4 Victorian Aboriginal Deaths in Custody

> *Each and every death in Custody is a death too many … it must be recognised that by taking people into custody, the state takes upon itself a particular duty-of-care, because of their vulnerability, and a special responsibility to ensure their protection and to uphold their human rights* (House of Lords, House of Commons, Joint Committee on Human Rights, 2004: 11).

4.1 Summary

- Aboriginal deaths in custody were the starting point of the Royal Commission and are the starting point for reporting on the findings of the Victorian Implementation Review.
- This section commences with the three Victorian Indigenous deaths investigated by the Royal Commission. Since 1991, there have been a further seven Aboriginal deaths in custody (four in prison and three in police custody) in Victoria – three women and four men, the last death occurring in 2000.
- The circumstances of the seven deaths, while not fully investigated by the Review, are described. Families of the two most recently deceased Indigenous persons give accounts of their experiences and a number of significant concerns are identified. These are related to specific Royal Commission Recommendations which deal with hanging points in cells, public drunkenness, provision of health services while in custody and also include the manner in which the families were treated – how news of the deaths was given, access to counselling, understanding the coronial process and access to legal representation.
- Links are drawn between these Aboriginal deaths in custody and the fundamental, underlying factors so strongly emphasised by the Commission as lying behind these deaths. Poor health, housing, substance abuse, unemployment, lack of cultural awareness all played a role in these deaths.
- This section also emphasises the need for locating these Indigenous deaths in custody within a human rights framework, recognising the responsibility of government for protecting a person's human rights when they are detained by the state, and also in ensuring equitable access to basic services.
- A number of recommendations are made to address the issues identified in the section.

4.2 Victorian Aboriginal Deaths in Custody Investigated by the Royal Commission

As part of this Implementation Review, and as an important preamble, it is instructive to consider the three Victorian deaths investigated by the Royal Commission. This material has been reviewed and set into a broader context by Dr Kate Auty, who was the former Regional Co-ordinating Magistrate in Shepparton and the first Victorian Koori Court Magistrate. In 1987, Dr Auty was the instructing Solicitor for the Royal Commission's hearings in Victoria. Her analysis is presented below.

Each of the deceased investigated by the Royal Commission in Victoria was a senior man from a country region in Victoria. Each of them died in a country police cell. Each of them died as a result of a medical condition.

> *Harrison Day was a great horseman and a drover. He was very well known around Moama and Echuca and everyone liked him ... men like Harrison were really great men. The way they've been coming across in the Royal Commission hearings is as if they are just nobodies. As if nobody wants them, that they are unloved. That's not true. They were dignified men ... He was a gentleman* (Euphemia Day, sister in law).
>
> *James Moore was a good father to all of us ... he did the best he could in difficult circumstances* (Nellie Moore, daughter).
>
> *Arthur Moffatt has committed no crime, other than yelling out that he had missed his station. Why therefore was he placed in a police cell?* (Dr Trevor Cutter, Victorian Aboriginal Health Service).

Harrison Day died on 23 June 1982 in the Echuca District Hospital having been transferred there from the Echuca police cells after an epileptic seizure.

James Moore died in the Swan Hill District Hospital on 15 May 1982, two weeks after being transferred from the Swan Hill police cells. He had suffered a massive pontine haemorrhage while in the police cells.

Arthur Moffatt was found dead in a police cell in Warragul on 11 June 1987.

At the time of their deaths, these Aboriginal men were senior in their communities. Harrison Day was in his forties, James Moore had turned 58 and Arthur Moffatt was 51.

Harrison Day was asked by the police to walk to the police station and surrender himself for unpaid fines, which he did. He was not at the time of this arrest committing any offence. The fines were for public drunkenness.

James Moore had been taken into custody at the Swan Hill District Hospital by police who knew he had outstanding fines. He was described as creating a disturbance at the hospital by the police who arrested him. He was initially given the opportunity to go home, which he declined. The fines outstanding were for public drunkenness.

Arthur Moffatt was in the Warragul police cells after having been collected from the railway station in a state of collapse, which was erroneously attributed to excessive alcohol ingestion. His arrest was for public drunkenness. It is highly probable that he was in fact in a state of hypoglycaemic reaction due to diabetes, poor nutrition and alcohol intake. Ambulance officers called to the police cells failed to make the diagnosis.

There are many issues associated with the administration of the law, which play out in the Royal Commission reports of the deaths of these three senior men. The law has not changed in relation to public drunkenness in Victoria, although an inquiry has been virtually ongoing since these reports were tabled and it is clear that Aboriginal people still find themselves before the courts and in custody at alarming rates for public order offences.

The fundamental causes and underlying factors leading to Aboriginal deaths in custody remain remarkably static. This is in spite of some positive initiatives in criminal justice, such as the employment of an Aboriginal Liaison officer at the Magistrates' Court, the appointment of a number of Aboriginal Bail Justices and the establishment of Koori Courts. The *VAJA* provides the basis for many changes in the justice system in recent years. These are important but they are plainly not the only changes necessary.

The underlying issues in the cases of the three senior men who died, continue to impart their legacy in this state. If one takes the cases of the three men who died and examines the circumstances surrounding their deaths, and contrasts their circumstances with those seven who have died since 1990, one might well (must) ask – what has changed?

Each of the three senior men who died was part of a kinship structure and part of a community. Their communities had been fragmented and fractured but they had not been erased.

Harrison Day

Harrison Day was a member of the Yorta Yorta people. He could have been born in 1939, 1940, 1942 or 1943. He was born on Moonacullah mission in southern New South Wales, a place where many Yorta Yorta people from Cummeragunja and Echuca and the Shepparton region still know and visit. Moonacullah is still populated by a small group of Aboriginal people. It is 34 kilometres from the town of Deniliquin and is an isolated and small settlement. Harrison Day's mother Bessie came from Cummeragunja and his father, Barney, from Deniliquin. His twin had died. His mother had died and his father drowned in the Murray River when working at Bellpool Station when Day was five years old. The impact of the deaths of his parents was not recorded by the Royal Commission, but the prevalence of death in the Aboriginal community is still something that resounds in every family.

Harrison Day and his brother Tom were raised by their maternal grandparents, the Coopers from Moama. Both boys understood themselves to be administratively excluded from secondary school as a function of their Aboriginality. Neither was removed from their grandparents' care. The struggle (that) this (looking after them) might have entailed for these senior people is not recorded. From the age of thirteen, Harrison worked in shearing teams with his cousin's husband Francis Atkinson. He was known as a horse breaker and he played football for Moama.

From about 1969, Harrison worked less and less and this might have reflected the onset of his epilepsy, which was recorded as the reason for refusal of a Victorian driver's licence in 1971. He had already been disqualified from driving in NSW. In about 1969, when he was about 30 years old, Harrison Day was awarded an invalid pension. He suffered severely from epilepsy which, given the time of onset, was unlikely to have been prompted by

alcohol abuse, as he was not at the time of its onset drinking heavily. Harrison Day was not rigorous in his medication regime and he drank heavily after he was unable to work. It was during the rural recession of the 1960s that he found himself unemployed and, because of his condition, unemployable.

Harrison married Marilyn Austin in the late 1970s when he would have been 40 or so. Marilyn Austin was from the Western District of Victoria. She died and he moved from the family group, up and down the Murray and Goulburn Rivers in an area which could be roughly described as Yorta Yorta and Wemba Wemba territory. During this time, as a pensioner, he drank heavily, often in public, and came to the attention of the police. The relationship the police had with Harrison Day was familiar and non-confrontational. His criminal record was for the most part related to driving and public drinking matters. His medical history involved treatment for a bleeding ulcer and numerous attendances for epileptic fits. On the basis of his medical records, Harrison Day averaged two or three epileptic fits a year from the 1970s until his death. There may have been occasions when he did not seek treatment.

Astounding as it seems, at the time of his death, Harrison Day at around the age of 41-42, was approaching the life expectancy of Aboriginal men in Victoria.

James Archibald Moore

James Archibald Moore, born in Balranald NSW in 1924, was a Wemba Wemba man. He lived and worked all his life in and around the Murray River and its tributaries. James Moore could trace his father's family back to his grandfather, Lenky Mantann, a member of the police force. His mother, Mary Matilda Coombs came from the Ebeneezer Mission near Dimboola in Wotjaboluk country. She married twice, first to Reg Wise and then to James Moore (senior). Mary Coombs had four children in her first family and six children in her second. James Moore left school at age 12, having had a fragmented education, which had mostly been overtaken by working on stations where his family lived. He married, at the age of 20, Betty Clayton, who had Tasmanian Aboriginal ancestry. As was customary, James Moore and his family of Betty and five children moved about, working on stations, trapping, wood cutting, labouring and at saw mills. Rations administered by police at Balranald sometimes, but rarely, filled the void when there was no work and no capacity to trap or hunt for food. James Moore kept his family together even as they moved around. They subsisted, as did many Aboriginal people, on the fringes of townships and along the riverbanks where they were able to find camping places. Nellie Moore – James Moore's daughter – said that her father kept the family away from the missions and that he hated the rations system, avoiding it unless there was absolutely no other option. James Moore and his family separated in 1952 and the children were placed with extended family members. He moved to Deniliquin, gained some permanent work and had some of his children come to live with him.

James Moore was given an invalid pension in 1973, some five years after the cataclysmic event of his life, the loss of his son Russell in a fire in 1968. It was after the death of this child, and in the time of the rural down turn, that James Moore started to drink heavily. This senior man spent two of the next six years in custody for offending against the public drunkenness laws. James Moore's two daughters, Nellie and Beverly, had no recall of their father having a drinking problem until the death of their brother. Before 1968, James Moore had only one prior court appearance, in 1957, for driving under the influence of alcohol.

In the 1970s and early 1980s, James Moore developed hypertension and whilst often treated for the condition, he was not very compliant with medication regimes. Finally, in

1981, he had what his daughters describe as a total collapse when he lost another child, his youngest daughter, Pat.

Throughout his life, Nellie Moore described her father as a person who encouraged his children to respect the police. The police responded by finding him generally affable and never violent.

Arthur Moffatt

Arthur Moffatt came from a family which had been extraordinarily pro-active in working to retain Lake Tyers Aboriginal settlement for Aboriginal people. In 1923 this settlement was one of the last pieces of land retained for the use and occupation of Aboriginal people in Victoria. Significant other settlements, like Ebeneezer Mission in Wotjaboluk country and Corranderrk in Wurundjeri territory had been closed down in 1904 with the land dispersed to non-Aboriginal people, even though it was not properly de-gazetted. Lake Condah Mission in Gunditjmara country was sub-divided for soldier settlement blocks after World War I and although many members of the Aboriginal families in that region had served in the war, their applications for grants of their own country were ignored. Arthur Moffatt had been born at Lake Tyers in 1936. It was not until 1967 when Lake Tyers was formally settled on the Gunai/Kurnai and other forcibly relocated Aboriginal people in Victoria, that some of the Aboriginal people in the region could be said to have acquired any secure title to any of their lands anywhere in Victoria. As the grant provided title to those who continued to reside on the settlement, and Arthur Moffatt had not, he was not amongst those who actually acquired a legal interest in the property.

Arthur Moffatt lived at Lake Tyers after he finished his primary schooling. He worked picking vegetables in the region until he joined the army when he was 18 years old. He was one of a number of Lake Tyers men and youth who joined the armed forces, just as had been the case for Aboriginal men from Lake Condah.

Arthur Moffatt worked for the State Electricity Commission in the La Trobe Valley until he retired on an invalid pension in 1972. He never married. He, like Harrison Day and James Moore, was mostly criminalised and incarcerated for public drunkenness.

This senior man suffered both from diabetes and epilepsy, and both conditions were poorly controlled. He was also struggling with excessive drinking, which compounded his health problems and probably reflected some of his despair about his health and social circumstances generally.

Arthur Moffatt's final incarceration came as result of police apprehension at the Warragul railway station when he had been put off the train after becoming excited about having missed his station. In a final and profound irony, he was 'helped' from the train by two other Aboriginal people who then returned to the train after being told to hurry as the train was leaving immediately. The police formed the view that he was drunk even though he did not smell very heavily of alcohol. A more careful investigation of the last hours of Arthur Moffatt encourages the view that he died of untreated hypoglycaemia. All of his symptoms suggest this conclusion. Had he been treated in the police cells, almost certainly he would not have died.

These three men grew up in a time when the management of Aboriginal people's lives and lands in Victoria was completely arbitrary. The mission system and every 'protectorate' had been starved of resources and Aboriginal people had been at one time forcibly concentrated into, and then equally forcibly dispersed from, the stations. Families and their children struggled to cope with, much less understand, the circumstances which prompted either the

land 'grants' or revocations, both equally arbitrary and urgent, each of which met with Aboriginal resistance of infinite complexity and with despair of equal magnitude. Every Aboriginal person responded individually but without becoming an individual. Every Arthur Moffatt, James Moore and Harrison Day maintained community and kinship as focal points, however personally unique these connections were.

In hindsight, reviewing the Royal Commission Reports into the deaths of each of these three men, and notwithstanding the understood need to contextualise the deaths and histories, what becomes apparent is that the focus of the Reports is on the mechanics of managing custodial arrangements. Certainly when we held these inquiries, we were concerned to promote law reform about the issue of public drunkenness, coronial enquiries, compliance with Police Standing Orders, custody management, arrest procedures and medical duty-of-care. We also knew that it was the underlying issues which we had to seek to address. We did not do this part of the inquiry very well, even if we did better than was the case in the past. It is no accident that the best information about the lives and deaths of James Moore, Harrison Day and Arthur Moffatt actually came from other Aboriginal people or Aboriginal service providers.

Table 1 presents a summary of these three deaths and enables comparisons with the seven Indigenous deaths in custody which have occurred in Victoria since 1990.

Table 1: Victorian Indigenous Deaths in Custody, 1982-1987 investigated by the Royal Commission

Year of Death	Name	Sex	Age	Reason for Custody	Cause of Death	Custodial Authority	Location
1982	James Moore	Male	58	Public drunkenness	Pontine haemorrhage	Police	Swan Hill
1982	Harrison Day	Male	Early 40's	Unpaid fines/public drunkenness	Epileptic seizure	Police	Echuca
1987	Arthur Moffatt	Male	51	Public drunkenness	Hypoglycaemia	Police	Warragul

Source: Royal Commission (1991b).

The deaths in custody of three Indigenous Victorians, which occurred so long ago, have not been forgotten, neither by the families of the deceased, nor by the communities where they lived. The current Implementation Review found there was a strong sense of unfinished business with many concerns of the families still unresolved and with a wider impact on the local community and in particular on relations with Victoria Police (see also Section 6.2 – Police).

> *We fought for nothing. Bringing the [Commission's] hearings to this town showed them the bigger picture. At the hearings all these police were saying that he [James Moore] was dirty and a drunk. That's what I'm trying to make a point about. It shows how significant the Royal Commission is. We have a more significant thing than any other community. The loss of a life should be counted for something. Deaths in Custody have to be worth something more than this* (Regional Victoria).

Police lack of knowledge about these events, combined with lack of cultural understanding, can compound this sense of 'unfinished business'. When the Review Team visited the police station in this regional town, it found that some of the recently arrived police reportedly had no knowledge of the Indigenous death that had occurred at the police station. When told of the history they appeared to gain some understanding of the nature of current police and community relations which had been difficult over a long period of time. As a result, the police invited the Review Team to facilitate a meeting between the police and the Aboriginal community to commence the dialogue so long overdue:

> *This is a pretty daunting task as officer-in-charge to mend this bridge. I'm a bit overwhelmed. Where do I start?* (Regional Police Station).

Generally, the Review consultations showed (as reported in Sections 5 – 6) that there was often a lack of knowledge and understanding of the Royal Commission's Recommendations amongst staff in criminal justice and other agencies.

4.3 Victorian Indigenous Deaths in Custody after the Royal Commission (1991)

A critical point at which to lead into the findings of this Review is with an examination of the Indigenous deaths in custody that have occurred in the 14 years since the Royal Commission tabled its *Final Report*. The subsequent deaths represent very different profiles to those examined by the Royal Commission, described above by Dr Auty. These deaths are, in many ways, the current reality of the criminal justice system and how it has operated in practice to care for its detainees. These deaths can also be used as an indicator of broader underlying issues that can often explain why a person might end up in custody. Further, the circumstances of the actual deaths can provide a strong indicator of the extent and effectiveness of the implementation of specific Royal Commission Recommendations by the Victorian Government since 1991 to prevent such deaths from occurring.

It should be noted from the outset that the new deaths in custody have not been thoroughly examined as a result of a Royal Commission process and this limitation is acknowledged. In the original Royal Commission Report for those Indigenous deaths in custody investigated:

> *All contemporary documents were subpoenaed and studied. Relevant people were interviewed wherever possible and in the great majority of instances this was possible. In many cases post-mortem reports were reconsidered by eminent pathologists. Not only the cause of death, but all aspects of custodial care and the orders binding were critically examined. Hearings were held in public; families of the deceased were represented by legal counsel. All documents were made available to counsel* (Royal Commission, 1991b, Vol. 1, 1.2.1).

Despite the constraints of this Review, many key indicators and measures used in the Commission's Report, where possible and practical, have been adopted and explored by the Review Team in relation to the new deaths.

The Review Team also had the opportunity to speak to several families of the deceased regarding the post-death experience, including the coronial process itself, from their

perspective. Members of the Review Team also visited, where possible, the locations where the deaths occurred. As noted in the Royal Commission's *National Report:*

> *Deaths in custody are particularly distressing for families and friends, and engender suspicion and doubt in their minds and also in the minds of members of the public. The deceased person has been in the custody and care of the State, not accessible in the general sense, his or her life controlled and ordered by functionaries of the State, out of sight and of normal contact. Deaths in such circumstances breed anguish and suspicion equally. Time may heal some of the anguish, but the suspicion can be allayed only by the most open and thorough ... laying of the facts on the table. [Emphasis added]* (Royal Commission, 1991b, Vol. 1, 1.2.4).

The views of the families of two of the seven deceased are related below but it is important at the outset to reiterate that the Royal Commission acknowledged the following:

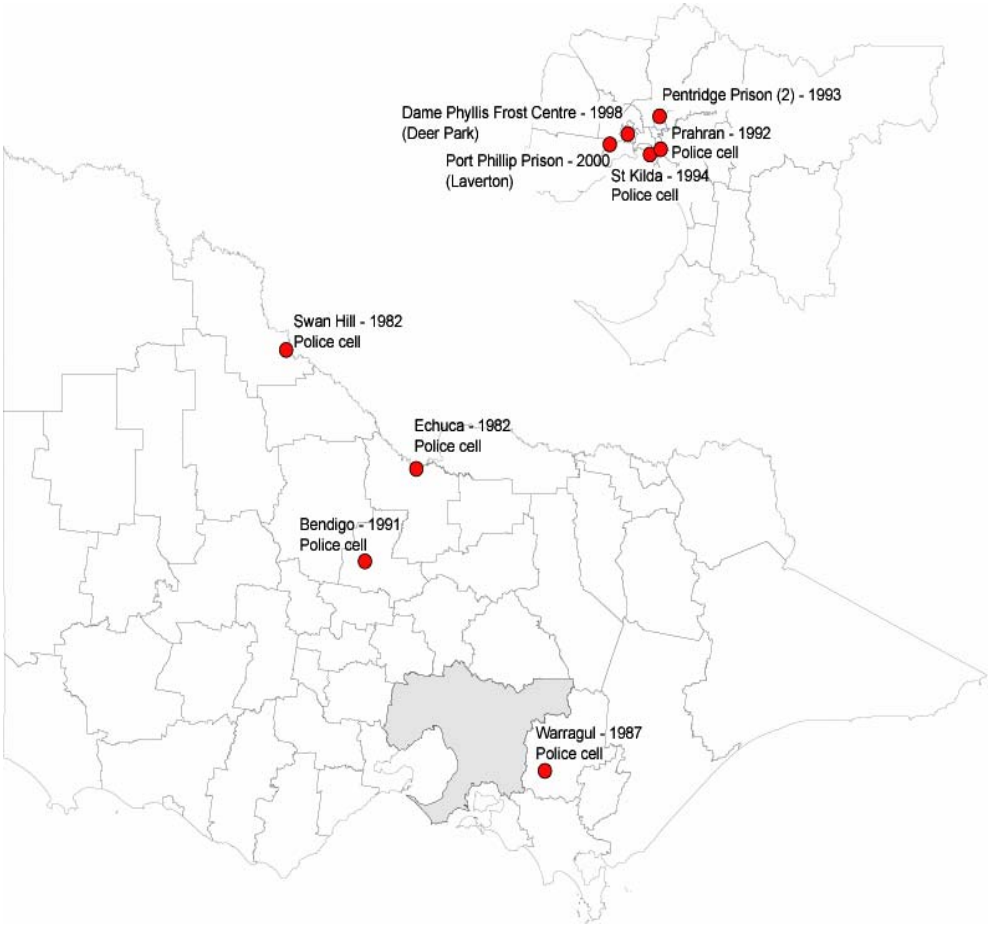
> *The official record keepers saw all, recorded all, and rarely knew well or at all, the people they wrote about.*
>
> *The Royal Commission examined all of the files, but it also heard the life stories from those who knew them best – the family and friends who shared the life and the hardships with each of the individuals.*
>
> *Slowly a picture would emerge from all the sources. Sometimes there would be a level at which truth emerged in the official records; more often not. What did emerge was that to understand the circumstances of their deaths Commissioners had to know the whole life of the individuals and, equally important, had to understand the experience of the whole Aboriginal community through their two hundred years of contact with non-Aboriginal society* (Royal Commission, 1991b, Vol. 1, 1.2.13 – 1.2.15).

This current Implementation Review, having a much more restricted scope, acknowledges that the information extracted from the records of the deceased and shown in Table 2 does not reflect the full story of the person as an individual and cannot adequately cover the underlying factors which may have contributed to the contact with the criminal justice system and to the deaths.

Details showing the location of the subsequent seven Victorian Indigenous deaths in custody are contained in Figure 2. Table 2 outlines the following details of these subsequent deaths:

- Year of death;
- Sex;
- Age;
- Place of Birth;
- Reason for custody;
- Cause of death;
- Custodial Authority;
- Location of death; and
- A brief summary of the events surrounding the death.

Figure 2: Indigenous Deaths in Custody in Victoria – Investigated by the Royal Commission and subsequently*



* It should be noted that there were 2 Aboriginal deaths in custody not shown on this map. In 1986 the death of an Aboriginal juvenile (16 year old male) in Turana Youth Training Centre and in 1989 the death of an Aboriginal man aged 25 in Gippsland Hospital from police custody. They were not investigated by the Royal Commission.

Source: Department of Justice (2004b).

Table 2: Victorian Aboriginal Deaths in Custody, 1991-2003*

Year of Death	Sex	Age	Place of Birth	Reason for Custody	Cause of Death	Custodial Authority	Location of Death	Brief Summary of Events
1991	Male	32	Swan Hill, Victoria	Intoxicated Person	Self-Inflicted Hanging	Police	Bendigo Police Station (Shower Cell)	D had consumed alcohol after an evening of socialising with work colleagues. At about 10.00pm he was questioned by police. He requested that they lock him up despite the police offering to take him home – he was then arrested. Upon arrest he indicated that he was Aboriginal but the police dismissed his claim. He was intoxicated (0.22%), depressed due to personal issues and did not want to return home to his wife, having lost money gambling. At 2.00am D was advised he would be released shortly and was subsequently discovered in a shower recess hanging by his shoe laces at 2.35am.
1992	Female	28	Melbourne, Victoria	Behaviour Only (Protective Custody: Medical Condition)	Self-Inflicted Drug Toxicity	Police	Prahran Police Station Detained in police divisional van	D attended and was admitted to the Alfred Hospital at approx 4.20 am. She received treatment until approximately 8.00am when she discharged herself against the wishes of the medical staff. She left the hospital and was noted to be aggressive, unco-operative and behaving in an erratic manner. This behaviour continued on the streets where she was involved in several incidents until she was subdued by police, handcuffed, placed in a divisional van and conveyed to the police station where she died a short time later whilst still in the divisional van.
1993	Male	24	Penrith, NSW	On remand since 20 March 1992 for 3 counts of murder	Self-Inflicted Hanging	Prison	Pentridge Management Unit, Prison reportedly at his own request.	D had been on remand for 11 months and on 23 February 1993 he appeared to behave routinely, accepted all meals, exercised, collected his canteen order. At ~ 4.30 pm D was checked at final muster. At 7.20pm D was issued his medication (Mogadon). At 7.30am on the following morning he was discovered in his cell slumped against the wall with a television aerial cable knotted around his neck with its end tied to an electric jug cord which had been looped then fixed to a metal wall bracket that supported a shelf.
1993	Male	33	Swan Hill, Victoria	On remand since 19 May 1993 for Enter with Intent	Epilepsy	Prison	Metropolitan Reception Prison, Coburg, D was placed in a special purpose unit in K Division which accommodates intellectually	D had been on remand for ~2.5 months and was locked in his cell at 3.30pm on 2/8/93. He was administered his prescribed medication for epilepsy at 7.30pm. D went to bed on a mattress on the floor as a precaution against failing due to convulsions at 10.00pm and woke his cell mate at ~1.00am with the noise of a convulsion. D told his cell mate that he was alright. D was unable to be roused and was discovered deceased at ~7.00am the following morning.

Year of Death	Sex	Age	Place of Birth	Reason for Custody	Cause of Death	Custodial Authority	Location of Death	Brief Summary of Events
							disabled prisoners.	
1994	Female	42	N/A	Attempt to assault Police with tomahawk	Homicide-Shot by Police	Police	St Kilda Welfare Services	On two consecutive days D attended her clinic (Hanover Welfare Services Centre) with a hatchet. On the second day she refused to relinquish the hatchet, and was told to leave the clinic. Her caseworker locked the clinic door and called police. Police attended and indicated that D raised the hatchet several times as if she were about to throw it, they fired a "warning shot" into the garden behind the deceased but D then challenged police to shoot her, raised the hatchet and began to "run" towards them. The police officer indicated that he instinctively fired five times "without aiming" killing D. D had a Blood Alcohol Content (BAC) of 0.3% at the time of her death.
1998	Female **	23	Adelaide, SA	Undergoing sentence for shop steal, going equipped, unlawful possession, assault, state false name and assault police as well as Breach of Parole. Due for release on 3 July 1999 with non-parole period to 17 October 1998. D faced disciplinary charges at prison as a result of her conduct (including an alleged assault on a prison officer) on 4.09.98.	Simulated suicide (Self Inflicted Hanging)	Prison	Deer Park Women's Prison	After almost 5 months in custody D was involved in an incident on 11th September 1998 where D reacted aggressively to being denied some food specially brought for her. The episode ended with D assaulting a prison officer. She was lifted and dragged to a vacant cell. Just prior to mid-day she was checked when she kicked or hit the door. D called out abuse in the cell and used the intercom system consistently from 11.57.32 until 12.21:51, her last call, which was cancelled by her at 12.21:58. D used the intercom 29 times. She was apparently abusive, demanding to go back to her cell and also to be given her radio. At approx 1.10pm D was observed by another inmate hanging by a nylon shower curtain (in a position between sitting and standing) in the shower entrance.
2000	Male	23	Colling wood, Victoria	Aggravated burglary and other offences	Toxic effect of Methadone	Prison	Port Philip Prison	After being on remand for ~6.5 months, at 4.00 pm on 3/07/00 D was seen by the doctor. At 7.45pm D responded to a conversation with a "grunt" at lock down and was noted to be sitting/lying on his bed.

Year of Death	Sex	Age	Place of Birth	Reason for Custody	Cause of Death	Custodial Authority	Location of Death	Brief Summary of Events
								At 8.10am on 4/07/00, D was found on his bed in an unresponsive state. CPR could not revive him and he was certified as deceased. D was not on a Methadone Program and was not administered this drug by the doctor.

* No new Indigenous deaths have been recorded since 2000 in Victoria.
** The source for this case was the legal representative at the inquest and the Review Team decided to include this death. However, Corrections Victoria advised the Review Team that this death was not regarded as fitting the criteria for an Aboriginal death in custody because while the person was apparently of Aboriginal descent, she did not identify as Aboriginal (see Section 4.5.1 – Defining a death in custody and Section 4.5.2 – Defining Aboriginality). The Australian Institute of Criminology (AIC) has since counted this death.

Source: McCall (2004), Australian Institute of Criminology (unpublished), State Coroner Victoria (2004).

As shown in Table 2, of the seven Indigenous deaths in custody identified by the Implementation Review, five occurred between 1991 and 1994, while two occurred between 1995 and 2000. None have bee reported since 2000. There were 175 non-Indigenous deaths in custody during the 1991 to 2003 period indicating that 4 per cent of all Victorian custodial deaths were Indigenous.

Gender

Three of the seven Victorian Indigenous deaths in custody post Royal Commission were females and four were males. Across Australia, the proportion of females investigated by the Royal Commission was 11 per cent, although none of the three Victorian deaths involved females. The gender profile of those who have died in custody in Victoria since 1991 has therefore significantly changed. This may indicate a particular vulnerability of Indigenous women in custody, whose numbers have been rising more rapidly than males in terms of police and corrections contact.

Age

The average age of Aboriginal Victorians in custody who died between 1991 and 2000 was 30 years, with their ages ranging from 23 to 41 years. This is comparable to the national figures for the Royal Commission deaths with the average age being 32 years, ranging from 14 to 62 years. It is however in stark contrast to the three Victorian deaths examined by the Royal Commission, which involved no-one under 40 years of age. Their ages were early 40s, 51 and 58 years. The new deaths therefore represent a significant lowering of the age profile of those who have died in custody since.

Place of death

Three of the seven Victorian Indigenous deaths occurred in police custody including one which occurred at the time the deceased was being apprehended by police (a fatal shooting) and four died in prison. The original three Victorian deaths all occurred in police custody. In comparison, Royal Commission figures showed that of the ninety-nine deaths across Australia more than half (sixty-three) of the deaths investigated had occurred in police custody and thirty-three were in prison custody. There were also three who died whilst being held in juvenile justice centres. The new Victorian cases therefore suggest a shift since 1991 to more deaths occurring in prison than in police custody and this is confirmed by the Australia-wide trend (McCall, 2004).

Cause of death

The cause of death determined by the Coroner was, in two instances – self-inflicted by hanging; in one instance – a suicide by hanging but likely to be accidental (simulated suicide); in two instances – drug toxicity; in one instance – by fatal gunshot wounds and in one instance – the result of epilepsy. Again, this represents a departure from the original three Victorian deaths reviewed by the Royal Commission which were all reported as deaths from natural causes. The recent Victorian deaths now more closely reflect the profile from the Royal Commission findings across Australia, which included a number of deaths by hanging, gunshot wounds and deaths immediately associated with substance abuse.

Offences

Offences for which the Aboriginal persons who died in custody post-Royal Commission were detained (in one case undergoing sentence) consisted of:

- murder;
- burglary;
- three separate sets of charges involving aggravated burglary, indecent assault and intentionally cause injury;
- intoxication;
- shop steal and assault as well as breach of parole;
- attempt to assault police; and
- in one instance the person was detained in protective custody.

This again represents a different profile from the three original Victorian deaths, each of which involved cases which related to the offence of public drunkenness; one for unpaid fines relating to being drunk and two for public drunkenness, (although Dr Auty noted in one case that *it was highly probable that [the deceased] was in fact in a state of hypoglycaemic reaction* rather than intoxicated). The Royal Commission mentioned the heavy involvement of alcohol use in reasons for custody across Australia. It should be noted, however, that whilst only one of the persons in the subsequent Victorian deaths was detained for public drunkenness (with a BAC reading of 0.22), another had a BAC reading of 0.3 at the time of death and high alcohol consumption (among other substances) was also a feature affecting the lives of the other deceased persons.

Time in custody

The length of time spent in custody prior to death varied greatly depending on whether the custodial authority was police or prison authorities. In the three cases involving the police, the length was less than three minutes, less than 15 minutes and approximately 4.5 hours. In contrast, the length of time of those who were held in prison was approximately 2.5, 5, 6.5 and 11 months. It should also be noted that in one case (recorded as an accidental simulated suicide) the person would have been eligible for release approximately three weeks from the date of death. These results appear to indicate that people held in custody are vulnerable and at risk of death regardless of the period of time detained or the period of time left prior to release.

Underlying issues

A closer examination of the lives of many of the seven Victorian Aboriginal deaths revealed tragic histories with many common features which should be considered in the reasons why these individuals actually found themselves in custody. They included:

- Of the seven deaths, four experienced childhood separation from their natural families (one was formally adopted). This is in contrast to the original three Victorian deaths in which no childhood separation was reported but is closer to the Australia-wide profile of the Royal Commission where 43 of the 99 people experienced childhood separation.
- In addition, the four Victorian Aboriginal people who experienced childhood separation had extensive criminal records which included numerous periods of incarceration:

> *… the periods out of custody were short, such that he is more likely to have developed means of coping with institutional life than life in the community* (Coroner's Report).
>
> *D had more than 90 prior convictions and had been in prison on 25 different occasions. D spent 2 years and 3 months out of the last 3.5 years of his life in custody* (Coroner's Report).

- Further, of these four Victorian Aboriginal deceased, two suffered significant traumatic events during their childhood (one was 11 years old when he witnessed his mother being hit by a car and killed when she was chasing him to get off the road and the other, also at the age of 11 years, witnessed the murder of his nine year old sister by their father). These circumstances were unlikely to have resulted in appropriate post-traumatic counselling and were significant background events that could have contributed to their periods of incarceration.
- Further, one of the four deceased was adopted by a non-Indigenous family before she was two years old (she had six foster placements before the age of 20 months) and experienced many incidences of sexual assault from the age of 15 years (outside the adoptive family environment). It appears likely that issues surrounding identity weighed heavily on this person's mind and was a contributing factor in her background that may have led to her periods of incarceration.
- Another of the four individuals was the victim of a serious assault with a hammer which led to brain injury and a marked deterioration in his life circumstances.

These are just some examples of traumas which occurred in the lives of those who died in custody.

However, the overwhelming common feature of the seven Indigenous individuals who died in custody post-Royal Commission is that in six of the seven cases there was evidence of mental health or emotional and spiritual concerns and substance abuse. One individual was also identified as intellectually disabled. The mental health problems varied greatly and in some circumstances may have been produced by traumas and other tragic life events suffered by the detainees. The addition of substance abuse may have exacerbated these conditions and, unlike the original three Victoria deaths, the recent deaths featured multiple drug abuse problems (heroin, amphetamines and other substances) in addition to alcohol abuse.

4.3.1 Specific Royal Commission Recommendations and the new Victorian Indigenous deaths in custody

It is with some reluctance that this Review comments on aspects of the new Victorian deaths. As noted above, the examination of the new deaths has been brief and in no way can duplicate the extensive process carried out by the Royal Commission. In these circumstances the Review Team is mindful that the Review's remarks as well as omissions, may offend or disturb those who were involved in the original deaths, whether they be family members or otherwise.

With these precautions in mind, the Review Team has prepared some brief comments below, with the primary objective of grounding the Review's specific recommendations in the context of the actual deaths. It also serves to highlight areas that may need urgent attention. Royal Commission Recommendations that are relevant are referred to below and then cross-referenced with the further examination in Section 6 of the Report dealing with the criminal justice system.

As a prelude to what follows it is important to note that:

> *Every unnatural death in custody presents a human rights issue … we examine the problem of deaths in custody in light of the human rights obligations of the institutions which compulsorily detain people, and those*

> *who investigate deaths of people who are so detained* (House of Lords, House of Commons, Joint Committee on Human Rights, 2004: 11).

Australia is a signatory to the International Human Rights Treaties which states that:

> *In international law the state, in protecting people in its custody and investigating deaths has obligations to comply with international human rights standards and guidelines including those under the European Convention on Human Rights, and United Nations human rights treaties* (House of Lords, House of Commons, Joint Committee on Human Rights, 2004: 2).

In parallel with the findings from the Report of the House of Lords, this Review Report aims to contextualise the lives and deaths of Indigenous people within a framework of human rights and social justice in Victoria. In his foreword to the *VAJA* in 2000, the Victorian Attorney-General noted that while *Indigenous Victorians should have access to the same justice outcomes as other Victorians,* this was not the case, and that to redress this inequity, the Victorian *Government was committed to working with the Aboriginal community, the wider Victorian community and the Commonwealth Government …* (Department of Justice, 2000: 3).

The Royal Commission noted Australia's ratification of the International Convention on the elimination of all forms of Racial Discrimination, citing Article 5 which:

> *Creates a positive obligation to Australia to prohibit and eliminate racial discrimination and to guarantee equality before the law. Such equality of legal protection extends not only to the protection of individuals before the criminal law but also to equality of entitlement to economic, social and cultural rights* (Royal Commission, 1991b, Vol. 5, 36.4.2).

The Victorian Attorney-General made this connection between human rights and economic and social disadvantage in the 2004 *Justice Statement*:

> *Addressing disadvantage is fundamental to the maintenance of human rights and for genuine equality of individuals before the law. Special measures are needed to ensure the promise of equality is not destroyed by social and economic disadvantage, and that disadvantage does not deny people their rights or their ability to seek redress when those rights are breached* (Department of Justice, 2004a: 11).

He went on to formulate one of his specific initiatives as being:

> *[To] establish a process of discussion and consultation with the Victorian community on how human rights and obligations can best be promoted and protected in Victoria …* (Department of Justice, 2004a: 10).

By taking people into custody the State assumes responsibility for those person's rights, including the right to life. However, by providing for basic human rights, and the access to services that are the rights of all citizens, prior to the point at which an arrest is made, that is, addressing underlying influences first, is the level at which effective interventions also need to be made. Implementation and ongoing monitoring of the Recommendations should be part of the process which enables the State to meet its obligations to citizens at both these levels.

Public drunkenness (Recommendations 79, 80, 81 and 85)[10]

> *79. That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness. (3:28)*
>
> *80. That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons. (3:28)*
>
> *81. That legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons. (3:28)*
>
> *85. That:*
>
> *(a) Police Services should monitor the effect of legislation which decriminalises drunkenness with a view to ensuring that people detained by police officers are not being detained in police cells when they should more appropriately have been taken to alternative places of care;*
>
> *(b) The effect of such legislation should be monitored to ensure that persons who would otherwise have been apprehended for drunkenness are not, instead, being arrested and charged with other minor offences. Such monitoring should also assess differences in police practices between urban and rural areas; and*
>
> *(c) The results of such monitoring of the implementation of the decriminalisation of drunkenness should be made public. (3:29)*

The law has still not changed in relation to public drunkenness in Victoria since the Royal Commission Recommendations, although it has been the subject of discussion and inquiry.[11] The first new death, which occurred in 1991, involved a male person who was held for *public drunkenness*. As noted above, the cause of death was determined as self-inflicted by hanging. It was also noted that the deceased *asked* to be locked up. Despite these circumstances, could this death have been avoided if a sobering up centre existed? A fuller discussion regarding the Recommendations in relation to public drunkenness is located in Section 6.2 – Police.

Hanging points (Recommendations 165)[12]

> *165. The Commission notes that prisons and police stations may contain equipment which is essential for the provision of services within the institution but which may also be capable, if misused, of causing harm or self-harm to a prisoner or detainee. The Commission notes that in one case death resulted from the inhalation of fumes from a fire extinguisher. Whilst recognising the difficulties of eliminating all such items which may be potentially dangerous the Commission recommends that Police and Corrective Services authorities should carefully scrutinise equipment and facilities provided at institutions with a view to eliminating and/or reducing the potential for harm. Similarly, steps should be taken to screen hanging points in police and prison cells. (3:291)*

As shown in Table 2, three of the seven deaths involved death by hanging. One occurred in police cells and two occurred in prison. These occurrences, as a matter of necessity, mean that each deceased person had at their disposal the means (including a piece of equipment and a suitable hanging point) to hang themselves and were able to remain undetected whilst doing so. The means used in those three cases are described below:

- The deceased's shoe laces were used in the 1991 police cell death. They had not been taken away as the police formed the view that they posed no risk. At the same police station, and on the same evening, another detainee's shoe laces were taken away because of potential danger to himself. Police at the station were cleared by the

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10 These Recommendations are further discussed in Section 6.2 – Police.

11 Drugs and Crime Prevention Committee, *Inquiry into Public Drunkenness*, June 2001

12 This Recommendation is further discussed in Section 6.2 – Police and Section 6.4 – Corrections.

Coroner of contributing to the death. Another death almost occurred in similar circumstances in a Regional Police Station in 2004 and is discussed in Section 6.

- The deceased used a TV aerial cord and an electric jug cord which were permanent items in his prison cell, to hang himself in the 1993 death. In that case, the Coroner made the following comment:

> *It must however be recognised, that it is not possible to prevent the determined individual from inflicting self-harm. To deprive prisoners of normal bedding, clothing, eating utensils, entertaining facilities and to maintain them under constant observation in order to prevent such occurrence, would be to create an inhumane and unworkable environment.*

- The deceased used a shower curtain in a prison cell that she had temporarily been placed in, in the 1998 death. The Coroner noted that following this death, plastic shower curtains attached to the ceiling were replaced by curtains with Velcro attachments. There were conflicting versions as to whether the installation of the shower curtains was approved or whether they were tested for force.

These new deaths continue to raise the issue – do hanging points still exist in police and prison facilities in Victoria today? In 2003 a non-Indigenous woman died by hanging while in custody in the Warrnambool police station, after which new prisoner monitoring cameras, were installed, new blankets provided and an enhanced procedures for collecting information on medical status about persons detained (Warrnambool Standard, 2005). Further discussion regarding the Recommendations on this issue is located in Section 6.

Provision of health services (Recommendations 151, 152 and 154)[13]

151. That, wherever possible, Aboriginal prisoners or detainees requiring psychiatric assessment or treatment should be referred to a psychiatrist with knowledge and experience of Aboriginal persons. The Commission recognises that there are limited numbers of psychiatrists with such experience. The Commission notes that, in many instances, medical practitioners who are or have been employed by Aboriginal Health Services are not specialists in psychiatry, but have experience and knowledge which would benefit inmates requiring psychiatric assessment or care. (3:278)

152. That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

(a) The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;

(b) The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates. Particular attention should he given to drug and alcohol treatment, rehabilitative and preventative education and counselling programs for Aboriginal prisoners. Such programs should be provided, where possible, by Aboriginal people;

(c) The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;

(d) The development of appropriate facilities for the behaviourally disturbed;

(e) The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care;

(f) The establishment of detailed guidelines governing the exchange of information between prison medical staff, corrections officers and corrections administrators with respect to the health and

[13] These Recommendations are further reviewed in Section 6.4 – Corrections.

safety of prisoners. Such guidelines must recognise both the rights of prisoners to confidentiality and privacy and the responsibilities of corrections officers for the informed care of prisoners. Such guidelines must also be public and be available to prisoners; and

(g) The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:

i. persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;

ii. intoxicated or drug-affected persons, or persons with drug or alcohol-related conditions;

iii. persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or

iv. persons who have made any attempt to harm themselves or who exhibit, or are believed to have exhibited, a tendency to violent, irrational or potentially self-injurious behaviour,

v. apparently angry, aggressive or disturbed persons;

vi. persons suffering from mental illness;

vii. other serious medical conditions;

viii. persons on medication; and

ix. such other persons or situations as agreed. (3:278)

154. That:

(a) All staff of Prison Medical Services should receive training to ensure that they have an understanding and appreciation of those issues which relate to Aboriginal health, including Aboriginal history, culture and life-style so as to assist them in their dealings with Aboriginal people;

(b) Prison Medical Services consult with Aboriginal Health Services as to the information and training which would be appropriate for staff of Prison Medical Services in their dealings with Aboriginal people; and

(c) Those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services. (3:281)

The importance of culturally appropriate health (and mental health) services was a matter relevant to most of the new deaths. As noted above, in six of the seven cases there was evidence of mental health concerns affecting emotional and spiritual wellbeing, and substance abuse (with one individual identified as intellectually disabled). It was further noted that case histories revealed difficulties in the reporting, diagnosing and managing of these issues and that some services did not appear to have taken into account the cultural dimensions of the lives of the deceased. A further discussion regarding the Recommendations on this issue is located in Section 6.4 – Corrections.

Lethal use of firearms (Recommendation 162)[14]

162. That governments give careful consideration to laws and standing orders or instructions relating to the circumstances in which police or prison officers may discharge firearms to effect arrests or to prevent escapes or otherwise. All officers who use firearms should be trained in methods of weapons retention that minimise the risk of accidental discharge. (3:290)

As noted above, the 1994 death occurred in circumstances where the deceased died from multiple gunshot wounds inflicted by police (and has been the subject of two appeals which were heard by the Supreme Court on 6 September 2001 and 13 June 2002). In that matter, the Coroner found that a police member *contributed to the cause of death of the deceased.* The issue of police use of force is one that has received extensive attention[15] and is discussed further in Section 6.2 – Police.

[14] This Recommendation is further reviewed in Section 6.2 – Police and 6.4 – Corrections.

[15] Taskforce Victor, Operation Beacon, and the subsequent introduction of oleoresin capsicum spray and stun guns.

4.4 Community Responses

4.4.1 Post-death experience of the families of the deceased

At this point it is essential that the devastating long-term impact on the families of the deceased be re-emphasised. This is shown with the death in 1982 in Swan Hill investigated by the Royal Commission which has left an indelible mark on family members and the Aboriginal community:

> *The way they reported in the media, police reports and coroner's reports was that they said he was 'drunk, dirty and diseased' and that was stated during the Royal Commission hearings* (Regional Victoria).
>
> *You're looking at one family who has lived, if you can call it that, through all of this* (Regional Victoria).
>
> *In 13 years where did it leave the families? The Royal Commission was heard in [Regional town] and the community felt so ashamed about how they reported on his death. We carried this load all on our own* (Regional Victoria).
>
> *We have a more significant thing than any other community. The loss of a life should be counted for something* (Regional Victoria).
>
> *Deaths in custody have to be worth something more than this* (Regional Victoria).
>
> *My thing about these deaths in custody is that they didn't die in vain. Particularly Uncle Arthur Moffatt* (Regional Victoria).

What is not evident from a reading of the Coroner's files and various related documents is the actual post-death experience itself from the perspective of the family members of those who have died in custody since the Royal Commission. While the self-assessment responses provided by government agencies and the community responses (including those of the families of the deceased) will be presented in Section 6 it is at this stage relevant to highlight a number of the issues raised by the families.

The two most recent deaths in custody involved that of a 23 year old Indigenous woman (A) in 1998 whilst being held at the Melbourne Metropolitan Women's Correctional Centre, Deer Park, and that of a 22 year old Indigenous man (B) in 2000 whilst being held at the Port Phillip Prison, Laverton. Family members of these individuals kindly agreed to speak to the Review Team regarding their experience of the post-death processes.

It was overwhelmingly clear from discussions with these families, that despite the file being closed from the perspective of the State, there has been no closure for these families. The families are still seeking answers in relation to these deaths. This highlights the need for independent, ongoing monitoring of the Recommendations through a central body, which is discussed further in Sections 7 and 8.

> *When we were contacted to come and talk to you about this we went into this because we need outcomes* (Interview with Family A).

Whilst it was beyond the scope of the Review to resolve the immediate issues raised by the families, it is important to highlight some of the concerns that were identified. They include:

Concerns

Both families were distressed by the manner in which the news of the custodial death was communicated to them. Recommendation 19 states: [16]

> *19. That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known.*

> *The only way I heard about it was on the radio on the day whilst I was driving through the city … Nobody from the prison even bothered to contact us and they had my mobile phone and everything* (Interview with Family A).

> *I had no formal communication from the prison telling me what happened to [B] … Any communication about deaths in custody should not be done by them [police]. As a basic mark of respect it should be the head of the jail who does this, and maybe they should be accompanied by an appropriate community member* (Interview with Family B).

Access to appropriate post-death counselling was an issue for both families. Recommendation 5 states[17]:

> *5. That governments, recognising the trauma and pain suffered by relatives, kin and friends of those who died in custody, give sympathetic support to requests to provide funds or services to enable counselling to be offered to these people.*

> *There was not even any offer of counselling to help us get through this* (Interview with Family A).

> *There was no counselling for me after [B] died. It was only when I was at the Coroner's Court that I found out I could have counselling. I didn't want to talk then* (Interview with Family B).

Difficulties regarding the family accessing the place of death. Recommendation 24 states:[18]

> *24. That unless the State Coroner or a Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.*

16 This Recommendation is further discussed in Section 6.3 – Courts.

17 This Recommendation is further discussed in Section 6.3 – Courts.

18 This Recommendation is further discussed in Section 6.3 – Courts.

> *One of the Royal Commission Recommendations is that family members should have access to the place of death. The prison never offered that to us. The legal team were offered that access but there was no suggestion that the family could do it too* (Interview with Family A).

General dissatisfaction with the conduct of the Coronial Hearings.

> *We went through the farce of a coronial inquest … All through the Inquest we just felt that the Coroner had already made her own judgements about [A] and that's not right … the way she delivered her finding was appalling. It was all over in twenty seconds and all she said was that we could get a copy of her findings on our way out … It was brutal* (Interview with Family A).

Lack of confidence in the substance of the Coronial Findings. Recommendation 12 states:[19]

> *12. That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.*

> *When a prisoner is placed in the Management Unit they are supposed to have half-hourly observations. That never happened for [A]* (Interview with Family A).

> *At the inquest the evidence they presented didn't add up … They had five Queen's Counsels there. Every time my lawyer tried to present letters in evidence they always questioned the relevance. The whole process from investigation to Inquest failed. The whole process failed me and B.*

> *I could go through [B's] Inquest transcript and challenge or seek clarification on every second statement made by all witnesses. I could question the relevance of some of the information presented to the Inquest, I could challenge a number of statements made, I question the integrity of a number of people who took the stand and so it goes on. I don't believe we ever had the opportunity to do so at the Inquest and I made it clear to all who could hear me afterwards that I thought the whole process was a crock of s*** and a waste of my time and energy even attending* (Interview with Family B).

Lack of forewarning regarding evidence that would be presented at the Inquest as Recommendation 24 states:[20]

> *24. That unless the State Coroner or a Coroner appointed to conduct the inquiry otherwise directs, investigators conducting inquiries on behalf of the Coroner and the staff of the Coroner's Office should at all times endeavour to provide such information as is sought by the family of the deceased, the Aboriginal Legal Service and/or lawyers representing the family as to the progress of their investigation and the preparation of the brief for the inquest. All efforts should be made to provide frank and helpful advice and to do so in a polite and considerate manner. If requested, all efforts should be made to allow family members or their representatives the opportunity to inspect the scene of death.*

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19 This Recommendation is further discussed in Section 6.3 – Courts.

20 This Recommendation is further discussed in Section 6.3 – Courts.

> *There were things that came out of the Inquest that we didn't even know about until then. We didn't know that [A] was strip-searched by male prison officers* (Interview with Family A).

Lack of understanding of procedural matters in respect of admissible evidence:

> *[B] was bashed by the screws nine months or so earlier before his death. I wanted and tried to bring this up at the Inquest and was told there was no relevance. The relevance was clear in that the officers on duty the night he died may well be those involved in his bashing. One of the prison guards was asked by our lawyer [at the Inquest] about the incident where [B] was bashed. He stated he recalled the incident and that he preferred not to talk about it. The whole process from investigation to Inquest I thought was flawed* (Interview with Family B).

> *We went through the farce of a coronial inquest. We wanted the Recommendations to make a difference for other prisoners. At the Coroner's Inquest the Coroner stopped an officer from giving evidence because it might incriminate that person* (Interview with Family A).

Difficulty for families to obtain legal assistance for representation which compounds an already stressful situation Recommendation 23 which states:[21]

> *23. That the family of the deceased be entitled to legal representation at the Inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise.*

> *Why should it be so difficult for families to be represented at the Inquest? Why do you have to go through all that extra stress?* (Interview with Family B).

> *We couldn't pay for legal representation at the Inquest but we are ever grateful for the help we got from VALS and [name withheld]* (Interview with Family A).

Other matters raised by the families included:

- Pressure from representatives of government agencies regarding possible legal action by families.
- Ignorance by government agencies of the normative standards set by the Royal Commission Recommendations.
- Suspicion and disbelief in official explanations.
- Lack of an integrated approach to case management issues.
- Failures in duty-of-care.
- Impenetrable/bureaucratic systems and structures.
- Lack of accountability to families.

Overall the families believed, on the basis of their experience that the implementation of the Royal Commission Recommendations had not been adhered to:

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[21] This Recommendation is further discussed in Section 6.3 – Courts

> *We need prisons and government to be accountable because if you look at all the Royal Commission Recommendations you can see that they haven't been followed and that they did not care for her as they should have. The Regulations are there but there's no accountability. As time goes on it gets harder.*
>
> *At least someone up there in Spring Street [Victorian Government] is thinking about how to deal with the deaths in custody. I just hope the report gets read by the right people in the right place and they are willing to take up the cause at that [Government] level. What happens to people in the system who fail in their duty-of-care – seems to me they just promoted up the ladder. You see – it's that accountability factor again* (Interview with Family A).
>
> *Even at the Inquest the prison gave evidence which led you to believe they had an Aboriginal Liaison Officer on board at the time of [B's] death. That's not true. My counsel had to highlight the fact that the ALO position was not in place at that time and was only a recent addition to their structure under the Aboriginal Justice Agreement. It's like an American TV show … All the horrors, violence, breaching of human rights, neglect, racism, gangs, dope, corrupt prison staff – you name it it's there.*
>
> *You need an ongoing review and need to keep all these agencies on their toes. The community deserves it. I'm really sick and tired of the Deaths in Custody Recommendations being quoted or giving legitimacy to strategic and program development that never eventuates in anything that actually addresses those who are in custody or prevents contact with the justice system or provides support to the families of those in custody* (Interview with Family B).

In the matter of deceased A, the family asked the Coroner to acknowledge her Aboriginality and to make recommendations regarding cross-gender strip searching, but no findings on either point were made. Whilst not commenting on the appropriateness or otherwise of this outcome, these are matters of great concern to the family of A as detailed below.

> *To have to suffer the indignity of a cross-gender strip-search, to be held down whilst her clothing was cut from her, to be isolated when she desperately needed not to be, to be devoid of all visual and personal stimulation and to be totally and continually ignored while in that state, is nothing short of total abuse of her being and should – nay – MUST NEVER EVER be inflicted on another human being …. EVER … under any circumstances. To be involved in such an episode as a perpetrator, defies description. There is no excuse for such behaviour.*
>
> *The manner in which events leading up to [A's] untimely and unnecessary death, in a place where she was supposed to be in 'protective' custody, have been mishandled and gone un-recorded or un-reproduced as a litany of lies, in some instances, is completely devoid of any semblance of 'professionalism' and is, to us entirely unacceptable* (Interview with Family A).

In the matter of deceased B, his family is of the view that:

> *[B's] inquest needs to be re-opened. There are too many unanswered questions* (Interview with Family B).

4.5 Review Comments and Recommendations

The matters outlined above indicate that the post-death experiences of these two families were grossly unsatisfactory. Concerns identified included lack of post-death contact, counselling, legal assistance and issues with the coronial process. This may indicate not only the need to continue progressing implementation and for independent ongoing monitoring for compliance with the Recommendations, but also an urgent need for specific practical assistance for families to help them through this difficult experience. As noted by the Royal Commission ... *Time may heal some of the anguish, but suspicion can be allayed only by the most open and thorough laying of the facts on the table* (Royal Commission, 1991b, Vol. 1, 1.2.4). Such assistance must also be culturally appropriate, highly expert and readily accessible.

While examining Aboriginal deaths in custody in Victoria since 1991, a number of general issues were also identified by the Review in relation to defining and monitoring the occurrence of these deaths. It should be noted that these are related to, but discussed separately from, the assessment of implementation of the Recommendations relating to deaths in custody (see Section 6.3 – Courts).

4.5.1 Defining a death in custody

The Royal Commission had restricted its investigation to Aboriginal persons who died in police and correctional facilities. However, as an outcome of the Royal Commission, the monitoring of custodial deaths by the AIC since 1992 uses a broader definition covering deaths, wherever occurring, of a person who dies or is fatally injured in the process of police and correctional officers attempting to detain the person or where the person is trying to escape from custody (Williams, 2001). In 2001 a process was established to examine cases where there is uncertainty as to whether the death should be classified as a death in custody[22].

In the course of this current Review, other Aboriginal deaths have been identified, which occurred while not technically in custody, according to the definition used by the AIC. These were deaths of Aboriginal persons in circumstances involving contact with the criminal justice system, while out on parole, on weekend leave, or shortly after leaving prison. It is also possible that deaths which occurred in association with police pursuits may have involved Indigenous persons, although the Review was unable to establish this with certainty. The Review is of the opinion that any deaths which occur during or immediately after police vehicle pursuits should be examined to establish Indigenous status of those involved and, if positive, should be reported as an Indigenous death in custody to the AIC. In addition any Indigenous offender who die while on non-custodial orders, or on day release, should be monitored in the same way. The Review also received a submission from K. Alberts who argued that:

> *... the definition of a death in custody Recommendation 6(a) should be extended to cover the deaths of Aboriginal people who are involuntary patients in psychiatric hospitals* (Alberts, 2004).

[22] Such 'borderline' cases are excluded until further determination by a coroner has been made (McCall, 2004:15).

Similarly, the family of deceased B also raised the question of the definition of a death in custody:

> *What about the death of my nephew? That was in 1998 when he was only 18 years old. He was on day release from [juvenile detention centre] and he was put on the train to go home to his mum. When he didn't turn up at the station at the time he supposed to his mum rang up [juvenile detention centre] to find out what was going on. She was told that he was on the train. He had a taste of it [drugs] and was found dead in [location withheld]. It was his first time on day release. He was serving a one-year sentence for burgs and drug offences. Who is responsible for his death? He was in custody* (Interview with Family B).

It should also be noted that the Royal Commission had conducted research on Indigenous deaths occurring in non-custodial settings, that is, when offenders are on probation, parole, community service and other court orders. It was found that across Australia 8 per cent of the 394 non-custodial corrections deaths in 1987 and 1988 were Indigenous and that *the death rate of those Aboriginal people on non-custodial orders was approximately twice that of Aboriginal prisoners* (Royal Commission, 1991b, Vol. 3, 22.1.2).

Recommendation 1.

- That the Victorian Government expand the definition of an Indigenous death in custody to incorporate other categories including:
  - police pursuits;
  - community custodial orders, such as Intensive Corrections Orders and Community Custodial Permits;
  - other custodial arrangements such as day/weekend release and parole;
  - involuntary psychiatric patients in hospitals; and
  - in expanding the definition of an Indigenous death in custody the Victorian Government should seek National agreement.

As Table 3 shows there have been other Indigenous persons who have died in circumstances following contact with the criminal justice system, which can clearly come within the intent of the Royal Commission and its Recommendations.

Table 3: Other Victorian Aboriginal deaths in contact with the criminal justice system 1991-2003

Year of Death	Sex	Age	Circumstances	Incident Location	Cause of Death	Place of Death
1998	Male	18	No curfew call made	On unescorted weekend leave pass from Malmsbury	Heroin toxicity	International Motel, Frankston
1998	Female	20s	Released from prison 1 day prior	Coburg Coach House	Combined drug toxicity	Coburg Coach House
2002	Male	16	On youth supervision order[23]	Princes Freeway, Moe	Multiple blunt trauma	Princes Freeway, Moe
2000	Male	26	On parole	Derby St, Kensington	Toxic effects of morphine (OD)	Derby St, Kensington

Source: Department of Justice (2004b).

4.5.2 Defining Aboriginality

In counting the number of Aboriginal deaths in custody, nationally the AIC uses the Royal Commission definition, that is, an Aboriginal person is someone of Aboriginal descent who identifies as such and is recognised by the Aboriginal community to be so. It is possible, indeed likely, that its figures may well be underestimates, as Indigenous status is not always clear or known prior to or at the time of death. Thus in 1998, while there were 20 custodial deaths reported in Victoria with none involving Aboriginal persons, at the inquest of one person in that year it was discovered that the person who had been classified by Corrections Victoria as non-Aboriginal was in fact of Aboriginal background – born of an Aboriginal mother and then having been adopted by non-Aboriginal parents. While her Aboriginal background was raised during the Inquest, the Coroner made no reference to this issue in her finding. This death for the purposes of the Review has been included in the seven Aboriginal deaths since 1991 (and has now been counted by the AIC). There may well be other instances where Aboriginal background remains unidentified among those who die in custody.

The issue of determining who is Aboriginal is relevant not only to custodial deaths and where information is collected by the Coroner, but also to the broader issue of contact with the criminal justice system as well as in accessing the many services and programs which are intended to address the underlying issues. This problem was noted at the coronial inquest of the Indigenous person who had died in police custody in 1991, when the Coroner found ... *that it was reasonable for the police officers to have formed the view he was not Aboriginal. This was because [name withheld] was in a jovial mood, he did not look Aboriginal, and two of the police had never received any instruction about Aborigines and their culture during their training ... [and that therefore] ... the police definition of an Aborigine should be made clearer to encompass a person 'who claims to be' an Aborigine, rather than one who 'identifies themselves' as an Aborigine* (Athersmith, 1992: 20).

Refer to Section 6.3 – Courts for the **State Coroner's** Response to Royal Commission Recommendation 40.

[23] The 16 year old boy's regular chroming had involved extreme risk-taking behaviour in the past, which led to him being known to the local police, but who were not aware of his Aboriginality or that he was subject to a Youth Supervision Order. For the Coroner, the issue here was that if there had been communication between Victoria Police and Juvenile Justice and an exchange of information, then this death could have been avoided.

4.5.3 Post-prison Aboriginal deaths

While deaths in custody are unacceptable, research has also shown that deaths occurring soon after release from custody can be disturbingly high, and include Aboriginal people. These post-custodial deaths are not classified as 'deaths in custody' as defined by the Royal Commission, yet are highly pertinent to the intent of the Recommendations of the Royal Commission and their implementation. In a recent study by Graham (2003), a total of 820 (736 males and 84 females) deaths following release from prison between January 1990 and December 1999 in Victoria were analysed. It was found that an ex-prisoner is 10 times more likely to die an unnatural death than persons of the same age in the general population (female ex-prisoners were 27 times more likely and male ex-prisoners seven times more likely). Many of these post-release deaths (60 per cent) resulted from drug toxicity (especially involving heroin), 10 per cent occurred within the week after leaving prisons and 15 per cent within several months.

In respect of Indigenous unnatural deaths post-prison, Graham noted that the risk was not significantly different to that faced by non-Indigenous ex-prisoners but given their over-representation in prison, Indigenous ex-prisoners are at risk of dying post-release.

Other research has also shown high mortality rates among young offenders in Victoria. According to Coffey et al (2004: 2):

> *Social adversity is common in this group, often accompanied by early offending, psychiatric disorder, substance misuse and self-harming behaviour; these factors predispose to high risk of death. Indigenous young people and those of Asian background are consistently over-represented in custody, and have characteristically high rates of psychiatric disorder and drug offences, respectively; these may be identifiable groups at increased risk of early death.*

The vulnerability of many who arrive in custody with mental health and/or substance abuse problems not only highlights the importance of close supervision and care in prison but also points to the critical nature of the release and post-release processes, which need to be pro-active to reduce post-custody deaths. This is further discussed in Section 6.

Recommendation 2.

- That the Departments of Justice (Corrections Victoria) and Human Services (Juvenile Justice):
  - (a) ensure that there are adequate and appropriate pre- and post-release procedures and programs in place to reduce the risk of death occurring post-release; and
  - (b) provide a report to the Aboriginal Justice Forum on (a).

4.5.4 Reality of the risk of Aboriginal deaths in custody

Victoria has fewer Aboriginal deaths in custody, compared to most other Australian jurisdictions, and there have been no deaths recorded using the AIC definition since 2000 (see Volume 2 – Statistical Information). However, over-representation in Victoria continues – in police cells, prison and juvenile detention centres. The further risk of deaths associated with such over-representation is real. To illustrate how real that risk is, a submission received from the VALS, argues that Victoria cannot be complacent about Aboriginal deaths in custody and, to demonstrate that this risk is still very real, describes an incident where a

VALS client almost died in a Regional Police Station whilst in custody in 2004 (where one of the three Aboriginal deaths had occurred in 1982 and was investigated by the Royal Commission).

In this recent incident, an Aboriginal man tried to hang himself using his belt. Not removing the belt is a breach of Victoria Police operating procedures and the Royal Commission Recommendations 122-128 whereby hanging points and objects in cells must be removed. That a tragedy was averted there is little doubt, but this was due only to the quick action of a fellow Aboriginal prisoner rather than effective implementation of the relevant Recommendations. VALS notes that this is a:

> *... harsh reminder that deaths in custody are still a threat in 2004 ... and calls for the Government to implement Recommendations about education, training and strategies related to Indigenous people in police cells to ensure the Swan Hill incident is not repeated with disastrous and tragic consequences* (VALS, 2004: 16).

Shocking as the details surrounding the deaths of Victorian Aboriginal people in custody undoubtedly are, they represent the end point in a vicious cycle of systemic social and cultural disadvantage as well as progressive, continuing entanglement with the criminal justice system. The Royal Commission into Aboriginal Deaths in Custody was extremely insightful when it emphasised, time and again, that the fundamental questions to be addressed related to the underlying influences that lead to over-representation of Aboriginal people in the criminal justice system as a whole and in custody in particular. It is to this crucial issue that the Review turns in Section 5.