Aboriginal and Torres Strait Islander Female Custodial Deaths Post Royal Commission Into Aboriginal Deaths in Custody: Breaches of RCIADIC Recommendations

A Discussion Paper

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This paper investigates the eleven female Aboriginal and Torres Strait Islander (ATSI) deaths in custody since the completion of the Royal Commission Into Aboriginal Deaths In Custody (RCIADIC) up until May 1998. Of particular interest are the blatant and systematic breaches of the 339 Royal Commission recommendations. More than ninety-five recommendations were breached in the eleven post-Commission female deaths investigated in this study. Although other researchers state that ATSI deaths in police custody have decreased post-Commission, the author's analysis shows that whilst the claim of post-Commission improvement may be an accurate account of Indigenous male deaths in custody, it is certainly not reflected in their female counterparts. For example, the 73% of post-Commission female Indigenous deaths occurring in police custody or police related operations.

Since the close of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in 1989, eleven Aboriginal and Torres Strait Islander women have died in custody. This number falls one short of the twelve female custodial deaths investigated by the RCIADIC between 1 January 1980 and 31 May 1989.

This paper will draw a comparison between the deaths investigated by the Royal Commission and the eleven female deaths that have occurred since. Of particular interest will be an examination of the reasons for these women being placed in custody, the last place of custody before death, the cause of death and, of specific importance, the actual recommendations of the RCIADIC that were breached on each occasion.

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The argument of this paper will be that very little has changed for Aboriginal and Torres Strait Islander (ATSI) peoples, and particularly ATSI women, in regard to their relationship with the criminal justice system since the conclusion of the RCIADIC on 31 May 1989. In analysing the relations between the Australian criminal justice system and Aboriginal and Islander people, one needs to acknowledge and understand the socio-historical/ oppression/ dispossession argument. Primarily, the historical interactions between ATSI peoples and the police have contributed to the contemporary over-representation (and subsequent deaths in custody) within all jurisdictions of the criminal justice system.

The RCIADIC investigated one hundred Indigenous Australians who died in custody between 1 January 1980 and 31 May 1989 (twelve women and eighty-eight men), and concluded that the majority were detained for minor offences and all of them died prematurely. Further, it was argued that all those who died shared a similar history of poverty, racial discrimination and excessive levels of State intervention in their lives; and that the circumstances of their deaths mirrored history, involving racist attitudes, stereotypical representations and breach of duty of care on the part of their custodians.[1] Commissioner Elliott Johnson also concluded that on the basis of the evidence presented to the RCIADIC, *racism* endures as a weapon of power in the war for Aboriginal and Islander subjugation and exclusion, stating that:

> "[t]he relations between Aboriginal and non-Aboriginal people were historically influenced by racism, often of the overt, outspoken and sanctimonious kind; but more often...of the quiet assumption that scarcely recognises itself. What Aboriginal people have largely experienced is policies nakedly racially-based and in their everyday lives the constant irritation of racist attitudes. Aboriginal people were never treated as equals and certainly relations...were conducted on the basis of inequality and control...As this report shows, this legacy of history goes far to explain the over-representation of

1 *Royal Commission into Aboriginal Deaths in Custody. National Report,* Commissioner Elliot Johnston, QC, Canberra: Australian Government Publishing Service, 1991, p 1-12. ("*RCIADIC National Report*")

> Aboriginal people in custody, and thereby the death of some of them." [2]

The consequences and continuation of the conflict between the *'coloniser'* and *'colonised'* are heart-wrenchingly reflected in the words of one Indigenous Australian, expressing that:

> "it is difficult to write...about the last 200 years in an objective rational way, while repressing strong feelings of pain and anger. This is not distant history that can be discussed dispassionately. It is the reality of Aboriginal life today. The enforced cultural change, the removal of people from an economic base, making them vulnerable to whims of government policy and charity and the continual denial of a people's right to determine their own future has directly affected the quality of life of Koories today. Understand this and you have the framework in which to discuss contemporary issues confronting Koories."[3]

Thus, to conceptualise historically and truthfully the contemporary relationship between ATSI peoples and the dominant Anglo-Australian criminal justice system, we must acknowledge the fact that for 209 years, Indigenous Australians have been, and continue to be, abandoned to a standard of living comparable to third world nations. This occurs via the dominance of the European system of law and the maintenance of the lie, terra nullius. There is an entrenched racist ideology and a negative stereotypical representation of ATSI peoples as 'drunk, lazy, good for nothings', introduced at the time of the British invasion, that has maintained the status quo and led to the over-representation and high levels of deaths in custody still experienced by ATSI peoples in 1998. This continues despite the 100 reports, 339 recommendations of the RCIADIC and four million dollars allocated for the recommendations to be implemented.

Before embarking upon an analysis of the post-Commission deaths, it is important to be aware of the nature and circumstances of the twelve female ATSI deaths investigated

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2 *RCIADIC National Report*, (vol 1), above n 1, p 10-11.

3 Anderson, I, *Koorie Health in Koorie Hands: An Orientation Manual in Aboriginal Health for Health Care Providers*, Melbourne: Koorie Health Unit, Health Department of Victoria, 1988, p 21.

by the Commission, and the way in which the reports of these deaths, when combined with those of the male deaths in custody, formed the basis of the Commission's extensive recommendations.[4] Of the twelve female deaths investigated by the RCIADIC, there were seven deaths in Queensland, three in Western Australia and two in South Australia. The age of the deceased was unknown in more than half the cases, but the known ages ranged from fourteen to fifty-eight years of age.

Most significant were the reported details of the last place of custody and the cause of death of these twelve women. The last place of custody was, in eight of the cases, a police watch-house; in two of the cases, a police lockup; in one case, a women's prison; and in another, a children's home. Eleven of the twelve deaths occurred in police custody or in custody-related operations. As for the causes of death, nine of the twelve were listed as health-related causes, otherwise known as natural causes. These were cases of respiratory disease, heart problems, bleeding disorder, drug or alcohol-induced disorders and serious head injury. The other three deaths were not health-related: these were caused by fire, an attack by fellow prisoners and hanging.

At the conclusion of its investigations, the RCIADIC made 339 recommendations, 179 of which specifically concerned the criminal justice and coronial systems.[5] These included basic recommendations aimed at decreasing the prevalence of ATSI peoples in custody in the first place: legal reforms were recommended, such as the abolition or decriminalisation of the offence of public drunkenness (R79 and R85); and arrest

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4 The deceased were: in Queensland, Muriel Binks, Patrine Misi, Karen O'Rourke, Deirdre Short, Barbara Tiers, Barbara Yarrie and Fay Yarrie; in Western Australia, Faith Barnes, Nita Blankett and Christine Jones; and in South Australia, Joyce Egan. The twelfth female death was also in South Australia, listed only as "Ceduna" (the deceased died in Ceduna Watch-House), her name having been suppressed by order of the Commissioner. This person was identified as female in Section 3.2.37, in Volume 1 of the *RCIADIC National Report*, above n 1, p 73, where it reads: "no less than nineteen persons died of a heart problem [one of whom was] the woman who died at Ceduna".

5 References to RCIADIC recommendations throughout this discussion paper are those 339 listed in the *RCIADIC National Report*, Volume 5, above n 1, p 69-146. Numbers in brackets are references to recommendation numbers.

and imprisonment were to be considered sanctions of last resort (R87 and R92).

Further, the Commission recommended that systemic changes be made in relation to the practical handling of prisoners and arrestees once in custody, such that they would receive adequate health assessment and medical treatment. For example, it recommended that there be a regular medical or nursing presence in watch-houses in capital cities and other major centres (R127a). The Commission also recommended regular, careful and thorough observation of detainees in police cells (R137). Police officers would have to be trained to recognise those in distress or at risk (R133), and seek immediate care if doubts arose about a prisoner's condition (R161). A screening form was to be carefully completed and risk assessment undertaken prior to the detainee being placed in a cell (R126), and at the end of a shift, an exchange of information and written checklist passed over to the officer in charge of the incoming shift (R132). It was recommended that those people brought in unconscious or not easily roused be immediately taken to a medical service, and not a watch-house (R135); and those found in a cell or watch-house unconscious or not easily roused were to have immediate medical care (R136).

The RCIADIC also appreciated the need for an attitudinal shift in those employed within the criminal justice system. Naturally, police services were to take all possible steps to eliminate rough treatment or abuse of Aboriginal prisoners (R60). The Commission further recommended that the negative stereotypes of Aboriginal people and people with drinking problems be addressed through staff selection, supervision and training and through clear instructions (R255), and that police and custodial authorities should recognise their legal duty of care to persons in their custody (R122).

Recommendations were not confined to procedures aimed at the avoidance of death in custody, but also the management of the inquiries conducted where death did occur. It was recommended that coroners investigate not only the cause and circumstances of death, but also the quality of care, treatment and supervision of the deceased prior to death (R12), and that they suggest ways to prevent further deaths (R13). Police investigations, too, were to be approached on the basis that the death may be a homicide, inquire into the arrest or apprehension, lawfulness of the circumstances and

treatment and supervision of the deceased, and thoroughly examine the scene of death and forensic exhibits (R35).

The failings of the criminal justice and coronial systems addressed by the above mentioned eighteen recommendations were found to be 'if not the cause of death, then a contributory factor' in the twelve female ATSI deaths investigated by the RCIADIC.

These RCIADIC recommendations demonstrated an acknowledgment of the underlying issues of racism, both historical and contemporary, and the negative stereotypical perceptions of ATSI people held by police and others within the criminal justice system. However, whilst they look good on paper, one must remain sceptical of the rhetoric of the recommendations when regard is had to their inadequate implementation at grass roots level. This scepticism is reinforced when one notes the most recent figures released by the Institute of Criminology in March 1998, regarding the continuation of over-representation and, in particular, deaths in custody, of ATSI peoples between 1990 and 1997.[6] The report uses the post-Royal Commission definition of a "death in custody", which includes deaths in institutional settings (such as police vehicles and hospitals) and during police operations where the police were in close contact with the deceased (such as raids), as well as other deaths during custody-related police operations (such as sieges and pursuits).

According to the Institute of Criminology, this recent period 1990 – 1997 saw a fairly steady increase in the total numbers of deaths (both indigenous and non-indigenous) in all custodial circumstances – from an overall total of 65 custodial deaths in 1990, to a remarkable total of 103 deaths in 1997 (the highest number of custodial deaths on record).[7] The levels of indigenous deaths as a proportion of these totals showed no particular pattern of decline, averaging around 13 to 14 deaths per year, though the composition of police and prison custodial deaths has begun to change in the last several years. In 1990, there were 5 indigenous deaths in police custody and 5 in prison custody; in 1991 there were again 5

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6 Dalton, V, "Australian Deaths in Custody & Custody-related Police Operations, 1997", *Trends and Issues in Crime and Criminal Justice*, No 80, Australian Institute of Criminology, March 1998, p 7.

7 ibid.

deaths in police custody but 8 in prison custody. 1992 saw an increase in police custodial deaths to 7, while prison custodial deaths dropped to 2 deaths. From 1993 to 1997, indigenous deaths in prison custody outnumbered those in police custody. There were 3 police deaths in both 1993 and 1994; the number of prison deaths in these years being 7 and 11 respectively. In 1995 there were 4 police deaths, and a shocking 17 prison deaths. In 1996 there were 6 police deaths and 12 prison deaths; and in 1997 again 6 police deaths and 8 prison deaths.

It is clear that implementation of the 339 RCIADIC recommendations has been haphazard and incomplete, and as a result, a further one hundred and three Indigenous Australians (ninety-two men and eleven women) have died in custody. Like the deaths investigated by the RCIADIC, the majority were detained for minor offences, and all died prematurely in circumstances that were the result of systemic racism and breaches of the Royal Commission's recommendations. As Cunneen and Behrendt note in their *Report to the National Committee to Defend Black Rights* -

> "It is apparent that the national rate of Aboriginal custodial deaths has not decreased, and many of those who have died have done so because key areas of reform highlighted by the Commission have not taken place."[8]

Scepticism and caution in regard to the actual implementation of the recommendations is well founded on analysis of the eleven female ATSI deaths in custody since the conclusion of the RCIADIC in 1989 to early 1998. Of the eleven post-Commission female ATSI deaths, eight deaths occurred in police custody (or during police pursuits, sieges or operations), while three deaths occurred in prison. Eight of the deaths were listed as health-related deaths, ie. natural causes or drug induced.

Examining the female ATSI deaths since 1989 by year, there were two deaths in 1990, followed by one death in 1991, three deaths in 1992, one death in 1993, two deaths in 1994, one

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8 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*. Commission for Prevention of Custodial Deaths, p 2.

death in 1995, and there has been one death to May, 1998. A summary of each of these eleven deaths follows.[9]

1. <u>Debra Lorraine Dick</u>: died of a stabbing injury at Brisbane Women's Correctional Centre, Qld, on 8 January 1990, aged 30.

The deceased died in prison of massive internal haemorrhage, as a result of stab wounds to the neck and chest. The circumstances of the homicide are unknown, and no coronial inquiry was conducted. On this point, the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner in its *Indigenous Deaths in Custody, 1989–1996* report expressed considerable concern:

> "The decision by the Coroner not to carry out an inquest is disturbing. The fact that a criminal trial was to follow for an offence relating to the death in custody should not exclude the role of the Coroner. Unlike the court, the Coroner can dispel suspicions and look at broader issues underlying the deceased's arrest and imprisonment. The Coroner can examine the adequacy of structures and procedures in place to supervise prisoners. The Coroner can look at organisational matters that may have contributed to the death, and ways of preventing similar deaths. A full inquest, which looks at the quality of the care and supervision of the deceased prior to death, should be held."[10]

In this case, there were two breaches of RCIADIC recommendations, these being the recommendation that all deaths in custody be required by law to be the subject of a coronial inquiry, culminating in a formal inquest (R11), and that such an inquiry investigate the quality of care, treatment and supervision of the deceased (R12).

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9 Most of the information below regarding the post-RCIADIC ATSI female deaths is derived directly from the profiles of the deceased women in Part E of *Indigenous Deaths in Custody 1989-1996: A Report Prepared by the Office of the Aboriginal and Torres Strait Islander Social Justice Commission to the Aboriginal and Torres Strait Islander Commission*, Canberra: ATSIC, 1996 ("*IDIC Report*"). Information has also been gathered from Cunneen and Behrendt, above n 8; and also B Mason, "The Girl in Cell 4", *HQ Magazine*, March/April 1997.

10 *IDIC Report*, above n 9, p 399.

2. Jennifer Mary Garlett: died from injuries sustained in a car accident on Tonkin Highway, Wattle Grove, WA, on 5 April 1990, aged 14.

The deceased was killed at a highway intersection in a fatal car crash. She died of multiple injuries she received as a passenger in a stolen car which, while being pursued by police, crashed into another vehicle. The driver of the stolen car and the other passenger, both male Aboriginal youths aged fifteen, also died in the accident, as did the occupant of the other car. The high speed pursuit, which took place in the early hours of the morning, lasted some fifteen minutes, and just before the crash, the stolen car was driven through a red light at a speed judged to be in the vicinity of 220 kilometres per hour.

Again, the case involved two breaches of RCIADIC recommendations. These were the recommendation that police eliminate rough treatment of Aboriginal prisoners (R60) and the recommendation that programs be developed to reduce the incidence of motor vehicle offences where they are a major factor in Aboriginal imprisonment (R95).

3. Marlene Tomachy: died as a result of a head injury at Townsville Hospital, ex Palm Island Watch-house, Qld, on 14 November 1991, aged 44.

The deceased was arrested on 4 October 1991 after police were called to a domestic disturbance at her home. When the deceased refused to comply with other occupants' requests that she leave, the police physically conveyed her outside the house and into the street, where they then arrested her for public drunkenness. Witnesses claimed that there was a struggle in the course of the arrest, but no injuries of any kind were noted on the deceased, either by police or by medical authorities.

According to Coroner Fisher, the deceased was then taken to Palm Island Watch-house, Queensland, awake but drunk. She was found unconscious the following morning and was transferred to Townsville Hospital, but remained comatose until her death five weeks later. The Coroner found that the cause of death was respiratory failure arising from cerebral necrosis, a result of head injury, but no person was charged with an offence in relation to the death. It was noted by the Coroner that the imminent creation of detoxification centres would assist what was said to be a very difficult, if not

impossible, task in relation to the assessment of the condition of drunken persons.

In its report to the Aboriginal and Torres Strait Islander Commission (ATSIC), the Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner was critical of aspects of the coronial inquiry, suggesting that the Coroner's investigation highlighted the problems associated with the ad hoc nature of the coronial system in Queensland. Relying solely on evidence of the police and medical staff, the Coroner had rejected witness statements to the effect that the deceased had been "carried and thrown" into the back of a police vehicle, and had made no comment about the questionable nature of the legality of the arrest. The proceedings had been characterised by lengthy delay (the inquest was not completed until some three years after the death), and had failed to dispel public suspicion of misconduct. The Social Justice Commissioner recommended the urgent enactment of legislation providing for a centralised and independent investigation process.

In all, there were thirteen breaches of RCIADIC recommendations. Clearly, many of these related to the police treatment of the deceased, there being obvious breaches of recommendations relating to the rough treatment of prisoners (R60), the completion of a screening form prior to placement in a cell (R125), more frequent checking of prisoners at risk (R137) and the proper medical attention delivered immediately to those not easily roused (R135 and R136). Important, too, was the seemingly unnecessary (and possibly unlawful) nature of the deceased's arrest for "public" drunkenness - this involved breaches of the RCIADIC recommendations regarding the abolition of that offence (R79), the establishment of properly-funded facilities for intoxicated persons (R80) and a statutory duty to consider and use alternatives to police detention for intoxicated persons (R81). As the Social Justice Commissioner pointed out, a number of RCIADIC recommendations regarding the coronial investigations were also breached – that of the assignment of a special coroner for these sorts of inquiries (R7), the development of specific rules for such inquests (R8), the recommendation suggesting that the coroner be legally required to consider the deceased's treatment before death (R12), and that the coroner recommend ways to prevent further deaths (R13). The RCIADIC recommendation regarding the conduct of police investigations into deaths in custody was also breached (R35).

4. Janet Blundell: died from a deliberate drug overdose in a police van at Prahran Police Station Car Park, Vic, on 10 February 1992, aged 28.

At 4 am on the morning of her death, the deceased attended Albert Hospital, where she complained of coughing up blood. Other symptoms noted were a heart rate of 130-150 and a low potassium reading, and the attending doctor described her as oriented but smelling strongly of alcohol. At about 8 am, the deceased discharged herself from the hospital against medical advice. A short time later, she was arrested by police near the hospital, having become aggressive and assaulted a person. She was violent and abusive upon arrest and was restrained by handcuffs, placed in the rear of a police van and taken to Prahran Police Station.

On arrival, the deceased was not removed from the van because of her aggressive mood and the fact that she had smeared excrement on herself during transit. The police called the hospital for her details, and inquiries were set in train to obtain mental health certification from a forensic medical officer. However, ten minutes later, the deceased was found unconscious in the rear of the van. She was removed from the van and police officers attempted to revive her. A senior constable was unable to locate a mouthpiece for further cardio-pulmonary resuscitation either in the watch-house or in any of the vehicles at the station. An ambulance attended, but she could not be resuscitated.

Toxicological analysis during post mortem was negative for alcohol, and Deputy State Coroner, Iain West, found the deceased had deliberately taken an overdose of theophylline tablets (an asthma medication), which she had not disclosed at the hospital. The deceased, who had a history of mental illness and drug abuse, had been supposed to appear in court the next day on a charge of public drunkenness. The Coroner found that it would not have been appropriate for the hospital to detain and sedate the deceased, but made the recommendation that public hospitals make available facilities and personnel such that competent after-hours psychiatric assessment could be obtained of suspected patients who may be at risk.

Reporting to ATSIC, the Social Justice Commissioner noted that the use of the police van to hold the deceased at the police station had been justified by the Coroner because of the short time involved, the deceased's aggression, and the immediate intention to take the deceased to be certified.

However, it was suggested by the Social Justice Commissioner that a preventative role could have been more vigorously pursued. After all, the police knew that the deceased had only recently discharged herself from hospital, and the forensic medical officer was primarily sought to provide mental health certification rather than treatment. Constant supervision should have been maintained.

In all, fourteen breaches of RCIADIC recommendations can be identified in this case. The recommendations mentioned above relating to the abolition of the public drunkenness offence and alternative handling of intoxicated persons were breached (R79, R81 and R80). Recommendations of protocols for the care and custody of persons who are intoxicated (R127f (i)), those who are angry, aggressive or disturbed (R127f(v)) or those suffering from a mental illness (R127f(vi)) were also contravened. So were basic medical care recommendations about the immediate medical treatment of those not easily roused (R135), the availability of safe, effective resuscitation equipment and trained staff (R159), the training of police officers to recognise those in distress or at risk (R 133) and check those persons more regularly (137), and to seek medical care if in doubt (R161). The hospital doctor's belief that the deceased smelt strongly of intoxicating liquor was indication of a breach of the RCIADIC recommendation advising review of casualty procedures in hospitals regularly attended by Aboriginals to minimise the risk of incorrect diagnosis and treatment (R252), and the recommendation about the addressing of negative stereotypes of Aboriginal people and those with drinking problems (R255). The Coroner's failure to recommend ways to prevent further deaths constituted another breach (R13).

5. Daphne Armstrong: died of a heart attack at Brisbane City Watch-house, Qld, on 25 May 1992, aged 58.

Around 1:30 pm on the afternoon of her death, the deceased was arrested for public drunkenness after police had been called by some residents. She was incapable of walking unassisted or communicating spontaneously. The deceased had frequently been arrested for drunkenness in the past, and police assumed that she was intoxicated. She was placed in a cell at Brisbane City Watch-house. Approximately two and a half hours later, police noted she was unconscious and unsuccessfully attempted to resuscitate her. She was

conveyed by ambulance to Royal Brisbane Hospital, where further attempts at resuscitation also failed.

The deceased had not, in fact, been drunk. A post mortem revealed that there were no traces of alcohol in her body. She had actually suffered a heart attack some twelve to twenty-four hours prior to her death. At the Coronial Inquiry, Coroner Gary Casey was concerned about the inherent difficulty confronting police of distinguishing between drunkenness and other medical conditions, and recommended that administrative procedures be swiftly implemented so that the "unfair and unrealistic" onus on non-medically trained personnel could be removed.

The Social Justice Commissioner found that the Coronial Inquest had been totally inadequate and had failed to dispel public suspicions. The conduct of the police had not been scrutinised, and the twelve police officers involved had invoked the privilege against self-incrimination and declined to give evidence to the Inquest.

The *Indigenous Deaths in Custody 1989-1996* report also notes that this case was referred to the Queensland Criminal Justice Commission. The Criminal Justice Commission found that the police officers' inference of intoxication was reasonable in the circumstances and that the arrest was preferable as the deceased was incapable of looking after herself. However, the instruction of the police Custody Manual, that persons being removed from premises be left free as soon as the street is reached (if they are not engaged in criminal conduct), was mentioned.

There were a staggering twenty-six breaches of RCIADIC recommendations in total in this case. Clearly, the recommendations regarding the "last resort" approach to arrest, the inappropriateness of a criminal penalty for public drunkenness and desirability of alternatives had been ignored (R79, R80, R81 and R87). The failure to introduce cell visitor schemes and improved complaint procedures (R145 and R226) can also be noted as contrary to RCIADIC recommendations.

Other recommendations breached were those requiring the development of improved medical services, including protocol for dealing with intoxicated persons (R127, 127a and 127i), as well as procedures for thoroughly and regularly checking detainees, and carefully recording and communicating relevant information about them (R137, R126, R138 and R132). So too were recommendations advising the training of

police officers to identify those at risk (R133) and training of police and prison officers in resuscitative measures (R160), with the most safe and effective resuscitation equipment readily available (R159). Like many of the other deaths, the case involved breaches of the recommendations about the handling of those unconscious or not easily roused (R135 and R136) and the immediate seeking of medical attention where doubt arises as to a detainee's medical condition (R161).

The conduct of the coronial inquiry in this case failed to live up to the coronial reform recommendations which have been mentioned above (R7, R8, R12 and R13), nor that recommending that the State Coroner be empowered to make such recommendations to the Attorney-General or Minister for Justice as s/he deems fit (R18). The recommendations about the need for thoroughness of police inquiries in such cases (R35 and R36) seem also to have been ignored.

6. Phyllis Christine May: died by self-inflicted hanging at Macquarie Fields Police Station, NSW, on 10 June 1992, aged 38.

The day before her death, the deceased decided to withdraw an appeal in relation to a conviction for what the chairman of the Aboriginal Legal Service later described as a "very, very minor" cannabis offence, and to serve the one month sentence instead. She was detained overnight at Macquarie Fields Police Station while she awaited transfer to Mulawa Women's Prison. The deceased was found in her cell at 6 am hanging by her pantyhose. She had last been observed at 4:40 am that morning.

Senior Deputy State Coroner, John Hiatt, was critical of the practice of detaining newly sentenced prisoners in police cells. He noted that it was contrary to the court warrant, the *Prisons Act* and the Police Commissioner's instructions, but had apparently been the subject of unofficial agreement between the police and the Department of Corrective Services, and condoned by Government ministers for a number of years. The Coroner also found the custodial care at the police station to be substandard and prima facie negligent. The assessment form had been filled out incorrectly, the officer had failed to inquire of the deceased whether she was Aboriginal (indeed, neither the police, nor the courts nor Corrective Services had ascertained her Aboriginality), the officers were inexperienced and had failed to observe the deceased regularly.

In all, sixteen RCIADIC recommendations had been breached. Given the minor nature of the deceased's offence, arrest and imprisonment had clearly not been considered as last resorts, as had been recommended by the RCIADIC (R87 and R92). The inadequacy of the cell detainment was another key source of the breaches of recommendations. These included the recommendations dealing with the provision of safe and humane cells (R148) and the fact that Aboriginal detainees should not be placed alone in a cell (R144).

Other breaches of recommendations could have been avoided with training and changes to police practices. The RCIADIC had recommended the training of police to recognise those at risk (R133), that there be protocols to be followed where detainees are at risk of self-harm (R127f(iii)), the regular, careful and thorough observation of police cell detainees (R137) and the adequate recording by police of these observations and other information relating to the detainee's health (R138), including the use of a screening form (R126). Instructions on the care of persons in custody were supposed to be known, understood, enforceable and publicly available (R123).

More breaches of recommendations relating to the provision of health services can be identified (R127), such as the recommendation of a regular medical presence in watch-houses (R127a), better liaison between police and Aboriginal health organisations (R127e), and the recommendation that persons detained on behalf of Corrective Services have a standard of health care equivalent to the general community (R128). The conduct of the inquest also involved breaches: there had been no implementation of the RCIADIC recommendation that an inquest should not proceed in the absence of appearance for the family of the deceased (R22), nor that of a legal requirement that the coroner consider how the deceased was treated before death (R12).

7. Sandra Wingrove: died in a police vehicle in Darwin, NT, on 30 August 1993, aged 40.

The inquest into this case was adjourned on account of delays due to difficulties in locating the deceased's family. There is insufficient information on this death to say if, and how many, RCIADIC recommendations were breached.

8. Janet Beetson: died of heart complications at Mulawa Prison, NSW, on 3 June 1994, aged 30.

One week before her death, the deceased had been placed in remand at Mulawa Women's Prison on a stealing charge. Reception forms completed at the Central Court and at Mulawa indicated that she had a heart condition (endocarditis), a scar from previous heart surgery and high blood pressure, but her full medical history, which included an aneurism and spleen problem, was not recorded.

The officer notified the reception nurse that endocytis (sic) was highlighted on the lodgment application form. The reception nurse, however, could not remember this and denied seeing any reference to endocarditis. These documents were then passed on to the assessment nurse, although she denied receiving them until three days later on 30 May 1994 (this evidence is dubious – on that date, the deceased was in court, and her documents went with her). On 31 May 1994, the reception nurse informed a doctor of the deceased's endocarditis. Without consulting her files, this doctor gave evidence to the Coronial Inquiry that she did not remember the patient. In fact, the deceased had attended the doctor for endocarditis just two years before, in 1992. The doctor formed the opinion that the deceased was merely undergoing drug withdrawal (it is doubtful whether this was ever a real factor), and ordered tests, but did not test the patient herself. A simple heart check generally detects the murmurs which indicate endocarditis. The deceased was detained alone in her cell despite indications of the screening forms that she was a high medical risk.

For the next three days, other prisoners told prison officers that the deceased was suffering more than drug withdrawal: she was pale, not eating, had had a fit and fallen. Nursing staff were also informed, but little medical attention was given. On the last two nights before her death, other prisoners reported that the deceased was moaning and groaning. She was dying from the effects of complications of mitral valve prosthesis endocarditis. The nurses' denial of hearing such noises was undermined by the fact that the prisoners' evidence was corroborated by a prison officer who was attending to a medical emergency in an adjacent cell.

State Coroner, Derek Hand, was highly critical of the nursing and medical staff. Both the reception nurse and the assessment nurse had been sufficiently alerted to the deceased's condition and action should have been commenced earlier. The doctor should have examined earlier files which

would prompted her to examine the deceased immediately. The Coroner was also critical of the nurses for failing to act after comments by other prisoners and the deceased's moaning. However, the Coroner did not make any recommendations for reform because the State Director for Nursing Services for Corrections Health Service had submitted evidence of changes that had been made since the death. These included: the appointment of a part-time medical director at Mulawa whose consent was required to place prisoners in the annexe, and an increase in the appointment of outside medical practitioners; an on-call doctor and psychiatrist twenty-four hours a day and an increase from one to three psychiatric nurses; the transferral of 120 women to another prison and development of new, safe cells; the codification of policies and procedures, clear definition of nurses' responsibilities and co-ordination between the Departments of Health and Corrective Services; and the creation of a medical alert and health notification forms. The Social Justice Commissioner, however, was more sceptical about whether the circumstances which made this death so "appalling" had been properly remedied.

Eighteen RCIADIC recommendations were breached. According to the Social Justice Commissioner, a key breach was the failure to observe the recommendation that a medical practitioner assess a prisoner within seventy-two hours of reception (R156), especially since the deceased's condition was so detectable. Indeed, one of the most disturbing aspects of this case was the lack of communication of what was, or should have been, a known health risk. This was in clear breach of a number of recommendations: those requiring health care in correctional institutions (and police stations holding detainees on behalf of correctional institutions) to be of an equivalent standard to the general community (R150 and R128), a review of the health services provided to Aboriginal detainees (152a), the establishment of detailed guidelines for the exchange of information between medical and prison services (R152f), the development of protocols for the care and management of Aboriginal prisoners who suffer illnesses (R152g(ii)), and the securing of comprehensive medical history from outside and from previous instances of incarceration, which would accompany prisoners on transfers (R157).

Also breached were some of the RCIADIC recommendations with respect to the training of personnel. The Commission had recommended the training of medical services staff in Aboriginal history, culture and lifestyle (R154a), the

instruction of Corrective Service officers for courteous interaction with prisoners (breach of which being a disciplinary matter) (R176), the training of police and custodial authorities to recognise their legal duty of care to those in their custody (R122) and that the instructions on care of persons in custody to be known, understood, enforceable and publicly available (R123).

The RCIADIC recommended the simplification of procedures for prisoner requests and other matters (R179), and that if a prisoner was found unconscious or not easily roused (or even if some doubt merely arose about the detainee's condition), the officers seek immediate medical attention (R136 and R161). These too were breached.

The authorities' treatment of the death after the event can also be called into question. The RCIADIC had recommended debriefing procedures after incidents in order to reduce future risk (R124), government efforts to settle claims by negotiation in order to avoid the further distress to families of litigation (R4b), funding for counselling for the family of the deceased (R5), and establishment of an independent complaints officer in each prison (R176) - none of these were followed.

9. <u>Colleen Richmond</u>: died from police gunshot wounds at 22-28 Fitzroy St, St Kilda, Vic, on 23 September 1994, aged 42.

The deceased, who suffered from psychiatric illness, was highly intoxicated on the day she died. A post mortem later revealed a blood alcohol reading of 0.3%, as well as therapeutic levels of sedative/hypnotic and anti-depressant medication. On two consecutive days, the deceased had attended her psychiatric clinic with a hatchet. On the second day, when she refused to relinquish the hatchet, she was locked out of the clinic and the police were called.

When the two police officers arrived, the deceased was demanding entry to the clinic, knocking on the door with the blunt end of the hatchet, but causing minimal damage. Witness accounts of what happened next differ: some said they felt afraid for the deceased, but the witness with the clearest view of the incident remembered being afraid for the police. The police radioed base and were told (inaccurately) that backup was only five seconds away. Uncorroborated police statements recorded that the police put their guns on the ground several times in an attempt to diffuse the

situation, but that the deceased raised the hatchet several times as though to throw it. The police also claimed that a warning shot was fired by one officer into the garden behind the deceased, and that the deceased then challenged them to shoot her, raised her hatchet and began to run towards them. One of the officers stated that he fired instinctively five times "without aiming". The deceased died from multiple gunshot injuries to the chest and back.

Deputy State Coroner Iain West, found some inaccuracies in the police accounts: the distance between the officer and the deceased was further than the police had indicated, and the space was too confined for the deceased to have "run" at them (although it was accepted that the word "run" was used to indicate sudden movement). However, some elements were found to be consistent with the evidence: a bullet had lodged under the head of the hatchet, corroborating the fact that it was raised. Three bullets had lodged in the deceased's back, but the Coroner found that the first bullet spun the deceased around. The Coroner's overall conclusion was that the police officers' response was appropriate in the circumstances.

However, the Coroner was critical of a number of aspects of the incident: the lack of proper training given to police in the use of firearms in the context of persons with psychiatric disabilities, the clinic caseworker's failure to communicate information about the deceased's psychiatric background in her phone call to the police, and the failure of the caseworker and the doctor at the clinic to call the Crisis Assessment Team. Post-death investigations were also criticised. The police's Internal Investigation Branch had not overseen the homicide squad, police interviews of witnesses had been inappropriate and the police brief insufficient.

The Coroner did note, though, that since the death, "Project Beacon" had been introduced. This was a five-day police training course (with two additional training days each six months), aimed at instructing police in how to deal with emotionally and psychiatrically disturbed people with minimal use of force. Other procedural changes since the death noted by the Coroner were the introduction of expandable batons and evaluation of the use of capsicum spray and recording of psychiatric histories on the L.E.A.P computer system, as well as the clarification of types of incidents requiring the Crisis Assessment Team and protocols introduced at the clinic the deceased attended.

However, the Coroner did go on to make a number of further recommendations. He recommended a critical evaluation as to the merits of a firearm being the only effective weapon to counter an attack by an assailant using an edged weapon (apparently a universally held belief). Consideration of a specialist professional unit for high risk crises was also recommended, as were the need for a "Critical Incident Review" in all cases involving death from contact between police and public, and the maintenance of complete, accurate and up-to-date entries on the L.E.A.P. Management Project computer system. The Coroner also recommended improved police internal investigation procedures: that the Internal Investigation Department be vigilant in actively overseeing investigations, that police officers involved in such incidents have their interviews recorded, and that investigators ensure appropriate background material on the officer is included in the brief to the coronial inquiry.

ATSIC's Social Justice Commissioner agreed that the situation was "a difficult one". However, the police officers' self-defence procedures might have been queried, given that witnesses had given evidence that the six firearm rounds were fired in quick succession, casting doubt upon the police account of a preliminary "warning shot". The family of the deceased are suing the Victorian Police and the State Government in negligence.

Three breaches of RCIADIC recommendations can be identified. These are the recommendation that laws and instructions on the use of firearms in arrest or prevention of escape be reconsidered (R162), and the recommendations requiring thorough police forensic investigation of deaths in custody (R35 and R36).

10. (Name Unknown): died of a drug overdose on 17 November 1995, aged 18.

The deceased died in hospital of a drug overdose, after being transferred from Mulawa Women's Prison. More complete information on this death has not, at this stage, been made available.

It is, however, possible to say that at least five breaches of RCIADIC recommendations occurred. These recommendations all relate to the immediate examination by the Police Service (in negotiation with Aboriginal Health Services and government health and medical agencies) of the delivery of

medical services to those in police custody. Specific recommendations cover liaison between police and Aboriginal health organisations to ensure transfer of information (R127e), the involvement of Aboriginal Health Services in the provision of medical advice, assistance, care and funding (R127c), and the development of protocols for managing intoxicated persons or those with serious illnesses or medical conditions (R127f(i) and (ii)).

11. Jenny Woods: died at Central Cells, Sydney, NSW, on 28 January 1998, aged 19.

The deceased was arrested on the day of her drug-related death by Darlinghurst Police, and later transferred to Central Cells. A friend noted that "she was on three different types of pills – she was really flying" when she was arrested. She was left unattended in a cell bunk with a blanket over her head, and was found dead three hours later.

An inquest is not yet complete, but there were at least seven breaches of RCIADIC recommendations according to the available information. The identifiable breaches are of the recommendations that arrest be a last resort (R87), that police recognise their legal duty of care (R122) and that there be a regular medical presence in main watch-houses (R127a). Also breached were recommendations to train police to recognise those in distress or at risk (R133) through regular, careful and thorough observation (R137), to arrange immediate medical care for those found unconscious or not easily roused (R136) and seek immediate medical care if in doubt (R161).

Discussion

A total of at least ninety-six recommendations were clearly breached in the course of the arrest and detention of these eleven women. However, it is important to note that this figure is a conservative one, given that inquiries into two of the deaths are incomplete.

Several studies undertaken and published since the conclusion of the RCIADIC make the claim that there has been a significant decrease in ATSI deaths in police custody in the past nine years. For example, Cunneen and Behrendt[11] state that looking at the overall figures of ATSI deaths in custody, "the proportion of deaths occurring in prison has increased in the period following the Royal Commission, while

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11 Cunneen and Behrendt, above n 8, p 9.

the proportion of deaths occurring in police custody has declined." This view is echoed by the Indigenous Deaths in Custody, 1989-1996 report,[12] where it is noted that 'there has been a significant decline in the proportion of deaths occurring in police custody and an increase in deaths occurring in prisons", and also by Dalton:

> "Since the Royal Commission into Aboriginal Deaths in Custody, the number and proportion of prison custody deaths have risen; in 1997 they represented 93 per cent of all institutional custodial deaths, compared to 63 per cent in 1990. There has been a substantial reduction in the proportion of both Indigenous and non-Indigenous deaths in police 'institutional' settings (e.g. a police lockup, police vehicle, or in hospital following transfer from a lockup) as distinct from custody-related police operations (e.g. deaths in community settings such as shootings, sieges or pursuits). During 1997, 21 per cent of all police custody deaths (including custody-related police operations) were "institutional", compared to 58 per cent in 1990."[13]

Whilst having no argument with this statement in general terms, the author of this paper has found that whilst this may be an accurate account of ATSI male deaths in custody, it is not representative of ATSI female deaths in custody within the same period. Of the twelve female ATSI deaths investigated by the Royal Commission, 91% died in *police* custody and 66% were health-related. Of the eleven investigated post-Commission, 73% died in police custody or police-related operations and 73 % died of health-related causes.

The Australian Institute of Criminology has recently released an *Annotated Bibliography on Deaths in Custody (1970-1996)*. The bibliography does not include everything that has been published or written on the subject of deaths in custody. It does, however, include material that is central to the topic or which is frequently used or referred to by those researching the area. On analysis of the Bibliography and its 800 odd articles, it is relevant to note that there are less than ten articles specifically related to female deaths in custody and

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12 *IDIC Report,* above n 9, p xiii, 2.7.

13 Dalton, above n 6, p 8.

even less for ATSI female deaths in custody.[14] As noted above, much has been written and published about over-representation and deaths in custody of ATSI men since the publication of the RCIADIC report, with relatively sparse literature or publications that specifically examine ATSI female over-representation and deaths in custody. [15]

ADC Overview 1991: The overview paper devotes a separate general section to ATSI women. It significantly recognises the double disadvantage they endure within the criminal justice system because of their race and gender.[16] Although this is all laudable, the document makes no reference to the women's actual future position in relation to the criminal justice system. Instead, the problem of these women's involvement has been homogenised with that of their menfolk, and both sexes have been treated collectively in the paper in the section on Law and Justice,[17] despite their gender differences.

Brooks (1994),[18] *Aboriginal and Torres Strait Islander Women in Custody.* This paper includes discussion on:

a) ATSI Women in Custody: A view from the RCIADIC;

b) ATSI Women in Custody. A case study since the RCIADIC;

c) ATSI and the Experience of Custody;

d) ATSI Women in Custody: Recent Data;

e) Future Prospects and Discussion Points.

Brooks (1996):[19] *The Incarceration of Aboriginal Women.* This chapter covers:

a) Introduction and Statistical Trends;

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14 Dalton, V (ed), *Annotated Bibliography on Deaths in Custody (1970-1996),* SBN 0642: Australian Institute of Criminology. (Note: Reports of the RCIADIC have not been included).

15 Howe, A, "Aboriginal Women in Custody: A Footnote to the Royal Commission" (1988), 30 February *Aboriginal Law Bulletin* 5.

16 *Aboriginal Deaths in Custody: Overview of the Response by Governments to the Royal Commission,* Canberra: Australian Government Publishing Service, 1991, p 31-33. ("*ADC Overview of Response*")

17 *ADC Overview of Response,* above n 17, p 32.

18 Brooks, M, *ATSI Women in Custody* (1994). A paper presented to the Australian Institute of Criminology Conference on Aboriginal Deaths in Custody, Post Commission. Townsville, 1994, p 1-20.

19 Brooks, M, "The Incarceration of Aboriginal Women" in Bird, G, Martin, G and Nielsen, J (eds), *MAJAH, Indigenous Peoples and the Law:* Sydney: The Federation Press, pt 261-280.

b) The Double Jeopardy: Gender and Race;

c) The lesser nature of ATSI Crime;

d) Doing time;

e) Future Prospects.

As mentioned earlier in this paper, there were at least ninety-six contraventions of the RCIADIC recommendations in the eleven ATSI female custodial deaths that occurred between 1990 and 1998. There were also eight deaths that occurred in police custody or during police related pursuits, sieges or operations. So one must question the integrity and commitment of signatories to the *Overview of the Response by Governments to the Royal Commission,* when one considers the extremely high numbers of recommendations that have been blatantly breached in the eleven ATSI female deaths under investigation post-Commission.

The *Indigenous Deaths in Custody, 1989-1996* report noted the haphazard implementation of the recommendations and went on to suggest alternative mechanisms to promote implementation. At [12.1] it stated:

> "Recommendations which require legislation, such as those on the principle of custody as a last resort, public drunkenness, the sentencing powers of justices of the peace, prisoners' rights and legally enforceable custodial health and safety rules, have *not been implemented* [my emphasis]. This indicates that a co-ordinated program is required, necessarily involving the Commonwealth and State Law Reform Commissions."[20]

It went on in [12.2] to highlight the legal implications for failure to implement the recommendations:

> "The recommendations are *not* [my emphasis] mere suggestions. They can have precise legal implications under common law relating to negligence, misfeasance in a public office and, potentially, other actions. If a custodial authority breaches recommendations, and that contributes

20 *IDIC Report*, above n 9, p xx.

> to a death in custody, the custodial authority may be liable in damages."[21]

When one examines the particular recommendations breached in the eleven deaths post-Commission and notes the number of times the specific recommendations that require legislation have been breached, one must question the value of the RCIADIC. Unfortunately, it seems that nothing but lip service has been put into practice.

The *Indigenous Deaths in Custody 1989-1996* report includes in Appendix I a table of government implementation, which records the degree of governmental compliance with RCIADIC recommendations in each State and the Northern Territory. However, that information must be tempered with the statistics of post-Commission deaths - the effectiveness of implementation must be questioned if the implemented recommendations do not appear to be preventing the continuing deaths of ATSI women in custody.

In New South Wales, for example, of 144 RCIADIC recommendations dealing with police practices, courts and imprisonment, custodial conditions, juveniles and post-death investigations, a total of ninety-seven are said to have been fully implemented by the New South Wales Government (not including one which has been implemented but with funding in question), and twenty-one recommendations partially implemented, with application in principle in the case of one recommendation, and a pilot program in the case of one other. Another nine are the subject of ongoing implementation, and support has been noted for a further seven recommendations, and qualified support for another two. No information could be obtained on five of the recommendations. New South Wales would thus appear to have a fair record of implementation of RCIADIC recommendations, the *Indigenous Deaths in Custody 1989-1996* report recording some degree of implementation in many cases. Yet the effectiveness of that "implementation" still remains questionable: it is disturbing to note that of the eleven post-Commission female deaths, four occurred in New South Wales, a significant increase considering that State did not have any female ATSI deaths in the nine-year period investigated by the Commission.

The Victorian Government has almost as high an implementation rate as that of New South Wales: it has fully

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21 id, p xxi.

implemented ninety of the 144 RCIADIC recommendations, and forty-four recommendations have support for implementation. Two recommendations are not relevant, and eight recommendations have not been implemented. However, like New South Wales, there were no ATSI female deaths in the State of Victoria in the period investigated by the RCIADIC, yet there were two deaths in that State after the Commission.

So the two States which were not investigated for ATSI female deaths in the nine-year Commission period have experienced increases in the nine years since then, despite "implementation" of many of the Commission's recommendations. Conversely, the States and Territory in which female deaths were investigated by the RCIADIC all experienced decreases of ATSI female deaths in the nine-year period post-Commission.

In Queensland, for example, three ATSI females have died in custody since the RCIADIC, compared to seven in the RCIADIC investigation period. The *Indigenous Deaths in Custody 1989-1996* report records a fairly slow start to implementation in that State. At the date of its publication, a mere fifty-seven recommendations could be described as fully implemented, with thirty-six partially implemented and twenty-one imminent. Twenty-five recommendations were still in the process of ongoing implementation, two were not implemented at all, and no information could be gathered on three recommendations.

Western Australia also experienced a decline: one ATSI female death occurred in Western Australia since 1989, compared to three in the RCIADIC investigation period. Despite this decline, Western Australia, like Queensland, lags behind New South Wales and Victoria in its implementation of recommendations. The *Indigenous Deaths in Custody 1989-1996* report noted that seventy-seven recommendations were fully implemented, forty-five the subject of ongoing implementation and nineteen partially implemented. In one case, full implementation was not supported, in another, the State was not responsible for implementation and one recommendation was not implemented at all.

South Australia was another State in which the ATSI female custodial death rate in the nine-year period post-Commission appears to have improved since the nine year period investigated by the Commission. The deaths of two ATSI

women were investigated by the Commission in South Australia, but none at all were recorded in the post-Commission period - this despite a level of recommendation implementation which falls below Victoria and New South Wales standards. In South Australia, seventy-eight of the 144 relevant RCIADIC recommendations were described as fully implemented in the *Indigenous Deaths in Custody 1989-1996* report. Twenty-two were partially implemented, thirty-seven in a state of ongoing implementation and seven not implemented at all.

Tasmania recorded no ATSI female custodial deaths since 1989, and neither were any investigated by the Commission. That State has seen only twenty of the recommendations fully implemented and five partly implemented, but that State has had the least need to implement the RCIADIC recommendations, with forty-six of them already covered, addressed or current practice and one partially covered. A further forty-six recommendations have received support, one qualified support, four have support for certain parts of the recommendation and thirteen are subject to ongoing implementation. Three of the recommendations are not applicable in that State and five remain unsupported.

One death occurred in the Northern Territory in the nine years after the Commission, compared to two in the RCIADIC investigation period. The Territory had the highest - yet still not complete - level of full implementation of recommendations, with 106 of the Commission's 144 relevant recommendations fully implemented and twenty-one partially implemented, according to the *Indigenous Deaths in Custody 1989-1996* report. One further recommendation had full support and ten recommendations had qualified support. Two recommendations received no support at all and the Government was not responsible in another four cases.

That any ATSI deaths occur in custody at all since the exposé of the Royal Commission is concerning. But perhaps what is even more concerning is the fact that (apart from the comparatively encouraging rates of implementation in the Northern Territory) two of the States with the highest levels of full implementation of RCIADIC recommendations (New South Wales and Victoria), still saw increases in their ATSI female custodial death rates; whereas some States with poorer levels of implementation (such as Western Australia and Queensland) actually saw some improvement in such death rates in the post-Commission period. It seems that the

conclusion to be drawn is that governmental "implementation" bears little relationship with improved outcomes for ATSI women, begging the question of whether it can really be said that the recommendations have been "implemented" at all.

There can be no doubt from the evidence presented in this paper that in recent years the number of Indigenous people in Australia's prisons has continued to increase, as has their level of over-representation in both police and prison custody. It needs to be emphasised that Indigenous people are heavily over-represented in the number of custodial deaths compared with their number in the community. Nationally, Aboriginal adults represent about 1.6 per cent of the Australian adult population, but they represent approximately 17 per cent of the total prison population. In 1997, more than 13 per cent of all custodial deaths were of Indigenous people.[22]

A number of explanations have been offered for this over-representation,[23] but in many ways it can be directly related to the first point of contact between the police and ATSI peoples. As Cunnen and Libesman state, it is the police who "stand at the entry point for Aboriginal people into the criminal justice system".[24] It has been noted that Aboriginal and Torres Strait Islanders are over-represented in many categories of criminal offences, but the level of over-representation is especially alarming in the very common area of public order or "street offences".[25]

David Brown, et al, point out that, It is the police who:

> "decide which behaviour to pursue, effect the arrest, lay the information, make decisions and submissions as to bail, attend to basic court

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22 Dalton, above n 6, p 8.

23 For example, the recent ATSIC publication *As A Matter of Fact: Answering the Myths and Misconceptions about Indigenous Australians*, Canberra: ATSIC, 1998, outlines a complex mix of factors: socio-economic factors, offending patterns, the impact of policing, legal factors, cultural difference, an attitude of defiance and history of marginalisation.

24 Cunneen, C and Libesman, T, *Indigenous People and the Law in Australia*, Sydney: Butterworths, 1995, p 60.

25 Cunneen and Libesman, as above, record that a national survey conducted for the RCIADIC in 1988 found that 63.7% of Aboriginal people in police custody were there for public drunkenness and street offences. The authors note that a similar survey in 1992 yielded a similar result.

> administration, act as complaining witnesses and prosecute the accused".[26]

They add that it is the police who are also identified as the victim in respect to many offences – particularly some common offences committed by ATSI peoples:[27] resisting arrest, assault and offensive language charges ("the trifecta"). Those authors then note that the police are vested with enormous (and often unreviewable) discretion as to whether to investigate, whether to summons or arrest, whether to charge, what to charge with and how to proceed. Police should also surely be vested with a great deal of responsibility as custodians when they elect to detain indigenous persons.

Indeed, the findings of the RCIADIC centred heavily on the question of a 'duty of care'. Reporting on the custodial care of those who died in custody, the Commission found glaring deficiencies in the standard of care afforded many of the deceased, during at least portions of their incarceration. While these deficiencies of care were found, broadly speaking, across all types of custody, they were found to be more glaring in relation to police custody in police cells.[28]

The Royal Commission noted that:

> "...the existence of the duty of care is fundamentally associated with the fact that by definition a person in custody has been taken from his or her ordinary environment, cut off from normal sources of assistance, whether from friends and relatives or from medical welfare and other such services, and made dependent for all requirements upon the custodial authority."[29]

It added that the general lack of understanding by police of their duty of care was reflected in the evidence of the individual cases that were under investigation by the Commission.[30]

The RCIADIC found that being detained in custody also means that the prisoner is deprived of access to normal medical

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26 Brown, D, et al, *Criminal Laws, Volume II*, 2nd ed, Sydney: The Federation Press, 1996, p 912.

27 See, for example, NSW Anti-Discrimination Board, *Study of Street Offences by Aborigines*, 1982, noted in Brown, et al, above n 26 p 948.

28 *RCIADIC Report*, Volume 2, above n 1, p 77.

29 id, p 81.

30 id, p 79.

services, thus the courts have held that the duty of care owed by the prison officers extends to the provision of medical care and assistance in cases where the circumstances reveal that a prisoner does or may need such care and assistance. [31]

I can think of no better way to end this paper than with the following poignant words of Kev Carmody.

> *In 1788 down Sydney Cove the first boat people land*
>
> *and they say: sorry boys, our gain's your loss - we're gonna steal your land*
>
> *and if you break our British laws, then sure you're going to hang*
>
> *work your life like our convicts, with a chain on your neck and hands*
>
> *They taught us: black woman thou shalt not steal, say hey black man thou shalt not steal*
>
> *gonna civilise your black barbaric lives and teach you how to kneel*
>
> *but your history couldn't hide the genocide, the hypocrisy of what was real*
>
> *and your Jesus said you're supposed to give the oppressed a better deal*
>
> *say to you white man thou shalt not steal*
>
> *our land you'd better heal...*
>
> *and a racist contradiction that's understood by none:*
>
> *the left hand holds the bible*
>
> the right hand holds the gun...[32]

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[31] ibid.

[32] Kev Carmody, *Pillars of Society* and *Freedom* albums.