As Good as Their Word: A Reply to Melville, Jeans, Adcock and Preston

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The Criminal Justice Commission recently observed that there is a considerable difference between reporting on the fact of implementation and evaluating its success or impact.[1] Healthy scepticism is an important ally in ploughing through the volumes of official responses to the 339 recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).

There is, no doubt, much to commend in the Queensland Police Service's (QPS) response to the 100 recommendations referred to in Table 1 of Melville et al's article. The initiatives described demonstrate that many police have taken the Royal Commission's sometimes searing criticisms to heart. Individual programs such as the mobile cross-cultural training unit and the community based intensive training program show a commitment to attitudinal change and recognition of some of the principal findings of the Royal Commission.

Nevertheless, the public is entitled to ask questions about the real value of the RCIADIC dividend. After all the initiatives described by Melville et al apparently cost about $3.36 million over two to three years. That is a lot of extra money, and one would expect something to show for it. Melville et al tell us what that is. The question is whether those programs have brought a fundamental change in the policing practices so roundly criticised in the Royal Commission.[2]

Rather than respond to each program detailed by Melville et al, this article focuses on the key area of watchhouse procedures and demonstrates that expensive programs with reassuring titles do not always translate into better police practice. In the benchmark areas of custodial health and safety and the duty of care owed to detainees, the gap between Royal Commission word and implementation deed remains considerable.

Custodial Health and Safety

> The Overview Committee acknowledges the considerable effort by the Police Service in producing the Police Custody Manual ... However, until the operational procedures in [this manual] are embraced, given strict adherence, and carried out to the letter of the law,

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1 Criminal Justice Commission, *Report on the Implementation of the Fitzgerald recommendations relating to the Criminal Justice Commission* (1993) at vi.

2 See eg, Wyvill, L F, *Regional Report of Inquiry in Queensland* (1991) Royal Commission into Aboriginal Deaths in Custody at 20–36.

> the high risk situation of Aboriginal and Torres Strait Islander people in custodial environments will not have changed.[3]

The Royal Commission's Regional Report of Inquiry in Queensland, reviewing the 27 deaths in custody which occurred in this state between 1980 and 1989, isolated five cases as preventable deaths in the sense that "they would not have occurred if the custodial authorities had adequately attended to their responsibilities". Amongst the failings it particularised were "entrenched habits of non-compliance by police with General Instructions" and "a failure to give sufficient attention or appropriate priority to the assessment of the condition of a detainee before placing that person in a particular cell".[4]

Surely amongst the wealth of policy prescriptions generated by the Royal Commission, few were more specifically directed to preventing future deaths in custody than mandating police compliance with appropriate watchhouse procedures and ensuring medical assessment and treatment for those at risk of dying behind bars. It is worth examining more closely just what progress has been made over the past few years on these two fronts.

1. April 1988: Draft Guidelines on Preventing Aboriginal Deaths in Custody

The Royal Commissioner for Queensland, Lew Wyvill QC, points out in the Regional Report that police services around the country were first alerted to the importance placed by the Royal Commission on assessing the condition of detainees by the circulation of guidelines for the prevention of Aboriginal deaths in custody in April 1988. The Queensland Police Service responded that General Instruction 9.467(h) dealt with this situation.[5] It was the first in a long line of reassuring references to written procedures. Unfortunately, despite these assurances, deaths in custody have continued to occur and many of the investigators' findings — including disregard for or ignorance of explicit police instructions, and the failure to obtain medical assessment for detainees in distress — have a depressing familiarity for those acquainted with the original Royal Commission investigations.

2. December 1988: Justice Muirhead's Interim Report

In December 1988, Muirhead J published the Interim Report of the Royal Commission. The purpose of releasing the Interim Report was preventive — although examination of the "underlying issues" of social and economic disadvantage meant the Royal Commission would continue sitting until 1991, it was seen as imperative that immediate recommendations designed to eliminate preventable deaths in custody reach the desks of the relevant authorities. Recommendation No 12 could hardly have been more emphatic:

> In no case should a person be transported by police to a lock-up or watch-house when that person is either unconscious or not easily roused. Such persons must, if found on a patrol, be immediately taken to a hospital or medical practitioner or, if neither facility is available, to a nurse or other person qualified to assess their health.

The subsequent death of Barbara Tiers and Muriel Binks caused Commissioner Wyvill to lament:

> How then did it come to pass that on 1 February 1989 Barbara Tiers, who had to be carried to her cell, was left to lie in the Rockhampton Watchhouse, and, that three weeks

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3 Department of Family Services and Aboriginal and Islander Affairs, *Queensland Government Progress Report on Implementation to December 1993*, Vol 1: Summary at 29.

4 Above n2 at 27.

5 Id at 34–5.

later Muriel Binks should be locked up in the Innisfail Watchhouse when her condition was such that she could not give her name when first arrested? [6]

3. *March 1989: The Death of Muriel Binks*

Muriel Binks was 38 when she died in Townsville General Hospital in March 1989. The pneumonia which damaged her lungs, liver and kidneys and led to her death was contracted on the day of her arrest in Innisfail, two weeks earlier. Commissioner Wyvill found that had she received medical treatment the night she was taken into custody or even the following morning when her symptoms were manifest "it is very likely ... that this damage could have been halted and that she would have survived".[7] Instead Muriel Binks finally left custody for hospital at 4.40 in the afternoon, by which time her chances of survival had fallen dramatically.

What particularly distressed Commissioner Wyvill about the death of Muriel Binks was that:

> [I]t occurred after the delivery of Commissioner Muirhead's Interim Report and after numerous publicised hearings of the Commission in this State and elsewhere in the Commonwealth had highlighted deficiencies in existing legislation and custodial and investigatory procedures.[8]

The report into Muriel Binks' death referred to the duty of care owed by police to those in their custody and said that the duty:

> [E]xtends to providing appropriate medical treatment for illnesses which may strike a prisoner, be they contracted prior to or during custody ... [and] ... to taking measures to prevent the contraction of illness as a consequence of confinement or to minimise the risks of any illness worsening. These must include reasonable supervision.[9]

Commissioner Wyvill added that these common law duties were reinforced by provisions of the then Queensland Policeman's Manual and various Commissioner's Circulars.

In Muriel Binks' case, the failings of the Queensland Police were "not those of commission but of omission — neglect, ignorance and uninquisitiveness".[10] Commissioner Wyvill found infrequent supervision, "universal disobedience" of instructions to personally check prisoners on a regular basis,[11] no compliance with requirements to record particulars of Mrs Binks' health in the watchhouse book[12] and failure to take particular care, as the then Manual required, to distinguish between drunkenness and the symptoms of some other disease or state (although he attributed some blame to the police hierarchy for failing to provide sufficient guidance and training in this respect).[13] In short, their supervision of Mrs Binks was "infrequent, careless and insensitive".[14]

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6 Id at 35.
7 Wyvill, L F, *Report of the Inquiry into the Death of Muriel Gwenda Catheryn Binks* (1991) Royal Commission into Aboriginal Deaths in Custody at 4.
8 Id at 2.
9 Id at 74.
10 Id at 77.
11 Id at 78.
12 Id at 80.
13 Id at 81–2.
14 Id at 84.

In his Regional Report on Queensland, Wyvill remarked in relation to Muriel Binks' death:

> It was apparent to me that if the Interim Report was greeted with any sense of urgency at all by the Queensland Police, that urgency did not translate itself into change at watchhouse level. Even as late as August 1990 misguided attitudes remained. That situation must not be allowed to continue.[15]

4. *May 1991: The Death of Sidney Punch as the Royal Commission Draws to a Close*

Unfortunately, continue it did. Sidney Punch died in the Rockhampton watchhouse on 2 May 1991, one month after the Royal Commissioners had presented the final National Report to the Queensland Government[16] and two months after Commissioner Wyvill had presented his Regional Report of Inquiry in Queensland. Punch had been arrested on a warrant for an unpaid fine resulting from the use of obscene language. The cause of death was epilepsy.

The Coroner investigating the death of Sidney Punch reported that with regard to the Queensland Police Service's claim to have implemented various recommendations of the Royal Commission into Aboriginal Deaths in Custody:

> [T]he use of the word "implemented" ... seems entirely inappropriate as I understand the meaning of that word. The facts are that, at least in Rockhampton watch house, a number of those ... recommendations ... have not been implemented. That is patently clear.[17]

Cunneen and Behrendt record that Coroner Smith remarked, at the very least Sidney Punch should have been medically examined upon his placement in custody, and he went on to say that Punch's death:

> [H]as vividly highlighted and emphasised the current deficiencies in the present watch-house system and the shortcomings and inadequacies of the present standing orders, notwithstanding the Royal Commission's recommendations and the purported implementation of some of the recommendations, certainly as far as the Rockhampton watch-house is concerned.[18]

It should be remembered that throughout 1990 and into 1991, the time leading up to the presentation of the final National Report, a steady flow of individual reports on deaths in Queensland custody, which repeatedly highlighted deficiencies in custodial practice, was reaching the Queensland Government and presumably the upper echelons of the Queensland Police Service.

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15 Id at 79.

16 Forty-six of the 339 recommendations in the National Report dealt with custodial health and safety. Several dealt with the need for police training in the recognition of distress or risk factors and the ready recourse to medical practitioners and nurses. Recommendation 135 forbade the transport of people who are unconscious or not easily roused to a watchhouse in the same unambiguous terms as Interim Recommendation 12.

17 The findings of Coroner B L Smith SM, 15 January 1992 at 119–25, reported in Cunneen, C and Behrendt, J, *Aboriginal and Torres Strait Islander Custodial Deaths Between May 1989 and January 1994. A Report to the National Committee to Defend Black Rights* (1994) at 39–40.

18 Id at 40.

5. *March 1992: The Queensland Government Responds to the Royal Commission Recommendations*

In March 1992 the Queensland Government formally responded to the Royal Commission recommendations made almost 12 months previously. In relation to Recommendation 135 on the handling of people who are unconscious or not easily aroused, it responded in the following terms: "The Queensland Police Service currently observes an instruction which directs that, where a person is in need of urgent medical attention at the time of arrest, that person is to be conveyed directly to a hospital to receive treatment".[19]

The 1992 Queensland Government Response also offered the assurance that the principles underlying the recommendations on custodial health and safety would be embodied in a new Custody Manual. The process by which that manual came into being is described in Melville et al in the section entitled "Review of Custody Procedures".

The new Custody Manual has been well received.[20] It is a thorough and conscientious attempt by the Queensland Police Service to tell officers how they should discharge their duty of care to those they arrest and detain.

Two recent deaths in custody are a sad but telling indication, however, that merely committing Royal Commission principles to paper is no guarantee that individual police officers will observe them, even when they are fresh out of the training academy. These cases show that the Queensland Police Service has a long way to go before it can claim to have implemented the Royal Commission recommendations on custodial health and safety.

6. *November 1993: The Death of Daniel Yock*

On 7 November 1993, Daniel Yock, an 18 year old Aborigine, was arrested in Brisbane and placed in the rear of a police van. After arresting a second person the police van patrolled the area for 17 minutes before arriving at the Brisbane City Watchhouse.

> Upon arrival Yock was found not to be breathing and without a pulse; an ambulance was called and resuscitation attempts were undertaken. Yock was taken by ambulance to the Royal Brisbane Hospital and, despite further resuscitation attempts, he failed to respond and was pronounced dead.[21]

Commissioner Wyvill QC concluded that there was not sufficient evidence to support a prima facie case against any member of the Police Service on a charge of manslaughter or to support proceedings for misconduct against any of the police officers involved. However, he made several recommendations including the following:

> The Police Service should ensure that all serving officers have access to and do study the contents of the Custody Manual. Whilst there was tendered in evidence a Commissioner's Circular in relation to the Custody Manual, the evidence of [two police officers involved in Yock's arrest] indicates that they did not have sufficient, if any, knowledge of its contents. The evidence of ... the officer-in-charge of the West End Police Station also

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19 Department of Family Services and Aboriginal and Islander Affairs, *Royal Commission into Aboriginal Deaths in Custody. Queensland Government Response to the Royal Commission* (1992) at 96.

20 See the Overview Committee's comment, for example, above n3.

21 Wyvill, L F, *A Report of an Investigation into the Arrest and Death of Daniel Alfred Yock* (1994) Criminal Justice Commission at vii.

indicates that there was an inadequate system in place to ensure that all officers complied with the circulars and familiarised themselves with the contents of the Custody Manual.[22]

7. *June 1994: The Inquest into the Death of Roger Kelly*

Counsel Assisting:There was a poster in the watch-house ... that has certain indicia that one should look for [in distinguishing illness from intoxication]. Had you had an opportunity, whilst you were in the watch-house, to read that poster?

Constable (who received Kelly into the watch-house and recorded him as "too drunk/unconscious"): I haven't actually read it, I seen it as like wallpaper basically.[23]

If the patient is unconscious ... under no circumstances take them to a watch-house. An unconscious patient in this town belongs in Cairns Base Hospital.[24]

A few months before Daniel Yock died in the back of a police van in Brisbane, Roger Kelly, a non-Aboriginal man, was found dead on the floor in the Cairns watchhouse, his face surrounded by vomit. Kelly, who had been arrested and charged with public drunkenness, was found by the Coroner to have died from massive brain damage due to a fractured skull. The Coroner found that the 13cm fracture occurred when he fell from a stairs landing in Draper Street, Cairns, while severely intoxicated.

The police officers who were called to Draper Street had arrested Kelly and taken him to the watchhouse. Although recorded in the watchhouse charge book as "too drunk/unconscious", he was received into the watchhouse and though he remained unrousable throughout the night, no medical treatment or assessment was sought.

At the inquest, the Coroner refused the Cairns-based organisation Family and Prisoner Support (FAPS) leave to appear. FAPS is a community-based organisation which administers the Cell Visitors Program, set up in response to Recommendation 145 of the Royal Commission into Aboriginal Deaths in Custody. Despite strenuous efforts, Kelly's next-of-kin could not be located and hence were also not represented at the inquest.

As a result, apart from the Counsel Assisting the Coroner, the only lawyers present and in a position to examine and cross-examine witnesses were the solicitor for the Queensland Police Service and the solicitor for the individual police officers involved in Kelly's arrest and detention. Nevertheless, yet again disturbing evidence emerged from the inquest about procedures, training and custody awareness within the QPS.

The Kelly inquest confirmed that many of the custody programs outlined by Melville et al had touched the Cairns watchhouse. Commissioner's Circulars, training videos, lecture packages, posters and the new Custody Manual had all come through the door after May 1992.[25] Sadly, there is little to suggest they had entered the consciousness of the officers within, before they "went missing"[26] or found themselves buried on someone else's desk or "somewhere near the station sergeant's desk somewhere".[27]

The following is a summary of the most worrying aspects of the Kelly inquest:

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22 Id at 103.

23 Id at 137–8.

24 Transcript of Proceedings, *Inquest into the death of Roger James Kelly before Mr T Pollock SM Coroner*, 6-9 June 1994 at 196, evidence of Dr M J McAuliffe.

25 Id at 56–60, evidence of Sgt Preston.

26 Id at 121.

27 Id at 108–9, 117, 121, 138, 144, 152, 179, 183 (the evidence of five constables, a sergeant and an inspector).

(i) Roger Kelly was received into the watchhouse in an unconscious or semi-conscious state. Medical assistance was not sought then or subsequently when he continued to be unrousable.

Recommendation 135 of the Royal Commission states that "in no case" should a person who is unconscious or not easily roused be taken to a police watchhouse. Instead they should be taken to a hospital, doctor or trained nurse for assessment. Section 2.6.1 of the Custody Manual translates this recommendation into policies, orders and procedures binding on individual officers. The custody awareness poster, referred to earlier and said in evidence to be displayed on the wall of the watchhouse, indicates that where a person is unable to sit or walk through the charging process, or unable to answer a question, medical assistance should be sought.[28]

Yet when Roger Kelly was received at the watchhouse, an entry was made in the watchhouse charge book that he was "too drunk/unconscious". Conflicting evidence was given about Kelly's levels of consciousness and what "tests" for consciousness were used by different officers. It was clear, however, that Kelly was unable to sit up let alone stand, unable to speak coherently or respond to questions and there is certainly some evidence that he was in fact completely comatose.[29] He remained unrousable throughout the night. At no stage was medical assistance or assessment sought

(ii) Almost all the police officers involved gave evidence that they were ignorant of the contents of the Custody Manual, and in some cases even of its existence.

The Custody Manual is dated July 1993. It was circulated to all police stations in Queensland in August 1993, following an extensive period of consultation and of course in the aftermath of the Royal Commission into Aboriginal Deaths in Custody, with all its attendant publicity. Yet not one of the nine police officers involved in Kelly's arrest and detention gave evidence they had read it in full. Here is a sample of their sworn evidence on whether they had read the Custody Manual prior to the night of Kelly's arrest on 27 October 1993:

"I'd heard there was one out but I'd never actually come across it."[30]

"No, I hadn't. I had flicked through the manual itself. That was all."[31]

"I didn't know that one existed."[32]

"No."[33]

"I had flicked through it at one stage. I hadn't read it extensively, no."[34]

(iii) The Commissioner's Circular dealing with implementation of the Custody Manual was buried in a folder in the sergeant's office and its contents were unknown to police officers within the watchhouse.

On 10 August 1993 the Commissioner of the Queensland Police Service issued a circular dealing with the implementation of the Custody Manual. It instructed officers in charge to

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28 Id at 64, evidence of Sgt Preston.
29 Id at 196, evidence of Dr McAuliffe.
30 Id at 108, evidence of Constable Eriksen
31 Id at 117, evidence of Sgt Mason.
32 Id at 138, evidence of Constable Gilmour.
33 Id at 144, evidence of Constable Manns.
34 Id at 183, evidence of Constable Faint.

ensure that all police under their control had access to and familiarised themselves with the Custody Manual.

The evidence concerning the Commissioner's Circular carries worrying echoes of the Royal Commission findings of "entrenched habits of non-compliance by police with General Instructions"[35] and the Yock enquiry[36]. Of particular concern is the failure of senior officers, in this case a sergeant of 14 years' experience, to bring the contents of Commissioner's Circulars to the attention of younger officers.

The following extract typifies the evidence given by six police officers regarding the Commissioner's Circular:

> **Counsel Assisting:** Are there any Commissioner's Circulars in the watch-house, that you're aware of?
>
> **Constable:** No. I don't think there is. I think they're all held over at the main police station.
>
> **Counsel Assisting:** In the sergeant's room?
>
> **Constable:** Yes. That's right.
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> **Counsel Assisting:** Now does anyone bring your attention to the fact that the Commissioner's Circulars are in existence?
>
> **Constable:** No. I think it's the responsibility of the individual officer to make himself conversant with the — check if there's been any amendments to any policies ....
>
> **Counsel Assisting:** Does anyone else sort of try and go out of their way to become aware of the Commissioner's circulars?
>
> **Constable:** I think it's — I think it's just something that the individual officer has to do really. No-one has brought it to my attention.[37]

(iv) Even after the death of Roger Kelly in the watchhouse, a CJC-led investigation, considerable publicity in the local press and some extra training for Cairns Police, old habits die hard.

A worrying indication of the prospects for future change was the evidence several officers gave about their attention to issues of custodial safety since Roger Kelly died while in their care.

After an Interim Report, reports on 99 individual deaths, a five-volume National Report with 339 recommendations, enormous attendant publicity, a welter of implementation documents, a training package, a new Custody Manual, and an actual death in custody while he was the officer in charge, it beggars belief that a sergeant with 14 years experience could in June 1994 give the following evidence:

> **Counsel Assisting**: Had you read the [Custody Manual] prior to that date [27 October 1993]?
>
> **Sgt Mason:** No, I hadn't. I had flicked through the manual itself. That was all.
>
> **Counsel Assisting:** Have you read it subsequently?
>
> **Sgt Mason:** No, I haven't ....

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35 Above n4.

36 Above n22.

37 Above n24 at 152, evidence of Constable Cox. See also at 95 (Franklin), 108 (Eriksen), 117 (Mason), 144 (Mann) and 183 (Faint).

> **Coroner:** You've worked in the watch-house since this event, have you?
>
> **Sgt Mason:** Yes, I have, yes.[38]

The sergeant also gave evidence that faced with an incoming detainee in the same condition as Roger Kelly was that night he would not adopt a different approach.[39] Pointing to his lengthy experience in the QPS and the fact he has acted as watchhouse keeper since Kelly's death, the Coroner commented in his Findings that "anyone not moved to a more careful assessment of a person who can not stand or talk after this event is a person with a perhaps unacceptable mind-set".[40]

Three other officers also testified they had not properly read the Custody Manual since Roger Kelly died.[41] Another officer testified that by the time of the inquest he still hadn't undergone a custody awareness course.[42] One constable gave evidence that he had to tell his superiors he could not perform the shift in the watchhouse he had been allocated because he was yet to undergo training relating to the custody manual.[43] This latter evidence tends to suggest that the problems are systemic, rather than confined to the attitudes of individual officers.

(v) Serious questions remain about the QPS's performance in ensuring an acceptable standard of custody awareness within the ranks.

Coroner Pollock SM found no basis to criticise the Queensland Police Service in relation to its implementation of custody awareness programs and training. This finding is difficult to square with the cross-section of nine police officers from Cairns whose evidence is adverted to above.

It is also considerably more difficult to reconcile with the evidence given by an Inspector of Police, attached to the Criminal Justice Commission, who was jointly in charge of the investigation into Roger Kelly's death. After interviewing the constables involved, Inspector Neville Cooper clearly felt that the QPS needed to do more:

> [T]hey weren't aware of the procedures under the custody manual. I think one constable hadn't seen them. And through the thread of our investigation it became quite obvious that there was no training in depth being carried out as far as the custody manual was concerned.[44]
>
> [T]ogether we agreed that it was obvious that the training wasn't being carried out — well put it this way. The necessary training wasn't being carried out.[45]
>
> It was the concern of the constables that they weren't receiving their training. They couldn't locate the custody manual. Lack of standing orders, they couldn't find the standing order in the watch house. They're all requirements under ... [cut off by Coroner's question].[46]

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38 Id at 117, 120.
39 Id at 120, 122–3.
40 Findings of Coroner Pollock, *In the Matter of an Inquest into the Cause and Circumstances surrounding the death of Roger James Kelly*, 9 June 1994 at 8.
41 Above n24 at 139, 144, 162.
42 Id at 107.
43 Id at 139.
44 Id at 25.
45 Id at 27.
46 Id at 29.

To be fair, evidence also emerged from the inquest that things were improving at the Cairns watchhouse. Apparently it is now required that the watchhouse keeper holds the rank of sergeant, that no officer works in the watchhouse without first undergoing custody awareness training,[47] and some officers conceded that placed in the same circumstances again they would call an ambulance rather than take someone in Kelly's condition to the watchhouse: "Everyone's become a bit more wary. Even if there's the slightest doubt, they get an ambulance in".[48]

The Royal Commissioners no doubt hoped that it would not take first-hand experience of another death for police officers to change their custodial practices.

Conclusion

The news about watchhouses is not all bad. The Australian Institute of Criminology recently reported that although there was a worrying 24 per cent increase in the number of deaths in institutions[49] from 1992 to 1993, the number of deaths in or on transfer to or from police lockups fell from 12 in 1992 to eight in 1993. "Furthermore, fewer deaths of Aboriginal people were reported as occurring in police custody during the 1993 year than in any of the previous 3 years, and no Aboriginal people died in police lockups during 1993."[50]

Nevertheless persistent ignorance and disregard for the unequivocal police instructions on safeguarding the welfare of detainees, most recently illustrated by the Kelly inquest, show there is no room for complacency.

Postscript: Auditing Compliance with the Custody Manual

Melville et al mention that the Police Commissioner's Inspectorate Section carried out a compliance audit of the Custody Manual. This document, in the spirit of the CJC's admonition with which this article commenced, presumably takes the reader beyond the *fact* of implementation (in this case the production of a Custody Manual) and assesses its *impact* (whether police officers are aware of its provisions and putting them into practice). This is important information which would allow the public to make a more informed assessment of the Queensland Police Service's response to the recommendations on custodial health and safety.

Unfortunately attempts by Tharpuntoo Legal Service Aboriginal Corporation in Cairns to obtain a copy of the compliance audit have so far proved fruitless. The Policy Branch of the QPS responded to Tharpuntoo's request by indicating that it was an internal document and therefore not for distribution. Application was made under the Queensland *Freedom of Information Act*, which provides for a 45 day processing period. That period passed without a decision on the application. Indications from the Freedom of Information

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47 Although see text at n43.

48 Above n24 at 103.

49 Defined to include police lockups, prisons, juvenile detention centres, or during transfer to or from such institutions and in hospitals following transfer from such facilities.

50 Morrison, S, McDonald, D and Dalton, V, "Australian Deaths in Custody 1993" (1994) *Deaths in Custody Australia No 4* (1994) Australian Institute of Criminology, Canberra at 14–15.

branch of the QPS are that due to staff resources, a decision was still at least 3 weeks off and probably more.[51]

The Royal Commission made it very clear that the implementation process must be open and accountable, "carried out in a public way as part of the process of education and reconciliation of the whole society".[52] The Queensland Government responded in the following way:

> The Queensland Government accepts that, given the extent of the contribution of all organisations including Aboriginal and Torres Strait Islander organisations and individuals as well as government bodies to the Royal Commission into Aboriginal Deaths in Custody, the implementation of recommendations be carried out in as public a manner as possible.[53]

One hopes that in respect of the compliance audit which reviews the much-vaunted Custody Manual, the Queensland authorities will be as good as their word.

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51 Since the writing of this article Tharpuntoo Legal Service was notified that access to the document was refused. The Legal Service is currently seeking review of that decision.

52 Recommendation 1 of the Royal Commission into Aboriginal Deaths in Custody.

53 Above n18 at 1.