police cell	No
March 1990 S.K.	McPherson	0	Hanging	Yes	0.245	No	N/A	N/A	N/A	No	9 mins	Police cell	No
November 1990 R.L.	Cotterell State Coroner's Office	0	Choke vomit	Yes	0.389	No	N/A	N/A	N/A	No	No info	Police van	No
June 1991 P.C.	Wilmoth State Coroner's Office	0	Combined alcohol/ drugs toxicity	(Yes) No info	0.17	Yes	Yes	No	Yes	Yes	No info	Police cell	No
August 1991 J.W.	Wilmoth Deputy State Coroner	4	Hanging	Yes	0.22	Yes	Yes	No	Yes	Yes - S.O. 9.10 removal shoelaces	35 mins	Police cell	Yes
October 1991 D.S.	Wilmoth Deputy State Coroner	1	Hanging	(Yes) No info	0.15	Yes	N/A	N/A	N/A	Yes - S.O. 9.3(2) 9.81 9.69 interval inspection	2 hrs 30 mins	Police cell	No
December 1991 G.W.	Wilmoth Deputy State Coroner	4	Drug overdose	Yes	0	Yes	Yes	No	Yes	Yes - S.O. 9.74 seek medical advice	45 mins	Police cell	No
November 1992 P.J.	Heffey State Coroner's Office	1	Head injuries mis-diagnosed drunk	Yes	0 Admission hospital	Yes	Yes	No	Yes	No	No info	Police cell	No

Notes:
S.O. - Standing Order
N/A - Not applicable

The Prisoner Medical Checklist was disseminated in 1991, and was apparently published in all watch-houses in November 1991. While it is required that the checklist be clearly visible in watch-houses, there is no formal requirement that custodial officers must assess all prisoners according to the checklist. The fact that RCIADIC Recommendation 123 advised that "instructions relating to the care of persons in custody should be in mandatory terms and be both enforceable and enforced" was not noted by any of the coroners, nor was the general strategic importance of a mandatory approach acknowledged, even though lives had been lost after failure to utilise the checklist in the cases under investigation.

Prior to the development of the Prisoner Medical Checklist, a Force Circular Memo on the Care and Welfare of Prisoners was circulated by Victoria Police on 24.12.1990. Section 3.6 states that:

> *The physical well-being of prisoners must be assessed. Where health problems may occur, for example, a heavily intoxicated prisoner, or a prisoner suffering drug withdrawals, in addition to any consultation with a Forensic Medical Officer or other Doctor, the prisoner must be physically checked as often as possible, but at least once every hour. Other prisoners must be checked at least every four hours including change of shifts.*

In one of the cases of suicide of an intoxicated detainee, in which the interval of inspection had been two hours and thirty minutes, the Deputy State Coroner who heard the case discussed at length the interpretation of the meaning of Standing Order 9.3(2) that prisoners be observed frequently; of Standing Order 9.81 that prisoners charged with drunkenness be visited as often as practicable; and, of Standing Order 9.69 that mentally ill prisoners shall be visited at least every half-hour. While the coroner concludes that "all reasonable steps to care for the prisoner" were taken, the finding also stated that "it would have been preferable if at least one more observation had been made, in keeping with what appears to me to be intended by Standing Orders" (Case No. 3359/91).

This case provides an interesting cameo which demonstrates the short-comings of a civil notion of a standard of a duty of care compared with an ideal preventive standard of custodial care. It would appear that the emphasis upon "blame" or whether or not the custodial officers complied with the intention of Standing Orders blurs the focus upon the adequacy of the Standing Orders themselves. The coroner drew attention to the lack of clear guidance for custodial officers and focussed upon whether or not their behaviour was within the confusing guidelines and standing orders, rather than upon the need to provide more clear and effective guidance for such officers on what might constitute an acceptable interval of inspection. No recommendation was made that this matter be addressed. In short, this appears to be an instance in which legal blinkers obscure a preventive focus. While remarking that the behaviour of the deceased did not alert police to any idea that he might take his life, there is also reference to the lack of observation of his behaviour, but the coroner did not highlight that this might actually explain why the police had no suspicions. In this same suicide case, the findings contained extensive discussion of the delays in the installation of closed-circuit television monitoring equipment in the watch-house prior to the death of the detainee. The coroner noted with approval that, after the death, cameras had been installed. The coroner also noted in a recommendation that such cameras must be supplemented by some means of communication between prisoners and the watch-house keeper, such as an alarm button, so that emergencies could be communicated. While acknowledging that, in this case, more frequent inspections would have been "preferable" in the absence of monitoring equipment, the coroner did not appear to be aware of the Royal Commission's Recommendation 139, relating to the use of TV monitoring devices in police cells, which emphasised that "where such equipment has been installed, it should be used only as a monitoring aid and not as a substitute for human interaction between the detainee and his/her custodians" and that "personal cell checks be maintained" (RCIADIC 1991, Vol. 3, p. 247). The mild tone of the finding by the coroner could have been interpreted as tacit approval of the use of electronic equipment as a substitute for human interaction, which would have contradicted the thrust of the RCIADIC recommendation.

Communication about risk status

The communication of information about the potential suicide risk of the detainee was commented upon in two of the hangings cases in correctional custody, giving rise to a specific recommendation in one case and in the other case communication of information was not problematic.

Quality of supervision

Interval and quality of inspections

Recommendation 137 of the Royal Commission focuses upon the timing and quality of inspections of detainees in police custody. In particular, part (b) states that:

> *During the first two hours of detention, a detainee should be checked at intervals of not greater than fifteen minutes and that thereafter checks should be conducted at intervals of no greater than one hour;*

and part (d) states that prisoners at risk "should be subject to checking which is closer and more frequent than the standard" (RCIADIC 1991, Vol. 3, p. 246).

According to both the 1992 and 1993 Victorian Government (RCIADIC) Implementation Reports, Police Standing Orders instruct members to check all prisoners who are heavily intoxicated or suffering from health problems as frequently as possible and at least once per hour. All other prisoners must be checked regularly, at least every four hours, and at change of shift (Victoria 1992, p. 85; 1994, p. 143). There is clearly some discrepancy between the RCIADIC recommended standard and the Victorian standard. The RCIADIC recommended standard was not mentioned by any of the coroners in any of the cases and there was no discussion of the adequacy of the required standard against the recommended standard.

It should be noted that under New South Wales police guidelines for the care of "at risk" detainees, checks were required to be made every ten to fifteen minutes (RCIADIC 1991, Vol. 3, p. 214). There is clearly some latitude (between one hour and ten minutes according to the documents cited here) for what might constitute an "acceptable" interval of inspection and there is some need for clarification of precisely which detainees should be assessed as "at risk". At present in Victoria, the required interval of inspection for "acute arrests", that is those who are arrested "off the street" and about whom no medical information is available, is every thirty minutes for the first four hours.

As can be seen from Table 1, information about the interval of inspection was not provided by the coroner in the findings of seven of the thirteen cases to which this issue is relevant. In all cases but one, the only information which is given is the time at which the inmate was previously inspected and not the regular inspection routines in the facility. Information about the quality of inspection was provided in only a couple of cases.

Four of the cases fell within the required standard of interval of inspection, and only one fell within the RCIADIC recommended standard. Police Standing Orders or other equivalent guidelines on required intervals of inspection were referred to in only one case. Coroners were critical of the interval of inspection in two cases: strongly critical in the most egregious case (fifteen hours) and mildly critical in another (two hours and thirty minutes). The failure to refer to an accepted standard of care or acknowledge existing guidelines in almost all cases does not foster the systematic development and recognition of consistent and adequate standards of custodial care. None of the cases contained recommendations relating to interval of inspection.

In none of the cases in which the detainee should have been classified as "at risk" due to intoxication or suspected intoxication was there any mention of the increased risk of self-inflicted harm because of diminished power to reason or as a result of the increased predisposition to depression which accompanies withdrawal from alcohol. The need for more frequent and more intensive inspections of such detainees was not acknowledged in any of the alcohol-related suicide findings. In only one of the two cases in which detainees died from choking on vomit was there reference to the need to place heavily intoxicated persons in a coma position. In this case, a specific comment was made to this effect.

Cell design

All of the six cases of self-inflicted hangings were facilitated by the existence of anchorage points in cells. However, in three of the six cases, the design of the cell did not attract adverse comment. Specific reference was made to the inadequacy of the cell for an "at risk" detainee in one case, and in another, anchorage points were removed from the cell after the death occurred, which was commented upon favourably. Only the case involving an Aboriginal detainee led to a specific recommendation calling for the inspection of all police cells in the State to locate anchorage points, with a view to assessing the feasibility of their removal.

Police shootings cases

Before examining the three police shootings cases selected for analysis, it is useful to digress a little and consider the findings of Coroner Hallenstein in relation to seven other cases of police shootings. The high number of police shootings in Victoria since the late 1980s resulted in a special investigation by then State Coroner Hallenstein into the deaths of seven people in police operations some six years after the earliest of the deaths. These seven deaths do not involve any of the cases under discussion here.

In the lengthy Hallenstein findings, the coroner was particularly critical of the composition of police training. He stressed the need for police officers to avoid high risk situations in which use of lethal force was likely to occur, such as the use of forced entry raids as a first and only option. He advocated a change in police training and policy in order to emphasise more strongly the need to preserve the safety of police officers, the general public and suspects. He also drew attention to the existence of "a police ethic or culture of a police member's public duty requiring courage and physical exposure to personal risk" which is "reflected by the essentially counter-terrorist-type function of the Special Operations Group" (Hallenstein Findings, Case No. 695/88).

Hallenstein made comparisons between the Victorian Police and the New York Police in attitudes to the use of lethal force. He noted that both police forces had a similar policy on the use of minimum force, the avoidance of the use of firearms and the paramount importance of the safety of the public, police and suspects. However, the New York Police are required as a matter of policy to achieve their operational objectives without using guns, whereas the Victorian police are "apt to use guns if the situation arises, [are] not specifically required as a matter of policy to achieve operational objectives without using guns" (Hallenstein Findings, Case No. 695/88).

In his 1994 finding on the police shooting of Alfred Sader, Hallenstein set out five propositions for policy in police operations concerning dangerous people who have or might have guns. The central principle of these propositions is that police should actively avoid situations in which they might be exposed to a dangerous person who has a gun, recognising that "the personal safety of police members best ensures use of minimum force, best ensures avoidance of firearms use and best ensures the safety of the public and of suspects as well as police" (Hallenstein Findings, Case No. 695/88).

Coroner Hallenstein proposed a test for the use of police firearms force and confrontation: "if, and only if all other response has not achieved and cannot achieve safety of police and safety of the public in circumstances of imminent injury or death by conduct of a dangerous person with a gun" (Hallenstein Findings, Case No. 695/88).

While noting that this finding was only presented in June 1994, some six years after Sader's death in February 1988, Hallenstein's test provides a framework for deducing some of the elements of the public interest in police shootings cases. These elements of the test were applied retrospectively to the three lawful homicide cases under investigation in the present study. They include whether or not all available options to the use of lethal force were explored; the availability of medical services in the case of a siege or raid; and access to psychiatric services if appropriate.

In the three cases under investigation in the current study (not Hallenstein's cases) the findings contained extensive examination of the sequence of events leading to the deaths, the background of the suspect and the options open to the attending officers. Two of the cases were heard by the Deputy State Coroner and the third by a coroner who was also a regional magistrate.

In one of the cases, the coroner was critical of the decision to effect a forced entry raid on the premises rather than commence negotiation with the occupants of the house. "Negotiation of a peaceful surrender should have been the paramount consideration given the information available" (Case No. 4144/91). The coroner found that the officer in charge of the Special Operations Group (SOG) raid had contributed to the cause of death through his decision to effect the raid. He referred to the Police Force Circular Memo no. 5 of 1989 under the heading "Siege/Hostage Situations", which states that "the most important factor working in favour of the police in these situations is time".

In this same case, the coroner was also critical of the distortion of information about the suspect that occurred in the course of the communications between officers, stating that "it is essential that every attempt is made by investigating police to obtain and communicate the most accurate information". The failure to secure the attendance of an ambulance at the time of the raid also attracted criticism from the coroner, as did the delay in notifying the next of kin of the death of the deceased.

In spite of the strong criticism of the actions of the officers, no explicit recommendations accompanied this case which might have lead to the avoidance of future deaths in similar circumstances. Given the alarmingly high number of police shootings in Victoria, this is noteworthy. While it might be argued that the coroner's critical remarks should have been sufficient to initiate a remedial response, crafting a specific recommendation would ensure that need for corrective action was communicated explicitly and ideally an appropriate response would follow. Perhaps the coroner could have recommended that ambulances should always be in attendance or that armed force should only ever be used as an absolute last resort. No recommendations were made in either of the other two findings, and there was no criticism of the actions of the officers nor of police policy.

Another of the police shootings cases demonstrates the application of a civil "blameworthiness" framework to an investigation, and the consequences of failure to consider a preventive perspective. In considering the decision to conduct a forced raid, the coroner stated:

> *Whilst it is difficult to find much in the way of persuasive support for the decision, among the list of considerations contained in . . . statement, I do believe there was justification for the decision based on the SOG members' deteriorating operational effectiveness due to deplorable weather conditions and their inability to obtain relief. In these circumstances the decision of forced entry as against containment, cannot be said to be so unreasonable or inappropriate as to amount to contribution to the cause of death* (Case No. 2490/90).

He further stated that, at the time of the shooting: "There was no indication that the deceased was contemplating any violent act or was a danger to the public or himself, with his condition at the time believed to be improving" (Case No. 2490/90). The coroner acknowledged that the operational weakness of not being able to obtain relief staff had been corrected since the shooting. However, the preventive lessons to be learnt from the incident were considered in only one short paragraph, and the need for SOG members always to have access to wet weather gear was not mentioned.

Unlawful homicide cases

In two of the cases selected the deceased died as a result of injuries sustained during a violent attack while in prison. The coroners' findings on these cases are each less than half a page long, and provide the briefest description of the identity of the deceased, the location, time and circumstances of the death. There is no reference to any health and safety matters relating to the custodial circumstances of the deceased.

There is an ongoing debate in coronial circles (at Australian Coroners' Society conferences and elsewhere) about the proper way to proceed with an inquest when it is discovered that the cause of death involves homicide. This debate is reflected in differing legislative approaches from State to State in Australia. In some jurisdictions, coroners have the power to refer cases in which it is suspected that an indictable offence has been committed to the Director of Public Prosecutions, as is the case in Victoria. In other jurisdictions, including South Australia, coroners do not.

If it appears that persons could be charged with a murder or manslaughter, the inquest is usually adjourned, pending the outcome of a trial. When no charges are laid, the inquest usually proceeds. If the coroner believes that an indictable offence has been committed, the matter must be referred to the Director of Public Prosecutions.

The debate revolves around the relationship between a criminal hearing and the coronial hearing, both of which can deal with the same case at different times, although the rules of evidence apply in the former and not in the latter. Thus it is possible that different evidence on the same case could be presented in the two different forums and the coroner's finding might then not be consistent with the verdict of the criminal trial, which can lead to public disquiet and possibly bring disrepute to either or both proceedings. In addition, there are potential civil liberties concerns in that evidence could be presented in the coroner's inquest which could be misused in a criminal trial. As a result, coroners' findings in such cases are usually very brief, in an attempt to avoid these pitfalls.

In the brief coroners' findings which usually follow a homicide, preventive issues are not addressed. These matters could include the quality of supervision of detainees; responses to previous incidents in which the detainee may have been injured; whether the detainee disclosed fears for his/her safety and whether these fears were responded to effectively. None of these matters was referred to in the findings of the cases under consideration.

This brevity of the coroner's findings in each case is in stark contrast with the two detailed reports of the comprehensive internal Office of Corrections (OOC) investigations into the two deaths. In one OOC report, criticism was made of the lack of security of prison tools and equipment, and recommendations made

TABLE 3
Recommendations/Comment made by Coroners

Anchorage points	Medical check-list usage	Care of intoxicated persons	Employ medically trained nurse	Emergency communication mechanisms	Aboriginality training/ understanding	Systemic communication of information
J.W. 29/8/91 D.O.D. Wendy Wilmoth Deputy State Coroner	P.J. 2/11/92 D.O.D. Jacinta Heffey State Coroner's Office	R.L. 6/11/90 D.O.D. Barbara Cotterell State Coroner's Office *Comment only*. First aid - not medical check	G.W. 1/12/91 D.O.D. Wendy Wilmoth x 4 Deputy State Coroner	D.S. 10/10/91 D.O.D. Wendy Wilmoth Deputy State Coroner	J.W. 29/8/91 D.O.D. Wendy Wilmoth x 3 Deputy State Coroner	D.T. 25/9/92 D.O.D. Tim McDonald Regional Magistrate/ Coroner

Note: D.O.D. - Date of death

regarding the need for a tightening of procedures in relation to this matter. Recommendations were also made on the need for more regular searches of cells. The deceased in this case died from stab wounds and other injuries sustained in the prison gymnasium in a swift and apparently well-organised attack. In the other OOC report, recommendations were made relating to the management of emergency incidents within the prison. These concerns could also have been reflected in coronial findings for each case, and appropriate recommendations made. This did not occur, however. In both cases, the internal investigation reports demonstrate that the prisoners received swift and appropriate medical assistance.

CORONERS' RECOMMENDATIONS

Which cases included recommendations?

Sixteen of the total of thirty-six cases of deaths in custody occurring in Victoria during the period 1990-1992 were selected for examination in this study. Only five of the thirty-six cases contained recommendations. One other case, in which the person died from the aspiration of stomach contents, contained a comment upon the vulnerability of intoxicated detainees. Table 3 sets out the number and types of recommendations made. Three of the five cases which contained recommendations were suicide cases and in the other two cases, the detainees died from head injury and drug toxicity respectively. The cases which involved lawful homicide (police shootings) or other homicide did not contain recommendations.

Overall, ten different coroners heard the cases selected, three of whom were also regional magistrates. Of the total of twelve recommendations made, nine were made by one coroner who heard three of the cases.

The case in which an Aboriginal man died from self-inflicted hanging in police custody generated four recommendations, three of which were concerned with the need for greater awareness of the Aboriginal socio-cultural issues, and the other focussed upon the need to eliminate anchorage points.

The small number of recommendations and the wide range of issues covered does not allow any assessment of the impact of recommendations made upon subsequent deaths. In any case, the crafting of a recommendation is only one of the first steps in a preventive strategy which ideally would end with remedial action. This study does not examine the strengths and weaknesses of the recommendation implementation process, although additional research in this area is planned.

The main conclusion to be drawn from the above analysis of patterns for the inclusion of recommendations is that not enough advantage is taken of the opportunity to learn preventive lessons from investigations into deaths in custody cases, and this deficit is reflected in the lack of appropriate recommendations, overall. While many matters were the subject of implicit or explicit criticism by the coroner, recommendations which might have led to remedial action were made in only a few cases and mostly by one coroner.

Targeting of recommendations

Recommendations were generally targeted to the appropriate agency, implicitly if not always explicitly. One recommendation was directed specifically to the Police Department and was specifically referred to the Attorney General for dissemination. Another set of recommendations was directed to "the appropriate authority"; however, a specific recommendation that the finding be "distributed to officers in charge of all police stations which contain facilities for holding persons in custody" was also made in this case. The Department of Justice is the agency to which another recommendation is directed regarding the availability of prisoner documentation. In another two cases, the content of the recommendations clearly implies that the Victorian Police would be the responsible agency, although this is not specifically articulated. The failure to specify explicitly who would be responsible for implementing recommendations in these cases can blunt accountability. In all cases, recommendations were framed so as to have application to similar circumstances anywhere in Victoria where appropriate for example all police stations, all police training.

Appropriateness of recommendations

In all cases in which recommendations were made, the recommendations were generally appropriate to the circumstances of the death. However, in the case in which a heavily intoxicated man died in the rear of a police van after being arrested for drunkenness, comment was made on the need to ensure that such detainees remain in a supervised coma position, without consideration of the feasibility of ensuring this or the appropriateness of a policing response compared with a medical response to such a circumstance. Other matters which were the subject of general or specific comment could have been highlighted through the formulation of specific recommendations, to ensure that action would be taken to remedy problems identified, such as the frequency of inspection of "at risk" detainees. Many more issues were the subject of discussion than were the subject of recommendation.

Identification of patterns of death

Over the late 1980s and early 1990s, there appears to have been an increase in the number of deaths in police custody in Victoria which followed arrests for drunkenness. In 1990, five people died in this circumstance, which is the highest recorded number per year since 1981. The change in the number of deaths per year is too small to indicate whether or not the increase was statistically significant. Nevertheless, the increase should arguably have been noticed by coroners and responded to, at least to the extent of noting any emerging patterns. There is no evidence that there was any awareness on the part of the coroners of the links between these cases or the legislative position in Victoria in relation to the decriminalisation of public drunkenness. The fact that the eight cases in this study were heard by five different coroners may have contributed to the lack of awareness of the magnitude of the problem or any developing trend.

DISCUSSION

Frequently in the cases under discussion here, the coroner focussed primarily upon individual "contribution" to the death, and the circumstances of deaths were considered from the point of view of whether or not anyone was blameworthy for the death. Sometimes, reference was made to existing guidelines which were relevant to the circumstances of the case. However, the focus upon whether or not the custodial officers acted within existing guidelines detracted from taking advantage of the opportunity to assess the effectiveness of those guidelines. There is therefore an urgent need for the provision of prevention-specific training for all those involved in the investigation of health and safety hazards. Coroners, investigatory police officers, medical professionals and others could all benefit.

It is useful to consider why coroners might feel so attached to blame models. The legal training of coroners and investigatory officers has already been mentioned. However, it may also be the perceived lack of alternative tools and frameworks which may hinder the weaning process. At least the civil model of legal process provides a reasonably solid framework for representing individual interest in the furtherance of the public interest. This framework works well to the extent that it defines a purpose for the process and focuses this process in relation to clearly defined outcomes, in the form of identifying liability and awarding compensation.

By contrast, the preventive model for the coronial process is still in its formative developmental stage. The framework for the representation of the public interest is much less clear as is the means of defining appropriate purposes and outcomes. This apparent lack of framework needs to be remedied and the vacuum filled with appropriate tools and clearly defined purposes and new concepts of appropriate outcomes. At the moment, it would appear that the vacuum is being filled by the application of established but inappropriate skills without a clear sense of the limitations of these skills in the new context.

This issue has critical ramifications for the effectiveness of the coronial process as a springboard for prevention. Standards are blurred, therefore the impetus for correction is correspondingly muddled. Similarly, accountability is blurred, since the threshold of "adequacy" is less clearly defined. Thus, it is much harder to hold an agency to account and to gain the leverage which might lead to remedial action.

Some useful beginnings have already been made in creating a new framework in the coroners' jurisdiction in relation to other causes of death, such as single vehicle accidents in Victoria. In this context, a team approach has been applied to the identification of risk factors from which to develop preventive strategies. Injury prevention specialists from the Accident Research Centre at Monash University are engaged with the coroner, along with the Victoria Police, in developing strategies to reduce the number of single vehicle accidents. This type of model holds promise for the investigation of other types of deaths, including deaths in custody.

In the deaths in custody context, a key constituent of an alternative framework is apparently being overlooked, and this is the framework provided by the recommendations of the Royal Commission. This framework provides not only guidance on acceptable standards of general custodial health and safety, but also a useful comprehensive accountability structure, which can minimise the risk of threats to the integrity of the coronial process, such as conflicts of interest, narrow legal focus and inexperience in deaths in custody matters. In an environment in which the representation of the public interest is apparently so diffuse, the importance of holding on to existing frameworks of acknowledged acceptable standards of care is that much more important.

Unfortunately, the cases examined in this paper do not demonstrate any great awareness of the issues raised by the Royal Commission. The standard of care which has been applied in these cases is the standard of the individual coroner. Not surprisingly, there are different standards from coroner to coroner. Such a range of standards makes it more difficult for agencies to know whether the particular remarks which might be made in one case reflect a community standard of care or the particular idiosyncrasies of an individual coroner. In such circumstances, it is easier for agencies to dismiss critical comments as unreasonable, since from past experience it is known that the same set of circumstances may have been regarded in quite a different light, and not resulted in critical comment let alone recommendations for remedial action. This variation in standards of care is at once disconcerting to the relevant agency which is the focus of comment and also creates uncertainty in the protection of the public interest, since the public interest is not served by poorly defined standards.

The evidence presented here of inconsistencies in standards of custodial care and lack of awareness of custodial health and safety matters testifies loudly in support of the Royal Commission's recommendation that deaths in custody cases should be heard only by State Coroners and/or Deputy State Coroners. Given the wide range of cases with which coroners must deal, this is the only way in which it can be assured that specialist experience in deaths in custody will be applied to all cases, and the public interest reliably protected.

CONCLUSIONS

Coroners' inquests have the potential to impact upon the incidence of deaths in custody. This study has shown that much of this potential has been over-looked in the development of findings and recommendations. In most cases, the focus of coronial investigations on individual fault and not upon remedying the failure of custodial systems and standards has been the central explanation for this oversight.

Assessment of circumstances of death against a blame ledger leads to a false sense of rigour. This blaming approach has also led to the consideration of each case in isolation, without regard for any other cases which might have involved similar systemic risks factors. The limitations of this approach must be acknowledged by coroners if alternative approaches are to gain acceptance. New frame-works and tools are required if the preventive potential of the coronial jurisdiction is to be fully realised.

The extent of inconsistency in the treatment of deaths in custody cases has ramifications not only for the prevention of deaths, but also for the effectiveness of the coronial process as an accountability instrument. The protection of the public interest requires full presentation of relevant information, from which outside observers can determine whether or not the standard of care provided was adequate. These cases demonstrate that the information provided in findings is very variable in quality and coverage. It is not possible to determine whether the deficit reflects deficiencies in custodial care or deficiencies in the coronial process, or both. This matter raises questions about the accountability of the coronial process itself, the identity of stakeholders and their influence or lack of influence over the soundness of the process.

While the development of a proposed National Coronial Information System database would be of enormous assistance in the enhancement of the preventive potential of the coronial process, this potential will not be realised unless robust frameworks are developed which ensure consistency in the quality and presentation of information and the thoroughness of the preventive investigatory process. Moreover, such a database will need to be supplemented by a well-resourced and multi-disciplinary research team so that patterns of incidents can be identified and effective remedies achieved by supplementing records of the Australian experience with international experience. In the meantime, the Victorian coronial database could be of great assistance.

Overall, this study shows that there is still some distance to go in moving from a fact-finding/warning-provision coronial role to one of actually initiating preventive action. Without this cultural shift, and without the distillation of awareness of deaths in custody issues in a small number of senior coroners to whom all deaths in custody cases would be specifically allocated, the critical mass of specialist expertise and personal commitment is unlikely to develop. Such individual coroners can make it their business to ensure that the policy momentum generated by the Royal Commission is enduring, and that this critical window of policy opportunity does not slowly close over, leading to subsequent preventable deaths and injury. Each coronial inquest provides a the opportunity to breath new life into this process.

REFERENCES

Brend, W.A. 1907, "Bills of mortality", *Transcripts of the Medico-legal Society*, vol. 5, p. 140.

Hallenstein, H. 1986, "The twentieth century coroner: A review of the Coroners Act 1985", *Law Institute Journal*, vol. 60, no. 10, pp. 543-4.

Jervis, J. 1946, *On the Office and Duties of Coroners*, 8th edn, Sweet and Maxwell, London.

Johnstone, G. 1992, "An avenue for death and injury prevention", *The Aftermath of Death*, ed. H. Selby, Federation Press, pp. 140-84.

Law Reform Commission [England] 1971, *Report of the Committee on Death Certification and Coroners*, (Brodrick Committee Report), CMND 4810, Home Office, London.

Murray, B.L. 1990, *Report on the Behaviour of the Office of Corrections*, [The Murray Report], tabled by the Minister for Corrections 7.3.1990, Melbourne.

New South Wales 1975, *Report of the Law Reform Commission on the Coroners Act 1960*, LRC 22, Government Printer, Sydney.

Norris, J. 1980, *The Coroners Act 1958—A General Review*, Law Department, Melbourne.

Ontario Law Reform Commission 1971, *Report on the Coroner System in Ontario*, Department of Justice, Toronto.

Pilling, H.H. 1972, "The Brodrick Report, 1: A general view", *Criminal Law Journal*, February, pp. 70-7.

Public Interest Advocacy Centre 1988, *Review of the Coronial System in New South Wales: Preliminary Note to the Attorney General of New South Wales, Submission*, PIAC, Sydney.

Royal Commission into Aboriginal Deaths in Custody 1991, *National Report*, Australian Government Publishing Service, Canberra.

Selby, H. (ed.) 1992, *The Aftermath of Death*, The Federation Press, Sydney.

Victoria 1990, *Seventeenth Annual Report of the Ombudsman*, Government Printer, Melbourne.

---------- 1992, *Victorian Government Response to The Royal Commission into Aboriginal Deaths in Custody*, Government Printer, Melbourne.

---------- 1994, *Royal Commission into Aboriginal Deaths in Custody: Victorian Government 1993 Implementation Report*, Government Printer, Melbourne.

Waller, K. 1994, *Coronial Law and Practice in New South Wales*, 3rd edn, Butterworths, Sydney.

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