REGIONAL REPORT OF INQUIRY INTO INDIVIDUAL DEATHS IN CUSTODY IN WESTERN AUSTRALIA VOLUME 2

BY
COMMISSIONER THE HONOURABLE D.J. O'DEA

5.2.5 SUPERVISION AND CELL CHECKS

The police basically have a twofold role in relation to the detention and supervision of persons in their custodial facilities, first, to keep detainees secure and prevent them from escaping and secondly to ensure that detainees are adequately cared for, providing for their health and well-being. My inquiries have revealed that until recent times the emphasis of police policies and practices was on the first role relating to security with scant attention paid to the duties of the police in relation to caring for detainees.

The need to change the emphasis has been recognised by the Police Department. In the Submission of the Commissioner of Police and the West Australian Police Department to the RCIADIC (May 1990) it was stated (at pp 16-17):

> The traditional role of police with respect to the management of lockups was to keep the lockup reasonably clean and quiet, to feed detainees, keep them from escaping, and to get them to court on time.
>
> As the police officers responsible for the management of lockups are also responsible for other policing duties, the current emphasis on health and well-being of detainees, requires a shift in emphasis of policy and procedures to enable proper management.
>
> The physical structure of the majority of existing police lockups limits audio and visual contact between police and detainees with the result that the type of supervision required to provide detainees with protection from themselves and others in ail effective and efficient manner, is almost impossible.
>
> As a result, options have been developed to bring the philosophy and technology of lockup management into line with contemporary standards. The base line for the Police Department and the Commissioner has been an acceptance of the current standards of care and daily operations arc structured around this philosophy.
>
> The Commissioner of Police acknowledges that adequate policies and procedures must be established and followed in practice. These must also be supported by needs-based training to ensure that procedures are clear and members are in fact, able to implement the policies of the organisation.
>
> <u>IT IS THE POLICY OF THE WESTERN AUSTRALIA POLICE FORCE TO EXERT EVERY POSSIBLE EFFORT TO PREVENT</u>
>
> <u>LOCKUP DEATHS AND SUICIDES INCLUDING THE SCREENING OF DETAINEES AND APPROPRIATE SURVEILLANCE.</u>

To implement the policy the Police Department has considered further training, awareness raising, policy and procedure revision and better personnel management within existing resources. They have also given attention to maintaining records of supervision practices, the viability of electronic surveillance, installation of alarm systems and the need for adequate support ,services and liaison with community resources. These issues are discussed in more detail below.

5.2.5.1 What the Cases Have Shown

In all of the deaths I have investigated arising out of police custody, the level of supervision afforded to the detainees during the period for which they were incarcerated, was inadequate. As noted in the previous section dealing with Assessment and Screening, the inadequacies were discussed in the individual reports into the deaths where I emphasised the duty of care owed by police to detainees.

The following examples are illustrative of the inadequacies I have found throughout my case inquiries.

Christine Jones

Christine Jones was found dead within fifteen minutes of being placed in a cell at Midland Police Station Lockup. As noted in Section 5.2.3, proper assessment would have indicated that her condition required medical attention and that in the interim the police needed to keep her under continuous supervision. This case shows how quickly death can occur where a person in a highly distressed condition is placed in a lockup alone and the need for continuous supervision in these circumstances.

Albert Dougal

Albert Dougal as discussed in Section 5.2.4, dealing with detention of unconscious persons, was placed in the lockup in an unconscious condition. In the report into his death I described the cell checks as 'haphazard'.

Dougal was placed in the Broome Lockup at 8.45 pm. It was not until 7.30 am the following morning that an ambulance was called. During the period that Dougal was in the lockup only one cell check was noted in the police station occurrence book. This was at 2.55 am just prior to the police going off duty. I found that the police visited the cells on other occasions during the night but were not concerned about Dougal's condition. These other visits were not recorded in the Occurrence Book. During these visits the police officers made no effort to ascertain his condition or state of health. The police assumed he was drunk.

Broome Police Station was effectively not staffed from 1.00 am until 7.30 am. Even if other prisoners in the lockup had become aware of Dougal's condition they would have been unable to alert the police.

The situation at Broome Police Station continues today with the police station not being staffed from 2.00 am or 3.00 am until 7.00 am. Adequate supervision of detainees cannot be provided under these circumstances.

Robert Anderson

Robert Anderson was arrested and detained at Wiluna Lockup for drunkenness on a Saturday afternoon. He was unable to be appropriately assessed at the time of detention due to his intoxicated condition. One cell check was recorded half an hour after his admission. The only other cell check recorded on Saturday night was at I 1.00 pm. The following Sunday one police aide only was on duty. He performed two cell checks during the day. The police aide described what was required when performing a cell check:

> *We would just pop into the lockup, count heads and keep going.*
>
> [RCIADICW16:206]

> *If they felt crook they had to come and ask and we would say 'Well, go up to the nursing post'.*
>
> [RCIADIC WI 6:208)

On Sunday night the OIC conducted cell checks at 6.00 pm and 8.00 pm. The Police Station was unstaffed overnight. At 7.00 am the following morning Anderson was found dead in the lockup having died as a result of epilepsy.

The supervision and cell checks conducted during the period of Anderson's detention were unsatisfactory. No active inquiries were made of detainees to ascertain whether they required anything for their health or well-being. Anderson was a known epileptic and was also known to ask for his medication when detained. It was unlikely that the deceased would have had the opportunity to request his medication given the infrequent and perfunctory nature of the cell checks.

Wiluna Police Station is still not staffed overnight although prisoners may be detained there.

Kim Polak

Kim Polak was detained in the Kalgoorlie Lockup on Tuesday afternoon, 26 March 1985. He was assessed as 'intoxicated' although he was in fact quite ill. That evening he was observed by other prisoners to be vomiting. The following day his condition was much the same. He was unable to eat, and told the sergeant 'he had a crook stomach'. This officer had also observed that Polak's hands were shaking badly and attributed this to delirium tremens. He did not consider it necessary to call a doctor.

Polak's condition remained the same and he vomited whenever he had any food or fluid. On the Thursday morning he told another Sergeant that he was 'crook' from alcohol. The officer did not find this surprising. He considered there was a difference between being 'sick' and 'sick from the booze'. During the Thursday afternoon Polak had a fit and although it was witnessed by other prisoners they did not bring it to the attention of the police. Later in the afternoon a prisoner alerted the police that Polak could not be roused. He was examined by the sergeant who could find no signs of life.

The police officers in this case did not consider that the symptoms of withdrawal from alcohol constituted an illness requiring medical treatment. The two sergeants who conducted most of the cell checks during Polak's period of detention had no knowledge of the risks and little of the symptoms of acute alcohol withdrawal. The police relied upon those in custody to draw it to their attention if they were unwell or required medical treatment. Polak was seriously ill and although he may have been reluctant to seek out medical attention his ability to appreciate the seriousness of his condition is questionable.

Bernard McGath

Bernard McGrath died by hanging in the Kalgoorlie Lockup. I found that he died between 12.20 am and 12.30 am on Sunday, 15 November 1985. Police officers placed another prisoner in the cells at 12.35 am who noticed Bernard hanging from the cell door. At 1.00 am that prisoner was removed from the lockup for questioning by the police. The prisoner told the police there was 'a dead bloke' in the cell. The police did not believe him. When the prisoner was returned to the lockup at 2.00 am one of the officers asked *'Where's the body?'* to which the prisoner replied *'You'll find out'.* The police did not conduct a check of the lockup.

At 3.00 am the officer in charge of the shift conducted a cell check. He claimed that he entered the lockup and counted the prisoners and reaching the correct tally, left the lockup. At the time Bernard was dead and if the cell check had been properly conducted his body would have been discovered.

The officer was subsequently charged under the Police Regulations and disciplined for his failure to properly carry out the cell check.

As I noted in the report into McGrath's death, if the cell check was inadequate there was a good reason. The officer who conducted the cell check was alone in the police station. There were twelve prisoners in the lockup. It was unreasonable to expect that a single officer could properly conduct a cell check in those circumstances. The staffing at the Police Station that night was unusually low with only three officers on duty. As I said in the McGrath report: *'This was manifestly incompatible with the proper supervision of prisoners in the lockup and the maintenance of staff safety'.*

The issues raised by these and other cases, discussed in more detail below, are as follows:

- the adequacy of supervision
- the records of cell checks
- communication of observations by officers to the officer in charge
- problem of adequate staffing levels
- lack of twenty-four hour supervision at country lockups
- the physical structure of lockups and the impact on supervision
- the utilisation of other prisoners to monitor the wellbeing of detainees
- electronic surveillance and alarms
- liaison with other support services.

5.2.5.2 Current Police Practices

The orders and instructions of the Police Department relating to supervision and cell checks ate as follows:

Routine Orders

16-8.2 *On each occasion when commencing duty, a member who is in charge of a lockup shall personally visit the cells and take over the prisoners in the presence of the member being relieved and also take over the property which is specified in paragraph 16-8.13.*

16-8.3 *The member in charge of a lockup shall ensure that the locks of all cells or other places where prisoners are confined and all doors leading to yards or passages from the cells or such other yards or passages from the cells or such other places are securely locked.*

16-8.3.1 *The security of prisoners is the responsibility of the member in charge of a lockup and the security risk that each prisoner presents will need to be assessed according to the particular circumstances. Not only should measures be taken to prevent an escape, but also to protect pri soners from themselves or other prisoners if the need arises.*

16-8.3.2 *When assessing what security measures should be implemented for a prisoner, consideration should be given to:-*

(1) *the nature of the offence committed; (e.g. sex offences against children, murder, terrorist activities)*

(2) *the antecedents of the prisoner; (e.g. history of escapes)*

(3) *the behaviour of the prisoner at the time; (e.g. violent or suicidal)*

(4) *whether the lockup facilities and staff availability are adequate to provide for the segregation and/or constant supervision of a prisoner if so required.*

16-8.4 ...

(2) *each prisoner who is held in a cell or other place of confinement is visited frequently by a member for the purpose of ascertaining the prisoner's reasonable need@;*

Police Gazette Notice, 13.1.88

(v) *Observation of a person demonstrating mental and/or physical distress, including those suffering from the effects of alcohol or drugs, should be made with sufficient frequency to ensure the well-being of the person involved.*

Instruction of P.M. Myles, Supt Regional Officer Perth 14.7.88

Re: *Inmates of Lock-up - Welfare and Safety.*

It is essential that where there is a lock-up in use at any Police Station the precautions against deaths in custody are observed.

Instructions have already been circulated about frequently visiting prisoners in cells and recording such visits either in occurrence books or books for the purpose.

O.I.C.s of Stations are to check to ensure that visits are made and recorded. Entries should be initialled when checking. Divisional Officers or their Assistants are to make frequent checks to see that safeguards are carried out, properly recorded and monitored.

Should the Regional Officer or perhaps the Commander of the Inspectorate visit the station and check this aspect he will complete the chain of monitoring. Should there be any neglect in this respect it will reflect on us all.

P.M. Myles
Superintendent
Regional Officer
Perth Ext. 1077
July 14, 1988

Custodial Care Manual

The following suggestions are made in the Custodial Care Manual (distributed to officers who attend the Custodial Care course) as ways to prevent deaths in custody. They are not instructions of the Commissioner of Police.

(11) If it is necessary to detain an offender and there is any doubt as to the mental state of the prisoner and there is insufficient staff available to maintain a watch on such prisoner then transfer to a continuous duty (24 hour station) centre is to be considered and if deemed necessary then the transfer of the prisoner is to be carried out.

(12) Regular cell checks are to be conducted during the period of the offenders incarceration until the offender is either released to ball, transferred or released after court.

(13) Cell checks are to be conducted on a half hourly basis more frequently if possible and such cell visits are to be recorded in the station occurrences and to be included are any obvious change in the condition of the prisoner ie, restlessness, demeanour and attitude. Also reference is to be made as to whether the prisoner is awake or sleeping etc.

(16) Under no circumstances is a &stressed prisoner to be left unsupervised.

(17) Reliable prisoners who are permitted to sleep on beds in the compound at night could act as monitors, and call station OIC should a problem arise after close of station.

At one man stations where the OIC is called away, and a prisoner is in custody, arrangements could be made for local ambulance driver or nurse to visually check inmate as an additional safeguard.

(19) Where possible, arrests on warrant are made at a time when it is suitable for local police to convey prisoner to nearest regional centre to obviate necessity in retaining prisoner at an unmanned lockup.

(20) Where the prisoner's disposition or mental stability is suspect, the prisoner is to be conveyed to regional centre as soon as possible to allow more adequate supervision in custody.

(22) Early warning device (alarm) to be installed in a cell in the lockup, with direct link to OIC's quarters.

In the event of a prisoner requiring medical attention or other urgent assistance, the OIC can be alerted and investigate.

A report proposing to both permit and encourage civilian visitors to lockups, has been submitted to the Commissioner for consideration. This proposal originated in South Hedland.

The Police Department is of the view that the current instructions in regard to supervision and cell checks are adequate. (Responses of Commissioner of Police to Specific Questions Raised by RCIADIC Q. 10. I p.38)

Frequencv of Cell Checks

Although the Routine Orders do not specify how frequently cell checks are to be conducted, the custodial care manual suggests that they should be conducted as frequently as every half an hour. This however does not appear to be the current practice. It was suggested to Commissioner Bull that the Routine Orders should provide some guidance as to the frequency that cell checks should be conducted. However he resisted such a proposal.

Counsel. Assisting (C.A.): *Now would I be right in saying that there is nothing in routine orders to give any guidance to members as to how frequently they should be conducted, how they should be conducted or even whether they should be recorded.*

Cmr Bull: *That has changed. With the new instructions they certainly are to do them as frequent as circumstances dictate but again there can't be - you've got to be flexible according to the type of prisoner and also the nature of the station, mindful that outside of the metropolitan area only my regions - my eight regions sorry, seven of my eight regions work 24 hours a day. All other stations statewide do not work 24 hours a day. Frequently they would cease - and I have a schedule within my submission and that's the one we spoke of today but they would finish around midnight, I o'clock in the morning, rare for them to go beyond that.*

And, of course, many of them after that time, many of them still have prisoners in custody and because of their isolation there's no opportunity to transfer those prisoners. So it's because you can't have, you know, rigid orders that can be enforced statewide because of the difficulties. But even in the metropolitan area - we had a situation at Rockingham, you know, which is still fairly well out, and where two officers on duty arrested a person, placed them in custody, made arrangements for the *prisoner* to *be* transferred to *Fremantle because they couldn't go* to *bail, in the interim received another call, they had* to *attend* to, *they* attended *to that* call, *in the* interim *the* person *committed suicide.*

There is inability to *have sufficient staff* at all *of these stations where they can regularly do these checks.*

C.A.: *Well, if routine* orders *though* are the *guideline for members by and* large, *why* not *say: as* a *guideline* to *members cell checks should be conducted hourly, as a guideline.*

Cmr Bull: *But again you say hourly and they do it precisely just only do it hourly. You know, this is the difficulty with orders even if they are only for guidance. I want them to do them and this is* the *way the new ones are framed, that they must do them according to prevailing circumstances. If they've got a person that is a risk factor I'd be expecting* them to *do them every few minutes, or constantly observing the person, not doing them hourly.*

C.A.: *Well, the officer in charge of the station could say: well, there's nothing in routine orders to even give me a guide as* to *how often* they *should be conducted. I will decide that* there'll *be three* ---

Cmr Bull: *We say at least hourly - we say* at *least hourly.*

But we don't want them, you know, to just sit and believe that that's all they have to *do.*

C.A.: *That's in the new - it's in the new orders, is it: at least hourly?*

Cmr Bull: *Yes, yes.*

C.A.: *But the current routine orders don't provide* that, *do they?*

Cmr Bull: *No, no. No, it's at least hourly they are now required to do them.*

C.A.: *I see.* All *right. Is there any in these new routine orders - I don't have them,* but *in the new routine orders is there any* ---

Cmr Bull: *No, they're still being written.*

(Conference with Commissioner Bull 31.7.90:659-660)

The difficulty of the Department in this regard is recognised however the experience of the Royal Commission has clearly shown that more specific guidelines as to frequency of cell checks are required.

Commissioner Muirhead (as he then was) recommended in the Interim Report of the Royal Commission that persons detained in custody should be closely monitored for the first six hours as international research has shown this period to be crucial. Recommendation 15 stated:

> *15. Persons detained in custody must be closely monitored for the first six hours of detention and the appearance of the person should be recorded. Where persons detained are apparently intoxicated or appear angry or disturbed, very close surveillance must be maintained.*

It would not be difficult to draft guidelines requiring cell checks to be conducted every thirty minutes or one hour with the proviso that this is to take place when the police station is staffed.

24 Hour Supervision

I must make it clear however, that I do not regard the current practice of detaining prisoners in unstaffed police lockups as acceptable. There clearly cannot be adequate supervision in such circumstances.

The Police Department and the Commissioner of Police in their submission to the Royal Commission commented on this issue:

> *The monitoring of prisoners in country lockups after hours remains of concern. Where stations are not manned continually prisoners must be left unattended for several hours. Even if sufficient resources were available to place officers on continuous duty, the unpredictable nature of police work would mean that continuous monitoring is neither practical nor possible.*
>
> *Attached to this submission is a schedule of lockups in this State, together with options for continuous supervision and availability of alternative procedures. It is the Commissioner's belief that only a substantial commitment of resources by Government could achieve the optimum conditions and in the absence of such a commitment, existing police practices are the best that can be offered.*

The four options provided by the Police Department to ensure country police stations are manned 24 hours a day are as follows:

Option		Cost
1.	Provision of 24 hour police service at all country police stations (1753 additional staff at 122 police stations)	$280.5 million
2.	Provision of a permanent lockup keeper at all country police stations (610 additional staff at 122 police stations)	$97.5 million
3.	Provision of 24 hour police service at 20 larger police stations (I 61 additional staff at 20 police stations)	$25.7 million
4.	Provision of a permanent lockup keeper/guardian at larger police stations (100 additional staff at 20 police stations)	$15.9 million

The other option not adequately explored by the Police Department is to limit overnight detentions to police stations where 24 hour service is available and to ensure that if a prisoner is unable to be transferred to a 24 hour police station or alternatively a Corrective Services institution, that they are released on bail if possible or additional staff are rostered on duty on a needs basis.

Adequacy of Supervision

The cases I investigated showed that when cell checks were conducted they were usually no more than a head count, if that. Rarely were active inquiries made of the detainees as to their health and wellbeing or whether they had any particular needs. This reflects the previous emphasis of the police on maintaining security rather than caring for prisoners.

The need to provide guidance to officers as to how they should conduct cell checks was raised with Commissioner Bull and again he was reluctant to agree that such guidance was necessary maintaining the need to keep a flexible approach. The evidence in this regard is as follows:

C.A.: *Is there any guidance given to members as to how they should conduct cell checks? And I'll preface that question by saying that we've often heard evidence that cell checks didn't amount to too much more than a head count.*

Cmr Bull: *Yeah. That again depends on the circumstances. Now, the difficulty of, say, physically waking a prisoner in a cell check once every hour - now, that causes difficulties. You put a person in there that wants sleep and you're waking them up every hour -particularly if they have been drinking, generally they'll become very aggressive being woken up.*

And who wouldn't? If someone comes waking me up at every hour of the night I'd probably get a bit upset too. When they want to sleep and we're shaking them and telling 'em that they've gotta wake up. And it's the security aspect of -particularly in, say, the larger lockups in regard to this, there are difficulties in physically going waking people up on the hour or whatever time there may just - and for what purpose?

If they have a difficult[y] that we weren't aware of and they do die, well, all you achieve is perhaps you have detected the fact that they're dead within a shorter period.

C.A.: *Yes. Do you say it's not necessary to give members any guidance at all as to how they should conduct a cell check?*

Cmr Bull: *Because it's got to be flexible. I mean, when I say there is guidance but it can't be rigid because it's - in the new routine orders we've tried to give them guidance as to, you know, what they should be looking for. But again it's going to vary according to, say, the bulk of the prisoners who don't cause any problems, who don't have any medical problems, to those that, you know, perhaps have potential.*

And therefore it's again it's got to be flexible. You can't have rigid instructions that are going to cover all of these situations.

C.A.: *You agree though that members should be given guidelines and understand they ---*

Cmr Bull: *They've gotta be given guidelines, yes.*

C.A.: *But at the moment they don't seem to have any.*

Cmr Bull: *Not to the extent - in the current routine orders they have to some degree but they're probably not sufficient.*

(Conference with Commissioner of Police 31.7.90:660-1)

I agree with Commissioner Bull's conclusion that the current routine orders are not sufficient. Additional training and guidance is required. In individual reports I have stressed that adequate cell checks involve making active inquiries of detainees as to their health, medication requirements and other needs whilst detained.

The Webster Committee were also of the view that further training and guidance was needed in relation to supervision of detainees.

Records of Cell Checks

As noted above the frequency of cell checks as revealed by my inquiries has, in many instances, been shown to be unsatisfactory. In a number of cases police officers on duty during the period of the deceased's detention claimed that the cells were visited although no record was made of the fact, saying that it was not the practice at the time.

Commissioner Bull informed the Royal Commission that he had issued an order within the last twelve months requiring police officers to record all cell checks on the Police Station Occurrence Book, the record which is kept in all Police Stations of police activities. (See Commissioner Bull's evidence 31.7.90:662) However the Responses of the Police Commissioner to Specific Questions Raised by the RCIADIC stated that there was no official requirement that cell checks be recorded although 'over time a practice has grown that this is so and members now do this as a matter of course' (Q. 10.2, p.38)

As correctly informed by the Police Department, no such order has in fact been issued although a suggestion in the Custodial Care Manual (see reference to point (I 3) above) directed members to conduct cell checks half hourly and record them in the Occurrence Book. As the section of the Report dealing with police training notes, not all members of the Police Force received the Custodial Care training. Since Commissioner Bull gave evidence to the Royal Commission the requirement that cell checks be recorded has been reinforced by an order issued by Commissioner Bull on 27.8.90 and recently published in a Gazette Notice. The instruction is as follows:

> *(2)* Cell Checks
>
> *Existing orders require that prisoners be visited regularly to ensure their safety and welfare and to determine their reasonable nee&.*
>
> *Members conducting cell checks are to have possession of the cell keys during each check and must record the time of each check and their observations of each prisoner. Cell checks may be recorded in the Occurrence Book, on Prisoners' Cards where these are used, or in any other suitable book maintained for this purpose.*

Communication of Observations to Officer in Charge

In several cases I examined I found that although individual officers had made observations that there was something wrong with the deceased, the singular observation was not sufficient to alert the officer to the seriousness of the situation. The observations

were not recorded or passed on to the OIC of the shift. If the OIC at the time had been aware of all the singular observations of the officers on duty he would have been in a much better position to make a proper assessment of the detainee and determine appropriate supervision.

In the inquiry into Morrison's death, I found the arresting officers did not communicate their observations of the deceased's bizarre conduct prior to and at the time of his arrest to the OIC or the lockup keeper prior to his placement in a cell. The arresting officers who attended Morrison at the cells after their return to the police station were not aware of Morrison's unusual and aggressive behaviour at the police station. The lack of communication amongst officers contributed to the lack of appreciation of Morrison's mental state. Morrison died by hanging within an hour of placement in the cells.

The case of Waigana has been discussed previously. It showed an appalling lack of communication amongst officers as to the condition of the deceased. A number of police officers on duty during the period of Waigana's detention made observations of Waigana which if brought to the attention of the OIC should have prompted him to consider that the deceased needed some form of treatment. He did not smell of alcohol but appeared intoxicated; he complained of pain in the head; he hallucinated; he manifested terror and claimed that someone was trying to kill him. As these matters were not conveyed to the OIC he failed to grasp the full significance of the deceased's strange conduct. Waigana died from delirium tremens in the East Perth Lockup.

The lack of communication between police officers, particularly in busy police stations like East Perth, indicates the need to have effective systems whereby there is communication of information necessary to the adequate supervision of a detainee and that one officer has overall responsibility for the supervision of detainees.

It would appear that to ensure adequate communication of information about a detainee there should be a requirement that all observations of a detainee which may indicate that the person is at risk need to be communicated both orally and in writing. The Occurrence Book and the trial Admission Record referred to in the Assessment and Screening section would be appropriate places for information about a detainee's condition or behaviour to be recorded. The information should also be communicated orally to the OIC or the person allocated the responsibility for supervision of detainees. This is discussed in more detail below.

Responsibility for Supervision

In the section of the Report dealing with assessment of detainees, I discussed the need for one officer to be allocated the responsibility of assessing the condition of a detainee, similarly it would appear necessary that one officer is allocated responsibility of supervision of persons after their detention. Commissioner Bull indicated in his evidence to the Royal Commission that the OIC of the shift is responsible for supervision of the Police Station, including the lockup and welfare of prisoners in custody. (Transcript of evidence of Commissioner Bull 31.7.90:612.)

The final report of the Webster Committee also recommended that one officer should be nominated on each shift to perform supervision duties in all major lockups. The relevant recommendations have been listed in the Assessment Section but I list them again below:

> 5. *That physical surveillance of prisoners continues to be performed by the "cells man", supplemented by the OIC where necessary/feasible.*

7. *That responsibility for the surveillance of prisoners also be vested in the OIC or relief sergeant.*

8. *That within country areas similar parameters of responsibility be established, subject to local conditions and availability of staff.*

I support these recommendations.

Physical Structure of Lockups

Both the Submission of the Commissioner of Police and the Police Department to the RCIADIC (May 1990) and the Webster Committee Report have noted the impact that the physical structure of lockups has on the supervision of detainees.

The Webster Committee made the following brief comment on lockup design and the surveillance of prisoners:

> *(a) Lockup design - surveillance of prisoners*
>
> *The working party were most forthright in their statements concerning the existing facilities, design of lockups and prisoner observation/scrutiny. Police Officers on the working party supported the belief that the working conditions and lockup design were both highly negative factors with respect to improving care services in custody. The East Perth Lockup was visited on several occasions by working party members and it was noted as being less than adequate in terms of prisoner scrutiny, hygiene and assessment. Police Officers working in this area were disadvantaged by both the layout and those functions expected of them in dealing with the processing of prisoners.*

The inadequate design of the majority of police lockups is discussed in more detail in the section of the Report on Police Cells. I recognise the difficulties that poor lockup design and facilities present for police officers responsible for supervision and care of detainees. The fact that poor cell design makes easy supervision of detainees almost impossible means that police officers need to be even more vigilant in regard to their supervision practices.

Other Prisoners in the Lockup

The Custodial Care Manual suggests using reliable prisoners to act as monitors and to call the OIC should a problem arise after the close of a station. It is noted in the section dealing with cell design that the Carnarvon Lockup has an alarm in the cell usually occupied by a trustee prisoner so that attention can be sought if the need arises. The use of other prisoners in the lockup to assist in the supervision of prisoners has also been raised by Dr Reser (1989). He discusses cell designs which foster unobtrusive monitoring whereby staff and detainees know what is going on and monitoring for detainees' wellbeing can be carried out by one or more of the detainees. He suggests that good cell design makes high technology electronic monitoring unnecessary (Reser,1989:9).

The Police Department have already implemented a policy of placing Aboriginal detainees in multi person cells where possible, primarily to reduce the feeling of isolation of detainees, but this also has positive benefits in terms of prisoners being in a position to keep an eye on the wellbeing of other detainees.

I pointed out in the section of the Report dealing with the hanging/self harm deaths, that in all but one of these cases in Western Australia, the deceased was alone in the cell at the time of his or her death. 'The significance of the WA experience is even greater when placed in the national and international context where research has shown that an overwhelming proportion of suicides in custody occur in isolation. (Rowan J.R.& L.M. Hayes,1988; Biles D.,Mcdonald, D.& J. Fleming, 1989)

However it would be dangerous for a practice to develop whereby police relied upon detainees to notify them of any problems relating to another detainee's health or wellbeing. In several cases I have examined the other detainees in the lockup have not informed the police officers that a detainee was ill. It is also unreasonable to expect detainees to have the same level of understanding and awareness as the police of conditions requiring attention, medical or otherwise, e.g. in Polak the observations of detainees as to the deceased's ill health were not communicated in full to the police officers on duty.

Finally, there may be instances whereby a detainee needs to be protected from other detainees in the lockup. The police have a duty to ensure that detainees do not come to harm through the action of other detainees in the lockup, e.g. in Njanji the deceased was hit over the head by a piece of wood while detained in the lockup.

Electronic Surveillance

As has been noted by Reser, with proper lockup design the use of electronic surveillance techniques is unnecessary. As he points out [i] *is still necessary for someone to scan video monitors, and such a system further reduces staff/detainee contact and interaction, exacerbating the problem of sensed isolation thought to be an important factor in the suicides.' I* agree with Reser's conclusions.

The Submission of the Commissioner of Police and the Police Department to the RCIADIC May 1990 also discussed the issue of electronic surveillance. It states:

> *Electronic Surveillance*
>
> *The Commissioner endorses the view of the Billing committee that continuous monitoring of detainees should be the endeavour in all custodial establishments and electronic surveillance should only supplement the personal approach and only in special cells or holding areas.*
>
> *To date, the costs associated with installation have precluded implementation. Apart from capital costs, electronic surveillance is only appropriate in areas with a 24 hour police presence and adequate personnel to monitor the equipment.*
>
> *Instead safety at East Perth lockup is being enhanced by the provision of a holding cell with two-way viewing window to reduce feelings of isolation and despair. Similar modifications have been made to a holding room for female or juvenile detainees.*

I agree with the Submission in that the personal approach favouring human contact and personal interaction is the better method of supervision of detainees.

Liaison with Support Services

The Report of the Webster Committee highlights the importance of police officers having access to appropriate support services. In this regard the Committee has recommended the establishment of a Forensic Medical Support Service which would provide on-call medical/nursing services to support police officers responsible for the supervision of detainees.

The Report also suggests the need to provide officers with further training in regard to the utilisation of liaison services such as the Aboriginal Visitors

Scheme; Community and Welfare Services, Alcohol and Drug Authority; Sexual Assault and Referral Centre; State Government Forensic Service and Church/Chaplaincy Services (see Final Report of Webster Committee p.8). I regard the establishment of proper liaison with such services as an important aspect of providing care services to detainees and I discuss in more detail in the section dealing with Contacts in Police Custody.

In the section of the Report dealing with Medical Assistance Available to Police I discuss the merits of the establishment of a Forensic Medical Support Service.

5.2.6 LOCKUP KEEPER AND WELFARE OFFICER

The Role and Duties of a Lockup Keeper were described by Chief Superintendent Riseborough and Senior Sergeant Lacy in the Inquiry into the death of Waigana. They said:

> *The role of Lockup Keeper is to basically maintain the lockup itself. He is not connected with the normal shifts.*
>
> *The Lockup Keeper's duties would be providing for cleaning, making sure that the kitchen is functional, that the cells are operational and other practical matters.*
>
> *The Lockup Keeper would also be directly in charge of the supervision of the trustees although he himself is under the supervision of the Officer in Charge of the lockup.*
>
> *The Lockup Keeper is a permanent position and he works day shift from seven in the morning until three in the afternoon. It is a position of relatively longstanding. (W/14/40).*

Permanent Lockup Keepers are attached to Central (East Perth), Midland and Fremantle police stations. Narrogin and Albany police stations have officers designated as such in combination with other duties. In addition to the day to day running of the lockup, lockup keepers also have some welfare duties.

In addition to lockup keepers, the position of welfare officer/we1fare sergeant has been introduced to the East Perth Lockup. It is a 24 hour per day, seven day per week position. The Welfare Sergeant is responsible for assessing each individual prisoner and ensuring that adequate standards of custodial care are maintained, including welfare, medical, legal and basic human needs. East Perth Lockup is the only Police Station where such a position has been introduced. Riseborough and Lacy further described duties of welfare sergeant at the East Perth Lockup as follows:

> *The position of welfare officer or welfare sergeant was introduced at the* [East Perth] *lockup in March of 1988. The welfare sergeant conducts corridor patrols throughout the lockup and these are performed constantly throughout his shift -*

unless he is at the charge counter processing a prisoner or prisoners who have just been admitted.

The Welfare Sergeant sees every prisoner that is brought in and assesses them at the charge counter. His assessment is made by visual evidence and by what the prisoner tells the officers regarding his medical condition.

If a prisoner requires medication that is noted on the prisoner processing card.

If it is considered by the Assistant Reserve Officer (who completes the Prisoners Property Form) or the arresting officer (who searches the prisoner) that medical attention is required, then the final decision is usually left to the judgment of the Welfare Sergeant.

The officers stationed at the lockup who are responsible for assessing the condition of prisoners such as the Assistant Reserve Officer and the Welfare Sergeant receive no training in medical assessment of the prisoners additional to their initial training at the Police Academy.

... If permanent staffing for the lockup comes through then ... there will be some special course prior to officers going to the lockup. (W/14/40).

In police stations other than those mentioned above, the duties of Lockup Keeper and Welfare Officer are currently filled by the OIC.

The Police Department has informed the Royal Commission that consideration will be given to introduce similar positions of lockup keeper and welfare officer at larger lockups where a need can be demonstrated.

The Webster Committee has recommended that 'Assessment Officers' be nominated for each shift in all major lockups. As noted in the section dealing with assessment and screening the Committee specifically recommended that at East Perth Lockup on each shift an appropriately trained officer from the permanent staff should be responsible for the assessment of detainees (Recommendation 4). Ibis position has been filled by the welfare officer.

The Police Department has informed the Royal Commission that *'it may be desirable but not practical in all instances for all 24 hour stations to have a lockup keeper and/or welfare officer as a designated position.'* The Commissioner of Police provided me with costings of the options of staffing all country police stations with a permanent lockup keeper. ($97.5 million to provide 610 additional staff and houses) and lockup keepers to 20 larger police stations on a 24 hour basis ($15.9 million for I 00 additional staff and houses.)

The Special Government Committee on Aboriginal, Police and Community Relations in Annexure A of its submission to the Royal Commission proposed two approaches to the provision of lockup attendants, to ensure that prisoners who were detained in a lockup were supervised on a 24 hour basis. The proposals would also release police officers for other police duties. Their proposals are as follows:

a. *Security Firms* contracted to provide lock up attendants for *those times where the police are not in the station or are likely to be away e.g. short staff night shifts. In areas of high Aboriginal population it is recommended that Aboriginal staff be employed.*

NOTE: The Department for Community Services has reservations over this suggestion because of the lack of control over private security personnel.

b. *Lock Up Attendants*

Alternatively, the Committee suggests that the position of lock up attendant or watch house officer be created. This position would be responsible to the OIC of the Station. This position would enable the station to be left unmanned by police. The position's duties would be to look after the prisoner's needs i.e. meals, clothing, health,financial,famil y contact and to provide a person for the prisoner to communicate with on a regular basis. Whilst the position would not be to enforce security, (they are not guards or wardens,) they would however be responsible for maintaining security.

In areas of high Aboriginal population there is a high rate of unemplo yment amongst Aboriginals. The attendants would have to be Aboriginal and chosen in conjunction with the Aboriginal community. A regular assessment of the person's work and review of duties would have to be made in conjunction with the Aboriginal community.

The Special Government Committee also submitted to the Royal Commission:

That the notion of all Aboriginal Lockup Attendants be examined with the aim of creating such positions in stations north of the twentieth parallel and remote areas. (p.11 of Submission)

The Police Department was asked for its view on this recommendation. Their response is as follows:

This matter has not been fully assessed, however, to man all remote stations with lockup attendants would not appear practical (Responses of Commissioner of Police to Specific Questions raised by RCIADIC Q.8.4 p.32).

Despite the membership of two commissioned police officers on the Special Government Committee on Aboriginal Police and Community Relations, the response of the Police Department to the Committee's recommendation is not very helpful. It could be viewed as indicative either of the Department's approach to Aboriginal/Police relations or of the questions the Royal Commission asked of the Police Department. Whatever the reason the response does the Department little credit. In my view the suggestions of the Special Government Committee warrant serious consideration.

The Webster Committee also recommended that Assessment Officers should receive specialist training. They suggested the training include assessment procedures, mental disorders and other areas of general welfare, in addition to normal first aid and resuscitation training provided to serving officers. It would entail three days training. (See Recommendation 10, Final Report of Webster Committee 13 March 1990 p.9.)

Commissioner Muirhead in the Royal Commission Interim Report made recommendations with a similar theme in relation to police officers who were required to perform lockup keeper dudes.

14. *Police officers whose duties may require them to perform watch-house duties should undergo basic training in the recognition of symptoms of head injuries, major illnesses, and in first aid resuscitation techniques.*

15. Persons detained in custody must be closely monitored for the first six hours of detention and the appearance of the person should be recorded. Where persons detained are apparently intoxicated or appear angry or disturbed, very close surveillance must be maintained.

28. Police and prison officers whose work involves the apprehension and/or detention of persons in custody should receive training to enable them to identify persons in distress or at risk of death through illness, injury or suicide.

However, to date, no specialist training has been provided to police officers required to perform the duties of lockup keeper or welfare officer, whether they be specific appointments or part of the normal duties of the 01C of the police station.

I support the recommendations of both Muirhead in the Interim Report and the Webster Committee in this regard and note that implementation of appropriate training for officers performing lockup keeper duties, welfare officer duties or I assessment officer' duties is overdue.

5.2.7 ROUTINE ORDERS AND OTHER INSTRUCTIONS

In this section of the Report I have been reviewing police custodial procedures and practices with a view to reducing the dangers and preventing the likelihood of death occurring. In this context it is important to examine the police orders and guidelines.

Police Orders and/or guidelines may serve a two-fold purpose; firstly, providing assistance and direction to police officers in the execution of their duties and secondly providing a means whereby officers are accountable for their actions.

The Police Routine Orders are the primary written source of instruction for police officers when carrying out their duties. Other instructions or guidelines which may direct police officers are Instructions of the Commissioner of Police published in the Police Gazette, Instructions issued by regional officers, Station Orders issued by the officer in charge of a police station and police manual guidelines.

Compliance with Routine Orders

The Royal Commission found in many inquiries that officers had not acted in accordance with Routine Orders.

The Commissioner of Police explained the binding nature of these various instructions as follows:

> *Routine Orders issued by the Commissioner of Police pursuant to his statutory authority under the Police Act, provide the basic guidelines for police in the execution of their duty. If couched imperatively, these orders and instructions, whether issued by the Commissioner or other officers, are binding on members as being lawful orders.*
>
> *It is perhaps misleading to refer to all of these documents as 'orders'. They are essentially an outline of procedures with few, if any, mandatory instructions which require strict compliance. Instead there is scope for discretion and flexibility because of the geographical size of the State, the diversity of situations encountered and resource limitations.*

Police Manual guidelines are guidelines only and not binding in the same sense as orders and instructions.

(Responses of Commissioner of Police to Specific Questions raised by the Royal Commission Into Aboriginal Deaths in Custody, p.39).

The Royal Commission found that even orders that appeared to be in imperative terms were not in fact followed by officers.

Police Routine Orders provide at para 16-3.11.2:

As a guide to assist members to determine the need for medical assistance insensibility or unconsciousness should be considered as being of three levels as follows:

(1) *Drowsy - in this state the person is easily aroused but will lapse back into unconsciousness*

(2) Stupor - in this State the person can be roused but only with difficulty.

(3) Coma - in this State the person cannot be roused.

In the latter two cases medical assistance should always be obtained and in the first case members should be guided by the circumstances of the case.

The Samson inquiry revealed that the deceased at the time of arrest was unable to sit on a chair without falling off and was unable to walk or talk. Upon arrival at the police station he was unrousable. He was not able to be awoken. The officer in charge of the police station told the Royal Commission first that Samson was not insensible at the time of the arrest and the routine order did therefore not apply and secondly that these Routine Orders were a guideline only and notwithstanding the terms of the order, the need for medical attention was entirely at his discretion.

The claim that Routine Orders are guidelines only and need not be followed by members of the Police Force has been made on numerous occasions to the Royal Commission. The Commissioner of Police, Mr Bull, confirmed this interpretation of the Routine Orders. Where the Routine Orders say *'in the latter two cases medical assistance* should always *be obtained',* (emphasis added) according to the Commissioner of Police, these words are not of a mandatory nature but only give guidance to members.

If the Routine Order noted above imposes no mandatory obligation on police officers dealing with unconscious prisoners then it must be concluded that Routine Orders as a whole place no obligations upon police officers in their dealings with prisoners.

Given the number of deaths investigated by the Royal Commission in Western Australia either in or arising from police custody where the police officer has arrested the deceased in the mistaken belief that he or she was drunk when in fact the person was either seriously ill or injured, it is of great concern to the Royal Commission that there is no mandatory obligation upon a police officer to obtain medical assistance for an unconscious prisoner or a prisoner who is otherwise seriously ill or injured.

I consider that a much greater onus needs to be placed upon police officers in relation to their custodial responsibilities.

Knowledge of Routine Orders

Despite the fact that the Routine Orders provide the primary written source of guidance for police officers and were described to the Royal Commission by one officer in the following terms:

> *It is like our bible. We have to follow those orders and it covers everything* (Dunn in Brown case).

It was far more usual for the Royal Commission to receive the following type of responses from police officers when asked about the Routine Orders:

> Q. *You are aware that one of them* [Routine Orders] *was that the prisoners had to be treated kindly and as humanely as possible?*
> A . *No. No. That was never said in the Routine Orders.* (Sharp in Jones' case).
> .....
>
> Q. *Are there any Routine Orders or instructions you are aware of now that relate to assessment of a prisoners condition? Are there any guidelines that you have in your mind as to how to assess a prisoner's behaviour as to whether it is simply drunk or whether it is some other medical condition?*
> A . *Not that I am aware of.* (Murray in Waigana case).
>
> .....
>
> Q. *Are you aware of the Routine Order that starts off at 16-310?*
> A. *I couldn't rattle it off.* (Gibbons in Walker case).

Aboriginal police aides were placed in an even more difficult position. One Police Aide told the Royal Commission that although Police Aides were bound by Routine Orders, from 1986 onwards he was not provided with updates for the Routine Orders. He was told by the Penh administration he was not entitled to them as he was 'only a Police Aide' (Bellotti in Jones).

Another Police Aide, Walker, was asked about Routine Orders in relation to assessment of a person and whether they needed medical treatment or anything of that nature. His response was *'I would not know. You just cannot keep track of them all.'* (RCIADIC, W19).

Before instructions are actually incorporated into the Routine Orders they are issued through notices in the Police Gazette. I was particularly interested in officers knowledge and understanding of an instruction issued by the Commissioner of Police in the Police Gazette 13.1.88 which dealt with Aboriginal arrests. Most officers, including officers in charge of police stations had little or no knowledge of the instruction. Typical responses are as follows:

> Q. *Have you ever seen that before?* (i.e. Police Gazette 13.1.88).
> A. *I probably have but I can't recall actually having seen this particular document.* (Cullen, officer in charge, Midland Police Station in Jones).
>
> Q. *Well if you couldn't specifically recall this extract from the gazette dealing with notification of friends, relatives, or the Aboriginal Legal Service, do you think other officers at Midland Police Station would be aware of it and be able to specifically recall it?*

A . *Probably not, no. Not that specific instruction. (RCIADIC* W3:326)).

One regional officer although aware of the instruction himself was asked about the general level of knowledge of the instruction in the police force:

Q. *Is it your experience that these particular guidelines (Police* Gazette 13.1.88) *are not widely known within the Police Force?*

A. *Well, it may be that they are not widely known. We have numerous instructions put out from time to time and I suppose if all our Police Officers could remember them all verbatim they would be fairly cluey. We try to ensure that they know the main ones. (* (RCIADIC W21).

However the Commissioner of Police told the Royal Commission that he would expect officers to be aware of such an instruction:

Counsel Assissting (C.A.) *I think it'd be fair to say that often when Police Officers have been asked about these Australian Police MinistersCouncil guidelines they haven't known what we were talking about, or only had the vaguest idea of what was being discussed.*

Cmr Bull: *Well, I don't know what more you can do but put them in the Police Gazette, which they're obliged.*

C.A.: *Yes.*

Cmr Bull: *They are obliged, no discretion to read and to - that is a specific instruction and certainly they are involved such matters are highlighted in their initial academy training and in in-service training. I am afraid I don't as commissioner, accept if an officer says that they were only vaguely aware. I think that's a pretty poor officer,*

in my view, who doesn't know something as important as that. I could understand in some of the other - you know, perhaps you could quote some of the routine orders to me and I'd be a bit vague but they might be just more minor procedural matters. But if you asked me or asked any reasonable officer about deaths in custody, or duty of care generally, or a multitude of other matters which are important to their basic duty they would know and I would expect them to know.

Because of my concerns about the apparent lack of knowledge by police officers of Routine Orders and other instructions, the Police Department was asked if there were any procedures to monitor serving officers' knowledge of routine orders and instructions, especially in relation to newly issued orders. It appears that the only method of testing knowledge of police procedures is through promotional examinations otherwise it is supposed to be monitored through the chain of command. (See responses of Commissioner of Police to Specific Questions Raised by the Royal Commission Into Aboriginal Deaths in Custody p.39).

One officer was asked how difficult it was to know whether he was acting in accordance with routine orders. He said *'Well, I believe what I was doing was right'.* He was further asked:

Q. *There was no way organised to measure up what you thought was the normal thing to do with what might have been in the Routine Orders of the police manual?*
A. *No.*

Q. *Were you ever subject to in-service training or tests to do with your knowledge of Routine Orders?*
A . *No.* (RCIADIC W11).

The Commissioner of Police has recognised that the level of officers' knowledge and compliance with Routine Orders and other instructions varies and he has suggested procedural changes to 'alleviate this problem'. Changes that have been suggested include:

- Prominence and Headings so that orders and instructions in the Gazette are mom easily accessible.

- Simplification of Routine Orders.

- Acknowledgement Form accompanying each Gazette to be completed by all members.

- Specific audit of codes and instructions as part of station inspection. (Submission of Commissioner of Police and the Western Australian Police Department to the Royal Commission Into Aboriginal Deaths in Custody May 1990).

Consequences of Breach of Routine Orders and other Instructions

The Police Department has advised the Royal Commission that breaches of orders or instructions *'may be the subject of disciplinary proceedings or counselling, depending on the circumstances'.* (Response of Commissioner of Police to Specific Questions Raised by the Royal Commission Into Aboriginal Deaths in Custody p.40).

Of the cases inquired into by the Royal Commission in only three was there any internal action taken against police officers despite the fact that in most cases, officers would have been in breach of the Routine Orders. Perhaps this is not surprising given the fact that Routine Orders are generally regarded as being guidelines only and not imposing any obligation upon officers.

In the McGrath case several officers were prosecuted internally. One was prosecuted for failure to carry out proper cell checks. The penalty for such an offence is minimal ($40) however such a matter would presumably be taken into account in relation to an officer's promotional prospects.

The Pat case revealed that although internal disciplinary action was commenced against one officer for making a false entry in the Station Occurrence Book it was never proceeded with. The three or four copies of the file apparently went missing.

No satisfactory explanation was ever given to the Commission as to what happened to the files.

Conclusions

- The accountability of police officers in relation to their custodial responsibilities and the current status of Routine Orders is unsatisfactory. Routine Orders directing officers in their custodial duties need to be more than just guidelines. Possible alternatives to remedy this situation are: 1) Routine Orders needed to be given more weight by the Commissioner of Police so that they impose mandatory obligations upon officers in relation to their custodial duties. 2) Regulations be passed placing mandatory obligations upon officers in relation to their custodial duties. 3) The custodial obligations of police officers be given statutory recognition.

- Current method of ensuring officers knowledge and compliance with Routine Orders is unsatisfactory. Changes suggested by Commissioner of Police may improve situation. Further attention to this area is needed.

- Current enforcement procedures in relation to Routine Orders through disciplinary action unsatisfactory. The financial penalties are minimal and in the experience of the Royal Commission officers are rarely prosecuted for breach of Routine Orders relating to their custodial duties.

- Accountability of police officers in relation to custodial responsibilities unsatisfactory. Whether police officers should be made more accountable through adherence to Routine Orders and enforcement procedures for breach of orders needs to be examined.

5.2.8 TRAINING OF POLICE

In this section I examine various aspects of police training, both of recruits and serving officers, which affects police dealings with Aboriginal people including the care, supervision and treatment of persons detained in police custody. The aspects of police training which are focused upon are first aid and resuscitation, detection of medical conditions, custodial care, suicide prevention and awareness training in Aboriginal affairs.

5.2.8.1 First Aid and Resuscitation

In eleven cases examined by my Commission, police officers who attended at the cells, and found the detainee apparently dead, did not attempt resuscitation.

In some cases the officer's decision not to attempt resuscitation cannot be criticised as the deceased had been dead for some time and was clearly beyond revival (McGrath, Anderson, Samson, Chatunalgi). However, in at least seven cases, including three deaths by hanging, no attempt at resuscitation was made or the attempts made were totally inadequate.

In Christine Jones' case the officers found her hanging shortly after placing her in the cell. One officer had completed a resuscitation course at the Police Academy four years prior to the death. The other officer had completed the resuscitation course at the Academy in 1975, had done a refresher course in resuscitation in mid 1977 and in February 1979 (less than two years prior to the death). They performed cardiac massage without giving the deceased mouth-tomouth resuscitation. This action was regarded by Dr Oxer, Medical Director of St John Ambulance Association, as having no benefit when performed alone. He described the correct steps to be taken on finding a person hanging:

1 . *Remove the constricting force.*

2 . Check to see if the patient is breathing.

3 . If the patient is not breathing, per fiorm expired air resuscitation.

4 . After 5 breaths, check the carotid pulse to see if there is a heart beat..

5 . If there is no pulse perform external cardiac massage.

6 . Continue expired air resuscitation and external cardiac massage alternately (cardio pulmonary resuscitation).

This procedure will make recovery Possible if the brain has not already suffered irreparable damage.-

When Wayne Dooler was found dead in the cell by police officers after being detained in an unconscious condition, no attempt was made at resuscitation.

Hugh Wodulan was found hanging in Broome Police Lockup. The officers who discovered his body concluded he had been dead for some time and decided it was useless to attempt resuscitation. I found it unlikely that resuscitation could have had any effect but I went on to say *'but persons can be resuscitated and where it is not known how long a person may have been dead it is most desirable that resuscitation be attempted'.* (Wodulan Report page 20).

Stanley Brown was also found hanging in Broome Police Lockup. After the police lowered his body to the floor no attempt at resuscitation was made. The officers who attended at the cell decided that he was beyond resuscitation despite the fact that his body was still warm. The officer in charge of the station who found the deceased had had no resuscitation training for more than ten years and had no confidence in his ability to perform resuscitation. The other officer had done initial resuscitation training in 1970 and had done a refresher course three years prior to the death. He did not feel 100% confident of his ability to perform mouth-to-mouth resuscitation.

Again, no attempt was made to resuscitate Misel Waigana who died in a cell at East Perth Lockup. He had been seen alive about thirty minutes beforehand but was thought to be beyond resuscitation by the officers who found him in the cell. Indeed no ambulance was called to assist.

In the case of Edward Cameron who was found hanging in a cell in the Geraldton Lockup, not only did the officers not attempt resuscitation upon finding the deceased but they did not even release him from the noose. The justification for their action was that they wanted to preserve the scene

Kim Polak was acutely ill in the lockup. When he was found by the police with no signs of life, no attempt was made to commence resuscitation procedures although this would have been the prudent course.

It was also clear in some instances where resuscitation was attempted that the officers were not confident of their resuscitation skills. For example, in Morrison, two officers performed CPR, one officer being quite competent having been recently trained and the other being a little uncertain on the use of the Laerdal mask and having to read the directions on the pack first. This officer had not received any refresher training for thirteen to fourteen years.

Of the nine cases in which police officers were in a position to appropriately commence resuscitation procedures (Jones, Dooler, Wodulan, Brown, Waigana, Morrison, Polak,

Cameron, Wongi), police officers actually made adequate attempts in two cases (Morrison, Wongi).

The Police Department has taken action to improve police officers' resuscitation skills through training programmes. All police recruits undergo basic training at the Police Academy in resuscitation techniques together with training in the recognition of symptoms of head injuries and major illnesses. The recruit training is equivalent to the Red Cross Senior First Aid Certificate Course and runs for thirty-two hours. It includes fourteen hours of life saving which covers resuscitation training on mannequins (RCIADIC W15:384). Sergeant O'Meagher told the Royal Commission that since 1975 recruit resuscitation training at the Police Academy has had a high degree of emphasis (RCIADIC W15:385).

In 1989 a refresher resuscitation programme was conducted statewide. It was part of a six hour course in custodial care. Approximately 61.5% of police officers did the three hour re-training programme in resuscitation techniques. The trainers have indicated they would like to give the officers refresher training every twelve months (RCIADIC W15:387).

The Police Department have also implemented procedures to identify from Police Academy records, the current training level and qualifications particularly with respect to first aid and custodial care, of members on transfer. The information is relayed to regional officers.

My inquiries have also revealed a lack of knowledge amongst police officers in the use of and, location of resuscitation equipment at their police station, although knowledge in this regard has improved since the commencement of the Royal Commission. The Police Department has informed the Commission that instruction in the use of Laerdal Masks and Air Viva resuscitators has been given. Issue of this equipment has been prioritised with equipment and instructions being given to those centres and stations handling the greatest number of detainees. Thirteen major lockups have been fitted with Laerdal air vivas. Sergeant O'Meagher told the Royal Commission that in 1987 all police stations and vehicles were issued with a Laerdal Mask (RCIADIC W15:389). The mask is designed to avoid facial contact with the person.

The location of the equipment is not standardised within police stations with different stations keeping equipment in different places. The Commissioner of Police assured the Royal Commission that the location of such equipment has been stabilised so that it is readily available and everyone knows where it is, however he said it cannot be located in the same place in all police stations, e.g. the lockup area, because the construction of the police stations vary (Conference with Commissioner of Police, 31.7.90:665,667).

It appears there is still no specific obligation placed upon police officers to perform resuscitation on either persons in custody or members of the public. The Police Department was asked as to their policy in this regard. The response is as follows:

> *No specific policy exists because there is a general obligation to preserve life. This obligation is fulfilled by police in a variety of ways according to the circumstances* at *the time. Members are trained in CPR to enable them to respond to emergency situations.*
>
> (Response of Commissioner of Police to specific questions raised by the Royal Commission Into Aboriginal Deaths in Custody July 1990 p.53).

When the Commissioner of Police was asked by me whether he intended to indicate by order or direction the need for officers to exercise resuscitation procedures he said:

Yes we have updated that and I am now in the process of training all officers in resuscitation statewide. The programme is well down the track and the routine orders are being amended - or have been.

There is already an order gone out but the routine order will be amended to provide for the resuscitation.

I then asked:

What is the effect of that? Does it say that it shall be undertaken?

Commissioner Bull responded:

It gives 'em guidance - yes - as to how it should be undertaken and in regard to the need for officers to be updated and, for OICs to ensure that their staff are available and when, the training units go around - not to miss people (Conference with Commissioner of Police 31.7.90:664).

It still is not clear whether the Routine Orders place an obligation upon police officers to perform resuscitation.

I refer to the earlier section of this Report in which the duty of care is discussed. In that section I refer to the duty to resuscitate.

5.2.8.2 Refresher Training

In early 1983 there was a change in the way refresher training courses were conducted. It was based upon officers returning to the Academy every three years for refresher training but it was discovered that this did not in fact occur. In 1986-87 the refresher training courses were discontinued as they were found to be a failure. The courses were changed so that a team of instructors were sent out to the police stations around the State - the Outreach Programme. This Programme was commenced in July 1989 and included the resuscitation refresher course described above.

Commissioner Bull told the Royal Commission that the refresher training in resuscitation provided (discussed above) mainly focuses on operational people rather than the scientific people and is given to a level adjudged by St Johns Ambulance to be sufficient provided it is updated (Conference 31.7.90:665).

It appears that refresher training in resuscitation will be continued with St Johns Ambulance carrying out future training in country areas and the training branch conducting training in the metropolitan areas. (Response of Commissioner of Police to Specific Questions Raised by the Royal Commission Into Aboriginal Deaths in Custody, July 1990, p.52).

5.2.8.3 Detection of Serious Medical Conditions

The Royal Commission inquiries clearly demonstrated the skills of police officers in detecting serious medical conditions were very poor. Three inquiries showed that police officers detained persons in an unconscious condition in the lockup, in each instance assuming them to be drunk, where in fact the person was suffering from a head injury which later led to their death. (Faith Barnes, Roy Walker, Albert Dougal). The time period it took for officers to realise that the person needed medical attention ranged from five to

twelve hours. In another case (Wayne Dooler) the deceased was placed in the lockup unconscious. He later died from alcohol poisoning. In a further inquiry the deceased was placed in the lockup in a semi-conscious condition, being unable to walk nor carry out a conversation. He was very intoxicated, was also known by the police officers on duty to suffer from a serious medical condition (epilepsy) and also from alcohol withdrawal seizures. Nevertheless he was left in a cell unattended for six hours (Ginger Samson). In a further three inquiries the persons who later died were placed in the lockup in extremely poor health (Misel Waigana, Kim Polak, Milton Wells). The fact that these persons who were very sick went unnoticed suggests a number of possibilities: the intoxicated state of a detainee masked a serious medical condition; the indifference of the officers involved; that the state of health of detainees generally is very poor or that police officers are lacking in skills in the recognition of detainees with serious medical conditions, especially if they appear to be affected by alcohol.

In another case investigated by the Commission the deceased who displayed classical signs of mental illness was placed in a cell alone and a short while later hanged himself (Ben Morrison).

Medical experts who have given evidence to the Royal Commission have commented that it is not difficult to train police officers to a level where they are able to recognise a person who is unconscious, suffering from a head injury or has a very serious medical or mental condition (See Professor German in Morrison; Dr Oxer in Jones; Dr Hamilton in Dougal; Dr Spencer in Dooler).

As mentioned above, police recruits at the Police Academy receive training in the recognition of head injuries and major illnesses, however serving officers have not received training in these areas to date. It is unclear whether the Police Department intends to cover these areas in their future refresher courses on first aid and resuscitation.

Commissioner Muirhead in the Royal Commission Interim Report specifically recommended that police officers who performed watchhouse duties undergo training in the recognition of symptoms of head injuries and major illnesses in addition to first aid and resuscitation techniques (Recommendation 14). As noted above there are a limited number of police officers allocated specifically to the position of lockup keeper or welfare officer (three permanent lockup keepers, one each at Central, Midland and Fremantle Police Stations, two officers who perform these duties in conjunction with other duties at Narrogin and Albany Police Stations and one Welfare Sergeant at East Perth Lockup). These officers do not receive any special training for these positions. However, the Commissioner of Police, Mr Brian Bull, told the Royal Commission that the permanent lockup keepers at Central endeavour to seek further training so that they are more proficient (Conference 31.7.90:665).

It would appear that further efforts need to be made to ensure that all officers who carry out lockup keeper duties are adequately trained to recognise unconsciousness, persons suffering from head injuries and serious medical and mental health conditions.

5.2.8.4 Custodial Care and Suicide Prevention

In July 1989 the Police Department introduced a two hour course entitled Custodial Care. All recruits receive the Custodial care lecture and it was envisaged that all serving officers would also do the course. The serving officers did the course in conjunction with the first aid and resuscitation refresher course, discussed above, as pan of a one day package.

The custodial care course looks at the duty of police officers towards a detainee from the time of arrest and during the period of detention in police custody. According to one of

the officers responsible for teaching the course, emphasis is placed on alerting officers to factors which indicate a detainee may be at risk or under stress.

A booklet which outlines the course content, which I refer to as the custodial care manual, is provided to all officers undertaking the course. It draws attention to the relevant Routine Orders, section 262 of the Criminal Code, risk factors, past coronial inquiries into deaths in custody and recommendations made by the coroner and steps to prevent suicides and deaths in custody.

During the course three videos are also shown. The Royal Commission has been provided with the video '320 Deadly Seconds' which has been produced by a Police Department in the United States of America. It points out the factors about a detainee which should put an officer on alert. The video possibly has its limitations because the detainee portrayed is a white middle class middle-aged man. The officers who are responsible for the preparation of the course syllabus have not established a typical profile of a West Australian police lockup detainee but on the basis of the information held by the Royal Commission one would expect a typical Western Australian detainee to have quite different characteristics to the detainee portrayed in the video. This imbalance may be corrected by another video shown during the course on suicides by young Aboriginal men, a film made by Dr McLaren, a psychiatrist, and Dr Garrow, a doctor with Broome Aboriginal Medical Services.

Further information is provided to the officers through print media articles which discuss deaths in custody.

To date about 61.5% of all serving officers have completed the course. Although the officers are not compelled to attend the course they are under instruction to attend.

The Royal Commission considers that the concept of the custodial care course is to be encouraged however it appears to need further evaluation and development.

At the time the Royal Commission received information about the course (October 1989) there were no plans to monitor and develop the course (RCIADIC W15:470).

In October 1989 the training section responsible for the course received no information from other sections of the Police Department about further deaths or attempted suicides in custody when they occurred. Despite the fact that the course encouraged use of the Aboriginal Visitors Scheme, no attempt at liaison with AVS has been made by the training section to see whether they could provide feedback about police and lockup practices which should be modified to reduce the chance of deaths in custody (RCIADIC W15:468). There was also no input from Aboriginal Police Aides into the running of the course, although they do attend the course.

I was also interested to learn that at least some of the officers in the careers training section at the Police Academy providing training to the recruits and serving officers had no teaching qualifications or training and had been transferred to the training section at the Academy after a period of operational duties. In the case of one such officer who gave evidence to the Royal Commission he appeared willing enough but appeared to lack teaching skills. I consider that the use of such inexperienced personnel in the teaching of other officers or potential officers requires evaluation by the Police Department.

I also consider that the custodial care course needs further evaluation and development and could benefit from officers involved in the provision of the course receiving more feedback from other sections of the Police Department, the AVS and Aboriginal Police Aides about further deaths and attempted suicides in custody and suggestions as to ways in which police and lockup practices could be modified to prevent further deaths.

5.2.8.5 Aboriginal Affairs Training

The statistical information discussed earlier in the Report indicates that Aboriginal people are over-represented in both police and prison custody to an alarming extent. The first point of contact that Aboriginal people have with the criminal justice system is invariably the police.

The Report of the Aboriginal Issues Unit (Western Australia) summarised the Aboriginal perspective on police understanding of Aboriginal people:

> *... most police officers, like other Government officials, had little or no understanding of Aboriginal history, culture, society or lifestyle. This widespread ignorance (especially noticeable among police officers of recent overseas origin, and among new recruits) was due in part to* the failure of education systems to properly inform all *young people about Aboriginal issues, and to limited and inadequate police training in Aboriginal affairs.*
>
> *Poor training caused police recruits to come out of the Academy with pre-conceived ideas about Aboriginal people which saw them setting out to prove that they were 'boss'. These bad attitudes toward Aboriginal people resulted in prejudicial and discriminatory treatment. There was little if any attempt to work with the Aboriginal community (AIU Report p.8).*

It has been argued time and again that by improving police understanding of Aboriginal culture, history, the economic and social difficulties confronted by Aboriginal people, and teaching police appropriate communication skills, it is likely that police will be better equipped to work with Aboriginal people and better Aboriginal/Police relations will result. However, the Royal Commission has considerable concerns that although the message has been repeated over and over again it is not receiving the attention it deserves from the Police Department.

Over the last fifteen years the issue of police training in Aboriginal affairs has received considerable attention. In Western Australia most inquiries and reports which have focused on Aboriginal/Police relations have invariably included recommendations on improvements that need to be made in the area of police training in Aboriginal affairs.

In 1976 the Laverton Royal Commission recommended that a unit be established within the Police Department capable of giving expert and intensive instruction in Aboriginal society and culture and the economic and social problems Aboriginals commonly face (Recommendation 10). It recommended that the training should be given to recruits and officers serving in the field. The Commission further recommended *'that a small committee or council be established consisting of two police officers and* a *like number of Aboriginals and outside experts* to *advise* the *Police Commission on all aspects of the training programme'* (Recommendation 11). The Commission was of the view that it was crucial that Aboriginals should have a role in the programme and recommended *'that* suitably qualified *Aboriginals should play a part in any training programme* that *may be introduced in the Police Department'* (Recommendation 12).

The Special Government Committee on Aboriginal/Police and (later) Community Relations was established to advise on Aboriginal affairs training for police.

In more recent times recommendations have been made in this regard by the Western Australian Interim Inquiry Into Aboriginal Deaths in Custody in January 1988 (the Vincent Report), the Royal Commission Into Aboriginal Deaths in Custody (the Interim Report), the

Special Government Committee on Aboriginal/Police and Community Relations (April 1989), the Equal Opportunities Commission Report of Review of Police Practices (July 1990) the Aboriginal Issues Unit of the Royal Commission Into Aboriginal Deaths in Custody in Western Australia (August 1990).

The Interim Report of the Royal Commission (Muirhead) recommended:

> *Recommendation 32*
> *All personnel of police, prison, social welfare or other departments whose work will bring them into contact with Aboriginal people should receive appropriate training or retraining to ensure that they have an understanding and appreciation of Aboriginal history, culture and social behaviour and the abilities* to *communicate effectively and work with Aboriginal people.*
>
> *Recommendation 33*
> *The Aboriginal component of training courses should be prepared in consultation with representatives from the Aboriginal community. Training courses in Aboriginal issues should be examinable.*

The Western Australian Government advised the Royal Commission that these recommendations had been implemented. However despite the fact that police recruits do receive some training in Aboriginal affairs it is apparent that the current level of training is totally inadequate. In addition, no training is provided to serving police officers although the Police Department has advised the Royal Commission that training for *'other personnel has been considered but no specific programme has yet been developed because of other demands on resources'.* (Responses of the Commissioner of Police to Specific Questions raised by the Royal Commission Into Aboriginal Deaths in Custody.)

The attitude of the Commissioner of Police to the effectiveness of the current recruit training course in Aboriginal affairs is as follows:

> *The course has been shown to be effective by the running of critiques and other feedback.* (Response of Commissioner of Police to Specific Questions raised by the Royal Commission Into Aboriginal Deaths in Custody July 1990 p.43).

The Special Government Committee on Aboriginal Police & Community Relations in its submission to the Royal Commission provided a summary of the history of Aboriginal affairs training to the police:

> *Initially the Aboriginal affairs training was provided by the then Department for Community Welfare and the Western Australian Museum, with the assistance from prominent Aborigines. The initial training courses in 1976 were a minimum of 8 hours for inservice training and a minimum of 7 314 hours for recruit training. The involvement of the Committee and other Government Agencies basically remained constant until 1984. At that time negotiations began between this Committee, the Police Academy, Western Australian Institute of Technology and Western Australian Colleges of Advanced Education to have the Aboriginal Affairs training component delivered by an external academic institution. Western Australia Institute of Technology's Centre for Aboriginal Studies was chosen to conduct the first course in November 1985 with 10 hours of instruction. In May, 1986, a decision was taken by the Police Academy to cut training to 6 hours.*
>
> *In mid 1987, the Police Academy decided to approach the Institute for Applied Aboriginal Studies as it was not satisfied with the training being delivered by the Centre for Aboriginal Studies. The negotiations that took place included this Committee, Mt Lawley*

College for Advanced Education and the Institute and the Police Academy. The new segments to be taught by the Institute were developed in consultation with the Police Academy (April 1989).

In 1987 a Review of the Police Recruit Training Programme was carried out by the Curriculum Development Unit (CDU) of the Police Department. The CDU did not make any judgments concerning lectures given by Curtin University staff on Police/Aboriginal Relations as the area had already been assessed by the Academy. A short time later the Police Academy discontinued the services of the Centre for Aboriginal Studies (Curtin University) which was providing the training in Aboriginal awareness to police recruits at the time and approached the Institute of Applied Aboriginal Studies which provided the training to the recruits until July 1989.

Submissions to the Royal Commission by the Centre for Aboriginal Studies point out that they were never properly informed as to why the Police Academy chose to discontinue their programme. The Centre acknowledged that the initial training programme provided to the Academy was not very successful and worked to develop a more appropriate course.

Despite a positive response from the recruits to the revised programme the Centre found that Academy staff continued to have a negative attitude towards the programme. The time allocated to the programme was reduced from 10 x 40 minute periods to 6 x 40 minute periods per squad.

Because Academy staff informed the Centre that their own evaluations indicated that their performance was not satisfactory the Centre approached the Academy with the intention of increasing their performance so that it was satisfactory from the Academy perspective.

The Centre for Aboriginal Studies was concerned that the programme was viewed as an 'outside' programme imposed on the Academy and that Academy staff undermined the effectiveness of the programme with negative comments. The Centre wanted the Academy to take more responsibility for the programme and suggested that the programme should become a joint project of the Academy and the Centre. The Centre felt the programme should be integrated with other aspects of Police Training. Although the approach seemed to be supported by Academy staff at the time, a short while later the Academy took unilateral action to exclude the Centre from Recruit Training and without notification or explanation ceased communication with the Centre and commenced negotiations with the Institute of Applied Aboriginal Studies of the Western Australian College of Advanced Education. (See submission by Centre for Aboriginal Studies, Curtin University of Technology 18 July 1990 G/W/32).

Mr Tom Baban, Head of the Institute of Applied Aboriginal Studies (IAAS), Western Australian College of Advanced Education, has provided information to the Royal Commission on the course provided to recruits at the Police Academy by IAAS to July 1989. He said that the recruits received *'two hours and forty minutes of Aboriginal studies training per se'* (RCIADIC, Dodson:245).

The length of the full police training course has increased from thirteen weeks in 1976 to 22 weeks in 1990. It is of great concern that the length of training in Aboriginal affairs has decreased from 7 3/4 hours in 1976 to two hours forty minutes in 1990 particularly in view of the repeated recommendations made by various inquiries to improve and increase the level of training.

Mr Baban also informed the Royal Commission that the Police Department have discussed further reducing the time spent by recruits on Aboriginal affairs to 140 minutes by reducing each unit by five minutes (RCIADIC, Dodson:25 1).

In 1989 the Police Academy agreed to the Aboriginal affairs training course being examinable. Assessment of the course was carried out by way of a multiple choice test and a 600 word essay. Recruits were required to get 65% in all assessable subjects. By making Aboriginal affairs examinable it gave the course more status and presumably it had to be taken more seriously by the recruits. However Mr Baban has indicated to the Royal Commission that it was not easy getting the Police Academy's agreement on the way in which the course was to be assessed and that the Police Department was unhappy that the providers of the course, the lecturers from the Institute of Applied Aboriginal Studies, also wanted to maintain responsibility for the assessment of the course.

In 1989 the management committee of the Institute of Applied Aboriginal Studies advised the Institute to withdraw its services from the Police Academy, which they did temporarily, because they wanted the Police Department to consider the following matters:

(i) time devoted to Aboriginal affairs studies
(ii) assessment of the course
(iii) racism being experienced by the lecturers who attended at the Academy.

The third issue had become so severe that half of the lecturers (four persons) had refused to go back to the Academy to lecture.

Following this action on the part of the Institute of Applied Aboriginal Studies control of the course was removed from the Head of the Institute and given to the Dean of the School of Community and Language Studies, who was ultimately in charge of the area at Western Australian College of Advanced Education. (RCIADIC, Dodson:244)

It appears that the course provided by the IAAS has not been reinstated by the Police Department to date.

The Centre for Aboriginal Studies recently made these comments on the course provided to the Academy by the IAAS:

> *This programme merely bandaids a problem which requires much more commitment from the Aboriginal community and the Western Australian Police Department to be adequately addressed*

and

> ... *that responsibility for Aboriginal/Police Relations had to be taken seriously with the participation of the Aboriginal community, not only through academic enclaves. We outlined* that *the current programme was grossly inadequate and that a more intensive, long term, multi-levelled (involving the entire Western Australian Police Department) programme was urgently required to properly address Aboriginal/Police relations.* (Letter from Pat Dudgeon, Head, Centre for Aboriginal Studies to Tom Baban, Head, Institute of Applied Aboriginal Studies, 10.5.90).

Mr Baban had indicated agreement with some of the ideas expressed in the letter and has told the Royal Commission that in relation to input into the development and operation of the Aboriginal studies course that representatives should be included from WACAE, RCIADIC, Police Academy, the Aboriginal Legal Service, the Aboriginal Medical Service, the Special Cabinet Committee on Aboriginal Police & Community Relations, AAPA,

ATSIC and other relevant organisations. He believes that the community is very concerned and it is important that participation in the course is extended beyond the involvement of a couple of people from the college and Police Academy (RCIADIC, Dodson::2445). He also suggested that the Aboriginal studies should be treated as a separate area and not lumped in with the concept of multi-culturalism. (RCIADIC, Dodson:244)

Mr Baban discussed two suggestions about the future location of the course, one being that a trainer from inside the Police Academy be trained to deliver the course, the other being the possibility that Aboriginal studies takes place within the tertiary setting (RCIADIC, Dodson:254).

Mr Baban expressed the belief that the level of police recruit exposure to Aboriginal studies should be increased from the current limit of two hours forty minutes (T245).

He told the Royal Commission that the Police Department recruits were not really interested in Aboriginal culture and would rather get rid of units like pre-history. Their main focus was wanting to know how to handle the person on the street. He believed that there was a need for police recruits to be exposed to Aboriginal culture through a long sustained unit. He understood why recruits would want to focus on practical techniques given that they only received 4 x 40 minute units on Aboriginal studies. (Royal Commission transcript 18.7.90 p.254).

Although there was apparently a willingness on behalf of the IAAS to resume responsibility for the recruit training course if consideration was given to the matters they raised with the Police Department, the Police Department approached the Aboriginal Educational Liaison Unit (AELU) of the Ministry for Education to provide the training to recruits in 1990. The AELU provided training to the first intake of recruits in 1990. The training appears to have consisted of 4 x 75 minute sessions which covered Pre History Aboriginal Studies; Contact History and Legislation to 1967; social issues reflecting pre-history Aboriginal societies and post-contact history, and a panel discussion.

Representatives from the AELU provided the Royal Commission with further information about the course the Unit provided to the recruits. They did not examine the course themselves. Their submission to the Royal Commission made these comments about the course:

Difficulties, if any, experienced by those lecturing

- *It was felt that the number of recruits attending the lectures was too large. There are 90 recruits per lecture. Large groups tend to have 34 people asking all the questions.*

- *In those sessions where recruits were not examined on the content, attention spans were short and the attitudes of some were blase.*

- *There were some recruits whose questions/comments were racist but the lecturers were able to redirect those questions/comments back to the group to answer. This proved a valuable teaching tool in educating all the group.*

- *Recruits could not see the relevance of some parts of the course - particularly history.*

- *The allocated time was brief and allowed only an overview of some of the topics. More in-depth analysis or explanations would have been advantageous in some cases.*

Suggestions/Recommendations to improve Police Training

- *An increase in lectures contained in the entire course. The current number stands at 4 lectures per training.*

- *Those attending lectures should have some type of follow-up eg*

  - *Work/contact with Aboriginal community or youth group.*
  - *Talking on an individual basis to an Aboriginal person.*

- *Include more Aboriginal police personnel in the lectures.*
  eg The presence of (Aboriginal) CIB officer Neville Collard as a lecturer on one occasion brought a level of credibility and expertise which had been lacking previously. He was able to relate his own experiences as a policeman working with Aborigines and was able to answer questions relating directly to police procedure and the law in dealing with Aborigines.

There was agreement amongst staff of the AELU that the course was not long enough, that police recruits needed some practical experience in relation to Aboriginal issues and that they should be assessed on each topic studied. Mrs Verna Vos, previously a field officer with the AELU and currently coordinating a programme with IAAS at WACAE, provided the Royal Commission with additional information about the training course provided by AELU to the recruits. She agreed that giving lectures to large groups of 90 students was problematic. She suggested that small workshop groups were needed with more Aboriginal people involved so that people would feel more comfortable asking questions and the contact would be closer. She also suggested that Aboriginal studies should be incorporated throughout the training course rather than in a few concentrated sessions. Mrs Vos also stated that there was not enough importance placed upon the course and that the lectures were seen as 'special treatment'. She said that a lot of cross-cultural awareness workshops were required before the topics covered in a lecture situation could be adequately addressed. She was also concerned about the way the course was assessed and that those involved in structuring the questions forming the basis of the assessment were not Aboriginal.

Mrs Vos formed the impression that the Police Academy had been carrying out the course in a certain way over the years, they had an idea of the way the course should be presented and wanted the group presenting the course to 'fit in' with what they considered the normal procedures.

However Mrs Vos was sure that an adequate Aboriginal studies course was essential to proper police training and could work but it had to be given importance and credence and someone had to take responsibility for it.

The Police Department advised me that the AELU were unable to provide the Aboriginal training segment to the second recruit course in 1990 due to staff shortages and other commitments. So the Recruit Course (2/90) received training in Aboriginal/Police Relations from a senior training officer with the Department of Corrective Services.

I was also informed by the Police Department that the course length had been increased from 4 x 70 minute periods to 5 x 70 minute periods or one full day. The Police Department states that the period of training is presented by an external organisation and is assessable. In addition the area of Aboriginal/Police relations is touched upon in other segments of the training course and the Police/Aboriginal Liaison Unit provides staff to speak to recruits about their function for I x 70 minute session in addition to the sessions previously mentioned.

The Police Department also advised me that the content and duration of recruit courses are being re-evaluated and it is expected that the course will be restructured for the next intake of recruits scheduled for July 1991.

I have also been informed by Mr Baban of IAAS that a group is being organised to discuss teaching Aboriginal affairs to Western Australian Police. It has been suggested by the organisers that members of the group should include Police Academy representatives, representatives from the WACAE and Aboriginal persons from the community. At the time of writing there were some concerns about the membership of the discussion group, both Aboriginal and nonAboriginal, given the importance and sensitivity of Aboriginal/police and community relations at the training of police in this regard, particularly from the perspective of the Aboriginal community.

The Report of the Review of Police Practices by the Commissioner for Equal Opportunity has also suggested that training on Aboriginal issues should be incorporated into the entire training programme and that recruits should be assessed on their knowledge and understanding of the topic.

The Equal Opportunity Report made the following recommendations relevant to police training in Aboriginal issues:

> *Recommendation 6*
> *Training programs for recruits should incorporate Aboriginal (and other minority group) issues in each component, to be assessed in the same way as other course components.*
>
> *Recommendation 9*
> *Promotional training programs should reflect Aboriginal issues in all their components and satisfactory completion of these aspects should be required before promotion is recommended.*
>
> *Recommendation 10*
> *The department should support external training options to be available to all personnel through the sponsorship of such officers to undertake appropriate degree courses.*

My Commission is also of the view that current training provided to both police recruits and serving officers in the area of Aboriginal affairs is completely inadequate. Immediate steps need to be taken to provide improved training to recruits. In addition urgent steps should be taken to provide an appropriate course to serving police officers, particularly officers currently serving in areas with significant Aboriginal populations or officers who are soon to be transferred to such an area.

I consider that the current level of consultation with representatives from the Aboriginal community in provision of training to recruits and serving officers is insufficient and immediate steps need to be taken to improve the consultation process.

5.2.9 AVAILABILITY AND USE OF MEDICAL ASSISTANCE

5.2.9.1 Access to Medical Information

The question of police having access to medical information about detainees was canvassed to some extent in Section 5.2.5 on the Computer System. In a number of

cases into which I have inquired I have found that if the police had had some information about the medical or mental health condition of the deceased there would have been an increased likelihood that medical attention would have been sought and the death prevented. There are currently no Routine Orders or instructions requiring the police to make inquiries about the medical or mental health condition of a detainee.

The cases of Robert Anderson, Kim Polak and Benjamin Morrison are in point. If police had known of the chronic health conditions affecting Anderson (epilepsy), Polak (epilepsy, alcoholic hepatitis) and the mental health condition suffered by Morrison, they may well have shown more concern for their wellbeing and sought medical attention.

In the section dealing with the Computer System I discussed the confidentiality of detainees' medical information and the issues involved in giving police access to basic medical information via their computer system.

An alternative method of obtaining medical information about a detainee is through active inquiries of the detainee. The section dealing with Assessment and Screening discusses the implementation of an admission form which requires the police to record information about the health of a detainee. The introduction of an admission form may alleviate some of the problems associated with police having custody of people who are sick or suffering from serious mental or health conditions. An admission form or police Routine Orders should require the police to ask a person if they are sick, suffer from certain conditions or are in need of medication. It is important that the police have access to basic medical information about detainees so that they may properly care for the person and obtain medical attention if necessary. The police should not rely on detainees to volunteer information about their wellbeing but should have a duty to actively obtain that information. However, the confidentiality of the medical information must be maintained.

5.2.9.2 Medical Emergencies and Ambulance Services

The Police Department informed the Royal Commission that all lockups in Western Australia have provided medical treatment to detainees by way of St Johns Ambulance, amongst other medical services. (Submission of Commissioner of Police and Western Australian Police Department to RCIADIC - May 1990, p.11.)

However, in a number of cases I have investigated the police have either not called an ambulance or have delayed calling an ambulance in circumstances where immediate medical attention was clearly warranted. In Dooler although the deceased appeared to have stopped breathing at 1.00 pm, an ambulance was not called until 1.15 pm and did not arrive until 1.30 pm. No attempt at resuscitation was made in the interim. In Wells, although the deceased was showing unmistakable signs of illness (he was fitting) at 7.45 am, an ambulance was not called until 8.20 am. In the interim the police sought to discover whether the deceased was an epileptic. It emerged from one officer's evidence that he would have been unconcerned about Wells' condition if he had been found to have been subject to fits. It was only when the police were told that Wells had no such history that an ambulance was called.

There are no routine orders or instructions directing police officers as to what action to take in a medical emergency. It may seem like common sense that in a medical emergency an ambulance would be called as a matter of course but my experience demonstrates that this is not necessarily so.

Police officers should be directed to call an ambulance if it appears that they have a medical emergency on their hands. If it appears that the detainee is not breathing, police officers should also be instructed to commence resuscitation procedures immediately.

The issue of resuscitation training is discussed in more detail in section 5.2.8 of the Report which deals with Police Training.

5.2.9.3 Access to Medical Attention

In the Interim Report, Commissioner Muirhead (as he then was) made the following recommendations in relation to medical attention for detainees:

> *39. Police officers should ensure that any person detained in police custody who asks to see a medical practitioner receives immediate medical attention. Police departments should ensure, wherever practicable, that police officers have access to medical practitioners 24 hours a day.*
>
> *40. Police and prison officers should be instructed to immediately seek medical attention if any doubt arises as to a detainee's condition.*

The Police Department has informed the Royal Commission that its policy regarding provision of medical services is contained in Routine Order 16-2.28 which provides that the services of a Government medical officer, a medical practitioner or a hospital will be utilised. (Submission of Commissioner of Police and Police Department to RCIADIC May 1990, p. 11.)

The Routine Orders that appear to be relevant in regard to access to medical attention are as follows:

> *Royal Perth Ho-spital Inquiries Act*
>
> *13-3.10 Before a prisoner is taken from a lockup, etc., to the hospital for treatment, the hospital is to be advised by telephone, of the person's name and any previous treatment received at the hospital. This will enable hospital staff to obtain any medical record of the patient prior to arrival and avoid unnecessary delay.*
>
> *Responsibility to Prisoners*
>
> *16-8.10.1 Members are to ensure that in every case where a person is suicidal, intoxicated to the extent of being at risk or suffering or suspected of suffering any medical disability which may place the person at risk, all due care is to be taken any medical assistance available is to be utilised to ensure the welfare of the prisoner.*
>
> *Medical Treatment for Prisoners*
>
> *16-.8.28.1 These instructions are to be read in conjunction with paragraphs 16-3.10 to 16-3.16 of these Orders which deal with the subjects of "Drunkenness" and "Diabetes".*
>
> *16-8.29 Where a prisoner requires medical attention, the member in charge will, as soon as possible, arrange to have the prisoner visited by a Government Medical Officer or by any legally qualified medical practitioner if a Government Medical Officer is not available; or.--*
>
> *(1) where a legally qualified medical practitioner is not available, have the prisoner conveyed to hospital;*

(2) where a legally qualified medical practitioner is not available and the prisoner cannot be conveyed to hospital, obtain advice from a legally qualified medical practitioner by the quickest practicable means and give effect to that advice.

16-8.30 Generally, any costs incurred in relation to medical treatment for an unsentenced prisoner for an illness or injury unrelated to the confinement is the prisoner's own responsibility. The costs concerned are to be brought to the notice of the prisoner and the accounts are to be paid, if practicable, before discharge from police custody. The name and address of the prisoner should be supplied to the medical practitioner or the hospital staff and to the ambulance attendant where ambulancefacilities are used.

16-8.30.1 The Hospitals (Service Charges) Regulations provide for sentenced and remand prisoners to be treated as public patients free of charge at public hospitals Therefore, no costs are incurred against the Prisons Department unless it is necessary to arrange treatment at other than a public hospital.

16-8.31 A report is to be submitted to the Regional Officer following any action to obtain medical attention for a prisoner.

16-8.32 While it is appreciated that some prisoners will feign illness, medical attention is to be arranged in every appropriate instance rather than incur unnecessary risk.

16-8.33 At the time of the admission of a prisoner, anything which may indicate that a prisoner is receiving or requires medical treatment is to be noted, and any obvious injury or injury complained of by the prisoner is to be recorded on the Property Sheet in the section "Condition of Prisoner". Members should endeavour to record these details as accurately as possible as a means, among other things, of determining the prisoner's condition should such subsequently become necessary.

The Routine Orders listed in the section of the Report dealing with assessment of intoxicated detainees are also relevant.

The following paragraph from the Police Gazette Notice 13.1.88 on Aboriginal Arrests provides further instruction to police officers in relation to medical attention for detainees.

(iii) An Aboriginal detained or arrested who exhibits signs of mental or physical distress should receive a medical examination at the earliest practicable opportunity and, where possible, within one hour of being taken into custody, by either the prison medical officer, a qualified medical practitioner, a registered nurse or, if any of the foregoing are unavailable, another suitably qualified person.

The submission of the Commissioner of Police advised the Royal Commission that *'EPLU has, in common with all other lockups, provided medical treatment to detainees by way of government hospitals, private doctors, Aboriginal Medical Service, St John's Ambulance and first aid by police'. I* have no reason to doubt that this is so. It would appear from my inquiries that medical services of some sort are available in most places where a police lockup is located. These may vary from a nursing post staffed by qualified nursing sisters and serviced by the Flying Doctor Service in remote locations like Wiluna to large modem hospitals in the Perth metropolitan area. Possibly a more coordinated service is required which is something the Department is currently addressing in its proposal to establish a Forensic Medical Service. This is discussed in more detail below.

Clearly one major factor which inhibits 24 hour medical attention being available to detainees is that most country police stations are not staffed 24 hours a day. Thus, even if the medical services were available for police officers to call on, if a detainee required urgent medical attention in the early hours of the morning it is unlikely that he/she would be able to alert the police to his/her need and obtain the necessary medical attention. This situation is most unsatisfactory.

The Custodial Care Manual suggests that *'at one man stations where the officer in charge is called away, and a prisoner is in custody, arrangements could be made for local ambulance driver or nurse to visually check inmate are [sic] an additional safeguard'.* Although it is commendable that police officers make such arrangements in the event of them not being in a position to properly supervise a detainee I query whether it is appropriate that police officers abrogate their responsibility in such circumstances. I suggest that it would be preferable for detainees not to be held in police stations that am not staffed.

The other major problem which I perceived to exist in relation to detainees' access to medical attention was the lack of understanding of police officers as to when medical attention should be sought. Police officers must have the ability to make an adequate assessment of a detainee to determine whether medical attention is needed.

I have previously said in this Report and my individual Reports into the deaths that the onus should not be solely on the detainee to request medical attention and police officers should not rely on detainees to make a complaint before medical attention is provided. In other sections I have discussed the difficulties that Aboriginal detainees may have in either complaining to police officers about their wellbeing or requesting medical attention. Although it is not always the case, I have found in many instances that Aboriginal detainees may be shy or reticent in this regard.

The Police Custodial Care Manual (W/15/52) states the following observations about arresting Aboriginal persons:

> *Most Aboriginals suffer from some form of diabetics [sic] and or epilepsy, on most occasions will tell the arresting officer, usually to avoid being locked up. An astute officer will assess the seriousness of the condition of the prisoner and seriousness of the offence. In some instances it may be wiser to proceed by summons where a person is injured, or known to take epileptic fits.*

The first sentence of this extract does not accord with my experience as I have noted above. The manual also suggests certain considerations be taken into account before deciding to arrest someone. These include:

> *(4) Ask the suspect if they are suffering from any illness or injury, or taking medication.*
>
> *(5) If the suspect is unconscious, or not readily awoken, take DIRECT to the nearest medical and station BEFORE going to the lockup.*
>
> *(6) If in doubt as to a suspect's condition, seek medical assistance to ascertain the true state of their health.*

These suggestions are sensible guidelines and police officers should be instructed to follow them in all circumstances. The following points are listed in the Manual as measures that may help guard against deaths in custody:

(1) *Where a prisoner has a medical dressing such as a bandage on a wound or injury, and the prisoner is going to be detained, a medical practitioner should examine the wound/injury to see if the dressing can be removed before the prisoner is placed in a cell. Where a Doctor cannot attend or where the bandage cannot be removed, the prisoner must be kept under continuous surveillance.*

(10) *Under no circumstances are requests for medical attention to be denied or ignored.*

(17) Reliable prisoners who are permitted to steep on beds in the compound at night could act as monitors, and call station OIC should a problem arise after close of station.

At one man stations where the OIC is called away, and a prisoner is in custody, arrangements could be made for local ambulance driver or nurse to visually check inmate as an additional safeguard.

(22) Early warning device (alarm) to be installed in a cell in the lockup, with direct link to OIC's quarters.

In the event of a prisoner requiring medical attention or other urgent assistance, the OIC can be alerted and investigate.

A report proposing to both permit and encourage civilian visitors to lockups, has been submitted to the Commissioner for consideration. This proposal originated in South Hedland.

Suggestion (17) is discussed above. Suggestion (22) relating to alarm systems is discussed in section 5.2.1 of the Report dealing with police cells. I have noted in dealing with individual reports into the deaths that if detainees are held in police lockups which are not staffed it is absolutely essential that an alarm system is available so that attention can be obtained if necessary.

The Webster Committee Report recognised that the skills of officers responsible for the care of detainees need to be upgraded. The Webster Report points out that the police need to be supported by relevant services and facilities. After surveying the number of people requiring medical attention in lockups through out the State and the medical services available, the Committee made the following observations:

The EPLU is the main metropolitan centre processing large numbers of prisoners and the injuries, illnesses and attempted suicides at the unit are indicative of the need for some form of alternative medical assessment and management.

The country lockup facilities with a relatively high incidence of treatable cases (including suicide attempts) are Broome, Geraldton and Kalgoorlie. These centres and other country lockups in major towns utilise the medical services at District Hospitals and local general practitioners.

Figures for the metropolitan area strongly support the proposal to adopt an on-call 24-hour medical service for the region. A nursing service for EPLU would be applauded, however existing accommodation and physical resources would make this difficult to implement. [p.5]

The Webster Committee recommended the establishment of a Statewide on-call medical/nursing service which would initially be seen as an immediate service in support

of police officers responsible for the care of detainees. I have extracted the following recommendations from their report relating to the establishment of the Forensic Medical Support Service:

> *Recommendation I*
> *That an on-call Forensic Medical Support Service be established on a Statewide basis.*
>
> *Recommendation 2*
> *That medical practitioners involved in the above service be issued with guidelines on clinical forensic medicine as prepared by the Chief Forensic Pathologist, State Health Laboratory Service, QEII Medical Centre.*
>
> *Recommendation 10*
> *To establish an in-service training programme for permanent staff of lockups (and where practicable, other staff) with an objective of heightening their awareness and assessment skills with respect to prisoner care.*
>
> *Recommendation 11*
> *That a reference booklet be published which supports the various components of care services in custody.*
>
> *Recommendation 12*
> *That instructions be issued to all officers concerning the need to assess all prisoners upon admission and that ANY doubt regarding such person's medical/health status or ability to withstand long or short term incarceration be referred to the Forensic Medical Support Service or other general medical support.*
>
> *Recommendation 13*
> *The police personnel be acquainted with the philosophy of this service to enhance ready acceptance.*

I support the concept of an on-call Forensic Medical Support Service. I have not examined in any detail the way in which such a service should operate. It would appear that the establishment of such a service should involve consultation between the Police Department, the Health Department and relevant health organisations such as the Aboriginal Medical Service in view of the number of Aboriginal detainees in police lockups. I agree that appropriate training support services as listed in recommendations 10 to 13 are also necessary.

I should also point out that the Police Department is already in the process of renovating EPLU, part of the programme provides for a Nursing Post/Treatment Room in the lockup. On completion of the renovations a trial nursing programme will be implemented. Like the Webster Committee I commend the establishment of a Nursing Post at East Perth Lockup and urge its speedy implementation.

The Police Department has also informed me of the current provisions for medical attention at East Perth Lockup. Two locum medical services are now in use and doctors attend as required by the police for minor illnesses and injuries. A Psychiatric Emergency Team from the Health Department is utilised to assess distressed persons and if necessary to transfer them to suitable hospitals. (Submission of Commissioner of Police, p.11.)

However, access to 24-hour medical support service still places the onus on police officers to adequately assess a detainee's condition.

Police officers cannot be expected to make an assessment of the same standard as trained medical personnel however they can be trained to make a reasonable assessment and if there is any doubt medical attention should be sought. I suggested in my Report of the Inquiry into the Death of Kim Polak that some of the burden placed on police in this regard would be alleviated by the implementation of a system of daily or regular visits to the lockup by health workers from the Aboriginal Medical Services. It is a practice which has been established with a good deal of success at a number of lockups throughout the State. In section 5.4.3 on AMS and the Aboriginal Health Workers, I discuss the contact that has been made between the Police Department and the AMS and the individual police lockups where a system of visits of AMS health workers to the lockups have been established.

In Polak I suggested that a system of daily visits to the Kalgoorlie Lockup by the AMS be established as a matter of urgency. I support the implementation of a similar system in other areas where there is a demonstrated need.

The success of such systems depends on a level of cooperation between the Police Department, the individual police stations and the various Aboriginal Medical Services. In areas where the system is working well it appears that it is largely dependent upon the goodwill of the individuals. It is important that formal systems of liaison and communication be established so that current systems do not flounder if and when the individuals leave the area.

The Police Department has indicated its policy on establishing contact with Aboriginal Medical Services in its submission to the Commission which stated:

> *The provision of general medical care to prisoners is covered in existing orders and procedures, however, if the individual officers of AMS consider they can offer a better or more suitable service for Aboriginal detainees,* then they should make contact with *local stations for this purpose.* [my emphasis]

Given the extremely limited resources of Aboriginal Medical Services, it is my view that more is required of the police in this regard and they should not sit back and wait for the local AMS to contact them. The Police Department should take active measures to involve the AMS and to establish good communication with them. As I note in section 5.4.3 if the AMS are to be involved in custodial care then it is essential that they are adequately funded to enable them to increase their workload.

5.2.10 CONTACTS

5.2.10.1 Aboriginal Visitors Scheme

In a report dated 10 December 1987, the Special Government Committee on Aboriginal/Police and Community Relations recommended to the Honorable Minister for Police that a prison visitor system be established to regularly check on lockups and to provide a welfare or friends service to prisoners.

The Vincent Report supported the recommendation of the Special Government Committee. The Vincent Report envisaged that Aboriginal visitors appointed under an Aboriginal Visitor Scheme should (inter alia):

> *Be Aboriginals who are representatives of local community groups and can relate to the group of Aboriginals to whom they will cater;*

Be able to observe, interact with and provide care and companionship to prisoners from their time of admission into custody, including the stage of processing at the police station, through any period of custody at the police lockup or prison.

In February 1988 State cabinet approved the implementation of major recommendations of the Vincent Inquiry, among them being the introduction of an Aboriginal Visitors Scheme (AVS).

The basic function of the scheme is to provide a roster of Aboriginal persons in areas where police lockups or prisons are located who are available to attend the lockup or prison and provide support or counselling to Aboriginal detainees who may be in a state of emotional disturbance.

The AVS was initially established at Kalgoorlie in June 1988. It was subsequently introduced to the Perth metropolitan area, Broome and Geraldton.

The responsibility for the scheme rests jointly with the Ministers for Aboriginal Affairs, Police and Corrective Services. The Minister for Aboriginal Affairs through the Aboriginal Affairs Planning Authority (AAPA) is primarily responsible for the establishment and administration of the scheme.

The Commissioner of the AAPA has a delegation from the Minister for Aboriginal Affairs to administer the scheme on a day-to-day basis. Within the AAPA there is an AVS Management Unit comprising a Coordinator, Research, Policy and Training Officer, Project Officers and Administrative Assistant. The AVS Management Unit is located in the Special Projects Branch of the AAPA.

The role of the AVS Management Unit is:

- *Recruitment, supervision, training and support of visitors*
- *Administration, including rosters, payments and staffing*
- *Intervention and liaison with Police, Corrective Services and other Government agencies*
- *To increase public awareness of the needs of Aboriginal people in custody*
- *To provide research data aimed at (i) improving conditions for Aboriginal people in custody, (ii) identifying gaps in service provision, (iii) reducing the risks of death/self harm amongst detainees* (Submission of the AVS to the Royal Commission dated 22 June 1990).

In April 1989 a firm of private consultants (P. Alexander and Associates Pty Ltd) were commissioned to conduct a review and evaluation of the AVS. Their report was presented to the AAPA in July 1989 and contained a number of recommendations relating to the management of the scheme. The recommendations included:

- Expansion of the scheme throughout the State
- Improvements in management and administration
- Increase in administrative staff

- Introduction of forward planning with anticipated outcomes

A response plan based on the recommendations of that review and evaluation has been developed by the AVS Management Unit: The AVS Operational Plan 90/91. The objectives of the scheme as stated in the operational plan are:

1. To provide one means of reducing the likelihood of Aboriginal deaths/self harm in custody.

2. To ensure conditions for Aboriginal prisoners/detainees/juveniles improve by consulting with Government Departments and decision makers with information and advice on just and humane treatment.

3. To ensure advancement of Aboriginal Visitors Scheme by providing staff and the community with education and information in relation to the needs of Aboriginal prisoners/detainees/juveniles.

Selection of Visitors

Visitors appointed under the AVS are Aboriginals who have the confidence of their local community and who are expected to be able to make informed and objective judgements and to report appropriately. Visitors are granted an authority from the Commissioner of the AAPA which is used as their identification when attending lockups or prisons.

Visitors are employed on a casual basis by the AAPA. Payment is made on the basis of the 'Group Workers' rate of $10.70 per hour with a 50% loading to cover the nature of the work, twenty four hour availability and the 'casual' status of the employment. Visitors are also eligible for the Public Service motor vehicle allowance rate.

Visitors are appointed to participate in the scheme on a rostered basis in each area of operation. The roster provides for regular attendance at prisons and police lockups as well as crisis visits. Appointment of a visitor is made from nominations made by relevant local Aboriginal organisations or by individual application. This is followed by an interview-selection process conducted by the AVS Management Unit and the local spokesperson of the AVS.

Current Level of Service

The Commission has been informed that as at June 1990 there were 60 visitors engaged on a casual basis to provide assistance and services to detainees. The visitors also provide an ad hoc demand driven service and are expected to respond on a 24 hour basis to crises involving detainees in potentially life threatening situations.

The Submission by the AVS to the Royal Commission anticipated that in JulyAugust 1990 the scheme would be extended to Albany and Bunbury. In addition, a 12 month pilot project in conjunction with the Carnarvon Aboriginal Medical Service was due to commence in July 1990.

As at January 1990 visitors were rostered on a 24 hour basis in the following regions:

Perth Metropolitan Area

Police Lockups: Central, Midland, Warwick, Fremantle

Prisons:	Fremantle, Canning Vale, C.W. Campbell Remand Centre, Bandyup
Institutions:	Longmore, Nyandi, Graylands Hospital

Kimberley (based in Broome)
Broome Police Lockup

Broome Regional Prison

Gascoyne/Murchison (based in Geraldton)
Geraldton Police Lockup
Greenough Regional Prison
Eastern Goldfields (based in Kalgoorlie)
Kalgoorlie Police Lockup
Eastern Goldfields Regional Prison

It is interesting to note that at January 1990 over half (28 of a total of 47 visitors) were women.

Training of Visitors

Training for visitors is an ongoing process. New recruits to the scheme undertake an eight module introductory workshop before they are engaged in the field. The initial training programme covers topics on:

- orientation to the AVS
- policies and procedures of the AVS
- geographical and procedural orientation of prisons, police and institutional facilities
- report writing
- legal issues
- crisis management and communication skills
- supporting detainees who are in crisis
- basic first aid
- stress management

For visitors to efficiently perform their role it is essential that they possess a sound working knowledge of the two main custodial agencies - police and prisons. Visitors need to know the standing orders and basic procedures of the major institutions that they arc required to visit. This is for their own protection and knowledge base. The AVS 90/91 Operational Plan anticipates that training will be expanded to include rules and procedures at juvenile and mental institutions.

Through their training visitors are expected to be equipped to recognise signs of distress, depression and potential self-destructive behaviour in detainees and to be capable of responding to the detainee in a constructive manner. The effects of intoxication and other alcohol related problems are also considered in the initial training programme.

Once the initial training has been completed, visitors are required to undergo compulsory monthly training sessions to update their skills.

Visits to Lockups - Practice and Procedure

Visits to lockups occur in three ways:

1. On the request of a prisoner or detainee

2. At the request of a police officer at the lockup

3. Random visits carried out by the visitors - visitors have the right to visit lockups without notice, providing that their attendance does does not disrupt the normal and orderly functioning of the lockup.

The Interim Guidelines for the operation of the AVS were published by the Commissioner of Police in the Police Gazette dated 19 October 1988. Guideline 4 provided :

> *Visitors may enter all areas where detainees are located, however they may have access to staff/administrative areas only with the agreement of the Officer in Charge ... Where access to such area on any occasion is denied to visitors or the location of an inmate is not conducive to the discharge of the visitors duties, the Officer in Charge ... shall, where possible, provide a suitable area within which the visitors may visit the detainee.*

Visitors at Geraldton informed the Commission that their practice on attending a detainee at the lockup is to physically walk into the cells and sit on the floor or a mattress to talk. On a few occasions the officer in charge of the lockup had made the interview room available for visitors to talk with detainees (RCIADIC W21:49).

At the East Perth Lockup the practice is for detainees to be brought into an interview room to meet the visitor. The interview room is adjacent to the charge counter in the lockup (W/14/43).

The Commission has been informed of regional variations in the manner in which visitors are contacted and a request made for their attendance at a lockup. At Kalgoorlie evidence was given that it was the practice for police to telephone the local spokesperson of the AVS and advise her that there was a detainee who they felt required consultation with a visitor. She would then arrange for a rostered visitor to attend at the lockup (RCIADIC W18:276).

At Geraldton two visitors are rostered for each day on a 24 hour basis. Each visitor in that region is also provided with a 'beeper'. The police have been provided with a list of the beeper numbers and the telephone numbers of the visitors. The local AVS provide the police with a roster sheet each fortnight and when police feel that the attendance of a visitor is required they refer to that roster and the list of telephone and beeper numbers (RCIADIC W21:18-19). Apparently Geraldton is the only region where the use of personal beepers for rostered visitors has been introduced. It appears to be a sensible practice which should be considered for expansion to all regions of operation of the AVS.

Visitors generally use their own transport to attend lockups, however the Commission has been informed of instances where police will provide transport for visitors who do not have access to a vehicle (RCIADIC WI 8:322).

There is a visitors book at each lockup and prison in the regions where the scheme is operational. Visitors are required to enter the time of their arrival, the reason for the visit and the time of their departure from the lockup or prison in the book. Each visitor also has a report book which is made out in duplicate. Visitors are required to prepare a report on each visit made. The original of the report is then submitted to the AAPA.

Reports by visitors that are routine and do not require any special attention are checked by project officers when pay claims are submitted. Reports which require urgent or special attention are dealt with by project officers in the following manner:

(a) Visitors are instructed to advise the project officers as soon as possible after the incident of the nature- of the incident and action taken, if any.

(b) provide a full written report to the Coordinator of the AVS as soon as possible thereafter.

(c) Depending on the nature of the incident, the AVS management may deal with the matter internally or refer it to the appropriate authority for action e.g. Police, Prisons, Aboriginal Legal Service or Aboriginal Medical Service.

(d) A separate filing system has been developed to deal with urgent matters arising out of visitors reports. The system has been designed to facilitate appropriate action, follow up and confirmation of outcomes.

(e) Visitors are informed of any action taken and detainees are advised where this is felt necessary. Visitors and detainees are similarly advised of any outcome where appropriate.

In its submission to the Commission, the AVS stated that it was proposed that a new reporting form and process be operational by September 1990. The new form would be designed to improve the collection of data concerning the practical operation of the scheme.

In a joint session before myself and Commissioner Dodson, the Commissioner of Police, Mr Bull, was asked whether the reports of the visitors were brought to Ws attention or to the attention of one of Ws senior officers. He replied:

> *To my regional officers who are responsible for the region, and then ultimately to my assistant commissioner operations - it is the assistant commissioner responsible for general uniformed staff statewide. He personally assesses the system* (Underlying Issues Conference 31 July 1990 T644)

Commissioner Bull added that he was not aware of any serious matters raised by visitors that would require investigation by himself or officers under his charge:

> *I am sure there would be matters they would have raised that would have been fixed at a local level, but certainly, from the assistant commissioner, he hasn't reported any serious matters* (Underlying Issues Conference 31 July 1990 T644)

It is also normal practice for visitors to communicate orally with police or prison officers before they leave the lockup or prison and advise them of any concerns that they may have or whether the detainee appears to have settled down.

Support Committees for Visitors

The report of the Interim Inquiry into Aboriginal Deaths in Custody (The Vincent Report) stated that local Aboriginal/Police Liaison Committees where established, could provide a useful support service for visitors (Vincent report page 68). It has been the experience of the AVS that due to the established structure of the Liaison Committees, they may not necessarily be capable of adequately meeting the needs of the local AVS.

Project officers of the AVS, in conjunction with AVS spokespersons and delegates, have been consulting with local Aboriginal community organisations, shire councils and police and prison authorities to assist in the establishment of committees that would be able to provide appropriate support in resolving Aboriginal issues arising out of AVS work at the local level.

The Commission has received evidence of a relatively high resignation rate of visitors from the scheme. One of the visitors in Geraldton estimated a rate of 50% due to stress (RCIADIC W21:13). When questioned about the pressures affecting visitors Ms Brockman stated:

> *Well, some of the problems they seem to have is in regard to the employment side of it and also there is personal problems in regard to - if the person is married or living in a defacto relationship you're getting calls all hours of the day and night so you have to leave more or less immediately. A third one is the stress part of it because people are dying in custody or attempting suicide so some people can't cope with that* (RCIADIC, W21:17).

As a response to the problem of stress affecting visitors a support panel has been organised for the visitors at Geraldton. The panel comprises doctors, psychologists and social workers. The Superintendent of Police and the Superintendent of Greenough Regional Prison may also participate in the panel. It is considered that the establishment of similar support panels in other regions of operation of the AVS would be a positive move towards reducing the likelihood of 'burnout' and ensuring the retention of visitors in the scheme. It is recognised, however, that with the anticipated expansion of the scheme throughout the state smaller country centres may not have the necessary human resources to allow for the establishment of similar panels.

Other Difficulties Confronting the AVS

Visitors have stated in evidence before the Commission that in addition to providing immediate crisis counselling and emotional support to detainees they often find themselves being asked to perform a welfare or paralegal role. (The 'welfare' aspect of a visitor's role in relation to prison inmates is considered in detail in Part 5.3.6 of this Report).

Detainees may request assistance or information from visitors regarding bail, representation on charges, contacting family members, the Community Services or Social Security Departments or they may require medical attention or referral to a medical agency such as AMS. Much of this work requires follow up by visitors once they have counselled a detainee creating extra pressure and demands on the visitors' time.

Visitors have informed the Commission that where possible they will act as referral agents, notifying the appropriate Department or organisation that a detainee requires their assistance. There have been experienced regional differences in the degree to which visitors have been provided with support by outside agencies. Joseph Bridge, a project officer with the AVS with responsibility for country areas informed the Commission:

> *I was recently in Kalgoorlie. To my observation Kalgoorlie in comparison with Geraldton and Broome - there appeared to be a willingness on the part of the other agencies which I referred to earlier to co-operate or certainly assist the Aboriginal Visitors Scheme. Now, to my observation in Geraldton and Broome it is the contrary. I feel that the visitors are not getting the assistance in these centres which our visitors are getting in Kalgoorlie. That is mainly from Agencies.*

Q. *Which agencies?*

A. *The Aboriginal Legal Service, the Department of Community Services and the Health Department. These are the agencies that we mainly come into contact with through the course of our work* (RCIADIC, W21:58)

In section 4.2.5 of this Report I have referred to the under-resourcing of the ALS in this state and their resultant inability to adequately service all Aboriginal detainees - even in towns where a solicitor or field officer is based. Consequently, part of the burden of providing legal advice and assistance with matters such as bail has fallen to members of the AVS.

Another matter of concern which has been brought to the attention of the Commission (and particularly so in the initial stages of the scheme) has been a lack of knowledge among police and prison officers about the scheme:

> *You may find one or two senior officers at each lockup who are aware of the scheme and who work towards it's proper operation, however, I have found that there are young officers at the lockups who seem to know nothing about the scheme* (RCIADIC,W14)

It is essential for the continued successful working of the scheme that police and prison officers have a sound understanding of the operation of the AVS and the respective rights of visitors, detainees and officers under the scheme. Training in the operation of the AVS should be a component of police cadet and probationary prison officer courses.

I must emphasise however, that the overwhelming impression received by the Commission from both police officers and visitors was that the scheme is both successful and necessary. Joseph Bridge stated:

> *I personally have had discussions with police superintendents, sergeants of police, and generally the response from them has been very good and they certainly welcome the scheme and the continuation of the scheme. They see it as necessary and certainly a scheme which relieves the Police Department and the prisons department of some of the concerns and responsibilities* (RCIADIC, W21:8 1)

<u>The Future of the AVS</u>

I consider that the AVS is a valuable initiative in moves to reduce the likelihood of suicide, attempted suicide and incidents of self harm amongst Aboriginal detainees. For example, the scheme commenced in Geraldton in November 1988. Whilst there had been two deaths in the six months prior to the introduction of the scheme, there has only been one death in custody in the Geraldton area since the AVS commenced operation in the region.

A further indication of the success of the scheme and its acceptance by police may be found in evidence of police requests for Aboriginal visitors to attend distressed European prisoners (RCIADIC W21:55). I believe that it is imperative that the scheme be expanded to all areas of the state and that it be assured of continuation by commitment of resources and recurrent funding.

I note that to date the AVS has not received recognition in state legislation. Presuming that Government is intent on the retention and expansion of the scheme it appears proper and necessary that the scheme be given legislative backing - either by amendment to existing relevant legislation relating to lockups and prisons or by the introduction of a

separate statute. Such a move would enable the AVS to negotiate on more equal terms with the Police Department, the Department of Corrective Services, the Department for Community Services and the Health Department when seeking changes in custodial practice to the betterment of Aboriginal detainees.

I also note the recommendation contained in the AVS submission to the Commission that a high level coordinating/advisory group comprising representatives from visitors and the main departments and agencies involved in the operation of the scheme be introduced. Such a body could provide a senior forum for consideration of strategic plans, policy issues, broad programme direction and scheme promotion.

5.2.10.2 Family and Friends of a Prisoner

Stress amongst detainees may be caused or contributed to by (inter alia) a sense of confinement and of isolation from family and friends. Such stress may be considerably alleviated (if not removed) where a detainee is aware that he or she has the right and the practical ability to maintain reasonable contact with their family during their time in custody.

In addition, it may be necessary for contact to be made with relatives in situations where the detainee requires a surety before he or she may be released to bail.

I have already referred to the resolution of the Australian Police Ministers' Council regarding Aboriginal arrests and published in the Police Gazette under the authority of the Commissioner of Police on 13 January 1988. The summary of practices and procedures adopted by the Council provided in clause (ii)(b) that:

> *Should it be necessary to detain an Aboriginal person every effort should be made to advise relatives, friends or the Aboriginal Legal Service.*

This is commendable in theory, however in practice notification, or attempts to notify friends and relatives following an arrest may not take place. Inspector Cullen (officer in charge of the Midland Police Station) gave evidence on this point in the inquiry into the death of Christine Jones:

> Q. *But is it a case of the prisoner having to ask to make contact or is it the case that it's part of the procedure that the police will automatically ensure that either they contact relatives, friends or the ALS or at least give the opportunity to the prisoner to contact relatives, friends or the ALS?*
>
> A . *I would say that - no, it's not always the practice that that is done. But, as I say, the overriding factor is that we do our best to get all prisoners out of the lockup as soon as possible. If it means advising the relatives and friends, we do it.* (RCIADIC W3:323)

In a letter from the office of the Commissioner of Police to the Crown Law Department following upon a request from the Royal Commission it was stated:

> *Any decision concerning a request to inform friends or relatives of an arrested person is determined at the local level. Prevailing circumstances would no doubt have some bearing on the resources that could be utilised.* (W/17/119)

Where a person is not arrested in the presence of friends or relatives it is important that they be given opportunity and, where necessary, assistance to contact the same. Any sense of isolation of the detainee and concern of the family as to his or her whereabouts

would thereby be allayed or reduced. It is suggested that Police Routine Orders and/or Station Orders at each lockup be amended to reflect a right of a detainee to make a telephone call to family and friends once processing after reception at the lockup has been completed.

In relation to visits to persons detained in police lockups, Routine Order 16-8.26 provides:

> *Any relative or friend of a prisoner is entitled to visit the prisoner at any reasonable hour approved by the member in charge, but any such visit is to be held in the presence and within the hearing of a member. Sentenced prisoners are entitled to weekly visits from relatives and friends and such additional visits as the member in charge may allow.*

The entitlement of prisoners to visits from family and friends as expressed in Routine Orders is noted with approval. I have earlier commented on the design and arrangements at the Wiluna Lockup which allow for face to face contact between detainees and visitors, and on the recommendations of Dr Reser (1989) in his paper on the Design of Safe & Humane Police Cells.

I note that the current Halls Creek Lockup also allows for easy access by family to detainees. During the day prisoners are confined in a large grassed exercise area separated from the street by cyclone fencing. Family and friends may converse with prisoners through the fence and occasionally provide them with food and drink. The relatively relaxed and easy going atmosphere that this engenders is likely to better maintain the psychological well-being of Aboriginal prisoners than the enclosed structures that exist at lockups such as Broome and South Hedland.

5.2.10.3 Aboriginal Legal Service

A potential source of stress for detainees awaiting an appearance in court is uncertainty as to their fate regarding both possible conviction and sentence. Ibis is particularly so where persons have been charged with indictable (or serious) offences. It is important that detainees have the right to notify a legal representative of their arrest and the right to consult with that representative whilst they are in custody. This need was recognised in the Muirhead Interim Report, Recommendation I I of which provided:

> *Where practicable the Aboriginal Legal Service should be notified in all instances of the detention of any Aboriginal person in custody, where it is not possible to contact an officer of that service, such notification should be given to a person designated by the local Aboriginal community to receive such advice.*

I consider that the words *'where practicable'* should be read as applying to those areas where an ALS solicitor or field officer is stationed in the same town or immediate locality as the lockup.

Police Routine Order 16-8. 23 presently provides:

> *A prisoner held a lockup is entitled to communicate with a solicitor or solicitor's clerk and all necessary arrangements to enable a prisoner to communicate with a solicitor are to be made. A member shall not influence prisoners in their choice of a solicitor.*

There is no requirement under Routine Orders that police automatically notify the ALS upon detention of an Aboriginal person. The Commissioner of Police has informed the

Commission that the ALS is advised of the arrest of an Aboriginal person only where a request is specifically made by that person (Response of the Commissioner of Police to specific questions by the Royal Commission page 18).

It is also noted that some statutes (e.g. Section 63 of the Road Traffic Act) contain a requirement that police notify a person charged that they have a light to communicate with a legal practitioner and another person nominated by Wm.

Attendance by officers of the ALS at police stations in WA is specifically recognised in Police Routine Order I -I :

> *1-1.8*
> *Aboriginal Legal Service Field or Liaison Officers will visit Police Stations from time to time as part of their duties in arranging bail, interviewing witnesses and so on. Members are to facilitate the performance of those duties.*
>
> 1-1.10
> *Any advertising card or notice received from the Service is to be displayed so that Aboriginal people in need of legal assistance may know whom to contact.*

From evidence presented to this Commission it appears that in country areas where ALS field officers are located, the common practice is for the field officer to either attend at or telephone the local lockup each morning prior to the commencement of the days court. Police then provide the field officer with a list of those Aboriginals held in custody overnight and the offences with which they have been charged.

The Commissioner of Police has informed the Commission that the situation in the Perth metropolitan area is as follows:

> *At the East Perth Lockup and at other metropolitan lockups, police only contact the ... ALS at the request of the Aboriginal person in custody. The ALS does not visit the lockup and the arrangement is that any Aboriginal person in custod y is allowed access to the Legal Aid [Commission] solicitor who visits the lockup each morning before court. This solicitor either represents the Aboriginal prisoner in court or refers the prisoner to the ALS.* (Response of the Commissioner of Police to specific questions by the Royal Commission, July 1990 page 18)

One former ALS field officer who had been stationed at Broome told the Commission:

> *The police co-operated fully in allowing me to visit clients in the lockup and they notified me when clients were arrested to explain to the client the charges of DUI [Driving Under the Influence] prior to the client being placed in the lockup* (W/12/30)

This is the only instance brought to my attention of police notifying ALS upon the arrest of an Aboriginal person, although other ALS field officers who gave evidence before the Commission noted that they had access to their local lockup at any time and could attend to interview clients without notice (RCIADIC W18:335).

As a general principle I support the recommendation of Commissioner Muirhead (as he then was) that current procedure be modified to provide for notice to be given to the ALS by police upon the arrest and detention of an Aboriginal person. However, I would make the following comments: as detailed in section 4.2.5 of this Report, the ALS is currently understaffed and underfunded, particularly in country areas. For the ALS to be notified of *each* arrest of an Aboriginal person irrespective of the nature of the charge could place an

intolerable burden upon their resources - similarly with the police who would be required to perform the notification.

In many areas a substantial numbers of the arrests made are for relatively trivial matters e.g. Street drinking and public order offences such as Disorderly Conduct. Provided that in those situations bail is promptly considered, detainees have the ability to notify friends or relatives of their arrest and, where necessary, police notify agencies such as the AVS or AMS, there may be little need for immediate notification or attendance by officers of the ALS.

However, I believe that a different set of considerations apply where an Aboriginal person is arrested on a serious or indictable matter. Whereas a detainee may have some idea of the range of possible penalties that he may face upon conviction for disorderly conduct, the same cannot be expected where he or she is charged with offences such as serious assaults, woundings, break and enter offences or sexual assaults. These are charges that are likely to require detailed and considerate explanation to the accused person. In many instances they are incapable of being dealt with upon the accused person's first appearance in court and he or she may also require assistance in obtaining a surety before they may be released to bail.

I consider that it would be of considerable value if there existed some arrangement whereby the ALS is notified by police on each occasion that an Aboriginal person is detained on a serious matter as outlined above. This may call for a process of negotiation between the ALS and the Police Department to establish a mutually satisfactory set of procedures.

5.2.10.4 AMS and Aboriginal Health Workers

Matters concerning access of AMS staff to detainees in police lockups, in particular Aboriginal Health Workers, are considered in section 5.4.4 of this Report.

5.2.11 ABORIGINAL/POLICE RELATIONS

'They're in control, they're the boss' (RCIADIC W/18/331)

Introduction

In my inquiries into the deaths in Western Australia the issue of relations between Aboriginal people and the police has been of considerable significance. When one examines the reasons for the high level of over-representation of Aboriginal people in police custody and the disproportionate number of Aboriginal deaths in police custody it is not difficult to understand the hostility and suspicion that appear to mark relations between Aboriginals and the police. Commissioner Dodson has examined the nature of Aboriginal/Police relations in detail in his Report but it is also an issue which I feel I must address. In my inquiries throughout the State the message that came through to me very strongly from Aboriginal people was that they thought Aboriginal/Police relations were very poor. On the other hand, although police officers generally were aware that problems existed in their relations with the Aboriginal community, the prevalent view appeared to be that relations were reasonable and had probably improved in recent times. There seemed little understanding or awareness amongst police of the Aboriginal perspective on the state of relations. That lack of understanding seemed to me indicative of the problem.

It was clear that the situation was particularly poor in some areas, e.g. Kalgoorlie. In other areas where there had been a lot of work to try to improve police and community relations the efforts had paid off to some extent, e.g. Broome. However there always seemed to be room for improvement. I will discuss these areas in more detail below.

Another issue directly related to Aboriginal/Police relations was the dissatisfaction in Aboriginal communities with Aboriginal Police Aides and their role in Aboriginal/Police relations. Police Aides who appeared before the Commission were generally dissatisfied with their situation. Right from the start of the police aide scheme there- has existed a dilemma between the policing duties and the liaison role of police aides. Again, this issue has been discussed in detail by Commissioner Dodson in his Report but, given the amount of information conveyed to me during my inquiries, I have addressed this issue in more detail below. I will also consider the roles of Aboriginal police officers and efforts made by the Department to increase their numbers.

In discussing the state of Aboriginal/Police relations I am all too aware of the volume of material that has already been written on this issue and previous recommendations that have been made. It is with some dismay that I feel compelled to add my voice to that of others because my inquiries reveal that very little has changed. I add that it is with some degree of circumspection that I focus on police and their relations with the Aboriginal community, as Commissioner Muirhead (as he then was) pointed out in the Interim Report (p. 19), the police *'are likely to be regarded as the cutting edge of an uncaring white society'. The* lack of understanding and recognition of Aboriginal society and culture is widespread throughout white society. Yet the extent of contact between Aboriginals and the police and the resentment that Aboriginal people have at the high level of interference by police in their lives has been an issue which has arisen in many of the deaths I have investigated.

Aboriginal Attitudes Towards Police

The bitter 200 year history of contact between Aboriginal people and nonAboriginal society, and the way in which police have been used by the white community to control Aboriginal people is a starting point in understanding Aboriginal attitudes towards the Police. Maureen Kelly, a community development officer with the W.A. Alcohol & Drug Authority at Pon Hedland, summed it up in this way:

> *A lot of Aboriginal people in Port Hedland don't like the police, it stems back from a long time ago. I don't know of an Aboriginal people who can say that he likes a policeman, whether they've been arrested or not it is just a - the same as they don't like native welfare, because native welfare took their kids away. The police used to lock them up, it is a part of your tradition that you don't like policemen* (RCIADIC W8:266).

The major concerns expressed by Aboriginal people about the police were their lack of understanding and ability to communicate with Aboriginal people; their racism; the harassment of Aboriginal peoples especially the younger people, through intimidating policing practices; the use of abusive and racist language; rough treatment received by Aboriginals, again especially the young men, at the hands of the police; the general attitude of the police towards Aboriginal people; the unfair treatment Aboriginals received in relation to complaints against the police or non-Aboriginal people; the lack of training and knowledge police have about Aboriginal society and culture, especially younger officers, and the inappropriate placement of police officers in towns with significant Aboriginal populations. I discuss many of these concerns below in greater detail.

Police Attitude Towards Aboriginals

Most police officers who gave evidence to the Commission expressed the opinion that the main factor in police contact with Aboriginal people was alcohol.

During the course of my inquiries the strongest impression I gained about police attitudes towards Aboriginal people was a general lack of care for Aboriginal people especially those who had been detained in their custody. It was a view that I have expressed in several individual case reports. I recognise the conflict that exists for a police officer in carrying out his/her custodial duties in providing secure custody and at the same time having to provide for the welfare needs of detainees, yet this conflict in the custodians role does not justify the lack of care and indifferent treatment that my inquiries have revealed all too starkly.

Police understanding of and ability to communicate with Aboriginal people

Throughout my inquiries I found that the general attitude of most police officers was that they believed they could communicate adequately with Aboriginals and that Aboriginal people understood them.

Many Aboriginal people disagreed with this view. One Aboriginal person expressed the situation in Port Hedland in this way:

> *Police Aides would understand what the Aboriginal people are saying and maybe I or 2 policemen that have been here for quite a long time, all who have been to school with Aboriginal kids, all who have been involved in Aboriginal communities would be able to communicate. But say out of 25 policemen that you have got here now I would say maybe two of them could communicate effectively with Aboriginal people* (RCIADIC W8:278).

In my inquiry into the death of Jimmy Njanji the police claimed they could easily understand him and he they, yet all other evidence indicates he had virtually no understanding of English and spoke his tribal language.

Many Aboriginal people were also of the view that most police officers have little or no understanding of Aboriginal history, culture and lifestyle. Obviously this would reflect on their ability to communicate with Aboriginal people.

One Aboriginal witness, when asked about prevention of deaths in custody, said:

> *I think the police officers need to understand Aboriginal people more than they do at the present moment. I think their attitude towards Aboriginal people compared to white people needs to change in that they've got to understand that the Aboriginal person is still a human being the same as a white person and treat them as fairly as they can* (RCIADIC W18:345).

Many Aboriginal people and senior police officers expressed the view that it was the young police officers who had recently finished their training who were particularly ignorant in relation to Aboriginal affairs. It is interesting to note that the AIU Report also pointed out that officers of rec ent overseas origin were noticeably lacking in understanding (A.I.U. Final Report, p.8).

Use of Abusive and Racist Language

Aboriginal people complained about the lack of respect shown to them by the police swearing when talking to them. Aboriginal people thought that police would not act in this way if talking to white people. In the Morrison case a police officer gave evidence that the police referred to Ben Morrison as 'a warb', a derogatory term for a person, particularly an Aboriginal, who is frequently arrested for drunkenness (RCIADIC W15:55). In some places the complaints were more severe and Aboriginals spoke of some police officers using racist or abusive language towards them.

Evidence I heard in Kalgoorlie caused me grave concerns about the level of racism that existed in the police force. Many Aboriginal witnesses told me about police officers using offensive and provocative language towards them. Two former senior police aides (both with ten years duty in the force) gave evidence that the police at Kalgoorlie used racist terms such as 'Nigger', 'Coon', 'Boong', and 'Rock Ape' to describe Aboriginal people. Other terms Aboriginal people complained of were 'black bastard' and 'black cunt' (W/17/20).

One former police aide said:

> *If anybody said it in front of me, I said 'Look, cut it out'. That's what I would say, but if I keep on going out and pulling them up, they mightn't talk to me, you know. I had to work there. It was my bread and butter. Who wants to go to work where nobody is going to talk to you for the whole day or they're not going to go out and do patrols with you?* (RCIADIC W18:127)

The same aide was also asked:

> Q *Were there any people at the police station who, from your experience, appeared to be really racist people, who really disliked Aboriginal people?*
> A: *I think skin deep they all don't like Aboriginal people.*
>
> Q *You think they all dislike Aboriginal people?*
> A: *I reckon.*
>
> Q. *Did that make your job as a Police Aide difficult?*
> A: *Why do you think I got out* (RCIADIC W18:134)

The other former police aide was also asked about the use of racist language:

> Q *Was that only the odd few officers or was it pretty common for police officers in Kalgoorlie to use those names about Aboriginal people?*
> *A:* *I think it was common terms that Police officers used in practice* (RCIADIC W18)

Police officers who gave evidence in the Kalgoorlie cases agreed that some officers used racist terms but gave the impression that the usage was limited to a small minority. One officer expressed the view that the term 'Nigger' was not offensive (RCIADIC W17:405). The Aboriginal witnesses conveyed a very different perspective to me.

The Royal Commission asked the Police Department what steps it had taken to counteract racist attitudes amongst police officers. The response of the Commissioner of Police was:

> *None, specifically, however, all police officers are required to be accepted by the community where they work. Any person exhibiting racist attitudes is not*

accepted and appropriate action would be taken by the department, i.e. training or supervision

(Response of Commissioner of Police to specific questions raised by the Royal Commission, p.44, Q. 12.8).

The Royal Commission then asked the Police Department to clarify its answer given the evidence in the Kalgoorlie cases which showed that the use of racist terms generally appeared accepted by the officers stationed there. The Commissioner of Police said:

> *On our interpretation of the evidence in the Kalgoorlie cases, the use of derogatory and racist terms was not widespread and did not reflect a systematic practice. Individual officers on occasions may use such terms and they may swear and utter profanities. None of this conduct is necessarily evident of discriminatory attitudes that require a firmer response* (Response by the Police Department which the Royal Commission would like clarified 31.8.90 Q. 12.8).

1 find this response of the Department illustrative of a general lack of preparedness to accept the evidence of witnesses other than the police and to respond in a positive way to criticism. This attitude has coloured the police response throughout the life of my commission in Western Australia.

Harassment

The AlU informed the Royal Commission that most Aboriginal people who they spoke to believed that some police officers set out to harass Aboriginal people causing many Aborigines to develop a fear of all police. They found that:

> *There was general agreement that intimidation by harassment fostered hostility towards police among the Aboriginal community (this was often accompanied by harassment in hotels and business houses)* (Final Report of AlU Sept 1990 p. 9).

Aboriginal people have told me in evidence about harassment by the police. The resentment it causes is obvious.

There appeared to be a general perception amongst Aboriginal people that they were singled out for attention through discriminatory policing practices in a way that non-Aboriginal people were not. Aboriginal people were particularly concerned about the way in which Aboriginal youths were treated.

Targeting of Communities, Families and Individuals

Some families felt that they had been targeted by the police for special attention. This seemed to be a particular problem for some families actively involved in campaigning for Aboriginal rights who felt that they had been labelled as 'troublemakers' by the police. These people complained of policing practices such as spotlighting their houses at night and regular patrols of their neighbourhoods (e.g. Cameron family). There were also complaints that certain individuals who were known to the police because of previous offences committed would be singled out for attention by the police whenever an offence had been committed. This would result in arrest and questioning by the police (e.g. Bernard McGrath).

There was evidence in the Pat case of the police making patrols of the town area, the hotel and 'the village', an area consisting of half a dozen streets occupied by Aboriginal families, as frequently as five-six times on the afternoon shift of pension week. An officer commenting on the frequency of the visits to the hotel said:

> *The purpose of going into the hotel was to show the flag. Show the uniform. I still do the same thing today. It shows the uniform to those who are there in case there might be trouble (RCIADIC* W19:3382)

In particular, Aboriginal youths felt they had been singled out for unfair attention by the police. Many young Aboriginal people in Kalgoorlie complained that the police would stop and question them in the street when they were just walking along. This was especially the case at night (see statements of Mark Champion, W/17/18a; L Champion, W/17/20). I was also told about young Aboriginal fellows being stopped by the police for trifling matters (RCIADIC W18:320)

Aboriginal Police Aides in Geraldton spoke of their policing practices in relation to juveniles. They said it was good policing practice to stop and speak to all juveniles who they considered should be at school and may be truanting. They also said they would question any person who appeared to be new in town.

It is interesting to note that what is seen as good policing practice by the Police Aides is seen as harassment by many Aboriginal people.

I should point out that last year the Commissioner of Police issued an instruction in the Police Gazette (No. 38, 27.9.89) which set out the circumstances in which police officers could lawfully demand a person's name and address pursuant to section 50 of the Police Act. He said:

> *(The power is exercisable only where there is a reasonable suspicion that the person on whom the demand is made, has committed an offence or is a witness to the commission of an offence.* It *is not to be used for name checks unless this suspicion exists.*
>
> *Where a member may lawfully demand a person's name and address, the member shall:-*
>
> *(1) leave no doubt in the mind of the person being questioned that the request is being made by police;*
>
> *(2) unless in uniform, identify themselves by name and designation and produce his or her Certificate of Identity;*
>
> *(3) advise the person of the reason for which their name and address is being requested; and*
>
> *(4) fully explain to the person the consequences of refusing to supply their name and address*

He advised members that any unreasonable exercise of the power of arrest under Section 50 would be viewed seriously.

it would appear to me that in some areas with significant Aboriginal populations little attention is paid to this instruction. This is not surprising in view of the lack of adherence to Routine Orders and instructions which I have observed throughout my inquiries (see discussion at 5.2.7 of the Report).

Vehicles

I have also been told of the way in which vehicles occupied by Aboriginal people are singled out for attention by police. A witness in the Kalgoorlie cases told me about how his car has been followed by police for about 50 kms. He said:

> *I think the police have this idea in the back of their head - they see a car driving along. They will pull the car up under any sort of explanation. They will say 'You didn't have your indicator lights on', things like that. But the moment that car is stopped they ask everyone to get out, ask them all their names. That happened to me a couple of days ago - down at Coolgardie* (RCIADIC W18:321)

The witness pointed out the resentment that actions of this kind cause in the community (RCIADIC W18:321).

Rough Treatment

I found in the McGrath case that Bernard McGrath suffered injuries in the police station the week prior to his death. Many of McGrath's friends made allegations of mistreatment by the Kalgoorlie police. One witness told the Commission that many young Aboriginal men were scared of the police saying that they will get a 'flogging up' or a 'smack in the mouth' (RCIADIC W18:320). Another witness told me that he was punched in the stomach and charged with resisting arrest (W/17/71a).

Other witnesses told me of their treatment on arrest. One witness said:

> *I remember one time being picked up when I refused to give the police my name and address. They handcuffed me and lay me down in the back of the paddy wagon. They then drove around quickly, so I was rolling around the back hitting my head on the seats. I struggled to sit up so I wouldn't hurt my head. I believe they did it on purpose.* (W/17/18a).

Murray Stubbs told the Commission that there are lots of complaints about Aboriginal people being mistreated and rough-handled by the police in Kalgoorlie. He said he receives complaints that Aboriginal people are being assaulted by the police at the police station and at the time of the arrest.

Aboriginal Drinking Places

Elsewhere in the Report I have discussed police practices in relation to Liquor Act offences of street and park drinking and the impact these offences have on Aboriginal people.

There was evidence of police practices in Roebourne at the time of John Pat's death which involved constant patrolling of the town with people being moved from the park to the river. Then when they were drinking down at the river the police would come and make multiple arrests for drinking in a public place. The more recent approach taken by the police in Roebourne appears to be far more low key with comparatively few arrests for these offences.

However, the evidence in Kalgoorlie and Halls Creek indicated that many people were still being arrested for street and park drinking. Evidence showed that the police in Kalgoorlie were constantly patrolling the drinking spots favoured by the Aboriginal fringe-dwelling population and moving them on when they were found drinking in these places. As I said in the Polak Report:

> *Arrest is undoubtedly a very expensive way to deal with the relatively minor problem posed by the Aboriginal fringe dwellers who have nowhere to drink in Kalgoorlie and not only in monetary terms. It is extremely wasteful of police and court time, and in social terms aggravates tensions between police and Aboriginals. Effectively it persecutes some of the most unfortunate members of our society.* (Report page 5l)

Warrants

I also received complaints from Aboriginal people that the police would execute warrants on them twice, i.e. they would have paid the fine or served time in default, the police would not cancel the warrant, the person would then be rearrested and have the warrant executed against them again. The inquiry into the death of Stanley Brown found that there had been a double execution of a warrant against the deceased shortly before his death. The Police Department was asked about this and its response was as follows:

> *Warrants are normally endorsed on the reverse side, upon execution by the arresting officer. In some cases, due to human error, double execution could occur but this would be the exception rather than the* rule (Responses by the Police Department which the Royal Commission would like clarified, 31 August 1990).

This seems a rather feeble response when the double execution can result in the unlawful detention of a person in custody due to police error. It would seem that police practices in this regard need to be given further attention especially in view of the number of complaints made by Aboriginal people of this practice.

Aboriginal Perceptions of the Attitude of the Police

The above response perhaps highlights some of my concerns about the attitude of the police towards Aboriginal people. Aboriginal people expressed many concerns about the way in which the police took advantage of people who did not know their rights. One Aboriginal witness expressed the police attitude in this way:

> *If the police are speaking to me then he knows that I know the law. If he is speaking to a fringe dweller he will stand over that person and do what ever he likes* (RCIADIC W18:332).

I was also referred to perceptions by Aboriginal people of unfair or discriminatory application of the Law. In Kalgoorlie I was told how the police would always pick up Aboriginals first in fights before they would touch any white persons involved (RCIADIC W18:320-321). Aboriginal people also felt that they had difficulty in obtaining police action or assistance if they presented a complaint, particularly against a police officer or white person.

Complaints Against the Police

The subject of complaints against police is discussed in detail in Commissioner Dodson's Report and I will go no further than to say that it is apparent that it is extremely difficult for Aboriginal people firstly to make complaints about the police and secondly that the current mechanisms for dealing with such complaints are ineffective in relation to Aboriginal people.

The difficulties for Aboriginal people in making complaints appear to be numerous. A primary concern is the possibility of harassment or retribution if a complaint is made. There is also a reluctance if the complaint involves questioning the word of the police against the Aboriginal person. Aboriginal persons have expressed the need to have witnesses before making a complaint.

The Report of the Equal Opportunity Commission entitled 'Review of Police Practices' addresses some of the problems with the current mechanisms for lodging complaints under the Equal Opportunities Act (see Recommendations 4 & 5 and discussion at pp. 56-58 of the Report). Commissioner Dodson examines the difficulties in lodging complaints with the Police Department and the mechanisms of internal police investigations. He also looks at the investigation process of the State Ombudsman in relation to complaints of Aboriginal people.

Aboriginal Police Aides

Background

The Aboriginal Police Aide scheme was established in Western Australia in 1975. Since the 1830s, 'black trackers' had been used by the police force in this State. It could be said that the introduction of the Police Aide scheme to some extent legitimised their ongoing employment.

The scheme originated from a request from the Mowanjum Aboriginal community (near Derby in the Kimberley region of W.A.) for assistance in establishing a system of community policing because the Mowanjum Council was concerned about law and order issues in both the community and in the town of Derby. They wanted a community policeman who would primarily be accountable to the Council of Elders which would select the applicants, contribute to the wages and pay for the uniform. The community policeman would live at Mowanjum. Police assistance was requested in the provision of uniforms and training and to make daily visits from Derby (Report 'Law Enforcement or Liaison, A Review of the Aboriginal Police Aides Scheme', 1987, pp. 8-1 1).

Legislation enabling the appointment of Aboriginal police aides was passed in 1975. In June 1975 the first police aides were appointed in the Kimberleys. One of the first aides appointed said he received no training or guidance as to his role and duties, prior to commencing work (RCIADIC W4:181).

The police aid scheme that was introduced was quite different to the original request of the Mowanjum Aboriginal Community. Police aides are selected, equipped, paid and controlled by the Police Department. They are attached to the police stations and live in town. The day to day training and supervision of police aides is the responsibility of the officer in charge of the police station to which an aide is attached. The police aides are accountable to the Police Department and not the Aboriginal community.

In 1983 the Police Department published a guide entitled -Directives for the Guidance of Aboriginal Police Aides. This provides the only guidance to aides as to their role and duties. It describes the 'main aims' of the scheme as follows:

(a) To improve Aboriginal/police relations

(b) To improve communications between Aboriginals and police, i.e. aides acting as interpreters

(c) To assist Aboriginals who are in police custody

(d) To assist Aboriginals to understand basic statute laws

(e) To encourage Aboriginals to approach police stations or police for assistance

(f) To encourage and promote racial harmony within the community.

Number of Police Aides

There are presently 61 Aboriginal police aides in Western Australia, three under approved strength. They were located in the following areas as at 19 July 1989:

TABLE 5.1: NUMBER AND LOCATION OF POLICE AIDES IN WESTERN AUSTRALIA

Police Station	No.
Albany	1
Broome	4
Carnarvon	2
Collie	1
Derby	1
Esperance	1
Fitzroy Crossing	2
Geraldton	4
Halls Creek	3
Kalgoorlie	1
Kununurra,	2
Laverton	1
Leonora	2
Marble Bar	1
Meekatharra	1
Metropolitan	1 3
Midland	1
Moora	1
Mt Magnet	1
Mullewa	1
Narrogin	1
Newman	1
Northam	1
Nullagine	1
Onslow	1
Pon	2

Hedland	
Roebourne	2
South Hedland	2
Wiluna	3
Wyndham	2
TOTAL	60

Since the establishment of the scheme, 128 police aides have been recruited, of that number sixty have resigned, three were dismissed, one is deceased and eight have subsquently joined the force as police officers (Review of the Aboriginal Police Aide Scheme 19 October 1989).

Problems with the Police Aide Scheme

In March 1986 the Special Government Committee on Aboriginal/Police Community Relations commenced a review of the Aboriginal police aide scheme with the approval of the Minister for Police. This arose following strong expressions of dissatisfaction with the police aide scheme at the Government summit meeting into Aboriginal/police relations in 1984 following the death of John Pat.

The review was completed in June 1987 and the Report entitled 'Law Enforcement or Liaison, A Review of the Aboriginal Police Aides Scheme' (Police Aides Review (1987)) was forwarded to the Minister for Police. The Report was never released publicly although some of its recommendations were incorporated into the scheme. The Police Aides Review (1987) described the 'central theme' arising out of the review as the 'widespread confusion about the aides' role and duties'. My inquiries showed that most Aboriginal people and aides themselves thought aides should primarily function to provide liaison between the Aboriginal community and the police. the role that they were actually fulfilling was one of policing and law enforcement.

The main thrust of the Report was that the conflict between police aides' law enforcement duties and their liaison role had to be resolved. The Report recommended that the conflict be resolved in favour of the liaison role. These recommendations have not been implemented.

Many of the issues that were raised in the Police Aides Review (1987) were the same as the concerns expressed to me during my inquiries by members of Aboriginal communities and the Police aides. It is apparent that similar concerns were presented to the Equal opportunity Commission in its Review of Police Practices (see Report at pp. 62-64) and to Commissioner Dodson.

I set out below the main concerns expressed to me about the current police aide scheme. A more detailed examination of the 1987 Report is found later in this section together with an examination of a more recent review of the police aide scheme conducted by the Police Department.

Concerns of the Aboriginal Communities

Although some Aboriginal people thought the original concept of Aboriginal police aides was good it was clear that there was a high level of dissatisfaction with the way the police

aide scheme operated throughout the State. Maureen Kelly, in her evidence in the Njanji case, highlighted many of the concerns held by Aboriginal people, particularly in relation to the aides' policing role.

> *It was supposed to be a liaison between the Aboriginal people and the police but somewhere along the line it got lost, and Aboriginal people see police aides as glorified black trackers or policemen, because he's got that same thing on, he wears the hat, he hangs about with the white policeman, he drives around in that car with that white policeman and he's a policeman, and they don't trust them because they know that that same bloke is going to arrest them, the same as that white policeman and they don't relate to them* (RCIADIC W8:278).

One Aboriginal witness called the police aide system 'a joke' and said that police aides were 'cheap labour for the police force' (RCIADIC W21:316-317). Police aides were often referred to as 'Jackies' or 'black trackers'. Aboriginal people were well aware that police aides were lacking in authority and were only empowered to arrest Aboriginal people, even for example, in a domestic dispute between an Aboriginal person and a non-Aboriginal person. This was perceived to be unfair and discriminatory. Police aides did not have the trust of the community and a few were accused of being 'a bit heavy' or of handling Aboriginal people roughly. It was also pointed out that police aides wearing uniforms was not a good thing as it represented white authority and that Aboriginal people could not relate to that.

Other concerns expressed by Aboriginal people related to the problems aides had in working in the Aboriginal community. Many police aides are posted to police stations outside of their home region. People in areas where an Aboriginal language was the first language of most of the population were critical of police aides' inability to speak the local language. Aides were also criticised because they did not understand traditional Aboriginal law or culture. It is interesting to note that in Geraldton, where this particular comment was made, the Aboriginal police aides stationed there said that there were no tribal people in Geraldton and there was no Aboriginal law or ceremonies for youths (RCIADIC W21,90-91). However, I also heard evidence that traditionally oriented people from areas such as Meekatharra and Wiluna frequently visited Geraldton, residing there for periods with friends or relations.

Aboriginal people said that it would be better if police aides came from the local area rather than from out of town. It was a common criticism that aides did not mix with the local Aboriginal population and they did not relate to Aboriginals on the same level. However in some communities Aboriginal people presented the view that local people do not want to become police aides because they would be 'putting their own people in'.

In addition to reluctance in exercising authority over their own people, potential difficulties arising out of avoidance and obligation relationships were discussed. It was noted by the officers in charge in Wiluna and Halls Creek that attempts had been made to recruit local police aides but without success. In Halls Creek they were unable to appoint a local person because all the applicants had criminal records (RCIADIC W29:87). Another issue raised was that the Aboriginal community were not involved in the selection process and there were problems with police aides, not being accountable to the local community.

Changes that were suggested by various Aboriginal people included the following:

- Aboriginal Police Aides should be carrying out duties which involved liaison with the community

- Aboriginal Police Aides should provide communication between Aboriginals and the police

- Aboriginal police aides should provide welfare assistance in the lockup including notifying the family of the detainee

- Aboriginal Police Aides should explain people's fights to Aboriginals

- They should act as interpreters, especially at the police station.

It was also suggested that Police Aides should not be employed by the Police Department but should be operated by another agency. Another suggestion was that they should be civilians with their primary function being interpreting. Other Aboriginal witnesses thought that it would be better to get rid of Police Aides altogether and train the present ones to be police officers.

Generally the weight of the evidence was that Aboriginal Police Aides should mainly perform a liaison role between Aboriginal people and the police as well as providing some welfare assistance to detainees at the lockup and an educative role in relation to explaining people's fights. It was felt that policing functions should be very restricted if not completely abolished.

Concerns of Aboriginal Police Aides

Police aides raised similar concerns in their evidence before me as they did during the Police Aides Review (1987) and the Review of Police Practices conducted by the Equal Opportunity Commission (1990). The major concern was that although they were termed 'police aides' they were in reality only second class police officers doing similar, if not the same, work as ordinary police officers but without the same rewards.

There was concern over the career structure which was very limited with a senior Police Aide with over ten years experience being junior in rank to the most junior police constable and earning a little more than junior constables. Several ex police aides who each had eight-ten years experience and who had reached the level of senior police aide resigned over the issue of lack of career structure (RCIADIC W12;W4).

Police Aides also felt there was a need for a duty statement setting out their role and duties. This was not only for their benefit but to assist the officers in charge of police stations and other police officers in understanding the role of the police aides. A number of aides expressed frustration at the amount of variation in duties they were assigned, according to who was officer in charge of the station.

Most Police Aides said that in practice their primary role was one of law enforcement with liaison work taking a secondary role. One ex Police Aide said he 'felt used' because he was obliged to carry out policing duties rather than liaison duties (RCIADIC W21:539). The current Police Aides who gave evidence in Geraldton cases said that although they did a lot of enforcement work in relation to minor offences (RCIADIC W21:85) they also did a considerable amount of liaison work (RCIADIC W21:85). An ex Police Aide told me how he had arguments with the Police Department over the importance of the liaison role. He said he did not feel there was enough time for the liaison and communication part of being a Police Aide although he said he always made sure he found time for it (RCIADIC W12:45-47).

Police Aides were also very conscious of their lack of authority, especially in relation to their powers of arrest, i.e. having powers of arrest in relation to Aboriginal people but not for non-Aboriginal people.

Another issue that arose was the lack of training. Some Police Aides received no training at all prior to commencing their duties. However the evidence of the Police Department suggests that police aides were able to attend a two-week inservice course at Pundelmurra College at Pon Hedland from the inception of the scheme. The length of the course has gradually increased but as the Equal Opportunities Commission Report notes, metropolitan police aides currently receive more training than country police aides and the training for both is considerably less than that received by police recruits. Police Aides complained that they received little or no training in relation to the liaison aspect of their job.

Another major concern expressed by Police Aides, particularly those who have since resigned, was the attitude of the police officers with whom they had to work. I have already discussed the evidence I received in Kalgoorlie about the use of racist language and racism generally. I was also informed about difficulties experienced by police aides working with officers with little or no training in the cultural differences between Aboriginals and non-Aboriginals. One former Police Aide expressed it in this way:

> *It would cause all sorts of problems. They'd do things and not realise where they were, that the situations could get out of hand if they said the wrong thing at the wrong time. If they just stopped and listened to people of some experience then I'm sure a lot of the situations wouldn't have arisen. They would have just waited a couple of minutes or whatever just to let people more experienced to go in ahead of them.*
>
> *... The Police Aides were there to help them. A lot of them wouldn't take their advice. A lot were very stubborn in their ways* (RCIADIC W4:188-9).

He went on to say that:

> *It could be either a young constable without proper training or a more senior person who hadn't spent enough time in country towns* (RCIADIC W4:189).

When asked about the kinds of mistakes that were made by inexperienced officers, he said:

> *Just their attitude, the way they spoke, the way they addressed people, the way they went about their work* (RCIADIC W4:190).

Another ex police aide spoke of the difficulties in working with police constables:

> *If they want to make a Police Aide, there should be a separate body. You can't have policemen and police aides together. ... You can't work together. You don't know whether you are going to say something to the bloke - if its right or wrong* (RCIADIC W18:125).

Obviously some police officers are quite happy to take the advice of police aides but the impression I gained from the police aides was that this was the exception rather than the rule.

Reviews of the Police Aide Scheme 1987-1989

I have mentioned above how the Police Aide Review (1987) by the Special Government Committee on Aboriginal/Police and Community Relations came about. More recently, as the result of a directive from the Commissioner of Police, a further review of the Police

Aide Scheme was carried out by a Working Party formed by the Commander of the Inspectorate. Its report was dated 19 October 1989.

Before examining the two Reports and the difference in their approaches and conclusions, it is interesting to note the composition of the committee responsible for the 1987 Report and the working party responsible for the 1989 Report and their methods of consultation with the Aboriginal community, Aboriginal police aides, police officers and other organisations and individuals.

The Committee of Review responsible for the 1987 review comprised a police superintendent, a member of the Aboriginal Legal Service, a member of the Aboriginal Advisory Council and a project officer and coordinator, who were both employed on a consultancy basis for the review. By way of contrast the working party responsible for the 1989 review was comprised of nine commissioned police officers (the Commander of the Inspectorate, three Chief Superintendents, one Superintendent, four Inspectors) and one other person, apparently a civilian.

The 1987 Review sets out the thirty-four locations where thirty-eight meetings were held, the fact that submissions were invited from all interested parties, with newspaper advertisements and specific requests to OICs, police aides and other government authorities. The Report also appended a list of persons and bodies from whom submissions were received (seven individuals, six Government Departments and Agencies, five police officers, the Police Union, nine Aboriginal communities and organisations and eight Police Aides). The Report gives a clear indication of the consultation process involved.

By way of contrast the 1989 Review sought to update the information in the 1987 Review with additional information about the schemes operating in other States. The Report stated that research conducted was 'based upon the most recent information available' without giving the sources of that research. At the conclusion of the 1989 Review the following comments are made about the consultation process:

> *Prior to this review, the office of the Commander of the Inspectorate had conducted a great deal of research by way of direct contact and consultation with Aboriginal Police Aides. This was expanded upon during the course of the review where it was agreed by all concerned and consulted that there should be a change to the present Aboriginal Police Aides Scheme.*
>
> *Members of the Working Party, were able to discuss the majority of the foregoing recommendations with senior and junior Aboriginal Police Aides from both the North of the country and the Metropolitan Area. Also consulted were Aboriginal Police Officers (one of whom was a recent graduate from the Academy) and former Aboriginal Police Aides. These too endorsed the recommendations.*

It is interesting to note that during a confidential session held by Commissioner Dodson with a number of Aboriginal police aides in Perth (30 June 1990) the following remarks were made by a serving police aide:

> *We have had several reports: one was called Law Enforcement or Liaison which was given by the special government committee on Aboriginal police relations, and that was in 1987, and the department's response to that was they implemented certain things and then decided to come up with a review of their own which ended up with a 30 point recommendation, and that was completed in August 1989, and we were given it to us [sic] in July this year for us to have a look at and pass comments on it, although in the review it says that we had input into it*

and that we were consulted in regards to certain recommendations and these consultants were actually after the fact that the report had been completed.

There was no input by the actual police union; no input by ourselves or the Aboriginal aides in the country which actually the majority of the scheme are in the country. I have taken it upon myself to issue that review to certain members in the country so they are aware of what is going on - because it is their job, they want to know what is going - and I felt that it was my undertaking to let them know as well.

A lot of them are surprised that there [sic] weren't even involved or consulted. A lot of us are surprised that we weren't involved or consulted regarding a lot of these recommendations which appear to me, myself, have no real design in them - they are not going to actually help or work for Aboriginal people. They believe us to be liaison officers and, yet again, they prefer us to be police officers. It seems to be whatever the department want at the time that they use us in that role RCIADIC, Dodson 30.6.90:464).

The earlier Law Enforcement or Liaison Report is a comprehensive document (195 pages) which is well researched and fairly presents the major issues of concern or conflict which were raised during the review.

The issues which the Report addresses are the role and duties of police aides, recruitment and selection procedures, accountability, an appropriate name, training and staff development, pay and conditions of service, women aides, metropolitan aides, powers of aides and the conclusion and summary of recommendations. The Report concluded that there was widespread dissatisfaction with many aspects of the police aide scheme. It said that a large majority of respondents believed that the aims of the scheme were not being translated into practice and that instead of 'building bridges between Aboriginals and the police' they are working as 'de facto police officers'. They identified that the central issue was whether the primary role of police aides should be one of liaison or law enforcement. They concluded that the overwhelming view was that aides should operate as liaison workers and that there was a need to make the role of aides in theory consistent with their role in practice.

The recommendations then set out a practical means of bringing about the changes that the review identified as necessary to give effect to the liaison role of police aides taking into account the major areas of concerns raised during the review. The 1987 Review makes forty recommendations but the major recommendations include a one-off package of transfer and training be offered to any currently serving police aides wishing to become police officers and that the position of Aboriginal liaison workers be established. Police aides who did not wish to take advantage of the one-off transfer package were to be given the choice of applying for a new Aboriginal liaison worker position, accepting a severance package or be redeployed to another government department.

As a result of the review very little changed. As mentioned above the Report was never publicly released by the Government. Some of the recommendations were adopted but the major concerns relating to conflicts in the role and duties of Police Aides, accountability, the selection process, the career structure, pay and conditions of service, training, powers of police aides have still not been adequately addressed or implemented. For the last two and a half years, and as recently as 30 July 1990, Aboriginal communities and Police Aides were still voicing the same concerns about the current Police Aide scheme.

The 1989 Review by the Police Department (19 pages) provides background to the review, concluding comments of the chairman of the review and the recommendations accompanied by support comments together with seven annexures.

I consider that the 1989 Review does not adequately address the fundamental issue which was discussed in the 1987 Review and which was the major concern raised in relation to police aides during my inquiries, i.e. is their role one of law enforcement or liaison?

Despite the overwhelming evidence to the contrary, the Police Department Review does not support the removal of the law enforcement role in favour of the liaison role, nor does it acknowledge the major conflict that exists for both the Aboriginal community and police aides in performing both roles. The 1989 Review presents the following discussion on the issue:

> *However, the Working Party does not agree that the current concept should be changed by removing the law enforcement point of the concept, in favour of liaison only and with operations being more aligned to that of a Welfare Worker. A better alternative is to ensure that a more even balance of duties are being performed.*
>
> *Experience before and since 1975, has very well demonstrated that to be effective in preventing a break-down of law and order among some Aboriginal communities and groups, or in the dealing with some individuals, it was absolutely necessary for Aboriginal Police Aides to be readily available for on the spot liaison.*
>
> *The only effective way that the latter can be best performed was by the current concept of police officers and Aboriginal Police Aides working side by side and in many cases, pairs or as a combined team. A proven way of establishing trust, co-operation and preventing police/aboriginal confrontations.*
>
> *In addition, this method of operation has resulted in enormous benefits, by way of providing an excellent avenue of training for many police officers in dealing with aboriginals. Conversely the Aboriginal Police Aides have received major training benefits themselves, which includes actual training in the field in general policing and its problems, something that is unique to the concept and which is not available through any other system.*
>
> *It has also been clearly identified that in order to effectively fulfil their unique role, it is necessary for the Aboriginal Police Aides to have police powers.*
>
> *The role not only calls for a person to have some heir [sic] of authority, but also to be able to enforce the law in order to quickly defuse a given situation.*
>
> *The Working Party also recognised those situations that are now frequently arising on the roads and away from homes and communities, brought about the mobility of many aboriginals of today. In order to meet the need, a greater demand has been made for both the policing and liaison actively to be mobile together.*

The major concern of the Police Department appears to be the maintenance or imposition of 'law and order' on Aboriginal communities rather than improvement of liaison with Aboriginal people and the betterment of Aboriginal/police relations. The latter concerns are not even mentioned and the Aboriginal voice appears to have been completely ignored.

The 1989 Review contains recommendations which would enhance the policing roles of police aides including increasing powers of police aides (to be called Aboriginal Auxiliary Constables), issuing them with the full police uniform and accessories, that they carry handcuffs and long batons, and that they receive the same firearm training as police officers. However the 1989 Review has also recommended that duty rosters provide Aboriginal Auxiliary Constables with a greater opportunity to perform liaison duties.

Many recommendations address some of the more peripheral issues that were raised during the 1987 Review and during my inquiries. These include:

- that the present rank structure be maintained but with additional pay increments
- that Aboriginal police aide courses have a greater liaison content
- that Aboriginal police aides be permitted to return to their home region
- that Aboriginal police aides who are orientated to more liaison type work be attached to community policing sections in appropriate regions
- that duty statements be directed to all members of the Force
- increase police aides' access to police vehicles
- that positive encouragement be given to police aides to achieve entry into the police force as police officers
- that a special recruit training course be introduced at the Academy for Aboriginal police recruits
- that the same consideration be given to Aboriginal police officers in enabling them to return to their home region following training.

The last three recommendations relating to recruitment of Aboriginal police officers will be examined in more detail later in this section.

It is my view that although addressing some of the concerns of the Aboriginal community and police aides about the current police aide scheme, the changes recommended by the 1989 Police Department Review do not adequately address the major concerns relating to the scheme as discussed above. I regard the improvement of the liaison role of police aides as the crucial issue and support the recommendations of the 1987 Review of the Police Aide Scheme.

I also note that the Commissioner for Equal Opportunity was of the same view and made the following recommendation in the Review of Police Practices:

> *Recommendation 12*
> *The Commissioner for Equal Opportunity should urge the Government to adopt the recommendations of the 1986 review of the Police Aides Scheme, with a view to improving the capacity of Police Aides to liaise effectively between Aboriginal people and police.*

Aboriginal Police 0fficers

There are currently twenty-three Aboriginal police officers who are members of the Western Australian Police Force. As mentioned above, eight police aides have left the Police Aide Scheme to become police officers. The total police strength is 3751 (as at 30 June 1990).

The Police Department has expressed a policy of giving positive encouragement to Aboriginal people to join the Police force. Although the Police Department does not agree with lowering the academic level to decrease the difficulties of some Aboriginal people meeting recruit entry requirements, the 1989 Police Aide *Review has suggested that 'a special knowledge of aboriginal problems could be given greater weight when considering factors overall'* (Recommendation 9, pp.3-4).

This Review has recommended that future selection of police aides (Aboriginal Auxiliary Constables) recruits be, where possible, *from those persons most likely to achieve entry into the Force as a Police Officer and every encouragement be given them to do so consistent with an aim to increase the number of Aboriginal Police Officers serving within the Force'* (Recommendation 8, p.3). It has also been suggested that the experience of a Police Aide be taken into consideration during the selection of Police Recruits.

The Review also said that more could be done to assist Aboriginal Auxiliary Police improve their educational standards and suggested obtaining the assistance of school teachers to conduct coaching courses, particularly for Aboriginal Auxiliaries in country areas.

The Review also recommended that a special Recruit Training Course for Aboriginal police recruits be introduced at the Academy (Recommendation 9, p.3). The reason for this being the perceived difficulties of some newly qualified Aboriginal police in a new environment which placed them at a disadvantage. As noted above the Review has suggested that Aboriginal police officers as well as Aboriginal auxiliary police (police aides) be permitted to return to serve in the region from which they were recruited. The working party has recognised that this would remove a significant barrier which currently deters a number of police aides and potential recruits from joining the police force as police officers (see Annexure "E", 1989 Review).

In December 1988, the Police Department introduced a pilot scheme known as the Aboriginal Police Cadet scheme. The scheme commenced with 20 Aboriginal cadets being appointed and it was anticipated that these would eventually become police constables (see submission of Commissioner of Police and the Western Australian Police Department to the Royal Commission, May 1990 at p.21). There are now only 14 of those cadets still employed by the Police Department (Response of Commissioner of Police W.A. to specific questions raised by Royal Commission, p.47).

Commissioner of Police, Mr Bull, told the Royal Commission that some of the cadets from country areas who were brought to the metropolitan area had difficulty coping because they found it hard to adjust. He said that the Police Department is looking at posting them back to their country towns after an initial period in the city (Bull 31.7.90:657).

Commissioner Bull explained the concept of the police cadet scheme:

> *With the police cadet system the idea is there that generally they come in at 16, 17 years of age. If there is any difficulty so far as education standards we take it upon ourselves to increase the standard so that they can enter the academy on an equal footing with others.*

The initiatives are indicative of positive measures being taken to increase tile number of Aboriginal people in the police force. It has been suggested that the Aboriginal cadet

scheme should be extended and the Police Department has indicated its support for that (Response of Commissioner of Police to specific questions raised by the RCIADIC, p.48).

The Aboriginal Issues Unit of the Royal Commission in Western Australia have advised me of concerns in the Aboriginal community that there are too few fullyfledged Aboriginal police officers with the Police Department and have expressed support for the employment of a greater number of Aboriginal people as police officers. (Final Report of A.I.U. Western Australia September 1990, p.12).

In the previous section dealing with police aides, I raised the difficulty for Aboriginals working in a policing role in their own areas with respect to their cultural affiliations and the problems that may arise, e.g. avoidance and obligation relationships. It is recognised that the same problems could arise for Aboriginal police officers. In addition, another problem that has been raised with the Royal Commission is that of recruiting Aboriginal people to work in an organisation such as the Police Force which is representative of the nonAboriginal authoritarian structures which have been imposed upon Aboriginal people since 1788.

This difficulty is inherent in the recruitment of Aboriginal police and prison officers. The latter will be dealt with in the section of the Report which examines reducing the likelihood of death in prisons.

Recruitment and Placement of Officers

In the Interim Report, Commissioner Muirhead recommended that screening procedures be implemented to ensure that potential officers who would have contact with Aboriginal people were not recruited if they held racist views. He also recommended that currently serving officers should not be retained if those racist views prevailed (Recommendation 27).

The Police Department was asked what it had done to implement this recommendation. The Department responded that the recommendation was difficult to address as screening procedures would involve complex psychological assessments initially and on an on-going basis. Despite this, the Department said:

> *Current recruitment procedures which include interviews apply some safeguards against the recruitment of persons holding prejudices towards Aboriginals and those of ethnic origin* (Response of Commissioner of Police to specific questions raised by the RCIADIC, p.45).

When asked to elaborate upon this response, the Police Department provided this additional information:

> *Applicants to join the Police Force are subjected to a background and integrity check. Interview panels can go beyond the structured interview questions if any prejudices are revealed and the Chairman of the panel may also make specific comments if further questions reveal any intolerance to any race of people* (Responses of the Police Department which the RCIADIC would like clarified, Q. 12. 10)

The Aboriginal Issues Unit presented the following perceptions of Aboriginal people about police staffing practices:

> *... It was felt that management decisions within the police force in relation to staffing practices did not generally reflect the expressed concerns of the Aboriginal community or serve the interests of Aboriginal people.*
>
> *There was concern that 'good cops' were often moved away from areas where they had established a close relationship with the local Aboriginal community; that female officers and aides were often inappropriately located; and that police numbers were greater in areas with large Aboriginal populations regardless of the size of the white population* (Final Report of the Aboriginal Issues Unit W.A. September 1990 at page 12).

The Aboriginal Issues Unit Report also expressed concerns that police officers identified as having a problematic relationship with the Aboriginal population who were moved because of local Aboriginal pressure, were simply relocated to another area with a significant Aboriginal population (AIU Report, p. 12).

The Police Department states that it has recognised the need that officers posted to communities with large Aboriginal populations have specialised policing skills. When asked about selection of police officers for these areas and the method whereby the Department ensures that officers have appropriate training and skills, the Department responded as follows:

> *(T)his requirement forms part of the description of duties in these areas. It is a requirement that any member seeking a transfer as the Officer in Charge, demonstrate previous experience in these areas.*
>
> *The specific requirements of each position are considered before a member is transferred* (Response of Commissioner of Police to specific questions raised by the RCIADIC, page 48).

The experience and ability of police officers, particular the officers in charge of police stations, to work with Aboriginal people was an issue in a number of the cases into which I inquired. It appeared to me that in previous years an officer who, for example, might have served a number of years in the communications branch or scientific branch, a branch not related to normal station duties, would then be transferred to the position of officer in charge of a station like Kalgoorlie or Port Hedland. The officer may not have had any training in station management and no experience in working with Aboriginal people.

Commissioner Bull was questioned about this issue and said:

> *In the past, yes, but not for man y years now. Certainly, as I've indicated, my policy has been, particularly where they would be stations that we'd regard as the more difficult, whether it be through the predominance of Aboriginals or whether it be a difficult mining town situation where the officer must have the ability to, say, handle union matters, the sensitivity of union matters, then we do select officers and we do not take them when they have not had the experience.*
>
> *It has occurred before. A classic example was Roebourne with the death of John Pat where an officer in charge of the police station had come from the scientific bureau. That was before my time. I'm not saying that would've been any different but I'm saying that was before my time. But certainly as I have been commissioner I have required that for those stations that officers do have a proven ability in that type of work elsewhere at a subordinate rank* (Bull 31.7.90:593).

He also said:

> *If an officer is going to serve in an area predominantly Aboriginal then we will certainly look for the proven ability of that officer, particularly the officer in charge, who has served in areas where there are predominantly Aboriginals previously and has shown that they have the ability to cope with such a situation (Bull* 31.7.90:592-3).

However Commissioner Bull also pointed out that sometimes there were not enough experienced officers to fill all the positions in areas with significant Aboriginal populations so it was inevitable that young or inexperienced officers would sometimes be posted to these areas (Bull 31.7.90:595).

Although Commissioner Bull recognised this, he was reluctant to accept the proposition that officers should receive refresher training in Aboriginal issues and the special needs of policing in Aboriginal communities, prior to posting to an area with a significant Aboriginal population. The situation remains that a constable who had completed his initial training four or five years before, who had since served at a city station may be transferred to the country with inadequate experience or training.

Commissioner Bull explained the situation in this way:

> *That is correct, that could occur. As a constable he could go to an area predominantly Aboriginal or where there are union situations. It just is not possible with the movement of officers throughout this state to provide that sort of training. There are in-service course that are conducted but not prior to a posting. They do in-service course which include what you are speaking of. They do do refresher courses i n regard to matters but there's only a certain amount of time that you can spend on training.*
>
> *We have academy that's bursting at the seams, totally. We cannot having difficulty in coping with training as it is, with the types of training - you know, we must do resuscitation training, riot training, we have to do resuscitation training; we do so many types of training for the officers that this all takes time. These officers have to be withdrawn from the field and that, in turn, is very difficult and of course very costly, particularly when you are talking about the country* (Bull 31.7.90:594).

I have already discussed the need to improve the training of serving police officers in relation to Aboriginal affairs in section 5.2.8 of the Report and I believe that the insufficient numbers of experienced officers provides support for my conclusions in this regard.

<u>Aboriginal/Police Liaison Committees</u>

Since the summit meeting on Aboriginal/Police Relations in 1984, the Special Government Committee (SGC) on Aboriginal Police and Community Relations has been involved in developing local Aboriginal/Police Liaison Committees. The idea of the committees is to improve Aboriginal/police relations at a local level by providing a structure for communication between the Aboriginal community and the police.

The SGC was initially hampered in establishing the committees because of lack of resources.

There are also a number of liaison committees which have been established at a local level on an informal basis (see Submission to the Royal Commission by SGC April 1989 pp.8-9).

The main benefit in establishing these committees is the provision of a structure whereby there can be an ongoing working relationship between the Aboriginal community and police. If the committees become entrenched then they should continue without being dependent on the goodwill of particular members of the Aboriginal community or the police force. This is important in view of the turnover of staff in country police stations.

The establishment of Aboriginal Police Liaison Committees was supported in the Recommendations of the Report of the Interim Inquiry into Aboriginal Deaths in Custody (Vincent Report, Recommendation 27).

Commissioner Dodson has discussed the Committees in his Report and the comments I make below arise out of the evidence I received during my inquiries.

The Liaison Committees appear to have had variable success in different towns. To a large extent the success of each committee is dependent upon the degree of commitment of those involved, particularly the police, to the improvement of Aboriginal/police relations in their town or area.

In Kalgoorlie the OIC of the police station is not involved in the local liaison committee. Sgt Denholm told the Royal Commission that 'that is all done at a regional level' (RCIADIC W18:283). The same officer did not have any contact with the Aboriginal community leaders in Kalgoorlie 'unfortunately' (RCIADIC W18:285).

One Aboriginal member of the liaison committee in Kalgoorlie said that he often sorted out complaints with the regional officer before it even got to the meeting. He gave the impression that the regional officer was very approachable (RCIADIC W18:319). However in commenting on the current state of Aboriginal/police relations he said that they were 'The same as a few years ago' (RCIADIC W18:323). Champion noted that there were no representatives from the fringe dwelling community on the committee although he had tried to encourage a couple to participate. He said:

> *I think the y're afraid to get in there and sit down and talk with the leading police officers* (RCIADIC W18:323).

Murray Stubbs, the ALS field officer in Kalgoorlie, is also a member of the liaison committee. He also was of the view that nothing had really changed in regard to Aboriginal/police relations over the last six years (RCIADIC W18:330).

He gave the impression that little was being achieved through the efforts of the committee.

> *... really its at a stage where we're just talking about the same things over and over and nothing is being done* (RCIADIC W18:331).

He was somewhat sceptical of the view of the committee that individual complaints about the police were not to be talked about and that problems had to be discussed generally rather than on an individual basis (RCIADIC W18:332).

In Geraldton the Aboriginal/Police Liaison Committee meets once a month. An Aboriginal member of the committee felt that the committee had a positive effect on Aboriginals, the police and the general community in Geraldton. He said that the main aim of the committee was to provide an opportunity to discuss problems that arise in the community and raise them with the police in order to try and achieve a solution (RCIADIC W21:504). He said that the meetings were open to any member of the community. The regional officer of Geraldton, Superintendent Davies, agreed that the committee provided a forum for anyone to present difficulties they may have had or complaints in a particular area

(RCIADIC W21:531). Superintendent Davies gave an example of the sort of action that the committee may take on an issue:

> *In February last year there was a lot of publicity because we had a heavy crime rate going on. There was a serious assault on a person in the main street. There was talk of them forming vigilantes here. The newspaper article made it appear as though every second Aboriginal was a criminal. There was a lot of resentment to that article, so this committee met pretty promptly and wrote a letter off to the newspaper objecting to the style of reporting. That sort of thing will bring the committee together pretty quickly.* (RCIADIC W21:53 1)

By way of contrast, Arthur Gordon (Sandy) Davies had a different view on the ability of the liaison committee to improve Aboriginal/police relations.

> *DAVIES:* *I think we are choking on committees. We are choking on committees and we are choking on experts. You go to meetings and everybody has got a theory. You have all the different experts, be it drug and alcohol, be it prisons. Everybody has a theory. You have experts; you have committees. I couldn't count on both my hands the number of committees that are set up in this town to do with Aboriginal people. It is incredible. Every time there is an eruption between police and the Aboriginal people in this community, another committee seems to get formed and nothing ever comes of it.*
>
> *COMMISSIONER:* *You mean a joint committee of Aboriginals and non-Aboriginals?*
>
> *DAVIES:* *Well, different groups set up committees. The police set up committees. The city council called public meetings over at this building over here, the opera house or whatever it is. There are all sorts of discussions held, but that is all it is. There is nothing ever positive coming out of it. If you want to improve relations in this town, it gets back to - you have to have something to offer to the young Aboriginal people. Now, there is nothing in the town at this point in time. There is nothing at all. I mean, we need to face up to that. What we need is some sort of facility where we can set up training programmes, where we can set up apprenticeship programmes..*

A more positive view of the value of an Aboriginal Liaison Committee was expressed by Vanessa Read, a committee member in Broome. This committee now meets once a month after being revived in 1988. The member said that the committee was re-established after receiving a firm commitment from the police that they would be supportive of the group. (RCIADIC W12:298).

On discussing the current level of co-operation between the police and other community groups in Broome, Read said:

> *There has been a tremendous amount of work ... put in to try and improve police and community relations and co-operation between agencies. I think the police generally have a more sympathetic approach than when I first came to town but I think there is still room for a lot more liaison and people meeting on a more equal stance* (RCIADIC W12:298).

At the time of inquiries in Carnarvon, Port Hedland, Wiluna and Halls Creek, there had been no formal liaison committees established. One Aboriginal witness in Carnarvon thought it would be a good idea. (Mitchell in Dooler, T334) whereas one Aboriginal witness in Pon Hedland did not think it necessary saying *'If Aboriginal people have anything to say to the police, they say it to them'* (RCIADIC W8:267).

In Wiluna there was no liaison committee although the OIC of the police station would attend meetings of the Nganganawili community if he was invited (RCIADIC W16).

In Halls Creek an Aboriginal witness said he was not aware of meetings between the police, police aides and the community but he thought that they could help (RCIADIC W29:26). The OIC at the Halls Creek police station said he had tried to get police aides to attend specific meetings but without success (RCIADIC W29:85-86).

Both the Royal Commission Interim Report (Muirhead 1988) and the recent Equal Opportunity Commission 'Review of Police Practices' expressed the view that local Aboriginal/police relations committees had the potential to improve Aboriginal/police relations.

The Final Report of the Aboriginal Issues Unit W.A. (1990) also was supportive of the establishment of local liaison committees. It suggested:

> *Local police-Aboriginal committees should be formed in all regions where requested by Aboriginal people. This would foster constructive communication and improved relations.*

It is important to note that the AlU has only suggested the establishment of committees in areas where the Aboriginal people have requested them thus Aboriginal people would provide the initiative rather than having the committees imposed upon them.

5.3 PREVENTION OF DEATH IN PRISON CUSTODY

5.3.1 PHILOSOPHY AND DESIGN OF PRISONS

> *... there is a huge and disproportionate number of prisoners in the Western Australian Prison System who are Aboriginal. This matter is a cause for concern at a variety of levels; not the least should be the management and welfare of that large grouping, whose culture is totally different from those who ... devised and brought into being the prison system* (Counsel for the family of the deceased, Paul Fanner, at page 55 of his Final Submission to the Commission in its inquiry into the death of Mr Fanner, March 1989).

> *... I think we are all in Corrective Services aware that Aboriginal prisoners do have distinct needs and what we're endeavouring to do is ... wherever possible make provision for addressing Aboriginal needs - double cells, triple cells, Aboriginal staff, specifically Aboriginal programmes and of course, more importantly, pushing the whole diversionary approach on the basis that prisons are not good places for anybody but they are particularly bad places for Aboriginal people* (Dr D.A. McCotter, Acting Director Prison Operations, Western Australian Department of Corrective Services, in evidence before the Royal Commission at Geraldton, April 1990).

In the years immediately following European colonisation of Western Australia, white authorities considered it necessary to establish a special prison for 'native offenders'. The site chosen was Rottnest Island. Rottnest held prisoners from 1838 until 1932, in its final years holding only European prisoners, having been closed as a 'native prison' in 1903.

Although Aboriginal prisoners were first placed on Rottnest in August 1838, the Act which formally constituted the island a prison was not passed until 1841. The reasons for the establishment of the prison are set out in the preamble to the Act. Rottnest was intended to provide Aboriginal prisoners with a greater degree of personal liberty than was possible in mainland prisons. It is interesting to note the similarity between the following observation contained in the preamble to the 1841 Act and the comments of Dr McCottcr made some 150 years later and cited above. The preamble states that:

> *'...close confinement is prejudicial to their [Aboriginals] health, as being so uncongenial with their ordinary habits.'*

Currently, there arc fourteen prisons throughout the State of Western Australia. There is today no 'special' prison for Aboriginals. The locations of the prisons are as follows :

Albany	Albany Regional Prison
Broome	Broome Regional Prison
Bunbury	Bunbury Regional Prison
Geraldton	Greenough Regional Prison
Kalgoorlie/ Boulder	Eastern Goldfields Regional Prison
Mount Barker	Pardelup Prison Farm
Penh Area	Bandyup Women's Prison Canning Vale Prison C.W. Campbell Remand Centre Fremantle Prison Karnet Prison Farm Wooroloo Prison Farm
Roebourne	Roebourne Regional Prison
Wyndham	Wyndham Regional Prison

A new maximum security prison is under construction at Casuarina south of Penh and is due for completion in 1991. Upon completion of the new prison, Fremantle prison is to close. Such a move is long overdue, Fremantle Prison having been condemned as being unfit for human habitation on more than one occasion in past years. Following a riot at that prison in January 1988 Mr J. McGivern (who had retired as Deputy Director, Custodial

Services in 1986) prepared a report to the Minister for Corrective Services on the causes of the riot. His report stated that conditions in Fremantle Prison were :

> ... *undoubtedly sub-standard and could best be described as early Victorian. Prisoners are required to spend approximately 14 hours per day in a small cell with a bucket for a toilet (and often with another person)* ... [They] *are thus compelled to eat* [there is no dining room at the prison], *sleep and defecate in one small confined space.*

It is disappointing to note the announcement by the State Government in October 1990 of a new prison to be constructed in the metropolitan area (this in addition to Casuarina Prison). It appears that the Government is anticipating that Western Australia's lead over other states in the rate of imprisoning its population is to continue. This Commission takes the position that all means to reduce the numbers of people held in prison custody must continue to be explored. The provision of further institutions only encourages that they be filled, if only to justify the expense of construction.

Aboriginals in Prison in Western Australia

Western Australia has and continues to have a very high rate of imprisonment. The extent of the over-representation of Aboriginal people in the prison population of Western Australia has been examined in Part 4 of this Report. However, before proceeding to set out my findings concerning the structure and management of the prison system in Western Australia (particularly as it affects Aboriginal people), it is worthwhile to reiterate some of the figures concerning the rate and extent of imprisonment of Aboriginals in Western Australia.

Although comprising 2.69% of the total population of Western Australia, Aboriginal people have accounted for about 36-37% of the State's prison population over the last three years. The Department of Corrective Services has informed the Commission that, on average, Aborigines comprise between 36-40% of the Western Australian prison population.

Royal Commission Research Paper No. I I 'Australian Deaths In Prisons 1980 1988' revealed that the highest number of Aboriginal deaths in prison custody had occurred in Western Australia amounting to 37% of the national total.

Royal Commission Research Paper No. 16 'Self Inflicted Hann In Custody' found that the majority of the reported incidents of self inflicted harm amongst Aboriginal prisoners in police and prison custody occurred in Western Australia and South Australia. Western Australia accounted for 35% of all Aboriginal incidents and South Australia 22%.

Commenting upon the high levels of Aboriginal imprisonment in Western Australia in an article entitled 'Imprisonment of the Aborigine in Western Australia 1957 - 1985', Roderic Broadhurst noted :

> *Few distinct, if fragmented, cultural groups are subject to the highest levels of incarceration experienced in Western Australia. With estimates of between one in four and one in three Aboriginal males experiencing imprisonment, many repeatedly, widespread dislocation and disruption of the social, economic and cultural organisation of Aboriginal communities has occurred.* (Broadhurst, 1987:154)

This report has already referred to the Community Corrections Centres Act which provides for diversion of fine defaulters from the prison system and came into operation on I March

1989. Unfortunately, Corrective Services data for the period 1 July 1989 - 30 June 1990 is not yet available. Those figures should give the first indication of the success of that initiative in reducing the numbers of persons admitted to prisons in this state.

Of the deaths that fell for inquiry by the Royal Commission in Western Australia, thirteen (41 % of the total) occurred in prison custody. Of those deaths eight related to medical or what may be referred to as 'natural' causes, highlighting health problems amongst the Aboriginal prisoner population. Three of the deaths involved a struggle, or violent contact, with prison officers and two deaths were found to have been self inflicted. Those five deaths highlighted issues of crisis management and security within prisons and the management of disturbed or emotionally vulnerable prisoners.

In addition to inquiring into the particular circumstances of the individual deaths, this Commission has examined the prison system in Western Australia to determine whether and in what manner it may ensure a humane environment that both takes into account and provides for the cultural difference and special needs of Aboriginals. The Commission has also examined programmes within the prison system that may contribute to reducing the level of recidivism amongst Aboriginal prisoners. The aim has been to ensure firstly, that all prisoners that enter the system leave it alive and secondly to provide, as far as possible, some reduction in the probability of prisoners, once released, re-entering the system. An additional objective has been to identify those programmes which encourage the maintenance and development of personal and cultural identity within prison.

A large number of factors affecting Aboriginal prison inmates became apparent to the Commission in the course of its inquiries. Amongst these am:

Isolation from Country and Community

This is particularly so with prisoners from the northern and central areas of the State who, due to their security classification, are confined in prisons in the metropolitan area. The isolation of Aboriginal prisoners from their home country can have a spiritual and psychological impact not readily understood or anticipated by Europeans.

Language/Communication Difficulties Within Prison

Of the deaths investigated by the Commission, it is known that at least ten of the deceased spoke their own traditional language. The majority of Aboriginal people in this State speak varieties of their own traditional language, Kriol and/or what is sometimes referred to as 'Aboriginal English'. The latter can have significant differences in usage and meaning to standard English.

Communication Difficulties with Family

Many prisoners have a poor grasp of written English and this may also be the case with their family members in the general community. Relatives of many prisoners do not have ready access to telephones or transport.

Loss of Cultural Identity caused by Prison experience

This is of course, related to the first point mentioned above: Isolation from country and community. Aboriginal prisoners are placed in a totally alien environment. One which is

rightfully seen as an institution devised by and belonging to the dominant European culture. In addition, Aboriginal prisoners are subject to the direct supervision and control of staff, the vast majority of whom are of European descent. This may be seen as a continuation of the colonialism and paternalism towards Aboriginals that has occurred in Australia since 1788 - and in Western Australia since 1829.

It has been a major direction of this Commission to recommend and emphasise means for reducing the numbers of Aboriginal people that are taken into custody. That notwithstanding, it is recognised that at least in the immediate future, Aboriginal people will continue to comprise a significant proportion of persons in prison custody in this State. An indicator of this is to be found in the studies on recidivism amongst Aboriginal prisoners in Western Australia conducted by Broadhurst et al. These studies were published in 1988 and 1990 and were largely based upon statistics provided by the Western Australian Department of Corrective Services.

The 1988 study drew upon data relating to all prisoners released for the first time from Western Australian Prisons over the period I July 1975 - 30 June 1984. The later study expanded that data to include prisoners released up to 1 July 1987. The table set out below details estimates of the probability of recidivism for Aboriginals and non-Aboriginals together with the median (most common) time at which failure occurred after release. It should be noted that for the purposes of these studies, 'recidivism' was defined as reincarceration i.e. a further term of imprisonment.

TABLE 5.2: PROBABILITY OF RECIDIVISM FOR ABORIGINALS AND NON-ABORIGINALS

	Probability of Recidivism		*Median Fail Time*	
	1984	1987	1984	1987
Male Aboriginals	80%	76%	11 months	11 months
Male non Aboriginals	48%	45%	18 months	18 months
Female Aboriginals	75%	69%	16 mo	16 m

			nths	onths
Female non Aboriginals	29%	36%	23 months	20 months

Although the later study found a slight decline in the probability of recidivism since 1984, the figures for male and female Aboriginals remained disturbingly high. It should be noted that the study attributed the fall in the recidivism rate to changes in the definition of police offences and sentencing policy, rather than to the effect of prison programmes.

The study noted that, with the exception of access to pre-release programmes, most of the factors that contributed to a reduced chance of re-imprisonment related to matters that fell outside the direct influence of correctional agencies. Some of the factors that Broadhurst et al found contributed to higher rates of recidivism for both Aboriginals and non-Aboriginals were as follows:

- Age - younger prisoners were found to have a very much higher probability of failure than older prisoners.
- Education - lower recidivism was observed for those persons with more schooling (although this was found not to hold true for Aboriginals).
- Employment - prisoners who were employed at arrest or who found employment immediately following their release from prison were found to have a lower probability of failure than unemployed prisoners. Prisoners with employment qualifications were found to do better.
- Marital status - married prisoners or those divorced were found to have better outcomes than single and separated prisoners or prisoners in de facto relationships.
- Prior imprisonment - those prisoners with a record of prior terms of imprisonment had a higher probability of failure.
- Sentence type - prisoners who were released unconditionally had higher recidivism levels than those released on parole.
- Escapes - prisoners who had a record of escapes had significantly higher rates of recidivism than those who had not.
- Finance - prisoners who had more than $200 on release had both a lower chance of failure and a greater median time before failure occurred.
- Special leave - recidivism was lower for prisoners who had received special leave such as home and compassionate leave and work release.

Other factors such as the nature of the offence and length of sentence did not re ate to lower levels of recidivism for Aboriginal prisoners.

The evidence of these studies suggests little effect of different prison regimes on the rate of recidivism despite the varying character of prisons throughout Western Australia from the maximum security prison at Fremantle to institutions such as the minimum security 'open' style prison farm at Karnet. However, the Department of Corrective services has informed the Commission that as a result of its review of these studies it concluded that:

> ... *from a policy viewpoint, penal policies which encourage education, provide employment, cash on release, supervised early release and support for family relationships cannot be neglected and should have priority. Prospects for lower probabilities of recidivism are never better than at first release* (Answers by the Department of Corrective Services to questions from the Royal Commission, July 1990:4)

That conclusion is supported by this Commission. However, it must not be overlooked that the majority of Aboriginal prisoners received in Western Australia are serving short terms of imprisonment ranging up to six months. The 1988 Broadhurst study found that of the male Aboriginal prisoner population, 49% were serving sentences of one month or less and a further 41% were serving sentences of between one - six months. For female Aboriginal prisoners, 74% were serving sentences of under one month and and additional 23% sentences of between one - six months.

It is emphasised that nobody can expect a prison system, however 'enlightened' or 'welfare orientated', to counteract the accumulated effects of years of poverty, substandard health and education, discrimination, alcohol or other substance abuse and high unemployment. To this observation must be added the fact that if the majority of Aboriginal prisoners received in Western Australia are only serving short sentences, any potential positive effects of prison programmes must be even further limited.

The Broadhurst studies again confirm that the focus for reducing, if not eliminating, the risk of further deaths in custody cannot be confined simply to the practices and policies that apply inside prisons and police lockups.

A further observation made by a number of persons who gave evidence before the Commission was that for some Aboriginal prisoners, the material conditions in prison were actually better than those that they experience in the general community: shelter, regular food, better access to medical attention, abstinence from alcohol.

Patricia Lowe, a Clinical Psychologist, was employed by the Department of Corrective Services between 1976-1987. She worked at the Broome Regional Prison (where the majority of prisoners are Aboriginal) between 1979-1987. In her evidence before the Commission she stated it had been her experience that although long sentences were unpopular, short sentences of three-six months imprisonment were often welcomed by some Aboriginal prisoners as time out from the rough and tumble of a fringe dwelling existence. Some prisoners were candid about this and admitted that they appreciated the good food, the peace and quiet of a more orderly existence, the TV, cards and the opportunity to spend time with friends (RCIADIC, W12:224,228).

Far from being seen as supportive of any argument that conditions in prison are too lenient and resemble those of a 'holiday camp', such a situation must be seen as an indictment of any society which allows sections of its population to live in conditions where (at least for their physical and material well-being) it may be said that it is 'better' that they be deprived of their liberty within a prison.

Security -v- Welfare

> *All persons de prived of their liberty shall be treated with humanity and respect for the inherent dignity of the human person.*

International Covenant on Civil and Political Rights (United Nations)

Article 10.1. Ratified by Australia on 13 August 1980.

> *The management and routine of a person committed to prison should be just and humane and in keeping with prevailing community standards. Although prisons are separated from the community they are nonetheless still part of the community. A prisoner continues to be responsible as a member of the community but the person's liberty to move freely within the community is removed.* (Western Australian Department of Corrective Services, Annual Report 1988-89)

The continued use of imprisonment in Australia as a social sanction (at least in the foreseeable future) is recognised by this Commission. Whilst this is the case, it also commonplace to observe that our society is undecided and divided about what objects can and should be achieved by a penal system. A sentence of imprisonment imposed by the judiciary may have one or more of the purposes of deterrence, protection of the community, incapacitation, retribution and possibly the rehabilitation of the offender.

Society's interest in and demand for the secure custody of those persons sentenced to imprisonment is a matter often discussed in the contemporary media in this state. The Prisons Act 1981 specifics in Section 7 (1) that the Director of the Department of Corrective Services is responsible for *'... the management, control and security of all prisons and the welfare of all prisoners'.* In evidence before this Commission, officers of the Department of Corrective Services of every rank have consistently stated that the first priority of the Department is the maintenance of the custody or security of prisoners. Other considerations are necessarily secondary to this objective.

A prison system, by definition, has custody as its primary object, however, it must be emphasised that the extent of the punishment of imprisonment is the loss of liberty. Persons who are sentenced to imprisonment should only lose their liberty together with those rights which either expressly or by necessary implication result from that loss of liberty. A similar position was stated in the Report of the Royal Commission Into New South Wales Prisons, 1978 (The Nagle Report). We should also recognise that the vast majority of persons who enter the prison system will eventually be returned to the general community. Thus the product which such a system may make is a matter of general concern.

An important issue in considering means to prevent deaths in custody is a reduction in the general level of stress experienced by prisoners (and their custodians) in the prison environment so as to reduce the likelihood of suicide and violent conflict occurring. Some level of stress will inevitably exist in any institution where persons are detained against their will, no matter what regime is followed. Consequently, a further important issue is the identification and management of those prisoners who may be classified as disturbed or psychologically vulnerable.

An approach to prison and prisoner management that increases and supports a high level of personal interaction both between prisoners themselves and between prisoners and their custodians so as to minimise the effects of isolation is recommended. This is particularly so with Aboriginal prisoners given the high level of close community and personal interaction that is a characteristic of Aboriginal culture.

Also of significant importance are prisoner management programmes which (consistent with the requirement of maintaining custody) allow for a level of self determination and responsibility to be exercised by inmates with the intention of maintaining and increasing self esteem amongst prisoners. Programmes that enable prisoners to exercise some degree of choice and thereby retain the ability to function as independent human beings are supported by this Royal Commission.

A prison management model based on initiatives in many of the United States of America jurisdictions that relies increasingly on electronic surveillance and reduced staff/prisoner interaction is considered totally inappropriate for the management of Aboriginal prisoners and significantly less humane than the current approach adopted in Western Australia.

In this regard many of the current policy initiatives of the Western Australian Department of Corrective Services are supported by this Commission: policies such as normalisation of prisons, provision of multiple cell accommodation for Aboriginal prisoners and aspects of the Unit Management programme.

Normalisation

The prison environment and routines should reflect as closely as possible those of the community outside the prison. I would comment that if this policy is to address the multi-cultural nature of our society then the reference to 'community' should not be confined to a white middle class picture of community organisation and social responsibility.

The policy of Normalisation also requires that prisoners who for any reason are temporarily removed from the prison mainstream should be returned to the normal prison routine as soon as possible. An attempt should be made to allow for a level of self-responsibility amongst prisoners so that prison life is not so devoid of self-direction as to be institutionalising. There should be a balance between social interaction and privacy.

Unit Management

The division of the prisoner population into smaller groups and the management of these groups on a semi-autonomous basis with greater continuity of staffing: this policy will be discussed more fully below.

Provision of Multiple Bed Cells

In both instances where death was self inflicted the prisoners were alone, one placed in an observation cell and the other confined to his own single cell. Aboriginal prisoners should have the option of shared accommodation with other Aboriginals. They should not be confined alone in cells unless they specifically request it. The Department should take into account tribal and family grouping of Aboriginal prisoners and as far as possible allow prisoners of the same group to be accommodated in the same section of a prison.

It is noted that some cells at Canning Vale Prison and at the C.W. Campbell Remand Centre have been converted to multiple accommodation for use by Aboriginal prisoners. The plans for Casuarina Prison have been modified to provide for twelve two person cells. The Department has advised the Commission that, subject to funds, similar arrangements are planned for Bandyup, Bunbury and Albany Prisons.

Cells which can accommodate one, two, four and six prisoners have been constructed at Eastern Goldfields, Roebourne, Greenough and Broome regional Prisons. It is encouraging to note that some of these have been constructed in consultation with Aboriginal groups.

Open and minimum security rated prisons (Karnet, Pardelup, Wooroloo and Wyndham) have single hut and dormitory accommodation. They are managed on a more communal and interactive style than other prisons and prisoners have more ready access to other prisoners and prison officers.

Unit Management

The traditional role of prison officers in Western Australia has centred upon custodial and disciplinary duties, however in the last three years there has been a dramatic change in the role definition of prison officers and indeed in the structure and approach of prison and prisoner management as a whole.

Stemming from the Department of Corrective Services 1984 Corporate Planning Process, the concept of prisoner management through more constructive interaction between prisoners and staff was seen by the Department as providing a more satisfying role for prison officers and a more effective means of managing prisoners. A number of key strategies were developed by the Department, one of these being 'unit management'.

Unit management has been described above as providing for the division of the prisoner population into smaller, semi-autonomous groups or 'units'. The concept of unit management as a programme for prison management was first developed in Denmark over a number of years. It was initially trialled in one prison and has gradually been extended to each of the prisons throughout that country. Mr Erik Anderson, formerly a prison director in Denmark and the person who developed the concept of unit management assisted the Western Australian Department in planning the structure to be implemented in this State. Mr Anderson gave evidence before the Commission in its sittings in Geraldton in April 1990.

To function effectively the unit management system requires that the traditional role of prison officers be extended beyond that of custody and discipline and encompass their attending to the welfare needs of prisoners, assisting in the provision of constructive activities for prisoners and contributing to the provision of developmental opportunities for prisoners.

The concept involves increased continuity of staff in the units such that the same group of prison officers will be rostered to work in a unit with the same prisoners for periods of about three months. There are obvious positive benefits in this policy for prisoners. Particularly in the larger metropolitan prisons it will enable the degree of impersonality of the large institutions to be reduced and hopefully provide for a more relaxed atmosphere between prisoners and their keepers. There is a greater opportunity for understanding (and hopefully a measure of trust) to develop between prisoner and custodian with continuity of staffing. Prison officers should be in a better position to identify changes in moods of individual prisoners and to note those that may require closer observation, counselling or other assistance.

Unit management has now been extended to all prisons in Western Australia having been progressively introduced throughout 1987-989. Welfare officers (including Aboriginal welfare officers) were progressively withdrawn from the system through 1987-1988.

It is noted that problems have been experienced in the introduction of unit management into Fremantle prison due to the physical organisation of that decrepit Victorian structure. Smaller regional prisons however may be of such a size as to operate as one 'unit'. In a sense it can be said that the regional prisons have operated under a de facto unit management system for many years. The smaller prisoner and staff numbers and the lower security rating of these prisons allows for increased and more informal prisoner and staff interaction than at the large metropolitan prisons such as Canning Vale and Fremantle. Also, the reduced level of welfare resources at the regional prisons has meant that ordinary prison officers could be more actively involved in providing for those needs of their charges than their city counterparts.

Broome Regional Prison is an example of a prison operating as one unit. There have been no successful suicide attempts at that prison between 1980 and 1990. In evidence before the Commission the current Superintendent of Broome Regional Prison stated that among the reasons for this was that in a smaller prison the staff are closer to the prisoners and are more aware of behavioural changes amongst them. He also referred to the more informal nature of relationships in that prisons compared to the major metropolitan prisons and to the fact that at Broome Regional Prison all cells provide for shared accommodation. (RCIADIC W24:42-45)

Casuarina Prison (the new maximum security facility to replace Fremantle Prison) is the first prison in this state to be 'purpose constructed' for unit management. The internal design of this prison is to be based on a 'campus style' so that it will operate as a number of small communities.

Of course, even under unit management, the custodial role of the prison officer will always remain paramount. A level of suspicion and opposition must always be expected to exist between officers and prisoners and this can be greater where those parties are of two different cultures. (The issue of employment of Aboriginal prison officers will be discussed in section 5.3.2 of this Report.) 'Me Commission is aware of a certain amount of resistance to the new system from both prison officers and prisoners. This is to be expected in any inherently conservative institution such as the prison system.

Implementation of the unit management system is still at a comparatively early stage and the Commission is accordingly unable to reach any final conclusion regarding its effectiveness and in particular, the degree to which it is appropriate as a means of better managing and providing for the needs of Aboriginal prisoners. Mr Anderson, who has been referred to above, visited Western Australia in 1990 at the invitation of the Department of Corrective Services. His purpose was to review and comment upon the implementation of the unit management strategy in this state. Unfortunately, his report was not completed in time for it to be considered by this Commission.

It is positive to note the evidence of the Executive Director of the Department that since the introduction of unit management there has been a general reduction in the level of violence and disciplinary charges against prisoners in Western Australian institutions. Such charges are in part indicative of the climate in the prison and the degree of tension and stress inside. Unfortunately, the Commission has received no statistical information in support of the Executive Director's statement. However, the Superintendent of Albany Regional Prison told the Commission that since the introduction of the new system he had noted a *'... marked decrease in the amount of confrontation type discipline matters between staff and prisoners...'.* (RCIADIC W5:327)

Notwithstanding this, there are serious reservations concerning the ability of prison officers to effectively perform the role formerly assigned to Aboriginal prison welfare officers. This issue will be discussed in detail in section 5.3.6 of this report.

Case Management

Case Management is a new system of sentence planning designed to manage a prisoner during his or her sentence. It is expected that it will come into operation at some prisons in early 199 1.

All unit officers will have responsibility for case management and all prisoners (with the exception of very short term prisoners) will be case managed. The development of a formal sentence plan for a prisoner under the Case Management system is to be facilitated by constructive interaction between a prisoner and his/her nominated case manager.

Referring to the new system, the current Superintendent of Eastern Goldfields regional Prison stated:

> *The unit case management system is sentence release planning, that is if someone comes in with a long sentence they take part in helping to plan that sentence with an officer. So, if they have a couple o years, they can say : well, I realise I've got to be maximum security for* a *while. And then we say : well, if you get a minimum which one do you want to go to, which prison, are you going to education, skills training, lets see which is the best place for you.*
>
> *And there's an agreement, if you like, which then adds that component of responsibility and having a normal community sense to* planning one's future. (R. Donovan, Underlying Issues Conference with Commissioner Dodson, Kalgoorlie 7 June 1900, T14)

The Department has informed the Commission that the role of the Case Manager will be to provide:

(i) information and guidance;

(ii) an appropriate referral source to specialist areas (i.e. employment offender development programmes, community resources etc.); and

(iii) a documented sentence plan that meets the needs of the prisoner, the Department and the community.

In particular cases, case managers will be required to:

(i) design a sentence plan within the framework of the Prisons Act, Prisons Regulations and Executive Director's Rules;

(ii) implement the plan through the Department's decision making process,

(iii) monitor the progress of prisoners by liaison with other unit staff through weekly unit meetings;

(iv) set appropriate review dates and formally review prisoners to allow for progress through the system;

(v) evaluate the benefits of the programme to the prisoner, the department and the community; and

(vi) modify the programme as and when necessary.

Case managers will be required to communicate with industrial and programmes staff and maintain an up-to-date awareness of all matters relating to their assigned case. In addition they will have responsibility for making Parole recommendations and for automatic parole under section 37 of the Offenders Probation and Parole Act.

Professional Services in the Prison System

Parallel to the development and introduction of unit management, the Department of Corrective Services has restructured the whole of its professional services into a number of programmatic teams with the intention of better addressing critical problem areas within the system. 'Professional services' refers to psychologists, educationalists, social workers, counsellors, psychiatrists employed by or contracted by the Department. I emphasise that most of these resources are concentrated in the Perth area.

Teams have been developed in the following areas:

Substance Abuse Team

Department of Corrective Services research in 1987 indicated that between 65% 70% of the prisoner population (Aboriginal and non-Aboriginal) had significant substance abuse problems. Amongst the Aboriginal prisoner population alcohol was the major factor, although at Eastern Goldfields Regional Prison (whose 'catchment' area includes Warburton and the central reserves) an increasing number of prisoners are afflicted by petrol sniffing.

Substance abuse team programmes are available in Fremantle, Canning Vale, Bandyup, Karnet and Wooroloo prisons. The programmes are not available in country prisons. The Education Team offers an Aboriginal Alcohol Education course package at all prisons except Wyndham subject to demand and resource availability.

Skills Development Team

Many of the persons who are admitted to prison, both Aboriginal and nonAboriginal may be deficient in certain social skills that many in the general community may take for granted,

This team focuses primarily on three areas. The first is the area of employment and the basic education and training that are required to make a person employable or potentially employable on the outside, matters such as how to use a telephone, how to fill in a job application, how to present for a job interview.

The second area is recreation: attempting to develop skills in people whereby they can constructively occupy their time. The Department should ensure that this programme presents culturally appropriate information. For instance, it may be fine on paper to occupy prisoners' time in Fremantle Prison with western games such as table tennis. Yet, upon release Aboriginal prisoners from country areas may have no access to facilities to continue such a pastime.

The final area is the general social skills area: programmes on how to interact with people, to encourage social relationships to form and stress management.

These programmes are available to all prisoners at Bandyup, Wooroloo, Karnet, Fremantle and Canning Vale prisons. Wholly Aboriginal courses directed towards self-esteem are offered at Bandyup and Canning Vale.

Sexual Offenders Team

This team targets those offenders convicted of sexual assaults and offences such as incest and provides awareness and therapy programmes.

Special Needs Team

Targets those prisoners identified as being vulnerable and/or disturbed and provides crisis management and longer term management planning. There is a Special Needs team for the South West area (Bunbury, Pardelup and Albany prisons) as well as in the Perth area.

The functioning of this team will be examined more closely in the section of this Report dealing with Supervision and Monitoring of prisoners and in section 5.4.5 dealing with Mental Health Services.

Education Team

Education programmes of varying natures are available in all prisons, some have been specifically developed to place emphasis on ensuring that the subject matter of the studies is relevant to the experience and background of Aboriginal prisoners. These are discussed in section 5.3.7 of this Report.

All of these programmes are supported by the Commission however, the following observations are made:

1. Many of these programmes are either not available at country (regional) prisons or are available only in a restricted manner. The only justification for prisoners at country institutions to be denied equal access to the facilities and resources available to those confined in the Penh area is financial. This is a matter for Government as a whole to examine. The Department can only operate within it' budget. Expenditure on prisons, particularly when identified as being directed towards the welfare or material needs of prisoners has ever been a politically sensitive issue.

   In this regard I note the observation of Commissioner Muirhead (as he then was) at page 36 of the Report of his Inquiry into the death of Charles Michael at Bartons Mill Prison:

   It is acknowledged that when Correctional authorities are struggling to maintain services within budgetary restraints, the emphasis is likely to be on security. (RCIADIC W1)

2. 'Me limitations of any prison programme to counteract or otherwise affect the external conditions to which a prisoner will ultimately be released are again noted and emphasised.

Securitv Classification of Prisoners and Prisoner Placement

Upon admission to a prison in Western Australia, either on remand or as a sentenced prisoner, all prisoners are assessed by prison authorities and given a security rating. Security ratings are determined in accordance with Executive Director's Rule 2B. The Executive Director's Rules are made pursuant to the Prisons Act 1981 and apply to all prisons in Western Australia.

It is the policy of the Department (as expressed in Rule 2B) that every prisoner is to be classified at the lowest level of security deemed necessary to ensure their continuing custody within the prison system, the good government, good order and security of prisons and the security of the public.

Prisoners are also periodically assessed during the course of their sentence partly with a view to gradually reducing their security rating until they are eligible for release.

There are five categories of security rating that may be assigned:

(i) Maximum Security

(ii) Medium Security

(iii) Low Medium Security

(iv) Minimum Security

(v) Open Security

Prisoners are assessed according to the following categories:

- Remand Prisoners

- Very Short term Prisoners: prisoners serving effective non-minimum term sentences of up to and including four months.

- Short Tenn Prisoners: prisoners serving effective minimum term sentences of up to twelve months and all prisoners serving effective non-minimum term sentences of more than four months and up to and including twelve months.

- Long Term Prisoners: prisoners serving effective sentences with or without a minimum term of more than twelve months or indeterminate sentences.

Long term maximum security facilities are only available at Albany, Bandyup and Fremantle Prisons and at the C.W. Campbell Remand Centre. Long term medium security facilities are available at Canning Vale, Bandyup, Albany and Fremantle Prisons and at the C.W. Campbell Remand Centre.

Maximum security facilities for short term placement of prisoners (and generally used for persons on remand) are available at Broome, Bunbury, Eastern Goldfields, Greenough, Roebourne and Wyndham Regional Prisons. Other than at Albany there is no provision for placement of long term medium and maximum security prisoners in country prisons.

The result is that sentenced prisoners classified as medium or maximum security or long term remand prisoners from the Kimberley, Pilbara, North Eastern Goldfields and other country areas will be transferred to Perth (and possibly Albany) to serve at least pan of their sentence. Most prisoners from these areas are Aboriginal.

Pending formal assessment all remand prisoners are classified as maximum security. It has only been in rare circumstances that remand prisoners have been classified as other than maximum security. There is currently a trial scheme in operation at Roebourne Regional Prison for classification of remandees to be conducted by the Superintendent with the intention, where possible, of reducing a remand prisoners security rating so that he/she may be held in the prison closest to his/her home and family. AU classification of

remands elsewhere in the state must be with the approval of the Assistant Director, Prisoner Placement.

The fact that spiritual and psychological distress may be experienced by Aboriginal prisoners removed far from their home country and community has already been noted in this report. The degree of trauma may be greater than that experienced by non-Aboriginal prisoners and is an important matter for the attention of all correctional authorities. In any event, it must be acknowledged that for most prisoners, Aboriginal and non-Aboriginal, a sentence of imprisonment that is required to be served at a prison in Perth - hundreds and possibly thousands of kilometres from their home and family - is a more severe penalty than a sentence of similar length imposed on a person whose family and friends are resident in the metropolitan area and are able to make personal visits.

However, with the current practice of the Department of Corrective Services and the currently available facilities it is inevitable that some Aboriginal prisoners from country areas of the state will continue to serve at least part of their sentence in metropolitan institutions. This was the case in the death of the young prisoner at Sir Charles Gairdner Hospital in February 1983. At the time of his death he was classified as a medium security prisoner and had been serving his sentence at Fremantle and Canning Vale Prisons. He was from Roebourne and all his family resided there. Prior to being sentenced he had never been away from Roebourne and its surrounding area. He spoke his traditional language, Indjibandji.

In the Inquiry into his death by this Commission his family expressed their sadness and sense of loss at his removal to Perth and asked why prisoners from Roebourne could not serve their sentence at the Roebourne Regional Prison. He would still have been deprived of his liberty yet would at least have the comfort and security of being able to receive visits from his family and of mixing with a majority of prisoners from his own area.

The lack of facilities for the placement of medium and maximum security long term prisoners in country areas weighs most heavily on the Aboriginal population of this state, the majority of whom reside outside the metropolitan area. Ideally what is required is the provision of such facilities at Regional Prisons. That this would require considerable expenditure by Government and is unlikely in the short term is acknowledged. However, such an observation does not detract from the current position being highly unsatisfactory and discriminatory to many citizens of this State.

In the meantime it is considered that in determining the placement of Aboriginal prisoners within the prison system, the Department of Corrective Services should take into account the actual and classificatory (or 'skin') relationships of those prisoners and where possible, seek to place prisoners in prisons with other members of their tribal group. This would reduce the degree of isolation felt by those prisoners and the distress at separation from their home country. It is encouraging to note that in evidence before my colleague Commissioner Dodson, the current superintendent of Eastern Goldfields Regional Prison stated that such a factor is a consideration now taken into account in the assessment of prisoners (Underlying Issues Conference, Kalgoorlie, June 1990).

NAILSS Survey of Aboriginal Prisoners

During the course of the Royal Commission the National Aboriginal and Islander Legal Services Secretariat (NAILSS) conducted a survey of Aboriginal prisoners in prisons in each state and in the Northern Territory. In Western Australia, Aboriginal prisoners were surveyed in each metropolitan and country prison. The results of the NAILSS survey in WA were submitted to this Commission in

October 1990 in a document entitled 'A Report Into the Western Australian Prison System'.

In this State the NAILSS report was the result of a survey of 319 Aboriginal prisoners conducted in April and June 1990. Due to the low number of female prisoners surveyed no distinction was drawn between male and female responses. I note the following information concerning the respondents to the survey :

- 84.4% of the respondents were aged less than 34 years
- the average age of the respondents was 25.94 years
- 83% of respondents were sentenced prisoners
- 14.7% of the respondents were on remand

Prisoners who were included in the survey were asked questions in the following areas:

1 . Personal details of the respondents - age, family, marital status, education and employment history, prior involvement with the Criminal Justice or welfare systems as a juvenile etc.

2 . Status of the prisoner (sentenced or on remand).

3 . Whether the prisoner had had any contact with psychologists, drug and alcohol counsellors and parole officers in prison and the 'benefit' of that contact.

4. The prisoners' opinion on the desirability of stress counsellors in prison

5. Use of Aboriginal Welfare Officers by prisoners in the past

- matters for which welfare officer consulted
- degree of satisfaction with the assistance of welfare officer
- number of respondents with current welfare problems
- nature of those problems
- manner of dealing with those problems
- preference of person to deal with welfare matters

6 . Prisoners use of AVS

- satisfaction with AVS service

7 . Prisoners participation in training courses

- nature of courses undertaken by respondents
- introduction of specific Aboriginal education courses in prison

8 . If prisoners were in favour of an Aboriginal organisation being formed to represent Aboriginal prisoners interest.

9 . If prisoners were in favour of wings or units in prisons exclusively for Aboriginal prisoners.

10 . If prisoners were in favour of prisons being established exclusively for Aboriginal prisoners.

All areas surveyed by NAILSS are of interest and assistance to this Commission. Of particular interest are the series of questions relating to welfare services, the AVS and the possibility of establishing exclusive Aboriginal wings or prisons. In this section I turn to a consideration of the latter proposal - an area of both philosophical and practical difficulty. In section 5.3.6 I address the provision of welfare services and the operation of the AVS in prison.

Aboriginal Wings - Aboriginal Prisons?

The NAILSS report recorded the response of prisoners to the proposition that there be established wings or units within prisons exclusively for Aboriginal prisoners as follows

	Number	*%*
Yes	163	*51.1*
No	77	24.1
Don't Cam	7	2.2
No Answers	72	22.6
TOTAL	319	100

The response to the proposition that there be established prisons exclusively for Aboriginal offenders was as follows:

	Number	%
Yes	158	49.5
No	81	25.7

Don't Care	7	2.2
No Answers	73	22.6
TOTAL	319	100

Following those questions, the respondents were asked whether the staff in Aboriginal wings or prisons should be Aboriginal, non-Aboriginal or a blend of both:

	Number	%
Aboriginal	143	44.8
Non-Aboriginal	3	0.9
Abl & Non Abl	44	13.8
Don't Care	64	20.0
No Answer	65	20.3
TOTAL	319	100

The possibility of establishing prisons exclusively for Aboriginal offenders was also raised in two further documents submitted to the Commission by NAILSS. In a submission entitled 'Killing Me Softly - Juvenile Justice and Genocide' prepared by Ms V Jeavons on behalf of NAILSS, reference is made to the Danish prison system. Denmark also has responsibility for Greenland and its indigenous population. The Danish system includes prisons and special blocks constructed for Greenlanders with a component of Greenland staff. Ms Jeavons comments:

> *Indeed such a prison system is a desirable precedent - small prisons for Aboriginals with an Aboriginal staff component. The Victorian Government has commissioned a study to determine the feasibility of Aboriginal gaols with Aboriginal staff.* (pp83-84)

Further information on the NAILSS national prison survey contained in the submission by Ms Jeavons records (with the exception of prisoners in the Northern Territory) a response of 50% or above by prisoners in each state in favour of prisons being established exclusively for Aboriginals.

I have also been supplied with a draft copy of a paper by Ms K. Hazelhurst entitled 'The Privatisation of Service Delivery to Indigenous Peoples Within the Criminal Justice System : A Canadian Model'. That paper details a number of initiatives taken in Canada which provide for involvement of Canadian Indian community organisations in the operation of the criminal justice system. Ms Hazelhurst's paper concludes with a series of recommendations on behalf of NAILSS. One of the recommendations is:

> *7. That model Aboriginal run correctional facilities be established in each state at the soonest possible time.* (p54)

I have considerable reservations concerning the establishment of exclusive 'Aboriginal Prisons' as opposed to community correctional programmes developed and operated by Aboriginal organisations. As I have stated earlier in this section, it is recognised that imprisonment as a social sanction is likely to remain in use in this country in the foreseeable future and that numbers of Aboriginal people will continue to sentenced to terms of imprisonment. However prison remains an institution devised, controlled and belonging to European culture. Imprisonment is antithetical to the broadly communal nature of Aboriginal social relations. Indeed, the term 'Aboriginal Prison' may be seen as an oxymoron Le inherently contradictory.

Whilst recognising that special provision must be made for Aboriginal people in the criminal justice system, it is important that in doing so one does not appear to legitimise the continued imprisonment of large numbers of Aboriginal people. If it must be seen as a necessity, imprisonment must then be recognised as a 'necessary evil'. In introducing change into the criminal justice system, the focus must not be allowed to shift from imprisonment as a matter of last resort and reducing the numbers of people held in prison custody.

While recognising that ultimately direction must come from Aboriginals themselves, I suggest that the greatest scope for positive involvement by Aboriginal people is in the area of community based alternatives to sentences of imprisonment and in providing assistance in the re-integration into the community of those persons released after serving sentence.

The primary focus of Ms Hazelhurst's paper is on the operation of the Native Counselling Services of Alberta (NCSA) which was formed in 1971. She describes the NCSA as :

> *... a private, Native-run organisation which contracts to various government and justice agencies to provide specific services. It works closely with a range of other personnel to impart a better understanding of Native clients and their needs: correctional officers, police, probation and parole officers, court staff, administrators, foster parents, social workers, school teachers, medical personnel and others.* (Hazelhurst, 1990:4)

From its inception 19 years ago the NCSA has grown from a small agency to a province-wide multi service organisation. Government supports Native services because

they help provide equal access to the law for Native people. The NCSA works at two main levels: Community Development and servicing institutions.

In the latter area their operations are designed to assist Native offenders to cope with correctional institutions and to grow personally while under sentence. Assistance is also provided to offenders to enable them to adjust back into the community.

The NCSA has contracted with the provincial and federal governments to establish and operate a number of community correctional facilities and programmes such as:

- Grierson Centre - a minimum security pre-release centre for adult male offenders male offenders.

- Bush and Forestry Camp Programmes - Native run bush and forestry camp programmes set up as a minimum security alternative to case overcrowding in institutions.

- Half-way Houses and Group Homes for parolees.

It is noted that the NCSA has confined itself to the operation of community correctional programmes. It does not operate 'Native *Prisons'* although it does provide services to Native offenders serving terms of imprisonment. Some of those services are described in section 5.3.6 of this Report.

I consider that the experience of the NCSA in Canada provides a positive example for the future interaction of Aboriginal people and the criminal justice system in Australia.

5.3.2 RECRUITMENT AND TRAINING OF PRISON OFFICERS

Recruitment of Prison Officers

As at June 1990, there were 1206 prison officers employed by the Department. This figure was comprised of:

Probationary	1
Prison Officer's	2 0
Industrial Officers	1 8 3
Prison Officers	5 8 0
First Class Prison Officers	1 4 0
Senior Officers	1 6 2
Chief Officers	2 1
TOTAL	**1** **2**

The figure for the probationary prison officers includes seventy officers then undergoing initial training and fifty who were placed at institutions.

The Department currently employs only nine Aboriginal prison officers. Three hold prison officer rank with between four - eight years service. Three are Probationary Officers who have completed their training and have taken up positions at institutions. The remaining three were undergoing their initial training at the Department's Staff Training College.

The Interim Report of the Royal Commission (Muirhead) recommended:

> *Recommendation 26*
> *Police and Prison Departments should re-assess their recruitment policies and liaise with appropriate Aboriginal organisations and educational institutions to ensure that positive encouragement is given to the recruitment of Aborigines.*
>
> *Recommendation 27*
> *Appropriate screening procedures should be implemented to ensure that potential officers who will have contact with Aboriginal people in their duties are not recruited or retained by police or prison departments whilst holding racist views which cannot be eliminated by training or re-training programmes.*

The Department has informed the Commission that it believes that the recruitment of Aboriginal people for employment as prison officers is a necessary step to address the current racial imbalance in Western Australia's prisons - Aboriginal people being over represented in the prison population and under represented in terms of Departmental staff.

In 1989 the Department conducted an analysis into Aboriginal recruitment which resulted in a number of strategies being identified which it was hoped would increase employment opportunities for Aboriginal people. A new position was created in the Department's Staff Training Branch with the responsibilities of:

- researching and developing strategies for recruitment and support of Aboriginal staff,
- developing an Aboriginal community network for recruitment purposes,
- assisting in development, implementation and reviews of Departmental policy on Aboriginal issues,
- providing consultancy advice to branches on Aboriginal issues.

The present incumbent of that position is an Aboriginal person.

Other changes which followed the review of Aboriginal Recruitment included redesigning the selection tests for the position of Prison Officer as the former criteria were considered to be culturally biased against Aboriginal people. The psychological testing of applicants was discontinued for this reason.

It is noted that there are no formal requirements for the position of Prison Officer. Also, during the selection process, applicants for the position attend a forty-five minute interview before a panel of three. The interview considers skills and experiences based on the candidates previous employment and life experiences. Some questions also centre on the candidates attitudes and possible biases towards minority groups.

In the Fanner Inquiry, Mr D. Northcott, then Acting Director Prison Operations North in the Department of Corrective Services, informed the Commission that although the Department was very eager to recruit Aboriginal officers they had had very little success (RCIADIC W5:523-525). It is recognised that the role of prison officer may be very difficult for an Aboriginal person. Aboriginal prison officers, no less than Aboriginal inmates, may be subject to tribal obligations such as avoidance relationships and obligation relationships. These may cause great difficulty in the exercise of an officers supervisory and disciplinary role towards those prisoners with whom they have a family or skin relationship.

An Aboriginal Prison Officer currently employed at Broome Regional Prison but who is from the Eastern Goldfields area, informed the Commission that when she formerly worked at Eastern Goldfields Regional Prison many of the prisoners there were related to her. She stated that that had made some aspects of her job, such as giving instructions difficult. She added that she did not experience the same problems at Broome (RCIADIC W31:21). In some measure, similar problems would have confronted the Aboriginal welfare officers formerly employed by the Department, however, given the non-disciplinary function of their role and that they were non-uniformed, the degree of conflict was substantially lower.

If increased numbers of Aboriginal prison officers become available to the Department, consideration should be given where possible, to placement of several of those officers within the same institution(s). It is considered that such a move would reduce any sense of alienation or isolation that those officers may feel in a work situation where the vast majority of their superiors and fellow officers are of European descent. In this regard the Commission received evidence during its sittings at Broome in July 1989 that the first Aboriginal Prison Officer employed at Broome Regional Prison left the service after a very short period after experiencing difficulty in 'fitting in' with the other prison officers (RCIADIC W12:234).

Training

Training for Department of Corrective Services staff is coordinated by the Department's Staff Training and Development Branch. Successful applicants for the position of Prison Officer attend a twelve week residential course at the Department's Staff Training College at Wooroloo - the Probationary Prison Officer's Course. In addition to lectures and workshops the course includes three, weeks practical training: two weeks placement at institutions and one week's placement with the Metropolitan Security Unit of the Department.

The Staff Training and Development Branch also provide courses and programmes for serving officers and Departmental staff in areas such as Management and Supervisory Skills, Finance and Administration and Personal Development. The Branch also conducts the Prison Officer Promotional Courses for promotion to Senior Officer and Chief Officer rank.

The inquiries into the deaths in prison custody by this Commission have revealed at various times deficiencies in the training of prison officers in the areas of first aid and resuscitation, identification of medical conditions of prisoners, the identification and management of disturbed and vulnerable prisoners and the use of mechanical restraints and firearms. Together with the training of prison officers in their new role of primary providers of welfare services to prisoners, these matters are considered below.

Detection of Medical Conditions

Executive Director's Rule 3B establishes procedures for the identification and management for prisoners whose health is at risk. The definition of 'at risk' contained in that rule includes *'serious physical health problems'.*

Rule 3B 3.1 states :

> *All officers have a duty to facilitate access to necessary medical care for prisoners in their custody whose health is at risk irrespective of the cause of the condition requiring care.*

Rule 3B 4.1 provides that:

> *On admission to prison each prisoner shall be screened by the receiving prison officer and nursing staff involved in the reception of new receivals for signs that the prisoner is, or may be, at risk.*

Fremantle and Canning Vale Prisons have full time nursing coverage. All other prisons (with the exception of Wyndham Regional Prison) have pan time nursing coverage. Wyndham has only weekly visits from a Community Health nurse. A consequence of this situation is that at most prisons there will be portions of each day when the only staff on duty charged with the care of prisoners will be nonmedically qualified officers.

Further, although prisoners are routinely examined by medical staff after admission to a prison, admissions can and do occur on weekends and at other times when nursing staff may not be available to immediately examine a new prisoner. Upon admission to a prison a standard Reception History Sheet is completed for each prisoner by the receiving prison officer.

The Reception History Sheet (Departmental Form C41) contains a section requiring the receiving officer to note whether 'In *your opinion has the prisoner any apparent physical or mental condition requiring treatment?'* If the answer is *'yes'* there is provision on the form for the officer to make a brief decscription of the condition of the prisoner.

In order to adequately and safely discharge their duty of care towards their prisoners it is, therefore, essential that prison officers receive appropriate training both in first aid and resuscitation techniques and in the identification of persons who may be at risk or require treatment due to injury or illness. Obviously, officers (and the Department) cannot rely upon prisoners to fall ill or suffer injury only during those times when qualified nursing staff are on duty.

The death of Nita Blankett in 1982 from acute bronchial asthma was a case that illustrated the importance of training in the basic understanding of serious medical conditions. At the time of her death she was serving a sentence of imprisonment at Bandyup Prison. The asthma attack that ultimately caused her death only became severe and life threatening during the evening of 14 January 1982 - after the prison's nurse had completed her day shift.

Although nursing staff at the prison and some of the custodial staff were aware that Blankett was a chronic asthmatic, on the night of her death officers on duty at the prison either failed to understand or underestimated the severity of her asthma attack, consequently, there was a delay in the decision to seek medical attention. In the report of my inquiry into this death I stated at page 2:

Medical opinion before the Commission indicated that if the delay had not occurred it is likely that, with proper resuscitation [she] would have survived.

It is noted that following the death of Nita Blankett, Standing Orders that provide for the assessment and treatment of asthmatics were implemented at all prisons. In addition, Executive Director's Rule 3P details procedures for the medical testing and placement of asthmatic prisoners.

Current training for probationary prison officers covers issues relating to the identification of symptoms. Training covered in the 'Reception' section of the training course includes completion of the Reception History Sheet which requires the identification of any existing medical condition that may require treatment. In addition training regarding psychologically disturbed prisoners includes observation of physical symptoms such as sweating and respiratory distress.

First Aid and Resuscitation

Deficiencies in the competence of prison officers to give first aid and perform resuscitation where necessary were apparent in a number of the deaths in prison custody investigated by this Commission. The capabilities of prison officers in the areas of first aid and resuscitation are considered below. This is also a matter addressed in the Report of Commissioner Dodson.

In the cases of Nita Blankett, Charles Michael and Dixon Green no attempt at resuscitation was made by the prison officers who were either present at the time when respiration and heart beat ceased or who attended shortly thereafter. Despite doubts as to whether resuscitation would have been successful in preventing any of these deaths, in each case it should have been attempted but was not.

In the report of his inquiry into the death of Charles Michael, Commissioner Muirhead found that neither the Superintendent of Bartons Mill Prison nor any of the other officers on duty on the night of Michael's death had updated first aid and resuscitation skills.

in the case of the death of Robert Walker at Fremantle prison, five prison officers were involved in his removal from his cell and the subsequent struggle outside the cell block. Two of those officers had no first aid training whatsoever. Of the other officers, none had had any refresher course in first aid or resuscitation since their initial training upon joining the prison service.

Two officers were on duty at Broome Regional Prison on the night of the death of Dixon Green in November 1985. One officer had received no training in resuscitation techniques. The other officer had received training during his probationary prison officers course in 1981 but had had no refresher training subsequent to that time.

Currently, first aid and resuscitation training is a component of the Probationary Prison Officer's Course for new recruits. Training is provided by the Red Cross and consists of twenty four, forty minute sessions (a total of sixteen hours). It is noted that this is only half the amount of time currently devoted to the first aid training of Police recruits. However, as stated previously, whilst there are currently no Police Stations or lockups in this state with pan time or permanent medical staff, all prisons (with the exception of Wyndham) have at least part time coverage by nursing staff.

The Department has informed the Commission that:

> *The training provided by the Red Cross to Probationary Prison Officers is restricted to enabling Prison Officers to provide emergency treatment such as first aid and resuscitation, until medical help arrives.* It *is not intended to, nor appropriate, to train Prison Officers as diagnosticians or medics.* (Department of Corrective Services answers to supplementary questions provided by the Royal Commission, September 1990)

A formal programme providing for regular refresher courses in first aid and resuscitation for all serving officers has yet to be introduced by the Department of Corrective Services. In answer to written questions from the Commission the Executive Director of the Department stated:

> *Budgetary restraints have restricted training in [first aid and resuscitation] however it is intended that it will commence about November 1990 when new prison officer staff complete probationary training and take up positions throughout the state; this will allow training to take place within the institutions without incurring large amounts of overtime.* Department of Corrective Services answers to specific questions raised by the Royal Commission, July 1990, page 34)

The Commission has received evidence that staff at some prisons have received refresher training in first aid and resuscitation, however where this has occurred it appears to have been at the initiative of the particular Superintendent and/or the nursing staff of that prison. Examples are Albany Regional Prison and Broome Regional Prison.

The Department of Corrective Services is aware or should be aware that many of its serving officers have limited or outdated knowledge of first aid and resuscitation techniques. Indeed it is possible that some officers still in service have never received training in those matters. The provision of a programme of refresher training to prison officers should be a matter of immediate priority to the Department. The Department should also give consideration to the implementation of procedures to identify and maintain records of the current training level and qualifications with respect to first aid and resuscitation of all institutional staff.

Identification of Suicide Risks/Suicide Prevention

After heart disease, suicide is the number two cause of deaths in Western Australian Prisons amongst the total prison population (W/5/43). It is prison officers who have direct contact with prisoners in our gaols 24 hours a day. They are staff in a position to monitor and assess prisoner behaviour patterns and, with training, should be capable of reacting appropriately to any change evident in a prisoner's behaviour which may give signs of possible suicidal intention. Particularly in country institutions, qualified medical or psychological staff will not always be in attendance (e.g. the circumstances of the deaths of Fanner, Michael and Walley).

In 1988 the Department developed and introduced a training programme for prison officers on the prevention of suicide in custody. The programme was included as part of the probationary officers syllabus and was also provided as in-service training for staff at institutions throughout the state.

The Probationary Prison Officer's course included a half day on prevention of suicide and a half day on psychologically disturbed prisoners. The training on prevention of suicide comprised formal instruction plus discussion and the viewing of a video entitled 'Suicidal Inmates' prepared by the United States Correctional Services.

The course provides officers with a list of signs that may indicate possible suicidal intention together with guidelines for the management of prisoners who are perceived to be 'at risk'. The emphasis is on positive human interaction between officers and prisoners. Officers are also instructed that the previous common practice of isolating potentially suicidal prisoners in observation cells may be detrimental to their psychological well-being. The course emphasises that it may be more beneficial to place the prisoner in the prison community where they may associate with their fellows.

It is disturbing to note that the Department has reduced the amount of time currently devoted to suicide prevention and psychologically disturbed prisoners in the probationary prison officer course. Such a move is difficult to square with any commitment to preventing further deaths in custody. Time has been reduced from a half day on each area to only a quarter of a day each, although the Department has informed the Commission that additional sessions on the following areas relate 'directly or indirectly' to these matters:

- Offender Development Programmes
- Special Purpose Cells
- Medication Issue
- Blood Spill Management
- Drug Spill Management
- Contagious Disease Policy
- Chaplaincy

(Department of Corrective Services answers to specific questions raised by the Royal Commission, July 1990, page 33)

It is difficult to see how all of those areas can relate to issues of suicide prevention or the detection and management of emotionally or psychologically disturbed prisoners. Areas such as Blood and Drug spill management and contagious diseases policy appear to relate to more to concern about issues such as 'AIDS' in the prison environment than to prisoners 'at risk' from psychological concerns. I note that Commissioner Dodson addresses the issue of AIDS in prison in Ws regional Report.

Mechanical Restraints, Chemical Agents and Batons

Section 42 of the Prisons Act 1981 confers power on a superintendent to authorise the restraint of a prisoner where, in his opinion, such restraint is necessary :

(a) to prevent the prisoner injuring himself or any other person; or

(b) upon considering advice from the prison medical officer or some other medical practitioner, on medical grounds; or

(c) to prevent the escape of a prisoner during his movement to and from a prison.

Executive Director's Rule 3K governs the use of mechanical restraints in Western

Australian prisons. The following types of mechanical restraints are in use:

- handcuffs
- leg irons (ankle cuffs with attached chains)
- body belts (waist belt with attached handcuffs)
- rope hobble (robe with attached fast application clips)

In addition, batons are available for use in the restraint of prisoners.

Executive Director's Rule 3F governs the use of chemical agents (such as 'mace' gas) as a method of restraining prisoners.

The use of restraints against 'disturbed' prisoners was an issue in two of the deaths that occurred in prison custody: Charles Michael and Robert Walker. In the case of Charles Michael, save for handcuffs, no restraint aids such as a body belt or rope hobbles were available at Bartons Mill Prison at the time of his death.

Officers improvised a crude form of restraint with handcuffs, two belts and a baton.

In the case of Robert Walker five prison officers were involved in restraining him. Apart from physically restraining the deceased, batons were also used by two of the officers. Of those five officers two had received no restraint training, one had some training in the use of handcuffs and the other two officers had completed some limited but broader training in restraint methods.

The Department has taken steps to rectify the lack of training in and availability of restraints for its officers following these two deaths. In the Walker inquiry the Commission was advised that currently most serving prison officers have up to date training in restraints. It was noted that officers in metropolitan prisons receive more training than those at country institutions e.g. at Fremantle Prison refresher courses in restraint training are held every Friday and officers attend on a rostered basis (RCIADIC W2:2946).

Restraint training was introduced into the Probationary Officer's curriculum in July 1981. In July 1984 a revised three day course incorporating the use of PR 24 batons, chemical agents and crisis intervention was introduced. The three day course was further developed and replaced by a five day course in 1984. This course placed greater emphasis on man management and counselling skills and was designed to increase the officer's ability to de-fuse potentially dangerous situations (W/2/140).

After the development of the five day course in 1984, due to an increased emphasis on person management, restraint training was condensed to a three day course. Restraint training to probationary prison officers is provided by the Metropolitan Security Unit (MSU) of the Department.

Officers are taught to use the minimum amount of force or restraint required on an occasion, and to only use restraint as a last resort. The decision to restrain a prisoner in a particular set of circumstances and the manner in which the restraint is made is one for the officer(s) involved to make at the time (W/1/74). It is noted that officers receive no training in neck or 'sleeper' holds and are specifically instructed to avoid the application of such holds (RCIADIC W1:2957).

Contrary to the situation with training in first aid and resuscitation, the Department does provide refresher courses in restraints for serving officers. The Department has informed

the Commission that it's aim remains the provision of two days refresher training for serving officers in Regional Prisons and half day refresher training courses in metropolitan prisons. However, *'due to budgetary restraint'* only 169 officers received such training in the 1989-90 financial year (Department of Corrective Services answers to specific questions from the Royal Commission, July 1990)

Welfare Role

Apart from two introductory sessions on unit management, welfare and unit management are no longer separated in the probationary prison officers course. The Department has advised the Commission that these two concepts are now 'in effect' the underlying themes of the training course.

Upon the introduction of the unit management strategy, currently serving prison officers underwent a four day course on the welfare role of officers in the new system. The welfare training for serving officers ceased in mid 1990 with twenty officers having failed to receive it. Those officers had all had several years practical experience in institutions and had received some components of the welfare package in regional and promotional training. It is not intended by the Department that they attend the course.

After the abolition of the welfare officer's position four Welfare Coordinators positions were established to supplement and oversee the welfare services provided by the prison officers. The Welfare Coordinators were all former welfare officers of the Department. Two of the coordinators also had previous experience as prison officers.

The four day 'Prisoner Management Skills - Care' course for current staff was conducted by the Welfare Co-ordinators and included areas such as:

- definition of new, enhanced role
- effective communication and body language
- effective listening
- assertive versus aggressive behaviour
- counselling
- feedback
- criminal justice system information
- prisoner's legal rights
- financial problems and assistance
- admission and release
- routine welfare issues

The Welfare Coordinator positions no longer exist within the Department. Those positions were temporarily created for the purpose of effecting the handover of welfare responsibilities to prison officers and to coordinate and evaluate the delivery of welfare services by prison officers during the transition period. The last of the Welfare Coordinators ceased acting in that role in July 1990.

It is noted that, although the Department expected prison officers to take over the role of welfare officers, including that of the former Aboriginal welfare officers, the officers 'in service' welfare training included only a three hour component on Aboriginal and Intercultural Issues.

Aboriginal Culture

This report has referred to the over-representation of Aboriginal people in the prison population in this state. At Eastern Goldfields Regional Prison and at each of the northern regional prisons, Aboriginal inmates comprise the majority of the prison population. As with police officers, it is essential that prison officers have training that provides them with the appropriate skills to communicate with Aboriginal people together with an understanding of Aboriginal history, culture and social behaviour.

The Probationary Prison Officer's Course contains a component on Aboriginal prisoner management. This aspect of the course is entitled 'Cultural Issues' and extends over two days. Day one covers general Intercultural Issues. Day two is devoted to Aboriginal Issues. There are eight forty minute sessions on each day.

The areas covered in the Aboriginal Issues section of the course include:

- Dreaming
- Traditional life
- Impact of Legislation on Aboriginals
- Urban Aboriginals
- Problems of adaption
- Arrest, court procedures, legal aid, offences and offending
- Problems encountered in prison
- 'Do's and don'ts of dealing with Aboriginals'
- Parole problems

The Intercultural Issues section comprises sessions on:

- Development of cultural numeracy
- Islamic and Buddhist religions
- Developing cultural literacy
- Culture and demography

The course detail is reinforced by participation in practical learning exercises including quizzes and debates. A video is shown to complement instruction in the area of legislative impact.

It is also noted that the syllabus for the Senior Officer and Chief Officer's Qualification course includes the complete training package in Aboriginal and Intercultural Issues.

The Aboriginal Issues component of the Probationary Prison Officers' course was prepared and is presented by Ms Annie Hoddinott, a staff training and development officer employed by the Department. She has experience in working with Aboriginal people in the Health Services and Corrections areas of the Department and has undertaken units in Aboriginal studies at University. During 1985 Ms Hoddinott spent six months in the Kimberley Region undertaking an evaluation of the Aboriginal Justice of the Peace Scheme.

Mr Ed Garrison (formerly of the Health Department and currently employed by the Ministry of Education) was responsible for developing the course on Intercultural Issues. He holds a B.A. in Anthropology and has worked with both Aboriginal people and migrant groups. Ms Hoddinott is also responsible for presenting this component of the course.

The Department has informed the Commission that it considers that *'... given budgetary restraints the training in Aboriginal prisoner management is adequate and covers all relevant matters'* (Department of Corrective Services answers to specific questions raised by the Royal Commission, July 1990, page 34).

Given the complexity of Aboriginal culture, its spiritual, philosophical and practical difference from European culture and the fact that Aboriginal people cannot be considered or approached as one homogenous group it is considered that one days training specifically related to issues of Aboriginal prisoner management plus a further day on general intercultural matters can only be considered inadequate.

It must be recognised that many probationary prison officers will have had no prior contact or only limited contact with Aboriginal people before joining the Department. This is shared in common with many non-Aboriginal Australians, particularly those from the large urban centres. It is still the situation that the majority of an officer's knowledge and understanding of Aboriginal prisoners must come from their practical 'on-the-job' experience. It is a matter of the time, effort and receptivity of the individual officer.

It is noted that there is currently no ongoing training in Aboriginal prisoner management for officers nor is there any training provided in that area for serving prison officers.

5.3.3 Availability and Use of Medical Assistance

Medical care and treatment of prisoners in Western Australian prisons is the responsibility of the Prison Medical Service (PMS). The administrative structure of the PMS places it under the control of the Executive Director of the Department of Corrective Services. Section 38 (1) of the Prisons Act 1981 provides

> The *[Executive] Director shall nominate for each prison a prison medical officer or a medical officer who shall be responsible for the medical care and treatment of every prisoner in that prison.*

The Superintendent of each prison delegates the health function to medical staff, however he retains ultimate responsibility for the continued security and custody of all prisoners.

Subsection (2) of Section 38 provides that a prisoner may be attended upon and examined by a medical practitioner other than the prison medical officer or medical officer only in certain limited circumstances and with the approval of the Superintendent of the prison, the prison medical officer and the Executive Director. In general terms, prisoners do not have the right to choose their own doctor or to change practitioners as is the right of patients in the general community.

Section 39 of the Prisons Act 1981 sets out the functions and duties of the Prison Medical Officer, these include:

- examining every prisoner as soon as practicable after their admission to a prison;
- maintaining a record of the prisoners medical condition and course of treatment;
- examine and treat every prisoner in the prison who requires medical care and treatment.

<u>Medical Officers</u>

The Department employs two full time doctors (or 'medical officers'). One is designated as the Prison Medical Superintendent and has as pan of his role the responsibility for the maintenance and provision of medical services to prisoners in Western Australian

Department of Corrective Services Institutions. The current Prison Medical Superintendent was the first full time medical practitioner appointed to the Department. His appointment followed a Public Health Department inquiry into health services in Prisons in 1978. Prior to that time the Department engaged the part time services of local medical practitioners to cover the health needs of its institutions (W/1/55).

The Prison Medical Superintendent is based at Fremantle prison. The other full time medical practitioner employed by the Department is stationed at Canning Vale Prison. In addition to those prisons, these medical officers also service the C.W. Campbell Remand Centre and Bandyup Prison. They are also assisted by visiting sessional medical officers. Visits to Bandyup Prison by the medical officers occur twice weekly (W/10/30). In addition the two full time medical officers are 'on call' on a roster basis after hours for the four metropolitan prisons.

Medical services for all other prisons are provided by visiting medical practitioners residing in the area close to the prison that they serve. The Commission received evidence that medical practitioners visit Eastern Goldfields, Albany and Broome Regional Prisons once a week. Wooroloo Prison receives visits four times per week. It is noted that until recently medical services at Broome Regional Prison were provided by a doctor from the Broome Regional Aboriginal Medical Service, however it is understood that that practice has now ceased.

It is also noted that a dentist and optician visit the two largest prisons (Fremantle and Canning Vale) at least once per week.

Nursing Send

A twenty-four hour nursing service is provided by the PMS at Fremantle and Canning Vale Prisons and at the C.W. Campbell Remand Centre. Nursing staff at those institutions are employed by the Department and are designated as 'Hospital Officers'.

Wooroloo Prison is adjacent to the Wooroloo District Hospital (the hospital is actually situated within the boundaries of the prison) and has access to twentyfour hour nursing coverage from the hospital. All other prisons have pan time nursing coverage with the exception of Wyndham Regional Prison. A Community Health nurse attends Wyndham Prison weekly and referrals are made to the public hospital where considered appropriate.

It is important to note that Hospital Officers, unlike most nurses, are not members of the Royal Australian Nurses Federation (RANF) but are members of the Prison Officers Union. Nursing staff at prisons other than Fremantle, Canning Vale and C.W. Campbell Remand Centre are members of the RANF. I will return to this matter in considering the issue of the 'independence' of the PMS.

The Department has a preference in the employment of hospital officers for 'double certificate' nurses i.e. nurses with both general and psychiatric nursing qualifications. The majority of hospital officers currently employed by the department possess both qualifications.

In addition to their nursing duties, Hospital Officers also have custodial responsibilities. Murray Corp, a hospital officer at Fremantle Prison, gave evidence in the inquiry into the death of the Aboriginal man who died at Sir Charles Gairdner Hospital on 25 February 1983. He was questioned about the dual role of the hospital officer:

Q. *Now you have to do both nursing and custodial duties?*
A. *That has always been the case.*

Q. *I see. What sort of custodial duties would you have?*
A. *Well, it's the same. You were responsible for unlocking and locking up the infirmary, for counting the prisoners to make sure that they were all where they should be and sending them, if they are required for visits or for other interviews - legal aid interviews and that sort of thing, so you had that responsibility. As of the last few months, we also do the welfare work side as well now.* (RCIADIC W9:103).

Availability of Nursing Staff

Five of the deaths in prison custody occurred 'after hours' or on a weekend when there were no nursing staff on duty at the respective prisons. Those deaths were:

Nita Blankett	Bandyup Prison
Paul Farmer	Albany Regional Prison
Charles Michael Dixon	Bartons Mill Prison
Green	Broome Regional Prison
Graham Walley	Greenough Regional Prison

At the date of death of each of those persons none of the above prisons had twenty-four hour nursing coverage. With the exception of Bartons Mill Prison (which has subsequently closed) that situation remains.

The Commission was informed that subsequent to the death of Nita Blankett further nursing staff were appointed to Bandyup Prison to allow nurses to attend the prison from 7.30 am to 9.00 pm Monday to Friday and from 8.00 am to 9.00 pm on weekends and public holidays (W/10/30). The Commission has also received evidence of an increase in recent years in the number of nursing hours at Albany, Broome, Eastern Goldfields and Greenough Regional Prisons.

This improvement in nursing coverage is encouraging, however, in a statement made to the Commission, the Senior Nurse at Bandyup Prison at the date of Blankett's death commented:

> *In my view the situation with Nita Blankett's death could happen again at any time unless there is 24 hour nursing cover at the prison. Prison Officers cannot assess prisoners for medical conditions. It is very difficult for an on call nurse to assess a prisoners condition over the telephone...'(W/10/16).*

In an addendum to that statement she continued:

> *I stated the view that such a death could happen again unless there is 24 hour nursing cover at the prison because prison officers are not nurses and it is placing too much onus upon them to expect them to be responsible for medical situations other than something that is obvious to a layperson.*
>
> *Some progressive illnesses are difficult enough for a nurse or doctor to properly treat. Prisoners suffering from chronic illnesses require a trained person to be*

*there. There are difficulties and delays when someone has to be called in to see a prisoner or a prisoner has to be taken out of the prison. (W/1*0/16)

The absence of twenty-four hour seven day a week nursing coverage at all prisons also means that all prisoners may not receive a medical assessment at the time of their admission to prison. Admissions can occur on weekends and after hours. If nursing staff are not available the only assessment that will be made of the prisoner is by the receiving prison officer. It is on the basis of this initial assessment that a decision is made as to whether the prisoner requires urgent medical treatment and/or further assessment or whether it is appropriate to wait until the next weekly visit of the doctor to the regional prison.

That situation is far from satisfactory. In a statement provided to the Commission in the course of the inquiry into the death of Bobby Bates, the Prison Medical Superintendent (referring specifically to Eastern Goldfields Regional Prison) averted to this problem stating:

> *As receptions occur at the prison on weekends it would be useful to have a nursing sister available at the weekends to enable receivals to be processed in a more effective manner.'(W/31/15)*

Recommendation 38 of the Interim Report of the Royal Commission (Muirhead) stated:

> *Recommendation 38*
> *Correctional institutions should have twenty-four hour a day access to medical practitioners In addition, as a minimum standard, correctional institutions should have permanent full time medical or nursing staff providing medical services to prisoners which is available night and day, seven days a week.*

It is now almost two years since that recommendation was made, yet it is still the case that no regional prison has twenty-four hour nursing coverage. In answer to specific questions put to the Department of Corrective Services by the Royal Commission in July 1990, the Department estimated that to provide twenty-four hour nursing care to all prisons would cost an additional $1.8 million dollars per year in recurrent expenditure. The Department did not seek to justify the absence of full time nursing coverage by reference to either need or prevailing community standards.

Why should prisoners at regional prisons or female prisoners at Bandyup have a lesser access to nursing services than their counterparts at the major (male) metropolitan prisons? There appears to be no reason other than the financial consideration for the Department to continue to fail to provide twenty-four hour nursing coverage to all prisons in Western Australia.

Whilst the Commission heard evidence that nursing coverage at Regional Prisons has increased over the last few years, evidence was also heard regarding both:

(i) a reduction in the number of hospital officers having occurred at Fremantle Prison, and

(ii) the number of hospital officers at Canning Vale Prison and the C.W. Campbell Remand Centre having remained constant whilst the number of prisoners at those institutions has increased.

Again budgetary constraints appear to have been the main factor.

Murray Corp was the Senior Hospital Officer at Fremantle prison in 1982-83. He was still employed as a hospital officer by the Department of Corrective Services when he gave evidence before the Commission in April 1989. In his evidence he referred to staff cutbacks having taken place throughout the Department, including the health services, *'2 years or so ago'* (RCIADIC W9:103). Whereas in 1985 there had been five or six hospital officers on duty during day shifts at Fremantle Prison, at the time that he gave evidence only three or four were employed. He stated that the staff cut backs had created extra problems for hospital officers and increased work pressure. He gave as an example occasions when ill prisoners had to be locked in the prison infirmary during the day as there was no hospital officer available to supervise them (RCIADIC W9:103).

Dr E.J. Smith was a medical officer with the PMS based at Canning Vale Prison. She commenced service with the Department in March 1984. In evidence before the Commission in the inquiry into the death of Donald Harris she stated:

> *There are 11 nurses, hospital officers, at Canning Vale. These serve the remand centre and the prison. The number of prisoners at Canning Vale has approximately doubled since I started working for the department. However, the number of nurses has remained approximately the same.*
>
> *The nurses have 8 weeks holiday a year. There are no holiday relief staff. In the remand centre there is a single hospital officer on at any one time. There is no hospital officer in the remand centre at night after II pm or before 7 am.*
>
> *Hospital officers in Canning Vale and Fremantle Prison are members of the prison officers union. Hospital officers in other prisons in the state are members of the Royal Australian Nursing Federation. This means that the rotation of relieving staff from other prisons is difficult because the prison officers union won't accept Royal Australian Nurses Federation Members.*
>
> *There has been the odd exception lately. Agency nurses were approved 3 years ago but we ran out of money to continue with this system. I have been fighting for more staff for the medical centre. Staffing is very tight and the officers are often pushed for time.'* (W/25/13).

Anba Anbanantham had been a hospital officer at Canning Vale Prison and at the C.W. Campbell Remand Centre since 1982. In a statement made to the Commission he also referred to the number of prisoners at the Remand Centre having increased while the number of hospital officers remained the same. He added:

> *In December 1989, the hospital officers were working 12 hour shifts due to nurse shortages. The workload is heavy.* (W/25/19)

The Commission also heard evidence that reductions or shortages in the numbers of hospital officers had meant that there was insufficient time for in-service training and refresher courses for nursing staff.

> *There is not sufficient training for nurses in prison because of shortages of staff. Training should be in the areas of diabetes ,resuscitation, asthmatic treatment, epilepsy.* (RCIADIC W25:48)
>
> *There is no real time for hands-on training by the hospital officers for example, resuscitation training, asthma, diabetes, advice on health, diet, exercise. I feel that nurses often leave the prison health service because of isolation and because they are very poorly served as far as ongoing training is concerned.* (RCIADIC W25:13)

In evidence before the Commission Dr Smith stated:

> *... the nurses themselves have complained bitterly about the lack of training time. The should have 10 days training a year under their award.*
>
> Q. *And that has not been given?*
>
> A. *No. All the ordinary prison officers are eligible for it but there is no way of providing nursing training ... We have had random people go out on short courses but that doesn't train your whole business. In hospitals, every nurse on the floor has to have inhouse hands-on resus training every year, and we are not achieving that - which we should.* (RCIADIC W25:48)

I should note however, that the Prison Medical Superintendent in a statement provided to the Royal Commission in the inquiry into the death of Steven Michael, informed the Commission that nursing staff at Canning Vale have had the use of a cardiopulmonary resuscitation model in the prison for *'at least the last five years'.* He added that Dr Smith, upon reviewing her statement made in the Harris inquiry, recognised that training in CPR had been occurring for nursing staff. He did not address training in other areas (RCIADIC W/26/24).

Medical Facilities at Fremantle and Canning Vale Prisons

Fremantle prison has an infirmary comprising a fifteen bed main ward, three isolation rooms and two rooms for persons with AIDS (W/9/17). There is no infirmary at Canning Vale Prison although it does have an observation centre to the side of the prison's medical centre. If a prisoner's condition required that he be constantly monitored he would be transferred from Canning Vale to the infirmary at Fremantle.

I also note that the Superintendent of Wooroloo Prison informed the Commission that prisoners who may be suffering from a chronic illness or incapacity often serve their time at Wooroloo due to the proximity of the District Hospital to the prison and the resultant access to twenty-four hour nursing coverage (RCIADIC W7:164).

The infirmary at Fremantle provides observation and recuperative facilities for prisoners. Apart from very minor surgical procedures (such as boil lancing) prisoners who require surgical treatment are transferred to public hospitals. A doctor visits the infirmary each weekday accompanied by a hospital officer responsible for carrying out the doctor's instructions for the treatment of the prisoner patients. The hospital officer makes notes on the prisoners medical file in accordance with the doctor's instructions. He would also attend the daily medical parade with the doctor.

Lockup of prisoners for the evening occurs at Fremantle prison at 4.30 pm. At that time the prison infirmary is also locked. As previously stated, there is one hospital officer on duty at the prison during the evening and night shifts. After lockup all keys at the prison (including the keys to the infirmary) are held by the Chief Officer at the front gate of the prison. The duty hospital officer, whose office is adjacent to the infirmary does not retain any key to the infirmary. There is an alarm in the infirmary which prisoners may ring to alert the duty hospital officer. The hospital officer's office is also close enough to the infirmary for prisoners to call out to the officer on duty.

If an emergency involving a prisoner in the infirmary occurred at night the Chief Officer on duty would have to attend to unlock it before entry could be gained by the hospital officer.

The length of time required for the Chief Officer to attend at the infirmary would depend on his position in the prison at the time that the emergency arose.

If medication is required to be dispensed at night it is passed to the prisoners in the infirmary through the barred windows. Security checks at night are performed by simply looking through the windows of the infirmary. I have found these arrangements to be far from satisfactory.

In the Report of my Inquiry into the death of the Aboriginal man who died at Sir Charles Gairdner Hospital on 25 February 1983 1 discussed the operation of the Fremantle Prison Infirmary at some length.

> *While this procedure* [checks on prisoner patients being conducted at night through the windows of the infirmary] *may have been adequate for security purposes such as to determine whether a prisoner was missing, it was manifestly inadequate for checking on the medical condition and well-being of prisoners in the infirmary. A prisoner ... who was in a serious condition could well have been unconscious. Simply by looking through the window, the officer per fiorming the security check would not be able to ascertain this. Moreover, it is wholl y unsatisfactory that in a medical emergency the Chief Officer should have to be called to unlock the infirmary before the hospital officer has access to a patient. On 22 February* [19831, *when there was an emergency ... it took approximately fifteen minutes for the Chief Officer to arrive to unlock the infirmary allowing the hospital officer access to the prisoner.* (page 15)
>
> ...
>
> *This is a glaring example of the incompatibility of the security arrangements at the prison with the duty to provide a proper system of caring for ill prisoners. There does not appear to be much point in having trained medical staff on duty round the clock if they do not have ready access to their patients during the night time lockup.* (page 16)

Aboriginal Prisoners - AMS - Traditional Healers

I have already referred to the generally poor standard of health conditions experienced by the Aboriginal population of this country. This is a matter that is dealt with in depth in section 5.4 of this Report and in the report of my colleague Commissioner Dodson. Aboriginal prisoners may in many instances be expected to display poorer health upon admission to prison than prisoners from other cultural backgrounds. It is important that PMS staff are aware of the broad picture of Aboriginal health in this State (and country) and that they be aware of cultural factors that may impact upon health and the provision of health services to Aboriginals.

The ability of PMS staff to effectively communicate with Aboriginal prisoner patients is of prime importance. In this regard the Department has informed the Commission that:

> *No specialist* [Prison medical] *staff training is provided by the Department in respect of Aboriginal culture or communicating with Aboriginal people. However, a number of staff recruited in predominantly Aboriginal areas have worked in the Aboriginal health services and are selected because of their knowledge and experience of Aboriginal health issues. In addition, a number of outstation sisters are involved in medical groups where they receive training and information on Aboriginal health.* (Department of Corrective Services answers to specific questions by the Royal Commission, July 1990 at page 57)

I believe that training in Aboriginal culture and in effective communication with Aboriginal people is no less important for PMS staff than for the general body of prison officers. Whilst accepting that some PMS staff have had prior professional experience in dealing with Aboriginal people, they should also be eligible for the same training as is provided to prison officers in the area of Aboriginal culture. This is a matter that needs to be addressed by the Department. Commissioner Dodson also comments on this deficiency in the training of PMS staff.

The Department does have a 'Use of Interpreter Policy' as a guideline for staff when dealing with prisoners who have limited fluency in English. Interpreters may be obtained from the Commonwealth Telephone Interpreter Service. However, the Commission has not received any information regarding the use of this service by PMS staff in their dealings with prisoner patients. I note that the Telephone Interpreter Service has no Aboriginal language interpreters available.

Evidence before the Commission indicates that, where possible, with an Aboriginal prisoner who does not speak English or who is of limited fluency, an attempt is made to find a fellow prisoner from the same tribal group to sit with the prisoner and give him support during his dealings with PMS staff (RCIADIC W/25:55). However, in general it is up to the skill of the individual nurse or doctor to ensure that they explain matters and ask questions in a manner that is comprehensible to the prisoner. A detailed examination of the use of interpreters in the provision of medical care to Aboriginal patients is contained in section 5.4.3 of this Report below.

The importance of adequate communication between PMS staff and Aboriginal prisoners is underlined by the necessity for a pro-active approach to health cam to be adopted when dealing with many Aboriginal prisoners. Prisoners may be reluctant to seek the assistance of western health professionals (e.g. the PMS) or have an inadequate understanding of the need for further review of their condition once they have commenced a course of treatment.

In the inquiry into the death of the Aboriginal man who died at Sir Charles Gairdner Hospital on 25 February 1983, the Commission was told by one of the visiting medical practitioners employed by the Department that once a prisoner is prescribed medication, it is left to him to request to see the doctor for a further review should he feel no improvement in his condition (W/9/18).

In the same inquiry one of the hospital officers stationed at Canning Vale informed the Commission that it was the practice at that prison to encourage prisoners to be self-directive in relation to their health care. It was left to the individual prisoner to take responsibility for attending appointments with medical staff. Staff did not 'chase' prisoners to ensure that they attended scheduled appointments (W/9/15).

Such an approach may be assumed adequate when dealing with European prisoners who may be presumed to be familiar with the procedure of doctorpatient consultation and with western concepts of time and keeping appointments'. However, such a presumption is not justified when dealing with many Aboriginal prisoners. These prisoners may require active inquiry and follow-up by PMS staff to ensure that their health care needs are discovered and treatment followed. Shortages or reductions in the number of hospital officers may prevent such a course from being followed.

Where an Aboriginal Medical Service is located adjacent to a prison, visiting Aboriginal health workers may be of assistance in providing health care to Aboriginal inmates. Use of AMS staff in conjunction with the staff and facilities of the PMS may create increased confidence in Aboriginal prisoner patients and eliminate or reduce communication

difficulties between prisoner and medical officer. This is a matter that is examined below in section 5.4.4 of this Report.

The Department has stated that its practice is to liaise with the Aboriginal Medical Service in cases where an Aboriginal prisoner is released while still requiring continuing medical care (Department of Corrective Services, Annual Report 1988-1989). This practice should continue in all cases where it is known to the Department that an AMS is located in the area to which a prisoner is to return following their release. It is also noted that the Department has participated in the endeavour of the Community Health Service to immunise all Aboriginals of about 18 years of age against Hepatitis B.

Finally, there have been, and it is likely that there will continue to be, instances where it will be appropriate that a traditional Aboriginal healer or 'Mabarn man' be utilised in the care of Aboriginal prisoners, particularly traditionally oriented and semi-traditional Aboriginals from the northern and central regions of the state. Prison records for Kim Polak reveal that on at least two occasions when in prison custody he was treated to positive effect by mabarn men for problems that western medicine would commonly diagnose as psychological or psychiatric in origin (W/18/2).

This Commission was also told of the occasional use of traditional healers at Eastern Goldfields Regional Prison (RCIADIC W31:14). In session before Commissioner Dodson, the current Superintendent of Eastern Goldfields Regional Prison referred to the use of tribal healers within his prison. He stated:

> *So, it's real and we use* it *often. I'm not talking about 10, 20 times a year but usually a couple of times a year in most of the prisons in the bush. Very useful and I believe implicitly we'd have more deaths in custody if* that *wasn't the case. Absolute statement.* (Commissioner Dodson, Underlying Issues Conference, Kalgoorlie 7 June 1990:35)

It is positive to note such instances of flexibility within the Department to accommodate the cultural beliefs and realities of many Aboriginal inmates.

Prisoner Medical Records

It is obviously important that PMS staff have access to thorough records of the medical history of prisoners. In the course of his or her sentence, a prisoner may spend time at several institution-, being subject to transfer as their security rating is reclassified. Transfer of information between institutions to accompany prisoners is of particular importance where prisoners have any form of chronic health condition. The Department of Corrective Services has informed the Commission of the introduction of a system allowing rapid transfer of medical information between it's institutions:

> *The Department is in the process of developing a computer-based medalert system which will be used to maintain and provide important medical alert data for each prisoner. The facility will be available to medical records personnel at prisons for the maintenance of medalert information on prisoners. Medalert information can either be created for newly received prisoners, updatedfor existing prisoners or printed for lockup purposes. The following alert flags will be available on the system: asthma, cardiac, diabetes, epilepsy, psychiatric and other* (including HIV positive and hepatitis B).
>
> *This information will be made available to a receiving prison in case of the prisoner's transfer so that appropriate medical attention can be provided.*

All data will be accessed electronically, however in the case of prisoners transferring between prisons a paper copy of the medical alert information will accompany them as a back-up in the event of system downtime at the sending or receiving institution.

(Department of Corrective Services answers to specific questions by the Royal Commission, July 1990 at page 54)

This innovation is commended by the Royal Commission.

Compulsory Medical Examination and Treatment

I have already referred to section 39 of the Prisons Act which sets out the duties and functions of the Prison Medical Officer. One of those functions is to perform a medical examination of every prisoner as soon as practicable after his or her admission to a prison.

Section 45 of the Prisons Act lists a number of situations where the prison medical officer may make a medical examination or administer medical treatment and use *'such force as is reasonably necessary for the purpose'.* Those situations as defined by the Act are:

Where a prisoner refuses to undergo -

(a) a medical examination upon admission to a prison; or

(b) a medical examination required by the Executive Director or the superintendent; or

(c) a medical examination which the prison medical officer or the medical officer, as the case may be, considers necessary; or

(d) medical treatment and the prison medical officer or medical officer ... is of the opinion that the life or health of the prisoner or any other person is likely to be endangered by that refusal ...

In those circumstances a prisoner may be compelled to undergo an examination or treatment. In addition section 46 of the Prisons Act 1981 provides for compulsory medical examination of a prisoner where there are reasonable grounds for believing that such an examination would afford evidence of the commission of an offence.

The Department of Corrective Services was questioned by the Commission regarding the issues of compulsory medical examination and consent by prisoners to treatment. The Department informed the Commission that:

All PMS staff adopt accepted community standards of medical counselling and information provision when informing prisoners of their medical condition, treatment and obtaining consent to treatment

It is the responsibility of all PMS staff to clearly outline to all prisoners the procedures involved in a particular treatment and to gain their consent to that treatment. With the exception of medical examinations covered by Sections 45 and 46 of the Prisons Act 1981, no treatments, including procedures, are undertaken without the consent of the prisoner involved. (Answers by the Department of Corrective Services to specific questions by the Royal Commission, July 1990 pages 58-59)

In addition the Department stated that prisoners are routinely informed of the results of tests or treatments.

Examination on Admission

Upon admission to a prison in Western Australia, each prisoner is subjected to a medical examination performed by a hospital officer or other nursing staff and an examination by a doctor - the prison medical officer. Whether a prisoner is first examined by a nurse or the prisons medical officer varies from institution to institution. For example, the Commission was informed that at Fremantle Prison a hospital officer may see the prisoner either before or after the doctor has examined him (W/9/17), whereas, the Prison Medical Superintendent gave evidence that at the C.W. Campbell Remand Centre all prisoners are examined by a hospital officer prior to their attending the doctor (RCIADIC W27:196).

The adequacy of the initial medical examination is of considerable importance in relation to the continued well-being of Aboriginal prisoners. I have already referred to the fact that, in general, Aboriginal people endure a lower standard of health than the non-Aboriginal population of Australia. That is a matter that is considered further in section 5.4 of this Report. Of the thirteen deaths inquired into by this Commission that occurred in prison custody nine died of health conditions which may be referred to as 'natural causes' (although one had been involved in a violent struggle at the time he suffered the heart attack that ultimately caused his death - C. Michael).

Earlier in this Part I have mentioned an estimate that between 65%-70% of prisoners are admitted to prison custody with substance abuse problems, the most significant of these being alcohol. In my inquiry into the death of Bobby Bates evidence was given of the poor condition in which many prisoners arrive at Eastern Goldfields Regional Prison. Alcohol withdrawal, and in recent times, petrol sniffing were cited as significant problems (RCIADIC W31:19-20, W/31/16).

With the exception of Ronald Ugle, records of the initial medical examination on their final admission to prison exist for all thirteen persons who died in prison custody. In the case of Ugle there is no record that he was medically examined at any time during his final period of imprisonment. I also note that in the Sir Charles Gairdner Hospital case there is no record of a medical officer having seen the deceased subsequent to his examination by a hospital officer. However, I did not find any case in which the adequacy or otherwise of the initial medical examination contributed to the death of the prisoner.

The initial medical examination is conducted along standardised lines. The nurse who conducts the examination is required to complete a standard form designated by the Department as form C195. The examining medical officer also runs through the form with the prisoner and with the nurse in attendance. In her evidence during the Harris inquiry, Dr E.J. Smith described the initial medical examination performed by the PMS nursing staff as an examination at the community nursing practitioner level. She added that the examination was *'rather better'* than a lot of insurance medicals (RCIADIC W25:24).

Areas covered on the C195 form include:

- Height and weight
- Blood pressure and pulse rate
- Examination of the eyes ears and teeth

- Examination of the scalp and skin
- Gait and speech
- Whether the prisoner is on any current medication
- Allergies
- Whether the prisoner has had any serious diseases or major operations
- Whether the prisoner has experienced convulsions or blackouts or had ever been unconscious.

In addition samples of urine and blood are taken from the prisoner for analysis. It is routine to check for venereal disease and with Aboriginal prisoners to check for hepatitis B. Depending upon the history given by the prisoner a liver function test may also be performed (W/25/19).

> *We also question prisoners about smoking, alcohol, drugs and homosexuality and if drunk at the time of the offence. If the answer to drug use or homosexuality is yes, we test the blood for HIV if the patient consents. If the patient doesn't consent we leave the decision to the doctor.* (W/25/19).

In his evidence in the Vicenti inquiry the Prison Medical Superintendent stated that in recent years there had been expansions in the psychological questions asked, similarly with questions regarding alcohol and HIV (RCIADIC W27:196). He added that any prisoner presenting with specific (psychological) difficulties would be met by the nursing staff's assessment of a psychological problem. Such a prisoner would then be referred to the visiting psychologist (where available) or the nurse would refer any psychological instabilities to the superintendent or the superintendent of prisoners (RCIADIC W27,196).

I have no doubt that the efforts of the PMS has improved the health standard of many prisoners and may, in some cases, have extended the life expectancy of particular prisoners. However, a cautionary note was sounded by Dr Bockman in a statement tendered in the inquiry into the death of Charles Michael:

There are limited resources for health education and preventative medicine for prisoners. Imprisonment theoretically provides an ideal opportunity to assist this undeveloped group in health care. However in the Prison Health Service we are really only able to react to the acute situation with primary medical attention. Health education would require a much larger resource than we have. (W/l/55).

A similar view was expressed by hospital officer Anbanantham in the Harris inquiry:

> *If we saw the prisoners more often instead of only at the initial screening and when they come with a problem, maybe we might be able to develop greater confidence and be more helpful towards their health.* (W/25/19)

<u>Transfer of Prisoners from Prison to Hospital - Use of Mechanical Restraints</u>

The general issue of transfer of prisoners to public hospitals for treatment and the means whereby that transfer is effected is considered in section 5.4.3 of this Report. However, I

would make some comment regarding notification of a prisoners family following upon transfer of a prisoner to a hospital for treatment.

The question of notification of the family in such circumstances was an issue in the inquiries into the deaths of Donald Harris, Bobby Bates and the Sir Charles Gairdner Hospital case. It received particular attention in the report of my inquiry into the latter case.

Executive Director's Rule 2C 9 provides:

> *The Superintendent may, subject to security considerations:*
>
> *9.1 arrange for the prisoner's next of kin to be advised of the removal of such prisoner to a hospital or other place of treatment.*

Obviously it should not be seen as necessary for the Department to notify a prisoner's family where the prisoner is transferred to a hospital or other outside medical institution for the purpose of receiving outpatient care. However, I am of the view that it is a matter of common human consideration for the Department to institute a procedure whereby the family of a prisoner is notified in each instance where a prisoner is admitted to a public hospital for treatment as an inpatient.

Mechanical Restraint

The application of mechanical restraints to prisoners transferred to a public hospital was an issue in two of my inquiries: the young man who died at Sir Charles Gairdner Hospital and Donald Harris. In the former case, at the time that the deceased was admitted to Sir Charles Gairdner Hospital for treatment of suspected tubercular meningitis his security rating was maximum. He was then under guard by a prison officer and mechanical restraints in the form of handcuffs and leg-irons were available. His physical condition at the time was, at best, semi-conscious. Nursing notes from the hospital show that at a time when there was no response to stimulation of his legs (indicating paralysis of the lower part of his body), he was still chained to his bed. He was then a dying man. The notes do not indicate whether handcuffs, leg-irons or both were being used.

Donald Harris, a remand prisoner in custody on a relatively minor charge, had been automatically classified as a maximum security prisoner under the Executive Director's Rules. Upon transfer to Fremantle Hospital with suspected acute pancreatitis he was placed under mechanical restraint. However, unlike the prisoner who died at Sir Charles Gairdner Hospital, restraints were promptly removed when it was realised that Harris was sufficiently ill to warrant transfer to the intensive care unit of the hospital.

Executive Director's Rule 2C 7 provides in part:

> *A prisoner being removed to a hospital or other place of treatment who is rated maximum or medium security shall be placed in mechanical restraint except where the particular circumstances or nature of the treatment are such that the mechanical restraint is in the opinion of the superintendent, not necessary in order to maintain the charge and supervision of the prisoner* ...

This is in contrast to the provision of Rule 33 of the Standard Minimum Rules for the Treatment of Prisoners. Those rules were approved by the United Nations Economic and Social Counsel in 1957. Although the rules are not binding in international law in the sense that treaties bind states parties to them, they do provide a basic standard which, if not met, indicate inadequacies in a penal system.

Rule 33 of the Standard Minimum Rules provides that chains and irons shall not be used as restraints on prisoners. Handcuffs and strait-jackets may be used only *'as a precaution against escape during transfer',* or on medical grounds by direction of the medical officer, or by order of the director if other methods of control fail, in order to prevent a prisoner from injuring himself or others, or from damaging property. The Rule further provides that:

> *Such instruments of restraint may not be applied for longer than is strictly necessary.*

Executive Director's Rule 2C 7 provides for 'blanket' coverage, the base position being that all prisoners rated maximum or medium security *'shall'* be placed under restraint when transferred to a hospital. Little guidance is provided as to the circumstances under which mechanical restraints, such as leg irons, may be dispensed with.

It cannot be argued that it is not a degrading experience for any human being to be chained by leg-irons to a bed whilst being detained in a hospital due to illness. I consider that a more appropriate and humane procedure in determining the necessity for the application of mechanical restraint should be found. I further suggest that such a procedure be based on an individual examination of the circumstances of each prisoner as the case arises. Factors to be considered in making such a determination should include:

- the security rating of the prisoner
- has the prisoner any prior record of escape?
- has the prisoner displayed any disposition to escape on this occasion?
- is the physical condition of the prisoner such that he is capable of effecting an escape?
- if the prisoner did escape is it likely that he would offend in so serious a manner as to warrant the imposition of mechanical restraints?
- such restraint as may be applied must not be incompatible with the proper medical treatment of the prisoner.

It should not be forgotten that in any event, whether restraints are applied or not, maximum and medium security prisoners kept as in-patients at public hospitals will still be under guard by one or more prison officers.

Psychiatric Service in Prisons

This area is considered in section 5.4.5 of this Report in the general context of mental health services for Aboriginals.

Independence of the Prison Medical Service

The Royal Commission Interim Report (Muirhead) recommended that:

> *Recommendation 37*

> *Governments should ensure that Prison Medical Services are completely independent of Departments of Correction and that the relationship between prisoners and medical staff is one of general confidentiality.*

As I have already noted, in Western Australia the PMS is a division of the Department of Corrective Services under the control of the Executive Director of the Department. The Department has expressed its view on the question of independence of the PMS in the following terms:

> *The Prison Medical Service must remain under the control of the Executive Director of the Department of Corrective Services if the mandated responsibilitiesfor the management, control and security of all prisons and the welfare of all prisoners as set out in Section 7 of the Prisons Act are to be discharged. Because this Department is responsible for the totality of a prisoners needs, it is able to appropriately balance welfare and custodial considerations. The efficient and effective management of prisoners rests upon a 'whole person' approach in which it is essential that all aspects of care custody and welfare are facilitated* (Answers by the Department of Corrective Services to specific questions by the Royal Commission, July 1990 at p 53).

The Department's interpretation of section 7 of the Prisons Act may be correct, however, legislation can be amended or repealed.

It is understandable that the Department should wish to continue to be the sole body with responsibility for the custody and care of prisoners. Few, if any, organisations would willingly open their doors to a situation of potential 'interference' in their operation by an outside agency - over which they have no direct control. However, there appear to be cogent arguments in favour of medical care in prisons being provided by a body independent of the Department of Corrective Services. (See also the discussion of this issue in the Report of Commissioner Dodson.)

I believe that it is fundamental to the provision of proper medical and health care in prisons that the PMS be capable of acting as an advocate for prisoners' welfare in situations where there is an an apparent conflict between that welfare and secufity/custodial requirements. The PMS must be in a position of strength in order to appropriately represent the interests of prisoner health care in negotiations with the Department. Such a position may be obtained if the PMS was, for example, a division of the Health Department.

In an article by Patricia Fox published in New Doctor/Legal Service Bulletin entitled 'The Role of the Prison Medical Service' it was stated:

> *In essence* a *prison medical officer's opinion relates to health and not custodial or correctional considerations. The latter would appear to be irrelevant except in so far as they present obstructions* to *the delivery of adequate health services or affect the prisoner's health.*

Currently, the PMS is a division of a Department, the prime consideration of which is the maintenance of custody. In such a situation I consider there exists a real potential for health cam considerations to be compromised.

Dr E J. Smith has given evidence to this Commission on some of the difficulties that she has experienced in initiating improvements in the practice of the PMS under its current structure:

A prison nursing ticket has ... been proposed to try *and establish more recognition and training for nurses in the prison system. However, this has not gone anywhere.*

I designed a new 195 form for the initial medical screenings in prison so that all the questions that should be asked relating to alcohol, cigarettes, drug use, homosexuality, etcetera, were separately provided for. It was an attempt to make the form easier to complete and to ensure that all necessary information was recorded.

I gave the suggestions to Dr Bockman but nothing seems to have happened. It *has become lost in the prison machinery.*

I also designed a new diagnosis sheet to enable diagnosis and discharge medication to be easily forwarded by facsimile when a prisoner was being transferred to another prison. At present the nurse rings through the information. Nothing has happened there either.

The Prison Health Service has no structure to facilitate ideas for changes and improvements going up the ladder from those directly concerned with problems. (W/25/13)

Such matters as raised by Dr Smith may be more promptly addressed were the PMS to be an independent body with no consideration other than the provision of appropriate and adequate health care to prisoners rather than it being a cog in the overall operation of the Department.

I recognise that in any event there may be difficulties in establishing a normal doctor/patient relationship of trust and confidence between medical officer and prisoner in the prison setting. This may be due to the isolation of prisoners from the general community, their inability to select the doctor of their choice and their subjection to a largely compulsory regime. I believe it probable that prisoners would feel more confidence in prison medical officers and nursing staff if they knew that they were independent of the custodial authorities.

As I have detailed earlier in this section, the medical officer or nurse is involved when a prisoner is first admitted to a prison in conducting a compulsory medical examination. Again it is likely that even if the PMS was structurally independent of the Department of Corrective Services that prisoners would from the outset still identify the doctor as (at least in some measure) part of the penal system and as part of the removal of personal freedom and choice imposed by imprisonment. These are difficulties which may remain insurmountable within a prison environment.

A further matter of concern to this Commission is that whatever level of independence there currently exists between PMS staff and custodial staff, it is compromised by Hospital Officers being members (and a minority) of the Prison Officers Union. As members of the union they are subject to union discipline and solidarity. There currently exists the potential for conflict between the hospital officers' patient care concerns as nurses and the concerns of the bulk of union members. I also consider that it is inappropriate that nursing staff should be required to perform custodial duties in addition to their health care responsibilities.

One would hope that if the PMS was administratively separate from the Department of Corrective Services as a division of the Health Department that it might be better funded. The PMS currently appears both under-funded and under-staffed. As I have noted

elsewhere in this Report, in times of budgetary constraints welfare considerations in the prison system will of necessity be a secondary priority of custodial authorities.

If the PMS is administratively independent of the department of Corrective Services (e.g. as part of the Health Department) an important matter for consideration is the nature of the structure that should exist for liaison between the PMS and Corrective Services. There is the possibility of antagonism between the two, as the first consideration for Corrective Services will always remain the maintenance of custody/security. This is a matter which I do not feel is appropriate for further comment in this Report.

5.3.4 SUPERVISION & MONITORING OF PRISONERS

In this section I consider the procedures within the Department for the supervision, monitoring and management of prisoners who are emotionally or psychiatrically disturbed, suicidal or suspected of being suicidal or who are otherwise in a state of personal crisis.

I have earlier referred to Executive Director's Rule 3B which provides for the identification and management of prisoners whose health is 'at risk' by virtue of physical or emotional factors (see section 5.2 of this Report). Rule 3B details procedures for the management and placement of prisoners who are or are suspected of being suicidal or otherwise disturbed.

Two of the deaths in prison custody investigated by the Commission were self- inflicted: Paul Fanner at Albany Regional Prison in 1985 and Graham Walley at Greenough Regional Prison in 1988. In both instances the deceased had displayed oven signs of emotional or psychological disturbance on the day of their death. In each instance the response of prison staff to the behaviour of the deceased was to place them alone in a locked cell. Fanner was secured in an 'observation cell', Walley in his own cell, however, neither were kept under the constant observation of prison staff. It was during the period of their isolation that both men took the action that brought about their death.

Had either Fanner or Walley been placed under constant supervision or in a cell with the company of other Aboriginal inmates, it is possible they may still be alive today. At the least, one can state that the chance of their having ended their lives at the time they did would have been greatly reduced.

In the Report of my Inquiry into the death of Graham Walley I stated:

> *The tragic experience suggests a need for the Department to issue guidelines on the use of the observation cell. I believe it should be provided that placement be mandatory following suicidal threats or other indications of disturbed behaviour by prisoners. (33-34)*

Subsequent to the preparation of that Report I have had the opportunity of considering the Department of Corrective Services revised policy on the management of prisoners 'at risk' as detailed in the current Executive Director's Rule 3B. My conclusions after such consideration follow:

At times of personal crisis it is important that Aboriginal prisoners have the option of association with other Aboriginal inmates. Even allowing for the 'institutionalisation' that some Aboriginal prisoners may have developed, isolation from one's community and country during imprisonment can be a source of significant distress. Total isolation from one's peers in an .observation' or 'isolation' cell has been shown to have possibly devastating results.

A prisoners separation from the general community during a sentence of imprisonment may itself be a most significant factor in causing the distress that leads to a suicidal impulse. Of major concern to Walley was that his de facto wife had commenced a relationship with another man and that he had been denied access to his children. As a prison officer commented in the course of his evidence before the Commission:

> *You have got to bear in mind that molehills can become mountains in gaol when they [prisoners] haven't got outside access to problems with families and that* ... (RCIADIC W31:17)

To further isolate a distressed prisoner without compelling reasons is beyond sense and humanity. I also note that in the course of my inquiries I was told on a number of occasions that, although most prisons have separate 'observation' and solitary confinement' cells (the latter used for punishment), prisoners generally do not distinguish between the two and consider any solitary placement as a form of punishment.

Professor German provided a report to this Commission concerning the psychiatric and psychological factors involved in the death of Graham Walley. Referring to the situation that existed on the day of his death after Walley had exhibited considerable agitation and aggression and had erected a barricade in the maximum security section of Greenough Prison he stated:

> *'I believe that what he needed after the barricade incident was close and interested human contact for a period of time during which he could unburden himself of his feelings and feel that his situation was attracting warm and supportive sympathy. Instead he was isolated in his own cell and left with his own thoughts.* (W/22/25C)

Following the death of Graham Walley the Department of Corrective Services amended the Executive Director's Rule relating to the placement and management of 'at risk' prisoners. The current Rule 3B recognises the importance of the considerations discussed above. It provides that, in determining the course of management of a prisoner identified as being at risk, consideration shall be given to the following matters

1. The effects the placement is likely to have upon the prisoner;

2. The placement of the prisoner in a cell with other prisoners as a means of providing social support and reducing isolation;

3. The placement of an Aboriginal prisoner with other Aboriginal prisoners from the same area or tribal group, or a foreign prisoner with other prisoners from the same country.

The Superintendent of Greenough Regional Prison at the time of the death of Graham Walley gave evidence before the Commission at its sittings in Geraldton. He stated that he had learnt from the death that a critical matter in such a situation would have been some peer group support. Unfortunately, it was not a consideration of which he was aware at the time he ordered Walley confined to his cell. In answer to questions from Counsel Assisting, he stated that he had gained an appreciation of the importance of peer support for Aboriginal prisoners following discussions with other Aboriginal inmates after the death (RCIADIC W22:189).

The current Superintendent of Broome Regional Prison gave evidence before the Commission in the inquiry into the death of Dixon Green. He was questioned by Counsel Assisting regarding the use of the prison's observation cell. He demonstrated what I consider the appropriate approach to the use of confinement in an observation cell :

Q. *You showed us the observation cell this morning, superintendent; under what circumstances would you use that?*
A. *Where a prisoner was in such a state as he was unmanageable in a sense of being violent to others or to himself. That would be the only reason we would use that cell - is where the prisoner's behaviour was such that we couldn't put him with anyone else or it was better that he be confined away from everyone.*

Q. *What about suicidal prisoners?*
A . *If he wasn't being violent to anyone else then I wouldn't put him in there, no.*

Q. *What would you do?*
A. *I'd put him in a cell with some of the other prisoners; and we do that. If we think a prisoner is upset, it's best if he's put in a cell with others. Infact, the department's instruction recommends that action take place, but we've been doing that now for a long period of time.* (RCIADIC W24:37)

Rule 3B 5.3 provides that where a prisoner has been determined to be 'at risk' a written record is to be kept of all matters relating to the prisoner's condition and any subsequent action. In addition, the officer managing the prisoner is to be informed that the prisoner is 'at risk', of the nature of the risk and of the course of management.

I have expressed the view that the placement of a distressed or potentially suicidal prisoner in an 'observation cell' should be a matter of last resort. Rule 3B 5.4 provides:

> *If the Superintendent is of the opinion that for medical or psychological reasons the prisoner requires close supervision, the Superintendent may order that the prisoner be placed under close supervision in a cell and maintained there in accordance with a regime set out in Executive Director's Rule 3J* ...

(Rule 3J sets out a regimen for prisoners placed in an observation cell.) Rule 3B 5.4 further provides that where a Superintendent orders close supervision of a prisoner then the Superintendent shall :

1. *Order the frequency of checks to be made on the prisoner.*

2. *Ensure a record in writing is made of the name of the prisoner, the cell in which the prisoner is placed, the date and time of the placement, the reasons for the order, the name of the Superintendent who gave the order and the times when observations or visits were made during the placement.*

It is noted that the rule provides no guidance to a superintendent as to the frequency of checks to be made on a prisoner placed in an observation cell. I am of the opinion that 'close supervision' should mean '<u>constant</u> supervision'. If a prisoner is in such a condition that it is considered that he requires separation from staff and other inmates, then for the period of that separation an officer or officers should be detailed to keep him or her under constant visual surveillance. Such a requirement would reinforce the position that the initial consideration with a distressed prisoner should be placement with other inmates and that confinement in an observation cell is a matter of last resort.

Medical assistance should be available to all prisoners placed in an observation cell and a review of the prisoner by a medical officer should be performed as soon as possible after

placement in the cell. This requires arranging for the same at the time that the decision to place the prisoner in an observation cell is made. I believe that this should be a mandatory requirement. Daily review by medical or psychological staff should continue for the duration of the confinement.

Placement in an observation cell should only be maintained until the immediate crisis phase has passed. I note with approval that the Department's policy of ' normalisation' provides for the return to the general prison population and a normal routine as soon as possible for any prisoner placed in observation.

It is also advisable in view of special factors that may be affecting distressed Aboriginal prisoners that once they are placed in an observation cell they be visited there by a member of the Aboriginal community (this could be a fellow prisoner or a member of the Aboriginal Visitors Scheme).

Rule 3B 7.2 provides that prior to placement in an observation cell:

> *A search shall be conducted of the prisoner for items that could cause injury or affect the prisoner's health.*

In the case of Paul Fanner, a strip search was conducted prior to his placement in the observation cell at Albany Regional Prison. However, after conducting the search his original clothing was returned to Mm. It appears that secreted in that clothing was a razor blade which the search had failed to discover. He subsequently used the blade to take his life. Following his death Standing Orders at the prison were amended to include the requirement that where a prisoner is strip searched prior to placement in the observation cell a new set of clothing is to be issued to him after completion of the search. Such a requirement should be standard at all prisons.

As an additional safety procedure, all observation cells should be equipped with alarm systems for use by the prisoner. The Department has informed the Commission that:

> *Subject to the availability of funds the Department plans to equip all single occupancy closed security (maximum and medium security) classified prisons with alarm systems* (Answers by the Department of Corrective Services to specific questions by the Royal Commission, July 1990).

Currently all cells in the following prisons are equipped with alarm systems: C.W. Campbell Remand Centre, Canning Vale Prison and Greenough Regional Prison. In addition, the new extension at Albany Regional Prison has alarms fitted to all cells.

5.3.5 EMERGENCY PROCEDURES

Each prison in Western Australia has emergency procedures in the form of Standing Orders or Local Orders issued by the Superintendent under Sections 37(l) and 36 (3) of the Prisons Act 1981. These refer to local conditions and procedures and cover areas such as:

- Medical Emergencies
- Emergency medical equipment
- Fire

- Escape and Attempted Escape
- Riot and Hostage situations
- Recovery procedures
- Cyclones
- Transfer of Prisoners after lockup
- Suicide and Attempted Suicide
- Raising Alarm
- Personnel alarms
- Issue of keys
- Starting emergency power plant
- Leakage of gas or chemicals
- Medical care of prisoner's child (Bandyup)
- Flood and earthquake
- Use of Chemical agents

In addition to the Standing Orders that cover these procedures, some prisons have Emergency Manuals. These are a composite collection of emergency procedures/Standing Orders held at various locations in the prison. They are readily identifiable and are intended to assist staff to speedily respond to all situations.

A matter of particular concern to this Commission is the circumstances under which prison officers may use firearms against prisoners. I now turn to an examination of that issue.

Use of Firearms

In this section of the Report I largely draw upon the discussion on the use of firearms by prison officers contained in the Report of my Inquiry into the Death of Ricci Vicenti. I also note that the circumstances of Vicenti's death have been examined earlier in this Report in section 3.7.

It is still the case in Western Australia that a prisoner may be fired upon by an armed prison officer during the course of an attempted escape and that if the death of the prisoner thereby results, such a killing may be justified under law. The most directly relevant legislation is Section 47 of the Prisons Act 1981 and Regulation 25 of the Prisons Regulations 1982 made pursuant to that Act.

Section 47 Provides (inter alia):

> (1) A Superintendent, prison officer or a person lawfully charged by the Minister or Executive Director with the charge of a prisoner may use a firearm against a prisoner who -

(a) is attempting to escape from lawful custody if it appears to the user of the firearm that the use of a firearm is necessary to prevent the escape of the prisoner; or

(b) is assaulting or attempting to assault any person, if the assault or attempt appears to the user of the firearm to be of a character apparently dangerous to life or likely to cause serious injury.

(3) Before the use of a firearm under this section, steps shall be taken, where it is practicable in the circumstances to do so, to order the prisoner or other person to desist from his apparent course of conduct and to give warning that a firearm is about to be used.

Regulation 25 provides:

(1) Before using a firearm against a prisoner ... a prison officer shall, where it is practicable in the circumstances to do so -

(a) order the prisoner ... to halt;

(b) if the prisoner ... so ordered refuses or neglects to halt, the prison officer shall immediately call aloud "halt or I'll fire" or words to similar effect.

(2) Before using a firearm against a prisoner ... a prison officer may, where it is practicable in the circumstances to do so, fire a warning shot.

(3) In exercising his discretion to use or to continue to use a firearm, a prison officer shall have regard to the risk, in the immediate circumstances, of injury which the use of firepower would impose upon any person other than the prisoner or person against whom the firepower may be used.

Regulation 24 also relates to the responsibilities of prison officers when carrying firearms. Training in the use of firearms is provided to probationary prison officers by members of the Department of Corrective Services Metropolitan Security Unit (MSU). Currently a complete day of training is provided on the interpretation of Sections 47 and Regulations 24 and 25 (RCIADIC W27:229).

As I have noted in my report on the death of Vicenti, at the time of his death in 1982 security at the C.W. Campbell Remand Centre relied heavily on the use of armed guards positioned at four separate gun posts located on the perimeter fence of the Centre. In 1987 the system of armed guards was replaced with a 'Sentrack' system monitoring prohibited zones with sensors and cameras from a central control room. There is also an updated operational procedure in force whereby a two man Emergency Response Unit (ERU) guided by the officer in the control room responds to any threatened breach of perimeter security.

The ERU either has a vehicle patrolling the perimeter fence or in a position of constant readiness to to respond to any request for assistance. Members of the ERU are also members of the MSU and participate in an 18 day training course which includes 8 days firearms training. The ERU are trained in personal management skills to control emergency situations. In the event of an attempted escape they are trained to initially try to use their personal management skills and only as a matter of last resort to use firearms. However, I note that there are no local or standing orders stipulating that the use of firearms is a matter of last resort. Ultimately the decision to use a firearm is left to the officer 'on the spot' at the time.

In contrast to the previous situation of guards in gun towers, members of the ERU are able to talk with prisoners at close quarters and are in a better position to persuade an escapee to desist. If the escapee was outside the perimeter fence, the ERU would attempt to apprehend him. However, the fact remains that armed prison officers still, ultimately, control security at the Remand Centre. This remains a cause for concern.

The provisions of Section 47 of the Prisons Act allow a prison officer to use a firearm in the circumstances therein described on both unsentenced and unconvicted prisoners held on remand and on sentenced prisoners. No distinction is drawn. As I have pointed out earlier in this section the Prisons Act allows for the justifiable homicide of an escaping prisoner. In my report on the death of Ricci Vicenti I stated that:

> *When Vicenti died it was said to have been particularly offensive that a remand prisoner awaiting sentence, and who may not have been sentenced to imprisonment in any event, had been shot. While that added an extra poignancy to the tragedy, it is difficult to see why it would have been any less offensive if a sentenced prisoner serving a short term for a driving offence* [or serving imprisonment in default of payment of a fine] *had been shot and killed, or more offensive if Vicenti had denied the charges against him and had been remanded in custody awaiting trial. It seems rather that any death in such circumstances may be considered offensive, and that any provision which might be thought to allow it is inconsistent not only with enlightened standards of behaviour, but with the principles underlying other similar legislation.* (page 33)

In this regard it must be emphasised that the death penalty was abolished in this state in 1984, largely on the basis of a moral judgement. Whilst our judiciary may no longer impose execution as a punishment for even the most heinous of violent crimes, it is surely inconsistent and illogical (let alone immoral) to have allowed the possibility of 'administrative execution' to continue for what is a relatively minor offence : escape or attempted escape from a prison. 'Mat offence is punishable by a maximum penalty of only three years imprisonment. In practice in this state, it commonly attracts an additional term of imprisonment of between one and three months.

Section 47 of the Prisons Act introduces an element of proportionality to the requirement of necessity justifying a prison officer firing upon a prisoner. A prison officer may fire upon an escaping prisoner, but he may only do so in a manner which is necessary and proportionate to the object of preventing escape.

Whereas I consider that firing at the legs of a prisoner may be found to be necessary and proportionate, it is unlikely that shooting to kill could ever be considered necessary and proportionate to preventing the mischief of escape. This is particularly so when one considers that were the prisoner to succeed in his escape attempt, no matter how grave a crime he may commit (if any) whilst at large, the most severe punishment that he could receive from our courts is further imprisonment.

Certainly the rights of prisoners must be balanced against the need to protect the public, however the evidence before this Commission indicates that in relation to the use of firearms to prevent escape, a disproportionate weight has been attributed to the latter consideration. In my view there is no justification for retention of section 47 in its current forrn, justifying as it does, the use of potentially lethal force against escaping prisoners. Such force should only be justified in circumstances where there is an immediate danger of grievous bodily harm or death being caused to any person by the escapee, not merely the remote possibility that such *may* occur at some future time.

5.3.6 CONTACTS

5.3.6.1 Family

Under this heading I consider both contacts with family members and contacts due as an obligation under traditional law.

Prisoner Placement

Prisoners should, as far as is possible, be located at the prison closest to their family. It is noted that Executive Director's Rule 2B details that 'where possible' prisoners are placed at the closest prison with a suitable security rating to the location of the prisoner's family.

There is provision in Rule 2B where a prisoner is placed at a prison far from their home region for temporary placement of the prisoner at a prison closest to their home so that they may receive family visits. The placement is usually of two weeks duration.

Particularly at the Northern and Eastern Regional Prisons, there should be facilities for large or extended family groups to attend on relatives who are inmates. The Commission has heard evidence that this is already the case at the Eastern Goldfields Regional Prison.

Telephone-Calls

It is inevitable that under the present arrangements some Aboriginal prisoners will serve at least a part of their sentence at institutions distant from their family and country. Many of the prison population, including Aboriginals, have limited literacy skills. In this regard telephone contact with families is of considerable importance to prisoners. It is noted with approval that Executive Director's Rule 5D is currently being amended to provide for a prisoner's right to two telephone calls (at their own expense) per week.

Funerals

Attendance at funerals is an important aspect of Aboriginal culture. Failure to attend the funeral of a relative may cause great distress and possibly lead to consequences for the prisoner and/or his family.

Executive Director' Rule 7A sets out the Department's policy with regard to the attendance of funerals by prisoners. The current policy takes into account extended family and kinship relationships, closeness from frequent social contact and other cultural matters such as a prisoner's leadership obligations in determining a prisoner's eligibility to attend a funeral. Until the mid 1980s the policy of the Department was to define 'close relatives' as those composing the nuclear family, a practice which clearly did not take into account Aboriginal social and familial relationships.

It should be noted however that in reaching a decision to allow a prisoner to attend a funeral, cost is the over-riding consideration of the Department. Cost which may include accommodation, travelling and staff availability.

Other Traditional Obligations

Imprisonment may prevent an Aboriginal prisoner from participating in important ceremonial activities such as initiation ceremonies and otherwise prevent them from meeting their obligations under traditional law.

To date, the Department has not received any applications by prisoners (or significant others on behalf of a prisoner) to attend traditional ceremonies other than funerals. This may partly be accounted for by the fact that under the present policy and rules of the Department there is no provision for such a request to be granted.

5.3.6.2 Welfare Services

> *One of my major concerns is with the regional prison* [Greenough). *I feel the need for an Aboriginal welfare officer or an Aboriginal liaison officer in the prison. Simply my reason for that is that Aboriginal people coming from places like Wiluna and semi-tribal areas - a large portion of these people can't read and write and their english is limited, with some of these people. They go to prison. They get sentenced to maybe 2 or 3 years in prison. In that 2 or 3 years they have no contact with their family at all - none at all. Their families can't afford to come down and visit them. There is no one in the prison for them to turn to, to write letters for them or to make telephone calls. I feel* it *must put these people -* I *can imagine myself in that situation.* It *must put these people in a very depressing state to lose all contact with the outside world, especially their families. If we had Aboriginal welfare officers working in the prison - not employed through the bureaucracy of the prison system but employed through the community, not in uniform but just normally dressed people who went out there each da y and had an office- someone for the prisoners to identify with, who could assist them in writing letters, making telephone calls and making contact with their families to see how their families are getting on. I feel that would relieve a lot of the pressure that is put on prisoners in the prisons. Now I appreciate the fact that welfare training for [prison of ficers] may be beneficial in some areas but on a one to one level, Aboriginal people will not identify with non-Aboriginal prison officers on a personal level. I feel this is very important for the future.* (RCIADIC W21:327-328).

Prior to the implementation of the unit management strategy and the concomitant expansion of the role of prison officers, welfare officers performed a vital role in Western Australia's prisons.

Before 1978 (although non-Aboriginal welfare officers had been operating in the Western Australian prison system for many years) there were no Aboriginal welfare officers employed by the Department. Subsequent to 1978 Aboriginal people were employed as welfare officers in the prison system and were stationed both in the metropolitan area at Fremantle and Canning Vale Prisons and at the Regional prisons at Broome, Roebourne and Eastern Goldfields in Kalgoorlie.

At the time that the Department changed to the current system, there were six Aboriginal welfare officers in the employment of the Department. After the change over all welfare officers were given the opportunity to take up positions as prison officers, community based correctional officers or to apply for one of the new Welfare Coordinator's positions. I note that welfare officers continue to be on the staff of prison systems in each of the other states and territories of the Commonwealth. I have serious reservations about their removal from prisons in
this state.

The death of Graham Walley at Greenough Regional Prison on 23 October 1988 provides an illustration of the potential consequences of removal of welfare officers from prisons. I have already described how on the morning of the day of his death he had become extremely agitated and disturbed. Matters that were of concern to him on that day included a confrontation with a prison officer over provision of sugar for his tea, a mix-up over the calculation of his earliest date of release and the fact that his de facto had taken up with another man and he had not been able to see his children.

By the time of his death welfare officers had been removed from Greenough Regional Prison and prison officers bore the responsibility for the provision of welfare services. There was no-one at the prison that Walley could have confided in other than prison officers, other prisoners and possibly the nurse (who was not on duty). Unfortunately, a decision was made that he be locked alone in his cell and he was later found hanged.

In his finding upon inquest, Coroner Heaney stated, inter alia:

> *Without wishing to be too critical of the individual prison officers present at the time of Graham Walley's death, I would be extremely surprised if a properly trained welfare officer would have failed to recognise that the deceased's behaviour on the morning of 23rd October 1988 as requiring more than merely locking him in his cell for the rest of the day with half hourly checks of his cell.* (W/22/7)

The Coroner also criticised the Department of Corrective Services for dispensing with welfare officers and assigning their functions to prison officers after they had received a four day course. At pl7 of his finding he stated:

> *I find this* to *be absolutely incredible and cannot even begin to comprehend how the Department of Corrections can justify getting prison officers to perform the functions of welfare officers. There appears to me to be an obvious conflict between one's duty as a prison officer and one's duty as a welfare officer ... it is absurd to think that a prison officer can be converted into a welfare officer by way of a four day course.*

I have earlier referred to the report of Professor German which was provided to the Commission in the course of the Walley inquiry. Commenting upon the removal of welfare officers from the Western Australian prison system he stated:

> *I have no doubt at all about the seriousness of the absence of welfare officers. The entire account of this event [the death of Graham Walley] demonstrates that prison officers are not taught to be sensitive to basic elementary psychological matters, and are not in a position to provide the counsel and the empathy that so many of these deprived people require. It is essential - and I would have thought an elementary matter of responsibility and care - that adequately trained welfare officers (counsellors/social workers/or other appropriate professionals) be available to prisoners.* (W/22/25C)

<u>Review of the Provision of Welfare Services to prisoners</u>

During 1989 the Department of Corrective Services undertook an evaluation of the provision of welfare services by prison officers. In the course of that review some 30% of prison officers and prisoners as well as a number of prison administrators and non-uniformed professional staff were interviewed. Aboriginal prisoners were amongst those interviewed.

The results of that review were published in December 1989 in a paper entitled 'Evaluation of Welfare Services Provided By Prison Officers'. That paper listed the specific functions that had previously been carried out by welfare officers as:

- The provision of information to prisoners regarding criminal justice matters such as appeals and the arrangement of bail.
- The orientation of new prisoners to the prison and the prison system.
- The preparation of applications by prisoners for compassionate or special leave.
- Arranging for the collection and security of property.
- Administration of the home leave programme.
- The supervision of telephone calls by or to prisoners.

In addition to these specific functions, the welfare officers also performed what may be described as a 'catchall function' where they would be available to be a confidant for a prisoner's personal problems and a person to whom prisoners could initially direct complaints about the system or simply let off steam over the frustrations of prison life.

The evaluation of the new system conducted by the Department concluded that, given the relatively short period that prison officers have been providing welfare services, implementation of that aspect of their 'enhanced role' was on schedule and was satisfactory. However the published review itself contains a number of observations and findings which indicate that, at least with respect to Aboriginal prisoners, there are significant problems with the new system.

I cite the following extracts from the report:

> *Tribal Aboriginal prisoners may be less confident than other prisoners about approaching prison officers for a welfare matter, and may be more prone to giving a response which minimises problems.* (page 6)
>
> *Sixty five point eight percent (65.8%) of officers cited cultural and linguistic problems and difficulties with the remoteness of families and friends as presenting special difficulties when dealing with Aboriginalprisoner's welfare problems. However,32.2%saidthat Aboriginal prisoners welfare problems do not present any special difficulties.'(page 7)*
>
> *Many prisoners, including tribal Aborigines, are unable to clearly articulate welfare needs or concerns relating to their placement or other prison procedural matters. This argues for a more pro-active approach to welfare (page* 11 - Note: 64.4% of the officers interviewed stated that they did not go looking for welfare work)
>
> *Welfare officers* (who were non-uniformed) *were generally seen by prisoners not to be figures of authority and consequently prisoners are likely to have felt more comfortable asking them for assistance than they might asking a prison officer. Some welfare officers undertook a proactive role* ... (page 12)

1 also note the evidence of Christine Forrest in the Inquiry into the death of Bobby Bates. Ms Forrest is currently the longest serving female Aboriginal prison officer in the state with approximately ten years service. At the time that she gave her evidence she was stationed at Broome Regional Prison having
previously served at Eastern Goldfields Regional Prison:

A lot of Aboriginal people in prison are too frightened to talk to white people. Some used to wait until I came on duty to talk to me. (W/31/21)

There is an obvious conflict between the custodial and disciplinary roles of prison officers and any welfare role that they may perform. Whilst there has been an expansion in the role of the prison officer to encompass welfare matters, this Commission has not been informed of any reduction in the level of the custodial duties of officers to allow time to be devoted to their welfare role.

The Department's own report recognises that it is most unlikely that prisoners will ever see a prison officer in the same supportive light as welfare officers and this is particularly so where Aboriginal prisoners are confronted with nonAboriginal officers. Pan of a welfare officer's role should be to act as an advocate for the prisoners and their interests. This is plainly impractical where the prisoner's interest is in conflict with the actions/duties of the prison officer(s) to whom he or she is now expected to direct their complaints and requests.

As discussed earlier, probationary prison officers receive only one day of training on Aboriginal culture and specific issues that may confront Aboriginal prisoners. Any in-depth understanding and appreciation of cultural difference and the special needs and obligations of Aboriginal prisoners can only come from the officers 'on-the-job' experience. This requires the expenditure of time and effort by individual officers. Although the Commission has received evidence that some officers have developed a high level of rapport with their Aboriginal inmates, that is still a matter of individual choice by those officers.

It is recognised that in the regional prisons where there has traditionally been a reduced level of welfare and other facilities for prisoners (compared with the metropolitan institutions) prison officers have, of necessity, performed aspects of their current welfare role such as assisting prisoners in making contact with their families. However, I emphasise that that has been a matter of *necessity.* It is not to say that those services would not have been better provided by adequately trained and resourced Aboriginal welfare officers.

With the current system it is likely that some officers, due to their personal interest and effort, will bear a greater burden of the welfare role than others of their fellows. Inmates will likely approach those officers who demonstrate a measure of understanding and interest in them and their problems. This leads to an unfair distribution of the welfare work and an increase in the stress level and responsibilities of those particular officers and may affect their ability to effectively carry out all their duties.

It is also likely that members of the Aboriginal Visitors Scheme will be called on by Aboriginal prisoners to assist with some matters which formerly would have been brought to the attention of an Aboriginal welfare officer, for example, contacts with family and complaints about treatment or conditions within the prison. The Commission has received evidence that this has already been the case.

During my sittings in Geraldton in April 1990 evidence was heard from four members of the AVS. Counsel Assisting enquired whether a proportion of the call-outs for the visitors in the Geraldton area related to 'welfare-officer type duties' at the prison . He was informed by the witness that they had:

C A. *Have you raised this problem with, say the authorities at the prison that you're doing welfare type work rather than strictly visitor type work?*

Visitor: *Well, the answer that we've got there is seeing that the officers out there are prison officers they find it difficult at times communicating with Aboriginal prisoners and they can communicate better with us.*

C A: *Yes*

Visitor: *Especially if it's personal matters.*

We have spoken to the superintendent about it on several occasions.

C A: *And what has been the response?*

Visitor: *Well, more or less that the welfare officers have been abolished and they're not doing much about it at this stage.*

The prison authorities are quite happy for it to go along the way it's going with us doing welfare work.

C A: *Yes. But are you quite happy with it going along this way?*

Visitor: *Well, it's taxing us a bit more but so far we're handling it - most of us are handling it all right.* (RCIADIC W22:21)

The point to be made is not whether members of the AVS can cope with performing the function of a prison welfare officer but that they should not have to adopt that role., It was never the intention of the scheme that visitors should, in a de facto sense, take over the functions formerly performed by Aboriginal welfare officers, nor would such a move have been a consideration of the Department in reaching its decision to expand the role of prison officers to include welfare matters.

What the evidence cited above indicates is that the removal of Aboriginal welfare officers from prisons has left a vacuum that ordinary prison officers have not and likely cannot entirely fill. In some measure the Department of Corrective Services has abdicated its responsibility to provide adequate welfare services to the Aboriginal members of the prison population.

As stated earlier, the Department currently employs only nine Aboriginal prison officers. Were there a proportion of Aboriginal officers commensurate with the proportion of Aboriginal prisoners it is possible that the welfare needs of those prisoners would be more adequately catered for by the current system. However the problems of Aboriginal staff exercising western style authority over their fellows and the potential conflicts due to cultural matters such as obligation and avoidance relationships must be kept in mind.

Perhaps it is too early to be conclusive on this issue, however, it is considered that given the minimal training that prison officers receive in Aboriginal cultural matters allied with the removal of Aboriginal welfare officers from the prison system, one cannot be satisfied that the welfare needs of Aboriginal prisoners from people who live in remote areas to those who live in urban settings - are currently being satisfactorily met.

It appears that the decision of the Department to transfer the primary responsibility for the provision of the welfare needs of prisoners to prison officers as part of their 'enhanced role' has occurred at the expense of and, it appears, without due consideration for the special needs of many of the Aboriginal prison population. The decision after 1978 to employ Aboriginal welfare officers resulted from the recognition that Aboriginal prisoners had special needs and requirements. A decision taken less than ten years later to

abolish the position of welfare officer in the prison system can only appear as a backwards step.

Retention of Aboriginal welfare officers in all prisons would have better ensured the maintenance of adequate communication between prisoners and the prison authorities and a greater level of comfort and security for prisoners and their families.

It should also not be forgotten that the Aboriginal welfare officers served as a resource for prison officers in increasing their level of understanding of and means of effectively interacting with Aboriginal inmates. Such a resource has now been lost to the prison system in this state.

Welfare Services - What may be done?

The NAILSS Report Into the Western Australian Prison System observed that there are two conflicting views as to the nature of imprisonment for Aboriginal people and the services offered to Aboriginal people in prison. Their report described the first as:

> *... that although [one] may seek to make prisons a more humane place and although one may provide special services within the dominant structure directed towards Aboriginal prisoners nevertheless the control of service delivery to those prisoners lies with those with the power within the dominant culture.* (p5 8)

The contrasting view endorsed by NAILSS (and this Commission) is:

> *... that it is essential that there be a return of power to indigenous people for the control of their own lives and that part of this process involves the provision of indigenous organisations or services to indigenous people within a prison system. (p58)*

At the commencement of this section I quoted from the evidence of Mr A.G. Davies where he suggested that the responsibility for the provision of welfare services to Aboriginal inmates be in the hands of Aboriginal community organisations, independent of the Department of Corrective Services. An example of the practical operation of such a scheme may be found in the experience of a Canadian Indian community Organisation.

In section 5.3.1 of this Report I referred to the activities of the Native Counselling Services of Alberta (NCSA). One of those activities is the Native Liaison Officer programme. A description of that programme is contained in the draft paper by Kayleen Hazelhurst referred to above. It provides a valuable base for the consideration of the introduction of similar schemes for Australia's indigenous peoples.

- In 1972, NCSA signed a contract with the Canadian Penitentiary Service to provide the first native liaison service in Canada ... Soon after NCSA set up its own training package for liaison staff. This package was later presented as a series of workshops across Canada to train Native Liaison Officers from other provinces ... In 1973, NCSA signed a second contract, this time with the Alberta Correctional Institution.

- The Native Liaison Officer programme provides a network of ongoing services between Native inmates, their family, institutional staff and the general community. These groups provide the initial support system - the base from which inmates can begin their self development. (From the Native Counselling Story. Unpublished manuscript by the NCSA, Edmonton, quoted in Hazelhurst.)

The functions of the Native Liaison Officer are in many respects similar to those formerly performed by Aboriginal welfare officers. However, as a division of an indigenous people's Organisation their role encompasses broader considerations than 'pure welfare matters'.

Native Liaison Officers are to:

- provide liaison and communication between Native inmates, institutional staff, the family/community and outside agencies;
- assist in case planning for the Native offender with prison staff,
- provide explanations to inmates on institutional regulations;
- provide legal education and employment information;
- offer support at disciplinary hearings;
- help fill in applications for Parole and temporary absences;
- act as escorts on temporary absences;
- counsel inmates on personal, family, and other problems;
- increase the awareness of native needs in institutional staff,
- help set up relevant programmes for native inmates within institutions i.e. alcohol education, legal education, employment skills, family and life skills;
- facilitate special programmes for Native inmates, such as cultural awareness, language classes, elder contact and sacred ceremonies.

It may be unrealistic to expect the Department of Corrective Services to reverse its current policy and reinstate welfare officers (as staff of the department) in prisons in this state. However, I consider that the need for special services to Aboriginal prisoners such as those provided by the Native Liaison Officers in Canada is both real and a matter that is not adequately addressed by current policies.

Careful consideration should be given to the introduction of Aboriginal service programmes delivered by Aboriginal people along similar lines to the Native Liaison Officer scheme of the NCSA.

I note the suggestion contained in the NAILSS 'Report Into the Western Australian Prison System' that:

> ... *there is scope within the AVS to expand its role given proper funding and infrastructure support, so that it can become an indigenous community based service offered to the Department of Corrective Services.* (NAILSS 1990:5 1)

NAILSS suggests that an 'expanded' AVS could be based upon the same lines as the NCSA in Canada. However, I consider that there are a number of difficulties in such a proposal. Many current members of AVS are in full or part time employment, they are voluntary participants in the scheme and may be unable or unwilling to take on full time positions in an expanded programme. Extensive staff training will be required and even with a scheme such as that operated by the NCSA, there will still be the need for visitors

to attend police lockups and for an after-hours crisis service to be available for prison inmates. It may well be that a new organisational structure will need to be devised from the ground up. The nature of such an Organisation is for the determination of Aboriginal people themselves, although, obviously, the cooperation of and extensive consultation with Government will need to take place before any such programme could be implemented.

5.3.6.3 Aboriginal Visitors Scheme

The Aboriginal Visitors Scheme (AVS) is currently operating at the following prisons: Fremantle, Bandyup, Canning Vale, C.W. Campbell Remand Centre, Greenough, Eastern Goldfields and Broome prisons. I have examined the establishment and function of the AVS in detail in section 5.2.11 of this Report and again, I refer to the discussion of the AVS contained in the Report of my colleague Commissioner Dodson.

At Canning Vale and Bandyup prisons and at the C.W. Campbell Remand Centre special arrangements have been made between the superintendents of the prisons and the coordinator of the scheme to restrict visits to certain days of the week. At other prisons visitors are entitled to gain access at any time provided that the superintendent considers that the right of entry or continuance of a visit does not unreasonably interfere with the prison's operational requirements.

Generally visits occur during normal working hours and presently occur in three ways:

- On the request of a prisoner.
- At the request of the superintendent or a prison officer.
- Random visits carried out by the visitors. Except at those prisons where special arrangements have been made, visitors have the right to visit prisons without notice providing their attendance does not disrupt the normal and orderly functioning of the prison.

The NAILSS survey of Aboriginal prisoners found a high level of satisfaction with the service provided by the AVS. Although only 40.1% of the prisoners surveyed had used the services of the scheme this may largely be due to the fact that it is yet to commence operation in a number of prisons. Of those prisoners who had had contact with the AVS 49.4% found the service very helpful with an additional 30.5% describing the contact as helpful. Only 4.5% found the assistance of the AVS unhelpful or very unhelpful (NAILSS - A Report Into the Western Australian Prison System at p 53).

On the evidence before this Commission I consider that the scheme has been of great benefit both to prisoners and custodial staff at those institutions at which it is operational. The extension of the scheme to all regional prisons should be a matter of priority. Continued support to communities in which prisons are located is required to ensure the continued viability of the scheme.

It has been noted that one of the problems confronting visitors has been a lack of knowledge about the functioning of the prison system. 'Mere needs to be greater training for visitors and the opportunity for refresher training or updates in prison procedures, the duties of prison officers and the rights of prisoners. Prison officer training should include information on the operation of the scheme and the relevant rights and duties of visitors,

officers and prisoners. Such training should be included in the Probationary Prison Officer's Course.

I have noted that the nature of the work of the visitors is such that some welfare issues are inevitable and must be dealt with by the visitor. Had the scheme been in existence before the transfer of welfare responsibilities in prisons to prison officers, it would have been possible to assess whether the removal of Aboriginal welfare officers led to any increase in demand by prisoners on visitors for welfare type assistance. Unfortunately this is not the case. What has been the case is that AVS members are being called upon to deal with substantial numbers of welfare matters by Aboriginal prisoners.

5.3.6.4 Other Prisoners

The general importance for Aboriginal prisoners to be able to associate with each other cannot be over-estimated. All prisons should have facilities for shared accommodation for Aboriginal prisoners and where possible (and at request) prisoners from the same tribal or family grouping should be accommodated together. The importance of the support of other Aboriginal prisoners at times of personal crisis has already been emphasised in section 5.3.4 of this Report. Where security arrangements allow, transfer of prisoners to institutions where they have other family or kin should be encouraged.

Prison officers and administrators should also be aware of Aboriginal kinship customs such as avoidance relationships. These are observed between certain kin, notably in-laws. People who have an avoidance relationship may not normally speak or even look at one another. This may cause considerable problems for Aboriginal people within the close confines of a prison. Awareness of the terms of such relationships will avoid misunderstandings should an Aboriginal prisoner request a change of cell or job due to the existence of an avoidance relationship with a fellow prisoner.

5.3.6.5 Visiting Justices - Internal Discipline

Prison offences under the Prisons Act 1981 are divided into two categories: Minor Prison Offences and Aggravated Prison Offences. Section 69 of the Act sets out the minor prison offences which include matters such as disobeying a rule or standing order of a prison or the lawful order of a prisoner officer, idleness or negligence in work, behaving in a disorderly manner or swearing and insubordination or misconduct 'subversive' of the order or good government of a prison.

Section 70 sets out aggravated prison offences which include assaults, possession of drugs (including alcohol), escapes and attempted escapes and possession of weapons.

Charges of minor prison offences may be heard and determined by the Superintendent or a Visiting Justice appointed under the Prisons Act. A Visiting Justice may be a Magistrate or a Justice of the Peace. Currently there are forty Visiting Justices appointed to institutions throughout the state. It is noted that no Aboriginal persons have been appointed as Visiting Justices. Aggravated prison offences must be heard by a magistrate or two justices.

In the case of aggravated prison offences the prisoner may be legally represented, however Section 76 (1) of the Prisons Act provides that in the case of a minor prison offence a prisoner shall not be represented by a legal practitioner. However subsection (2) of that Section provides that where the Superintendent or Visiting Justice are satisfied that the prisoner does not sufficiently understand the nature of the charge or the

proceedings then they may appoint or nominate a person (not a legal practitioner) agreed to by the prisoner to assist him.

In determining a charge of a minor prison offence the Superintendent or Visiting justice are not bound by the rules of evidence. A prisoner's only avenue of appeal from the decision of a visiting justice in such a matter is by way of the Royal Prerogative where the rules of natural justice have been breached. It is the Ombudsman's view that review of the decisions of a Visiting Justice is outside his jurisdiction.

This report has already considered the difficulties faced by many Aboriginal people in understanding the nature of proceedings in Courts of Petty Sessions and superior courts. Similar difficulties are likely to be experienced by many prisoners charged with minor prison offences, Aboriginal prisoners may be particularly disadvantaged. It should be a standard requirement of justice that where a person is charged with an offence upon conviction of which they are liable to the imposition of a penalty, they be entitled to be legally represented at the hearing of that charge by a legal practicioner of their choice should they so wish.

There appears to be no justification for denial of legal representation to prisoners charged with minor prison offences beyond the 'convenience' of the prison administration. It is recommended that the Prisons Act 1981 be amended to provide for a prisoner's right to be legally represented at the hearing of both minor and aggravated prison offences.

5.3.6.6 Aboriginal Legal Service

Section 62 (1) of the Prisons Act 1981 provides that for the purposes of pending legal proceedings a legal practitioner may interview their client at a reasonable hour or as otherwise authorised by the Superintendent, within the view but not the hearing of a prison officer. Subsection (2) of that section further provides for a legal practitioner to interview a prisoner for 'a bona fide purpose'. What constitutes a 'bona fide purpose' is not defined in the Act.

The Department has advised the Commission that in the event of a request from either a prisoner or the Aboriginal Legal Service its policy is to facilitate contact between the parties.

Given the reliance of the Aboriginal Legal Service on court officers who are not formally legally qualified in addition to solicitors it is important that the visiting rights granted legal practitioners by section 62 be extended to court officers. It is understood that in practice this is the case but it is recommended that such practice be formally recognised either in the Act or the Executive Director's Rules.

5.3.7 ACTIVITIES

5.3.7.1 Employment

The provision of work opportunities within prisons through which a prisoner may learn skills and gain self confidence may help to raise self esteem and help alleviate the boredom and frustration of confinement.

The Department of Corrective Services has supplied the Commission with statistics concerning prisoner employment. As at 18 July 1990 there were 459 Aboriginal prisoners

engaged in work out of a total Aboriginal prisoner population of 600. The figures for non-Aboriginal prisoners were 907 engaged in work out of a total of 1140.

There are five broad categories of prison work in Western Australia:

- Primary industries (cattle, sheep, vegetables etc.)

- Secondary industries (carpentry, metal work, tailoring, laundries, auto repair etc.)

- Community work (delivery of goods, clearing of road verges etc).

- Domestic prison work (cooking, cleaning etc.)

- Cottage industries (arts and crafts etc.)

There are five different pay rates for prisoners varied as a function of the level of skill required to perform the job. The rates vary from $1 1 to $35 per week.

Over the years a number of observers have commented that Aboriginal prisoners have tended to be employed in the 'worst' jobs in prison. This has in part been seen as due to racist attitudes of prison officials and as a reflection of their generally lower socioeconomic position outside of prison. This Commission has not taken any evidence on this matter, however, in their answers to a list of questions supplied to the Commission the Department stated:

> *In general it has been observed that Aboriginal prisoners show a preference for working out of doors in jobs where groups of prisoners work together. Examples of this type of work include garden parties, concrete products, farm work and outside work gangs ...*

(Department of Corrective Services answers to specific questions from RCIADIC, p23)

It is the policy of the Department that race is not to be considered as a factor in determining work placement except to the extent that account may be taken of a request by an Aboriginal prisoner to work with another Aboriginal prisoner or prisoners.

The Department's Skills Development Team operates an employment training section designed to assist prisoners in the development of vocational skills and job search techniques. As part of the programme prisoners may participate in formal apprenticeship trade training programmes, short term vocational courses and vocational assessment. This programme is aimed at all adult prisoners. Currently approximately 15-20% of the users are Aboriginal. Apprenticeship programmes are of course only available to long term prisoners. All prisons have at least one trade training option.

It should be noted that vocational counselling is available to all prisoners in metropolitan and outer metropolitan prisons, though not in the regional prisons (most of which have a majority Aboriginal prisoner population).

In the education area, funding for courses for Aboriginal prisoners is provided by the Department of Employment, Education and Training. Many courses are provided by external tutors from TAFE colleges. Subjects which have been taught include landscape gardening, hair cutting, leatherwork and welding. One must question whether all of those topics are appropriate for Aboriginal prisoners, particularly those from remote areas.

5.3.7.2 Prisoner Education and Skills Training

For some time it has been standard policy and accepted practice that prisons offer some degree of educational opportunity for inmates. Prison education programmes need to be sensitive to, and to provide for, the special needs of Aboriginal prisoners and be relevant to their particular (and differing) cultural and life experience. In this regard there has been significant progress made by the Department of Corrective Services.

The Department's Education Policy lists a number of objectives:

> *Objective 6*
> *To provide adequate and relevant educational opportunities for prisoners recognising the overall educational deficiencies of the prisoner population.*

The policy includes the aim:

> *To develop prisoner social skills and personal growth including those of Aboriginals and migrants.*

It is positively noted that all prisoners may volunteer to utilise the Department's education services and that these services may not be withdrawn as a form of punishment. In addition, the Department categorises prisoner education as a form of prison work and it is accorded similar status and remuneration. It is possible for a prisoner to be engaged in full time study. However, again I would remark on the concentration of resources in the metropolitan prisons with the consequent disadvantage to persons serving sentence in regional institutions.

The implementation of the Department's education policy is the responsibility of the Offender Development Programme Education Team (the 'Education Team). The current implementation plan of the education team appropriately includes the intention to give resource priority to the identified special needs of minority groups including Aboriginals. The plan further recognises the continued use of Aboriginal languages and differing Aboriginal learning styles. Finally, the Education Team's Implementation plan records that the team *'seeks to promote Aboriginality as defined by Aboriginal offenders themselves'.*

As at March 1990, a total of 558 prisoners attended classes throughout the State. Of these, 220 (39%) were Aboriginal. The Department identified to the Commission particular educational needs of Aboriginal prisoners in the areas of literacy, numeracy, driver training, alcohol and substance abuse, social skills training and work skills training.

Literacy

In November 1989 the Department commenced a literacy screening programme for all prisoners serving effective sentences of six months or longer. The screening is carried out at all prisons with the exception of Wyndham and the C.W. Campbell Remand Centre. Tuition in literacy is now available at all prisons.

Wholly Aboriginal literacy classes are held at Fremantle, Albany, Broome, Eastern Goldfields, Greenough, Canning Vale, Bunbury and Roebourne Prisons.

It is positive to note that at Eastern Goldfields Regional Prison a local linguist attends the prison once a week and takes native speakers of Wangkatja and teaches them to read and write in their own language.

Numeracy

General class tuition is available at all prisons with the exception of Wyndham. Wholly Aboriginal classes are held at Canning Vale, Greenough, Eastern Goldfields, Bunbury and Fremantle Prisons.

As at March 1990, 173 prisoners were attending literacy and numeracy classes, of these seventy-six (44%) were Aboriginal. A total of seven Aboriginal tutors work in prison education centres: two at Fremantle, three at Canning Vale, one at Albany and one at Eastern Goldfields.

The Department also employs a full time Aboriginal Education Officer at Canning Vale. Agencies such as the Department of Employment Education and Training, The Western Australian College of Advanced Education and TAFE Aboriginal Access provide Aboriginal input for Education Team programmes.

Driver Training

Theory instruction is available at au prisons, practical instruction is available at all prisons except Fremantle, Canning Vale, C.W. Campbell Remand Centre and Wyndham. (Note: to be eligible for practical instruction a prisoner must not be disqualified from holding a drivers' licence). Due to practical considerations, prisoners serving sentences of less than three months cannot participate in practical instruction.

Alcohol and Substance Abuse

Substance Abuse Team's programmes are available at Fremantle, Canning Vale, Bandyup, Karnet and Wooroloo. They are not available at country prisons. The Education Team offers an Aboriginal Alcohol Education course package at all prisons with the exception of Wyndham (subject to demand and resource availability).

Aboriginal involvement in these programmes is mainly confined to the alcohol programme. In a course held on alcohol abuse at Fremantle prison in 1990, 80% of the participants were Aboriginal.

Women prisoners at Bandyup are offered educational awareness programmes featuring the medical, family and general health issues associated with alcohol abuse. It is the policy of the Department to facilitate Alcoholics Anonymous programmes where the local 'AA' chapter and prisoners are willing to attend.

One Aboriginal consultant and facilitator is used by the Substance Abuse Team.

Social Skills Training

Skills Development Team programmes (lifestyle/fitness/recreation) are offered to all prisoners at Bandyup, Wooroloo, Karnet, Fremantle and Canning Vale.

Wholly Aboriginal courses in self-esteem are offered at Canning Vale and Bandyup.

As at June 1990, life skills courses were under way at Canning Vale and Broome Prisons each involving ten Aboriginal prisoners.

One Aboriginal research assistant has been used by the Skills Development Team.

In addition to the above programmes, Oral Aboriginal history, Aboriginal current affairs, Aboriginal media, Aboriginal studies and Aboriginal art are part of the programmes of most prison education centres. 'Me tutors in these subjects are in the main Aboriginal people with the required expertise however some nonAboriginal tutors are used.

Observations that should be made in relation to the provision of education and skills training to Aboriginal prisoners are:

1. The reduced level of resources available to prisoners held at country institutions. Prisoners from the East Kimberley held at Wyndham Regional Prison are a case in point. There can be no reason (other than financial constraints) why inmates of regional prisons should be denied equal access to services offered by the Department with those held in the metropolitan area.

2. Aboriginal input into the development of programmes for Aboriginal prisoners is essential. Where possible, tuition to Aboriginal prisoners should be by suitably qualified Aboriginal persons. These are both matters for the Department's continued attention.

5.4 HEALTH

5.4.1 RISK OF DEATH IN CUSTODY

5.4.1.1 Health Status of Aborigines in Western Australia

In this section I will discuss issues pertaining to the general health of Aboriginal persons detained in custody. Many aspects of this subject have already been discussed in the sections concerning prevention of death in police and prison custody (5.2 and 5.3).

To aid the Commission in its understanding of prisoner health and to place this issue in perspective against the broader picture of Aboriginal health, Dr Neil Thomson, Head of the Aboriginal Health Unit at the Australian Institute of Health, has produced a report entitled 'Review of Aboriginal Health Status Western Australia'. Like many researchers before him, Dr Thomson concludes that the magnitude of health problems experienced by Aboriginals in Western Australia justifies recognition of Aboriginal ill health 'as a priority area for immediate action'.

A summary of the relevant findings include:

- Aboriginal mortality in 1985-86 was 2.5 to 3 times that of the total Australian population and Aboriginals could expect to live about 18 years less than other Western Australians. The greatest difference between Aboriginal and non-Aboriginal death rates is found among young and middle aged adults.

- Aboriginal death rates in 1985-86 in infancy and early childhood are much lower than those in developing countries. However, beyond the teenage years the position is reversed, with death rates for young and middle aged Aboriginal adults, particularly males, being higher than 'developing countries'. The countries referred to however are not defined.

- The major cause of Aboriginal deaths (males and females) was disease of the circulatory system. Deaths from these diseases (including ischaemic and other heart

disease) are more than twice those of other Western Australians (ICD Classification used).

- The second most frequent cause of death for Aboriginal males, and third most frequent cause for Aboriginal females, is 'External causes of injury and poisoning' which includes motor vehicle and other accidents; suicide and self-inflicted injury; and homicide and injury purposefully inflicted by others. Deaths from these causes are more than three times more frequent than expected from total West Australian rates.

- Suicide and self-inflicted injuries and the impact of alcohol on cause of death are likely to be under-reported.

- Aboriginals in 1988 were admitted to hospital in Western Australia 2.5 to 3 times more frequently than non-Aboriginals, with the greatest difference found among young and middle aged adults. The leading cause of hospitalisation was disease of the respiratory system with more than half of the admissions contributed by the 0-4 year age group. External causes of injury and poisoning contributed the next highest number of admissions.

- Dr Thomson briefly reviews social and economic disadvantages of Aboriginal people which are reflected in 'selected social indicators' education, employment, economic status and housing. Results include data such as in 1987 almost a third of all Aboriginals in Australia were homeless or living in inadequate accommodation.

5.4.1.2 Medical Histories of Individuals

Charles Michael (W/I)

Charles Michael died in 1984 aged 31 years of mycocardial infarction. There was extensive focal old ischaemic scarring at autopsy and gross atherosclerosis of all branches of the coronary arterial system. Charles was prescribed Tryptanol - to control depressive illness and referred to visiting psychiatrists by P.M.S. In July 1984 he was diagnosed a diabetic - for which he was treated and his progress monitored. He suffered pneumonia at age three months.

Robert Walker W12)

Despite alcohol and illicit drug use, Walker was physically fit. In 1982 he was admitted to hospital for suspected drug induced psychosis. He appears to have suffered hallucinations, often related to drug usage. His death at age 25 years was due to asphyxia. The heart was healthy on post mortem examination.

Christine Jones (W/3)

Christine Jones had pre-existing brain damage from chronic alcohol abuse at the time of her death at age 21 years due to compression of the neck from partial suspension. There are no records of Christine Jones receiving hospital care (apart from hospitalisation for the birth of her two children) and no history of psychiatric care in spite of instances of self-mutilation. On post mortem examination her coronary arteries and aorta were healthy.

Wayne Dooler W/4)

Wayne Dooler was treated for pneumonia in 1980 (the year of his death). The coronary arteries on post mortem examination showed early atheromateous plaque formation causing occlusion of no more that 10% of the origin and elsewhere being only minimal. Death was due to acute alcohol poisoning at age 19 years.

Paul Fanner (W/5)

Paul Fanner's Department of Corrective Services records reveal five incidents of self harm during the period of imprisonment from June 1981 to his death in July 1984 at age 33 years having cut his throat with a razor blade. He was seen by a psychiatrist in 1981 who made a primary diagnosis of schizophrenic illness. The Psychiatric Superintendent of Graylands certified Farmer as suffering from a mental disorder and he was admitted under the Mental Health Act. He escaped from Graylands in 1981 and was recaptured 7 months later. Subsequently a visiting clinical psychologist did not find any evidence that Fanner was psychotic or delusional and Fanner spoke at length about spiritual healing practices of his people. In 1982 following discovery of razor blades hidden in his sock in his cell he received treatment from sessional psychiatrists and was prescribed Thioridazine (an anti-psychotic drug) which was administered until his death. His medication was reviewed in 1983 following reports of tiredness and lethargy. It appears that no psychiatric review was perfomed for the twelve months prior to his death in July 1984. The psychiatrists involved in treating Fanner and the specialists who provided opinions to the Commission agreed that Fanner had a significant mental illness with elements of depression and psychotic disturbance. The description of his illness differed from 'schizo-affective illness' to 'psychotic depression'. The coronary arteries, valves and aorta were healthy at autopsy.

Darryl Garlett (W/7)

Darryl Garlett was generally speaking a relatively healthy, fit young man apart from coronary artery disease which apparently developed over a considerable period of time and remained undiagnosed and symptom free until shortly before his demise at age 26 years due to the disease. Post mortem examination revealed moderate to severe atheroma with substantial narrowing of lumen. He was treated in hospital for pneumonia in 1979, the year before his death.

Jimmy Njanji-(W/8)

Jimmy Njanji suffered from diabetes which was first diagnosed in 1981 although high blood sugars had been noted on hospital admissions in 1979. He achieved poor control because (according to medical records) he did not follow instructions and was reluctant to seek medical assistance. Public Health Department records for Njanji include referrals to eye specialist for 'blurred vision' in 1979. He was treated at Port Hedland Regional Hospital for bronchopneumonia in the same year and for pneumonia in 1981. The cause of cellulitis resulting in death went unrecognised. He died in 1985 aged approximately 55 years. The heart on post mortem was normal in size and shape: coronary arteries revealed moderate atherosclerosis, without significant calcification and no occlusions demonstrated.

The Aboriginal man who-died at Sir Charles Gairdner Hospital(W/9)

The Aboriginal man who died at Sir Charles Gairdner Hospital suffered pneumonia in 1975 at age one. He was hospitalised on five occasions from 1975-1981 for relatively minor ailments. He was described by his father as 'a fit and strong boy all his life'. A notation in the Roebourne Hospital file (1979) noted: deceased considered at risk for Hansen's disease (leprosy) and trachoma but was otherwise a 'healthy fellow with no problems'. He died at age 25 of tuberculosis. The heart was normal and the major views and arteries healthy on post mortem.

Nita Blankett (W/10)

Nita Blankett's death at age 41 years was due to acute bronchial asthma which was chronic and had been poorly controlled for at least twelve years prior to death. Her condition required repeated emergency attendances at hospitals, A.M.S. and Community Health. She also suffered from obesity, chronic middle ear infection and depression for which she was prescribed Amitriptyline. On post mortem her heart and coronary valves were healthy.

Albert Dougal (W/11)

Albert Dougal suffered from rheumatic fever and pneumonia as a child. In 1977 he was diagnosed as suffering from aortic incompetence and thereafter had a number of admissions to hospital for chest and heart related complaints. In September 1980 he was admitted to hospital suffering from alcoholic gastritis and rheumatic heart disease. His death at age 24 years was due to compression of the respiratory centre of the brain. At post mortem he had an enlarged heart probably due to old rheumatic fever. There was minimal atheromatous streaking in the aorta, indicative of heart disease.

Hugh Wodul an (W/12)

Hugh Wodulan suffered from chronic alcohol abuse. He was admitted to hospital in 1983 with alcoholic hallucinosis. In the 10 years prior to death he suffered a series of moderate and minor injuries: wounds from motor vehicle accidents and fractures mostly related to alcohol consumption. The Commission received a psychiatric assessment which described Wodulan as 'the type of early psycho social environment associated with personality disorder in adulthood'. He died at age 30 due to compression of the carotid arteries when he suspended himself by the neck. The heart at post mortem examination was normal.

Stanley Brown (W/13)

Stanley Brown medical records indicate that he received medical attention for loss of consciousness or fitting associated with alcohol abuse. Brown died from hanging aged 42 years. However on post mortem there was severe focal atherosclerosis with 85% occlusion of the right coronary artery by soft fibrous atheromatous plaque. Dr Hilton was of the view that 'If *I had not been given any information or history when the body had been presented* to *me* ... *I might well have said that the cause of death was coronary artery disease' (RCIADIC* W13:637). There was evidence of old traumatic injury to the brain which would have pre-disposed the deceased to epilepsy.

Misel Waigana (W/14)

Misel Waigana's Health Department records which date from 1976, note many admissions to hospital, often in a drunken state or suffering from alcohol-related conditions such as 'epigastric pain', 'laceration to left knee having been struck by a bottle', 'haematemesis'. In December 1985 a left parietal craniotomy was performed and an intracerebral haematoma evacuated. In 1986 he was prescribed Dilantin to control epilepsy. He was poorly compliant with medication. In August 1986 he was admitted to hospital for treatment of chronic alcohol abuse and gastritis. He also suffered cardiac arrhythmia and from Hepatitis B. He died aged 39 years of delirium tremens. There was some generalised plaque formation but no measurable occlusion of any major coronary arteries on post mortem.

Benjamin Momson M/15)

Benjamin Morrison received psychiatric treatment on several occasions between 1965 and 1981. Professor German was of the opinion that Morrison suffered from 'mania a potu'. The deceased was also suffering from the early stages of Alzheimers disease. He died at age 55 years of asphyxia due to hanging. The post mortem examination showed a moderate degree of atherosterotic thickening and narrowing of the coronary arteries.

Robert Anderson (W/16)

Robert Anderson suffered from epilepsy for most of his life. He experienced constant problems in complying with medication resulting in periodical fitting. His death at age 27 years was a result of an epileptic attack. On post mortem examination there was minimal atheromatous streaking but no occlusions demonstrated in the coronary arteries.

Bernard McGrath (W/17)

Bernard McGrathhad no records of ill health. His death at age 20 years was due to hanging. I could not conclude that the deceased intended to take his own life. The heart was healthy and the aorta showed minimal atheromatous streaking at autopsy.

Kim Polak (W/18)

Kim Polak's prison medical file includes records from 1980 to 1984 of Polak's symptoms of confusion and hallucinations. He was treated with psychotrophic drugs and periodically referred to visiting prison psychiatrists between 1980 and 1983 who noted evidence of neurological damage, hallucinosis and behavioural disorder due to alcohol withdrawal. In 1981 a diagnosis of schizophrenia was made while Polak was at Graylands Hospital. It appears that he received heavy medication throughout the years that followed often resulting in Parkinsonic signs. Post mortem examination revealed significant alcoholic hepatitis and alcoholic related organic brain damage. The deceased's heart valves were normal and his coronary arteries clear, however his heart was small in comparison to his height and weight. The two most likely causes of his death in 1985 at age 28 years were: alcoholic liver damage and alcoholic withdrawal.

John Pat (W/19)

John Pat died of closed head injuries, he was nearly 17 years of age. On post mortem examination the major arteries and veins of the deceased were healthy.

Edward Cameron (W/20)

Edward Cameron's health records do not reveal any serious illness. His death at age 23 years was due to hanging. On post mortem, examination of the heart there was mild left ventricular hypertrophy at the base of the anterior papillary muscle and minimal atherosclerosis of the aorta.

The Young Man who died in Custody at Geraldton on 31 December 1988 (W/21)

Wongi was hospitalised in 1970 for tympanolplasty as a child and in 1973 for acute glomerulonphtitis. He received an operation in 1979 for recurrent dislocation of the shoulder following injury in a fight. He died at age 28 years from asphyxiation as a result of self-strangulation. There was moderately severe focal atherosclerosis of the coronary arteries on post mortem examination.

Graham Walley (W/22)

Graham Walley's Department of Health file reveals no significant illness or injury. He died aged 21 years having hanged himself using a prison issue belt. On post mortem examination the coronary arteries showed scattered initial plaques, resulting in areas up to approximately 10% narrowing of the vessel lumina. There was mild atherosclerosis streaking of the aorta.

Ginger Samson (W/23)

Ginger Samson was a sufferer of epilepsy, probably of traumatic origin (marked old brain damage with scarred areas). He did not take medication regularly and was poorly compliant. Generally his seizures were of grand mal type and followed periods of heavy drinking. Apart from many hospital admissions for epilepsy, serious conditions include: 1974 - head injuries (laceration requiring five sutures); 1977 and 1978 - head injuries resulting from an assault and motor vehicle accident; 1979 - broncho pneumonia treated with antibiotics; 1982 - right lower lobe pneumonia; 1982 - haematemesis; 1982 - three fractured ribs; 1984 'alcohol overdose' 1985 - bronchitis; 1985 - bilar pneumonia; 1986 - fractured humerus; 1986 - pneumonia; 1986 - post alcoholic fit and bronchitis; 1988 - head injury received in drunken encounter. He died at age 44 years from epilepsy resulting from a closed head injury and excessive alcohol consumption. On post mortem examination the coronary arteries revealed moderately severe atherosclerosis, no occlusion was demonstrated.

Dixon Green (W/24)

Dixon Green's Health Department records reveal little serious illness or disease. He was treated for trachoma in 1976. Post mortem examination revealed two extensive areas of

white scarring of the ventricular myocardium and gross atherosclerosis of the coronary arteries. He died of heart disease at age 25 years.

Donald Harris (W/25)

There are few records of Donald's state of health prior to the diagnosis of acute pancreatitis in 1988 which led to death at age 29 years. At autopsy, examination of the heart revealed marked segmented atherosclerosis of the coronary arteries and aorta.

Steven Michael (W/26)

Steven Michael's health records reveal few serious illnesses or injuries apart from lobe pneumonia in 1986. At autopsy the ventricular myocardium. showed extensive focal old ischaemic scarring at autopsy with gross atherosclerosis of all branches of the coronary arterial system. His death resulted from heart disease at age 29 years.

Ricci Vicenti (W/27)

Little is known of Vicenti's health history apart from scant information contained in prison records. He died at age 19 years following a bullet wound to the brain. At autopsy the coronary arteries were healthy with no atheromatous degeneration.

Ronald Ugle (W/28)

Ronald Ugle was hospitalised for illnesses and trauma resulting from alcohol consumption including: 1977 and 1978 acute pancreatitis, 1967, 1977 alcoholic liver disease/gastritis. A positive tuberculosis test was performed in 1973. He was treated for scabies in 1975. The coronary arteries showed gross focal atherosclerosis, 90% narrowing of anterior descending branch of the left coronary artery at autopsy, which had caused his fatal heart attack at age 53 years.

Donald Chatunalgi W/29

Donald Chatunalgi's Health Department records include hospital admissions for the following: 1980 - (aged 19 years) complaint of epigastric pain after episode of drinking. In 1985 he appears to have experienced his first grand mal epileptic fit, diagnosed as an alcoholic fit. Also in that year he was taken to hospital by his sister. His condition was described as an anxiety state, alcohol induced. In December 1985 he was seen in hospital after suffering a seizure in the creek bed following a bout of drinking. There were no further records of seizures until 1988. The diagnosis then was: alcoholic withdrawal fit, and he was prescribed a tranquilliser. In an admission in 1988 a provisional diagnosis of alcoholic psychosis was made. It is likely that Chatunalgi died immediately after or in the course of an epileptic attack. He was 27 years of age. There was minimal atherosclerosis of the coronary arteries at autopsy.

Faith Barnes (W/30)

Faith Barnes had a history of cardiac bruit and pan systolic murmur. Childhood illnesses were indicative of poverty and poor living conditions including infected wounds, bums, scabies. From 1975 until her death in 1982 she suffered numerous severe assaults often involving head injuries. She was admitted to Kalgoorlie Hospital for head injuries on five occasions, received outpatient treatment on two occasions and was treated at Menzies Nursing Post on nine occasions for head injuries. During this period she also received treatment on numerous occasions for other traumatic injuries to her body such as - infected lacerated left heel, laceration to the forearm, blow to elbow with iron bar, injured right ankle, left leg injury caused by broken bottle, bums on left hand, stab wound to left thigh. The Health File Summary also reveals many attendances at Menzies Nursing Post when inebriated or for hangovers, vomiting, headaches. Faith Barnes received treatment for fits (almost certainly the result of head injuries) and diabetes. In 1982 she was diagnosed as having rheumatic valvular disease, hypertension, diabetes mallitus. She died aged approximately 27 years of severe head injury. On post mortem the major arteries, veins and aorta were noted to be healthy.

Bobby Bates (W/31)

Bobby Bates prior to his death from bronchopneumonia at age 33 years was a young and otherwise healthy male. He was diagnosed as Hepatitis B positive. The post mortem report from the Neuropathology Department, Royal Perth Hospital, showed early acute suppurative leptomeningitis and chronic Wernicks disease. The heart was healthy at autopsy.

Roy Walker (W/32)

Roy Walker's Health Department file reveals that in his early years he was a fit, strong, healthy person. In 1972 a chest X-ray records the heart as grossly enlarged. In 1975 an X-ray of his knees is recorded to be consistent with osteoarthritis. In 1978 he was admitted to hospital for gangrene of the right little toe and in 1980 hospitalised for right pneumothrax. He died in 1981 aged 62 years, following an operation to relieve the effects of a serious head injury likely suffered as a result of a fall while affected by liquor. On post mortem examination the coronary arteries both showed calcification atheroma with narrowing of their lumina to less than half of their normal diameter. The aorta showed moderate atheroma.

Milton Wells (W/33)

Milton Wells' Health Department records show treatment for injuries and illnesses including lacerated left wrist (1976), puncture wound to the forehead (1976), fractured jaw (1979), recurrent swelling of the jaw (1979), bruising and lacerations following being struck by cars (February and December 1982), dislocated shoulder (1983), head lice (1984), in December 1982 he was admitted to hospital for right lower lobe pneumonia, and in March 1984 for detoxification for alcoholism. He died from acute meningitis associated with lobar pneumonia, aged 30 years. At autopsy the myocardium showed no disease, atheromatous plaque formation was not infrequent in all major vessels but there was no calcification or significant occlusion.

5.4.1.3 Impact of ill health on the custodial experience

The general picture from the health histories of the 32 deceased is, as predicted by Commissioner Muirhead:

> *Consistent with the experience and studies emerging over many years, of Aboriginal people suffering ill-health* to *a degree significantly greater than that experienced within the general community* (RCIADIC Interim Report, 1989:53).

The Commissioner adhered that the combination of detention of Aboriginal people in custody in grossly disproportionate numbers and the general picture of ill-health has meant that there is a significantly greater risk of illness or death occurring during the incarceration of Aboriginal people (RCIADIC Interim Report, 1989:53).

The picture of the inhabitants of police lockups being more likely to include people in a state of chronic ill health and those entering prison often being in a debilitated state of health, is illustrated by the following evidence:

> *Most prisoners on entering prison are in a debilitated state largely through alcohol abuse. They are permanently* not *well, with a prisoner coming into prison with a viral type infection or flu we would, as a general rule, give an antibiotic. This was because due to the debilitated state of health of most prisoners and because of the cold cell type conditions quick recoveries were often not made. I would estimate* that at *least 60% of patients developed complications in prison from these type of infections. Many of the prisoners came into prison from sleeping on the ground - the conditions are as low as you can get - not even in tents. They don't come in in good shape which is often as a result of an alcohol binge* (Statement of Jon Dadd 8 June 1990, a Prison Medical Officer Eastern Goldfields Regional Prison April 1984 to January 1989 W/31/17)
>
> Q. *Can you say whether the people who are in the lockup are often chronically ill people, people who not only have serious alcohol problems but that have got serious life style problems?*
>
> A. *If they are not eating enough they are prone to pick up diseases or infections. They might be diabetic or epileptics and* that *sort of thing. They are living in very poor circumstances outside.*
>
> Q. *Is that the case in the lockup as far as you know?*
>
> A. *Yes* (Henry Councillor, Administrative Officer of the AMS, Halls Creek, T95)
>
> Q. *Often the prisoners you would have in the lockup would be not very healthy people?*
>
> A. *No they wouldn't be healthy people.*
>
> Q. *You would have a lot of the fringe dwelling people?*
>
> A. *The bulk of them who go in and out ... would be the same handful over and over and over.*
>
> Q. *Often these people would have health problems?*
>
> A. *Yes* (RCIADIC W18:113).

Specific aspects of Aboriginal ill health and the way in which these may manifest in both prisoners' custodial experience and in the responsibilities of custodians themselves are discussed in many other sections of my Report. Examples of the variety of such issues include the following:

- custodial methods for assessing the health of prisoners (5.2.2, 5.3.2),
- training of custodians in health issues (5.2.8, 5.3.2),
- the impact of cultural differences in relation to the seeking and receipt of medical services (5.3.2, 5.4.3, 5.4.4),
- the implementation of preventative measures by custodians where system inadequacies have been revealed,
- consideration of health conditions in the sentencing and placement of prisoners (5.3.6),
- the involvement of Aboriginal healers in the custodial setting (5.4.3, 5.4.4),
- detention of prisoners in unmanned police lockups (5.2.1, 5.2.5).
- the impact of the closed custodial environment on the delivery of medical services (5.3.3),
- petrol sniffing - although not discussed elsewhere this issue is referred to in the evidence of Superintendent Donovan before Commissioner Dodson.

An issue often forgotten when examining the impact of a prisoner's ill health is the effect a serious illness or death may have on other prisoners in an institution and on the custodians involved in an emergency health situation. The following extracts are illustrative:

> *The next time I heard of Michael was from the nurse who contacted me at home* (it was Saturday) *saying that he had been taken to hospital. I rang the hospital and found out he had died. My primary motivation for coming into the prison on that day was knowing that the prisoners would be upset. Initially I asked permission to speak to the football team. The nurse was also upset because you often see it as a failure when some one dies. I went to the prison as part of the support system. I went down to the blocks and talked to the prisoners.* **I** *told the prisoners that Michael had died. They were upset because they thought we'd done him in. The football team were particularly angry and anxious. They thought we hadn't done enough to save his life. I tried to reassure the prisoners. The gate occurrence book shows that* **I** *was* **at** *the prison for about 2 hours and I accept this.* (Statement of Dr Elizabeth Smith, Prison Medical Officer, Canning Vale Prison, in the case of Steven Michael)
>
> *I checked his passageway, there was a small amount of blood and vomit coming from his mouth ... I wiped his mouth with a tissue, I thought of giving him mouth to mouth resuscitation but I thought if I did this I might force any further vomit that may have been in his throat back into his throat or lungs and either choke him or cause even more damage or problems ... I was in a state of shock I have never had someone die in my custody or even look like dying, I wanted to help Donald but I was scared that I was doing or would do the wrong thing to him.* (RCIADIC W29:3).

These illustrations show the need for mechanisms to be in place to promptly disseminate to other prisoners as much accurate information concerning a death as is possible. In addition resources must be available to aid in counselling where necessary those involved in the circumstances of death.

The general picture of chronic ill health of Aboriginal prisoners presents special needs and obligations that must be met by custodians. It is also, sadly, an indictment on our society which condones the Aboriginal people of our community experiencing such a level of disadvantage. In this regard ill health in the sense of illness or disease is merely a reflection or symptom of our acceptance of perpetuated economic and power inequality experienced daily by many Aboriginal people.

5.4.2 HOSPITAL SYSTEMS

Thirteen of the deceased died in, or during conveyance to hospital: five following transfer from police custody and seven transported from prison custody. Included in these figures is Nita Blankett who died in the rear of the prison van during transportation from prison to the local medical centre. Bates was no longer a serving prisoner at the time of death in Sir Charles Gairdner Hospital, his sentence having been remitted by the Executive Council following information that it was likely that he would die while still a prisoner.

The cases raise the following issues concerning hospital systems:

- emergency procedures for transfer from custody to hospital
- emergency procedures existing within the hospital itself
- the difficulties experienced by Aboriginal people in hospital
- the role of health professionals
- the role and availability of interpreters in the hospital system.

5.4.2.1 Emergency Procedures - from Custody

In this section I do not discuss the correctness or timeliness of decisions to transfer prisoners to a medical setting. This is discussed in Part Five (see 5.2.2, 5.2.3, 5.2.5, 5.2.8, 5.2.9, 5.3.2.5, 5.3.5). Rattler I shall review the adequacy of the implementation of the decision once made. The matters which flow from this issue include the adequacy of the rules and orders applicable to transfers, the adequacy of resources enabling proper response, the minimisation of delay in the transfer, the means of conveyance to hospital and the provision of relevant information to hospital staff.

The issue of emergency procedures for transfer from custody to hospital arose in cases including the following: Dougal, Blankett, Wells, Steven Michael and Harris. A case which graphically illustrates an inadequate emergency transfer from custody is Nita Blankett's experience.
Nita Blankett's death could have been prevented by

(1) an appreciation of the potentially fatal nature of an asthma attack by those responsible for her custody

(2) adequate prison procedure for dealing with medical emergencies resulting in the elimination of unreasonable delay in her transference to a medical centre.

I found that the senior officer of the prison (although normally a concerned and compassionate officer) made a serious mistake in delaying taking action to ensure that the deceased saw a doctor (Report page 33). Once the decision was made a number of factors caused a further delay of approximately twenty-five minutes before the deceased left the prison in a prison van. These included:

(1) Some disputation and delay in resolving the deceased's security classification and hence the number of officers required as an escort.

(2) Delay in obtaining a wheelchair as it was located in the locked infirmary.

(3) Consultation with the nursing sister regarding whether an ambulance was necessary for the transfer or whether a prison van was adequate.

This case illustrates the inadequacy of the use of a prison van for such an emergency. I noted that with the benefit of hindsight an ambulance would have been a better choice in the circumstances as it could have conveyed the deceased more promptly and more safely to the medical setting than the van (Report Pages 34 &37).

The issue of delay also arose in the matter of Wells. An ambulance was called to the lockup some thirty-five minutes after Wells had been discovered by police to be having what the police described as a fit of some sort. I considered this delay to be inexcusable in the circumstance of that case (RCIADIC W22,23). I also refer to my discussion in section 5.2.9 of this Report.

The provision of relevant information to medical staff was raised in the matter of Dougal. At the time the deceased was admitted to hospital from the police lockup he was suffering from a fractured skull. By failing to make proper inquiries about the cause of his unconsciousness (and assuming it was from drunkenness), and by not communicating to doctors that it appeared he had been involved in a fight, the police deprived Dougal of the chance of early admission to hospital with the result that diagnosis was delayed and the prospect of recovery accordingly diminished (RCIADIC WI 1,19).

In the Inquiry into the Death of Paul Farmer the following evidence was given by the Superintendent of Albany Regional Prison:

> Q. *Would you have to bring on extra staff in order to transport somebody at night?*
>
> A. *We would certainly be bringing on extra staff and the instructions to officers is that it would depend on the particular emergency at the time. The basic operational procedure for a major emergency would be for the officer in charge to secure the prisoner as best he could, if the prisoner had to be removed, and escort the prisoner to hospital, at the same time calling in the quickest additional staff he could to take up the security of the prison as quickly as possible* (RCIADIC W5:323).

The distance between Broome Prison and the hospital is only some 300 metres.
The Superintendent of the prison gave the following evidence:

> Q. *What are the precise arrangements at the present time, since you've been superintendent, relating to emergencies that require medical attention?*...

A. *The first contact is the hospital and then the officer relies on whatever information he receives from the hospital, either to move the prisoner there or they'll send an ambulance or whatever* (RCIADIC W25:34).

Q. *If the prisoner happens to be in a state where he has got to be assisted ... then is there a protocol that sets out what happens and do you have dummy runs?...*

A . *... We don't have dummy runs. We have dummy fire drills and other emergencies but not medical emergencies, as such* (RCIADIC W25:36).

Prison Orders

The Department of Corrective Services has informed the Commission that all prisons have procedures for medical emergencies in the form of Standing Orders or Local Orders issued in accordance with s.37(l) or s.36(3) of the Prisons Act. The style and content vary with the requirements of the superintendent and local conditions. In addition some prisons have Emergency Manuals - a composite collection of Emergency Procedures and Standing Orders, held at strategic locations in prisons. While no new policies have been introduced since the commencement of the Royal Commission, and no instructions have been issued to staff on the use of ambulances during medical emergencies some prisons have introduced local orders regarding the use of ambulances. Ultimately the authority vests with the superintendent of each prison to use his/her discretion to order removal of a prisoner and the mode of transport to be used. Where practicable he or she should consult with the prison medical officer (s.27(l) Director's Rule 2C.3). At Canning Vale and Fremantle Prisons the superintendent has access to a hospital officer on duty twenty-four hours per day. This cover is not available at other prisons. Where a hospital officer is unavailable the superintendent may consult the prison medical officer.

Executive Directors Rule 2C 6.1 concerns the transfer of prisoners to hospital in medical emergencies and sets out the number of officers required as escort (see Rule 2J). Rule 2C 6.2 sets out the number of officers needed for each security rating to stay with a prisoner in hospital.

> *It is the Department's view that sufficient latitude exists in current legislation and in the Executive Director's Rule 2C to allow for speedy transfer of prisoner's for medical reasons ... Existing procedures have been designed to ensure that any delay in respect of emergency medical transfers are minimised.* (Department of Corrective Services answers to questions raised by the Royal Commission, Q 15.4)

Police Routine Orders

Routine Order 16-8.28 to 16-8.33 apply to 'Medical Treatment for Prisoners'.
The order relevant for present circumstances is 16-8.29. It provides:

> *Where a prisoner requires medical attention, the member in charge will, as soon as possible, arrange to have the prisoner visited by a Government Medical Officer or by any legally qualified medical practitioner if a Government Medical Officer is not available, or:-*
>
> 1) *where a legally qualified medical practitioner is not available, have the prisoner conveyed to hospital; or*

2) *where a legally qualified medical practitioner is not available and the prisoner cannot be conveyed to hospital, obtain advice from a legally qualified medical practitioner by the quickest practicable means and give effect to that advice.*

I refer to my discussion in section 5.2.9 in which I note the need for clear directions to police officers as to the action they should take in a medical emergency.
Prisoners and detainees are dependent on custodians for the provision and access to appropriate medical facilities, this is particularly so in emergencies. The protocol for such situations whether contained in Executive Directors Rules or Routine Orders must be known, properly interpreted and routinely practised. There must also be adequate resources to pen-nit custodians to respond to emergencies. In particular sufficient staff must be in attendance to allow for the prompt transfer of a prisoner without delay in summoning additional staff and without the requirement to seek unnecessary transfer approval from that in authority.

Hospital Emergency Procedures

The issues raised concerning hospital procedures are illustrated by the cases of Garlett, Dougal, Njanji and Blankett.

Garlett's death clearly raised the adequacy of Wooroloo hospital emergency procedures. Factors which mitigated against the receival of effective hospital treatment following a heart attack were an inadequate emergency routine, the nurse on duty had no resuscitation training and there was a lack of sophisticated resuscitation equipment. I described it as a matter of regret that the hospital and staff were unable to cope with the sudden grave illness of a prisoner (Gartlett Report page 15).

The doctor who treated Dougal following his admission to Derby hospital did not follow the usual and prudent procedure of viewing observation notes by nursing staff which would have alerted him to the unequal pupil size observed and perhaps even to suspect Dougal's head injury, although it cannot be said that this had a deleterious result in the deceased's circumstances (Dougal Report page 19).

The cause of Jimmy Njanji's cellulitis went unrecognised by hospital staff in Port Hedland in spite of what I described as 'their tireless efforts'. A tracheostomy was required and was not performed. The most appropriately skilled medical practitioner to perform the technique was not consulted (Njanji Report page 3).

In Nita Blankett's case I could not draw the conclusion that she was beyond resuscitation with confidence because of the evidence of the medical practitioner in attendance. When the prison van arrived at the Perth medical centre, the doctor did not attempt resuscitation because he believed that Nita was 'clinically dead' even though on his own assessment she had only been dead for a very few minutes. Secondly he believed that the delay involved in getting her from the prison van to the resuscitation equipment located in the medical centre was too great for successful resuscitation (Blankett Report page 37).

The cases have revealed errors and omissions by hospital staff in their response to medical emergencies. As I concluded in my Report into the Death of Garlett, the community is entitled to expect that hospital staff are possessed of sufficient skill and training to deal with an emergency in a calm and professional manner. This is particularly so in the case of a prisoner who, because of his or her status is removed from usual support networks, experiences diminished channels of communication and has a reduced ability to make his or her own choices for medical treatment.

5.4.2.2 Difficulties Experienced by Aboriginal People

A factor which has often arisen in the cases is the difficulty experienced by Aboriginal people when in the European type hospital environment. These difficulties may manifest in a feeling of unease and may result in early discharge from hospital prior to the completion of a period of treatment or observation.

The summary of Kim Polak's Health Department records reveals that he absconded from hospital, did not wait for treatment or discharged himself early, on some eleven occasions. Reasons for his hospital admissions on these occasions were: a stab wound to the thigh, chest infection, complaint of chest pain, 'psychiatric problems', drug induced Parkinson symptoms, treatment of schizophrenia, possible fitting, suspected ingestion of methylated spirits, early pneumonia, lacerations from a stabbing incident and suspected alcoholic hepatitis.

The following evidence was given by Sergeant Adams in the inquiry into Polak's death:

> Q. *These people* [Kalgoorlie fringe dwellers] *though as a group would often spend a lot of time in hospital, constantly?*
>
> A . *Some would, others wouldn't go to hospital. They would abscond or just wouldn't go to hospital.*
>
> Q. *Even though they needed the treatment?*
>
> A . *That's right yes ... They would rather go to the AMS but they wouldn't go the hospital.* (RCIADIC W18:193)

Similarly Jimmy Njanji's poorly controlled diabetes was contributed to by a reluctance to seek medical attention through fear and unease of hospital. His Public Health Department File makes reference to 'absconded', 'reluctant to seek medical help', 'discharged himself before time', and includes the following notation:

> *Seen in Nullagine last week, refuses to seek any form of medical attention unless desperately ill. Very frightened of hospitals.* (RCIADIC W8:173,433,434,439)

Dr Board through his experience at Carnarvon Hospital noted that Aboriginal people tended to self-discharge more than members of the white community (RCIADIC W4:31).

Dr R Roberts, Medical Director of Kalgoorlie Regional Hospital gave the following evidence in the Inquiry into the Death of Bates:

> Q. *Is there a high rate of absconding or leaving hospital against medical advice in Kalgoorlie?*
>
> A . *Yes, there is a high rate. It's one of the problems that we are faced with in treating these diseases ... that treatment is often not completed because people abscond; they leave the hospital.*
>
> *There are two reasons, basically two reasons: they feel as if they're out of place; and the other reason is that we don't provide the necessary facilities to make the Aborigines feel comfortable* (RCIADIC W31:57).

It is clear that hospital may often be an alien and threatening environment. Dr Kostov in his statement to the Commission in Polak described the experience as follows:

> ... *The isolation and loneliness are particularly strong because Of... very strong ties with the tribal/family groups; impossibility to identify with/trust white care providers - hence the sense of not being understood or the sense of futility of any efforts on his side to present his point to people ('Wadjella') who 'wouldn't understand anyhow'* (W/I 8/42).

Dr Board of Carnarvon referred to the recent employment of a number of Aboriginal people in the reception and casualty areas of the hospital *!for the purpose of reducing the frigid atmosphere or the discouraging atmosphere'* (RCIADIC W4:30).

The Central Australian Aboriginal Congress in its Submission to the Commission raised the issue of the architecture of hospitals contributing to patients' sense of unease:

The physical design and layout of the hospital is culturally inappropriate. All wards are above ground level severely limiting patient access to the outside. It does not lend itself to accommodating the presence of family members. Thus patients are often deprived of support from family, which is important to their morale and recovery (30 September 1988, page 4)

Commissioner Muirhead referred to this process in the hearing of Farmer during the evidence of Richard Wilkes of the Multicultural Psychiatric Centre:

> Q. *I remember in Darwin and the old Darwin Hospital had big wide wooden verandahs all around it. It was just a single storey building with big lawns in the middle and all the Aboriginal families could come in and sit on the lawn and talk to the patients. It was a kind of natural environment. Then they built a huge hospital there modelled on the Woden Valley Hospital in Canberra, all air-conditioned and lifts everywhere, and it's made the visiting very difficult, especially for tribal people, who they've never been in a lift or never been in the airconditioning, to come and see their people. It's really just not appropriate for those people. As you say, they feel uncomfortable from the moment they get in, and frightened?*
>
> *A. Yes, that's right. (RCIADIC W5:410)*

Richard Wilkes described his own experience in the following terms:

> A. *I mean, what we do find difficult is that - I know I went to hospital last year and I had to go in there and I had to share with other people, you know, the ward. I found that difficult in some stages, and I can mix with most people really, but I mean, you know, there's things that you find that you limit yourself to doing, and that kind of thing. I guess there is a cultural collision with Aboriginal people in general in going to, whether it's a medical service or a detox centre like the one they've got set up in Mount Lloyd, and the Aboriginal people in general do find, or Nyungar people in general, that it's hard to sort of come straight off the street and walk straight into a basically European-run centre* (RCIADIC W5:410).

Dr Roberts of Kalgoorlie provided a strong example of an institution which had responded to the needs of Aboriginal patients:

> *I will give you an example. there is a hospital in Leonora run by the only Aboriginal matron of a hospital in Western Australia, and I think throughout Australia, and that is one Matron Sadie Cameron ...*
>
> *She has a special ward there which she insisted on having. She had to battle with the Health Department to allow it - but it's a special ward where she nurses Aboriginal patients, particularly elderly Aboriginal patients. They're nursed on the floor. They have a mattress on the floor - they don't like to lie in beds ... If they want to get warm, they have afire outside and they sit around the fire. That's a completely different sort of hospital care to what we're used to but it seems to work* (RCIADIC W33:57).

Teresa Isaacs is an Interpreter with AMS. In describing the role of an interpreter as including explaining aspects of Aboriginal culture to Europeans she stated:

> *There are many things about Aboriginal culture that need to be understood. For some tribal people, being in hospital might be the first time they have had that type of food at regular meal times and maybe the first time they have slept with white starch sheets.*

The difficulties some Aboriginal people experience when encountering hospital treatment may result in a hampering of diagnosis, of treatment and of well-being of the patient. It is important that custodians and health workers are cognisant of the effects on health which may flow from feelings of reticence and fear. The role of Aboriginal liaison officers in hospitals should be expanded to provide custodians and hospital staff with a resource to assist in the transfer of Aboriginal people and in their treatment while in hospital. I note in this regard the reference in my Inquiry into the Death of Njanji to Lena Walker. She is employed as an Aboriginal hospital liaison officer largely through the efforts of the Aboriginal community in Port Hedland. She also acts as an interpreter and has been employed in the hospital since 1986 (RCIADIC W8:254). The employment of such persons should be encouraged and expanded.

5.4.2.3 Role of Health Professionals

Non-Aboriginal health workers should not assume that they are necessarily the professional in dealing with Aboriginal health matters.

Dr R. McKenzie (Medical Officer employed by the Carnarvon Aboriginal Community in their community operated medical service) expresses the following view:

> *I feel that for too long and its still happening ... that Aboriginal people are let down by the quality of white advisers and experts that are provided to them because, well-meaning as these people are, they take with them their own origins, of course, and their own culture and their own prejudices and a lot of them don't have empathy with the Aboriginal people and don't actually trust them in terms of their abilities and their wants and their needs and they feel that they have to do the doing* ... (RCIADIC W4:392).

It is clear that non-Aboriginal health personnel, if they are to work with Aboriginal people must possess a knowledge of Aboriginal cultural and environmental matters and communication skills which enhance diagnosis, treatment and recovery. I discuss this issue in the field of mental health in section 5.4.5.2. It is important that the difficulties experienced by Aboriginal people are acknowledged and constructively responded to. Such difficulties may include factors such as the following: (1) a reticence by many

Aboriginal people to actively seek health care, (2) frequent unease in the hospital environment, (3) the difficulties in continuity of treatment due to mobility, (4) possible feelings of alienation when dealing with scripts and chemists, (5) problems which may flow from distance between institutions/services and a patient's country. The experience of Misel Waigana and his non compliance with epilepsy medication provides an example of the impact of some of these factors. In my Report into the Inquiry into the Death of Waigana I noted that it was important that matters such as differing cultural concepts of time and mobile lifestyles were considered by medical practitioners in finding appropriate methods for increasing levels of understanding and compliance with treatment (Report page 47).

Solutions to some problems may merely require some imagination or slightly increased effort. An example is in the case of Anderson who was a diagnosed epileptic but often mislaid his medication or returned an unopened bottle of pills to the nursing post. To assist, the nursing sister labelled his medication half sun, full sun etc and issued it weekly to assist monitoring (W/16/56).

Dr Kostov, from his perspective as a psychiatrist with the Multicultural Psychiatric Centre, describes a process which may occur:

> *Reality has a spiritual dimension, which is for the Aborigine as real as any material reality; when outside of his usual material reality the Aborigine perceives a threat for the spiritual reality too, the non-*
> *Aboriginal care provider, with rare exceptions, is seen as doubting this reality (and he actually does in many cases) hence the Aborigine further excludes him from it.* (W/I 8/42)

Teresa Isaacs who runs the AMS Interpreter Service provides an example from her experience reflecting the necessity of the health professional to be informed and sensitive towards Aboriginal cultural issues:

> ... *I had to tell a tribal woman that her son had only one hour to live. I told the young doctor to watch her, because she may injure herself called 'sorry bleed'. When I left the room she hurt herself with a tin waste basket. They didn't understand and they put her in a psych. ward for the night.*

Dr McKenzie of the AMS in Carnarvon expresses a constructive view regarding the necessity for training in the following terms:

> *... it is m y opinion that it is too easy to be critical of the attitudes of non-Aboriginal people in the fields of health and police because I think its too easy to say that they're racist and to criticise their attitudes and its unrealistic to have expectations that they can have the appropriate attitude required to have the understanding and the empathy with Aboriginal people and their needs when the sort of contact that a lot of these people have had with Aboriginal peoples and communities is very limited and often confined to conflictual situations such as intoxicated people. I would think that Governments need to look very seriously at developing some type of institution where the importance of non-Aboriginal people going into Aboriginal affairs can receive the appropriate training in these fields, whether it be in health, police, teachers or whatever and that these institutions could be under the auspices of a university utilising the Aboriginal people on staff with large amounts of input and also utilising the existing Aboriginal organisations around in the community* (RCIADIC W4:392)

As in other areas of health services the real involvement of Aboriginal people is the only and most necessary way of aiding effective delivery of health services. Their presence

aids in educating non-Aboriginal workers (formally and informally) in Aboriginal health matters, in identifying potential problems in health service delivery and in locating appropriate solutions when problems arise.

5.4.2.4 Interpreters

> *Interpretation is not a simple technical exercise; it is a difficult and sophisticated art. It requires (on the part of the interpreter) an awareness and understanding not only of the respective languages but of the social, legal and cultural differences of the two communities* (Roberts-Smith, 1989).

I again quote Teresa Isaacs:

> *I think Aboriginal interpreters are very important, not only for explaining to the Aboriginal person whatever needs interpreting, but also to explain aspects of Aboriginal culture to Europeans. Recently I had to interpret for a young woman who was in hospital. The doctor said she was drinking too much alcohol. But she was hearing voices and wanted healing for her own people, from a mabarn* [or Aboriginal doctor]. *She didn't see her problems as to do with alcohol.*

This Interpreter Service operating in Perth was established to assist in the provision of medical services by the AMS. However the type of requests received indicate the lack of these resources in other areas. Teresa Isaacs has received requests from Department of Social Security to explain pension requirements, from Department of Community Services institutions such as Longmore and from the CIB on a number of occasions usually involving interviewing the victim of an assault.
Richard Wilkes refers to the additional roles played by an interpreter in his evidence in Farmer:

> *I have views on prevention of deaths in custody and I believe that the incidence would be reduced if there was a proper interpretation service available for people in lockups and prisons. Persons from isolated communities have a great difficulty in coping with their surroundings, whether it be in a prison, lockup or psychiatric hospital and their situation would be much relieved if they could communicate* ...
>
> *I am a Nyunga from the south and just for instance, I feel that even though I can speak English very well and there's lots of other Nyunga people who can too, but the thing is* ... *if their* [the interpreter's] *presence is there, that goes a long way to relax a person, to help a person* (RCIADIC W5:404,407).

This evidence and that of Dr Tregonning below, are important because they raise the issue of the ability to perceive when to use an interpreter. The risk that there will not be full understanding is greatest when there is some knowledge of English. Roberts-Smith in his article writes:

> *The tendency, inevitably is to assume a greater degree of understanding than actually exists. Much will also depend on the circumstances, the nature of the occasion, and the significance of the particular matter. In cases of doubt it is always wise to use a competent* ... *interpreter* (Roberts-Smith 1989:77).

Maureen Kelly, Community Development Officer with WAADA, in her evidence in the inquiry into the death of Jimmy Njanji refers to this process when she says:

> ... *one Of the points I made very clear was that when you are speaking to an Aboriginal person and you ask him does he understand you and he says 'Yo' you*

might think he is saying 'Yes' but he is not he is saying 'I hear you, I am listening That is alot of times mistaken ...

.... but if the Aboriginal people say, don't talk to me in 'Hundred dollar words, speak to me in one dollar words so I can understand you'. That means, 'don't talk to me with high words' (RCIADIC W8:277)

Similarly Rose Murray Coordinator of Wangka Maya, Pilbara Language Centre states:

Whilst introducing the general public and particularly those working with Aboriginal people, to Aboriginal languages we discuss crosscultural communication. Old Aboriginal values say that to disagree with someone is bad manners. So we often have Aboriginal people agreeing to things that they don't believe in. This has huge repercussions in any service industry but particularly in the criminal justice system.

I have found that to overcome this problem requires the ability to ask the question in a variety of ways so that you can confirm the Aboriginal person's answer.

In this way it can be determined that the answer is not based on cross-cultural manners or confusion through language difficulties.

There are some words in English that don't directly translate and this is another problem area. Our linguists here would be able to talk to people about that if required so that, as accurate as possible, interpretations were made (W/19/G3).

The Language Centre is a community based organisation promoting and recording Aboriginal languages. The centre has a non-Aboriginal linguist who has spent some years in the area and a trainee Aboriginal linguist who speaks Banjima and Yindjibandi. Like Rose Murray this trainee has a diploma of teaching.

It was clear that Jimmy Njanji could neither speak nor understand English, his language was a dialect probably of Putitjarra (a language of the Western Desert). The medical staff had been unable to communicate with him from the time of his admission to hospital prior to his death, because of his poor command of English. The use of patients who could speak Njanji's language was attempted but it was unsuccessful as soon as the interpreters realised that Njanji, in his delirious state, was divulging tribal secrets (See Report page 17). Dr Hendry, one of the doctors treating Njanji, acknowledged that he was disadvantaged by the situation in taking instructions and in continuing treatment (RCIADIC W8:471).

The problems which may flow from some fluency in English are highlighted in the case of the person who died in Sir Charles Gairdner Hospital.

The dead man's English was described as:

... *not too clear* (RCIADIC W9:28)

and

I don't think his communication was too good... if you asked him how he was feeling, how he is, I don't think he could communicate and tell me exactly where his pains and troubles were, you know. (RCIADIC W9:85)

Dr Tregonning, visiting prison medical officer, was asked in that case:

Q. *But are there instances where there is a difficulty in communicating?* [to Aboriginal prisoners]
A. *Yes, there is one or two.*

Q. *How do you manage to communicate medical matters to them?*
A. *What are you getting at? What sort of matters?*

Q . *Why they're taking drugs or antibiotics?*
A. *Yes this would be done by sign language - 'sick' monosyllable words. Things like that. 'Pain, chest, sick'. 'You take this. Make better'. That sort of thing.*

Q. *That generally conveys the meaning to them?*
A. *Yes.* (RCIADIC W9:125)

Q. *... Dr Tregonning you've had in excess of twenty years experience as a visiting medical officer in the prisons? That is correct?*
A . *Yes.*

Q. *And you would have examined a number of Aboriginal prisoners during that period?*
A. *Yes.*

Q. *And you said that only on one or two occasions did you experience any difficulty in communication with Aboriginal prisoners?*
A. *Yes.*

Q. *... Would you or any of your colleagues have ever thought the need to use an interpreter with an Aboriginal prisoner?*
A . *Yes we've done that a couple of times.*

Q. *Could you explain the system there?*
A. *Another prisoner was brought up with the man wanting to see the doctor and we'd ask the interpreter - we'd go through an interpretation thing. I would ask the interpreter, he'd ask the patient, the patient would answer the interpreter and the interpreter would tell me* ...

Q. *I see. So you're not aware of the use of any formal interpreters or outside interpreters either then or now, in the prison system?*

A. *No, I'm not aware of that* (RCIADIC W9:127).

It is at least questionable whether the communication is successful across such a language and cultural gap (Fagan and Swan, 1989:140; Kearins,J,1990)). In my Report in the Inquiry into the Death of the Aboriginal man who died in Sir Charles Gairdner Hospital I noted that the prison practice was 'open to potentially dangerous errors and incomplete communication' (Report page 16).

The Western Australian Department for Corrective Services has issued a 'Use of' Interpreter Policy' dated 28 February 1990. In it the Department presents details of the Commonwealth Telephone Interpreter Service (TIS) for the aid of officers and also instructions on conducting an interview through an interpreter. The policy also includes the warning that 'Unless accredited by the National Authority for the Accreditation of Translators and Interpreters, bilingual staff should only be used for minor matters with the level of competency'. However the TIS does not provide Aboriginal interpreters and the practice of using another prisoner or patient as an Aboriginal interpreter appears to be

common. In the Inquiry into the Death of Dixon Green, the Superintendent of Broome Regional Prison gave the following evidence:

> Q. *What about an interpreter - assuming that you have a tribal prisoner with this language difficulty who is given the assessment by the sister? You have not had the situation where the medical assessment has been frustrated because the prisoner cannot effectively communicate with the sister?*
>
> A . *Not to my knowledge, no. If the nursing sister has trouble talking to a prisoner, then she uses the same methods as prison officers. She will find a prisoner who has got the confidence and the competence to talk to the prisoner and will use that prisoner to act as an interpreter* (RCIADIC W24:16).

Dr Board spoke of his experience in this regard while practicing in Carnarvon from 1972 to 1979 at the hospital and in general practice from 1980:

> Q . *In Carnarvon do you have a number of people who come from the bush who have difficulty speaking the European language and understand?*
>
> A . *... I know of none in this area who cannot speak fluent English ... but communication as distinct from language is a problem).*
>
> *... if we insist that there's no communication problem at the hospital and if we insist that the Aboriginal patient must communicate fluently or without shyness as we expect the whites to, then we are misreading the situation and we are ignoring the essential problem* (RCIADIC W4:28,30).

The Perth Coroner, Mr McCann, was asked during the Inquiry into the Death of Donald Harris about his experience of the availability and provision of interpreters for Aboriginal people. Although his comments are from a legal context they are equally relevant to the provision of health services:

> *There is an abysmal lack of competent interpreters in European and Asian languages let alone competent interpreters in Aboriginal languages. Please advise me if you know of any! ... There are no presently available solutions. There must be a number of criminal charges which should be dismissed because the accused does not understand the nature of the proceedings, the Anglo-Australian legal system or any charge preferred under that system.*
>
> *The legal profession have probably compounded the problem and made the attainment of solutions more difficult by agreeing to appear for Aboriginal people charged with criminal offences, (people who, as I have suggested above, have no real understanding of what is going on) thereby giving a cloak of respectability to a system which has failed to understand and meet the needs of the original inhabitants of this Continent whose history has been steeped in tragedy and deprivation (W/25/25).*

The Final Report of the Aboriginal Issues Unit also highlights the need for Aboriginal interpreters. Following the Unit's Pilbara meeting one of the resolutions passed unanimously was 'That an interpreter/translator service with both male and female staff be funded for Aboriginal people to use in hospitals, clinics, courts etc' (RCIADIC AlU Report 1990:36).

Clearly interpreter services for Aboriginal people in Western Australia are inadequate. In my Report of Inquiry into the Death of Jimmy Njanji I described the provision and use of interpreters as a 'most desirable means of overcoming problems of communication and misunderstanding' (Report page 40). The need for interpreters impinges on many areas. The provision and receipt of medical treatment, participation in the criminal justice process and access to government resources are some of the areas affected. Injustice flows from the non availability of interpreters. This injustice needs to be acknowledged. I understand that the Department of Social Security South Hedland has been trialling Aboriginal interpreters working five and a half days a week (Submission CDBR W19,51). Such initiatives are to be applauded and duplicated by other service organisations. However a serious commitment to overcoming the injustices requires a commitment to a comprehensive review of the need for Aboriginal interpreters services in this state. Issues of professional training of interpreters, proposals for the employment of interpreters and the delivery of effective interpreter services should be addressed in the review. Clearly the project should be conducted by Aboriginal people and involve substantial consultation with the Aboriginal community.

5.4.3 AMS AND ABORIGINAL HEALTH WORKERS

Aboriginal Health workers can play an important role in the care and safety of prisoners.

Police Custody

Deaths in custody, particularly police custody, have revealed the important role to be played by Aboriginal health workers if they are able to have access to prisoners. Armed with local knowledge and understanding, they are able to assist in ensuring that police are aware of a detained person's current health needs.

The deaths of Robert Anderson and Ginger Samson illustrate the potential advantages flowing from access by Health Workers to lockups. Anderson was a sufferer of epilepsy for which continuing medication was prescribed. Two police officers on duty were not aware of this. The other officers and police aide on duty probably were aware of his condition although they claimed not to be. Nevertheless he was inadequately assessed prior to entering the lockup. The following day cell checks were conducted seven hours apart by a police aide who did not enjoy a good relationship with the local community. Anderson either did not have an opportunity to seek his medication, was reluctant or indifferent. All these obstacles could have been prevented by the involvement of a health worker. Their involvement may also reduce the likelihood of death in circumstances such as those involving Samson: a sufferer of epilepsy, often non-compliant with medication, he was left overnight in an unmanned station.

I further note that evidence was heard in the case of Anderson on the *'difficulty of delivering Western style medicine'* to many Aboriginal people (W/16/57), a problem which I believe would more constructively be dealt with by an Aboriginal health worker than a police officer.

Health workers may also be in a better position than police to appreciate the seriousness of a medical condition, particularly one resulting from chronic alcohol use as was in the case with Kim Polak. Although the precise cause of death could not be determined in that case it was likely to have been related to the deceased's chronic alcoholism. For the forty-eight hours of his custody prior to death, Polak was unable to retain any food or fluid and his custodians, although realising that he was ill, did not recognise the serious nature of his condition.

Health workers may also provide greater continuity in their recording of observations about a person's condition. This would avoid the situation which developed during Waigana's detention where the potential seriousness of his withdrawal from alcohol went unrecognised by police. The situation was exacerbated by the lack of communication of individual observations and efforts by officers to the officer in charge of the lockup in which he was detained.

The health worker's potential role in assisting police to promptly discover when detainees require medical treatment is illustrated by the case of Brown. Cell checks were conducted on the relevant day at 7.05 am, 11.35 am and 12.10 pm. There was nothing of note recorded. However at 1.30 pm when a cell check was conducted by an Aboriginal police aide, he discovered three prisoners, including Brown (who was suffering a bum to his abdomen) required medical treatment. In Brown's case perhaps if a health worker had visited the lockup the first thing in the morning the prisoners would have received immediate medical attention rather than having to wait until they were visited by a police aide with whom they were able to communicate (see section on Police Aides and the different views regarding their role of inquiring about detainees' general health). The evidence of Henry Councillor (Administrative Officer with the AMS Halls Creek) in Chatunalgi is also relevant in this regard:

> Q. *It might be difficult for you to say, but is it the case that when the health workers generally identify these health problems in the prisoners, it is more often that the prisoners themselves don't know if there is something wrong with them and the health worker spots it, if you like, or identifies it; or is it the case that the prisoners know that they have got something wrong with them but are reluctant to tell either the police aides or the police officers but are happy to tell the health workers, or is it a bit of both?*
>
> A . *They are reluctant to tell the police officers. They would rather speak to somebody they know and the health workers are the local people. They would rather tell the health workers* (RCIADIC W29:95).

Mr Green (ALS field officer) in his evidence in Chatunalgi illustrated another example of the role that may be played by health workers. Although he was referring to female police officers the situation is equally applicable to female health workers:

> *Just last week we had a lady* [in the lockup]... *and she wanted to talk with someone about a woman's problem... and she wanted to get it across to someone to bring a change in clothes. She tells us that she spoke to one of the constables and nothing was done, so she climbed the fence - just for that reason.* (RCIADIC W29:54-55)

The Police Department has informed the Commission of consultations with the Health Department and the AMS concerning the provision of medical care to detainees. In April 1988 the Chief Superintendent wrote to all Regional Officers informing them of arrangements that had been made in the metropolitan area with the AMS. He stated:

> *Please ensure that any medical services catering for both Aboriginal and non-Aboriginal citizens in your region are informed of that practice operating in the metropolitan area and afford every consideration for personnel to visit police lockups and respond to request either from police staff or inmates* (annexure 'B' to Responses by Police Department which the Royal Commission would like clarified 31.8.90)

According to the Police Department, arrangements with the AMS have been recently established in the following regions (see Responses by the Police Department which the Royal Commission would like clarified answer 5.5, 3 1 .8.90):

- East Perth lockup utilise the services of Perth AMS *'when medication is required for detainees, when Aboriginal visitors suggest contact is made for some reason, or because they are readily available and delay in obtaining help is minimised'.* There are doctors on call twenty-four hours, from the AMS. The Director of Perth AMS has informed the Commission in his statement dated September 1989 that the service does not apparently have sufficient health workers available or funding for additional workers to enable visits to the East Perth lockup on a regular basis (W/4/42).

- There are daily visits, Monday to Friday by two health workers to the Halls Creek lockup. The AMS doctor will attend if necessary. The system has been operating fully since approximately January 1990 (see Chatunalgi).

- AMS visit weekly at Derby and daily at Kununurra lockups.

- Attendance is on a 'needs' basis at Geraldton.

- The AMS in Newman, Roebourne and Kalgoorlie attend when requested by police.

- The AMS visit daily (Monday to Friday) at Carnarvon and provide police with a twenty-four hour access to a medical officer for advice or attendance at the lockup or casualty. I described the level of co-operation between the AMS and the police at this location in the Report of the Inquiry into the death of Wayne Dooler as 'model'.

There are clearly many advantages which flow from health workers having access to prisoners in police custody. The Administrator of the AMS in Carnarvon expressed the view that police lockup visits had helped Police/Aboriginal relations (RCAIDIC W4:236).

In his evidence Dr McKenzie of the Carnarvon AMS explained added benefits which flow from the involvement of health workers:

> Q. *Apart from the plan of extending the possibility of visitors for twenty-four hours a day, seven days a week - apart from that proposed plan is the scheme operating well or are there problems?*
>
> A. *I think it's operated well. I think that it's one of those little things that has happened in the community that has spin-offs. I know the health workers have commented that they feel welcome in the police station; that they feel part of the team and comfortable in being there and they feel that they can talk to police officers about problems and they have the book in there that they write in. ...*
>
> Q. *What is the book, sorry, that they write in?*
>
> A . *Well, there is a female and a male book and people who they've seen, that there is any problem, they write a comment in. It is more, I suppose, like any records that are kept - back-up in case difficulties arise - and they relate to myself or the other doctor problems with people that they might be concerned about and they have training in terms of being aware of the types of difficulties that could occur in lockups, looking for signs of depression and being sensible in terms of the types of dressings and things that they provide - that sort of thing* (RCIADIC W4:389-390).

Prison

The health issues and hence the role performed by the AMS and health workers in prison custody are often different in nature from those arising in police custody. The focus in prison is more with ongoing health care. In this regard the degree of trust many Aboriginal prisoners may have in the Prison Medical Service, access to 'second opinions', confidence in a worker outside the Prison Department's employ and access to workers with experience in Aboriginal health problems are important considerations. Mental health of prisoners is a particularly significant area where Aboriginal health workers may offer important skill and understanding to aid assessment and treatment (see section 5.4.5). The potential for health workers to be involved in preventative programmes such as alcohol counselling is also an important opportunity. They may also provide an avenue for prisoner advocacy to express their concerns about health matters and access to medical treatment to the Department and to outside organisations. The health worker's ready access to prisoners is particularly important where a person may be in custody far from their home territory. They are able to more effectively allay the fears of relatives of those in custody (W/14/42) and to act as a reassuring channel of communication. The identification of the need for traditional healers or securing the assistance of such a person, referred to in section 5.4.1. is also an important task for health workers. The assessment and screening of Aboriginal prisoners on entry to prison custody may be enhanced by the involvement of health workers, particularly in the taking of histories.

The Department of Corrective Services has informed the Commission that:

> *Discussions have been held with the Perth Aboriginal Medical Service to consider the possibility of the AMS providing medical services to Aboriginal prisoners in the metropolitan area. However, the AMS did not have sufficient staff to implement the proposals and considered that its resources would be better utilised elsewhere after viewing the level and quality of service provided by the Prison Medical Service.*
>
> *In the interim, the Aboriginal Visitors Scheme has been more fully implemented and this now provides a way for Aboriginals who feel disadvantaged by the system to obtain consultation from the AMS. These arrangements are made on a case by case basis.*
>
> *Because each AMS centre is an independent local body negotiations to develop a service have to be done in each centre. Negotiations have been held at all centres and with the exception of Broome, AVS liaison is seen as the most satisfactory method by which Aboriginal prisoners can obtain AMS consultation.*
>
> *At Broome Regional Prison all medical activities have been taken over by the AMS. This arrangement while working satisfactorily, is expensive because services must now be paid without benefit of rebate from the commonwealth* (Department of Corrective Services answers to questions from the Royal Commission; answer 13.4).

In the 1988/89 Annual Report reference was made to arrangements made for an Aboriginal health worker to attend Fremantle Prison weekly to see Aboriginal prisoners referred by medical staff for a second opinion. Ted Wilkes in his statement in tile Waigana matter noted that the referrals were to be made by the Medical Superintendent or a medical officer who would first discuss any request for a second opinion with the Aboriginal health worker. The health worker may then arrange for the attendance of the AMS doctor at the prison. Ted Wilkes concluded:

Ideally I believe that there should be a system in place within the prison system itself to adequately deal with the health needs of Aboriginal prisoners. We are aware that problems may arise if non Aboriginal prisoners and possibly prison officers perceive that there is preferential treatment being provided to Aboriginal prisoners (W/14/42).

In conclusion:

- Prisoner access (in police and prison custody) to Aboriginal health workers is to be applauded where it has occurred. Formal arrangements need to beput in place between the relevant AMS and the Departments to ensure that access is prompt and smooth. There needs to be continuing dialogue between custodian authorities and the AMS to ensure that developments or needs for expansion and change are addressed.

- It appears that a high level of cooperation between the health workers and local custodians is likely to be reflected in improved health care and better Aboriginal/police relations.

- If an AMS doctor is involved in treatment procedures, a formal means of ongoing communication between the Prison Medical Service, the Department of Corrective Services and the AMS needs to be established.

- Added responsibilities for the AMS and health workers cannot be expected without adequately addressing the funding of resource needs of the respective organisations.

- It is important that with increasing access to police and prison custody there is not a transfer of the responsibility for the provision of health services from the custodial authorities to outside organisations, except where explicit arrangements have been put in place.

5.4.4 MENTAL HEALTH SERVICES

It is futile to talk of Aboriginal mental health. That expression only suggests to people that we are blaming them for their horror by calling them crazy (John Cawte, Distinguished Fellow of the American Psychiatric Association, Professor of Psychiatry, University of NSW).

The deceased's mental health was an issue in a number of inquiries before the Commission including Paul Farmer, Robert Walker, Christine Jones, Stanley Brown, Hugh Wodulan, Benjamin Morrison and Kim Polak. Oral evidence and/or statements were given by the following psychiatrists:

Prof. G.A. German	Professor of Psychiatry, Dean of the Faculty of Medicine, University of WA, who gave evidence in the Inquiries into the Deaths of Charles Michael, Christine Jones and Benjamin Morrison and provided an opinion in the Inquiries into the Deaths of Wongi, Waigana, Cameron and Walley
Dr J.A. Lister	Psychiatric Superintendent, Graylands Psychiatric Hospital, who gave evidence in the Inquiry into the Death of Robert Walker and provided an opinion in the Inquiry into the death of Paul Farmer
Dr G.L. Rollo	Sessional Psychiatrist for Department of Corrective Services, who gave

	evidence in the Inquiry into the Death of Charlie Michael and provided an opinion in the Inquiry into the Death of Paul Farmer
Dr S. Kostov	Acting Psychiatrist Superintendent, Multicultural Psychiatric Centre who provided an opinion in the matter of Polak
Dr G.P. Smith	Director, Psychiatric Services, Department of Health who provided an opinion in the matter of Paul Farmer
Dr N. McLaren	Practising Psychiatrist in the Kimberley region. Gave evidence into the Inquiry into the Death of Stanley Brown
Dr E.M. Hunter	Research Psychiatrist in the Kimberley region, who gave evidence in the Inquiry into the Death of Hugh Wodulan
Dr P.W. Skerritt	President, College of Psychiatrists, who provided an opinion in the Inquiry into the Death of Paul Farmer

The issues raised by such evidence and which I discuss below, include:

- psychiatric services to prisoners
- the delivery of culturally informed services to Aboriginal people
- the responses of custodians to acute illness
- directions for future development of mental health services

5.4.4.1 Psychiatric Services

> *... the psychiatric needs of the Aboriginal population are basically little understood (W/5/59)*

The above quotation from Dr Smith in the case of Paul Farmer reflects the state of Aboriginal mental health services and the candid way in which inadequacy is acknowledged by professionals in the field. Francine Lorimer, in her paper entitled 'A Commentary on Psychiatric Assessments of Aboriginal Abnormal Behaviour for the RCIADIC' (March 1990) reviewed many of the contributions by psychiatrists to the Commission including some in Western Australia. She expressed the view:

> *Opinion regarding the quality of general treatment of Aboriginal mental illness was almost the only point on which all psychiatrists agreed: present treatment is poor* (Lorimer, 1990:36).

Dr Lister described the particular position of offenders in the following terms:

> *The current assessment and treatment of mentally disordered offenders in this state is fragmented, under resourced, out of date, ineffective, inefficient and reflects badly on a state that professes to be progressive and humane. This is particularly so in the country areas where a high proportion of Aboriginal people live and are jailed* (W/5/47).

The Department of Corrective Services has 'long acknowledged' that the psychiatric services for prisoners are limited. The Department has made attempts to recruit

psychiatrists. However, the demand for psychiatrists exceeds supply; psychiatry in prisons appears to have limited interest for the profession, and the combination of country prison work has very limited appeal for specialists (see Department of Corrective Services answers to questions from Royal Commission into Aboriginal Deaths in Custody; reply to question 14.1). The need for mental health services can not be seen only from the perspective of a need for more psychiatrists. I discuss this issue further in 5.4.4.4. It is also important that the Department seek the real reasons behind professionals being so unattracted by prison psychiatric work.

The Department of Corrective Services appears to rely heavily on the Health Department for psychiatric services. Dr Smith of the Department of Health informed the Commission of the mental health services available to prisoners (W/5/59). Graylands Hospital, the largest psychiatrict hospital in Perth, is the State's centre for offenders remanded for psychiatric assessment, for assessment and treatment of prisoners unfit to plead, for offenders found not guilty on the grounds of insanity and for mentally disordered prisoners. The hospital currently has no specialist forensic service and cannot admit persons requiring strict security. However, planning for a secure facility has commenced. While supporting the view that options must exist for the treatment of mental health problems outside prison I do not intend to enter the debate and express a view on the appropriateness on the proposed secure facility at Graylands Hospital. In this regard I refer to the 1985 Report of Professors R.W. Harding and W.A. Cramond 'Inquiry into the Appropriate Treatment of Mentally Ill and Intellectually Handicapped Offenders' and the 1989 Report of the Internal Departmental Committee on the Treatment of Mentally Disordered Offenders (known as the Murray Report) presented to the Commissioner of Health and the Department of Corrective Services. The members of this Committee were: Dr G. Smith, Dr J.A. Lister, Dr R.E. Fitzgerald (Director of Strategic Service Department of Corrective Services), Dr D. Bockman (Medical Superintendent, Prison Medical Service) and M.J. Murray QC (Crown Law Department).

Psychiatric assessment and treatment at Fremantle Prison is provided by Dr Rollo for six sessions per week. In addition two other consultant psychiatrists provide one session each per week for prisoners in the metropolitan area. Dr McLaren, a psychiatrist appointed by the Health Department, provides a psychiatric service to the Department of Corrective Services in the Kimberley Region as required. Pan of Dr McLaren's responsibility is to 'research special psychiatric needs for Aboriginal people' (W/5/59).

Health Department psychiatrists are available to assess and treat prisoners through regional services in Geraldton and Bunbury and visiting services are provided to Albany, Kalgoorlie, Port Hedland and Karratha.

In addition the Multicultural Centre in Perth employs one Aboriginal Welfare Officer, Richard Wilkes. Dr Smith describes him as 'the only person employed by psychiatric services as a specific service for Aboriginal people' (W/5/59). Richard Wilkes states that his services to Nyoongah people:

> *... are more by request from Graylands when the psychiatrist may request me to go and talk to one of the patients there and liaise with their families and communities to help get them back to their communities ... I travel all over the state in escorting people back to their own communities and take back with them directions for their treatment.*

In summary, Dr Smith describes psychiatric services in Western Australia as follows:

- Aboriginal people in both country and metropolitan areas have special needs which are poorly met by current services.

- Psychiatric services for Aboriginal people are poorly developed, particularly for those in custody.

- The services for prisoners in general are limited. The general lack of psychiatrists in WA and the reluctance of specialists to work in country areas lie at the basis of these deficiencies (W/5/59).

The experience of Paul Farmer illustrated the state of psychiatric services in Dr Skerritt's opinion. He stated:

> *This unfortunate case [Farmer] reflects a major deficiency in provision of treatment for psychiatrically disturbed offenders in WA. At present they are shuttled between prison and Graylands Hospital. The prisons have quite inadequate facilities for treating psychiatrically disturbed patients, while Graylands Hospital does not have facilities to provide sufficient security for convicted prisoners* ...
>
> *In the case of Mr Farmer this* [a secure facility run in close conjunction with a psychiatric hospital] *should have allowed a longer period of observation which might have clarified the presence of depressive phenomena in 1981 without the pressures to return him to the safer and cheaper custody of Fremantle Prison (W/5/48).*

Farmer absconded while undergoing treatment at Graylands Hospital in August 1981. He was recaptured in February 1982. It appears that there was no review by a psychiatrist and no review of medication prescribed while Farmer was in prison from August 1983 until his death in July 1984 (Report page 25-26).

<u>New Division Programme Fremantle Prison</u>

Following the death of Farmer and two other suicides at Fremantle Prison in 1984 the Department formed working parties to assess the *'important questions regarding the adequacy of the facilities and resources for the proper care and management of vulnerable and emotionally disturbed prisoners'* within Western Australia ('Management and Care of Vulnerable and Emotionally Disturbed Prisoners in the Western Australian Prisons Department' Report of the Director's Working Parties December 20, 1984, W/2/129). The results of that report included a recommendation that New Division at Fremantle Prison be developed with additional amenities for the management of vulnerable and emotionally disturbed prisoners. New Division is one of the cell blocks at Fremantle, so named because it was completed in 1902, the basic structure of the prison having been opened in 1855.

The report estimated that vulnerable prisoners comprise approximately 5% of the prison population at any given time. It identified the type of prisoners in this group which may include: alcoholics, drug addicts, depressives, those with a history of emotional disturbance, sex offenders, intellectually and physically handicapped, homosexuals, remandees, first offenders, juvenile offenders, prisoners recently sentenced to a long term of imprisonment. Emotionally disturbed prisoners may include prisoners who exhibit self-harm behaviour, show severe social withdrawal, respond with exaggerated aggression, are severely depressed, are hallucinating or delusional, or displaying other grossly inappropriate behaviour. It was estimated that these prisoners comprise between I % and 3% of the prison population.

David Northcott (Acting Director of Prison Operations) gave evidence in the Inquiry into the Death of Paul Farmer concerning the operation of New Division. He described the facility as follows:

> *The New Division programme has as its goal the provision of an emotionally safe environment for chronic and acutely disturbed prisoners.* It *also aims at developing in these prisoners the skills and resources necessary to cope with routine imprisonment ... Staffing in the New Division area is better resourced with a core group of officers to provide consistency and the formation of better interpersonal relationships with the prisoners ... Prisoners ... are reviewed on a weekly basis by a New Division committee. The committee consists of the Assistant Superintendent Prisoner Management, the Chief Officer Prisoner Management, the Senior Officer New Division, the Senior Hospital Officer, Occupational Therapist and the Senior Clinical Psychologist. The committee reviews progress, formulates management plans and recommends alternative placement and advises the Superintendent accordingly.*
>
> *.. there is also the medical case conference which meets on a weekly basis and includes the Consultant Psychiatrist, Medical Superintendent, Senior Hospital Officer, Senior Clinical Psychologist and Social Work Supervisor.*
>
> *This committee reviews those prisoners who are emotionally or psychiatrically disturbed. Where the prisoner is chronically disturbed, he is most likely to serve his period of imprisonment in Fremantle Prison. Initially he will be placed in new division or in some cases the prison infirmary. Where possible, the attempt is made to encourage the prisoner to try a placement in the normal prison routine. This is not always successful. In some cases* it *is possible that placement can be made in another prison. A determining factor in relation to such placement is often the availability of specialist support; for example, clinical psychologist or social worker in that prison.*
>
> *Management of vulnerable prisoners includes close, unobtrusive supervision, careful selection of cell block and work placements and, if necessary, placement in a special core environment, such as observation or the new division programme. Where an emotionally disturbed or vulnerable prisoner is received at a country prison, an assessment is made by prison staff and the prison medical officer in relation to their ongoing placement and management. If necessary, the person is transferred to Fremantle Prison or, in some cases, Graylands Hospital* (RCIADIC W5:483).

I have discussed aspects of the management of vulnerable and emotionally disturbed prisoners earlier in this Report in the section entitled Supervision and Monitoring of Prisoners (section 5.3.4).

Many of the specialists who gave evidence before the Commission referred to the problem of treating disturbed and psychotic prisoners within the prison system (see Report of Inquiry into the death of Paul Farmer).

The following quotation extracted from Dr Kostov's statement is illustrative of the general approach of the specialists towards the appropriateness of such treatment:

> *Treatment of any person with severe psychiatric problems in a prison is in my opinion unacceptable, professionally inadequate and morally wrong ... Under prison I intend an ordinary prison with general medical infirmary, but without specialized psychiatric section with appropriately trained staff* (W/1 8/42).

The evidence of Dr Lister in Walker, is a suitable conclusion to this section: *'Western Australia is a long way behind other States such as South Australia and Victoria, in that we have no central forensic psychiatric service and no cohesive policy for the mentally abnormal offender'* (RCIADIC W2:233).

5.4.4.2 Culturally Sensitive Services

In his report to the Commission in the matter of Paul Farmer, Dr Lister expressed the following opinion:

> *In my experience private practitioners rarely see Aboriginal people and from my experience when visiting a country clinic as a publically funded psychiatrist from Perth, very few Aboriginals are referred for an opinion and treatment* (W/5/47).

This view raises the question of the degree of access by Aboriginal people to mainstream services, a theme familiar in relation to other health facilities. It also questions the degree of exposure and competence of specialists to deal with Aboriginal mental health problems. This latter issue is addressed in Ms Lorimer's detailed analysis of psychiatric contributions to the Commission. Commissioner Dodson's Report also refers to the *'persistent lack of understanding'* on the pan of psychiatrists when dealing with mental health problems suffered by Aboriginal people.

The issue of the appropriateness of psychiatric knowledge in responding to Aboriginal mental health was referred to in the case of Farmer.

Counsel for the family in Farmer presented the following view of the mental state of the deceased:

> *Paul Farmer was examined only by European psychiatrists at Graylands Hospital and Fremantle Prison who could not evaluate his visions for their cultural significance. In European culture Farmer was mentally ill. In Nyungar culture he was in, spiritual danger. The European view was that Farmer had an alcohol problem and was schizophrenic. He was best treated by medication with anti-depressive drugs. This was the basis on which the prison authorities acted. It did not address in any way the state of spiritual anxiety which may have been the real basis for Farmer's unpredictable behaviour.*

Dr Smith stated:

> *The case of Mr Farmer highlights the problem of psychiatry in relation to the treatment of Aboriginal persons. Without a clear understanding of cultural factors or beliefs mental illness can be misinterpreted; or alternatively cultural beliefs can be wrongly diagnosed as mental illness. Psychiatry relies heavily on a cultural understanding of the client* (W/5/59).

Dr Skerritt, in the same case, described a similar process in the following terms:

> *I have had the opportunity of observing some of the difficulties of diagnosis of Aboriginal people myself. One factor of relevance in this case is the need to assess cultural factors carefully with respect to differentiation from psychotic phenomena. Although it may legitimately be a cause for concern that normal cultural phenomena may be incorrectly diagnosed as psychotic symptoms, in my experience the reverse provides the more serious risk and I have seen phenomena incorrectly put down to a simple cultural origin which may have*

indeed been important clues to the presence of mental illness which thus escapes treatment (W/5/48).

However, Professor German in the Inquiry into the Death of Benjamin Morrison stated:

> ... *if you have a population, like an Aboriginal population, about whom there are stereotypes, behaviours which might be regarded as very abnormal in a white Anglo Saxon resident of Nedlands may be disregarded, and I think that is another factor that has to be borne in mind, that one has to have some sort of awareness that these behaviours are abnormal in any population. They are not culturally characteristic. They are characteristic of pathology, and I would see that as the most important lesson* ... (RCIADIC W 1 5:443)

In their 'Draft Position Statement, Psychiatric Services for Aboriginal People' the Royal Australian and New Zealand College of Psychiatrists stated:

> *The network of psychiatric services in Australia is designed to meet the needs of the mentally ill who present in the European manner. Consequently, there are no special psychiatric services, no culturally appropriate facilities, few specially trained workers, and no specific policies for the diagnosis and treatment of Aboriginal people with mental illness.*

It is clear that specialists themselves acknowledge the difficulties in appropriately responding to Aboriginal mental health needs. This is due to their lack of knowledge of, exposure to and sensitivity towards the cultural issues with which they are confronted. This arises from a combination of many factors, including:

- a lack of specialist training and participation in Aboriginal treatment
- the lack of involvement of Aboriginal people in all stages of the treatment process
- the difficulty experienced by Aboriginal people in gaining access to appropriate treatment facilities
- difficulty in making correct or accurate diagnosis due to shyness or reticence on the part of the patient
- psychotic phenomena may be confused with culturally determined or religious experiences (and see W/5/48).

Fagan and Swan in the commentary of 'The Effects of Alcohol on Cognitive and Psychomotor, and Effective Functioning' address the lack of success of Aboriginal mental health researchers. They say:

> ... *Kleinman* (Major conceptual and research issues for cultural (anthropological) psychiatry; Culture Medicine and Psychiatry 4, 3*13, 1980) points out that:*
>
> ... *culture probably has its most profound and difficult to assess influence on psychiatry through the elaboration of conceptualisations of mental illness and psychiatric care that parade as value-neutral science but in fact represent a cultural construction of social reality that is only in part empirical, but also an admixture of professional ideology and shared cultural bias* (page 12).
>
> *This aspect of cultural psychiatry is virtually ignored by researchers. Psychiatric research is culturally based and ideologically biased. Researchers, like*

psychoanalysts can go only as far as 'their own complexes and internal resistances permit' (Freud).

These factors have an impact on the conclusions researchers reach, and help to explain why mental health/illness research has had little success in exploring, in usefully describing and defining the Aboriginal situation (page 14).

5.4.4.3 Response of Custodians to Acute Illness

Cases before the Commission have raised the issue of the appropriateness of custodians' responses to acute illness and the related issue of whether they are suitably trained to react to such emergencies.

In his report in Farmer, Commissioner Muirhead described the Superintendent's response in authorising prison officers (donned in protective clothing) to forcibly remove Farmer following his efforts to barricade himself in his cell, damaging it, threatening to 'cut himself' and kill anyone who came into his cell. He found that the Superintendent had *'no practicable alternative other than to remove Farmer from the cell as quickly as possible'* (Report page 49). However it was the geographic isolation of the observation cell where Farmer was confined, the unsatisfactory system of assessment and procedure for conducting the cell checks which drew criticism (Report pages 52-53).

Dr Lister gave evidence in the Inquiry into the Death of Robert Walker. He was of the opinion that prior to his death Walker could have been suffering from a 'flashback', a hallucinatory state occurring some time after the ingestion of a hallucinogen, usually LSD. The flashback can take place up to four years after ingestion. Dr Lister described it as an unpleasant or frightening experience with the hallucinatory effect usually being visual rather than auditory or tactile. In any event Walker was suffering from a psychotic condition. The established treatment for such a state is to try and calm the patient by reassurance, to avoid strong stimuli and keep the environment well illuminated and, if necessary, give tranquilliser medication (RCIADIC W2:234).

Dr Lister was of the view that the actions of the deceased prior to his removal from his cell should have alerted a hospital officer and experienced prison officer to the possibility of mental disorder. In addition, the response by custodians involving removal from the cell, down flights of stairs, the presence of a gun in the hands of a prison officer, would have exacerbated the condition (RCIADIC W2:246).

Dr Lister was of the opinion that Fremantle Prison Standing Order 18 (amended 29 August 1988) provided prison officers with a useful guide in dealing with aggressive and perhaps psychiatrically disturbed prisoners. However he referred to the necessity, in addition to provide officers with routine simulation training such as is regularly given to psychiatric nurses at Graylands Hospital (RCIADIC W2:240).

Standing Order 18 provides for the transfer of a prisoner from his cell to another cell, Prison Hospital, observation cell or other place within the prison after lockup. In particular the order details guidelines for the transfer of disturbed, aggressive or injured prisoners and outlines techniques for managing aggressive behaviour.

Professor German noted that it was possible to train police officers to identify and appropriately respond to behaviour that indicates a person may be at risk due to mental health problems (RCIADIC W15:442-443). In both Morrison and Jones, psychiatric evidence identified that the deceased were displaying behaviour characteristic of mental states related to organic cerebral dysfunction. In my Report into the Inquiry into the Death of Christine Jones I made the following recommendation: *'Police Officers should be*

trained and assessed in measures which will enable them to recognise mentally disturbed prisoners' (Report page 27).

In the Benjamin Morrison inquiry Professor German was of the opinion that the deceased was suffering a special mental condition (mania a potu) which became manifest during periods of intoxication. Typically the condition is characterised by impulsive and aggressive behaviour with subsequent total amnesia (RCIADIC W15:433). I described the psychiatric evidence as *'of great benefit in disclosing the nature and extent of the deceased's organic mental disease'* (Report page 37).

In contrast the police evidence at the inquest in that case suggested that Morrison was simply an aggressive drunk (Report page 7).

Professor German was asked:

> Q. *Is there anything about this case Professor German - given your familiarity with the death of Christine Jones and I believe you Ire familiar with the work of Dr Hunter which leads you to believe there are any general lessons for the commission, any matters of general significance to have arisen out of this death compared to the specific factors?*

Part of the Professor's reply was:

> A. *... The first general thing that I would mention is that a person who is alcoholic or is intoxicated has to be viewed with a certain amount of wariness because they are potentially at risk; secondly, the behaviours that have been described to me in both these cases* [Morrison and Jones] *were characteristic of organic mental states, by that I mean mental states related to organic cerebral dysfunction, and so typical were they, that to somebody who has a modicum of training there's no very great mystery about it. That degree of skill doesn't require a great deal of expertise. It is acquirable, and I have personally been involved in educating police officers to a point where they have been well able to recognise these states and handle them adequately.* (RCIADICW15:443)

The response of custodians to acute mental illness and their possession of appropriate training was raised by Dr Smith who stated:

> *Ideally, education of prison staff in the rudiments of psychiatric management of mentally disturbed prisoners should be developed. This could be achieved by the development of an adequate specialist forensic psychiatric service with this as one of its roles (W/5/59).*

For custodians to be able to respond appropriately to mental health problems, particularly acute circumstances, it is essential that they have the opportunity for proper and continuing training, have at their disposal appropriate facilities and reliable channels of communication to medical support.

5.4.4.4 Future Development of Services

The Commission has heard much evidence concerning the need for Aboriginal mental health services and the direction for future developments. Essentially such proposals come down to a single obvious factor - Aboriginal involvement. The words of Dr Kostov are appropriate:

> *It wouldn't be redundant to repeat ... that* without the actual and real *involvement of the Aboriginal people in the organization, management and running of such policies and structures they would never be fully accepted by the people ... The end result would be rejection and ultimately failure* (W/18/42).

Counsel for the family in Paul Farmer, while describing initiatives such as New Division in Fremantle Prison as 'significant', noted the absence in the Review Committee and the Medical Case Conference of an Aboriginal person with knowledge in Aboriginal culture, history, custom. He concluded *'without Aboriginal assistance there can be no real communication between those bodies and the Aboriginal prisoners'* (Final Submissions for Family, W5:56).

In his opinion to the Commission in the Inquiry into the Death of Kim Polak, Dr Kostov agreed with the diagnosis of the deceased's psychiatric condition but considered that the *'culturally specific factors ... whose exploration could lead to better insights and to eventual possible non-specific therapeutic avenues had not been sufficiently explored'* (W/18/42). In this regard he referred to involvement of Aboriginal healers, Aboriginal health workers, and Aboriginal communities in the management of psychiatric patients:

> *It would lead to less mistrust, and more openness on the side of the patients, better understanding of their world, less frustration and more satisfaction for the staff* (W/18/42).

Concerning the returning of Aboriginal people with chronic mental health problems to their communities, Dr Kostov noted that it was important that *'the community is not left to its own resources* or *with minimal specialised support',* reinforcing the need for trained Aboriginal mental health workers. Even the current employment of one such worker (in the whole State) has had *'the good response of the patients themselves when they deal with one of their own people, the easier and less mistrust full contacts with Aboriginal communities and organizations; involvement of traditional healers, discharges to appropriate communities etc'* (W/18/42).

According to Dr Kostov, Aboriginal healers could and should be used in psychiatric cases. *'The Western medicine is highly technical and sophisticated but could be insensitive to the patient's needs regarding his social role and position and outrightly frightening, alienating and bewildering'* (W/18/42).

Counsel for Farmer's family referred to the wealth of Aboriginal knowledge which would assist in the treatment of mental health problems when he said:

> *There is, as yet, no policy or directive which aims to incorporate the psychiatric and psychological services currently available with the knowledge of Aboriginal culture, now also available to the Department* (Final Submission page 26).

Richard Wilkes in his evidence in the Inquiry into the Death of Farmer gave an illustration from his experience of the effectiveness of involving Aboriginal healers:

> *We had a case where a young girl was arrested in the Kimberley area ... abducting a baby from a pram ... She was arrested for that and she was put into prison. When she got into prison they thought that there was some psychiatric problem with her and so she was sent through to Graylands. Fortunately enough the psychiatrist that saw her thought, well, no, really*, *I don't think there is any psychiatric illness here ... fortunately for her he heard about us being - Joy Kickett and myself were working at the Multicultural Centre ... We went down and we saw her and Joy said to me, 'Well, what do you think we should do?' and I*

> *said, I thought about it and I said, 'Well, she should contact her people'. We phoned around and we asked the traditional healer if he would come down and see her. He did. He came down and I must say this, he was able to get on to the aeroplane without a plane ticket and fly all the way down to Perth. He went over thousands of kilometres, so it was really well-known up in that area what he did... Anyhow, he came down and he treated her and after a few days she was well enough to go back and he nominated the amount of days that it would take to cure her and he was right. A week later she was sent back to her place, where she came from, and then she was put before the courts again because she was fit enough to plead, whereas before they thought she had these psychiatric problems. Anyhow, the psychiatrist did write a letter to the courts explaining that she had been under severe provocation from Aboriginal business* ... (RCIADIC W5:420).

The Department of Health's strategy for future psychiatric care to the Aboriginal community attempts to address the issue of involvement of Aboriginal health workers by promoting a three tiered approach to services:

- regional psychiatrist
- Sub-regional psychiatric nurse
- Aboriginal health workers in the local community (W/5/59).

The scheme for the provision of services appears to be in line with some of the views of Richard Wilkes:

> *My vision for the future of psychiatric services for Aborigines in this State would be to provide a number of centres around the State to respond to problems in the local communities. Aboriginal people are not all the same and some recognition must be made that there are different tribal groups such as a Nyungahs and Wongis and Bardi.*
>
> *They feel more comfortable with their own people rather than with another Aboriginal of a different group. In my view there should be centres set up by the government and properly funded to provide for a visiting psychiatrist, trained nursing staff, who ideally would be Aboriginal and local health workers* (RCIADIC W5:403).

Dr Cawte in a submission to the RCIADIC reproduced recommendations to the Government by the National Aboriginal Mental Health Association. These included the conducting of basic courses in Aboriginal mental health. Discussing a proposed two year tutor course in Aboriginal Mental Health. The recommendation continued:

> *Experience with Aboriginal health worker training programs across Australia shows that the chief deficiency is higher - level training. Lacking this, health workers rarely achieve status or positions of responsibility.* (Cawte 'Fourth World Suicide and Stress' page 155).

In the Report of his Inquiry into the Death of Paul Farmer, Commissioner Muirhead noted the efforts of Dr Cawte (Professor of Psychiatry and Honorary Editor of 'The Aboriginal Health Worker') to establish a chair in Transcultural Psychiatry to train doctors and Aboriginal mental health workers (Report page 30). Dr Cawte has described Aboriginal health workers as *'the hub of the helping professions'* (letter to G. Eames 22.5.90).

In my Inquiry into the Death of Hugh Wodulan evidence, was given by Ms V Read, Health education Officer with Milliya Rumurra, an alcohol rehabilitation centre in Broome. Ms Read is presently involved in running a mental health training programme for Aboriginal Health Workers. This course was run to meet a request from health workers, who had done a year in the field I *and felt that they hadn't got the necessary expertise in terms of counselling or advising or knowing how to refer people with mental or emotional problems. So last year Dr Jock McLaren, who is the regional Health Department psychiatrist, Dr Ernest Hunter and myself were invited to develop a programme, which was done that was piloted last year. This year we are repeating* it ...' (RCIADIC W12:294). Ms Read described the situation of the Aboriginal health worker in the following terms:

> ... *a lot of these people will be going back to isolated communities or going back to stations. We have got one student from Glen Hill*
> ... *We have also got a student from Roebourne at the moment. So they come from all over the Pilbara and Kimberley. They are concerned with lack of psychiatric services in the region and the fact that they may be the sole health service provider in isolated region and needed to know when they should be concerned, basically; that they felt that all too often the warning signs were being missed because people weren't knowing what to look for in people who were mentally* ill *or potentially suicidal* (RCIADIC W12:294).

In September 1990 the social and cultural section of the Western Australia Branch of the Royal Australian and New Zealand College of Psychiatrists ran a five day conference on 'Contemporary Issues in Psychiatry' including two training workshops on Aboriginal mental health issues for Aboriginal health workers and psychiatrists. The Branch noted *'the goal of these workshops is to explore the possibility of establishing a national training program which will be appropriate to the varying needs of all states and territories'.*

Dr Lister has recommended the establishment of a forensic psychiatric service with assessment and treatment responsibilities and facilities as well as performing an advisory research and teaching role. The service should form part of the Health Department. (RCIADIC W2:237).

Fagan and Swan made the following recommendation concerning mental health research in their commentary of the report prepared for the RCIADIC on 'The Effects of Alcohol':

> *That the ideological and cultural model within which Mental Health research is conducted be examined so that cross cultural research may begin to reflect the reality of the community being researched, rather than the values of the researchers (Fagan* & Swan, 1989,146).

The absence of a secure facility in Western Australia for the treatment of psychiatrically disturbed offenders has been referred to earlier in section 5.4.4.1. Dr Skerritt described the proposal as *'run in the method of a hospital but with security levels of a prison. This should be in close apposition to a Psychiatric Hospital'* (W/5/48). Dr Lister summarises the problem in his evidence in the Inquiry into the Death of Robert Walker:

> *The continuing problems associated with assessing and treating psychiatric patients within prison is principally due to the emphasis on custody in a prison system, compared to em phasis on assessment and treatment in a hospital system. This is particularly so in Fremantle prison due to the antiquated facilities'* (RCIADIC W2:236).

On 15 February 1989 an Interdepartmental Committee on the Treatment of Mentally Disordered Offenders delivered its report to the Executive Director and the Commissioner for Health. The recommendations included the establishment of a secure forensic

psychiatric facility (see page 20, 1988/89 Department of Corrective Services Annual Report).

Yet merely being able to identify the many needs in the area of Aboriginal mental health is not sufficient. The words of Dr Cawte are instructive:

> *I am under no illusion that it is going to be easy to get our-medical profession to take the necessary time and trouble for Aboriginal mental health. I have been trying for years without much success as yet. The tendency to ignore mental illness among Aboriginal people is widespread. These people don't often see doctors and hardly ever private doctors. Every time we approach government about Aboriginal mental health the answer is 'low* priority'...(Submission: 'Fourth World Suicide and Stress' page 169).

Conclusion

- Dr Kostov has noted that to arrive at a synthesis of two systems (Aboriginal and non-Aboriginal) in the areas of mental health requires *'significant effort and willingness on the part of both sides in overcoming many of the existing barriers'* (W/18/42).

- Custodians must possess the degree of skill and resources to enable them to recognise and adequately respond to prisoners who display behaviour characteristic of mental health problems.

- Systematic screening procedures on reception of prisoners into custody is needed to aid in determining vulnerability to mental health problems.

- As in many areas of reform, Aboriginal people must be intimately and significantly involved in the provision of services. This is an urgent requirement in institutions treating Aboriginal mental health problems.

5.5 ALCOHOL

5.5.1 SIGNIFICANCE OF ALCOHOL IN THE CASES IN WESTERN AUSTRALIA

Alcohol has been identified in a myriad of areas in the thirty-two lives and deaths investigated by the Commission. It has often played a significant role in the following areas:

- family history

- individual consumption

- arrest and offences - early and adult offending including last detention

- last detention

- health

- risk of death

The significance in the individual cases however, is that alcohol's presence is created, sustained and compounded by many other issues. The following flow chart shows some of the factors which have consistently contributed to the deaths in custody of thirty-two Aboriginal men and women. Alcohol is present but there are many other interlocking factors. Sections of this Report, in particular Pan Five, discuss the impact of some of these issues and identify areas where change must occur. It is clear that if these other factors concerning the involvement of the deceased persons in the criminal justice system and their custodial experiences had been addressed along the way then the majority of the deaths in custody could have been averted. It is important to keep the significance of alcohol in perspective and not let it overwhelm our thinking when seeking causes of death in custody and prevention of similar tragedies in the future.

Having attempted to place the significance of alcohol in a wider perspective, them is no doubt that its presence in the cases is extremely pervasive. The overwhelming amount of evidence before the Commission from a great variety of sources is testimony to the significance of alcohol in Aboriginal custody and custodial death. Alcohol has contributed to creating what Commissioner Muirhead described as 'a national tragedy'. Below I discuss the significance of alcohol in the thirty-two lives investigated by the Commission. It is in no way a picture of the Aboriginal community as a whole. Commissioner Dodson discusses in his Report the significance of alcohol in the wider Aboriginal community.

Family History

The presence of alcohol in the early lives of the deceased shows much variety. In many cases there are no records of alcohol use by parents of the deceased. If problematic alcohol use by parents is recorded the sources of the information are often Native Welfare and Child Welfare Department records relating to committals to the care and control of the Department and therefore perhaps somewhat slanted in emphasis. Examples of many are: Wongi at age eleven months and Donald Harris at age three years were committed to the Child Welfare Department following neglect applications which appear to have been brought because of excessive alcohol consumption by the boys' parents.

Individual Consumption

A pattern of excessive alcohol consumption has been extremely common among the individuals whose deaths have been investigated. Although the terms 'alcoholic' and 'alcohol abuse' are emotive and inexact, it is clear that at least in twenty-five cases alcohol consumption patterns of the deceased were seriously detrimental to health and well-being.

Individual patterns of alcohol consumption show much variety. There is rarely a single event or series of events which explains the level of alcohol consumption. Examples of the variety include Jimmy Njanji whose first 'drunk' charge occurred subsequent to his release in 1971 after conviction for a charge of manslaughter following infliction of a penalty according to Aboriginal law. He was approximately 40 years of age at the time.

In comparison drinking alcohol was common among Dooler's contemporaries after they left school. Donald Harris's drinking commenced after having spent his childhood years at Norseman Mission. Robert Anderson was in regular employment and only drank heavily on weekends.

Stanley Brown was regarded by his community as an important 'law man' however his relationship with his wife was marked by episodes of drinking and violent behaviour. He

became a fringe dweller in South Hedland, consuming alcohol at very high levels over an extended period.

Arrest and Offences

In considering the significance of alcohol as a factor in arrests and offences it is interesting to look at the history of legislative controls over the supply, receipt and consumption of alcohol by Aboriginal people in this State. Eggleston in her text 'Fear Favour or Affection; Aborigines and the Criminal Law in Victoria, South Australia and Western Australia' (ANU Press 1976 at 202) reminds the reader that repealed legislation may influence current attitudes and discusses the appropriateness and acceptability of the criminal justice system's involvement in the supply to, and consumption of, alcohol by Aboriginal people.

Numerous pieces of legislation have dealt with the prohibition on the supply of liquor to Aboriginals in Western Australia. Below I list many of these enactments. It is important to remember that this type of legislation formed only pan of what Commissioner Furnell described as the 'Early maze of legislation ... imposing rigid personal controls upon Aboriginal people' (Report of the Royal Commission upon all Matters affecting the well being of persons of Aboriginal descent in Western Australia, 24 July 1974 page iii).

The offence was first contained in 'An Act to make further provision for the regulating of Public Houses' (7th Vic No 3 1843) which provided that a publican was liable to a fine of five pounds for the knowing supply of liquor to an 'Aboriginal native' for the use of such 'native'.

The Wine Beer and Spirits Sale Act 1880 specified the offence applied to any person who sold, supplied or gave liquor to an 'Aboriginal native' for himself or any other person but exempted giving or supplying liquor by unlicensed persons to 'Aboriginal natives in their service' (44' Victoriae, No 9 Section 56). The penalty was increased to twenty pounds in 1886 (50' Vic 26 Section 13). In addition under the Wines, Beer and Spirit Sale Act a publican was liable for a two pound fine for knowingly permitting any 'Aboriginal Natives' to remain on or loiter about licensed premises (Section 57). This section was amended in 1902 by the Wines, Beer and Spirit Act Amendment Act to permit employment of 'Aboriginal Natives'(2' Edward VII No 44, Section 6).

The Aborigines Act 1905, 'An Act to make provision for the better protection and care of the Aboriginal inhabitants of Western Australia' (see No 14 of 1905) provided that the maximum penalty for 'any person who supplies or causes or permits to be supplied' liquor to an 'Aboriginal or half caste' was twenty pounds (Section 45). In 1911 the Licensing Act (an Act to consolidate and amend the law relating to liquor, see No 32 of 191 1) provided that no person shall sell, supply or give liquor in any quantity and whether or not mixed with water to any Aboriginal for himself or any other person (see Section 1.18). The penalty jumped to one hundred pounds or six months imprisonment or both. The Aborigines Act 1905 was amended aligning the nature of the offence and penalty with those in the Licensing Act 191 1 (see No 42 of 191 1, Section 10). The amending Act provided that any 'Aboriginal or half caste' who knowingly received liquor shall be guilty of an offence and liable on summary conviction to a five pounds fine or one month imprisonment. Section II 8 of the Licensing Act 1911 was amended in 1922 (No 39 of 1922) to include the offence of soliciting or receiving from an 'Aboriginal native', an order for the supply and delivery of liquor (section 95). The Aborigines Amendment Act 1936 (no 43 of 1936) made it an offence for a holder of a licence to pen-nit or suffer any 'native' to remain in or loiter about his licensed premises (other than a 'native' exempted from provisions of the Act - see Section 28). The offence did not apply to an employed 'native'. The penalty for a first offence was imprisonment not exceeding six months or a fine not exceeding 50 pounds (Section 29).

The Native Administration Act Amendment Act of 1940 made it an offence for ‚natives' to request, solicit any one to obtain liquor for them - penalty five pounds or one month imprisonment (Section 2 No 37 of 1940). The Natives (Citizenship Rights) Act 1944 'An Act to provided for the Acquisition of all rights of citizenship by Aborigines natives' (No 23 of 1944) provided for the issue by a magistrate of a Certificate of Citizenship to a successful applicant who was then 'deemed to be no longer a native or Aborigine not withstanding he Native Administration Act or any other Act' (see Section 6). It has been stated that this Act was principally used to enable Aboriginal people to legally obtain and consume alcohol (see Furnell 1974 page 25). In the Licensing Act 1911 1959 Section II 8 of the 191 1 Act was renumbered to Section 150 and the penalty for supplying Aborigines was 100 pounds or imprisonment for six months or both (see No 50 of 1959).

In the middle of this century, November 1953, the Labor Government of Western Australia brought down a long awaited Bill to repeal many of the restrictive clauses of the legislation concerning Aborigines contained in the Native Administration Act 1936. The conferring of citizenship fights on pan-Aborigines was also sought unless the applicant was unfit for such responsibility, as was an end to the prohibition on the supply of liquor.

Opposition was strong on the twin issues of citizenship rights and liquor. In summing up the view on the removal of prohibition, a member of the Legislative Council *stated, 'People in the Great Southern towns complain that, if the Bill is passed, there will be riots and drunken orgies and that it will not be safe for women to walk out after dark'* (Biskup, P., 1973:258).

The Bill was defeated, however a year later in September 1954 a watered down Native Welfare Act was passed. The sacrifices made were: no granting of citizenship rights; cohabitation and sexual intercourse with Aborigines remained a punishable offence and the prohibition on the consumption of liquor remained.

The Licensing Act Amendment Act (no 4) 1963 provided in Section 150 (1) that 'Any person who ... sells, supplies or gives liquor in any quantity whatsoever... to any native for himself or for any other person ... commits an offence' (penalty 200 pounds or imprisonment of six months or both). Section 150 (2) provided 'Any native who knowingly receives or is in possession of any liquor commits an offence' (penalty 10 pounds or one month imprisonment).

Commissioner Furnell described the final demise of the legislation relating to the prohibition on the supply and consumption of alcohol by Aborigines in the following terms:

> *This slow ... liberalisation of the laws and regulations affecting Aborigines was given impetus in 1963 when the Native Welfare Act was drastically amended and its last restrictive provisions finally removed. There remained, however, a provision in the Liquor Act specifically forbidding the supply of or consumption by Aborigines of alcoholic liquor in proclaimed areas. These areas were gradually reduced and by 1971 only two remained proclaimed - the Eastern Goldfields and the Kimberleys. In July 1971, these too were deproclaimed and all parts of the State freed of restrictive measures applying only to Aborigines. The Aboriginal (Citizenship Rights) Act thus became redundant* ... (Furnell Report of the Royal Commission 1974 page 26).

The Liquor Act Amendment Act 1972 repealed Section 130 of the principal Act on 20 November 1972. Section 130 provided for the proclamation of areas in which it was illegal for a 'native' to obtain or anyone to provide liquor to a 'native'.

The following points may be noted from this brief legislative history:

1. The legislation had little deterrent value and was ineffective in preventing access (Eggleston 1976:218,219).

2. Although the offences may have had as their aim protection, the 'victims' were fined or imprisoned often with great variations in sentences (Eggleston 1976:216-219).

3. The aim of the legislation was not reinforced by heavier penalties where liquor was supplied to derive monetary profit or sexual favours.

4. Supply charges, being more difficult to prosecute, were much smaller in number than the 'easier' possession offences (Eggleston 1972: 215).

5 . The aim of the Native (Citizenship Rights) Act 1944 was distorted, being used mainly by Aboriginals who wished to obtain the right to drink. The following anecdotal evidence of 'Brian' presented in the submission of CDBR in the Pat case (at p9l) is illustrative of the point:

Only when the citizen rights came in, those that had been accepted for citizen rights were supplying grog to their mates and relatives down the creek. But it wasn't so bad then they just had a plonk or two and that's it. Now its just gone mad. When free drinking rights came they just all went mad on drinking and its just got from bad to worse.

6. The legislation formed pan of an elaborate web of legislative control over the daily lives of Aboriginal people (Furnell 1974: 8-34).

7. It affected drinking patterns - consumption in seclusion, quickly and of strong alcohol (Rory O'Connor 1989: 3).

8 . It has supported single cause explanations for excessive drinking such as those being explored in the field of genetics (Fagan and Swan).

Early Offending

Many of the deceaseds' first or early offending related to alcohol. The early offences of Hugh Wodulan are typical. He broke into a house while drunk, stole alcohol and drove a Government car around. These offences resulted in Wodulan being committed to the care of the Child Welfare Department.

Adult Offending

The criminal records of the deceased have been discussed in Pan Four of the report. The majority of the cases reveal a pattern of offending which is either (1) directly related to alcohol - drunkenness, street /park drinking, offences relating to licensed premises or motor traffic alcohol offences or (2) indirectly related - disorderly while intoxicated, theft of liquor, assaults while in an intoxicated state. What is clear is that the public nature of drinking by the deceased made them more liable to arrest.

Last Detention

The connection between alcohol and arrest and detention is illustrated by the most serious offence leading to the last detention of the deceased prior to death. In the vast majority of cases the connection was direct through detention for an alcohol offence or indirect through the deceased's intoxication at the time of the offence.

Below, I set out the connection between alcohol and detention of the deceased.

- Ten of the deceased were in police custody for drunkenness or street drinking (Wayne Dooler, Albert Dougal, Roy Walker, Faith Barnes, Robert Anderson, Hugh Wodulan, Jimmy Njanji, Stanley Brown, Ginger Samson, Kim Polak).

- Two of the deceased were in police custody for disorderly conduct - (while intoxicated) (Ben Morrison, Misel Waigana).

- One of the deceased was in police custody for wilful damage - smelling of alcohol although ill due to pneumonia and meningitis (Milton Wells).

- One of the deceased was in police custody for a breach of a community service order (resulting from a conviction for damaging a hotel window and his father's property) (Bernard McGrath).

- Five of the deceased were in either police or prison custody for break and enter, attempted break, enter and steal (Wongi - intoxicated at time, Steven Michael - theft included alcohol, Edward Cameron - intoxicated, Donald Harris - smashing a hotel window, Ricci Vicenti - including theft of alcohol, Graham Walley - theft included alcohol).

- Five of the deceased were in either police or prison custody for DUI, exceed .08%, fine default for DUI or remanded for DUI offence (Darryl Garlett, Christine Jones, Nita Blankett, Bobby Bates, Donald Chatunalgi).

- One of the deceased was in police custody for aggravated assault and was intoxicated at the time of the offence (John Pat).

- One of the deceased was in prison custody for manslaughter (x 2) through driving a vehicle while under the influence of alcohol (Ronald Ugle).

However finding a connection between alcohol and last detention is in itself hollow. What can easily be seen from the criminal records is that this connection was present on many prior occasions in the lives of the deceased when death did not occur. The connection between last detention and alcohol is significant as a general indicator of the strong connection between alcohol and offending.

Alcohol and Risk of Death

Alcohol itself is dangerous enough in increasing the risk of death but the combination of alcohol and police custody has proved particularly lethal. Nineteen of the deceased were detained in police custody and all except one (Donald Chatunalgi) were intoxicated or were considered to be intoxicated at the time of their apprehension. What caused each death in custody involved many of the factors identified in summary form in the earlier flow chart. In many cases it was contributed to by a lack of care or expertise on the part of custodians in identifying the significance of the factors discussed above. In some instances the custodians were also lulled by past experiences of treating intoxicated persons as 'simply' drunk.

The cases have revealed the following themes concerning the mix of alcohol, police custody and risk of death:

- A need to increase the level of police knowledge concerning the masking by alcohol of serious underlying conditions.
- Underestimation by custodians of the seriousness of alcohol related conditions.
- Failure to assess or predict the behaviour of alcohol affected persons.
- The effect of alcohol in distorting human responses and values.
- The adequacy of the police system for dealing with intoxicated persons.

Masking Medical Conditions

Intoxication, presumed and actual, may cause custodians difficulties in assessing a detainee for the risk of serious illness or death. The cases have revealed instances where the police assumed that a person was 'simply' drunk, which paved the way for death from a serious 'masked' injury or illness. The grossest cases of 'masking' involve the arrest for drunkenness of unconscious persons. In addition, certain disease processes may mimic alcoholic intoxication, e.g. head injuries, a diabetic suffering the effects of hypoglycaemia, the post epileptic seizure period or meningitis. The following cases illustrate these processes.

In December 1980 Dougal smelling of alcohol, was arrested for being drunk when found unconscious and incontinent by the roadway outside a hotel. Police were told he had been involved in a fight. He did not regain consciousness. The following morning when found by police to be having what appeared to be a fit he was removed to hospital. Attempts to diagnose his condition were hampered by lack of information that he had suffered a head injury until an X-ray revealed a fractured skull.

Faith Barnes died in October 1982 of severe head injuries in Royal Perth Hospital. The day before her death she was arrested in Kalgoorlie by police who thought she was in a drunken sleep. She was in a semiconscious state lying in front of the police station. No attempts were made to wake her during her custody until almost **five** hours after arrest. Constable Power who assisted in the arrest was asked why he had formed the opinion that she was drunk:

> Q. *What was it about her that made you think she was drunk?*
> A. *Just her behaviour, the way she was lying on the ground she just appeared drunk to me.*
>
> Q. *The way she was lying on the ground?*
> A. *Curled up.*
>
> Q. *Nothing else?*
> A. *No.* (Power in Barnes)

As Counsel Assisting submitted, the police action was *'more akin to a conditional response: an Aboriginal person lying on the ground unconscious, therefore she was drunk and must be arrested'.*

The circumstances of Faith Barnes' death are more perturbing as Roy Walker had died after being in custody in the same lockup in similar circumstances approximately nineteen months earlier in March 1981. Police had attended on a complaint that a person had been assaulted and was unconscious. They found Roy Walker lying near a pipeline, smelling of wine. Unsuccessful efforts were made to wake him. He had a small amount of dry blood in the nostril area and there was an area of blood on the ground about the size of a dinner plate, although there was no sign of injury. Police discussed the matter with other people present and there was general agreement that he may have fallen over. Police attempted to take him to the house of someone who would care for Walker but there was no one at home. He was taken to the police station and charged with drunkenness. Walker was suffering from severe head injuries. His condition went unnoticed by police for eight hours prior to his transfer to hospital. The death led to instructions being issued by the then officer in charge at the station that persons placed in the lockup were to be visited hourly and awoken and spoken to after a reasonable time and that the shift Sergeant was to ensure that this was done.

The officer in charge at the time of Faith Barnes' death was not aware of the station order issued after the earlier death. If it had been followed it should have resulted in the early detection of Faith Barnes' serious condition.

Serious Alcohol Related Conditions

The cases have revealed a lack of knowledge on the part of custodians concerning the risk of death from alcohol related conditions. A regular user of alcohol requires a greater intake to achieve the desired level of intoxication and this may lead to potentially lethal levels of alcohol. Wayne Dooler died of acute alcohol poisoning. His post mortem blood alcohol level was .614%. If, instead of being placed unconscious in the lockup, he had been taken to hospital and treated his chances of recovery were reasonable. The police failed to distinguish between snoring from 'sleeping it off' and the irregular noisy breathing associated with alcoholic coma, through failure to conduct any adequate assessment.

It is likely that Kim Polak's death was related to chronic alcoholism. Because of the inadequacy of the post mortem examination it was impossible to determine the precise cause of death. He was arrested for street drinking. It appears that the police, because they were so accustomed to dealing with persons in poor physical condition, were inured to his physical welfare, failing to appreciate the seriousness of his condition.

Waigana died in 1987 at East Perth lockup of delirium tremens following arrest for disorderly conduct. The potential seriousness of his condition was not identified due to a lack of communication by officers of their observations about Waigana's condition to the Officer in Charge.

Anderson had a history of epilepsy from which he died in Wiluna Lockup. He sometimes suffered fits while drinking. His history would have been exacerbated by his failure to take medication whilst drinking. His condition was compounded by alcohol consumption and being in custody. On his last detention he was not assessed or searched on admission to the lockup and during his second day of custody cell checks were conducted seven hours apart. If he experienced alcohol withdrawal this would have increased the risk of seizure. The case reveals lack of adequate procedures for ensuring that custodians are informed of serious conditions which may be exacerbated by alcohol consumption and custody.

Alcohol Affected Behaviour

While Jimmy Njanji was in the Port Hedland Lockup a dispute commenced between he and another cell occupant both of whom had been charged with drunkenness. During the argument Njanji was wounded on his scalp when hit with a piece of fire wood which was located within the cell yard for use in building fires for cooking. Ultimately it is likely that his death could have been prevented if the cause of the cellulitis of his head and neck had been identified by hospital staff as related to the inflicted wound, appropriate treatment commenced and a tracheostomy performed. However the case also raises the issues of supervision of intoxicated prisoners and removal of possible weapons from cells.

In nine cases before the Commission the deceased died 'by their own hand'. Seven occurred in police custody and in each of these high blood alcohol levels were recorded at post mortem. Those cases were: Stanley Brown - .279%, Christine Jones - .25%, Hugh Wodulan - .264%, Wongi -.162%, Edward Cameron - in excess of .2%, Ben Morrison - .195%, Bernard McGrath. 223%.

Professor German in the Inquiry into the death of Christine Jones identified three categories of suicide victims. One category involved a person who displayed symptoms of confusion including the loss of capacity to grasp his or her environment. As the most common example of this, he gave alcoholic confusional state. In addition he said that alcoholics are sixty times more likely to suicide than non alcoholics. He also said that suicide when drunk or withdrawing from a period of alcohol intoxication are relatively common phenomena.

Consideration of the 'at risk' factors in such cases is discussed in section 3.4. However the case of Ben Morrison is of particular relevance in this section as the deceased was suffering from a particular mental condition which became manifest during periods of intoxication. In my Report into the Inquiry of this death I noted how the evidence before me in relation to the deceased's mental state contrasted with the police evidence at the inquest that Morrison was simply an aggressive drunk. The case indicates the need for training by police to enable them to distinguish a serious medical condition from drunken behaviour.

Distortion of Human Responses

A number of the deaths I have investigated illustrate the way in which people accustomed to dealing with intoxicated persons can become indifferent to their human condition. Having been arrested for drunkenness, Dougal, unconscious and incontinent, was hosed down in the lockup by police to remove excreta and placed in a prone position on the cement lockup floor.

Dooler, arrested for drunkenness, was placed unconscious in the lockup in rain sodden clothes, it appears without a blanket. The police then returned home to change their rain drenched clothes.

The indifference of local people to intoxicated street fighting and injury which may result is shown by the following extracts from Counsel Assisting's Submissions in the Samson case. He quotes a witness to a fight involving the deceased:

> *Ginger landed flat on his back on the footpath and his head hit the footpath real hard. The other guy just walked off and Ginger laid there bleeding from the back of the head.*
>
> *I stood there for a minute or so and saw that Ginger was breathing as I could see his chest moving. I then went into the shop for about ten minutes and when I*

> *came out Ginger was still laying on the footpath. He was moving from side to side slightly and was moaning and groaning.*
>
> *I didn't bother to do anything about it because I see it all the time, that is Aborigines laying around fighting and bleeding* (Counsel Assisting Submission Samson page 12).

In my Report of the Inquiry into the Death of Roy Walker I described the serious neglect on the pan of police involved in the deceased's arrest and custody as demonstrating *'apparent indifference to the welfare of those taken into their custody while apparently seriously affected by liquor'* (Report page 1).

The arrest of Faith Barnes I described in the following terms: '[She] *was certainly not treated in a humane and dignified manner, or with kindness and human consideration. She was simply scooped up and removed from public view'.* (Report page 28).

In my Report into the Inquiry into the Death of Morrison I stated:

> *Further matters involving the police, which came to my attention during the course of this inquiry, included the propensity of some policemen to refer to alcoholics, especially Aboriginals, in derogatory terms and to treat them less humanely and with less respect than other citizens. Under existing law it is the lot of many 'police officers to be confronted by persons who may behave in a drunken or aggressive manner. There is a tendency to regard them in an impersonal and stereotypical way, referring to them in derisive terms such as drunks, 'warbs', 'derros' and the like. Drunken and aggressive behaviour is generally regarded as abnormal behaviour in our society. It is unacceptable that a person behaving in such a manner should be characterised or stereotyped as a drunk and fail to attract the personal consideration which is his due as an ordinary citizen* [Report pages 6-7].

The above incidents am examples of the indifference with which drunken persons may often be treated. Yet the callousness, which may result from the attitudes described above, is not the fault solely of custodians for it is condoned through inaction by many members of our society.

Alcohol, Health and Custody

The cases where the combination of alcohol and poor health have been shown to be particularly dangerous involved police custody. Alcohol abuse may lead to chronic ill health, or may compound an underlying health condition. Alcohol use and ill health seem to be common characteristics of persons detained in custody (see 5.4.2).

The presence of the following factors relating to alcohol, health and custody may lead to disaster:

- chronic ill health
- alcohol abuse masking injury or illness including the effects of habituation and the risk of alcohol withdrawal effects
- a reluctance to complain of health problems by Aboriginal prisoners
- an inability to adequately communicate in English with custodians

- a fear and dislike of possible transfer to hospital
- inadequate police procedures for inquiring about health history or medication regimes
- habituation and tolerance leading to a less accurate assessment of risk by police officers
- lack of adequate knowledge by police of effects of alcohol withdrawal
- inadequate monitoring of prisoner's condition
- reduced opportunities for outside contacts
- unmanned police stations.

The circumstances of Samson's arrest are an example of these factors converging and resulting in death.

Police System for Dealing with Intoxicated Persons

When someone is drunk they are suffering from a 'state of drug induced psychosis'. Drunkenness, because it is common, is not usually regarded in that way. *'We get away with it quite a lot by treating drunken people as not ill but in fact some of them are and some of them suffer'* (RCIADIC W3).

Alcohol and its connection with ill health, risk of death and custody highlights the critical importance of an adequate police system for dealing with intoxicated persons. In the decade since the death of Wayne Dooler in 1980, the police system appears to have undergone some substantial changes.

It is hoped that today, views such as the following would no longer be held:

Q. *Apart from observing that he was snoring did you notice anything else about him?*
A . *No nothing new. He was just an ordinary Aboriginal who had been arrested for being drunk.* (RCIADIC W4)

Q. ... *Yes but were you concerned as to whether the arrest even with the benefit of hindsight, should have perhaps been carried out differently when someone such as Dooler can be placed in the lockup and die of acute alcohol poisoning, rather than, say be taken to hospital?*
A. *No, I wasn't unduly concerned about that. I believe he was correctl y handled by the police officers, and I reported it accordingly.* (RCIADIC W4)

Q. ... *What if the person was shaken and no word or no physical response of any description could be got from that person?*
A. *He couldn't talk?*

Q. *You couldn't get a word out of him; you couldn't get a movement out of him; you couldn't get anything out of him?*
A. *We'd lock him up.*

Q. *So you'd assume they were drunk and lock them up?*
A. *Well, yeah we'd assume that they were drunk and lock them up. Nine and a half times out of ten we were correct.* (RCIADIC W4)

I would arrest a person for drunkenness, as the only offence when a person was semi-conscious or out of it. They would be taken back to the lockup for their own protection. (RCIADICW19:3692)

A Roebourne Aboriginal style drunk is generally unable to walk, semi-conscious ... To use their own terminology 'I was full drunk' or 'I was sparked ... The average drunk that was arrested by me in Roebourne was full drunk. (RCIADIC W19:4551-4552)

There have no doubt been efforts by individual officers to perform the difficult task of dealing with intoxicated persons, with care and interest. However the cases do raise serious concerns regarding whether the police system for dealing with such persons is always adequate. The arrest of unconscious or unrousable persons is in point. Six cases before the Commission involved this circumstance: Dooler and Dougal in 1980, Walker in 1981, Barnes in 1982, Polak in 1985, and Samson - as recent as 1988.

Sections 5.2.2 and 5.2.3 examine police assessment and screening procedures in relation to intoxicated persons and persons found to be unconscious.

Section 5.2.7 of this Report discusses the unsatisfactory nature of the Routine Orders currently applying to such persons. Although the orders are expressed in mandatory terms requiring officers to obtain medical assistance in these circumstances, the orders are in fact interpreted only as offering guidance in making that decision. 'Guidelines' are not required for the treatment of unconscious or unrousable persons: police officers must be directed that such persons do not belong in a lockup but require immediate medical supervision.

Breathalysing

The intoxicated person is at risk for the diversity of reasons discussed above. In particular the cases have illustrated that a high degree of tolerance may develop the appearance of mild intoxication, masking the true state. Christine Jones for example had a post mortem blood alcohol level of .25% although experienced police described her as mildly intoxicated. Similarly Bernard McGrath had a post mortem blood alcohol level of .225% although neither police nor McGrath's friends thought he was intoxicated.

Breath testing has been canvassed as an aid to police in their assessment procedures. The proposition is that breath alcohol testing should be made available by police to prisoners (in particular those on drug or alcohol/drug related offences or who show signs of intoxication) before placing the person in the lockup. Police could use a hand held testing device. The process would enable blood alcohol levels to be obtained and compared with the expected level based on behavioural observations. Any difference would alert police that the person was at risk. Professor German suggested that if a person is known to be a heavy drinker and refuses to provide a sample of breath for analysis the person should be presumed intoxicated (Report of Inquiry into the death of Christine Jones, page 22). The breath analysis taken under these circumstances must be voluntary and could not be used in criminal proceedings. At the time of arrest a chronic alcoholic may have large amounts of undigested alcohol in their stomach and blood alcohol level could rise substantially over next few hours. Therefore it has been suggested that there may have to be at least one more reading to determine if the blood alcohol level is rising.

The proposal is a controversial one and one in which a variety of views have been expressed before the Commission. In my Report in the Inquiry into the Death of Christine Jones I recommended that *'The feasibility of compulsory breath testing of all persons admitted to police lockups who show signs consistent with consumption of alcohol should be examined'* (Report page 27).

Dr Stephen Freibers (Psychiatric Registrar with the NSW Prison Medical Service) in his Submission on the Interim Recommendations of the Commission supports the idea that all persons detained in custody should be breathalysed within a specific time of detention to alert police or prison authorities to potential risks (SO038 14.6.89).

Dr Aiden Foy (Royal Newcastle Hospital) addressed the issue of identifying obvious risk groups among prisoners. His proposal was that assessment must include objective criteria of age, sex, situation, known drug and alcohol use and blood alcohol at the time of assessment. For the latter factor he suggested:

> *A hand held digital read out breathalyser is available from the Lion's Club who make the standard police breathalysers ... I suggest that these be used to measure blood alcohol levels in prisons whilst I understand that it would cost a great deal ... they could at least be provided in larger city gaols* (Annexure to Submission to the Commission dated 1.6.88).

Dr Foy suggested the need for a formal study of blood alcohol levels in detainees in police stations to aid in establishing, scientifically, the correlation between blood alcohol levels and levels of risk.

Dr Hunter in Wodulan suggested that the proposal needs a study to be performed. He said that individuals had a limited capacity to judge how intoxicated a person is merely on the basis of behaviour. However he noted that there are problems with the proposed scheme (RCIADIC W12:424-425).

Commissioner Bull addressed this issue in his evidence before Commissioner Dodson and myself. He cast doubt on the proposal for the following reasons:

- [breathtesting] *could even cause the officers more difficulty in having confirmed what they believe, the person is intoxicated - they could overlook the matter that the person could in fact have a medical condition.* (T647 31 July 1990).

- *it would put a lot of onus on police officers to make the judgements involved.* (T648 31 July 1990)

- *a person because of their intoxicated condition may be incapable or unwilling to take the test.* (T649 31 July 1990)

- *the apparatus needed would have to be duplicated, general duties vehicles are not equipped with it.* (T649 31 July 1990)

Mr L. Thickbroom, the Assistant Commissioner of Police Traffic, gave evidence in Cameron, Walley and Wongi. He stressed the problems of cooperation of the prisoner in the administration of the test (RCIADIC W20:426, 431). He expressed the following views on breath testing of prisoners:

> *It certainly couldn't be said to be anything but an advantage for us to know what reading a person was. We would need to know at what reading we would consider a person drunk* ... (RCIADIC W20:36).

He was asked by the Counsel Assisting:

> Q. *Let's assume that the Royal Commission identifies larger lockups as being the problem lockups, by virtue of the fact that there haven't been any hanging deaths in small country lockups; ... Would you agree then that it may be just as effective to only have this testing in the larger regional lockups rather than throughout the state?*
>
> A . *I would agree that we could put them in large regional lockups for that reason that is a possibility - that we could do that* (RCIADIC W20:438).

It would be worthwhile to conduct a trial of voluntary breath testing of detainees in a major lockup, provided such a scheme had the support of the local Aboriginal community and was in conjunction with advice and services of medical personnel experienced in alcohol treatment e.g. the personnel of WAADA.

Conclusion

Alcohol is significant in the cases investigated by the Commission because it raises the following issues:

1. Alcohol in isolation will not provide any adequate picture of causes of deaths in custody.

2. The picture of individual alcohol consumption, ill health and custody must be seen against the wider historical picture of legislative control.

3 . The intoxicated person is suffering from a drug induced psychosis. This is often not recognised or appropriately responded to because the phenomenon is so common.

4 . The intoxicated Aboriginal person is often treated less humanely and with less respect than the non-Aboriginal 'drunk'.

5 . The underlying causes for the manifestation of alcohol consumption problems, and the power structures which support them, although not discussed here, are central to understanding alcohol's significance in the wider Aboriginal community. (This issue is discussed in the Report of Commissioner Dodson.)

5.5.2 DECRIMINALISATION OF DRUNKENNESS

Legislation

On 27 April 1990 the Acts Amendment (Detention of Drunken Persons) Act 1989 commenced operation. Thereby Western Australia became the sixth Australian state or territory to decriminalise drunkenness.

In presenting his second reading speech on 19 September 1989, the Minister for Corrective Services described the Bill as the last major item in the Government's package of measures to reduce the rate of imprisonment. He described it as:

A most significant initiative aimed at reducing the rate of imprisonment and, as a result, it is hoped, the rate of death in police resources (page 2128 Hansard).

The Act deletes the summary offence of public drunkenness from s.43 s.44 and s.53 of the Police Act 1892, the offence of habitual drunkard from s.65(6) of the Police Act 1892, and inserts a new Pan VA in the Police Act entitled 'Apprehension and Detention without Arrest'.

The main provisions of the new Part are as follows:

1. A person who is intoxicated (defined as 'seriously affected apparently by alcohol') and in a public place or trespassing on private property may be detained by police (s.53A).

2 . The police have a power to search and remove personal property from the detained person (s.53B). A register is to be maintained by police to record property taken and returned to the detained person or to a person into whose custody a detained person is released.

3 . Following detention a police officer has three options:

   (a) place the intoxicated person in a police lockup;

   (b) release the detainee to the care of a person who applies for his or her release - if the police officer reasonably believes that the person is capable of taking adequate care of the person and where the detained person agrees and signs the register (s. 53G).

   (c) arrange for the person's admission to hospital (s.53H).

4. Where a child is apprehended under the Pan then, where practicable, the child should not be taken to a police station or lockup to be detained until the police officer has first attempted to take the child to his residence or to release the child into the care of a person under s.53G (s.33A).

5 . A police officer may refuse an application to release a detained person on grounds that the applicant is not capable of taking adequate care of the detained person. The applicant may apply for review of this decision by a Justice (s.53 G (3)).

6. A register is to be maintained to record the date and time of entry and release from detention. The register is to be signed by the detained person, the person into whose care the detained person is released or a responsible person at an approved hospital to which the person is admitted. Release shall be deemed to be at the time and date recorded in the register (s. 53E).

7 . While a person is detained he or she shall not be charged with an offence, questioned in relation to an offence, photographed or fingerprinted (s.53F).

8. A person may be detained for 'as long as it reasonably appears to a police officer that the person remains intoxicated' (s.53D).

9 . A police officer shall not defer releasing a detained person except between the hours of midnight and 7.30 am, if release during these hours is not in the best interests of the detained person. The reason for the deferral shall be recorded in the register (s.53 J).

10. A detained person may request a police officer to take him or her before a Justice to make an application for release (s.53 1).

11. If, eight hours after a person has been apprehended, it 'reasonably appears to a police officer by whom the person is detained that a person is still intoxicated', the police officer shall bring the person before a Justice as soon as practicable (s.53 I (c)). The Justice shall order release where the person is no longer intoxicated, or may give directions to the police for the welfare and safety of the person. If the detained person objects the Justice shall not order his release into the care of another person.

12. A police officer shall not defer bringing the detained person before a Justice except where necessary to meet reasonable organisational requirements. The reason for any deferral shall be recorded in the register.
(s. 53J)

13. A Justice, police officer or any person performing a function under Part VA is not civilly liable for anything done or omitted in good faith in connection with the performance of functions under the Part (s.53K).

14. A person may, within thirty days of discharge from detention apply to a court for a declaration that at the time he was taken into detention he was not intoxicated. A declaration made does not establish that the detention was unlawful (s.53L).

15. A person detained under the Part shall not be regarded as being in legal custody for the purposes of law relating to escape from custody. (s.53M)

The Act is one aspect of attempts to: change attitudes away from penalising a person affected by alcohol, remove intoxicated persons from the rigours of custody, and move towards community solutions to a social problem. In this regard it is commendable that legislation has finally been enacted.

Decriminalisation legislation offers definite advantages to the police force including the following: relief from an unpopular type of work, reduced time spent on paper work, attendance at court and fine default enforcement, reduced expenses for provision of meals and transportation of prisoners, and possible satisfaction in having ensured that an intoxicated person is cared for in the community. In addition, the scheme of the legislation offers significant possible benefits by removing a substantial 'at risk' group of Aboriginal people from the hazards of frequent detention in custody.

However I am of the view that inadequacies and omissions exist both within the legislation itself and in the available community resources needed to respond to the legislation. The experience of other Australian States and Territories must be recognised if the legislation is to achieve its desired aim.

In 1985 New South Wales amended its legislation to provide an onus on police to exhaust alternatives before detaining a person in the police lockup. Commissioner Muirhead's Interim Report noted that such an approach *'should be reflected in all such legislation'* (page 28). The Western Australian legislature however has not seen fit to include a statutory duty on police (except as concerns the detention of children).

While it may be the Government's 'clear intention' that:

> .... *police officers should not passively wait for applications for the release of detainees. They will be expected to exercise some initiative in arranging placements in the community rather than in the lockup* (Page 2128 Hansard)

it is my view that a greater onus should be placed on custodians.

During the debate on the Bill the views of the Law Society of Western Australia were presented, including the following:

> *There should be a positive duty imposed on the police to make reasonable attempts after apprehending an intoxicated person to:*
>
> 1. *Notify the next of kin;*
>
> *2 . Place the detained person in a sobering up shelter or otherwise in the community* (Page 5727).

The Minister's response to this was:

> *I think those matters are reasonably covered. In any event I advise the Chamber that my office has been assured by the police that those matters will be directly addressed by inclusion in routine orders* (Page 5737).

Regarding the issue of a statutory duty the Department replied to questions by the Royal Commission as follows:

> *The Department ... does not endorse the principle that legislation of this type should cast a statutory duty on police to consider alternatives to detention.* (Responses by the Police Department which the Royal Commission would like clarified, 31 August 1990)

Commissioner Bull appeared to reject what he termed '... *a strict obligation on police. It must come back to discretion'.* He apparently relied on his knowledge of the Canadian experience and he envisaged problems of facilities not wanting to take 'the troublesome drunk' (T627 31.7.90). The Commissioner's Police Gazette notice in respect of the legislation provided:

> ... *where sobering-up shelters or other facilities are available, or where some other person is prepared to accept and care for intoxicated persons, members should endeavour to use these alternative arrangements rather than detention in a police lock up.* (5 April 1990).

In section 5.2.8 I discussed the weight of instructions given to Police for the execution of their duty. As I have noted earlier, the experience of the Commission has been that obligations contained in routine orders and instructions published in the police gazette require greater force and recognition than their current guideline status.

I am of the view that the wording of the New South Wales legislation in this regard is reasonable and inherently sensible and should be adopted in the Western Australian Act. There is still a wide area for police discretion. In most country areas the local police will know the intoxicated person and be able to assess alternatives to the lockup relatively easily. Because sobering up centres will probably not be established in the near future in many country areas a practical scheme needs to be created that will be able to be applied in smaller centres throughout the State. Perhaps some incentive and recognition could be offered to local police to encourage and recognise their efforts in ensuring alternative

placement. The real challenge for the Police Department is to be in touch with police officers at a local level, actively canvassing their opinions on what can be done now with the resources currently available. The Department should also encourage the drafting of local orders to be in touch with the needs and options of the local community.

I refer in this regard to the strategies employed in other States, identified by the Western Australian Alcohol & Drug Authority and presented later in this section. There may be a role for Aboriginal people to be paid to assist police in their assessment of alternative placement of intoxicated persons.

The Law Society of Western Australia also referred to s.53 I(c) concerning review of detention if the person is still intoxicated after eight hours. In the Society's view:

> *There will be situations where the eight hours expires whilst there are no police officers on duty. The Society considers that an intoxicated person should not be left unattended at a police station and that the legislation should make provision for continual supervision of a detained person.*

The Minister's response to this was:

> *We cannot use this Bill to re-organise police operations ... However I understand that the long-term aim of the Police Department is to have around the clock cover. This is not provided now and it is not practical to attempt to do so with a piece of legislation like this* (P.5738).

The Police Department was asked by the Royal Commission about their policy in relation to not encouraging detention of persons in unmanned stations, how it was communicated to officers at a local level and how it was monitored.

The Department's response was:

> *The 'policy' is left to be determined on a regional or local level because of the variety of conditions under which Police Stations operate. Factors such as remoteness, staffing, costs, other duties will become relevant at this level. There is no formal monitoring because some stations have no choice but to operate in this way.* (Responses by the Police Department which the Royal Commission would like clarified, Q 8.3, 31.8.90)

The unacceptable hazard of detaining an intoxicated person in an unmanned station was highlighted by the death of Ginger Samson. The issues of unmanned stations and lack of adequate supervision and communication in manned stations are discussed in section 5.2.1 of the Report.

While the legislation may be seen as having the potential of removing a portion of the custody cycle, i.e. imprisonment as penalty or for default of lines for drunkenness, the experience of other jurisdictions has been that decriminalisation has led to an increase in detentions (RCIADIC Criminology Research Unit Res. Pap. No. 3 Public Drunkenness - Australian Law and Practice (Oct 88)). In South Australia for example Ms O'Connor (who appeared on behalf of the National Aboriginal and Islander Legal Service) informed the Commission that an Aboriginal person was 46% more likely to be detained under the relevant South Australian legislation and kept in the city watch house than that Aboriginal person would have been if they were simply arrested for being drunk (RCIADIC SA3:1623). There appears to be a greater willingness by police in other jurisdictions to detain an intoxicated person where there is no necessary arrest and charge procedure.

It is too early to judge what will be the effect in this State. Achievement of the aim of reducing the number of Aboriginal people in custody or detained in police cells will depend on whether the experience of other jurisdictions is duplicated in Western Australia, the capacity and number of alternative facilities and initiatives and the possible increased use of alternative charges. The evidence of the officer in charge of Halls Creek Police Station is indicative:

> Q. *Would you be taking as many into custody now as you would have been before the change in the law?*
>
> A. *At the moment Yes. It's about the same. The only difference is that you have got the detainees instead of the arrests.* (RCIADIC W29:61).

The community perception which has been reinforced by some police evidence is contained in the following evidence:

> *I am against the abolishment of this drunkenness thing because in my opinion, if you abolish that, then you start upping things like being disorderly, or loitering. I mean, you are not going to wipe away anything.* (RCIADIC W8:267)

Officer in Charge of Halls Creek Police Station:

> Q. *We were told this morning too that in the opinion of Mr Green there has been an increase in the number of arrests for park drinking and street drinking. Would you agree with that?*
> A . *Since I have been here, it has increased, yes.*
>
> Q . *Is that as a result of an instruction you have given to your officers ?*
> A. *Not directly, no. What I have been trying to get the staff to do is that if there is an offence committed, rather than use the drunk charge, charge them with the offence they can see they are committing. The park drinking and street drinking mainly the park drinking would have gone up; the street drinking seems to be much the same as it always has been.* (RCIADIC W29:62)

Research conducted by the Royal Commission concerning arrests, custody and bail in Kalgoorlie (RCIADIC Criminology Research Unit Res. Pap. No. 18) has revealed a 'massive reduction' in the number of arrests for the offence of drunkenness in the period I March 1990 to 14 April 1990 as compared with earlier 1987 data. This is certainly a positive development however it is probably too early to determine whether this trend will occur in other centres and flow through to detention figures under decriminalisation. The Commission supports a constant monitoring of the effect of the legislation and endorses a formal review process after the legislation has been operating for an appropriate period e.g. twelve months (WAADA).

Sobering Up Centres

Calls for drying out centres have been made for years if not decades. In 1979 following the death of a woman in East Perth Police Station from acute alcohol poisoning, the Coroner directed that attention be given to establishing drying out centres. In his Reasons for Decision following the death of Wardle, Cameron, Morrison and Samson in 1988, Mr McCann noted *'The merit of the proposal has not diminished with time'* He continued:

> *In the absence of some other care facility, little purpose would be served by the drunk being driven to his or her home* ... [this] *would have the potential for disruption and disturbance and perhaps injury. What is needed ... is a shelter with facilities for sleeping, ablution and basic nourishment, supervised by staff with some training in observation for underlying injury and illness ... It may be possible to calculate the money spent on alcohol ... and it may be possible to calculate how much the State and Federal Governments receive by way of taxes and charges upon the supply and consumption of alcohol ... It is likely that the cost of a twenty-four hour night shelter would be but a fraction of the taxes and charges collected.* (Pages 87 & 120)

In answers to questions posed by the Royal Commission, the Police Department expressed the following view:

> *Police cells are considered an inappropriate place to detain intoxicated persons however in many areas these are the only facilities available.* (Responses of Commissioner of Police to Specific Questions Raised by RCIADIC Q3.3(a) PI 1)

In Wodulan, Dr Hunter expressed the following view:

> *I think we should study the experience of other places - N.T., S.A., and N.S.W. It seems to me that it should be a uni-purpose facility that it's just for sobering up and I think that it has to have a good relationship with the police ... I think that it has to be something that should be in place before one rushes into legislation, and in the meantime the police should be worked with in terms of the way they deal with those issues.* (RCIADIC WI 2:428).

In his Second Reading Speech the Minister described the placement of an intoxicated person in a police facility until he or she is no longer intoxicated as 'the option of last resort' (p. 2128 Hansard). He stated:

> *The Government will assist by encouraging and supporting the establishment of special sobering up centres in areas where public drunkenness presents a special problem* (p. 2128 Hansard).

In the report of my inquiry into the death of Wodulan, I commented that it was not in the community interest to have decriminalisation without the provision of sobering up facilities. Richard Midford, (Project Coordinator, Decriminalisation of Drunkenness, Western Australian Alcohol and Drug Authority) in a paper entitled 'Decriminalisation of Drunkenness and the Establishment of Sobering Up Centres in Western Australia' noted:

> *It was very clear from the onset that there would never be sufficient funds to operate sobering up centres in every location where public drunkenness was a problem. Accordingly some means of most effectively employing the allocated funding had to be devised.*

Basically public drunkenness arrest data was utilised. Two locations: Halls Creek and Fitzroy Crossing stood out as having the highest drunkenness arrest figures of the State and together with Perth they accounted for approximately 44% of all drunkenness arrests for 1988-89. Hedland was chosen as the fourth location for a number of reasons: its location in the Pilbara region, arrest data and anecdotal information indicated that drunkenness was a significant problem for existing community resources and there was community support for the project.

Capital cost funding of $800 000 was committed by the Commonwealth on a dollar for dollar basis for the establishment of sobering up centres in Western Australia (see Midford paper).

Currently established sobering up facilities are limited to one in the Perth area. Details provided by Mr R. Midford of the current developments are as follows:

- the Salvation Army has operated an interim service at premises in West Perth since May 1990. Purpose designed facilities will apparently be ready by early 1991.

Plans are in train for the establishment of sobering up centres at the following locations:

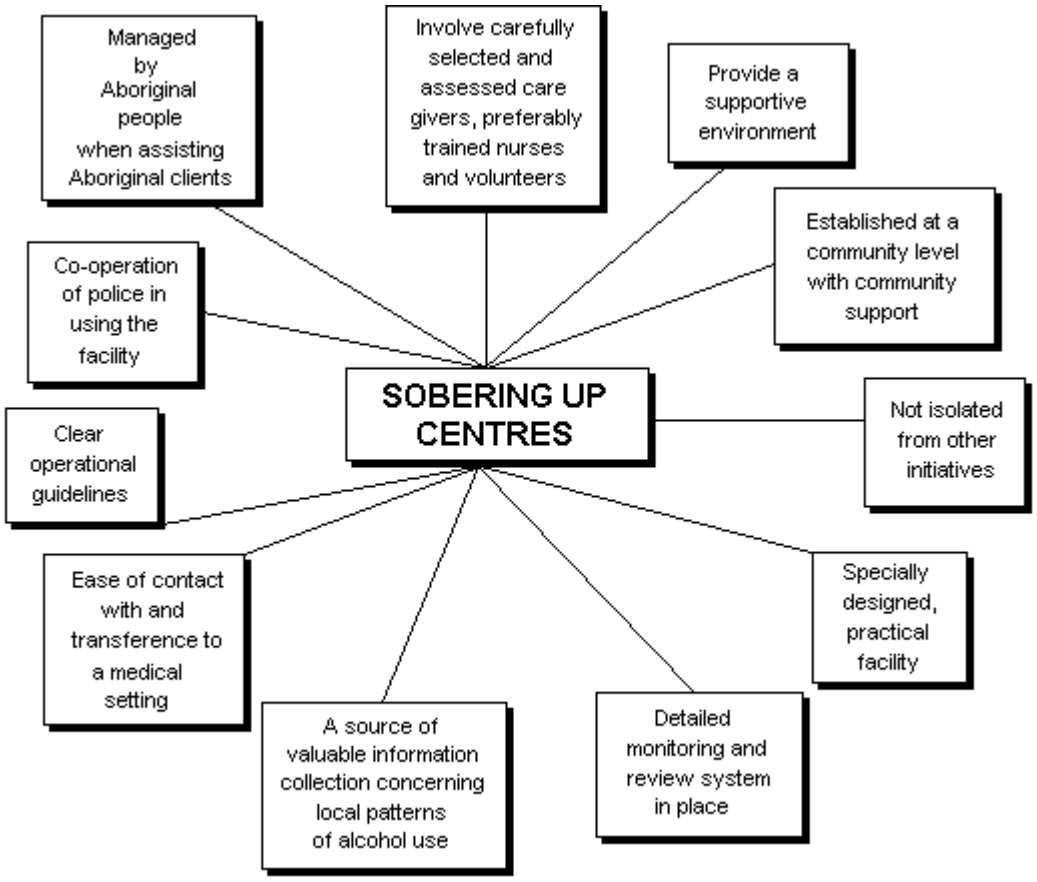
South Hedland: In August 1990 the Salvation Army were selected to operate the planned centre, a site has been identified and moves to acquire it commenced. An interim service should be operating from November 1990.

Fitzroy Crossing: A community group, substantially Aboriginal in membership, has recently formed with the intention of managing the local centre. There is substantial community agreement concerning the appropriate location for the sobering up centre.

Halls Creek: A local church (the People's Church) with a substantially Aboriginal congregation has been selected to operate the proposed centre and a management group has been formed. A lease is currently being negotiated for a site. Due to the scarcity of accommodation it is unlikely that a service will be operational until the purpose built centre is completed in early 1991.

I consider that the current number of sobering up facilities is inadequate. Eight of the cases before the Commission involved last detention following an arrest for drunkenness (Robert Anderson - Wiluna, Faith Barnes in Kalgoorlie, Roy Walker in Kalgoorlie, Stanley Brown in Broome, Hugh Wodulan in Broome, Albert Dougal in Broome, Wayne Dooler in Carnarvon and Ginger Samson in Roebourne). Would the situation of these eight deceased be any different in 1990?

Sobering up facilities must satisfy the following requirements:



The Western Australian Alcohol & Drug Authority in its submission to the Royal Commission commented as follows.

> *Four sobering up centres in a State as large as Western Australia, no matter how well sited, cannot cater for all people picked up for public drunkenness. Consequently the Authority is investigating the viability of alternative smaller-scale strategies to provide short term care for drunk people. Examples of strategies employed in other States are:*
>
> *1. People willing to take a drunk person into their own home overnight on a voluntary or fee for service basis;*
>
> 2. *Use of rostered volunteers to care for drunk persons when required;*
>
> *3 Adding overnight facilities to a day drop-in centre;*
>
> *4 Volunteers driving drunk persons home;*
>
> 5. *Adding sobering up facilities to an existing hostel;*
>
> *6. Setting up small sobering up centres under the management umbrella of local hospitals.*

I support the initiatives of the Authority in its attempts to continue to reduce the number of persons who may still be held in police lockups.

In conclusion it is considered that decriminalisation legislation will not result in a difference in practice between arrest and detention and produce the desired aim of reducing the number of persons in custody unless the following issues are fully addressed:

1. Provision of a statutory duty on police to utilise custody as a last resort.

2 . Involvement of Aboriginal communities in determining priority areas for the further establishment of alternative facilities, and in the control and methods of operation of such establishments or schemes.

3 . Acknowledgement of the potential enormous costs saved by removing a person from the criminal justice system, enabling the establishment of secure funding channels for sobering up facilities or alternative schemes, their maintenance and flexibility in responding to community needs.

4 . Securing cooperative working relationships between police and management of sobering up facilities.

5. Sobering up centres are not an end in themselves but must be linked to a multi-dimensional community response to the underlying causes of excessive alcohol consumption.

6. Ensuring (1) that the aim of the legislation is not diminished by utilisation of alternative charges such as street or park drinking or disorderly conduct and (2) formal monitoring of this process is pursued by relevant authorities.

7 . Addressing the practice of detention of intoxicated persons in stations that are unmanned or with inadequate communication facilities.

5.5.3 TREATMENT FACILITIES

5.5.3.1 Introduction

Commissioner Muirhead in his Interim Report noted the *'need for the establishment of detoxification centres and rehabilitation centres managed by Aboriginal people for Aboriginal people'* (Report page 29).

The issue of treatment facilities has arisen directly and indirectly in many of the inquiries. Later in this section I discuss the facilities available to Aboriginal people in four centres: Carnarvon, Roebourne, Broome and Kalgoorlie as a sample of facilities in this State. Ten of the deaths investigated occurred in those locations (Wayne Dooler, Ginger Samson, John Pat, Stanley Brown, Dixon Green, Ronald Ugle, Hugh Wodulan, Bernard McGrath, Milton Wells and Kim Polak).

In its submission to the Commission, the Central Australia Aboriginal Congress Inc., discussed the effectiveness and necessity for alcohol programmes for Aboriginal people. The congress stated:

> *The effectiveness of alcohol programs is controversial. While many intimately involved in a particular program have a strong belief in the effectiveness of their program, objective analysis has tended to show that a wide range of practices, have similar, and usually low success rates, if success is judged as recurrence rate after a period of time. Different approaches suit different people, and no single approach is likely to be universally successful.*

> *This is especially true, as none of these programs actually addresses the fundamental causes of alcohol problems in Aboriginal Communities - dispossession of land, unemployment and lack of community resources and activities, etc.* (Submission dated 30.9.88).

Commissioner Dodson in his Report has discussed the need to link stopgap measures such as sobering up shelters to the structural determinants of drinking.

It is important in any discussion of alcohol treatment facilities to retain a wide perspective towards the causes and treatment of excessive alcohol use. Alcohol use problems cannot be meaningfully viewed as solely an individual pathology. Likewise treatment facilities must be many-faceted, have community relevance and involvement. They must form merely one aspect of the attempt to address excessive alcohol use.

In my Report into the Inquiry into the Death of Jimmy Njanji I noted the sound submission by CDBR that *'what is needed is a many-sided program of community support aimed at rehabilitation in which the key organising forces are the Aboriginal people themselves'* (Report page 41).

Fagan and Swan in their commentary on 'The Effects of Alcohol on Cognitive, Psychomotor and Affective Functioning' (Report and Recommendations Prepared by an Expert Working Group for the RCIADIC) offered the following view in this regard:

> *Resource providers* (e.g., Department of Aboriginal Affairs) *do not have insight into the social and cultural factors that are associated with alcohol use in Aboriginal communities and therefore often provide only enough resources to treat one symptom of a multidimensional problem.*
>
> *Aboriginal communities are not homogeneous. Consequently, there cannot be an across-the-board single solution to substance abuse or a 'package deal' that can be applied nationwide. Each and every community needs to look at the causes and solutions taking into account individual pathology, physical, social, psychological and cultural factors* (page 137).

Treatment Facilities

Alcohol treatment facilities basically fall into three categories:

(1) sobering-up

(2) detoxification

(3) rehabilitation

Sobering-up Facilities

I have discussed sobering up shelters in the context of decriminalisation of drunkenness in section 5.5.2. Such centres are in operation or planned for Perth, Halls Creek, Fitzroy Crossing and Port Hedland. However there is a need for such facilities in other centres. In particular in my Report in the Inquiry into the Death of Polak I described the urgent need in Kalgoorlie for a sobering up centre managed by Aboriginal people (Report page 53). In such centres the services of Aboriginal counsellors should be available to ensure that

clients are aware of rehabilitation options and to offer support for those seeking to tackle their excessive alcohol use. I refer in this regard to Commissioner Dodson's Report and the necessity for integration between sobering up centres and other treatment and educative initiatives. Dr Foy in his submission to the Commission noted that often the most helpful person for someone experiencing drying out is a relative, friend, recovering alcoholic or community member who has no formal training but who is able to communicate effectively, reassure and comfort the drinker. Dr Foy went on to outline guidelines for people who may be assisting a person who is drying out (Submission Sept 1988).

Detoxification Units

Detoxification is usually managed in one of three ways:

- in hospital by using predetermined procedures
- in purpose built detoxification units with medical support in the case of less severe withdrawals, in the community itself by trained lay people with medical back up (See Foy submission Sept 1988)

Evidence in the cases has revealed problems in the performance of detoxification in public hospitals (see e.g. later discussion concerning Carnarvon facilities). In my Report in the Inquiry into the Death of Wodulan I noted that detoxification patients tended to receive lower priority than other patients (Report page 25). This is certainly an unsatisfactory circumstance.

Rehabilitation Programmes

There is a need for diverse rehabilitation facilities and long term support schemes. They may vary from 'dry' bush locations many kilometres from liquor outlets, halfway houses in urban locations encouraging re-establishment of one's life without alcohol, to a wide variety of schemes adopting various counselling and rehabilitation philosophies.

5.5.3.2 A Sample of Western Australian Facilities

Canarvon

In my Inquiry into the Death of Dooler, evidence was given concerning alcohol detoxification and rehabilitation facilities in Carnarvon. The town has a population of between 6000 and 7000 with approximately one-fifth of the population being Aboriginal (ABS 1986).

Detoxification occurs at the hospital (RCIADIC W4:396). Although the hospital does not set aside beds, it appears that beds are always available for this purpose (RCIADIC W4:314). Dr John Williams was a salaried general practitioner at Carnarvon Regional Hospital until 1973 when he was appointed senior medical officer at the Community and Child Health Service for the Gascoyne area. From his experience Dr Williams noted:

> *While working at the Carnarvon General Hospital I gained the impression that the hospital staff didn't like treating drunken Aborigines. I believe this attitude filtered down from the top of the hierarchy at the hospital. The hospital staff were loath to treat Aborigines for minor matters. During a recent visit to*

> *Carnarvon in early 1988 It was still apparent to me that this attitude still prevailed at the hospital* (RCIADIC W14).

The Salvation Army runs a residential rehabilitation programme or bridging course at Ingada (formally the Church of Christ Mission). The programme is supported by the WAADA. The Salvation Army also has a residence in Carnarvon with capacity for five people for sobering up. There is one full-time staff member. The five places are apparently not usually fully utilised from day to day. The referrals may be voluntary, via the hospital or by the police. According to the coordinator of the residence, Aboriginal people are now the main users of the sobering facility (RCIADIC W4:397). People who use the residence are offered the facility of the bridge programme at Ingada (RCIADIC W4:398).

Finally Alcoholics Anonymous is available. There is also an Aboriginal 'dry' community at Mount James (RCIADIC W4:15-16) run by the Burringah Community. It is in the early stages of development (RCIADIC W4,330-33 1).

The AMS would apparently like to set up alcohol treatment facilities in Canarvon but *'lack of funds prevents a lot of things'* (RCIADIC W4:214); *'a lot of things want doing but they just haven't got the resources and things to do it'* (RCIADIC W4:329).

Dr Board who had worked both in the hospital and in general practice in Carnarvon since 1972 gave evidence that in his view alcohol treatment facilities were sufficient:

> ... *but with a qualification, those among the Aboriginal community who could perhaps benefit from the facilities tend not to use them ...individuals in the Aboriginal community ... tends to retreat from what might be seen as a predominantly white institution or facility* (RCIADIC W4:15).

The Assistant Hostel Manager of Aboriginal Hostels Carnarvon, Mr Mitchell, was of the view that Aboriginals did not use the Salvation Army facility extensively because Aboriginal people *'don't like being taken away from families and that and stuck out - you know, like an institution'* (RCIADIC W4:329).

Major Hoare of the Salvation Army came to Carnarvon to set up the alcohol rehabilitation program *'along the lines of the Salvation Army's bridge program but mainly directed towards Aboriginal people'.* It is the only Salvation Army bridge programme outside Perth (RCIADIC W4:401).

Two of the staff for the programme are Aboriginal, a cook and hostel supervisor (RCIADIC W4:407).

Major Hoare described the bridge programme which lasts about 18 weeks in the following terms:

> *Our whole set up is that we believe that a person who is suffering from an alcohol problem ... is allowing alcohol to control them, so that our process is that we want them to become winners and to take control of their life again ... We have a number of sessions of alcohol education ... the effects it can have in the short term and the long term ... Then we talk on ... the motivation side of things ... they've got to find something else to do for the 3 hours that they were occupying with drinking ... we aim at teaching them to communicate better and also to assert themselves ... We touch on the subject of anger management ... several sessions are done for stress management and also relaxation techniques and then we do a number of sessions that are general sessions but implicate a*

> *spiritual side of the program ... Fifty of the 74 admissions to the program in 1987188 were Aboriginal people* (RCIADIC W4:400).

The success rate for the programme is approximately 10% (RCIADIC W4:401-402).

Major Hoare expressed the problems of long term success as:

> *A number of them have said to me in the past that they have a problem that when they go out, if they go back to their old situation, that there will be quite a deal of pressure on them to drink again ... problems are where liquor is readily available and ... friends or relations are in a position to put a bit of pressure on to say 'prove your manliness by having a drink'* (RCIADIC W4:401-402).

Major Hoare endeavoured to make it possible for dependent children to be with their parents on the programme and had had one situation where a family group attended where four of the members of the family were on the programme.

Speaking of the reluctance of Aboriginal people to attend the programme, Major Hoare stated:

> *Initially there was quite a reluctance. I can remember being in court here one day when one gentleman who had been out at that area as a child, when he was asked if he would come and try the program said that no way would he go back out to the Mission*... (RCIADIC W4:403).

Broome

In my Report into the Death of Wodulan I stated that adequate detoxification and rehabilitation facilities in Broome are essential (Report page 25).

The Commission in that inquiry heard evidence from Ms Read (a registered nurse) who worked as Manager and Health Education Officer at Milliya Rumurra from 1984 to 1988. Milliya Rumurra runs a three month residential alcohol programme, primarily although not exclusively for Aboriginal people. The course can be extended for individual clients (RCIADIC W12:303). The Organisation has an Aboriginal Committee. Milliya Rumurra takes people from all throughout the Kimberleys and the Pilbara not just the Broome area (RCIADIC W12:273).

The only detoxification facility in Broome is at the hospital (RCIADIC W12:292).

Ms Daniele (a registered nurse) who worked at Milliya Rumurra from 1982 until 1987 stated:

> *We tried to establish this policy that they* [the hospital staff] *always kept a couple of spare beds ... if someone needed detoxification, but that didn't always work out when they had the visiting ENT specialist, or whatever ... It was only later on that we really pushed for that ... and then they started ... becoming more aware and understanding about the problem, and then started allocating a couple of beds. In the early stages it was very difficult.*

She was asked:

> Q. *Do you have any experience of trying to admit a person who needs detoxification to the Broome District Hospital where there are beds*

available but the hospital being reluctant or refusing to admit that person because they had already been there before for detoxification?

A . *Yes.. That happened quite often.*

Q . *Was it reluctance or did they just refuse?*

A . *Just refused.* (RCIADICW]2:281)

Ms Read told me:

> *There were possibly enough beds [at the hospital] but staff felt unable to cope with the amount of supervision that patients undergoing detoxification needed. They also felt that it was a special area of expertise that they weren't prepared for and weren't happy about taking responsibility for. There was a death at Broome Regional Hospital a number of years ago because of lack of supervision of a patient undergoing detoxification* (RCIADIC W12:292)

> *While I was employed at Milliya Rumurra we tried to standardise a detoxification policy because of the high turnover of doctors.*

> *Doctors coming from different regions had different ideas on detox management, also the people were being discharged from hospital far too early and were still being discharged on Hemineurin which is the usual drug used in alcohol detox* (RCIADIC WI 2:291).

On the relationship between Milliya Rumurra and the hospital Ms Daniele said:

> *It's something that has got to be reviewed regularly and negotiated on a constant basis because you get a turnover of new staff coming up here who just aren't aware and they need to be orientated in the local problems and issues* (RCIADIC W12:281).

The significance of involvement of Aboriginals in the detoxification process, Ms Daniele described in the following terms:

> *... a lot ... sort of get treated - how would you describe it - like they're a waste of time at the hospital. A lot of them get very rudely treated at the hospital, where they just don't feel comfortable there and will tend to run away a lot too. They just feel that they don't really understand what they're experiencing and they feel confident and more comfortable with someone of their own being with them, I think, to help them through that process* (RCIADIC W 12:282).

She advocated a community based Aboriginal-run detoxification unit or the involvement of people with understanding of Aboriginal cultures and ways and of what it is like to experience detoxification (RCIADIC W12:282).

Milliya Rumurra had in the past undertaken detoxification of patients out of necessity (RCIADIC W12:282). This involves substantial risk for the clients and workers. Such facilities must not be forced to perform this function due to lack of alternatives.

Aboriginal Hostels Ltd funds the day to day running costs of Milliya Rumurra with WAADA funding some positions. Other sources of income include the Lotteries Commission, Lord McAlpine and other donations (RCIADIC W12:302). Ms Read complained that minimal additional funding had occurred for staff. She said *'not only did we not have enough workers but they were paid at quite a low rate of pay'* (RCIADIC W12:302). The Committee also wanted to be able to have more staff for out reach work but funds were not available (RCIADIC W12:303).

Ms Read described Milliya Rumurra as *'a grossly under-resourced agency in terms of being available to provide adequate facilities for the clients there ... It was no good rehabilitating people and then not having adequate staffing resources to follow those people up once they returned to the community'* (RCIADIC W12:292).

Ms Daniele had worked at Milliya Rumurra both as a counsellor and coordinator of the organisation. The counsellor's role was to visit the communities, prisons, lockups, schools, hospitals and other Organisation to talk about, and help people with, alcohol abuse problems (RCIADIC W12:270,280). They could refer a person for admittance to the centre and the client would then be assessed by a doctor prior to admission (RCIADIC W12:270). The Centre relied on AMS doctors or the hospital doctors (RCIADIC W12:278). In 1982 and 1983 there were three counsellors, most were ex-alcoholics without specialist training although a couple had completed a course run through WAADA (RCIADIC W 12:27 1).

Ms Daniele spoke of the initiative that the centre tried to offer of having a day course for people who did not want to come to the residential course. *'We just didn't have the resources or the staff to carry that through'* (RCIADIC WI 2:284).

She described Hugh Wodulan's death as 'unnecessary' *and 'appeared to me to be a result of the refusal by various agencies to admit and support Hugh when he was in a very disturbed state'* (RCIADIC WI 2:270). He had been denied reentry to Milliya Rumurra shortly before his death because of his previous disruptive behaviour (Report page 25).

<u>WAADA Study</u>

In May 1987 Rory O'Connor and Associates consulted and reviewed fourteen Aboriginal organisations involved in alcohol counselling and treatment/ rehabilitation services. The project was jointly funded by WAADA and DAA ('Report on the Aboriginal Alcohol Treatment/Rehabilitation Programmes Review and Consultation' prepared for the Western Australian Alcohol and Drug Authority by Rory O'Connor and Associates Pty Ltd June 1988). 1 refer in this regard to the comments by Commissioner Dodson concerning the adequacy of this report.

The report stated that the average monthly occupancy rate of Milliya Rumurra was 40 persons with the mean length of stay 7.3 weeks. The Report discusses in detail the client flow and treatment outcomes, together with a history of the financial administration and treatment programmes. In summary the author describes the centre in the following terms:

> *Milliya Rumurra offer residential rehabilitation in addition to preventative and educative services. Residential rehabilitation has tended to develop into ever larger undertakings, this growth in the case of Milliya Rumurra has sapped many of the energies that would otherwise be expended on out-reaching activities ...*
>
> *Milliya Rumurra currently employ three counsellors, one manager, one health educator and an administrator/book-keeper. The pressures inherent in this type of work lead to high staff turnover...*
>
> *Issues of Concern:*
>
> *- Local senior police are concerned about the lack of feedback concerning the counsellors' activities.*

- Other Aboriginal organisations - liaison is essential to avoid wasteful duplication and co-ordination.

- Government Departments indicate there is a need for increased cooperation and liaison on the part of Milliya Rumurra.

Administrative, accounting and statistical records of clients are consistently of a high quality.

Milliya Rumurra's clients are expected to abide by the centre's rules and routines; those who do not are dismissed. Milliya Rumurra thus impresses as a well-ordered community where people live disciplined lives.

Ex-clients, speak very highly of the devotion to duty of the staff and the running of the centre. Milliya Rumurra has continued to offer periods of recuperation to chronic problem drinkers and general a number of total abstainers. The Health Educator suggests a 14% success rate ...

The population expansion in Broome is likely to *increase pressure on Milliya Rumurra and* it *may become necessary to consider restricting admissions* (page 9-10, 15 summary).

O'Connor's Report includes similar analysis of Djellingmarra, an incorporated group in Broome with the following objectives:

- *to promote action against alcohol dependence*
- *assist the development of economic programs*
- *help encourage people afflicted by alcohol to manage their own affairs and*
- *help keep Aboriginal culture*

A major activity is bringing clients and their families away from an alcohol environment and into such things such as bush trips and fishing expeditions. WAADA has assisted by funding a vehicle (O'Connor, Summary page 13).

Roebourne

The Committee to Defend Black Rights in its submission in the Pat inquiry pursued the issue of alcohol treatment in the Pilbara region of Western Australia.

It stated:

There are no detox centres in the Pilbara!

There are no rehabilitation centres in the Pilbara! (Submission of CDBR in Pat pI0l)

The Committee recommended to the Commission that facilities of both types be established in Roebourne, controlled and staffed by the Aboriginal Community (Submission of CDBR in Pat p108, Recommendations 4 *& 5).*

Marshall Smith of the Panyjima people (Probation and Parole Officer with Community Based Corrections) presented his experience of the lack of facilities in this region in the following terms:

> *We have no suitable place here for when a person is going through an alcohol problem stage. We get a lot of that from the courts. Quite often, a person has been put on probation or given a community service order or parole, with the condition that they get alcohol counselling and/or treatment. We don't have the facilities.*
>
> *Even the Aboriginal Medical Service doesn't have a centre. We are overloading Milliya Rumurra in Broome, which is 700-800 kms away* ...
>
> *We have no detoxification centre and we have to beg, book and plead with the hospital at times. The hospital tries its hardest to put someone through detox;* ...
>
> *We need a detoxification centre here, urgently. The police have the same concern. You can't just grab someone who's under the influence, put him in a vehicle and take him out - any number of things can happen. I'm talking about taking him out to Woodley's camp at Ngurawaana. There's no rehabilitation centre there but its away from alcohol.' for a period of drying time. They can come back into town at any time - next day for that matter* ...
>
> *Those are serious, vital problems. and we don't have a centre that can do that. The hospital is at its limits'* (W/19/178(s)).

Mr Smith's reference to Woodley's camp at Ngurawaana refers to a 'dry' camp in the bush in the Millstream area run by an elder, Woodley King. Aboriginal people are encouraged to attend to get away from alcohol (see CDBR Submission in Pat p99).

Ngurawaana has not developed as Woodley King had hoped. Mr Smith says:

> *The old fellow who runs Ngurawanna, the camp for alcoholics, had a vision some time back when he was himself an alcoholic. What he wanted was to have a place of his own out there where he could take his people on a station type system. His dream is there. But it's very difficult for any department or anybody else to expand on that, on his dream, in his situation, in his camp. You are on private property* (W/19/187(s)).

O'Connor in his Report Summary commented on Ngurawaana in the following terms:

> *The original concept was to establish a dry camp where traditional culture would be taught. The move from a 'dry camp' concept to establishing a 'rehabilitation programme' occurred in 1985 ... Ngurwaana has had a number of recurring problems;*
>
> *- poor management*
>
> *- isolation and*
>
> *- lack of clarity in the work relationship with Mawarnkarra [Health* Service) ...
>
> *Until 1987 the counselling method emphasised traditional culture as a rehabilitative procedure towards abstinence. The ADA funded counsellor's approach is a mixture of Christianity and AA. The status of the counsellor as a*

> *ritual leader adds credence and authority to his work role. Ngurawaana's dry camp status is well recognised and adhered to. However the majority of problem drinkers stay for only brief periods (seven days is the average)* (page 9 summary, O'Connor).

Mr Smith's view of what is needed includes the following:

> *My idea is that we need a half-way house; detox centre. When the police pick up someone for being drunk, maybe if we had this facility, with a bus service or a vehicle pick up service, if there was a relationship with the police going on, either they could drop a person off at the centre or ask us to pick up the person and take them to the centre* (RCIADIC W19,1875).

Lona Howie is Coordinator for the Mawarnkarra Health Service at Roebourne. This is an AMS which employs alcohol counsellors. Mawarnkarra has received some support from WAADA (see responses to questions by RCIADIC page 5). She expressed her view on recent funding changes to the centre as follows:

> *There has been a serious upheaval in the medical service. The funding bodies recently came here and reviewed the funding. As a result they have said that the alcohol co-ordinator's position is not required. That the alcohol workers should work back in the general health area and from there do their work. The current manager would be responsible for all health work whatsoever. He would then assist alcohol workers develop the necessary programmes and to ensure that alcohol counselling is carried out and planning work loads. The people who did the review acknowledged that there was an alcohol problem in Roebourne but they said that it appeared to have lessened and was not as serious as previously. This would be hard to justify. What this attitude says to me is that the federal funding body doesn't want to fund alcohol problems and believes that this is a state responsibility* (W/I 9/187(k)).

Mawarnkarra provides the following services according to Ms Howie:

> *As to the area of alcohol there is a coordinator and three alcohol workers. We provide alcohol awareness program ; co-dependence programs i.e. working with the family-non-drinkers who are suffering and the one and one counselling with the drinker as requested* (W/19/87(k)).

On alcohol rehabilitation in Roebourne she states:

> *There is a lack of rehabilitation places where people can live-in and attend a full-time program. They can live there for a month or 3 months and go out and do small work skill things and come back and stay. This would allow families to go in with the drinkers and stay for periods. They wouldn't be isolated from their families. This would be our Aboriginal style* (W/I 9/187(k)).

Kalgoorlie

In Kalgoorlie the Regional Hospital is the only facility for detoxification. Dr Roberts, Medical Director of the hospital, commented on the 'revolving door' of this treatment: *'it is often with the same people. We detox them and they go out and then a week later they are back again'* (RCIADIC W31:68).

Dr Roberts supported 'any moves' in the direction of establishment of an Aboriginal agency to undertake detoxification in cooperation with the hospital (RCIADIC W31,68). He believed detoxification could be managed in a 'low intensity son of unit' possibly by trained paramedics or lay people but under some son of medical directorship (RCIADIC W31:69).

Preston Thomas, retired police aide and Chairman of Ninga Mia Aboriginal Village gave evidence in the Inquiry into the Death of Polak. Ninga Mia was incorporated in 1983 and has about 60 permanent residents and a floating population. The aim is to keep the community dry and a half-way camp for drinkers has been set-up towards town where about 20-25 people live. Kim Polak stopped at Ninga Mia; *'He was in and out all the time'* (RCIADIC W I 8:106). Ninga Mia is run by a committee and receives funds from Aboriginal Hostels. According to Mr Thomas, Ninga Mia was originally *'meant to be put therefor fringe dwellers. If they want to go out there and stay they can'* (RCIADIC W18:121). There is no alcohol rehabilitation programme but the community runs a breakfast programme (RCIADIC WI 8:121-122) and a nightly pick up service (O'Connor Summary page 12).

O'Connor noted that there was community concern that while the official policy at Ninga Mia is to exclude drinkers, the drinkers are the real fringe dwellers and more action is required to assist drinking fringe dwellers (Summary page 16).

Yamatji Ngura near Kurrawang Mission offers alcohol rehabilitation (RCIADIC W18:121). It is an Aboriginal run centre which has been established for about six or seven years. It does not cater for people who may need occasional drying out. The centre runs a residential course (RCIADIC WI 8:312,314).

Following his 1987 review O'Connor noted in his Report that while there was general agreement within the Kalgoorlie Aboriginal community that Yamatji Ngura was needed, it had suffered from serious problems. However the current manager has attempted to effectively administer the centre and maintain proper records. The Manager is apparently establishing a programme involving religious elements, A.A. and regular activities. Apparently from 1981 Yamatji Ngura has only turned out one non-drinker (Summary O'Connor page 7-8 & 14).

O'Connor's Report recommended on going support for the centre from DAA, WAADA and AHL but suggested regular reviews and the institution of standard administration procedures (Summary page 24).

O'Connor specifically recommended in his Report that a night shelter be established in inner-town Kalgoorlie.

Dr N. Parekh made a statement to the Commission in the matter of Kim Polak. Dr Parekh worked in a part-time capacity for AMS because the service was unable to fund a full-time doctor (see evidence of Greg Stubbs in Bates). Dr Parekh was of the view that until a full-time doctor was appointed at AMS, the health needs of the Aboriginal people will not be adequately met (RCIADIC W18:310).

Conclusion

The provision of alcohol treatment facilities is controversial and an area which sparks a variety of strong views regarding function, means of control and usefulness. However the evidence I have received leads to the conclusion that there is general support within the Aboriginal community for increased staffing and funding for alcohol treatment facilities and

that current services are inadequate. The Final Report of the Aboriginal Issues Unit also lends support to this view:

> *Some communities acknowledged that Government could not solve alcohol problems without commitment from Aboriginal people ... There was a call for alcohol rehabilitation centres to be established where requested by communities. Some participants suggested that all Aboriginal people should stop talking about the problem and do something about it. They wanted the family within Aboriginal society maintained and strengthened.* (Report September 1990 page 27).

1 do not wish to imply however that in the provision of facilities we ignore the more fundamental reasons for why such facilities are necessary. The aim cannot be the provision of more and more facilities. The aim is real and permanent change. 'Me views of Fagan and Swan are important:

> *The motivation for government action comes from intermittent political pressure, rather than from a commitment to effective longterm solutions for future generations. Quick, expedient gestures for Aboriginal problems are sought by government, and the commitment lasts only until media attention has eased or until the next election at best* (page 137, Commentary of the Effects of Alcohol, Report prepared by an Expert Working Party for the RCIADIC).

O'Connor states that unless the:

> *thrust towards Aboriginal community development continues, the rehabilitation, recuperative or counselling services are doomed to continual failure because 'treated' clients will continue to return to awful and deprived circumstances* (O'Connor, summary, page 20).

There also appears to be clear support for the proposition that, as with many health facilities, Aboriginal people gain little benefit from the existing network of services for alcohol problems (see discussion by Commissioner Dodson in his Report).

Dr Foy has stated:

> *This mix of services and settings serves the general community quite well but is much less useful to Aborigines and other groups such as non-English speakers who are outside the cultural majority. In particular, Aborigines tend to stay away from the mainstream hospital system until their problems are very severe and they are equally reluctant to participate in community based services which are used mostly by non-Aboriginal people* (submission dated September 1988).

Similarly the WAADA observed that *'specialist clinical services are not readily utilised by Aboriginal people with alcohol and other drug problems'* (Replies to Questions by RCIADIC page 12 and see comments of Dr Board and Mr Mitchell in Dooler concerning Carnavon facilities).

As I discussed in the section on mental health services, mechanisms must be available for the real involvement of Aboriginal people in advocating facilities and designing the provision of services. Dr Foy suggests that the mechanisms of Aboriginal control may include: the management of centres, an increased responsibility by the AMS for training and planning, the appointment of Aboriginal people to the governing bodies of hospitals and health services which have a substantial Aboriginal clientele and Aboriginal community control in preventative measures (see submission September 1988).

The WAADA in an attempt 'to encourage a more accessible and integrated health response to alcohol and other drug problems', is developing a three month programme for Aboriginal health workers to develop skills in addiction, counselling, brief interventions and preventions (see Replies to Questions of RCIADIC).

Proposals and measures for increased involvement of Aboriginal people in: setting priorities, establishing appropriate methods of rehabilitation, staffing and managing facilities and evaluating success, are to be supported and expanded.

CDBR also recommended to the Commission that Government should reevaluate the cost of ill health and social damage as against the financial benefits gained from its relationship with the liquor industry. It suggested the implementation of an additional levy on the industry to pay for the cost of detoxification and rehabilitation centres (Submission of CDBR in Pat p108, Recommendations 1, 2 & 6).

This view has been supported in other evidence before the Commission. Dr John Spencer formerly Director of Clinical Services of the Western Australian Alcohol and Drug Authority stated:

> *I believe that a levy of one cent on each can of beer sold in Australia would provide enough money to set up treatment facilities. This approach has already been implemented in other countries, including New Zealand* (W/4/48).

Such a proposal is indeed worthy of investigation, particularly when one considers revenue earned by liquor licensing (see section 5.4). Even dated total purchase figures by licensed retailers of all kinds (stores, hotels, taverns and clubs) give an indication of the potential success of this suggestion. (In 1984 total purchases by licensed retailers of all kinds were $301 241 295, see Report of the Licensing Court of Western Australia year ending 30 June 1984.)

Finally I wish to comment on more traditional approaches to people with alcohol problems. The CDBR recommends:

> *That there be no legal impediments placed on communities taking their drunken members out to the bush to be dried out in accordance with traditional belief* (Submission of CDBR in Pat, Recommendation 14).

Inspector Ronald Court, currently in charge of the Aboriginal Liaison Unit, gave evidence in the Inquiry into the Death of John Pat. He supported the view that there should be some legislation to enable elders to perform such a function without fear of charges e.g. deprivation of liberty (RCIADIC WI 9:817).

Dr Spencer noted that:

> *We* [the WAADA] *have found that when the elders of communities take on responsibility for alcohol control, with a degree of autonomy, there has been greater success. It is of course difficult to measure success in this type of work* (W/4/48).

Snowy Judamia, an elder of Warralong in the Pilbara, has stated:

> *This drunk fella is in trouble with my law and I can force him, take him away, make him sober. But the police say I can't force him not unless he's a juvenile. But my law says I can force this fella. I ask the police to be a bit helpful but they say I can't force this young fella. They won't help us with our law* (W/8/18, RCIADIC W8:12 1).

The proposal for support and legislative recognition of traditional authority in addressing alcohol problems has clear merit and requires further review.

5.5.4 LIQUOR LICENSING LAWS

> *Although much is done to prevent the publicans from supplying drink, the law is easily and continually evaded* (Victorian Select Committee of the Aborigines of 1859).

During the second reading debate on the Liquor Licensing Bill reference was made to earlier inquiries into the liquor industry including a 1969 Committee of Inquiry into Liquor Laws and an Honorary Royal Commission in 1983 to examine the then Liquor Act 1970. It was noted:

> *This highlights that the laws governing liquor are of concern to the community and need to be constantly reviewed* (Hansard 3717, 13.10.88).

The evidence before the Commission on this topic has highlighted the strong concern about liquor laws particularly from some Aboriginal communities in country locations.

Commissioner Muirhead voiced this concern when he recommended that Governments should re-examine legislation to ensure that licensees who serve liquor to persons who are already intoxicated, or to persons who are underage, are not only prosecuted but are subject to penalties likely to deter, including suspension or cancellation of licences (RCIADIC Interim Report, 1989:29).

In her second reading speech in respect of the 1988 Liquor Licensing Bill, the Minister for Racing and Gaming stated:

> *For many years the Act* [Liquor Act 19701 *provided an adequate framework for liquor licensing in this State. Increasingly however it has been unable to meet with the changing demands of the industry and the public, especially those relating to tourism. The Act has also been amended so often that it is now difficult to interpret and apply.*
>
> *The Government recognises the important role played by the liquor industry in the economic and social life of the State. Within the industry itself, there are several competing interest groups. With social legislation such as this there are also the legitimate expectations and interests of the general community to be considered. While maintaining regulation of the industry and a balancing of industry interests through different licence categories and criteria, the Bill takes greater account of general community considerations by placing emphasis on the public interest and the requirements of the public in specific localities.* (Hansard 2651/3 13.9.88).

Acknowledgement of community consideration and the public interest is not on its own adequate. Concerted programmes of public awareness to ensure that the provisions of the Act are known and understood and a process to monitor the Act's public interest utility, are required.
The Liquor Licensing Act 1988 ('the Act') came into operation on I February 1989 repealing the Liquor Act 1970. It is a substantial piece of legislation, some 200 pages in length.

The Legislation - in brief

Section 5 sets out the objects of the Act. They reflect to some extent the competing interests in this area of legislative control. They include:

- to facilitate the use and development of licensed facilities reflecting the diversity of consumer demand (s.5(c)); and

- to provide adequate controls over, the persons directly or indirectly involved in, the sale, disposal and consumption of liquor (s.5(d))

Section 7 establishes the licensing authority comprising the Liquor Licensing Court (established under the previous Act and preserved by the current Act) and the Director of Liquor Licensing. The Director is responsible for the administration of the Act. Provision is made for him to expeditiously and informally determine applications and matters under the Act not subject to the jurisdiction of the court (see s.13). 'Me decision of the Director may be reviewed by the court (s.25).

Part 3 concerns 'Licences and Pen-nits'. The Act makes provision for ten classes of licence: hotel, cabaret, casino, special facility, liquor store, club, or club restricted, restaurant, producers, wholesalers and occasional.

The Revenue Section of the Liquor Licensing Division of the Office of Liquor and Gaming is responsible for the assessment and collection of penalties imposed under the Act. The total revenue received for the year ending 30 June 1989 was $57 557 543 ($56 131 208 for license fees, $878 613 for general fees under the Liquor Licensing Regulations 1989 and $547 722 for premiums paid under the repealed Act (Office of Racing and Gaming Annual Report 1988-89 page 24).

Part 5 is headed 'Financial Provisions' and Division I concerns license fees. The fee payable varies depending on the class of license. Generally however the fee payable shall be I 1 % of the gross amount paid or payable by the licensee for liquor (other than low alcohol liquor) and 7% of the gross amount paid or payable by the licensee for low alcohol liquor purchased during the assessment period (s. 132).

Division 7 of Part 4 concerns complaints. Section 117 (1) provides that a complaint may be lodged with the Director alleging -

(a) that the amenity, quiet or good order of neighbourhood of the licensed premises is frequently unduly disturbed by reason of any activity occurring at the licensed premises; or

(b) that any -

(i) behaviour of persons on the licensed premises;
(ii) noise emanating from the licensed premises; or
(iii) disorderly conduct, occurring frequently in the vicinity of the licensed premises on the pan of persons who have resorted to the licensed premises,

is unduly offensive, annoying disturbing or inconvenient to persons who reside or work in the vicinity, or to persons in or making their way to or from a place of public worship, hospital or school.

The Director may, by notice in writing, require the licensee to show cause why an order should not be made under this section.

Section 117 (a) sets out the persons and bodies who may complain. A complaint by an individual must be authorised by at least ten adult persons who reside, work, worship etc in the vicinity of the licensed premises.

The Director, having given the complainant, the licensee and other person with a relevant interest the opportunity to be heard, shall determine the matter. If the complaint is established on the balance of probabilities and cannot be settled by negotiation the Director may make an order or dismiss the complaint (s. 1 17(4)).

The Director has the power to vary conditions of a licence, redefine the licensed premises, prohibit or limit the provision of entertainment or otherwise deal with the matter in a manner likely to resolve the complaint (s.1 17(5)). If the licensee contravenes such an order he is liable to a penalty of $5000 (s.1 17(7)).

Part 6 makes provision for the enforcement of the scheme of the Act. It includes s.155 which is headed 'Duties of Police'. The Commissioner of Police is required to issue all orders, and directions to members of the police force as may be necessary (in the Commissioner's opinion) for matters including the following:

- prevent any sale or consumption of liquor that contravenes the Act
- ensure the lawful and orderly conduct of licensed premises and the good behaviour of persons present
- provide for the bringing of complaints and objections before the licensing authority as may be necessary for the proper administration of the Act.

Headed 'Breaches of the Liquor Act', Police Routine Orders 12-3.8 to 12-3.9 (25.7.86) provides:

> *Where a licensee, or a servant or agent of a licensee, is suspected of having breached the Liquor Act and an arrest has not been made, a report is to be forwarded through normal channels for the information of the Officer in Charge of the Liquor and Gaming Branch, Perth. Due to the complexities of the Liquor Act a decision will be made by that Officer as to whether there is sufficient evidence to proceed with a prosecution.*
>
> *On the conviction of a licensee, or a servant or agent of a licensee, for a breach of the Liquor Act, the member initiating the prosecution is to submit a report for the information of the Officer in Charge of the Liquor and Gaming Branch, Perth. This will enable the making of reports to, and the bringing of such applications, complaints and objections before the Licensing Court as are necessary or required.*
>
> *Prosecutions for minor breaches of the Act, E.g. Street Drinking, Obtaining Liquor Underage, etc., may be instigated by the member handling the inquiry.*

In addition, Routine Orders 12-3.15 to 12-3.17 (25.7.86) provide:

> *As a result of findings and comments made in the past by Royal Commissioners and the Licensing Court, members in charge of Stations throughout the State are to ensure that licensed premises in their districts are visited as frequently as possible. Particular attention is to be given to the following offences.*

(1) *The supply of liquor by the licensees, their servants or agents of any other person on licensed premises, to a person visibly affected by liquor - Sections 126 (1) (d) and 129 (1) (b).*

(2) Permitting intoxicated person to remain on licensed premises Section 127 (b).

(3) Juveniles purchasing or attempting to purchase or obtain liquor - Section 129 (1) (g).

Where a person is drunk on public parts of licensed premises and an arrest is considered necessary, the person is to be charged with being drunk in a public place, to wit, that portion of the licensed premises which was, at the time, available for public use (Section 53 Police Act).

It is the duty of a member in charge of a Police Station to ensure the proper and lawful exercise of any licence or permit issued under the Liquor Act and to ensure the lawful and orderly conduct of licensed premises in the district. To this end members in charge of stations are to make frequent, personal visits to licensed premises and not leave all the visits to subordinates.

Evidence from the Cases

The main concerns that have arisen from the cases in respect of liquor licensing laws include: the sale of alcohol to intoxicated persons and to juveniles; the approach of police to the enforcement of liquor laws in this regard, the role of licensees and the offences of street and park drinking.

Sale of Alcohol to Juveniles

The takeaway [liquor] outlet doesn't ask for identification of age. There are kids 12 and 13 years old going in and buying alcohol ... they are not going to stand there and ask, 'Where's your ID?' If they have got money, they get sold what they want'

Maureen Kelly, Community Development Officer
WAADA Port Hedland (RCIADIC W8:262)

Constable Suiter acknowledged that at the time the Victoria Tavern [Kalgoorlie] *was notorious for serving under-age drinkers* (Report of Inquiry into the death of Bernard McGrath, page 20).

The position of juveniles is covered separately in Division 9 of Pan 4 of the Act. Section 121 provides that subject to the Act where liquor is sold or supplied to a juvenile on licensed premises - the licensee, manager, other person by whom the liquor is sold or supplied and any person who permits the sale or supply, commits an offence and is liable to a penalty varying from $1000 to $5000 - the latter sum in the case of a licensee.

Routine Order 12-3.26 (25.7.86) provides:

Offending juveniles are frequently detected on licensed premises. Action, appropriate to the circumstances, is to be taken against licensee, their servants

and juveniles where juveniles are knowingly or carelessly permitted to remain of licensed premises.

The Order continues on to specify the circumstances where and when juveniles may lawfully remain on licensed premises (12-3.27 to 12-3.31.1).

Evidence was heard by the Commission in the Inquiry into the Death of Pat concerning offences against the Liquor Act 1970 (applicable at the time of the deceased's last arrest).

One of the officers involved in Pat's arrest was asked:

Q. *It was an offence committed by the juvenile and an offence committed by the person serving* [to obtain and supply liquor] ?
A. *We used to run into problems then of someone else - one of the adults - buying for the juvenile inside the hotel. That's where we used to run into problems.*

Q. *So, you're saying that one explanation for not laying charges against the licensee or the bar staff is because of the difficulties of proof*
A. *It was difficult to prove anything* ... (RCIADIC W19:3843).

Q. *There's numerous offences against juveniles of being on licensed premises. It's an offence under the Liquor Act if the licensee, and I'm putting this very generally, allows a juvenile to remain on licensed premises if unaccompanied by a responsible adult?*
A. *Mm.*

Q. *Yet no charges have been laid against the licensee for that offence?* ...
A. *... We get numerous complaints from the licensee of juveniles on licensed premised and they want them out and they're refusing to leave. And we used to act on these complaints ... There was none that I know of up there that there was any times that we could've charged the licensee with the evidence available.*

Q. *... did you only arrest juveniles as a result of complaints from the bar staff, or the hotel star.*
A . *No* (RCIADIC W19:3844).

Q. *I mean there must have been occasions when you went ... On patrol, and you saw a juvenile you know and asked him if he's got a responsible adult, or having a meal, no, so you arrest the juvenile. Do you ever approach the bar staff and say: you know, this person is a juvenile, how long's he been here?*
A. *And the bar staff might say: I haven't seen 'im come in, I haven't served 'im, I haven't seen 'im come in.*

Q. *Yes, well the question is did you ever interrogate the bar staff concerning the presence of juveniles at the hotel?*

A. *Yes, plenty of times.*

Q. *And so you say - ... that no charges have been laid against the licensee or bar staff because of the difficulties of proof?*
A. *Because of insufficient evidence to prove a charge in court.*

Q. *Did you ever ask questions of the other customers in those circumstances? ...*

A . *You'd say to friends of whoever's in there: who bought him a beer. And you'd get the: 'I don't know'. And then you'd say: 'well, who's supplying 'im the beer', and you used to get the shrugged shoulder every time* (RCIADIC W 19:3845).

Society accepts that controls should exist over the provision of alcohol to juveniles. There is evidence which appears to imply that regular offences against the Act are being committed. The police view appears to be that prosecutions are not commenced because of the difficulties in proving offences. The statistics for offences under the Liquor Act and the Liquor Licensing Act certainly supports the view that few convictions against licensees for the offence of supply to a juvenile are achieved. Although the Police Department were asked to provide the Royal Commission with a breakdown of offences under the Liquor Act and the Liquor Licensing Act, I was advised by the Commissioner of Police that the current computer programme used by the Police Department did not enable any further breakdown of offences than 'Liquor General' or 'Liquor Juvenile' so that it was not possible to identify whether the offence was committed by a licensee or by a juvenile. However the Annual Report of the Police Department for 1987/88 provides a breakdown of prosecutions under the Liquor Act which reveals that for that year 72 prosecutions were made for 'Supply Juvenile' and 613 prosecutions were made for 'Juvenile on Licensed Premises/Obtain Liquor' i.e. 10.5 % of prosecutions were against licensees and 89.5% were against juveniles.

It is clearly unacceptable to say 'it is too difficult so we will do nothing'. The police must adopt strategies to overcome difficulties in gathering evidence. A comparison may be drawn with drug enforcement techniques. The utilisation of under cover officers not known to the local population is one example of the means which could be adopted. With the Act making provision for severe penalties (up to a fine of $5000) it is suggested that a small number of successful prosecutions may be sufficient to bring about changes in attitude and a search for more constructive and cooperative solutions to the damage caused by excessive alcohol consumption. The words of Ian Temby QC are applicable 'It *is wonderful to observe how an impending court hearing sharpens the mind* ('Neglected to Death' Criminology Australian July/August 1990 page 19).

Sale of Alcohol to Intoxicated Persona

When the grog was only at the pub the fellow would say 'No more, you've had enough' but now that the grog is at Coles, if you can crawl in they'll sell the grog if you've got the money. I've seen fellas get grog there earlier in the morning before opening time. (RCIADIC W8:12 1)

Q. *Have you actually seen the licensee sell beer or liquor to drunken people?*

A. *Yes. I don't know how many of you have been around Halls Creek but there is a corner store that sells liquor and that is on a major corner; that's the Great Northern Highway running straight through town. They are selling liquor to people from Red Hill just across the road that are really intoxicated, and they stumble across the road and you've got these big heavy hauling trucks flying through.* (RCIADIC W29:93)

Q. *Is there a problem here in Halls Creek, Mr Green of the hotel serving people until they are drunk and then, say ringing up the police and*

saying 'We've got a drunk person in the bar we want you to pick them up?'

A . *Yes. I hear that goes on a lot here.* (RCIADIC W29:41)

Q. *Do you as a Field Officer* (with the Aboriginal Legal Service) *come across many cases where people have been arrested in hotels for being drunk...?*

A . *Yes. Like you know, when this drink charge was still on I would look at the complaint and so and so is charged for drunk and the place is public bar, beer garden or Kimberley Hotel or Roberta Avenue, the street just outside. (RCIADIC* W29:14)

Q. *Can you say, while you have been officer in charge* [since 12.1.90] *of the station, whether there have been any prosecutions against any licensee for serving intoxicated patrons?*

A. *Since I have been here there has been no prosecution - no.*

Q. Do you know whether before the change in the law people were still being picked up and charged with being drunk, with the place of the offence being licensed premises?

A *Not in the licensed premises - mainly outside the licensed premises. Since I have been here, [12.1.90] 1 have done inspections at the hotel and the staff are very good. They do try their best not to breach the provisions of the Liquor Licensing Act, so the majority - although there were some charged with drunk on the premises, we are mainly called down there because they are behaving disorderly. The drunk charge was an easy way out for police officers because there was no paper-work apart from the complaint. You didn't have to compile a brief and such, as you would with disorderly and what have you.* (RCIADICW29:58-59

Section 1 15 of the Act provides:

(1) Where a licensee, whether personally or by an employee or agent

(a) permits -
(i) drunkenness; or
(ii) violent, quarrelsome, disorderly or indecent behaviour to take

... on the licensed premises that licensee, and the employee or agent concerned, commits an offence (penalty - $5000 for licensee or manager; $2000 - employee or agent)

(2) A person shall not, on licensed premises -

(a) sell or supply liquor, or cause or permit liquor to be sold or supplied, to a drunken person;
(b) allow or permit a drunken person to consume liquor;
(c) obtain or attempt to obtain liquor for consumption by a drunken person; or
(d) aid a drunken person in obtaining or consuming liquor.

(3) For the purposes of this Act a person shall be taken to be drunken if, at the time, the person is visibly affected by liquor to the extent that any further consumption of liquor is liable to endure drunkenness.

(penalty - $5000 for licensee or manager; $2000 - employee or agent, $ 1 000 for any other case).

CDBR in their final submission in the Inquiry into the Death of Pat argued that a significant problem with the section was the difficulty of determining when a person is 'drunken' in terms of the Act or 'intoxicated' in terms of the Liquor Act 1970 (see s.126 (d)). The Committee submitted that officers varied in their understanding of the test but generally placed the standard far higher than that contemplated in s. 1 15 (3) of Act:

> *Clearly the intention of the Act is to prevent certain things happening. However the tools to do that are missing. It is your word against mine as to whether someone is intoxicated, because that state is not defined. Only if some power figure makes that decision do we have a verdict on sobriety.*
>
> *Police and licensees are the power figures specified by the Act to make this determination. Thus their decisions can only be made on the basis of their experience of how an intoxicated person behaves.*
>
> *One cannot blame them if they err in individual cases, in failing to judge correctly the state of affectedness. But what if this is the general rule. And what if the level of drunkenness is such that a person must be comatose before the Act has been perceived to be breached?* (Submission pages 125-126).

Similar patterns of non-enforcement of suspected offences by licensees involving the serving of intoxicated persons, were described in the evidence in the Pat Inquiry.

An officer who assisted in Pat's arrest was asked:

> Q. *I want to go to this - what is a vexed question amongst Aboriginal people in Roebourne as to why there's no prosecution. Considering ... massive aggregate of arrests on the premises of Aboriginal people have occurred, why there's been never any arrest or prosecution of the people who are the licensees of the hotel, the managers of the hotel or the agents of those persons in any way, shape or form over this period for selling, in contravention of the law, alcohol* to *people who are already drunk or severely affected by alcohol. Have you ever participated in a prosecution of such a person?*
> A . *No.*
>
> Q . *Have you any idea why nobody has been prosecuted?*
> A . *No.*
>
> Q. *How is it that you can pick up drunks in the hotel in your terms and never, ever, prosecute the persons nominated* [licensees]?
> A *I don't know* (RCIADIC WI 9:3722).
>
> Q *And you told Mr Olive that you'd never taken part in any prosecution of anybody associated with the hotel for a breach of the act. To your knowledge, whilst you were at Roebourne, was* there ever a prosecution of anybody associated with the *hotel?*
> A . *Not that I can remember.*

Q *... I mean people talk abut things of course. Did you ever hear, while you were at Roebourne, of a case of the hotel or its licensee or its employees or managers or anybody associated having been prosecuted in the past?*
A. Not that I can remember, no (RCIADIC WI 9:3724).

Another officer was asked:

Q . ... I think it's accepted that most of the offences, most of the charges in Roebourne relate to drink-related offences, either drunk or entering licensed premises, remaining on licensed premises - this sort of thing, and yet there haven't been any charges in the period examined, that is, from 6 August until 14 November, of any charges laid against the licensee. Now, that might be too narrow a time period but there must've been occasions where an intoxicated person is served liquor that you have seen in your experience?
A . No, not really.

Q. Never seen that?
A . Nope.

Q. Never seen it?
A . Nope. I've seen intoxicated people in the bar but not being served, and that is the crux of it. You've got to have your evidence to charge someone. If you don't see him served - and that's where you run into your problems.
Q. Have you ever had to warn bar staff about serving intoxicated people?
A . I've spoken to the bar staff many times about intoxicated people in the bar.

Q . But in what sort of context
A . You'd find a drunken person in the bar, you'd say to the bar staff, ... 'Who served him?' They said: 'I haven't served him'. And what's happened is one of the other Aboriginals not so drunk has gone up and bought him a beer. He's sitting in the corner drunk as a monkey because somebody else has bought him a beer; and that becomes a very complicated set-up. Unless you actually see him getting served you've go no proof so the charge is not going to succeed in court (RCIADIC W19:3842).

The comments that I have made concerning enforcement of offences involving juveniles are equally applicable to this offence. The Act's purpose through s.1 15 is to halt the serving of alcohol prior to a person reaching a state of drunkenness. Although it is clearly a grey area factually, the police must attempt to approach the problem uniformly and in a way which reflects the objects and intention of the Act.

As I noted in my Report in the Inquiry into the Death of Chatunalgi:

> ... *it is* difficult *to resist the conclusion that the police in Halls Creek are using charges under the Police Act and the Liquor Licensing Act as a means of social control in addressing a substantial alcohol problem ... While there are obvious problems caused by the over consumption of alcohol ... it is doubtful whether vigorous enforcement by prosecution of consumers for liquor and public order offences is an appropriate approach to this problem. Solutions must and can be found only at the community level. Meanwhile action against the suppliers should be vigorously pursued where there are offences against the legislation (*Report pages 20-21).

The Committee to Defend Black Rights submitted:

> *The reasons given by police* [for the lack of charging licensees for possible offences under the Act] ... *is that they couldn't prove an intent to sell to a drunken person or that the person was going to drink on the street ... or that they didn't know that the person was barred* ...
>
> *It is unconvincing when they never try, when they never ask how long an affected person has been in the bar, and set unrealistically high tests for drunkenness.*
>
> *The Aboriginal people have no knowledge of the rights and so were powerless and easy to arrest without any repercussion* ... (Submission in Pat page 134).

Role of Licensees

> *They tend to say it is a police responsibility rather than a licensee's responsibility and then one contacts the police and the police say they do not have the adequate manpower to police the problem ... The licensees tend to pass the buck. ... I think there is a significant problem there* [in Broome]. I *think a lot of that comes from - that we do not get support from licensees, that licensees are still breaching the Liquor Act and still serving alcohol to heavily intoxicated people. Until that problem is really addressed I don't think we'll see a significant decrease.* (RCIADICW12:289-290)

Mr A. Delint was overseer of the Victoria Hotel in Roebourne and licensee of the Wickham Hotel in Wickham. He had been involved in the hotel industry for 15 years from 1972 (RCIADIC W19:1336). Mr Delint was asked:

> Q. *Do you agree with me that, where people take liquor away from your hotel as it was ... and immediately collectively consumed it outside, then there is a breach of the Act?*
> A . *I agree with that.*
>
> Q . *Yes ... and that ... situation has probably gone on for a long time?*
> A. *For years.*
>
> Q . *Yes. Have you ever sought to do any thing about it?*
> A. *No.*
>
> Q. *... if this situation has gone on for a long time, then surely if it is in breach ... of the law - the something should have been done about it?*
> A . *It happens everywhere, everywhere in Australia.*
>
> Q. *You took it, as a person who worked in the hotel, that the problem really was not yours or it was too big for you to solve?*
> A. *I would not say that. I mean, it is a problem nation wide. On my side of the hotel all I can do is refuse a person alcohol if I think he or she is inebriated ... once they step outside I mean, if they open a can or a bottle there is nothing I can do about it* (RCIADIC W19:1450-1452).
>
> *... As I say it happens everywhere in Australia. I mean people buy liquor and we are not to know ... that they are going to go outside, round the corner and drink it. I mean, when someone comes in the bottle shop and asks for two bottles of beer ...* I *will sell it to them. I am not going to*

> *ask them 'are you going outside' ... 'or are you going down the river' ... 'are you going to the park and drink it?'* (RCIADICW19:1468).

A licensee, whether of a hotel, liquor store or other premises often plays a significant role in community life, particularly in smaller country centres. Their experience, expertise and power means that they are in a position to significantly enhance enforcement not only of the Act but of its intentions. In addition they are able to contribute to the search for greater community involvement and support for solutions to the problems of alcohol use.

Police Enforcement

> *Recently I received a complaint from the Assistant Commissioner (Operations) of liquor offences allegedly rife in Roebourne.*
>
> *These were ...*
>
> *Drunks served liquor on licensed premises.*
>
> *Drunks being permitted to remain on licensed premises.*
>
> *Underage persons drinking and remaining on licensed premises.*
>
> *This file was written off disputing these allegations.*
>
> *Today I received a deputation from the local Aboriginal Legal Aid that these offences were being committed and in some instances in the view of police and aides ...*
>
> *It is apparent by the tone of the ALS that the Hotel and or Police will be set up to attempt to get action in these matters.*
>
> *I have advised the Hotel staff to pay extra attention regarding the service of all patrons especially drunks and juveniles.*
>
> *Police patrols are to give this matter extra attention with a view of apprehending offenders or deter others from offending.*
>
> *Should youths be observed in the area of the licensed premises I would suggest that their names be noted so that their age can be checked later.*
>
> (From Roebourne Station Order 14.5.86)

I have given examples above of the police view of the difficulty of enforcing certain offences under the Act. It is however disheartening to reflect on the tone of the above Station Order which in 1986 presents Aboriginal people and the ALS as adversaries to the implied partnership between the police and hoteliers. There must be greater efforts to view the problems of alcohol use as the problems of our society not of one group against another. Such an approach is reflected in the following extract from the Western Australian Alcohol and Drug Authority Submission to the Royal Commission:

> *Last year [*1988] *in Kalgoorlie an attempt was made to introduce a co-operative approach by publicans, police and community representatives to the enforcement of the Liquor Licensing Act regulations, regarding the serving of alcohol to intoxicated patrons. This approach has the potential to significantly control harmful and hazardous drinking patterns in the community. The Authority*

believes a practice involvement in this area for 1990 is highly desirable (Submission dated 22 January 1990).

Commissioner Bull referred to informal arrangements between licensees and the police in his evidence before myself and Commissioner Dodson:

> Commissioner Dodson:... *In response to those sorts of complaints and I understand from some of the officers that they've put back to some of the very people who've complained to them that they're quite happy to take people's money from the liquor outlet and it's only when people are enjoying the stuff that they're selling that they're getting agitated about it and when they try to encourage some of the retailers of alcohol to take a more responsible approach it's not always forthcoming. Now is that area able to be tidied up or fixed up a bit better or influenced to a greater degree?*
>
> Commissioner Bull: *Well, certainly that depends on the licensee - the attitude of the licensees. In a number of places my officers do have arrangements with the licensee only to sell certain types of alcohol, to get away from the fortified types ... I mean, my officers do all this at their own discretion. You know, they have no legal standing in regard to it. It is purely by co-operation with licensees. Also to not serve it in bottles because of brawls that occur - of the serious injuries that are occurring ... So there are lots of arrangements that you probably would've encountered already in country towns where my officers, yes, do have arrangements with licensees in an effort to minimize this very problem that we're encountering.*
>
> (Conference Session 31.7.90:631)

Street and Park Drinking

Street and park drinking offences are recorded in the criminal records of ten of the deceased as follows:

Jimmy Njanji (x 4), Hugh Wodulan (x 1), Robert Anderson (x 2), Kim Polak (x 1), Edward Cameron (x 1), Ginger Samson (x 8), Donald Harris (x 1), Milton Wells (x 3), Darryl Garlett (x 1), Misel Waigana (x 7), Wongi (x 2), Bobby Bates (x 1). Jointly this amounts to thirty-two occasions when the deceased were in custody merely for drinking alcohol in a park or street (excluding probable subsequent detentions for fine default). Kim Polak's last detention in custody was for street drinking. His case illustrates some of the issues involved with these offences.

Evidence was given concerning the popular drinking places in Kalgoorlie. One was 'the long park' the location where Kim Polak was arrested, which was the medium strip in Wilson Street. The park near the swimming pool in the town was another until the area was fenced.

Evidence explaining why some Aboriginal people do not drink in the hotels when they buy alcohol has included dress rules, racist remarks and wanting to separate from other Aboriginal groups:

> *... they just don't like going to the hotels to drink. Most of the fringe dwellers I know, they sort of haven't got the right standard of dress ... they make remarks. I see it as they feel sort of uncomfortable ... you know.* (RCIADICW18:137-138).

Q. *What do you see as the reasons why Aboriginal people aren't drinking in the hotel?*

A. *I think, that's how I see it is, once they all get there together, that's when the trouble starts. You get different tribes from a different background area getting together and it just doesn't work out. That's why a lot of them tend to just buy their drink and try to go away from the hotel.* (RCIADIC W24:19; W29)

Ms V. Read, Health Education Officer described the situation from her experience in Broome in the following terms:

> *... people are getting picked up for drinking in a public place, but they tend not to have an option, and with people coming in from outlying communities it's been identified that they are the people who are getting arrested most of the time. Before we used to say that it was the reserve areas that had the drinking problem. The reserve areas in town are now trying to address their drinking problems and are not allowing outsiders to bring alcohol back. So they can't drink in the pubs; they can't drink in the reserve areas, so they're forced into a public drinking situation, and I don't feel that the issue is being properly addressed, or in an appropriate way being addressed.* (RCIADIC W12:307)

According the former Police Aide Thomas:

Q. *If someone like the deceased went into Kalgoorlie and brought some take away alcohol?*

A: *They've got nowhere to drink it.* (RCIADICW18:136)

Counsel for CDBR in the inquiry into the death of Pat gave his explanation for a drinking style which is conducive to apprehension for street and park offences, in the following terms:

> *As is usual in predominantly European societies the Aboriginal drinkers tend to be more visible to the European. This is the result of several factors.*
>
> *Firstly, Aboriginal culture ensures that they drink out in the open. It also ensures that they drink in groups. In those groups they will act out all of the problems capable of resolution in traditional ways. As a result there will be yelling and fighting.*
>
> *Secondly, when Aboriginal drinkers have consumed too much they do not always take themselves home. Where is home in a town like Roebourne? The river reserve has always been home. The 'village' is the western cultural construct of home.*
>
> *Thirdly, the Westerners who look at this scene do so with culturally determined values, and often without understanding and/or respect for other cultures* (Final Submission page 124).

Although not directly concerning Park and street drinking, Dr Hunter's evidence in Wodulan is interesting in this regard as it concerns attitudes to styles of drinking. He describes 'the cultural exclusion' in Broome as follows:

> *It's seen in the way Broome is changing. The traditional black drinking establishments have gone, because in the up market tourist influx we don't want black fellows sitting on the steps on the Conti drunk. It's not aesthetic; it doesn't fit into the new image of Broome ... subtle ways of getting around that - not*

> *banned but dress requirements, entry fees. At the Conti, they've now got the tote bar around the back. This is a very interesting way of shifting clientele from the front to the back ... and the irony is that it returns Aborigines to drinking practices that are more characteristic of precitizenship rights days, that for that subgroup - and it is a sub group of poor, homeless Aborigines that get hit most.* (RCIADIC W12:430)

Ex-police aide Thomas described the facade of police involvement with these types of offences in the following terms:

> *If you are drinking at one particular spot and the [police] van goes around and says, "Look, you mob have got to move from here", so they go to the next place. You know they just ... get moved on from one place, they go to the next place. If you go there and you've moved one - they just do the circuit ... around and around* town. (RCIADICW18:135).

Commissioner Bull referred to police practices regarding street and park drinking in his evidence before me and Commissioner Dodson:

> *Street drinking is a matter that they try and enforce, you know, with a certain amount of discretion because we do get criticised often for taking action in regard to street drinking. I know certainly a number of towns, I've had complaints from people within the town and local government areas ... because police they say, have not taken action against Aboriginals for street drinking we try to, you know, exercise the law with discretion. If Aboriginal people have a certain place they want to drink, if it's out of the way, well, you know, my officers won't take any action but I've had a number of complaints of claiming my officers have been neglecting their duty.* (31.7.90:631)

<u>Decriminalisation of Street and Park Drinking?</u>

Counsel Assisting the inquiry into the death of Chatunalgi asked the Officer in Charge of Halls Creek Police Station about the penalties for street and park drinking:

> Q. *What is the average penalty for street drinking and park drinking?*
> A. *$2.69 with $22.91 costs or $7.69 with $22.31 costs.*
>
> Q. *Do you find that the prisoner will usually serve the default rather than pay?*
> A. *Very few will pay the fine.*
>
> (RCIADIC W29:83-84)

Apart from the significant indirect costs in the form of damage to Aboriginal/ Police relations, the direct costs involved in enforcing street and park drinking offences include:

- Utilisation of two arresting officers and possibly two additional officers to convey the person charged in the police van.
- Police resources for assessment and screening, search, completion of the inventory of property sheet and occurrence book, checking for outstanding warrants, supplying of meals while in the lockup and attendance in the form of cell checks.
- Preparation of the police brief.
- Court and police time in appearance at Court of Petty Sessions.
- Possible warrant of commitment preparation and enforcement, if fine default occurs.
- Further time and costs involved in imprisonment for default.

The options for action concerning street and park drinking are:

(a) Continue current arrest practices.
(b) Ignore public drinking and, providing no breach of law occurs (disorderly conduct, assault etc) let drinkers consume alcohol in peace.
(c) Establish areas within town where Aboriginal people may drink without fear of arrest.
(d) Decriminalise street and park drinking.

Option (c) appears to have some community and police support. For example Mr David Champion, a member of the Aboriginal Visitors Scheme in Kalgoorlie gave the following evidence:

> Q. *We've heard, Mr Champion, that Aboriginal people around the township who drink will often be picked up for street drinking or park drinking. There is no place in town for them to drink. Are you aware of any proposal to set aside an area to enable people who want to drink in the township, where they could drink without being picked up for these offences? Is there any proposal you're aware of to do that?*
> A . *We have tried to get vacant land around here for quite some years now. I have tried myself on the police liaison committee. I mean even the police have tried that too.*
>
> Q . *The police have tried to get the land too?*
> A . *Yes.*
>
> Q. *And nothing has ever happened?*
> A. *No. It's acquiring the land. You see, we have to go through the shires and now it's a city - that is the biggest problem - but we certainly do. I mean they can't walk into the hotel and drink because they're not dressed for the occasion.*
>
> Q. *Yes?*
> A. *They can't drink on the street and they can't drink in the park so where do they drink? Because they get the drink and they drink it somewhere, well they're going to be put in gaol for it* (RCIADICW18:327).

In Halls Creek several areas to accommodate people from different regions and groups who may not want to drink together have apparently been informally established. The Sergeant of Police described the situation:

> *There are designated areas which were agreed to by the previous Officer In Charge where they could go and drink without getting arrested or charged. There's the dinner camp, which is just to the west of the townsite up on the hill; there's down on the creek bed going towards the north there, and that's where they normally do most of their drinking. There's only a certain few that will go up to the basketball courts and sit around there and drink. They go into vacant land near the Government buildings just down the bottom of the town here - but that was all explained to them. They all know very well where they can drink and where they can't drink, and that was before I got here. So I have maintained the same thing; they've got these designated areas where they know they can drink and they're quite safe* (RCIADIC W29,62-63).

Society must examine the reasons for maintaining street and park drinking offences. As I said in my Report in the Inquiry into the Death of Polak at the moment Kalgoorlie Police Lockup performs essentially the same functions as a dog pound, it keeps the streets and parks tidy and free of human strays (Report page 53).

It may be argued that all members of the community should have the opportunity to use the streets and parks without being disturbed or confronted by persons drinking. In addition the offence of street drinking aims at preventing injury through collision with motor vehicles. However these objects could still be achieved through utilisation of offences such as disorderly conduct.

Whereas drinking in the street or park appears insufficient without more to warrant arrest and conviction the establishment of public drinking areas upon request by Aboriginal communities should be examined by local authorities. However any such review must examine the reasons behind Aboriginal people choosing or having to drink away from liquor outlets. I refer in this regard to the evidence of Ms V. Read, Health Education Officer who gave evidence in Wodulan in the following terms:

> *I was involved and called as an expert witness to a shire meeting because there was a request from licensees who wished to address the problem of street drinking and specifically drinking on the oval area. What they weren't prepared to address was the fact that most of the hotels, because of the tourist boom, are now going upmarket, and they don't want Aboriginals drinking in their pubs any more. They're still prepared to serve them in grossly intoxicated states through the bottle shop, but they're not allowed - not prepared to have them on the premises. What the shire was recommending as a solution to the problem was to put up a bough shed and some 44 gallon drums on the foreshore, and declare* it *a proclaimed place for drinking, and this was seen as not the way* to *go;* that it *was demoralising for people;* that it *was out and out racist and would they like to have to go and drink on the foreshore and* that *was the only place they could drink* (RCIADIC W12:307).

Incidence of Liquor Act Offences

As noted above, the statistics provided by the Police Department in relation to Liquor Act offences were not particularly useful. Not only did they not provide a breakdown of all offences under the Act but the apprehension statistics supplied broken down into 'Aboriginal' and 'Other' did not include all minor offences. This would of course mean that the majority of Liquor Act offences were not included in the statistics provided.

I have set out below a table derived from Police Department Annual Reports 1985-1988 which provides a breakdown of selected charges and total charges laid under the Liquor Act in Western Australia 1985-1988.

TABLE 5.3: SELECTED CHARGES LAID UNDER THE LIQUOR ACT 1985-1988

Charges	*1984/85*	*1985/86*	*1986/87*	*1987/88*
Supply Juvenile	40	83	75	72
Juvenile on Licensed Premises/Obtain	343	437	550	613

Liquor				
Park Drinking	539	578	676	715
Street Drinking	738	772	867	1137
Liquor Act Total	**3065**	**3193**	**3389**	**3808**

Although my Commission was unable to compare the number of charges laid against juveniles, intoxicated persons and street and park drinkers, with the number of charges laid against licensees for Liquor Act and Liquor Licensing Act offences the limited data obtained together with the evidence given in Royal Commission hearings indicate the disproportion between charges brought against juveniles, intoxicated persons etc. and those brought against licensees who supply liquor in contravention of the legislation.

Conclusion

The lack of seriousness with which Liquor Licensing Act offences are pursued against the holders of licenses compared with the charges laid against the easy targets, the people who are drunk or juveniles, mirrors the level of our society's commitment to finding solutions to alcohol use problems.

Review of police practices in Roebourne in the Inquiry into the Death of Pat caused the CDBR to make a recommendation to the Commission in the following strong terms:

> ... *the Commission make a positive finding that the police officers are guilty of grave dereliction of the duty imposed on them by S. 10 of the Police Act 1892, in that they have failed to carry out the intention of the Liquor Act 1970 by regulating the consumption of liquor in accordance with the provisions of the Act, as a result of which incalculable damage has been suffered by the Aboriginal people and the officers should be punished* (Final Submission Recommendation 6, page 139).

Clearly the duties of police in prosecuting offences must be clear. Training concerning their obligations under the Liquor Licensing Act must be vigorous. Greater resources are required to be channelled into the acquisition of evidence of offences. The investigation of complaints must be thorough and findings open to public scrutiny. Finally initiatives which involve not only police and licensees but most significantly the affected Aboriginal communities, must be established and encouraged.

PART SIX ACTION FOLLOWING DEATH

6.1 POLICE INVESTIGATION OF DEATHS IN CUSTODY

The Coroner has no power of investigation under the Coroner's Act, nor is the Coroner currently empowered to instruct others to conduct investigations on his behalf. As in most other jurisdictions in Australia, the Act is silent on who is responsible for conducting coronial investigations (by 'coronial investigations' I refer to investigations into the circumstances of a sudden death which are conducted prior to a formal inquest being held by the Coroner or prior to a decision by the Coroner to hold an inquest). In Western Australia, coronial investigations are conducted by members of the police force on behalf of the Coroner. This includes investigations of deaths in police and prison custody.

The Perth Coroner, Mr McCann, has commented that it is the responsibility of the Coroner to monitor investigations into sudden deaths (Peter Tan Inquest Findings). He has also commented upon the virtual impossibility of this occurring to any adequate extent under present arrangements. In his finding upon inquest into the deaths of Cameron, Wardle, Morrison and Samson, Mr McCann made the following observations:

> *... while some individual police officers perceive their duty to be to investigate the death on behalf of the Coroner, and this approach is reinforced by Routine Orders issued by the Commissioner of Police,* it *is clear that the police force generally see this to be a police investigation out of which comes* a *report to the Coroner, and not an investigation by the Coroner in which the individual police officer acts as an agent for the Coroner.*
>
> *It has been usual for the police reports to the Coroner to be received some two months to six months, or even more, after the death. By the time an Inquest is commenced, the Coroner is able to do little more than call witnesses identified by the enquiring police officer. The Coroner, after so great a lapse of time, is usually unable to exert any influence on the actual investigation of the death.*
>
> *This is particularly so in the case of Country Magistrates who are part-time Coroners in addition to all their other duties.*
>
> *Where a police officer has investigated a death in custody, it might be said that often the outcome is a fait accompli. This comment should not be seen as a reflection on the impartiality and thoroughness of the individual enquiring officers. However, the result is that the Coroner is unable to exert any real influence over the investigation, and to that extent it might be said that the Coroner's Inquest is not in reality an independent inquiry by an impartial judicial officer.*
>
> *The likelihood of achieving an independent inquiry into a death is dependent upon the ability of the Coroner to influence the direction of the inquiry from the earliest possible moment, that being from the time of the death.*
>
> *This is not an easy task. The resources available to the full-time Perth Coroner are limited. The resources available to the part-time Country Coroners are almost non-existent. None of the investigative resources are under the direct command of the Coroner* (Finding Upon Inquest Into the Deaths of Cameron, Wardle, Morrison and Samson pages 97-98).

It should be noted that Mr McCann did remark that in the majority of cases, inquiries into deaths conducted by police officers were adequate. In particular he noted thorough inquiries into motor vehicle accident deaths. However the problems outlined by Mr McCann in the passage quoted above are of particular significance in the case of investigations into deaths occurring in police or prison custody. The examination made by the Royal Commission of the police investigations into each of the 32 deaths within jurisdiction has given added weight to the observations of the Coroner and revealed serious deficiencies in current procedures for the conduct of coronial investigations in this state.

In this Part I examine past and present procedure for the conduct of police investigations into deaths in custody and consider options for the improvement of present practice and alternatives to coronial investigations being conducted by police.

In August 1989 an Ad Hoc Committee for the Review of the Coroners Act, chaired by Mr McCann, reported to Government recommending substantial reform to the Coronial system in Western Australia. To date, no action has been taken to implement the

changes recommended. A number of the recommendations of the Ad Hoc Committee are considered in this Part. Further consideration of its recommendations is contained in section 6.4 of this Report.

6.1.1 POLICE ROUTINE ORDERS CONCERNING SUDDEN DEATHS

As I have noted at the commencement of this Part, the Coroners Act is silent as to who is responsible for conducting coronial investigations. There is no provision, either in that Act or in the Police Act, empowering the Commissioner of Police to direct that an investigation or any pan of an investigation into a death be conducted on behalf of, and for the purpose of reporting to, the Coroner. However, almost by default, the responsibility for coronial investigations has been left to police officers.

Routine Order 19-16 provides guidelines for police officers conducting investigations into sudden deaths. Routine Order 19-16.16 provides that where a police officer receives a report of a death, he is to notify the Coroner's Clerk or Coroner in whose jurisdiction the death occurred.

Routine Order 19-16.2 sets out the initial action to be taken upon receipt of a report of a sudden death:

19-16. 2 *When a report of a sudden death is received, a member will immediately attend, view the body and: -*

(1) ascertain that the victim is in fact dead:

(2) without disturbing anything, access the scene and establish as far as possible by making a *preliminary examination of the body if death was due to natural causes (Any suspicious circumstances must be reported immediately to the C.I.B.);*

(3) *make careful notes of the position of the body, marks of violence on it and the position of surrounding objects;*

(4) *make a sketch of the scene;*

(5) collect information about the circumstances surrounding and the cause of death;

(6) *obtain information as to the identity of the deceased and endeavour to have the body identified;*

(7) *notify relatives as soon as possible;*

(8) *ascertain the doctor who, if any, was or has been, treating the deceased and if the doctor is prepared to issue a death certificate:*

(9) *endeavour to have life certified extinct by a doctor immediately, or as soon as possible;*

(10) *arrange removal of the body to the mortuary if no certificate is forthcoming;*

(11) *report the circumstances to the Regional Officer.*

The attending/investigating officer is also responsible for the completion of a number of standard forms containing information concerning the deceased:

- Form P99 Certificate of Life Extinct.

- Form P92 Identification of Deceased Person (identification may be made either by another person or by fingerprint or dental evidence).

- Form P98 Mortuary Admission Form (for the information of the pathologist conducting the autopsy. Contains a brief note regarding the circumstances of death and history of deceased, if known. This form accompanies the body to the mortuary. Its contents are of particular significance given that at the time that most autopsies are conducted the mortuary admission form is the only information available to the pathologist concerning the deceased and the circumstances of death).

- Form P100 Report of Death (contains general information concerning the deceased and circumstances of death).

- Form P78A to Accompany Post Mortem Exhibits.

Routine Orders contain specific instructions in circumstances of death occurring in police or prison custody or in cases of suspected homicide. Routine Order 1916.39 provides:

Deaths in Police or Prison Custody and Homicides

19-16.39 *When a death occurs and the time of death is likely to be of importance, e.g. homicide victim, death at lockup, or unusual fatality, which may well be the subject of a medico-legal inquiry, the Coronial Inquiry Section is to be advised before the body is moved. The duty officer at the Coronial Inquiry Section will notify the duty forensic pathologist who will in turn advise on the procedure to be followed.*

16-16.39. 1 *Where a death occurs in a prison or police lockup or otherwise in prison or police custody the Coronial Inquiry Section is to be advised and a request made of the Duty be Forensic Pathologist to attend the scene fore any change to the physical situation is made so long as death has in fact been confirmed.*

If it is not practicable for a forensic pathologist to attend then arrangements are to be made for a medical practitioner to attend the scene forthwith and that medical practitioner should consult by telephone with the Duty Forensic Pathologist so that independent observations can be made of the scene of the death.

In addition to that Order, Routine Order 19-16. 69 provides that where a death occurs in a police lockup, the regional officer is to be advised forthwith, and if the deceased was a sentenced or remand prisoner, the superintendent of the nearest prison is also to be advised of the death. Current procedure followed bypolice in the investigation of deaths in police and prison custody is discussed in detail in section 6.1.3 below.

The Coronial Inquiries Section (CIS) is a section of the Police Department and is staffed by a commissioned officer, two sergeants and seventeen constables. The specific role of the CIS is to conduct inquiries into deaths and fires and to provide reports to the Perth Coroner. The CIS is based in Perth, there are no country branches of the section.

In his Finding upon Inquest into the deaths of Cameron, Wardle, Morrison and Samson, Mr McCann noted two areas of concern in the current operation of the CIS

1. *The officers [of the CIS] are police officers who are responsible to their superior officers and are only indirectly responsible to the Perth Coroner who may express a wish but not give an order in respect of their activities.*

2 . *The section is responsible for investigations into only part of the area covered by the Perth Coroner. In those other parts, police serving at local police stations carry out the enquiries. They report through a hierarchical structure, and often a considerable time passes before the coroner receives the inquiry file.* (At pages 100 - 101)

Mr McCann added that he felt the potential of the CIS to develop a nucleus of experienced investigators has not been realised due to the temporary posting of officers to the section. Promotion within the police force or transfer at the direction of superior officers has meant that officers with aptitude and zeal for the coronial investigatory task have been lost to the CIS. This Commission considers that the task of coronial investigations should be considered a specialist role. It is therefore essential that continuity of staffing be provided to a body such as the CIS so that a coherent and detailed body of expertise and procedure can be developed and be available to the Coroner. Means whereby this may be better achieved than under present arrangements are considered in more detail below.

I note that the Perth Coroner is not directly involved in the selection of police officers for the CIS and is only indirectly involved in the selection of some of the more senior officers.

6.1.2 THE EXPERIENCE OF THE ROYAL COMMISSION

As part of my inquiry into each of the deaths that came under my terms of reference, an examination was made of the circumstances, nature and result, of the coronial/sudden death investigations that had been conducted by police. Similar examinations were made by my colleagues Commissioner Muirhead QC (Charles Michael, Paul Farmer), Commissioner Wyvill QC (Robert Walker) and Commissioner Johnston QC (John Pat) in the inquiries which they conducted in this State.

In twenty of the thirty two cases investigated in this State the coronial/sudden death investigation conducted by the police was found by Royal Commission investigations to have been inadequate, in some instances seriously so.

Adequacy of Police Coronial/Sudden Death Investigation

Found Inadequate	Generally Adequate/Through
Robert Anderson	The Sir Charles Gairdner Hospital Case
Faith Barnes	
Nita Blankett	Bobby Bates
Stanley Brown	Donald Chatunalgi

Wayne Dooler	Daryl Garlett
Edward Cameron	Dixon Green
Albert Dougal	Paul Farmer
Christine Jones	Donald Harris
Bernard McGrath	Steven Michael
Charles Michael	Ginger Samson
Benjamin Morrison	Ricci Vicenti
Jimmy Njanji	Graham Walley
John Pat	Wongi
Kim Polak	
Ronald Ugle	
Misel Waigana	
Robert Walker	
Roy Walker	
Milton Wells	
Hugh Wodulan	
TOTAL 20	TOTAL 12

The main areas of criticism of the coronial investigations examined by the Royal Commission in Western Australia are as follows:

- Lack of independence of investigation by police of deaths in police custody.

  In a number of instances police officers concerned with the custody of the deceased were detailed to conduct the coronial investigation.

- Lack of scrutiny of police/prison officer version of the circumstances of death.

  Investigating officers placing reliance upon the version of events provided by their fellow officers or prison officers without due consideration of other possible evidence including the taking of statements from fellow prisoners of the deceased. Statements not taken or requested from all officers on duty at time of death or otherwise concerned with the deceased.

- Lack of experience of investigating officers.

  In a number of instances the officer detailed to conduct the coronial investigation had little or no experience in sudden death inquiries.

- Narrow focus of police investigation.

  Investigations were often directed towards excluding the possibility of suspicious circumstances/criminal involvement in the death. Due regard was not paid to matters such as the circumstances of arrest, condition of prisoner on arrest and supervision of prisoner whilst in custody.

- Presumption that death by hanging was suicide with no suspicious circumstances.

- Inadequate photographs taken of scene of death and body of deceased in situ.

- Inadequate brief forwarded by police to Coroner.

  In a number of instances the Report on Death prepared by the inquiry officer and forwarded to the Coroner contained misleading or false statements. Statements from police witnesses contained in the brief were sometimes misleading.

- Significant delays occurred in completion of investigations and forwarding of brief to the Coroner.

- Failure by investigating officers to adequately preserve scene of death or collect and retain relevant exhibits.

1. Lack of Independence of Investigation by Police of Deaths in Police Custody

In the course of the Royal Commission's inquiries, concern has been expressed at the continuation of the current procedure whereby deaths in police custody are investigated by other police officers. It engenders suspicion, particularly amongst the family and friends of the deceased, that there may be a lack of impartiality by investigating officers where aspects of their inquiries concern possible wrongdoing by fellow officers. That suspicion is naturally heightened where the officer conducting the investigation was amongst those responsible for the arrest or supervision of the deceased during his/her period in custody. The investigating officer is required to assess whether there are any suspicious circumstances warranting the involvement of the CIB.

In the Interim Report of the Royal Commission, Commissioner Muirhead (as he then was) recommended:

> *Recommendation 53*
>
> *In the case of deaths in police lockups, or from causes possibly sustained therein, the police involved in the deceased's custody should never take part in the investigating process, save as witnesses, or, where necessary, in securing the scene for general and forensic inquiry. Police investigation should be conducted by senior officers who may be regarded as independent from the officers who were custodians at the time of death.*

That recommendation, insofar as it requires that there be an investigator independent of those persons responsible for the custody of the deceased, is strongly supported by this Commission. That, however, was not the case in seven of the deaths inquired into by this Commission:

Robert Anderson - The sudden death inquiry officer was on duty during the period of Anderson's custody.

Faith Barnes - The Sudden Death report was prepared by one of the arresting officers.

Stanley Brown - Sudden death inquiry officer was on duty at the lockup on the day of Brown's death.

Wayne Dooler - The inquiry officer was both the arresting officer and one of the persons who placed the deceased in the lockup.

Christine Jones - The officer in charge of the police investigation was one of the officers whose task it was to assess the condition of Christine Jones when she was lodged at the lockup. He was self-appointed.

Kim Polak - The sudden death inquiry officer was the senior officer on duty at the time of Polak's death and was one of the officers responsible for conducting cell checks. He was the first officer to examine the body of the deceased after he was alerted by Kim Polak's cellmate.

Misel Waigana - Part of the investigation into the death was conducted by a senior officer who was responsible for supervision of the lockup at the time of death. The CIS officer who prepared the Sudden Death Report relied in part on the investigations conducted by the senior officer.
I consider that in each of the above seven cases it was inappropriate that the officer who conducted the coronial investigation was the person to do so.

2. Lack of scrutiny of police/prison officer version of circumstances of death

In a number of the investigations the inquiry officer failed to take statements from all officers concerned with the arrest and custody of the deceased and in others interviews were not conducted and/or statements were not taken from other prisoners at the lockup or prison. Some investigating officers appeared to have taken the attitude that once one police officer had given a version of events there was no need to interview any other officer present at the same time as all the latter would do is corroborate the story of the other. That was the explanation given to the Royal Commission by the investigating officer in the inquiry into the death of Jimmy Njanji. He had failed to request statements from all officers on duty at the time that Njanji was injured in the Port Hedland Lockup. Dougal and Anderson were other cases where all relevant officers were not interviewed by the police investigator.

Examples of cases where the investigating officer failed to interview fellow prisoners of the deceased who may have been able to provide relevant information to the coronial investigation include Njanji, Wodulan, Polak, Waigana, Farmer, Anderson and Blankett. In the case of Nita Blankett the police inquiry officer only interviewed those prisoners whom the Superintendent of Bandyup Prison advised her were relevant. She made no independent inquiries concerning the potential relevance of prisoner witnesses.

In another case the Perth Coroner has commented:

> *In custody deaths frequently the only witnesses to the circumstances surrounding the death are the police or prison officers responsible for the care of the deceased person. If there are any other witnesses it is usual that they will be either convicted persons detained in the cell or prison, or alleged offenders detained temporarily in police cells.*
>
> *It appears that the information coming from prisoners or detained persons is treated with scepticism by police investigators, which attitude arises because the informant is perceived to be tainted by criminal conviction or alleged criminal activity. Often such persons will not even be interviewed, and, if they are, the weight and importance of that information is discounted* (Finding on Inquest into the deaths of Cameron, Wardle, Morrison and Samson p 103).

Those observations have, regrettably, been borne out in inquiries conducted by this Commission.

3. Lack of experience of investigating officers

In the Interim Report of the Royal Commission, Commissioner Muirhead recommended that police investigations into a death in custody should be akin to to those relating to a homicide (Recommendation 51). 1 concur with that recommendation and consider that, prima facie, all deaths which occur in custody must be treated as if 'suspicious' until or unless investigations prove otherwise. Current police procedure for investigation of deaths in custody emphasises the importance of such investigations and the high degree of thoroughness and caution required on the part of investigating officers. Regrettably,

that was not an approach adopted on all occasions by police in past investigations into Aboriginal deaths in custody in this State.

In many instances it was found that the officer who conducted the investigations into the deaths was a junior officer who had little or no prior experience in investigation of deaths in custody and/or sudden deaths in general. Apparently a low priority was accorded to these investigations by the senior police officers who appointed the inquiry officer.

In the cases of Blankett, Brown and Polak the appointed inquiry officer had no prior experience in the investigation of sudden deaths, whether in or out of custody. One of the two police officers who conducted the initial inquiries into the death of Charles Michael had no prior experience in sudden death investigations. The other officer had never investigated a death in prison custody before - that was also the case for the two police officers who conducted the initial investigation into the death of Robert Walker.

4 Narrow focus of police investigation

Apart from the most recent deaths, the majority of the Royal Commission inquiries have illustrated the limited scope of police investigations into deaths in custody. They have focused upon whether or not there were suspicious circumstances in relation to the death. Upon determining that there were no such circumstances (often an initial assumption made by the inquiry officer - see below) the investigation usually went no further. In very few cases did the police investigator examine inadequacies in medical treatment, failure of systems, breaches of statutory duties by custodians or police Routine Orders and whether and in what manner these may have contributed to the death.

The police inquiry into the death of Wayne Dooler failed to highlight the fact that he had been unconscious at the time of the arrest and also when police placed him in the lockup. The Sudden Death report displayed a lack of awareness of the risk of failing to assess the level of consciousness of detainees placed in police lockups or that the lack of such an assessment was relevant to the death of Dooler. Consequently, nothing was learned by police as a result of the death. There were no changes in practice and procedure at Carnarvon Police Station following the death.

The police inquiry officer in the matter of Albert Dougal did not interview or contact the officers who were on duty at the Broome Lockup during the period of Dougal's detention. At no stage of the police investigation was there an inquiry into the conduct of the officers on duty at the lockup. There was no immediate examination of or change to lockup procedure to avoid the occurrence of a death in similar circumstances.

The police investigation into the death of Hugh Wodulan made no reference to the level of police care or supervision of the deceased after he had been placed in the lockup. Hugh Wodulan probably died whilst the lockup was unattended. No attempt was made to identify procedural lapses or to discover whether the death may have been preventable.

Other instances of a failure by the investigating officer to consider or adequately consider the issues of proper assessment of detainees and custodial care include the deaths of Ginger Samson, Benjamin Morrison, Kim Polak and Misel Waigana. Details of each police investigation are contained in the individual reports of my inquiries into each death.

5 . Presumption that death by hanging was suicide with no suspicious circumstances

The inquiry into the death of Bernard McGrath was hampered by an assumption made by the police initially responsible for the investigation that his death was an unaided suicide. Relevant exhibits were not collected and potential suspects (fellow detainees) were released from the lockup on bail without having been interviewed.

A similar assumption was apparently the premise behind the inquiries into the deaths of Hugh Wodulan and Benjamin Morrison.

6. Inadequate photographs taken of scene of death and of body deceased in situ

High quality photographs of the scene of death and of the body of the deceased in the position in which it was found should be a normal incident of every investigation of a death in custody. Such photographs can be of considerable assistance to the forensic pathologist who conducts the autopsy on the deceased, particularly in the case of deaths occurring at country locations where the pathologist may not himself attend and view the scene of death.

In the case of Robert Anderson only three poor quality photographs were taken by police. The officers who initially attended Fremantle Prison following the death of Robert Walker took an inadequate number of photographs and photographs of relevant areas and exhibits were not taken. In the case of Stanley Brown, only five photographs were taken.

7. Inadequate brief forwarded by police to Coroner

If the Coroner has little ability or no opportunity to direct the course of the investigation into a death (as is the case under present arrangements) he is understandably heavily reliant on the accuracy and thoroughness of the brief provided to him by the investigating police officer(s). The investigations of the Royal Commission have shown that on a number of occasions the brief to the Coroner contained omissions and/or false and misleading statements.

In Njanji the Sudden Death Report contained no reference to a possible connection between the injury that he had suffered whilst in police custody and his subsequent death. The inquiry officer had been alerted to the connection by the forensic pathologist who conducted the autopsy. Statements from police officers included in the brief for the Coroner contained significant omissions concerning events on the day that Njanji was taken into custody.

Statements from police officers included in the brief for the Coroner in Polak asserted that at no stage were officers aware that the deceased had been ill whilst in the Kalgoorlie Lockup. Before this Commission those officers admitted that those statements were incorrect in that particular.

The Sudden Death Report compiled in Wells stated that the deceased had been detained overnight at the Kalgoorlie Lockup because he was intoxicated and, further, that at no stage did the deceased complain to his cellmate that he was unwell. Both statements were false. In addition, I found that two officers who submitted reports for inclusion in the Coronial brief collaborated in the preparation of one officer's report and that their reports contained false statements concerning their prior contact with the deceased.

In Brown I found that there were a number of omissions from statements by police included in the brief for the Coroner. In addition, three and possibly four affidavits made by police officers and tendered before the Coroner in that matter contained misinformation.

8 . Significant delays occurred in completion-Of investigations and forwarding of the brief to the Coroner

In a number of instances the Sudden Death Report was not completed until several months after the death:

Robert Anderson	3.5 months
Jimmy Njanji	3.5 months
Ronald Ugle	5.5 months
Roy Walker	4 months

The Perth Coroner has commented:

> *If there is a criticism to be made generally [regarding police coronial investigations], then it is that there will be a delay between the date of death and the date upon which the inquiry file is received by the Coroner.*
>
> *This delay is usually occasioned ... by the fact that the inquiry is a police inquiry by a police officer, who reports to senior police officers and not directly to the Coroner. Reports are often delayed because police officers senior to the enquiry police officer intercept the report and return it for further inquiries. This action is no doubt well meant but those senior officers are presuming that their views, including the question of relevance, are the views of the Coroner* (Finding upon Inquest into the deaths of Cameron, Wardle, Morrison and Samson pages 99-100).

The evidence of Police Inspector Moran in the Royal Commission Inquiry into the death of Christine Jones bears out some of the concerns of the Perth Coroner. Moran told the Commission that his role as officer assisting the Coroner was to ensure that the investigation was carried out to the satisfaction of the Coroner. He stated that he would receive the brief first and if he was not happy that things had been done he would send the brief or report back to the inquiry officer, have the necessary matters attended to and when everything was 'correct' he would place the file before the Coroner.

When commenting whether he could make a decision to obtain an additional statement for the brief he stated:

> *I would obtain the information if I read the report and it wasn't to my satisfaction, which obviously meant to the satisfaction of the Coroner* (RCIADIC W3:35 1).

9. <u>Failure by investigating officers to adequately preserve scene of death or collect and retain relevant exhibits</u>

In the case of Robert Walker the condition of the observation cell in which Walker died was interfered with after death. Clothes of the deceased went 'missing' and no register of exhibits seized was kept. The investigating officer in the matter of Stanley Brown did not consider that the clothes of the deceased were a relevant exhibit and they were not sent with the body to the pathologist.

In the case of Charles Michael, police officers who attended the scene at Bartons Mill Prison seized items from the deceased's hut as potential exhibits. These items were subsequently lost with no record being made by the police of the fact that they were seized, what happened to them and if and when they were disposed of. At that time the CIS had no system for maintaining records of potential exhibits. An improved procedure is now in place.

In the case of Bernard McGrath the steps taken to preserve, inspect and photograph the death scene left much to be desired. The case illustrates the problems and lost opportunities involved when police automatically assume that a hanging death is a suicide without suspicious circumstances.

Bernard McGrath when found dead was barefooted, however he was almost certainly wearing Rome Adidas runners when he was arrested. A different pair of runners appear in the photographs taken at the death scene and McGrath's shoes were never located. This line of investigation was never pursued by the police. There was also discrepancies in the evidence as to the towels in the cell. Police photographs of the scene show two towels in the cell. Galbraith who was tried (and acquitted) of aiding Bernard McGrath to kill himself, claimed he tied a full towel to the cell door, yet the deceased was found hanging from a torn strip of towel. A proper examination of the scene and retention of all exhibits may have assisted the preparation of Galbraith's trial.

In the case of Edward Cameron the deceased, who was found hanging in a police cell, was left hanging with no attempt being made to release him and commence resuscitation. The justification for this action by the police was the need to preserve the scene. This was obviously inappropriate. Attempts to preserve life Or to resuscitate should always take precedence over preservation of the scene if there is any doubt.

The, Coroner has no power under the current Coroner's Act in relation to preservation of the death scene and retention of exhibits. Under the draft legislation prepared by the Ad Hoc Committee the Coroner investigating a death may restrict access to the death scene (s.32) and has powers of entry, inspection and possession (s.33). Such powers would seem to adequately address the present deficiencies in relation to the preservation of the scene and exhibits.

It should be clear from the above examination of the findings of this Commission that there have been serious deficiencies in the practice and procedure of police investigations into many of the deaths before the Commission. I now turn to an examination of current police procedure and practice in the investigation of deaths in custody in this State.

6.1.3 CURRENT POLICE PROCEDURE FOR THE INVESTIGATION OF DEATHS IN CUSTODY

Since April 1988, police investigations into deaths and attempted suicides in police custody have been conducted by personnel from the Internal Investigations Branch of the Police Department. The investigators are responsible to the Chief Superintendent (Discipline). Police investigations into deaths in prison custody are now conducted by officers from the CIB.

The investigations into the deaths of Ginger Samson, Benjamin Morrison, Edward Cameron, Wongi and Donald Chatunalgi were conducted by officers from the Internal Investigations Branch. The investigation into the death of Graham Walley in Greenough Regional Prison was conducted by an officer from the Geraldton CIB.

In the Inquiry into the death of Robert Walker conducted by my colleague Commissioner Wyvill QC, Superintendent Weaver described the Police Department's current investigation procedure for deaths that occur in custody:

Prison Deaths

> *The present situation with regard to a death in a prison is that:*
>
> *1. The investigation will be carried out by the CIB.*

2. The investigation will be subjected to the overview by a commissioned officer who is not necessarily a CIB commissioned officer.

The first call will still be the uniformed officer who will attend and will then hand the matter over to the CIB via the Duty Sergeant.

Death in a Police Cell

Once death has been established, the officer in charge of the station is advised and the regional officer is advised.

The overall investigation responsibility rests with a commissioned officer attached to the Internal Investigations Branch.

If the death is in the country, then the regional officer commences the investigation on behalf of the internal investigations commissioned officer where he cannot attend immediately.

The regional officer will take care of such matters as:

(a) Notifying the Coroner

(b) Ensuring a medical officer attends

(c) Ensures forensic officer attends

(d) Interviewing witnesses to the death, other prisoners and police staff.

As soon as the internal investigations officer arrives, he takes over and confirms by re-interviewing the witnesses previously provided and completes the investigation for the Coroner. (W/2/100)

I also note that the Internal Investigation Branch has produced a 49 point questionnaire and guidance form for use by investigators when completing an inquiry into a death in custody. It is worthwhile reproducing the contents of that form. It is dated March 1988:

Cell Death/Attempted/Suicide

1. Full name, age, address, nationality, occupation of prisoner.

2 . Have Routine Orders 19-16. 39 and 19-16. 39 1 been complied with.

3 . Time, date and place of arrest (resident town of prisoner, or otherwise).

4 . Reason for arrest (charge and statute).

5 . Reason prisoner not summonsed.

6. Arrested on warrant or view.

7 . If arrested on warrant, is warrant and/or complaint correct.

8 . Was correct charge preferred.

9 . *Is evidence available to support charge preferred.*

10. *Has complaint been filed with court (to be withdrawn in case of death).*

11. *Full particulars of officer/s effecting arrest.*

12. *Full particulars of officers on duty upon arrival of prisoner at relevant police station.*

13. *Time, date, place of admission (to be supported by p 10).*

14. *Time, date and place of death/attempted suicide.*

15. *Full particulars of officer/person discovering body/person.*

16. *Full particulars of <u>all</u> officers on duty at time of discovery.*

17. *Details of circumstances of discover, i.e. cell check, another person.*

18. *Full particulars of police officers in cells at time.*

19. *Full particulars of prisoners in cells at time.*

20. *Was prisoner in cell alone, or in company.*

21. *If in company, details of other prisoners in cell.*

22. *Was placement in lockup suitable, i.e padded cell, cell, exercise yard.*

23. *Was cell searched prior to placement of prisoner.*

24. *Any previous history of unusual behaviour in lockup/prison.*

25. *Any indication to <u>any person</u> that prisoner may attempt to take life.*

26. *Any indication of business/domestic/financial problems.*

27. *Any mental/medical history of prisoner.*

28. *Conduct of prisoner upon admission, i.e. violent, subdued, etc.*

29. *Method used to cause death/attempt.*

30. *Was death/attempt physically possible for prisoner to effect.*

31. *In hanging/death/attempt, was instrument used the property of deceased.*

32. *If not, describe how it was obtained.*

33. *Did prisoner have Medi-Alert band, prescribed drugs or medicines - any other drugs in his possession, any injuries apparent at time?*

34. *Did prisoner ask for medical attention.*

35. *If yes, did doctor attend - were medical services made available.*

36. *If cell death, was doctor called to examine body and certify Life Extinct.*

37. *Any evidence of assistance and/or murder by other prisoners.*

38. *Any evidence of unauthorised entry to cell area by others.*

39. *What are the details of security at the lockup.*

40. *What part did officer in charge (at the time) display in providing adequate security in cell area.*

41. *What cell checks were conducted prior to discovery of prisoner.*

42. *At what time was Station OIC, regional officer and Coroner's clerk (if applicable) advised, and by whom.*

43. *Photographs taken of cell area and plan of cell area.*

44. *Have p1O (Prisoner's Property book), Charge Sheet, fingerprint forms, relevant occurrences, cell check records, cell cards been obtained.*

45. *Statements obtained from all prisoners (prior to release).*

46. *Statements obtained from all police officers (prior to ceasing duty).*

47. *Could prisoner have been admitted to bail forthwith at time of arrest (if not, explain).*

48. *Any recommendations regarding condition of lockup in respect to location, construction, or any of the aspect which may improve/-prevent the occurrences of cell deaths, i.e. visual observation, noise factor, isolation etc.*

I J Thomter
Chief Superintendent (Discipline)

Note:
These instructions will prevail in addition to and not in place of Routine Orders:
3-10.10
5-1.1 to 5-1.8
6-3.165 to 6-3.168
19-16.1 to 19-16.99
Relating to Sudden Deaths

That form provides a reasonably comprehensive coverage of those matters which I consider should be investigated in any thorough inquiry into a death in police custody. In addition the questionnaire provides for a uniformity of approach by investigators, something which was not evident in earlier investigations. I would, however, make the following comments:

- The reference to cell checks in Point 41 should also include a requirement to inquire into the form or nature of those checks i.e were they merely a 'head count' or did they also involve an inquiry or assessment of the detainees' welfare being made by lock-up staff.

- Point 28 refers to the conduct of the prisoner upon admission; Point 33 further inquires whether the prisoner had any injuries at the time of admission. I consider that the Form should also include specific reference to an assessment of the prisoner/detainee's state of consciousness upon admission.

- Point 21 notes details of other prisoners in cell with the deceased (if any). Inquiry should be made of all prisoners/detainees in the lockup, not merely those in the same cell as the deceased.

The above procedure is a significant improvement on past police arrangements for investigations of deaths in custody, however it is surprising that these new arrangements were authorised by the Commissioner of Police without any consultation with the Perth Coroner or any country Coroner. In conference with the Commission, Mr McCann stated:

> *... the Commissioner* [of Police] *didn't even advise me of his rearrangements of deaths in custody investigations, let alone say, 'This is what we intend to do. What do you think?* (Coroners Conference 31 August 1990:66).

The lack of consultation by the Police Department with the Coroner emphasises that under present arrangements the investigation of a death in custody remains a police inquiry, at the conclusion of which a report is sent to the Coroner. It is not an investigation directed by the Coroner.

Having said that the new procedures adopted by police constitute an advance over previous arrangements, Royal Commission inquiries into those deaths investigated pursuant to the new procedure have shown that deficiencies (and in the cases of Benjamin Morrison and Edward Cameron, serious deficiencies) in the investigation have still occurred.

Whilst the investigation conducted by the CIB into the death of Graham Walley in prison was thorough with all relevant witnesses being interviewed, the same cannot be said of three of the five investigations conducted by officers of the Internal Affairs Branch into deaths in police custody.

I found that the investigation conducted by Inspector Willers into the death of Ginger Samson was generally thorough, however, it failed to address significant issues such as neglect by police officers to adequately assess the state of consciousness of the deceased upon his admission to the Roebourne Lockup, the frequency of cell checks and whether any breaches of Routine Orders had taken place.

I found that the investigation conducted by Superintendent Weaver into the death of Benjamin Morrison was inadequate in a number of respects:

(a) He did not take statements from nor interview relevant witnesses who had had contact with the deceased prior to his arrest.

(b) His investigation was not conducted on the premise that the death was prima facie suspicious unless or until proven otherwise.

(c) There was an insufficient examination made of the assessment made by police of the deceased's condition upon his arrival at Fremantle Lockup. Morrrison had a number of minor injuries at the time of his arrival at the lockup. Weaver did not ask officers if they aware of the origin of those injuries.

(d) The arresting officers were interviewed in each others' presence and not individually. No inquiry was made by Weaver concerning the deceased's medical history.

(e) No examination was made of the deceased's Police File. Had he done so he would have discovered a record of previous suicidal conduct by Morrison when in police custody.

The investigation conducted by Inspector Couzens into the death of Edward Cameron also revealed serious deficiencies:

(a) Detailed interviews with police officers concerned with the death were not conducted until a fortnight after the death.

(b) The interviews were not especially probing and were carried out on a first name basis. This is inappropriate when considering a death that may potentially involve criminal actions and/or breaches of police discipline.

(c) Four of the six officers who prepared reports for Couzens discussed their reports with other officers before submitting them. All of their reports were undated.

In the Report of my Inquiry into the Death of Edward Cameron I concluded:

> *This case lends emphasis to the argument of those who advocate the need for deaths in custody to be investigated by a body independent of the Police Force and preferably under the control of the Coroner.*

The Requirement of Police Officers to Report

Police officers are bound by the provisions of the Police Act and the Police Regulations 1979. The Police regulations, insofar as they are relevant to this section of my Report are as follows:

> *Regulation 402*
>
> *Every member shall -*
> ...
> (c) *obey promptly all lawful instructions given by any member under whose control or supervision he is placed ...*
>
> *(d) promptly and correctly carry out all duties appertaining to his office, or any other duty he is lawfully directed to perform.*
>
> *(e) in due course and at proper times comply with, and give effect to, all enactments, regulations, rules, orders and administrative instructions made or issued for his guidance in the performance of his duties.*
>
> *Regulation 603*
>
> *A member or cadet shall not disobey a lawful order and shall not, without good and sufficient cause, fail to carry out a lawful order.*
>
> *Regulation 605*
>
> (*1) a member shall -*
> *(e) report any matter which it is his duty to report.*

Whether and in what manner police officers have complied with their statutory duties, Routine Orders, Station Orders and Administrative instructions are significant matters to

be inquired into in each instance of a death in police custody. They are also matters covered in the 49 point form produced as a guideline for investigators by the Internal Investigations Branch. Accordingly, where a death has occurred in police custody, officers concerned in the arrest and detention of the deceased must be questioned concerning the exercise of their discretion and performance of their duty in relation to those matters.

Initial inquiries into the death of Edward Cameron were conducted by the Regional Officer at Geraldton. He interviewed the officer who had been the welfare officer on the shift during which Cameron died. The interview was conducted at 9.45 am on 8 July 1988. Upon being asked his whereabouts at 3.00 am the officer declined to answer the question stating that he would rather seek further legal advice. He also refused to make a statement although he agreed to supply a report. He was further interviewed by Inspector Couzens on 9 July 1988 but refused to sign notes of the interview.

The officer later submitted a report which included the following preamble:

> *On instructions from Inspector Couzens and in accordance with the obligations placed on me by the Police regulations, I have to report as follows, but the following report is not provided of my own free will but pursuant to an obligation placed upon me and the report is tendered and the questions are answered on the basis that it and they will not be used in evidence in any action brought against me.*

Five other constables also inserted similar preambles to their reports. They all stated that they did so because it was suggested in their Police Union Diary. I also note that a number of officers required to provide reports in the matter of John Pat also prefaced their reports with a similar statement.

Neither the regional officer nor Inspector Couzens was able to obtain detailed information directly from the officers who were on duty at the time of Edward Cameron's death. The officers refused to answer even such basic questions as whether they had arrested the deceased or even whether they were aware that he had been arrested. The investigating officers had to await the written reports of the officers - the minimum requirement imposed on them under the Police regulations. After considering the course adopted by those officers in the Report of my Inquiry Into the Death of Edward Cameron I concluded:

> *This course could be expected to give rise to considerable suspicion, distrust and community hostility. Where a popular local figure such as Cameron is suddenly found hanged in the local Police Station, and the officers who were on duty refuse to answer questions on the grounds that they may incriminate themselves then the community would be understandably appalled. It is inconsistent with the duty of a police officer to make such a claim.* (Report p 19)

6.1.4 THE FUTURE

Mr McCann has stated on a number of occasions that he believes it essential that them be established a body of civilian investigators under the direct control of the Coroner. In conference with this Commission he commented:

> *I think that there are real reasons - there are very good reasons - that deaths in custody and other matters of serious import ought to be investigated by people who have a lot of skill in those death investigation situations* (Coroners Conference T 58).

The inadequacies of past police investigations of deaths in custody as revealed by the inquiries of the Royal Commission and the possible perception of a lack of impartiality on the part of police investigators when investigating the conduct of fellow officers, provides support for the Coroner's recommendation. There is also the difficult position of the Coroner potentially expressing criticism in his findings of officers belonging to the body upon which he relies to conduct his investigations.

The Ad Hoc Committee for the Review of the Coroners Act considered alternatives to the present system of police investigators. At page 18 of their Report the Committee commented:

> *The role of police officers carrying out duties as Coroner's officer has been questioned. The Broderick Committee which reported on Death Certification and Coroners in England in 1971 recommended that police officers should no longer serve in the capacity of Coroner's officer but should be replaced by civilians. A later report in 1986 on Coroners Courts in England and Wales prepared on behalf of Justice under the chairmanship of Evan Stone Q.C. recommended that Coroner's officers should form a national service, independent of the police and all other services.*
>
> *Neither of these recommendations have been adopted in England. Jervis on Coroners (10th Ed., 1986) after referring to some of the difficulties of such a scheme, reports that there is a trend towards civilianisation of coroner's officers, and this trend is now supported by the Home Office, in that it suggests that police civilian staff, rather than police officers, be appointed.*
>
> *In the Submission to this Committee from the Commissioner of Police it was said that from a police point of view one of the problems with the existing Coroners Act was the lack of specific authority for police to conduct investigations under the Act.*
>
> *The Commissioner went on to say that the police force must retain its traditional autonomous role and that any duties, and the powers exercised in pursuit of those duties, given to police should exist only insofar as these duties and powers assist police to achieve the objects of the Act. It was suggested that the Commissioner, at the request of the Coroner, should have the statutory power to direct that an investigation, or part of an investigation, be conducted on behalf of the Coroner for the purpose of reporting to the Coroner.*
>
> *It is pointed out that such an arrangement would leave the control Of the investigation in the hands of-the police. While the Coroner might be free to conduct his own investigations if he had the means to do so, so far as the police investigation was concerned, the Coroner would have no authority to direct the course of that investigation.*

I would add that a lack of power residing in the Coroner to direct police investigations is of particular concern in instances of death occurring in police custody.

The Ad Hoc Committee referred to the example of the Alberta Coronial system where death investigations are carried out by a civilian Medical Examiner. The system is medically oriented and persons with nursing experience are employed as investigators at two major centres. Elsewhere in the province the local police act as ex-officio investigators. If the death is suspicious there is also a criminal investigation.

In conference with Mr McCann before this Commission, Counsel for the Western Australian Police Union stated:

> *The submission of my clients would be that there should be police attached to the coroner's office with a hierarchical structure worked out so that they would be under the coroner's supervision or direction for the purposes of an inquiry but still within the general command of the commissioner of police who would assign them to this branch* (Coroner's Conference T 6 1).

I also note that in a Response to the report of the Ad Hoc Committee, the Western Australian Police Union supported the recommendations made to the Committee by the Commissioner of Police. The Union viewed the proposal for the creation of an independent body of investigators attached to the Coroner's Office as an attempt to create 'extra police forces' in this State. They added that the best investigative resources in the State were currently held by the Police Department and further stated that their prime concern was that the proposal would seriously impair the 'autonomy' of the office of Constable.

Mr McCann has rejected that view stating:

> *I don't accept the proposition that police officers are the only repository of expertise in the investigation; but it is clear that if we are going to have an independant death investigation into the serious cases - industrial deaths, medical practice deaths ... and deaths in custody - and if we are going to have people skilled in that sort of thing, there are not enough of those cases year round for them to fill up their time, so it seems to me that their skills can be developed and that pool of expertise can be retained if they are also involved in the straightforward death investigations in the metro area and we then call on that pool to do the extra [serious cases] deaths outside of that area in the country area where it is necessary, but the ordinary death investigations I think are quite suitably handled by police officers in country areas where there is no public concern situation arising* (Coroners Conference T 58).

In addition, Mr McCann recommended that where police officers are to conduct investigations into deaths the Coroner issue guidelines for the conduct of those investigations. These are to be no more than guidelines, they would not be couched as orders. Police officers would still be subject to the discipline of the force.

I consider that there is nothing necessarily inconsistent between having both civilian and police investigators concerned in inquiring into the circumstances of a sudden death. Were there created a body of civilian investigators under the control of the Coroner all or any police investigation into deaths would not thereby be displaced. In the case of deaths in custody where there is a suspicion of criminal conduct there should, properly, continue to be a CIB investigation, in any event an investigation by the Police Internal Investigations Branch as to police procedural and disciplinary matters should still take place. A Coronial Investigation cannot, in all truth, be called such unless the office of Coroner has the power to conduct and direct its own investigation into deaths.

The Ad Hoc Committee concluded that:

> *There should be a group of civilian investigators responsible directly to the State Coroner to assist in the investigation of complex and contentious cases, including deaths in custody. Police officers should be ex-officio coroner's investigators, but their involvement in any particular death should be subject to guidelines issued by the State Coroner* (Recommendation 5 of the Ad Hoc Committee).

Experience gained from the investigations of the Royal Commission tends to support the recommendation of the Ad Hoc Committee and the position of Mr McCann on the creation

of a body of investigators under the direction and control of the Coroner. If Government acts upon such a recommendation there will obviously be a period before sufficient civilian investigatory officers can be recruited and adequately trained. In the interim, the suggestion that police officers, most appropriately officers serving in the CIS, be seconded to the Coroner's office to conduct investigations at his direction appears sensible.

If civilian investigators are appointed to assist the Coroner they should be granted appropriate authority to preserve and seal a scene of death, seize and retain exhibits and to interview and obtain statements from witnesses. However, I do not consider that they should have the power to compel witnesses to answer their inquiries. Such a power would more appropriately reside in the Coroner himself, to be exercised only in the course of conducting a formal inquest and where a witness refuses to answer a question put to him or her in the course of their evidence. 'Ibis issue is considered further in section 6.4 of this Report.

6.2 INVESTIGATIONS OF DEATHS IN PRISON CUSTODY

It is a requirement of Section 34 of the Prisons Act 1981 that where a death of a prisoner occurs in prison custody, notice of that death shall be given to the Coroner. Where such notice is given, Section 34 (2) requires that the Coroner shall then inquire into the manner and cause of death of the prisoner.

The necessity for full and independent investigations into deaths occurring in Police and Prison custody has already been emphasised in this Report and in the individual reports of my inquiry into those deaths within the jurisdiction of this Commission. Currently, investigations on behalf of the Coroner into the manner and cause of death of prisoners who die in prison custody in Western Australia are conducted by the Western Australia Police Department.

The nature and extent of police involvement in investigations of prison deaths in Western Australia has already been considered in section 6.1 of this Report. This section of the Report focuses on the issue of internal investigations into the circumstances of deaths conducted by the Department of Corrective Services. Reference is also made to investigations into instances of attempted suicide and self-mutilation occurring in prison custody and to procedures whereby the Department of Corrective Services notes and considers any recommendations made by the Coroner that apply to the Department's practices and procedures.

The structure of the Department of Corrective Services contains the position of investigation officer. This position was established in the Department in 1980. Subsequently a further two assistant investigations officers have been appointed one in 1987 and one in 1989. In 1987 the Commissioner of Police appointed the investigations officer as a 'special constable'. The role of the investigations officer includes :

- Investigating all matters relating to the Department as required by the Executive Director,
- To liaise with Superintendents and senior staff on matters under investigation;
- To compile reports on his investigations for submission to the Executive Director,
- To liaise with other state and interstate investigatory and law enforcement agencies (W/2/96).

This Commission has received evidence of investigations having been conducted by the investigation officer into the circumstances of two of the deaths that have fallen for its consideration, those being the matters of Vicenti and Walley.

Prior to the death of Graham Walley at Greenough Regional Prison in October 1988, it was not the practice of the Executive Director to order that an inquiry into each death in prison custody be conducted by the investigations officer. Following the death of Walley, the executive director ordered the investigation officer to inquire into and provide a full report on that death. Since that time it has been a requirement of the Department that the investigations officer conduct an investigation into the circumstances of each death that occurs in prison custody in Western Australia.

The Department has informed the Commission that the nature and purpose of the inquiry conducted by the investigation officer is to determine whether all proper Departmental procedure had been carried out and whether the management of the deceased prisoner had been carried out correctly in the context of the Department's rules and regulations. In addition the investigations officer would consider whether any weaknesses had been revealed in the system and whether and in what manner improvements may be made.

The investigation takes the form of interviews with staff, prisoners, family members, the Aboriginal Visitors Scheme, examination of Departmental procedures and any other factors considered by the investigation officer to be relevant to the death. It should be noted that prison officers are not obliged to answer questions which may be put to them by the investigations officer.

The inquiry by the investigation officer runs parallel to that conducted by the investigating police officers, however it is positive to note that upon request, both the investigating police officers and the Coroner will be provided with full access to the report of the investigation officer. However, there currently appears to be no formal mechanism whereby this transfer of information takes place. It is considered that it would be of benefit if there was a positive requirement that a copy of the investigation officer's report be furnished to the Coroner in each instance of a death in prison custody. This would contribute to ensuring that as full a picture as possible of the circumstances of the death under inquiry is available to the Coroner.

I note that in the matter of Graham Walley the report of the Department of Corrective Services investigation officer did not form pan of the Coronial papers. The report of the investigations officer in that matter was deficient in a number of respects. It concluded that Walley's death could not have been forseen by staff at Greenough Regional Prison as the deceased had given *'no indication of the anger he felt towards the system or that he had any intention of committing suicide.'* This was patently incorrect. The only recommendation the investigations officer made was that tables and chairs in a maximum security section should be made of plastic. His report was, I believe, not of the standard or scope that would provide any assistance to the Department in preventing future deaths in similar circumstances, although it had the potential to be so.

As I stated in the Report of my Inquiry into the Death of Graham Walley:

> *The investigating officer did not query with Superintendent Farr his failure to place Walley in the observation cell, He believed there may have been guidelines on the use of the cell but had not examined them either before or during his investigation. He had no crticism whatsoever of any of the staff for their handling of the situation. How it could be that a person who had threatened to kill himself and attempted to kill himself could be put in his cell alone without any extra precautions being taken (apart from half-hourly checks) simply was not investigated.* (Report page 26)

However, it is considered that there is the potential for considerable benefit in the Department continuing the practice of conducting its own limited investigation into deaths

that occur in its custody. It is prudent for the Department to conduct a review of its regulations and procedures with the intention, not simply of determining whether existing requirements were followed in the case under review, but with a view to identifying any change to procedure that may eliminate or reduce the likelihood of a further death occurring in similar circumstances. The report of the investigations officer should not, of course, be seen as preempting the findings of the Coroner nor any recommendations that those findings may contain for change to existing Departmental procedure.

The general procedure to be followed by staff of the Department of Corrective Services upon the death of a prisoner is contained in Regulations 74 and 75 of the Prison Regulations and in Executive Directors Rule 2M. AB prisons have issued current Standing Orders in the general form of Rule 2M.

Executive Director's Rule 2M provides (inter alia) :

- *Upon the death of a prisoner the senior officer then on duty at the prison will notify the designated Superintendent of the prison of the death.*

- *The designated Superintendent will then notify the relevant Superintendent Administration, the officer in charge of the nearest police station and the prison medical officer.*

- *The Superintendent Administration will notify, as soon as is practicable, the Director of Prison Operations who will then notify the Executive Director.*

- *Except in 'extreme circumstances and where the designated Superintendent otherwise orders' the body shall not be moved and the scene of death shall not be altered or interfered with until the Police investigating the death authorise the removal of the body.*

- *Where practicable, the designated Superintendent shall arrange to have relevant photographs taken before the body is removed.*

- *The officer discovering the death, any other staff involved, and the medical or nursing staff attending, shall provide a written report on the death (including relevant details concerning the death) to the designated Superintendent.*

- *The designated Superintendent shall provide a confidential report to the Director of Prison Operations within twenty-four hours of the death.*

- *The designated Superintendent shall retain at the prison the warrants, copies of all reports, occurrence books, photographs and any other relevant information relating to the death of the prisoner.*

The Commission has received evidence that it is the initial responsibility of the designated Superintendent to ensure that reports on the death received from staff pursuant to Rule 2M are complete and contain all relevant information. These reports are later made available to the investigations officer and he may seek further information or clarification directly from the officers concerned.

It is noted that in the case of the death of Darryl Garlett at Wooroloo Prison Farm reports from all relevant officers were not obtained and in the case of Robert Walker the reports that were provided by some officers omitted relevant and vital information. In neither of these cases did the Executive Director order that an investigation into the death be conducted by the Department's investigations officer. In relation to the matter of Robert

Walker it is pertinent to reiterate that even if the investigations officer had interviewed the officers concerned he could not, under ordinary circumstances, compel them to provide him with any information he felt relevant to his inquiry.

The Prisons Act 1981 does provide special circumstances where an officer may s officer. be compelled to answer questions put to him by the investigation
Section 9 of the act provides that the Executive Director may appoint an officer to inquire into and report to him upon '... *any matter, incident or occurrence concerning the security or good order of a prison, or concerning a prisoner or prisoners'.*

The section further provides that for the purposes of carrying out such an inquiry, the reporting officer may require any officer or prisoner to give him such information as he requires and to answer any question put to him concerning the matter, incident or occurrence that is the subject of the inquiry. Where a person is required to give any information or answer any question under Section 9 of the Prisons Act, he may not refuse to comply with that requirement on the grounds that the information or answer may tend to incriminate him or render him liable to any penalty, however, the information or answer given by him is not admissible in evidence in any proceedings against him.

It is noted that in the Interim Report of the Royal Commission, Commissioner Muirhead (as he then was), recommended that a provision similar in effect to Section 9 of the Prisons Act 1981 be included in relevant prisons legislation in all Australian jurisdictions.

In Western Australia the current Executive Director has only initiated one inquiry under Section 9 and that did not relate to the matter of a death in prison custody. Considerable evidence regarding the purpose and use of Section 9 was heard from the current Executive Director, Mr 1. Hill, in the Robert Walker inquiry. That inquiry was conducted by my colleague Commissioner L.F. Wyvill QC. The Executive Director informed the Commission that it is his policy to reserve the use of Section 9 for serious matters relating to security or good order where other reporting or investigative procedures are inadequate (W/2/14 1 A).

It is understood that the Western Australian Prison Officers Union was opposed to the inclusion of Section 9 in the Prisons Act 1981 and has made subsequent representations requesting the repeal of the section. In the matter of Robert Walker the Executive Director considered the possibility of industrial action being instituted by the union should he have ordered an inquiry under Section 9.

The Department of Corrective Services is, similarly with the Western Australia Police Department, an organisation that has or should have a high level of public accountability. The level of accountability of staff employed within these departments must rightly be considered to be of a higher order than that of the average citizen. This is particularly so where there is public concern about actions that have taken place behind the relative security and secrecy of prison or lockup walls. That level of accountability is one of the responsibilities that officers take on when they join the police and prison services.

Confining my comments to the context of a death that has occurred in prison custody, it is considered that there is justification for the retention of Section 9 of the Prisons Act - whilst acknowledging that its use be reserved for situations where there is suspicion that officers of the Department are withholding information relevant to the circumstances of that death. Recourse to the provisions of Section 9 would, of course, be a matter of last resort by the Department and it is hoped that such action would not be necessary in any future investigation into a death in prison custody.

<u>Attempted Suicide and Self-Mutilation by Prisoners</u>

Staff at prisons where a prisoner has attempted suicide or has self-mutilated are currently required to furnish reports regarding those incidents. The prisoner, staff and any other prisoner who may have relevant information are interviewed in an attempt to determine the reasons for the prisoner's actions.

There is currently no requirement that the investigations officer inquire into every incident of attempted suicide or self-mutilation. However, the investigations officer or one of his assistants may, at the request of the Superintendent or on the instruction of the Director of Prison Operations, carry out an investigation where a prisoner has repeatedly caused himself injury or attempted suicide or where there am other unusual or suspicious circumstances. The Department has advised that all prisoners who attempt suicide or self-mutilation are seen by a member of the Special Needs team within 24 hours.

- I consider that there is considerable value in complete records of all attempted suicides and incidents of self-inflicted injury being maintained by the Department.

- It is suggested that the investigations officer or one of his assistants conduct or supervise the inquiry into each such incident rather than reporting on the incident remaining the responsibilty of the ordinary prison officers concerned. Some form of specialist investigation is required as each incident must be regarded as serious.

- The investigations officer's report on each such incident should be furnished to the Director of Prisons Operations and to the Special Needs Team dealing with Prisoners at risk for their information and consideration.

Coroner's Inquiries

Where the Coroner has made a finding in relation to a death that has occurred in prison custody, the Department of Corrective Services has an established procedure for an internal review of any recommendations made by the Coroner regarding the practice of the Department. If considered necessary, inquiries are made with outside organisations for specialist advice. A copy of the Coroner's finding is provided to the Minister for Corrective Services and he is informed of any action taken or proposed to be taken by the Department in relation to those findings.

At this point it is simply noted that the Department has expressed opposition to any proposed system whereby the Coroner would have power to direct the Department to report back to him. This matter will be considered further in section 6.4 of this Report relating to Coronial Inquiries.

6.3 AUTOPSIES AND FORENSIC TECHNOLOGY SERVICES

The autopsy or post mortem examination forms an extremely important pan of any post-death investigation. In the opinion of Professor S.M. Cordner, (Director of the Victorian Institute of Forensic Pathology and Professor of Forensic Medicine at Monash University) the aims of an autopsy include:

- description and recording of the pathological processes present in the deceased and relating these to the medical history;

- contributing to the reconstruction of the circumstances surrounding death; and

- recording relevant positive and negative findings so as to put another pathologist in the position of the pathologist performing the autopsy. (W/14/30A)

A flow of information should occur between the factual inquiry concerning the circumstances of death conducted by the police under the coroner's supervision, and the medical inquiry centering around the autopsy.

While primarily concerned with the cause of death in individual cases, autopsies, especially when performed by forensic pathologists, are a potential source of research information in the areas of health and epidemiology.

6.3.1 DEATHS IN CUSTODY AND THE DECISION TO PERFORM AN AUTOPSY

The Coroner's power to direct that an autopsy be conducted is contained in the Coroner's Act 1920-1983, s.40. In all thirty-two inquiries the Coroner exercised this power and autopsies were conducted. The section in the Act does not identify 'deaths in custody' as a specific category of deaths in which a direction to hold an autopsy will be made. For Commission purposes the Coroner's current power to direct that an autopsy be made is contained in two limbs:

(1) in the case of 'any inquest into the death of a person' or

(2) in the case of 'a sudden death of which the cause is unknown' to assist the Coroner in deciding whether or not to hold an inquest.

Reform of the Coroner's power to direct the performance of an autopsy has been advocated. The Perth Coroner, Mr McCann, SM, has suggested that the power should not be defined as above but should apply generally whenever the Coroner (or his or her clerk) think it is advisable to have an autopsy where a death has been reported pursuant to the Act.

In August 1989 the Ad Hoc Committee for the Review of the Western Australian Coroner's Act reported. The Ad Hoc Committee also proposed draft legislation (the draft Act). The Committee mentioned the issue of the Coroner's power to direct that an autopsy be performed. The relevant section of the draft Act proposed by the Committee provides *'If a coroner reasonably believes that it is necessary for an investigation of a death',* (s.34 (1)) he or she may direct an autopsy be performed. While this proposal is supported, consideration should also be given to maintaining the rider contained in the current s.40. That is, if it appears that death was probably caused by improper or negligent medical treatment, then the person involved shall not perform or assist at the autopsy, although he or she shall be allowed to be present. It is also recommended that the direction to perform an autopsy be in writing (see Mr McCann's comments in conference session 31.8.90 T8 1).

Qualifications of those Conducting Autopsies

The current s.40 provides that the Coroner may direct 'any medical practitioner' to perform the post mortem examination. Similar legislation in South Australia provides that wherever possible, the post mortem examination should be performed by a pathologist in suitably equipped premises. It also provides that a pathologist on the staff of a hospital at which a person has died shall not perform the autopsy (except in specified circumstances).

In his submission to the Royal Commission Mr McCann, said:

> *I have sought to encourage* [the eight] *country coroners to ensure that in difficult, serious or involved cases, bodies are sent to the State Mortuary for post mortem examination there.*
>
> (Report prepared by the Perth Coroner on the Coroners Act)

Mr D. Walsh SM was Coroner in the matter of Ronald Ugle. No inquest was held in that case. Mr Walsh expressed the following view:

> *It was my practice to restrict post mortems to deaths from unnatural causes or those which were occasioned in suspicious circumstances.* (W/28/12)

The Ad Hoc Committee noted, when discussing this issue:

> *There are different criteria adopted by different Stipendiary Magistrates when deciding when to direct post mortem examinations to be carried out and by whom and where.* (Report of an Ad Hoc Committee for the Review of the Coroner's Act 4.8.89 page 6).

The legislation proposed by the Ad Hoc Committee provides that the Coroner may direct a 'pathologist or a doctor' to perform an autopsy (see s.34 (1)). Commissioner Muirhead in the Interim Report stated:

> *The pathologist performs a vital role. He or she should be a specialist forensic pathologist wherever the autopsy takes place. It is unacceptable (and unfair to all concerned) to place responsibility for autopsies upon a general medical practitioner* ... (Page 60)

It has been the Coroner's practice to direct that autopsies of persons who have died in custody in Western Australia be performed by forensic pathologists: in all but one of the cases before the Commission this was so. In comparison just under half of the deaths investigated in South Australia were performed by forensic pathologists. In his Report on the Coroners Act Mr McCann, expressed the view that post mortem examinations in Western Australia were of a relatively high standard as compared to other States. He noted that retirement of forensic pathologists since 1980 and the recruitment of young specialists has meant a new approach through more thorough macroscopic examinations and more detailed ancillary investigations. The forensic pathologists involved in the cases before the Commission were as follows:

1 . Dr J. Hilton, Chief Forensic Pathologist, State Health Laboratory Services, WA, who was admitted to the Royal College of Pathologists in 1972. Dr Hilton performed sixteen of the autopsies.

2 . Dr Pocock, then Senior Forensic Pathologist with the Department of Health, performed eight of the autopsies.

3 . Dr Hainsworth became a fellow of the Royal College of Pathologists of Australia in 1966 and became the first forensic pathologist in Western Australia employed by the State Health Department Laboratories. He retired in 1986. Dr Hainsworth performed three of the autopsies.

4 . Dr C. Cooke, Fellow of the Royal College of Pathologists of Australia, performed three of the autopsies.

In the matter of Polak the autopsy was performed by a local Kalgoorlie general practitioner. It appears that the Coroner's authorisation that the post mortem be performed locally was influenced by his belief that there were no suspicious circumstances, his knowledge of the deceased as a chronic alcoholic and a 'tragedy in waiting'. I described that decision as 'unsatisfactory' and one which .prejudged the outcome' (Report page 27). The post mortem examination was undoubtedly inadequate when measured by the standards one could expect from a forensic pathologist. The inadequacies made it impossible for me to establish the precise cause of death although it is likely to have been related to chronic alcoholism and made it difficult to say whether the death could have been prevented by prompt delivery of medical care.

In Dr Hilton's view local doctors ought only perform post mortem examinations 'in absolutely, non-controversial cases' (RCIADIC WI 3:635).

In his evidence before me in the conference session, the Perth Coroner discussed the performance of autopsies by general practitioners in deaths other than those occurring in custody or otherwise of concern to society. He stated:

> *... what we have tried to do, but not with any great success, is to identify those practitioners in country areas who would be interested in doing post mortems ... we would be in the position, hopefully, of providing a mortuary technician from Perth to fly to the country centre to assist the doctor in doing the actual post mortem work ...*
>
> *If we could provide a tech for each of those fellows, also encourage those doctors and say, 'We'll organise you to come to Perth to spend five mornings at the state mortuary' - and introduce them to the forensic pathologist there. Give them a training session within the state mortuary, send them back, and then continue to encourage them to be involved in various ways. You could set up a subgroup of interested general practitioners in country areas who could do quite adequately straightforward post mortems ...*
>
> *There is a vast expense incurred in moving bodies around the state. I can't tell you the cost last year but in 1988 it was well in excess of a quarter of a million dollars. Now, we could reduce that by providing a decent service to general practitioners to encourage them to get involved.* (Conference Session 31.8.90:15-16).

The involvement of forensic pathologists in the performance of autopsies on persons who have died in custody is currently the norm in Western Australia. Consideration should be given to encoding this practice in proposed legislation to provide that where the Coroner makes a direction in a 'death in custody' then whenever practicable the autopsy is to be performed by a forensic pathologist. The rider which forms part of the South Australian legislation should also be included (see page 2 of this section). The Ad Hoc Committee stated that because of the size of Western Australia, *'it will be necessary for post mortem examinations to be carried out in country areas by medical practitioners other than specialist pathologists'* (Report 4.8.89 page 21). Some discretion must therefore remain to counter practical problems of limited professional staff and problems of geography.

Autopsies and the Involvement of Relatives

<u>Notification</u>

The issue of the lack of notification of relatives concerning the post mortem examination was raised in the Royal Commission Inquiry into the death of Dixon Green. The deceased's brother Kenny Green stated:

> *Nothing was explained to any member of the family concerning the need for an autopsy nor any description of what an autopsy was designed to achieve. The family was shocked to hear that our brother's body had been removed almost immediately to Perth without any notification or discussion of the move with the family. We were most distressed (W/24/34).*

The Pitjantjatjara Council in its submission to the Royal Commission on behalf of its member communities and homeland areas in Western Australia, South Australia and the Northern Territory addressed the need for consultation. It stated that the need for an autopsy was often not fully understood and that resentment may flow when it was felt that the autopsy was in some way ' experimental' e.g. in cases involving young petrol sniffers [ppra/70].

Notification of intended autopsy cannot be permitted to occur in a similarly insensitive manner to the notification of death in the case of Robert Walker. The deceased's eldest sister stated that the family first heard of the death when an Aunt rang to say that she had heard a news item on the radio stating that a prisoner had suicided in Fremantle Hospital. (See also Notification of Next of Kin 6.4.5.)

It may be appropriate for notification to occur through the establishment of 'a special liaison network with Aboriginal organisations to communicate with Aboriginal families' (see Report prepared by the Perth Coroner on Coroners Act). This would hopefully involve more speedy, effective and sensitive communication. Mr McCann also noted the need to establish an information network to enable the community in general, and the Aboriginal community in particular, to be informed of 'what a coronial service is about and why things happen' (Coronial Conference Session 31.8.90 T21,T42). In addition, the Coroner supported the provision of a 008 number to facilitate communication between the Coroner and families of deceased and the availability of a precise pamphlet or handbook to be given by police at the time of notification, informing relatives about the coronial process (31.8.90 T43 and see also 6.4.5).

The means and timing of notification of relatives that the Coroner intends to direct the performance of an autopsy are most important issues. The question of who should have the responsibility for informing family members and the method of such informing must be addressed. The draft Act does not provide for the notification of relatives or interested persons that an autopsy is to be performed. Indeed no jurisdiction in Australia makes express provision for notification. Consideration should be given to the draft Act including a requirement that either the Coroner, the Police or some newly established 'liaison officer', make all reasonable attempts to promptly consult with the family or the family's representative. Consultation should include the following matters: the intention to direct an autopsy be performed, the reasons for an autopsy, where it will be performed, by whom, and the rights the family may exercise concerning the decision.

Adequate legislative notification procedures are essential, enabling a family to be informed and able to object to or request an autopsy.

Right to Request/Refuse an Autopsy

Under current legislation a Coroner's decision to direct or not to direct an autopsy is not subject to review.

The Victorian legislation (s.28) provides a right of review. The Ad Hoc Committee draft Act proposes that:

(1) Any person may ask the Coroner to direct that an autopsy be performed and if the Coroner refuses the decision may be reviewed by the Supreme Court.

(2) If the Coroner decides to hold an inquest, following a request not to by the 'senior next-of-kin' then review of the decision may be sought in the Supreme Court.

Mr McCann has expressed some reservation about this proposition. He stated:

> ... *I agree that we should make a very serious effort in involving the family in this situation, to tell them what is going on and why it is going on - not because I think it is appropriate that they should have the right of veto, but I think we ought to let them know what is going on. I think that any rule which would slow down the process of getting a PM going would have grave dangers in getting a decent PM. If we are talking about custodial deaths, it seems to me that the inquiries and the post mortem examination should proceed with expedition because the post mortem examination may have very serious implications for the investigation itself* (Coronial Conference Session 31.8.90 T20).

I support the recommendations of the Ad Hoc Committee concerning the right to request or refuse an autopsy and to seek review of the Coroner's decision.

Traditional Communities

The right to seek review of a coroner's decision to direct that an autopsy be performed may have particular significance for Aboriginal communities. In their submission to the Commission, the Pitjantjatjarra Council identified some specific repercussions of the holding of an autopsy such as the pathologist's interference with the body may prevent full burial rites being performed and, if a delay in burial is caused by an autopsy, the period of 'sorry business' may be extended increasing injuries and tensions. More generally, the Council's anthropologist in his 'Notes on Funerary Practices' which formed part of the Council's submission stated:

> *It is important to understand that the damage done by foreign interventions that are disruptive in nature rebound not only against the sentiments of close kin. They inhibit or prevent the working of social mechanisms which are critical to the well being of all members of the community.*

He noted that there was still considerable continuity of traditional practices and beliefs even where 'Christian' burial was the norm.

In its 'Submission to the Coronial Conference' the Committee to Defend Black Rights stated:

> *The Aboriginal people have a different cultural evaluation of death to that the majority Australian Culture. The death of a person sets in train a process of preparation for burial and of mourning. As Rose Murray of the Pilbara Aboriginal language centre told the writer:*
>
> *The timing and place of burial can take weeks to arrange. This is a very distressing time for people. Because of the strong kinship system in the Pilbara hundreds of people can attend funerals ...*

> *Of course this statement poses additional questions such as: Do all Aboriginal people adhere to the Aboriginal custom? We believe that there are obvious difference in the strength of culture from place to place. On the cultural aspect of death however the people all over the state are very much affected, and follow in part or in whole the culturally prescribed customs* (Submission dated 28.8.90).

In Mr McCann's view rules providing an obligation to take into account traditional customs and religious beliefs when directing an autopsy, should not restrict an autopsy where the Coroner thinks the examination is necessary (see Coronial Conference 31.8.90 T25). He stated:

> *Coroners should be sensitive to the wishes and culture of the deceased and next-of-kin be they Aborigines or from some ethnic minority and their needs should be accommodated so far as is possible, but I reject the proposition that such wishes should impede a thorough investigation* (Report prepared by Perth Coroner on Coroners Act).

These issues raise the question, whether it is necessary to embody in legislation or some other form that cultural funerary rites and practices will be recognised in the decision to direct an autopsy. The Aboriginal Legal Service in its submission on the Commission's Coronial Inquiry Discussion Paper stated:

> *It may also be prudent to empower the Coroner to make such directions as he considers proper in relation to the conduct of the autopsy to take into account any special cultural factors (ALS* Submission on Coronial Inquiry Discussion Paper 29.8.90)

I think it is important that cultural factors are given legislative recognition, both in the decision to hold, and in the conduct of, the autopsy. However the Coroner must have the power to balance these views against his assessment of the public interest.

Observers

In the Coroner's view 'it *has been a longstanding practice to allow medical practitioners nominated by the family of the deceased to be present and observe post mortem examinations. However such requests are rarely made'.* The cases confirm that this is not a common happening. In the second autopsy in the Pat matter, in Morrison and in Cameron a medical practitioner from the Aboriginal Medical Service attended as observer. In McGrath a lay observer viewed the body prior to autopsy.

The presence of a medical observer has significant advantages . It may:

(1) avoid the need to undertake a second autopsy
(2) allay concerns of the relatives
(3) aid as a means of communicating and explaining the cause of death to relatives
(4) corroborate the findings of the pathologist at inquest
(5) favourably affect the performance of the autopsy.

(See discussion papers of the South Australian office of the Royal Commission)

The presence of an observer is an important right. It highlights the need for full and informed notification of the relatives of the decision to hold an autopsy. Consideration should be given to establishing a recognised channel for liaison between the Coroner's office and relatives of Aboriginals who have died in custody which may facilitate the exercising of this right. It is also suggested that consideration be given to providing

legislative recognition of the rights of a family to be represented at the autopsy (see Report into the Death of Dixon Green, page 19).

Timeframe for the Performance of the Autopsy

The autopsies in the thirty-two cases occurred as follows:

1. In twenty-one cases on the day of death or the day following death.
2. In seven cases on the second day following death.
3. In three cases on the third day following death.
4. In one case on the fifth day following death.

The reasons for the delay included the geographical location of the body requiring transportation e.g. from Halls Creek to Perth, the availability and transportation of the forensic pathologist e.g. from Perth to Derby, the non-performance of routine autopsies on weekends (in 1983).

The autopsy must be performed promptly to enable relatives to be informed of cause of death, to provide information to investigators, to prevent the loss of information and testing opportunity through decomposition of the body, and to minimise disruption of funerary practices.

Notification requirements, appointment of an observer and a tight of review of the Coroner's decision may lengthen the time between death and autopsy. The draft Act makes provision for a 48 hour delay following notification of the Coroner's refusal of a request to direct an autopsy or the Coroner's decision that an autopsy is necessary in spite of a request not to hold an autopsy, to enable application to the Supreme Court. Expert evidence, as to whether such a delay is likely to significantly affect the usefulness of the autopsy should be obtained and this provision reviewed in the light of such evidence.

Legislation in the Northern Territory requires that the medical practitioner who performs the autopsy furnishes a written report to the Coroner within two months of receiving written directions. Significantly, legislation in the Territory provides that a relative of the deceased may apply to the Coroner for a copy of the post mortem report (s.s. 22 and 23 Coroners Act). Such sections provide greater Clarity in the production and delivery of post mortem reports and for this reason I support the inclusion of such sections in a draft Act.

6.3.2 ATTENDANCE AT THE SCENE OF DEATH BY THE FORENSIC PATHOLOGIST

The attendance of the forensic pathologist at the scene of death is seen as particularly important in deaths in custody. In Professor Cordner's view the functions able to be performed include:

- Certification of the fact of death
- Familiarisation with the physical characteristics of the scene and position of the body
- Assessment of the requirement of taking of evidence from the body or scene (including possible removal and securing of clothes).
- Initial assessment of injuries, damage to clothing etc.
- Observations concerning time of death, if relevant.
- Ensuring the recording of relevant findings and observations including photography (W/14/30(a):5)

In his findings following the inquest into the death of Stanley Brown the Coroner expressed the desirability of involving the forensic pathologist at the scene of death or at least providing telephone advice to the attending medical practitioner (see also Coronial Conference Session 31.8.90 T68).

The cases have revealed problems however in (1) promptly seeking the attendance of the pathologist, by the police, (2) a thorough addressing by the pathologist of issues such as those listed above and (3) where the pathologist's attendance is impractical in areas outside Perth.

Police Responsibility

The police routine orders provide that following a death in custody and before the body is moved, the Coronial Inquiry Section is to be notified. It is then the responsibility of CIS to notify the duty forensic pathologist who will attend the *scene where practicable. 'If it is not practicable for the forensic pathologist to attend then arrangements are to be made for a medical practitioner to attend the scene forthwith and that a medical practitioner should consult by telephone with the Duty Forensic Pathologist so that independent observations can be made of the scene of death* (Routine Order 19-16.31.1; 1OMay1988).

It appears that the duty pathologist system in the metropolitan area ensures a prompt response once notification is effected (RCIADIC W14:228). Misel Waigana died in East Perth Lockup in 1987. The forensic pathologist was notified one and a quarter hours after the body was discovered. The delay - not conclusively explained - was described by the pathologist as 'unfortunate' and minimised the usefulness of his attendance. The case also displays a confusion of responsibility as three officers (one from the CIS) testified that they had notified the forensic pathologist of the death.

In the Inquiry into the death of Robert Walker the police investigation officer's understanding of the Routine Order was that it was 'preferable' (RCIADIC W2:1545) that CIS be notified. As the prison medical officer was present at the scene of death he thought that was 'sufficient;' and it didn't cross his mind to call the Forensic Pathologist. Wayne Dooler was discovered by Carnarvon police at 6.25 am. Dr Dring arrived and certified life extinct at 6.50 am. Halls Creek Police were informed of Donald Chatunalgi experiencing a fit at 7.35 pm and at 8.00 pm Dr Saddler certified life extinct. The role of the attending medical practitioners contemplated by the Routine Order does not appear to be evident. The order should provide greater clarity directing the police to arrange an opportunity for the attending medical practitioner to promptly consult with the duty forensic pathologist. The necessity for such procedures may be alleviated to some extent by the proposed Forensic Medical Support Service.

Recommendation 31 of the Vincent Report concerns the investigation of deaths in custody and provides inter alia *'the duty forensic pathologist should be contacted by the Police Department immediately'. I* am of the view that Order 19-16.39 should be amended to provide that the notification of the CIS and the forensic pathologist occurs without delay.

Pathologist's Responsibility

Dr Hilton, Chief Forensic Pathologist with the Department of Health, has expressed the view that it is always desirable for the forensic pathologist to attend the scene of a death in custody. This practice has been followed, in deaths in the metropolitan area, since about 1986.

Dr Hilton appears to hold a more restrictive view of his function at the scene of death, compared with the role outlined above by Professor Cordner. Dr Hilton attended Fremantle Police Station in 1988 following the death of Benjamin Morrison. While describing himself as the 'eyes and ears of the coroner' (RCIADIC W15:487) and that the post mortem examination started 'the moment **I** saw the body' (RCIADIC W/15:486), he described the role of the pathologist in the following terms:

> *I think I personally see some advantage in a forensic pathologist attending the scene of most crimes, or most deaths - ... to get some sort of a feel for the situation of a fairly early state ... I think it's an extra independent person coming on the scene* (RCIADIC W15:501) *a preliminary examination to get the general feel, secure the body and get the body taken to a place where proper facilities for proper examination exist* (RCIADIC WI 5:509).

Dr Hilton did not agree that his function at the scene included the taking of trace evidence or removing clothing. He thought that the pathologist was in a position to request, but not direct, that particular photographs be taken.

Dr Pocock expressed the following view concerning the pathologist's attendance:

> *I think it is absolutely essential for a pathologist to attend any suspicious death. The post mortem really starts at that moment in time* (RCIADIC W2:64).

It is important that agreement exists concerning the attendance and functions of the forensic pathologist at the scene of death. A clear policy should exist and be understood by all those concerned: the police, forensic pathologist and the Coroner. The issue stresses the need for adequate liaison discussed below and may be a matter addressed in the proposed protocol (see 6.3.4).

Country Areas

In cases outside the metropolitan area it will usually be impractical for the forensic pathologist to attend the scene of death. The attendance instead of general practitioners with certain additional training in forensic matters has been sporadically addressed through proposals for a police surgeon service, similar to that in operation in the U.K. (RCIADIC W13:644)

Coroner McCann in his reasons for decisions in respect of the deaths of Wardle, Morrison, Cameron and Samson discussed such a system. Each large urban area could have a registered medical practitioner who provided forensic services at the request of the police. The practitioner, in possession of knowledge of clinical forensic matters, would be available to advise police on relevant procedures and exhibit collections through attendance at death scenes, in addition to performance of other functions such as the assessment of persons in lockups who are apparently injured, unconscious, mentally ill etc. The Coroner described introduction of such a system as 'essential' and although it would cost money was a *'means of removing a large part of the responsibility for the care of detained persons from the shoulders of police officers' (p.28).*

In conclusion the Coroner recommended that a forensic medicine service must be urgently formed and should be provided by the Health Department of Western Australia under the direction of the Chief Forensic Pathologist (p. 136).

In March 1990, Chief Superintendent, Training and Recruitment produced a report summarising research by a working party. It was entitled 'Care Services in Police Custody Working Party'. The Report commented:

> *Specialist skills in dealing with illnesses and injuries of a forensic nature however will require some form of continuing education. Forensic medical experts will need to develop such educational requirements and make recommendations as to how best these programmes can be implemented. The State Forensic Pathology Service, through the Chief Forensic Pathologist, would be prepared to provide dedicated short courses for nominated practitioners..*

It included the following recommendations:

> *R:1 That an on-call Forensic Medical Support Service be established on a Statewide basis.*
>
> *R.2 That medical practitioners involved in the above service undertake course work in clinical forensic medicine under the guidance and direction of the Chief forensic Pathologist, State Health Laboratory Service, QEII Medical Centre.*

I endorse the proposed Forensic Medical Support Service.

6.3.3 ADEQUACY OF AUTOPSIES

The cases before the Commission cover an eight year period and some autopsy practices have changed during this time. As noted by the Coroner the autopsies performed in this State have generally been of a high standard (see report prepared by the Perth Coroner of the Coroners Act). I agree that the autopsies reviewed by me during the course of the Commission have generally been thorough and performed by practitioners of competence. However when considering details of the autopsies certain general issues have arisen including lack of expert photography, omissions in provision of relevant and accurate information to the pathologist, method of completion of post mortem reports, exhibit handling, recording and storage and varied use of forensic pathology services.

Photography

In twelve of the cases before the Commission autopsy photographs were taken. (Brown, Cameron, Chatunalgi, Harris, McGrath, Morrison, Njanji, Pat, Samson, Wongi, Wodulan). Cases before the Commission illustrate that a lack of proficient photography or a total absence are not uncommon events (see section 6.1.2.5).

In Dougal the autopsy was performed in 1980 at Derby Regional Hospital. Even though there was the suggestion (at least) of criminality being involved in the death, the investigating police officer did not arrange for a properly trained photographer to be at the autopsy and no photographs were taken.

The autopsy in Anderson was conducted in 1983. No photographs were taken because:

> *In the absence of a suggestion of criminality and in the absence of positive findings then normally I wouldn't have photographs taken unless there was something unusual which I would wish to use for teaching purposes* (RCIADICW16:20).

The pathologist's practice in 1989 has not changed although he noted:

> ... *We're using photography more now and when funds are available we will have some apparatus installed whereby bodies can be photographed full length ... but those funds are not available yet* (RCIADIC W16:20)

In Robert Walker the police photographer was not experienced in post mortem photography and he appeared to have used *'whatever camera happened to be available'* at the mortuary (RCIADIC W2:67). Autopsy photography was deficient for the following reasons: insufficient in number to display all injuries, no close up photographs of external injuries, no measure to record the size of injuries, no full length photographs taken. Dr Pocock concluded 'I *think it emphasises the - I don't like to say amateur, but the non-pure professional's photographic record...'* (RCIADIC W2:7 1).

Commissioner Muirhead in his Interim Report noted that it was especially important:

> *Whether or not bruising was detected that the body surfaces be photographed and colour proofs and negatives retained. Significant findings on autopsy should be the subject of photography and where necessary, x-rays'* (p 6 1).

Dr Cooke notes that one of the many changes to post mortem practice that has occurred during the period with which the Commission is concerned is the inclusion of photography at autopsy (W/12/28). However Mr McCann in his evidence before me expressed the following view:

> *... I might say that I have requested every dead body that goes to the state mortuary to be photographed front and back before it is stripped and then when it is stripped, front and back - naked - and sideways, with all noted irregularities or abnormalities to be separately photographed by photographers who could be made available, with expense, within the state mortuary. I have expressed the view that that should be done and that has not been done because of financial considerations* (Coronial Conference Session 31.8.90 T19).

Proficient photography at an autopsy is a prudent and necessary practice and should be routine at least as regards deaths in custody. Professor Cordner notes that the basic principle is that every stage of the procedure of examining the body both clothed and unclothed is photographed. It is his practice to refuse to issue a report in a homicide or suspicious death until receipt and examination of photographs of the scene and autopsy. Colour photography is important for identification purposes, to provide independent verification of injuries, marks and findings and generally to put another pathologist in the position of the practitioner performing the autopsy (see Cordner W/2/139).

In deaths in custody (whether or not an element of criminality is suspected) a professional forensic photographer with appropriate equipment should be available for use by the pathologist. The forensic pathologist's power and responsibility to require and direct the taking of photographs should be clearly established.

Provision of Relevant Information

It is a relatively common occurrence when the forensic pathologist receives the body for the only accompanying information to be the Mortuary Admission Form completed by the police. The relevant police officer will include in the form a statement concerning the circumstances of death to assist the practitioner performing the autopsy. Cases before

the Commission have indicated that the information given in these forms concerning the circumstances of death may be incomplete or inaccurate. This may result in the pathologist being seriously disadvantaged in his attempt to determine the cause of death. The concern is not allayed by Station Orders such as that from Fremantle Station dated 1987 noting that 'Greater attention is to be given to compiling Mortuary Admission Forms' and attaching samples described as 'completely unacceptable' (W/15/33).

The case of Robert Walker is illustrative. The first pathologist was presented with the body which had been undressed and the Mortuary Admission Form. Following autopsy the pathologist was unable to determine the cause of death. Although the form had included a reference to a struggle against prison officers, if greater detail had been included a pathologist may have investigated earlier the possibility of obstruction of blood supply to the brain through compression of the neck. This was the approach adopted by Dr Manock who performed the second autopsy.

In the Bernard McGrath case Constable Donaldson included very specific information in the mortuary admission form including: *'at 03.00 hours ... laying on a mattress in a single cell ... appeared to be sleeping'.* Later evidence revealed that at least part of the information was false. Donaldson was asked how he was able to insert such specific information:

Q. *You have no explanation for that?*
A. *I don't know why I wrote that, no.* (RCIADICW17:715)

In the inquiry into the death of Jimmy Njanji, the Mortuary Admission Form accompanying the body described the deceased's admission to hospital following a head injury and the time of death. However no mention was made on the form that the injury had been sustained in the Port Hedland Police Lockup (Njanji Report page 22).

The case of Stanley Brown illustrates the importance of the pathologist being fully supplied with relevant history and information surrounding the circumstances of death. Dr Hilton on completion of the autopsy determined the cause of death as 'hanging (clinical)'. Both Dr Hilton and Professor Cordner (from whom a second opinion was obtained) were of the view that in the absence of a history of the deceased found hanging in the way he was, *'It would not have been possible to determine positively the cause of death'.* Indeed in the absence of a history, as the deceased had an 85% occlusion of one of the coronary arteries, Dr Hilton could have found the cause of death to be coronary artery disease. He stated 'If *I had not been given any information or history when the body had been presented to me ... I might well have said that the cause of death was coronary artery disease'* (RCIADIC WI 3:637).

The importance of the prompt provision of medical records by the police to the pathologist is displayed in the case of Waigana. The pathologist initially could not determine the cause of death but considered epilepsy as a possible cause. He requested production of medical records, however they were not produced and he did not have access to them until they were provided by the Royal Commission. The pathologist had produced a supplementary report nominating delirium tremens as the cause of death. The records revealed a history of epilepsy and the pathologist gave evidence that *'I am now of the view that the terminal lethal event may well have been a grand mal epileptic seizure superimposed upon a fairly florid episode of delirium tremens'* (RCIADIC W14:224). It is not suggested that the provision of the medical records would have changed the supplementary cause of death (in this case) but it is imperative that the pathologist is given the opportunity to examine records at the relevant time. It is a more serious omission in the light of the pathologist's evidence that he believed he was told by police that the medical records could not be found. Adequate procedures should be in place for

the prompt provision by the police of such information or written notification of the unsuccessful attempts to locate it.

The provision of all relevant medical documentation to the pathologist is particularly important when one considers that the pathologist is often called upon to give evidence concerning the appropriateness of medical treatment prior to death (see my comments on Expert Evidence, section 6.4.6). In the inquiry into the death of the Aboriginal man at Sir Charles Gairdner Hospital for example, Dr Hilton wrote to the Coroner stating *'the right thing was done for* [the prisoner] *in an attempt to diagnose his condition during life'* (W/9/22). While I found that the post mortem examination was performed promptly and competently, I was not inclined to place great weight on the pathologist's evidence concerning adequacy of treatment (Report page 71).

In summary, Dr Hilton in a submission to the Royal Commission noted:

> *A diligent coroner's officer in his role as a history gatherer is as essential to the medico - legal post mortem as a pathologist. (Whether the inquiry officer is a serving police person or not may be open to debate).*

Exhibits

The cases have revealed deficiencies in the system of identifying, receipting and locating exhibits seized by the attending police, conveyed to CIS or made available for examination by the forensic pathologist (see also 6.1.2).

The investigating officers in the matter of Robert Walker left the scene of death with five black and white photographs, razor blades and some paper with writing on it. The 'exhibits', possibly seen by the CIS officer, were not subsequently sighted. Clearly they, were not made available to the forensic pathologist.

Evidence was given in the matter of Charles Michael concerning the then procedure for exhibits taken at the scene of death, to be made available for examination by the forensic pathologist. Constable Johnson of the CIS said that generally speaking exhibits which could be relevant to a person's cause of death were not recorded - on the mortuary admission form, the record of the deceased property or other document - but were placed on the trolley with the body so that if the forensic pathologist wished to have the substances analysed he could request that it be done (RCIADIC W1:893). The pathologist would only be made aware of the existence of such items by their presence on the trolley.

Evidence was given that the samples taken from the scene disappeared without trace.

Dr Hilton in Wodulan states:

> *If the exhibits had been attached to the body then I would have made a note of them. If they were not attached to the body I would not necessarily have made such a note.* (W/12/27)

In that case the body was admitted to the mortuary by the admitting officer who noted that there was a *'medical gauze on right side of forehead'* (W/I 2/4 6). The bandage apparently disappeared. At the time of Wodulan's death in 1983 there were no instructions for the recording of receipt and the disposal of exhibits by members of the CIS. (W/12/46) The current procedure involves recording of exhibits which are stored at CIS, the exhibits are conveyed to the mortuary by the post mortem officer and made available to the pathologist before being returned to CIS. Such procedures must be

regularly reviewed to ensure that they are adequately ensuring the safe and efficient recording, locating and storage of exhibits.

Clothing

Two main issues have arisen in this regard:

1. ensuring that the forensic pathologist has a knowledge of the clothing worn by the deceased at death and an opportunity to examine it, and

2. the possible importance of returning clothing to the family of the deceased (see retention of clothing 6.4.5).

The case of Robert Walker is illustrative of the first issue. The deceased had been involved in a struggle with prison officers prior to death and there was evidence that batons were used. There was evidence that Walker had been wearing a greatcoat (RCIADIC W2:1109). The body was stripped when the forensic pathologist received it. The pathologist was not shown the clothes worn and did not inquire about them. Clothing may not have helped the pathologist determine the cause of death. However, if the forensic pathologist had been given the opportunity to examine the clothing he would have been able (at least) to give a more accurate opinion of the degree of force used to produce observable injuries (RCIADIC W2:143). Lack of adequate procedures for the recording and preservation of clothing fuels suspicion and mistrust surrounding a death in custody and deprives experts of sources of evidence. Dr Pocock gave evidence that where he did not attend the scene of the death he 'virtually' had no say in whether the body was presented clothed or otherwise to the mortuary. This situation must not be permitted to recur.

The significance of the clothing may not always be readily apparent. The decision of when and how to remove and store clothing should remain with the forensic pathologist and his staff. It is not a decision or task properly performed by police officers. As Dr Hilton said in Morrison 'I *think fiddling around trying to remove clothing at scenes is not a wise thing'* (RCIADIC W 1 5:509). 1 am of the view that the forensic pathologist should normally receive the body of a deceased who died in custody fully clothed and with any restraints or other attachments (e.g. a noose) in situ. However, resuscitation attempts should never be impeded by efforts to preserve the scene and clothing. The difficulties in this area may be minimised by the establishment of the Forensic Medical Support Service.

Forensic Pathology Services

Additional information concerning the cause of death may be provided to the pathologist from reports on the following: toxicology, histopathology, neuropathology, biochemistry and microbiology.

An example of the change in practice from 1980 is that the then forensic pathologist only required detailed toxicology when there was reason to suspect the involvement of drugs. Currently it is required in most cases and is standard for the Chemistry Centre (formerly the Government Chemical Laboratories) to receive samples of blood, urine, stomach contents, liver and bile (W/16/47). However in Dr Hilton's view, *'We tend to use a fair bit of toxicological analysis ... not as much as we used to in days gone by where there was more money available'* (RCIADIC W16:23).

In the Robert Anderson Inquiry Dr Hilton described his practice as follows:

> *Many people get toxicological analyses; everyone gets a histological - all my cases get microscopic examination. Virtually all my cases, the brains are referred for neuropathological examination.* (RCIADIC W16:14)

In the cases before the Commission return time for neuropathology reports seem to be longer than the other reports. In the case of Anderson for example, the post mortem report was performed on 2 March 1983. The macroscopic neuropathology report is dated 6 April 1983. The case produced two microscopic neuropathology reports one dated 24 June 1983 and one a year later in July 1984.

Dr Hilton commented:

> *I do not know why a further microscopic examination of the brain was carried out over a year later ... A delay of this extent was unusual. However the neuropathology department was very busy and it was not unusual for them to take a long time to forward their reports* (RCIADIC W16:14).

A familiar problem for both the Coroner and the Commission when considering these ancillary analysis reports is that perhaps because of the delay between completion of the written post mortem report and results of, for example, the neuropathology examination, the Coroner may not receive these subsequent reports. Clearly procedures need to be in place to ensure that the Coroner is put on clear notice regarding the awaited results and that they are forwarded promptly to him upon receipt.

Method of Completion of Reports

In Anderson, Dr Hilton explained that it was his invariable practice to use 'undetermined' in response to 'cause of death' as an interim diagnosis only. If after receiving all information he was unable to determine the cause he would formally advise the Coroner that the cause of death was 'unascertainable'. He thought the Coroners would be aware of his practice. The Coroner in that case was not. The Coroner said:

> *At the time I believe that I was unaware of the esoteric connotation of the word 'undetermined'. I was certainly aware of it whilst I was relieving Mr McCann for periods in 1985 and 1986, whilst he was on leave. Recent annual conferences of magistrates have included convocations of country coroners under the chairmanship of Mr McCann. This practice has facilitated universal dissemination of such information* (Report page 35).

This case reinforces the need for regular liaison between relevant persons involved in coronial services discussed in 6.3.4 below. The amended post mortem report giving epilepsy as the cause of death was never actually received by the relevant coroner. It appears this was as a result of an internal office mistake (Report page 30). I discuss this case in Inquests into Deaths in Custody, see Section 6.4.6.

Samples

Mr McCann expressed the view that current practices concerning the retention of samples from autopsy, needed to be reviewed (Coronial Conference Session 31.8.90 T22-24). He noted serious public health implications may flow from the method of retention adopted and that it was not appropriate for past informal arrangements to be maintained (Coronial Conference Session 31.8.90 T23). In the Coroner's view preservation of such material

may best be provided for in rules rather than guidelines to provide greater statutory authority for procedures. He noted the need for long term planning and the provision of adequate funds for the process:

> *... the storage of this material is expensive. It costs money. The Chemistry Centre was running out of space and was insisting that they had to destroy material. There was no facility at the state mortuary to take stuff back because they were full up. The Chemistry Centre has now got freezers which will carry the system through for about 2 years. At the state mortary you could squeeze a few more things in but not much. There is no plan in place there, at the state mortuary, for the retention of this material on a long-term basis.*
>
> *... It seems to me that somebody has got to put their hand in their pocket and say, 'We will fund appropriate services and they will be funded to a particular level'. The people making the decisions are the people who have no specific interest in forensic pathology in this state (*Coronial Conference Session 31.8.90 T23).

As with other areas discussed under the adequacy of autopsies, the provision of important and necessary public functions and services such as the retention of samples must be given recognition by governments through the provision of adequate and secure funding.

Is a Protocol Necessary?

Commissioner Muirhead in the Interim Report stated:

> *... it is inappropriate for me at this early stage to make firm recommendations which could amount to a protocol for the pathologist's work. (p. 60)*

In addition to the provision of opinions to the Royal Commission in individual cases in Western Australia and other jurisdictions, Professor Cordner has made a general submission to the Commission. In his view a protocol would be useful. He states:

> *It is clear that there is considerable variation in the quality of autopsies, particularly where there is reliance on government medical officers without pathology training. I think it is both possible and desirable to develop a protocol to ensure a consistent minimum performance in suspicious deaths and homicides. However such protocols will only be of use if appropriately trained and skilled pathologists are applying the protocols.* (W/2/139)

The purpose of the protocol as described by Professor Cordner is to provide an account of the major components of the forensic pathology investigation undertaken and to provide an explanation if these are not undertaken. In the Professor's view, *'It should thus provide a readily accessible guide to the thoroughness of the investigation'. (*GO/6 15.8.89*))*

Dr Hilton in a submission to the Royal Commission counselled against the creation of a protocol for autopsy examinations. He said:

> *A protocol for any professional work can be a dangerous and restrictive implement ... I feel competent practitioners in our ... profession would find such a restriction irksome.* (SOO18)

Clearly the notion of strict completion of a detailed pro forma document is inappropriate for use by expert forensic pathologists. However consideration should be given to the

adoption of a simple nation-wide statement which could provide in one document a complete description of the components of the medical examination undertaken or requested by the forensic pathologist following death, including as applicable - attendance and role at the scene of death, autopsy, photography, histology, toxicology etc. It could include the practitioner's qualifications and whether he or she consulted with any other expert or provided advice to any source.

6.3.4 LIAISON BETWEEN PATHOLOGIST, POLICE AND CORONER

The cases have revealed instances where liaison may greatly enhance the contribution of the forensic pathologist to the Coronial process. Following the post mortem examination into the death of Jimmy Njanji, Dr Hilton established a link between the head wound and the laryngeal oedema which had caused asphyxiation resulting in death. Although he informed the Coroner in discussions of his opinion of the nexus and had verbally informed the officer of the CIB, no written notification was sent to the CIB because Dr Hilton *'would not presume to send a letter to the Superintendent, CIB',* (Report of Inquiry into the death of Jimmy Njanji, page 23) and no reference to the nexus was contained in the police brief supplied to the Coroner. Opportunities for liaison may enhance the development of procedures to ensure that the police brief produced in such circumstances is adequate and to develop greater ease of communication between, for example, the pathologist and the CIB.

Mr McCann in the conference session before me noted that disparate locations of the various services meant that extra effort was required to ensure adequate liaison (Coronial Conference Session 31.8.90 and see Submission to the Commission by the Coroner 16.3.89 T79,80). The Coroner noted some degree of rivalry between forensic pathologists and police officers in the CIS leading to requests to police by the pathologists not always being received and processed smoothly. The Coroner spoke of recent attempts to develop greater liaison and apparently weekly meetings are being arranged between the forensic pathologists, Coronial Inquiry Section, a chemist from the chemistry section and the Coroner, *'to talk about the cases that have occurred in the last seven days and any particular problems that have arisen during inquiries'.* This practice is to be praised and encouraged.

6.4 CORONIAL INQUIRIES

6.4.1 INTRODUCTION

Pursuant to the Terms of Reference in Letters Patent issued to me I am required to inquire not only into the deaths of Aborigines and Torres Strait Islanders in custody in Western Australia since I January 1980, but also to inquire into:

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

In this section of the Report I will examine the following issues which have been raised during my individual inquiries into the deaths and in further submissions which I have received:

- Structure and administration of the coronial system in Western Australia.
- Coroner's jurisdiction in relation to deaths in custody.

- Initial matters relating to the coronial inquiry.
- The inquest.
- Coroner's findings
- Counselling/Liaison Services.

6.4.2 STRUCTURE AND ADMINISTRATION OF THE CORONIAL SYSTEM IN WESTERN AUSTRALIA

The coronial system in Western Australia is currently organised on a regional basis.

In the Perth area a Stipendiary Magistrate, Mr McCann, has been directed to perform the duties of a Coroner on a full time basis. He is responsible for the investigations of deaths and fires in the Perth metropolitan area, extending to Jurien and Moora in the north, the Hills district in the east and Mandurah in the south. In addition he is responsible for the Narrogin Police Region.

He investigates approximately 1200 deaths each year. An additional 600 cases are reported to him but do not require inquiry as there are proper cases for issuing of a death certificate by medical practitioner.

There are eight resident Stipendiary Magistrates in the country areas of Western Australia who are responsible for investigation of deaths and fires reported to them from their own districts. They fulfil their role as Coroners on a part time basis only as they perform this duty in addition to their normal duties in the Court of Petty Sessions and Local Court. Country Coroners investigate about 400 deaths per year.

Although s.4(l) of the Coroners' Act 1920 (the Act) provides for the appointment of a Coroner (or Coroners) and Deputy Coroners; it appears that no such appointment has ever been made (see Report of Ad Hoc Committee for the Review of the Coroners Act, August 1988). Section 5 of the Act also provides that Stipendiary Magistrates should be ex-officio coroners; and so it has been that Magistrates have carried out the duties of Coroner up until the present day. The Act also provides for justices to act as Coroners with the authority of the Attorney General or at the request of a Stipendiary Magistrate. However the Perth Coroner, Mr McCann, has informed the Royal Commission that no Justices routinely act as Coroners (notes to the Royal Commission 13.7.90 p.3).

The Perth Coroner has noted that the current system is unorganised and that the approaches of the nine Stipendiary Magistrates to their coronial duties differ. He has said that despite efforts to liaise with country magistrates by telephone and meetings it is difficult to obtain a consistent approach particularly in view of the high turnover of country magistrates.

The Ad Hoc Committee for the Review of the Coroners Act recommended that the present system should be abandoned and that a State Coronial System should provide for the office of a State Coroner who would bear the overall responsibility for investigation of deaths in Western Australia. It has been recommended that the State Coroner should be a judicial officer whose status and independence should be clearly established by legislation (Ad Hoc Committee Report p.6). Both the Perth Coroner and the Ad Hoc Committee have looked to the Victorian legislation, enacted in 1985, as providing a suitable framework for changes in Western Australia. It has been suggested that a new system should provide for a Deputy State Coroner and that given Western Australia's geography, resident Stipendiary Magistrates should have the powers of a Coroner for the period that they serve as Magistrates, albeit under the direction and guidance of the State

Coroner. This recommendation seems to have received general support and is consistent with recommendation 44 of the Muirhead Interim Report.

> *44. The functions and status of the office of Coroner require examination and re-assessment with full recognition of the public value of that role. I suggest the Victorian system be examined as providing a model which can be adapted where geographical considerations so require. I consider this recommendation deserves urgent consideration.*

Although not in total agreement with all aspects of the Ad Hoc Committee Report and the draft legislation they have proposed, the proposal for a State Coronial System in Western Australia has my full support.

How satisfactory are the current administrative arrangements of the Coronial System in Western Australia?

In a submission to the Royal Commission, Perth Coroner, Mr McCann, pointed out the difficulties created by the current administrative arrangements for the Perth Coroner. The Coroners Court, the State Mortuary and forensic pathologists, the toxicology unit of the W.A. Chemistry Centre and the Coronial Inquiry Section of the Police Department, are each located at four separate sites in Perth (Submission of Mr McCann to Royal Commission 16.3.89).

Mr McCann elaborated upon these difficulties in the finding into the death of Michael Tan (not a death investigated by the Royal Commission). An excerpt from the finding is set out below:

> *Unfortunately for the Coronial system, while the Coroner's Act is the responsibility of a particular Minister and the administration of the Coroners system is nominally under the charge of the Crown Law Department, the reality of the operation of that system is that it is beholden to other Government Departments.*
>
> *While the Coroner has the statutory responsibility for the investigation of deaths and fires which are reported pursuant to the statutory obligation, or convention, to do so, the means of fulfilling that statutory responsibility is not in the hands, or under the control, of the Coroner. The Coroner is dependent upon the HealthDepartment to provide forensic pathologists, technicians, laboratory staff and a Mortuary, is dependent upon the Police Department to provide investigators of the facts, is dependent upon the Mines Department to provide the facilities for toxicological analyses.*
>
> *The Coroner in Perth is dependent upon the Crown Law Department to provide staff, offices and equipment, to support the day to day work of the Coroner. In the country Resident Magistrates are called on to carry out the duties of a part-time Coroner. Their immediate support staff are the Magistrates' Court staff, who already have their ordinary duties to perform.*
>
> *The priorities for the provision of medical or paramedical staff and facilities, for the provision of investigators, for the provision of human toxicology analyses are set by those Departments. Those priorities are not set in consultation with the Coroners involved.*

The reality of the matter is that the Crown Law Department makes only a very small financial contribution to the Coronial system and has been happy to do so, leaving other 'big budget' Departments to absorb the real cost of the system.

At this point in time, so far as I am aware, the cost in financial terms of the Coronial system to Government is unknown and has never been calculated.

The real cost to the community in the widest sense may never be known (pp.64-65).
...

It is difficult to imagine how a system could be rendered more inefficient, even by deliberate act, than the present position where, in respect of the Perth Coroner, the Court and Court offices are separately located from the forensic pathologists and the State Mortuary, who are in turn separated from the principal police officers responsible for investigations, who are in turn separated from the chemists involved in toxicological analyses. Even the sharing of clerical officers and office machines would provide some savings (p.67).

The Perth Coroner has only three support staff to assist him, those being, the Coroners Clerk and two secretarial staff. The country coroners have no staff allocated to assist them in their coronial duties and they are dependent upon the services of the court staff.

The Western Australian legislation makes no provisions for the administrative and organisational arrangements of the coronial service. The Act does not recognise the existence of the Coronial Inquiries Section, or the role played by the forensic pathologists employed by the Health Department. However, the Act does provide for the appointment of a 'coroners clerk' by the Attorney General from the ranks of the public service. The clerk's functions are not specified, but under s.6(l) he may receive information concerning deaths within the State and under s.40(l) he may, in respect of an inquest, direct a post mortem examination to be performed. It is currently the practice that the clerk also directs post mortems to be performed under s.40(2) when a decision whether or not an inquest ought to be held has still to be made, although it is uncertain whether he has the power to do so under the legislation.

This highlights the difficulties for a coroner under the current legislation with respect to the delegation of his/her powers. There is no provision in the legislation for the Coroner to delegate his/her powers even in relation to routine matters. However, the draft legislation provides the coroner with powers of delegation in relation to certain functions.

The current administrative arrangements are inefficient. In addition, the resources available to Coroners are grossly inadequate making the provision of proper coronial services to the public extremely difficult.

Organisation and Administrative Arrangements in Other States

In Victoria, the State Coronial Service is closely connected to the Victorian Institute of Forensic Pathology. The State Coroner is responsible for the relationship between the Victorian Coronial Service and the Victorian Institute of Forensic Pathology, (Coroners Act (Victoria) ss. 66, 67(2)). The State Coroner is a member of the Council of the Institute (Coroner's Act (Vic) s.62(2)) and has the power to direct the functions of the Institute (s.66). The Coronial Services Centre in South Melbourne houses the State Coroners Office, the Victorian Institute of Forensic Pathology. It is open and functions 24 hours every day and the Coroner, the Coroner's Clerk, Pathologist and support staff are always

available (see submission of Mr Harold Hallenstein State Coroner, Victoria, to Royal Commission 3.10.88).

By way of contrast in South Australia, the State Coroner although in practice has a close working relationship with the Forensic Pathologists at the State Forensic Science Centre, he has no specific power over the Director or the resources of the Centre. State Forensic Science and the Forensic Science Advisory Committee (FSAC), have no statutory bases. State Forensic Science is an integrated and independent forensic science service. The services are available to the whole of the Justice System but the biggest single user is the Police Department. Users am able to have a say in the service through participation in the FSAC (see submission from State Forensic Science to the Royal Commission 5.9.89).

The Perth Coroner, Mr McCann, has expressed support for the statutory incorporation of the State Forensic service and a statutory relationship between the Coroner and the service.

Mr McCann suggested that in Western Australia there should be a statutory institute of Forensic Medicine controlled by a Board. The Ad Hoc Committee referred to the establishment of a statutory body for Forensic Medicine in Western Australia but as it was not thoroughly canvassed it refrained from making recommendations in this regard and suggested it should be examined separately. Mr McCann explained that negotiations with the Health Department over the State Forensic Service could be very time consuming and unduly delay the review of the Coroner's Act (Coronial Conference 31.8.90, T26).

6.4.3 STATUS AND QUALIFICATIONS OF CORONERS

Both the Perth Coroner and the country Coroners are Stipendiary Magistrates. They are Coroners by virtue of their office (s.5 Coroners' Act). As mentioned previously the current Act also provides for Justices to act as coroners with the authority of the Attorney General or at the request of a Stipendiary Magistrate. Although Justices do not routinely act as Coroners it is inappropriate that there is provision for them to do so. The draft legislation makes no provision for Justices to act as coroners. I support the non-inclusion of such a provision in the legislation.

Magistrates are now required to be qualified legal practitioners who have been admitted for at least five years. However there are still magistrates who do not hold legal qualifications, as previously this was not required for the position. 'Me appointment of Coroner under s.4(l) of the Act does not require any special qualifications.

The Ad Hoc Committee has addressed the issues of status and requisite qualifications of Coroners. It has recommended that each person appointed State Coroner and Deputy State Coroner should be a barrister or solicitor of not less than five years standing and that they should have security of tenure and receive emoluments on terms similar to those of a District Court Judge. The Perth Coroner has commented on his difficulty in exerting sufficient authority over certain aspects of the coronial system which are theoretically subject to his control. He has explained his problem as being two-fold. The first being lack of status attached to the position and second the lack of financial resources available to him. He said that if the appointment of Coroner had greater status then it might give a greater aura of authority which would assist in his relations with decision makers in other Government departments. Mr McCann's position is appreciated and I believe it is important that the positions of State Coroner and Deputy State Coroner be given the status suggested by the Ad Hoc Committee and the necessary resources to enable them to fulfil their role properly. The Ad Hoc Committee has also recommended that persons who are barristers and solicitors and persons who hold the office of Stipendiary

Magistrates should also be able to be appointed Coroners. I also support these recommendations.

Mr McCann explained some of the difficulties experienced in trying to improve the training for country magistrates who act as Coroners. There is currently a coronial component within the Magistrates' conference which is held annually. The component was initially an hour and was gradually increased to one day. However on the last two occasions when a full day session separate from the Magistrates' conference was requested it was unable to be arranged, one reason being financial constraints. Mr McCann has suggested the need for a one or two day training session for Coroners but has been told that there are insufficient financial resources. I find it astounding that the Government is unable to provide adequate resources for the proper training of judicial officers.

6.4.4 ROLE AND JURISDICTION OF THE CORONER IN RELATION TO DEATHS IN CUSTODY

Mr McCann has also pointed out that deaths in custody represent a very small number of the deaths reported to the Coroner each year and that long inquests into these deaths present great difficulties to Coroners, given the limitations of their resources particularly in view of their workloads and the geographic areas they have to cover. In the ten year period covered by the Royal Commission, Coroners 'would have investigated approximately 15 000 deaths, there having been only 34 Aboriginal deaths in custody requiring investigation by the Royal Commission.

The jurisdiction of a Coroner in relation to deaths in custody is set out in s.6(l) of the Coroners Act which provides:

6(1)

> *Subject to this Act, where a Coroner or his clerk is informed that a person has died within the State, and*
>
> *(a) there is reasonable cause to suspect that such person has died either a violent or unnatural death, or has died a sudden death of which the cause is unknown; or*
>
> *(b) such person has died in prison, or while detained in any hospital for the insane, or in such place or under such circumstances as to require an inquest under any Act,*
>
> *the Coroner shall have jurisdiction to inquire into the manner and cause of death of such person.*

Section 34 of the Prison Act provides:

> (1) *The superintendent shall give notice to the Director of the death of a prisoner occurring while the prisoner is in the charge of the superintendent and the Director shall cause notice of such death to be given to a coroner.*
>
> *(2) Where a coroner is informed under subsection (1) of the death of a prisoner the coroner shall inquire into the manner and cause of the death of the prisoner.*

The combined effect of section 6(l)(b) and section 34(2) of the Prisons Act is to make it mandatory to inquire into the death of a prisoner under the control of a prison

superintendent but leave it to the Coroner's discretion as to whether or not an inquest is held.

Mr McCann has made the following comments on s.6(l)(b) and the obligation and attitudes of Coroners on inquiring into deaths in custody:

> *So far as Section 6(l)(b) is concerned, it is clear that it is intended that there should be an inquiry into the death of any person who dies while deprived of his or her liberty.*
>
> *However there is no specific reference to a death in police custody. Most coroners in this State have taken the view in the past that an inquiry followed by an inquest should be held into a death of a person which occur's while under arrest or while detained in police custody pending being brought before a court. Any doubt in this matter should be removed.*
>
> *There is also some doubt as to what is meant by death in prison. The question has been raised as to whether this includes a death which occurs while in transit to or from a prison (see R. v. Greater Manchester Coroner, exp. Worch [1987] 3 All ER661 at 669(b)) or while being treated in a hospital although still a prisoner, or indeed where the illness or injury leading to the death has arisen while the deceased was detained either in prison or police custody but died at some later time after discharge from such custody.*
>
> (Comments on the Coroner's Act and Suggested Amendments)

There is no mandatory requirement to hold an inquest into a death in custody. Coroners in Western Australia have jurisdiction to inquire into deaths under s. 6(l) of the Coroners Act, but have a discretion whether or not the inquiry should proceed to an inquest.

Given the public interest in deaths involving State agencies it might reasonably be expected that inquests should occur in all such cases.

The Ad Hoc Committee is of the view that the discretion whether or not to hold an inquest should be vested in the Coroner as an independent judicial officer, in whom the public should have sufficient confidence to carry out those duties properly. The draft legislation requires a Coroner to investigate a 'reportable death' including the death of a 'person held in care' (see discussion below) but only requires a Coroner to hold an inquest if so directed by the Attorney-General or the State Coroner. Otherwise, if a Coroner has jurisdiction to investigate a death he/she may hold an inquest if he/she believes it is desirable (s.22).

In other jurisdictions the discretion to hold an inquest has been circumscribed to some extent. In South Australia, Victoria, New South Wales and Tasmania it is mandatory to hold an inquest in relation to certain deaths in custody.

In South Australia it is mandatory to hold an inquest into the death of *'any person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death arose, or may have arisen, while the person was detained in custody within the State pursuant to an Act or law of the State.' The* phrase *'detained in custody'* is not defined in the Act.

In Victoria it is mandatory to hold an inquest into the death *'of a person who immediately before death was a person held in care'.* 'A person held in care' is defined to include *'a person under the control, care or custody of the Director General of Community Services, the Director-General of Corrections or a member of the police force'.*

Mr McCann made this comment after discussing the Victorian definition of a *'person held in care':*

> *The requirement that the death of a person who was formerly held in care, if it is reasonably suspected that the cause of the death arose while that person was held in care although that person may have been discharged from care after the origin of that cause but before the death, may perhaps be regarded as somewhat over cautious. However, if any difficulty in drafting such a provision could be over-come, it would be a useful provision for the oversight of the conduct of those holding others in their care.*
>
> (Comments on the Coroner's Act and suggested amendments).

In the definition section of the draft legislation (Section 3) a 'person held in care' is defined as:

> *(a) a person under the control, care or custody of the Department for Community Welfare, the Chief Executive Officer of Corrective Services or a member of the Police Force; or*
>
> *(b) a patient in an assessment or treatment centre under the Alcohol & Drug Authority Act; or*
>
> (c) *a patient in an institution under the Mental Health Act 1962 - 1987 other than a voluntary patient and includes a person temporarily removed from such an institution; or*
>
> *(d) a person who had been held in care in circumstances referred to in paragraphs (a), (b) or (c) above and it is suspected that the cause of the death may have arisen while that person was held in such care even though the person had been discharged from such care prior to the time of the death.*

The New South Wales organisation Public Interest Advocacy Centre noted in its paper *'Review of the Coronial System in New South Wales'* (April 1988) that deaths which are the result of police or other activities where the person was not in custody e.g. people killed during police car chases, or shot after escaping lawful custody, would not be the subject of mandatory inquests in New South Wales. The same is true under the definition of a person held in care under the draft legislation.

Mr McCann expressed the view:

> *that somebody who dies as a result of the activities of an officer of the state - any Coroner would conduct a formal inquest into that sort of a situation irrespective of what the legislation said.*
> ...
>
> *These activities of an officer, a police officer or a prison officer or a mental health nurse - if in association with those activities a death occurs, you would have thought it is a lay-down misere that there is going to be an inquest.*
>
> (Coroners Conference 31.8.90, T5-6).

However in Western Australia there have been four deaths in custody investigated by the Royal Commission in which no inquest was held and as discussed in Part 2 of the Report, the jurisdiction of the Royal Commission itself has been challenged on a number of

occasions both in Western Australia and in other States because of the interpretation placed by Commissioners on what constituted a death in custody.

The Royal Commission experience has illustrated the importance of legislation providing a clear statement as to what constitutes a custodial death, including deaths involving state agencies.

6.4.5 INITIAL MATTERS RELATING TO THE CORONIAL INQUIRY

Notification of the Coroner

Section 46 of the Coroners Act provides that any person knowing of a sudden, violent or apparently not natural death or finding a dead body shall forthwith give notice to the nearest coroner, justice or member of the police force. The failure to do so attracts a $40 penalty.

The Police Routine Orders provide that a member of the police force who receives a report of death will notify the coroner's clerk or coroner in whose territorial jurisdiction the death occurred (R.O. 19-16.16).

Mr McCann has suggested that the Act should be amended so that the required notice be given to a coroner, a coroner's investigator or a police officer and the reference to a justice should be deleted. He further suggested that so there is no delay or confusion in respect of the channel of communication that there be a specific duty placed on a police officer to report such a death to the coroner as soon as practicable (Comments on the Coroners Act and Suggested Amendments).

Under the Victorian Act, the duty to report covers all 'reportable deaths' (s. 13). In addition, specific obligations are imposed on doctors and those holding persons 'in care' to report deaths to a coroner. The Victorian Act also imposes a duty on a coroner or police officer to whom a death has been reported to inform the State coroner as soon as possible (s.13(2)). A similar duty is found in the draft legislation (s. 17(2)). Section 17 seems to adequately address the issue of notification of the Coroner.

Notification of Next-of-Kin of Death

The issue of notification of the next-of-kin of the death arose in the cases of Stanley Brown, the Aboriginal man who died at Sir Charles Gairdner Hospital, and John Pat.

In the case of the Sir Charles Gairdner Hospital case, the deceased, who had been in custody at Canning Vale Prison, was transferred to the Fremantle Prison Infirmary (16.2.83) and was then transferred to Fremantle Hospital (23.2.83). He was transferred to the Intensive Care Unit at Sir Charles Gairdner Hospital later the same day. He died two days later from tuberculosis. At no stage while he was in the prison infirmary or after hospitalisation were his family in Roebourne notified of his illness or the fact that he had been admitted to hospital in a very serious condition. They were not notified of his death until six days later.

In the Stanley Brown Inquiry the ex de facto wife of the deceased was notified of the death of her former husband by a police aide in the company of a police officer. She alleged that the police when notifying her of the death told her that they had some 'good news and bad news' and then went on to tell her of her exhusband's death. These allegations were denied by the police officers involved. Without commenting upon the truth of the

allegations this case highlights the issue of who is the most appropriate person to notify the next-of-kin of the death? The issue also arose as to who is culturally the correct next-of-kin to notify first of the death.

In the John Pat case the issue of notification of the next-of-kin arose in relation to the following matters:

1. The Department for Community Services representative was notified of the death prior to the family and was asked to attend and identify the body at the police station.

2. The stepfather of the boy was notified at 3.20 am almost four hours after his death, a delay which is difficult to appreciate in a town the size of Roebourne.

3. Two police cars attended at the stepfather's home to notify the family of the death. A police officer informed the family of the death.

This case highlighted the issues of what priority should notification of next-ofkin take and how can delays be avoided? And again, who is the most appropriate person to notify the next of kin? Should notification be left to the police or could it be better carried out by someone else?

There is no provision in the Coroners Act for the notification of the next-of-kin of a death. The coroner relies upon the police for notifying the next-of-kin. The Police Routine Orders provide that the police should notify the relatives of a sudden death as soon as possible (R.O. 19-16.2(7)). No guidance is given to the police in relation to notification of next-of-kin of deceased persons of non European cultural backgrounds and the different considerations that may apply.

Mr McCann has commented that sometimes he receives complaints from relatives in relation to notification of death and this is usually because of disagreements as to the closeness of kinship (see Notes to Royal Commission 13 July 1990).

There has been discussion in other jurisdictions about involving other members of the community in the notification procedure. It has been suggested that in the case of the death of an Aboriginal person, in addition to the next-of-kin, an Aboriginal community organisation should also be notified of death. In South Australia it has been the practice of the Coroner for three to four years to notify the Aboriginal Legal Rights Movement of a death in custody in addition to the next-of-kin.

It has also been suggested that if the police are to notify the relatives of an Aboriginal person of a death that they be accompanied by an Aboriginal person who could advise the family of the death and the procedures to follow, including the need for an autopsy and whether an inquest is likely.

Mr McCann had told the Royal Commission that at this stage no attempt has been made to set up a special liaison network with Aboriginal organisations to communicate with Aboriginal families. He acknowledged the needs of the families. He said he would like to establish better liaison with the general community to explain the functions of the coronial system. He noted the need to establish a decent liaison system with various groups such as the ALS. He agreed with the suggestion that the police should have an information pamphlet which they could give to the relatives when notifying them of the death. It could include a 008 number for telephoning the Coroner's Office to facilitate communication. He also suggested providing the police with a coronial handbook which would ensure that they carried out their role in relation to the coronial system properly.

However Mr McCann again stressed the need for financial resources to build up such a system. (Coronial Conference 31.8.90 T42-43).

Preservation of the Scene/Exhibits

This issue has been covered in detail in the section dealing with Coronial Investigations and the Coroner's powers in this regard.

Retention of Relevant Evidence Personal to the Deceased, e.g. Clothing

Another issue which has been raised during the Royal Commission hearings is the retention of items at the death scene which are personal to the deceased, in particular, the deceased's clothing.

Clothing of a deceased Aboriginal person can have special significance for the relatives of the deceased, especially for people with traditional beliefs who need the clothing for the burial rites. (See case of Stanley Brown in which the sudden death inquiry officer did not regard the clothes as exhibits so they were not sent with the body. It appears they were destroyed.) The clothing may also be important for the emotional and grieving response of the family. The relatives may wish to retain the clothes that the deceased was wearing at the time of death for deeply personal reasons. In the case of Bernard McGrath despite the family's efforts to ensure that the deceased's clothing was retained and eventually returned to them, it was disposed of, probably at the time of post mortem examination at the mortuary. This caused the family, especially the deceased's mother, a great deal of distress (see W/17/121 and W/17/122).

It appears unclear upon whom the responsibility lies to collect and retain the deceased's clothing.

Recently the Superintendent of the Coronial Inquiry Section, together with the mortuary manager, have introduced a system for logging in the body, the clothing and all the effects when the body is received at the State Mortuary. There are specific instructions within the Coronial Inquiry Section to check with the deceased's family, possibly through the funeral director, as to what they want done with the clothing and personal effects. Mr McCann has also suggested that the clothes be dry-cleaned for people who want them returned. (Coronial Conference 31.8.90 T76).

However, Mr McCann acknowledges that the present system relies on word of mouth and there is the possibility of 'hiccups'. He also agrees that there is a problem in country areas where the body may be stripped by the Constable on duty who then disposes of the clothes and sends the stripped body to the State Mortuary. Mr McCann stated the need for clear, precise guidelines about removal of bodies from the country, plus clear guidelines for the mortuary staff. (Coronial Conference 31.8.90 T76). I agree that such guidelines are desirable so that distress to the family through the unnecessary loss and destruction of the deceased's clothing can be avoided.

Viewing the Body

In the McGrath case, the removal of Bernard's body to Perth for a post mortem examination prior to the relatives having an opportunity to view his body caused a certain amount of suspicion and disquiet. The family requested that the uncle of the deceased, Ken Colbung, view the boy's body on their behalf in Perth. The Coroner acceded and Mr

Colbung was able to view the body at the Perth Mortuary in the company of the forensic pathologist, Dr Hilton. Dr Hilton advised the Royal Commission that this was a very unusual occurrence.

The Superintendent of the Coronial Inquiry Section was asked by Commissioner Muirhead in the Charles Michael inquiry whether there was any system whereby a close relative could view the deceased's body prior to an autopsy being conducted.

Superintendent Weaver said that there was no system to meet the situation of a parent who would like to see the body before autopsy - he said that it had been arranged on occasions but was very rare. He said that:

> *The facilities of the state mortuary are such that they don't although there is provision there, a viewing room for general identification, however here are not the facilities you would find in a funeral parlour, for course, for visitation by relatives.*

Mr McCann expressed the view that in country areas more could be done to enable families to view the body with a better liaison system. He sees the main difficulty as being the supervision of the viewing, to provide security for the body, especially in instances where it may be better for the police not to be present.

He also told me of current problems that exist within the State Mortuary with regard to viewings taking place.

Recently an incident occurred in which some family members who were intoxicated attended at the mortuary after hours to view their deceased relative.

One of them was upset and wanted to fight the security officer and clerk who showed them the body. The mortuary staff members have no grief counselling training and were ill-equipped to deal with this situation, and situations involving grieving people generally.

The reaction of the Director of State Health Laboratory Services and the Health Department to the incident was to ban all viewings of bodies or to limit viewings to certain times when a police officer is in attendance. These changes in procedure were implemented without any consultation with the Coroner or the Police Force. The Perth Coroner is concerned as to how he and the police are going to be able to arrange suitable times for the families to view their deceased relatives.

He argued that the coronial system needs a welfare trained person but again noted the need for resources to tackle the problem. He has previously requested the sum of approximately $1000 to have a person with skills in grief to come in and assess the needs of the coronial service. Mr McCann said that as far as he knew *'that matter has been wiped from all consideration because of other things that are happening within the budget'* (Coronial Conference 31.8.90 T47).

I have the strong impression that although the Perth Coroner is very aware of the many problems that exist within the coronial system and has many ideas to deal with them, if the solutions require additional resources then his hands are firmly tied.

I suggest that in some cases there is a need for family members of the deceased person to be able to view the body before autopsy and appropriate facilities and personnel to assist with the viewing should be made available to the coroner for this purpose.

6.4.6 THE INQUEST

Inquests into Deaths in Custody

It has been noted earlier in the Report that it is not mandatory for an inquest to be held into deaths in custody in Western Australia.

It has also been noted that the Ad Hoc Committee was of the view that the Coroner's discretion to hold or not hold an inquest, in relation to all deaths including deaths in custody, should be maintained.

In four cases investigated by the Royal Commission the Coroner decided not to hold an inquest. The following reasons for their decisions were given:

1 . The Coroner was satisfied from the report of the forensic pathologist that the deceased died of acute alcohol poisoning and was satisfied from the particulars and statements contained in the police file concerning the deceased's custody, detention and death, that no other cause contributed to his death (Mr Buck, SM, in the Dooler inquiry).

2 . The Coroner, after inquiry, decided not to conduct an inquest as 'no good purpose would be achieved' (W/7/4 Mr Chapman SM in the Garlett inquiry).

3 . Although the Coroner was unable to determine the cause of death he said he did not conduct an inquest because *'there was no cause for suspicion by anyone'* (W/I 6/50 Mr Stapp, SM in the Anderson inquiry).

4 . *'The reason for not holding an inquest would have been that I was satisfied that the deceased died of natural causes and there was no suspicious circumstances.'* (Mr D W Walsh, SM in the Ugle inquiry).

In each of these cases I was of the view that an inquest should have been held and that the additional information and issues that could have been pursued in that forum would have been relevant to understanding the cause and circumstances of the death and prevention of such deaths in the future.

In the Report of the Inquiry into the Death of Wayne Dooler, I said

> *It appears to me that the actions of the arresting officers in taking Dooler to the police station instead of the hospital was a relevant factor in considering how the death came about. It appears that the Coroner failed to appreciate the significance of placing an unconscious person in a police lockup in such circumstances. The failure to highlight this issue in the police reports 'provided to the Coroner probably contributed to this. I consider that the circumstances in which Dooler died in custody ought to have been investigated even though the cause of death was found to be acute alcohol poisoning. An inquest was likely to have provided information relevant to the prevention of such deaths and may have served to allay anxiety felt by his family concerning the circumstances of Dooler's death.* (Report pages 14-15)

My report in the Anderson inquiry highlights the inadequacies of not holding an inquest in that case.

The relevant factors for the Coroner to consider were, inter alia:

(a) The cause of death could not be determined by the Forensic Pathologist. There was no statement from the Forensic Pathologist on the coronial brief and the Coroner had not had any liaison with him. The possible explanations for the death had not been canvassed;

(b) There were no statements from the police on the condition of the deceased at the time of arrest, during his custody in the lockup, or his condition when last seen alive. Them was no statement setting out the circumstances of the discovery of the body.

(c) There was no medical evidence as to the deceased's epileptic condition, only some medical records.

(d) The post mortem report stated that a number of samples were sent for analysis. The results of these tests were not included in the coronial brief The results may have been relevant to the cause of death.

(e) A matter that was squarely within the Coroner's inquiry was whether there had been any neglect on the part of the police. Information regarding police knowledge of the deceased's epileptic condition and his access to medication while in custody was not included in the coronial brief. There was also no information on whether Anderson had attempted to obtain his medication while in custody.

(f) One of the two photographs of the deceased's head showed what appeared to be a serious injury. This mark in the photograph was not explained in the coronial brief.

As noted earlier in the Report it is also important that the definition of 'deaths in custody' be given careful consideration.

It is suggested that consideration be given to making it mandatory to hold an inquest into deaths occurring in the following circumstances.

- deaths occurring in prisons, lockups or juvenile institutions whilst the person was detained therein;

- deaths the cause, or the possible cause, or a contributing cause, of which arose whilst the person was detained in custody;

- deaths which are the direct or indirect result of activities of custodial authorities, whether or not the person was in custody.

Objectives and Scope of Inquests

There is no clear statement in the legislation as to the objectives of an inquest, or the scope and ambit of an inquest.

Section 6(l) of the Coroners Act gives the coroner jurisdiction to inquire into the manner and cause of the death of such person.

Section II (3) provides that on an inquest the coroner shall give his decision or finding as to:

(a) who the deceased was, and

(b) how, when and where the deceased came by his death.

In the same way that police investigations into deaths in custody were limited in their scope, so too were many of the coronial inquiries in the deaths investigated by the Royal Commission. To some extent, Coroners were hampered in their ability to conduct a thorough inquest because of the inadequate police investigations and coronial brief upon which they relied. In some instances the affidavits of police officers included in the coronial brief were inaccurate if not misleading (see Brown, Njanji, Polak, Jones).

In many instances the Coroner focused on how the person died as required by the legislation but did not examine why the deceased died. The inquiries of the Royal Commission have revealed that 'the why' of the death is important in alleviating family and community concerns about deaths in custody. A wide ranging inquiry is necessary if the issues of 'the why' are to be addressed. I have found in some inquiries, especially where the deceased died by hanging, that although the Coroner has adequately examined how, when and where the deceased came by his/her death, he has not examined the prior demeanour and state of mind of the deceased which may have explained the death further (see Jones, Wodulan, Cameron, Morrison).

To do so, inquiries may need to be made of family, friends and agencies that have been in contact with the deceased prior to his/her death. In some cases it may be worthwhile to obtain the opinion of an expert, such as a psychiatrist.

In other inquiries, I found that the Coroner did not examine the issue of lack of resuscitation attempts by police, prison officers or medicos at the inquest (see Jones, Blankett, Waigana, Brown).

I also found that in many of the earlier inquests Coroners failed to address custodial systems and practices which may have contributed to the death. In doing so, the Coroners also failed to make recommendations which may have prevented a similar death occurring in the future.

The current legislation enables the Coroner to extend the scope of the inquest to some extent by making a rider:

> *Section 43(i)(a) The Coroner shall not express any opinion on any matter outside the scope of the inquest except in a rider which in the opinion of the coroner is designed to and may, if given effect to, prevent the recurrence of similar occurrences.*
>
> *(b) A rider is not part of the decision of finding of a coroner but it may be recorded if the coroner thinks fit.*

The Western Australian legislation in this respect is more restrictive than in most other jurisdictions except Queensland.

The Victorian legislation gives the coroner power to comment on *'any matter connected with the death including public health or safety or the administration of justice' (s.* 19(2)).

The draft legislation proposed by the Ad Hoc Committee has incorporated a provision in the same terms as the Victorian provision (s.24(2)).

The proposed provisions are broad enough to enable a coroner to address system inadequacies and deficiencies or compliance with statutory or other orders such as Police Routine Orders.

Later in this section the discretionary nature of the Coroners power to include a rider will be examined further.

Rights of the Relatives and Other Interested Persons - Notification that an Inquest is/is not to be held

In two cases investigated by the Royal Commission in Western Australia, relatives of the deceased did not receive notification that an inquest into the death was to be held (Njanji and the Sir Charles Gairdner Hospital death).

However in the Sir Charles Gairdner Hospital death it appears that the Coroner wrote to the ALS advising them of the Inquest but the information was never received by the family. The father of the deceased said:

> *Nobody told us about the Inquest. Nobody told us at all. All we heard was that my son was finished and that's all we were told* (W/9/37).

In the four cases investigated by the Royal Commission in which no inquest was held the relatives of the deceased were not notified of the decision not to hold an inquest (Dooler, Garlett, Anderson, Ugle).

In the remaining cases investigated by the Royal Commission the relatives were either represented by ALS or an independent legal practitioner or were at least given the opportunity to be represented at the inquest.

There are no provisions in the Western Australian Act relating to the notification of relatives of a deceased person or any other interested person of the holding of an inquest or of the time and place thereof. There are also no provisions in relation to notification that no inquest will be held.

The draft legislation proposed by the Ad Hoc Committee is silent on this matter although provision has been made for the advertisement of an inquest at least fourteen days beforehand (s.38).

In New South Wales and Queensland some provision is made for notification.

In the Queensland Act, s.29(2) provides that a Coroner may notify in such manner and at such time as he thinks fit, any persons who, in the opinion of the coroner have a sufficient interest in the subject or result of the inquest, or the holding of the inquest and of the time and place thereof.

Under s.29(3) of the Queensland Act a Coroner must give reasonable notice to the following persons of the holding of an inquest and the time and place of such inquest:-

- every person whose conduct, in the opinion of the coroner is likely to be called into question;

- medical practitioner who attended the deceased person at or immediately prior to his death or during his last illness or viewed or examined the body of the deceased at or shortly after death;

- every person who has made a post mortem examination of the body.

The current practice of the Perth Coroner is to write to the person arranging the funeral usually within 48 hours of the death, advising them that there is to be a Coroner's Inquiry. They are advised if there is to be a delay. Although contact is made in this way with the family, they are not asked if they want an inquest. If the Coroner thinks that an inquest might be usefully held he writes to the relatives asking them if they would like to come and talk about the death without averting to inquest as such. One reason he does not write to the relatives asking them if they want an inquest and explaining What an inquest is, is due to his already high workload. (McCann, Coronial Conference 31.8.90, T50)

In relation to deaths in custody it is the Perth Coroner's view that there should be an inquest in every case irrespective of the family's wish. He said that even if they did not want one, there ought to be one held, with the suppression of the name if necessary. (Coronial Conference 31.8.90, T5 1)

It has been suggested by the South Australian office of the Royal Commission that the next-of-kin and other interested persons should be notified by the Coroner's Office that an inquest is to be held and the time and date thereof and that this duty be given statutory recognition. It has also been suggested that interested persons should include any person against whom allegations of misconduct or other criticisms are to be levelled.

The Perth Coroner has suggested that a system of notification should operate when the family is informed of the death. This could be by way of a handout of some sort advising them to get in touch with the Coroner's office. He prefers the concept of providing information to the general community about autopsies and inquests and supplementing it by way of further information if somebody makes a specific request.

This option appears to place a heavy onus on the relatives to make inquiries of the Coroner and presumes a level of community education which currently does not exist and probably will not for some time. I support the proposal emanating from the South Australian office of the Royal Commission that the duty be placed on the Coroner's office to notify the next of kin and other interested persons that an inquest is to be held or not to be held. This could be incorporated in the legislation or in the rules or guidelines of the Coroner.

Standing

Under the Western Australia Act *'any person, who, in the opinion of the coroner, has a sufficient interest in the subject or result of the inquest'* is entitled to appear personally or by counsel (s.24(l)). Under subsection (2) trade unions are deemed to be persons with a sufficient interest in certain circumstances. Special statutory provisions in relation to standing also apply to deaths in the workplace or mining deaths: s.25.

The Ad Hoc Committee has suggested that definition of interested persons should be set out clearly to avoid uncertainty and to protect the rights of those who should have the opportunity of appearing and taking pan in an inquest. They have recommended adopting the definition of interested person contained in the English Coroners Rules 1984 and have incorporated the definition in s.42(2) of the draft legislation. The section provides:

Each of the following persons shall have the rights conferred by paragraph (I):-

(a) a parent, child, spouse and any personal representative of the deceased;

(b) any beneficiary under a policy of insurance issued on the life of the deceased;

(c) the insurer who issued such a policy of insurance;

(d) any person whose act or omission or that of his agent or servant may in the opinion of the coroner have caused, or contributed to, the death of the deceased;

(e) any person appointed by a trade union to which the deceased at the time of his death belonged, if the death of the deceased may have been caused by an injury received in the course of his employment or by an industrial disease;

(f) an inspector appointed by, or a representative of, an enforcing authority, or any person appointed by a government department to attend the inquest;

(g) the Commissioner of Police;

(h) any other person who, in the opinion of the coroner, is a properly interested person.

The Royal Commission sees merit in this approach.

Access to Legal Aid

In at least one case investigated by the Royal Commission counsel for the family made submissions about the difficulties in obtaining legal aid for the inquest and the inadequacy of the funding.

In the Interim Report Commissioner Muirhead (as he then was), made the following recommendation:

> *Recommendation 48:*
> *The family of the deceased should be entitled to legal representation at the inquest and Government should pay the reasonable costs of such representation through legal aid schemes or otherwise.*

The Western Australian Government made the following comment with respect to its implementation:

> *This is a matter for the Federal Government which funds the Aboriginal Legal Service. If State Government funding is sought each application is subject to guidelines for grants of aid.*

The Aboriginal Legal Service of WA provides representation to the family of the deceased at an inquest through its normal funding allocation subject to ALS guidelines. It is well recognised that the Aboriginal Legal Service is very stretched for funds, making it difficult to provide adequate services in relation to their normal workloads.

In the coronial inquiries into the deaths of Cameron, Wongi, Walley and Chatunalgi, the Aboriginal Legal Service received additional funding from the Department of Aboriginal Affairs. It would have otherwise experienced difficulty in appearing in those matters on behalf of the families (see letter from R Riley, Director ALS 30.8.90).

It is quite likely, with increased community education about the function of coronial inquiries, the Aboriginal Legal Service will receive an increase in this type of work. I acknowledge that without an appropriate increase in their funding the Service's resources would be even further strained.

I support recommendation 48 in the Interim Report and note that unless the Aboriginal Legal Service receives additional funding this recommendation will be unable to be fully implemented.

Access to Documents in the Possession of the Coroner

The Western Australian Act makes no provision for persons appearing at an inquest to have access to documents in the possession of the Coroner, prior to, or during, the course of an inquest. Although s.43(l)(g) of the Act provides that a person committed to trial by a coroner shall be entitled to a free copy of the inquisition and the deposition.

The draft legislation proposed by the Ad Hoc Committee adopts the provision in the Victorian legislation. s.41 (I) of the draft legislation provides:

> *A coroner may make available any statements that the coroner intends to consider to any person with a sufficient interest* (See s.45 of the Victorian Act).

In at least one case investigated by the Royal Commission (Robert Walker), the issue of access to documents in possession of the Coroner was raised. In that case the Coroner refused a request from the Director of the then Prisons Department to have the opportunity of perusing statements taken by the police and the ALS from prisoners at Fremantle Prison concerning the death, so as to allow the for the Department counsel to prepare for the inquest.

Following a similar request from the ALS, the Coroner gave counsel access to two affidavits and the post mortem report but would not make available the statements of other proposed witnesses. During the inquest Counsel for the prison officers also made mention that he had not seen the statements nor had he had access to them.

Superintendent Weaver who was Sergeant assisting the Coroner in the Robert Walker inquest (and who is now Superintendent in Charge of the Coronial Inquiry Section) expressed this view about access to information on the Coroner's **file** (W/2/100, pp6-7).

> *Either on or by the first date of the inquest, all Counsel were given a copy of the relevant documents, being the post mortem report of Dr Pocock, the Mortuary Admission form and the other test results but were not given any copies of statements taken by the police in relation to the investigation.*
>
> *This was normal procedure at that time and in my view is the correct procedure.*
>
> *In my view Counsel ought only to be given access to documents which are to be tendered as exhibits.*
>
> *Where there are prior statements obtained, the better course is to have those witnesses give their evidence on their recollection of the events, and in the event of there being a conflict in what is said in the hearing compared to what was in their statement, then that can be examined at the time.*
>
> *In my view by providing statements beforehand, it merely clouds the issues and provides Counsel with ammunition to challenge a witness on and thus discredit the witness.*

A letter from the Crown Solicitor to the Royal Commission expressed a different view of the situation. He said:

> *Generally, the legal representatives of parties, who have an interest in a death, are given the opportunity of perusing the entire Coroner's file, and are given copies of medical and other technical reports. This practice has continued for many years. In some instances, where a particular aspect of the investigation into the death, prior to the commencement of the inquest, is still continuing, it may be that the line of inquiry would not be disclosed until it was completed* (W/2/137 dated 4.11.88).

Mr McCann in responding to Counsel Assisting submissions in a letter dated 30.1.90 said:

> ... *it is my view that your submissions concerning prior access to documents and witnesses and the compellability of witnesses have considerable strength.*

The ALS in its submission to the Ad Hoc Committee also referred to difficulties experienced by counsel for the family in not having access to documents on the coroners file and noted that counsel for the family were placed at a considerable disadvantage because of this practice.

The ALS submission suggests that:

> *... it should be one of the duties of the Coroner's office to prepare the coronial brief in a similar manner to criminal depositions and to provide the brief to all counsel within a reasonable time before the inquest.*

The Perth Coroner accepts that prior to the inquest all information that is going to be produced at the inquest ought to be made available to any interested patty who wishes to examine it. However he said that the question of making up briefs would be very costly and very time-consuming (McCann, Coronial Conference T77).

I suggest that all documents (statements and other exhibits) which are relevant to any inquiry together with a list of proposed witnesses and exhibits be provided to persons appearing or represented at an inquest within a reasonable time prior to the inquest to enable them to properly prepare their case.

Evidentiary and Procedural Matters

Pre-Inquest Directions

The Western Australian Act makes no provision for pre-inquest directions hearings. However despite there being no formal procedure under the Act, Mr McCann advised me that on occasions he opens an inquest giving notice to the public and all identifiable interested parties that the hearing is for taking of applications to appear and to consider other matters in preparation to the calling of evidence. (Notes to the Royal Commission 13 July 1990) The Coroner appears to have taken this course in at least two cases investigated by the Royal Commission (Harris and Cameron).

Section 44 of the draft legislation proposed by the Ad Hoc Committee which sets out the powers of coroners at an inquest would appear to allow for a pre-inquest directions hearing. S.44(l)(e) provides:

> If a coroner reasonably believes it is necessary for the purposes of an inquest, the coroner may -
>
> give any other directions and do anything else the coroner believes necessary.

The Perth Coroner has argued that the Coroner has an inherent power to regulate his own proceedings and that it is unnecessary to provide for it in the legislation. He is of the opinion that only absolutely essential matters of principle should be included in the legislation(Coronial Conference 3l.8.90, T1O-11). However the provision for pre-inquest directions hearing in the legislation would formalise the current position and in addition make it clear to any person that the option was available. Alternatively matters of procedure, such as a pre-inquest directions hearing, could be incorporated in the rules.

The Calling and Examination of Witnesses

Under the Western Australian Act persons who are represented at an inquest may examine and cross-examine witnesses on matters relevant to the inquest. The Coroner has the power to disallow irrelevant or improper questions (s.24). There is no provision for a person represented at an inquest to call witnesses.

By contrast, under the Victorian Act persons appearing are permitted not only to examine and cross-examine witnesses but also to call witnesses at an inquest (s.45(3)).

The Ad Hoc Committee has expressed the view that *'one of the few strengths of the present system in Western Australia is that it is the practice for the Coroner to determine who shall be called as a witness'* (p.23). It goes on to say: *'If the power of the Coroner to commit for trial from the inquest is removed, there seems little justification for an interested party to be given the right to call witnesses and to make submissions' (p.23).*

The Ad Hoc Committee also expresses concern that there is no specific power in the Victorian legislation for the Coroner to disallow questions which are not relevant or otherwise proper (p.23).

The ALS submission to the Ad Hoc Committee has suggested that all Counsel be allowed to call witnesses. On this point they say (at p. 14):

> *Under the present Act, all witnesses are called by the Coroner although the city coroner, at least, is open to 'suggestions' by Counsel of other witnesses to be called. It is our experience that in cases where a person has died in custody, the family may have available many witnesses as to facts which may not have come to light during the police investigation. This may be because the witnesses prior experience with police which make them reticent about coming forward and giving information to police, whereas they are willing to provide that information to the family of the deceased.*

Mr McCann argued that it was important that the calling of witnesses be at the discretion of the Coroner. He said his general approach was to lean over backwards to call witnesses nominated by parties. He noted that it might be important to call evidence in a particular way and to maintain control to reflect the inquisitorial nature of the proceedings. He suggested that if a Coroner was 'sufficiently foolish' not to call a witness who had something to contribute then at the conclusion of the inquest a party could appeal to the Supreme Court and have the inquest findings quashed (see McCann, Coronial Conference 31.8.90, T45-49).

Despite the Coroner's argument I see merit in the proposal to allow counsel to call witnesses subject to the approval of the coroner presiding over the proceedings that the evidence of the witness is relevant. Consideration should be given to statutory recognition of the rights of parties in this regard.

Rights to make Submissions

In the Western Australian Act there are no provisions for interested persons to address the Coroner on facts and/or points of law at an inquest.

As mentioned above, the Victorian Act specifically provides that persons appearing at an inquest may make submissions (s.43(3)). In Queensland persons represented at an inquest are expressly excluded from addressing a coroner on the facts although they are permitted to address on points of law.

The Ad Hoc Committee is of the view that the right to make Submissions is a *further opportunity to advance partisan interests'.* However they note the practice of the Coroner *'to exercise a discretion to allow submissions where a particular party may be in jeopardy by reason of the coroner exercising some power under the Act'.* However as noted above the Committee expressed the view that if the power of the Coroner to commit for trial was removed there is little justification for an interested party to be given the right to make submissions.

Mr McCann has said that by retaining his discretion to allow submissions he maintains control over the proceedings. He was also concerned that the right to make submissions may materially extend the length of inquests. He also said that submissions were more in keeping with proceedings of an adversarial nature rather than an inquisitorial situation (Coronial Conference 31.8.90, T40-4).

In the inquiries I have conducted, written submissions in particular have been of great assistance to me and I suggest that the legislation should provide parties with the right to make written submissions.

Expert Evidence

In at least ten of the cases I have investigated, I have commented on the inadequacy of independent specialist medical/psychiatric evidence at the inquest (See Njanji, Sir Charles Gairdner Hospital death, Dougal, Morrison, Cameron, Harris, Steven Michael, Chatunalgi, Bates and Samson). In many instances too much reliance was placed on the evidence of the forensic pathologist who was often giving evidence on matters outside his field of expertise.

In the inquiry into the death of Harris, the Perth Coroner, Mr McCann, was asked a number of questions by the Royal Commission in relation to calling of independent medical evidence at inquests. I set out below selected questions and answers (W/25/26):

(Royal Commission letter dated 23.4.90, Coroner Response dated 27.4.90).

Q.2. *In the absence of any application by representatives of the family, under what circumstances would you consider obtaining expert medical evidence on matters of clinical treatment and practice (additional to the views expressed by the Forensic Pathologist)?*

A.2 *Expert medical evidence will be sought by the Coroner on matters of clinical treatment and practice, in addition to any views expressed by the Forensic Pathologist, in the following instances (not exclusively and not in order of priority):*

(a) *when the Forensic Pathologist advises the Coroner to do so*

(b) *where the particular case or the relevant field of medicine appears to warrant doing so. Obviously in a specialist field the question will be raised, but advice has also been sought in matters of general practice.*

Representation of the family of the deceased will be considered but such a representation will not be the only reason to do so. The Coroner may well act on his/her own initiative.

Q.3. *Are there any financial or other obstacles to your obtaining independent medical opinions?*

A.3. *There has been no financial obstacle placed in the way of the Perth Coroner in respect of obtaining independent medical advice. However, it has been made known to the Perth Coroner, in the case of seeking Counsel to Assist the Coroner from the Independent Bar, that the cost of brief counsel is a consideration. Coroners in this State, of course in the absence of a budget for the carrying out of their functions, have no means of engaging counsel themselves. This is done through the Crown Solicitor's Office.*

Q.4 *Have you previously sought independent medical opinions. If so, could you broadly indicate the type of cases?*

A.4. *Yes. In 1987 the Perth Coroner wrote to each of the learned medical Colleges asking that each College agree to nominate a referee, when asked to do so in particular cases, to advise the Coroner. This has occurred on a number of occasions. In a number of cases, the referee has not sought a fee, taking the view that this is to be regarded as a duty to the community. The types of care in which advice has been sought have been:*

(a) *all anaesthetic cases*
(b) *maternal deaths in childbirth*
(c) *surgical cases*
(d) *a case involving a psychiatric component*
(e) *geriatric cases*
(f) *general medical practice.*

Q.5. *Do you consider that medical opinions should only be sought in cases where medical negligence arises of an issue? If not in what circumstances do you believe it is warranted?*

A.5. *Expert medical advice should be sought in any case where the form of treatment etc. requires to be explained in detail or where the treatment etc. actually delivered should be compared with an accepted standard of treatment. The question of medical negligence as such should not be the criterion, although it may well be a matter of concern to a particular "interested person.*

However the Perth Coroner fundamentally agreed with the suggestion that in a few cases investigated by the Royal Commission it seemed that medical evidence had been taken 'on the cheap' from the forensic pathologist. However he said in recent times when forensic pathologists were giving evidence that there had been a much greater recognition of the limits of expertise. He also said:

> *[I]t seems ridiculous to me that they give the responsibility to a coroner to investigate deaths but provide absolutely no resources under his control to do so* (Mr McCann, Coronial Conference 31.8.90, T37).

The ALS Submission to the Ad Hoc Committee also expressed the view that it is undesirable to rely on the forensic pathologist to give expert medical evidence quite obviously outside his own scope of expertise. They suggested the establishment of an independent medical panel attached to the investigative unit as being essential (p.10).

I agree with a submission of the South Australian Counsel assisting the Royal Commission:

> *That the coroner have both budgetary and procedural resources to gain sufficient access to expert medical or other expert evidence (see Discussion Paper and Recommendations on the Coronial System by Counsel Assisting the Royal Commission in South Australia).*

Coroner's Powers

Summoning Witnesses and Documents

Under the Western Australian Act the coroner may summon a person who has made an affidavit to attend before him as a witness (s. 11(2a)). The Coroner may also summon any person as a witness and/or produce *'whatever in his custody, possession or control the coroner thinks ought to be produced' (s.37).*

The Coroner may also summon a medical practitioner who attended the deceased prior to death, as a witness to give evidence as to how in his opinion the deceased came to his death (s.38) and he may call additional medical evidence where the cause of death is not satisfactorily explained (s.39).

Mr McCann has noted that the only means available to secure physical objects or documents is to open an inquest and summons witnesses to produce those items under summons. He stressed the need for power to secure items for inspection at an earlier stage in an inquiry (see Comments on the Act and Suggested Amendments).

Section 4(l) of the draft legislation provides for the coroner to (a) summon a person to attend as a witness or to produce any document or other materials, and (b) inspect, copy and keep for a reasonable period anything produced at the inquest, if the Coroner reasonably believes it necessary for the purposes of the inquest. Section 33 of the draft legislation also gives the coroner powers of entry, inspection and possession during the investigative phase of the inquiry, i.e. prior to the commencement of an inquest. These powers appear to adequately address the current deficiencies in the legislation and I support their inclusion in the proposed legislation.

Suppression of Evidence

In 1983 the Western Australian Act was amended to give power to a Coroner to make an order forbidding the publication of the name of any witness or of any person referred to in the course of an inquest (s. 1 1 A).

In Victoria, New South Wales, the Northern Territory and Queensland, a Coroner may prohibit or restrict the publication of evidence given during an inquest.

The Ad Hoc Committee has expressed the view *'that courts should be open to the public and the publication of evidence should not be suppressed without good cause'* (p.24). However they have recommended that a Coroner should have power to restrict the publication of evidence if it is likely to prejudice the fair trial of a person or if it would be contrary to the public interest. (See s.48 in proposed draft legislation which is in similar terms to s.58 of the Victorian Act) I support the inclusion of a provision allowing for the suppression of evidence in the limited circumstances set out in the draft legislation.

Compellability of Witnesses and the Privilege against Self-incrimination

In the Robert Walker case one prisoner and four prison officers declined to give any evidence. The officers said that they declined upon legal advice or words to that effect. The officers were then allowed to step down.

Section 42(4) of the Western Australian Act provides that a person shall not be obliged to answer a question put to him if the answer to that question would tend to incriminate him or to produce documents etc. which would tend to incriminate him. The section expressly preserves the operation of s. l l of the Evidence Act which provides for the granting of a certificate of immunity from any prosecution.

In the Walker case, Counsel Assisting submitted that the Coroner should have established the basis for the witness declining to give evidence and if it was on the grounds of self-incrimination, the coroner should have at least determined whether the claim was 'bona fide and had substance' and only upon having determined these matters should the coroner have upheld the claim of privilege (see R v The Coroner ex parte Alexander [1982] VR 732). Counsel Assisting also discussed circumstances in which a Section I I Certificate should be granted.

The Coroner in a letter to the Royal Commission dated January 30 1990 expressed agreement with counsel's submissions regarding the law on this subject.

In a more recent inquest into the death of a non-Aboriginal boy who died at East Perth Lockup (Wardle), a number of police officers again declined to give evidence to the Coroner.

Such incidents are clearly frustrating to the Coroner. However under the current legislation the coroner still has the power to commit a person for trial so it is appropriate that the traditional model be retained providing a witness with privilege against self-incrimination.

However the Ad Hoc Committee has recommended that the Coroner's power to commit be abolished and provisions similar to s.6DD of the Royal Commissions Act 1902 (Cth) be adopted. The Royal Commission legislation requires a person to answer questions but also provides that anything that is said cannot be used against them.

The section provides:

> *A statement or disclosure made by any witness in the course of giving evidence before a Commission is not (except in proceedings for an offence against this Act) admissible in evidence against that witness in any civil or criminal proceedings in any court of the Commonwealth, or a State or of a Territory.*

The draft legislation proposed by the Committee S.44(l)(c) provides that a coroner may order a witness to answer questions.

Section 45 provides that:

> *A statement or disclosure made by any witness in the course of giving evidence before a coroner at an inquest is not admissible in evidence against that witness in any civil or criminal proceedings in any court other than a prosecution for perjury in the giving of such evidence.*

I agree with the proposal of the Ad Hoc Committee and believe it will enhance the Coroner's ability to find out what happened in relation to the death.

The Rules of Evidence

The Western Australian Act is silent on whether or not the rules of evidence apply. As common law principles still apply in Western Australian coronial procedure by virtue of s.7 of the Western Australian Act, the Coroner's Court would not be bound by strict laws of evidence. It has been held many times that because of the inquisitorial nature of the proceedings there is no need for such restrictions (see Jervis on Coroners p. 177).

In South Australia, Victoria, New South Wales and the Northern Territory the legislation expressly states that the coroner is not bound by the rules of evidence.

The proposed draft legislation (s.40) has adopted the Victorian provision which provides:

> *A coroner holding an inquest is not bound by the rules of evidence and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit.*

The South Australian office of the Royal Commission has noted that concern had been expressed in relation to the Coroner's somewhat unfettered discretion to receive evidence. It was submitted that a Coroner should be bound by the following rules of evidence:

- rules relating to opinion evidence
- Coroner should have power to reject the reception of evidence obtained in circumstances of unfairness or illegally obtained evidence
- claims for legal professional privilege, the legislation should specify that the principles of natural justice apply.

Consideration should be given to applying these limitations to the Coroner's discretion to receive evidence.

Coroner's Criminal Jurisdiction

Power to Commit for Trial

As discussed above the Ad Hoc Committee has recommended that committals for trial from an inquest should be abolished.

South Australia, New South Wales and Victoria have abolished the Coroner's power to commit to trial.

The Ad Hoc Committee Reports sets out the rationale for abolishing of the power (at p. 16):

> *This jurisdiction is the same as is exercised by Magistrates at a preliminary hearing into a charge involving an indictable offence, but without the safeguards which attend such a hearing. At an Inquest no charge need be formulated, there is no procedure for a subsequently accused person to be informed of the evidence against him or her prior to the commencement of the Inquest. The defence at such an Inquest hearing could be seriously impeded.*

I agree with the rationale of the Ad Hoc Committee and, as mentioned above, I believe that the abolition of the coroner's power to commit should enhance the Coroner's ability to discover the facts. It is inappropriate that in carrying out his inquisitorial role he should also have the power to punish in any way.

Procedure Upon Laying of Criminal Charges

Section 13A(l) of the current Coroner's Act covers the procedure after an inquest has been commenced if a person is charged with an offence in which the question whether the accused person caused the fire or death is in issue. The Coroner shall adjourn the inquest until after the conclusion of the proceedings in respect of the offence. Section 13A(l)(d) provides that if after the conclusion of the proceedings the coroner considers there is sufficient cause to resume the inquest he may do so. Section 13A(2) provides that if before the commencement of an inquest the coroner is informed that a person has been charged with an offence the coroner shall not commence to hold an inquest until the proceedings in respect of the offence have been concluded.

Subsection (3) provides that the inquisition shall not contain any findings inconsistent with the determination by the court in relation to the charge.

Mr McCann explained that there is a need for an inquest in some cases despite the finding in the criminal proceedings. He gave the example of a situation where the criminal issues have been dealt with but there is still some aspect of public safety which should be brought to the attention of the community and which has been submerged in the criminal trial because of the line taken by the prosecution and the defence. (See Comments on the Act and Suggested Amendments and Coronial Conference 31.8.90, T28-29)

Deaths in custody provide another example of where much broader issues may be canvassed in an inquest than would be examined in a criminal trial. In two cases examined by the Royal Commission a criminal trial had preceded the inquest (Dougal, McGrath). In Dougal the ambit of the inquest was very restrictive and the coroner did not examine issues which may have prevented such deaths in the future, e.g. no evidence was taken in relation to procedures for arresting intoxicated (unconscious) persons, supervision of detainees in the lockup, first aid training of custodians or ways to improve police practices to prevent such a death.

In McGrath, the Coroner took a much broader approach and examined the background of the deceased in some detail, his behaviour on the day preceding his death, the legality of the arrest, the custodial practices of the police, the adequacy of supervision, the cell conditions and recommended changes in procedures.

In that case however the Coroner was hampered to some extent by s.13A subsection (3), as he could not make a finding inconsistent with the jury's decision in Galbraith's trial. Counsel Assisting in his final submissions made the following observations:

> *The task of the jury in a criminal trial and that of a Coroner is, of course, quite different. The jury is required to consider whether the prosecution has satisfied them beyond reasonable doubt of the guilt of the accused. An acquittal does not mean that the accused is innocent; R. v. Hoar (37 A.L.R. 357). The community expects the Coroner, on the balance of probabilities, to find how the deceased met his death.*

The Coroner in that case was asked by the Royal Commission whether he believed that the sub-section prevented him from discovering the true circumstances of death or otherwise unduly restricted his inquiry (W/17/120). The Coroner's response is as follows:

> *The existence of section 13A(3) certainly made it impossible to make a finding which was inconsistent with the jury decision in Galbraith's trial. There are strong public policy reasons why the section should remain and yet there is a real prospect that an Inquest will be unable to achieve its primary function if the section remains. Is it preferable to hold the Inquest first and risk the witness obtaining a section 11 certificate? That is a matter for the legislature to resolve.*

Mr McCann thought that the position under the proposed Act would be the same as under the current Act. He noted his embarrassment when a jury has brought in a not guilty verdict where the evidence had indicated otherwise and he then has to write to the relatives to say 'It *is my finding that your relative died from accidental death'.* He said that under the draft legislation he could make an open finding but has not considered the possibility of making a finding contrary to the jury's finding (McCann, Coronial Conference 31.8.90, T29).

It is probably unnecessary for the legislation to contain specific provisions dealing with procedures to be adopted where criminal charges are laid against a person for causing the event the subject of an inquest. As the Perth Coroner commented:

> *It seemed to me that it is quite clear that as a matter of law, if there are criminal proceedings on foot and a coroner was silly enough to embark on a full-blown inquest at the same time, the prosecuting authorities would march down to the Supreme Court and get an order restraining him from continuing until the matter was decided.* (Coroners Conference 31.8.90, T28).

However the legislation should probably contain provisions making it clear that the Coroner has power to resume an inquest or hold an inquest once the charges have been finalised.

Findings as to Criminal Liability

In the Western Australian Act, s.43(l)(j) provides that a Coroner shall not frame his decision or finding in such a way as to appear to determine any question of civil liability or as to suggest that any person is found guilty of an indictable or simple offence.

The proposed draft legislation includes a provision preventing the Coroner from including in a finding or comment any statement that a person is or may be guilty of an offence (s.24(3)).

In all but one jurisdiction (Northern Territory), a coroner is expressly prevented from making any findings as to the criminal liability of any person.

It is appropriate that the draft legislation contains a provision preventing the coroner making a finding as to criminal liability.

Power to Refer a Matter to the Attorney General

The proposed draft legislation has made provision for the coroner to report to the Director of Public Prosecutions if he believes that an indictable offence has been committed in connection with a death which the Coroner has investigated s.26(3). A similar requirement is found in the Victorian legislation. I believe that such a provision is necessary if the Coroner's power to commit for trial is removed.

Counsel Assisting the Coroner

The Western Australian Act makes no provision for counsel assisting a Coroner at an inquest.

Until recently it has been a long standing practice for police officers to appear and assist the Coroner at an inquest. Of the 28 cases investigated by the Royal Commission in which inquests were held, the Coroner was assisted in 19 by a police officer and in 9 he was assisted by independent counsel.

It appears that the current procedure for having counsel appointed is for the Coroner to make a request to the Crown Law Department for independent counsel. The Crown Law Department will then arrange for counsel to assist the Coroner. As mentioned earlier, the Perth Coroner has pointed out that when seeking counsel to assist, cost is a consideration and that Coroners are without the financial resources to brief counsel themselves (W/25/26).

The Ad Hoc Committee was of the view that the practice of police assisting the Coroner should cease. The Committee said:

> *The 'presence of a police officer assisting the Coroner allows the inference to arise that it is a police officer who is directing the course of the inquest, which is inimical to the independence of the judiciary and the proper administration of justice.*
>
> *It is the view of this Committee that this practice should cease. At Inquests where complex or contentious issues are raised the coroner should be assisted by independent counsel. In other cases there is no reason why the coroner should not call and examine the witnesses as is the case in England (p.24).*

The Perth Coroner has assured me that a police officer would no longer assist the coroner in deaths in custody inquests. However, he said the resources are such that he routinely has independent counsel in deaths in police custody cases but not deaths in prison custody. He noted that it has been his practice more recently to do a lot of the examination himself. He said he would like to eliminate police officers assisting coroners in all matters (Coronial Conference 31.8.90, T73).

The proposed draft legislation provides for a coroner to be assisted by counsel or by such other persons as the coroner determines (s.44(2)). The Ad Hoc Committee has noted that the Victorian Act provides for the Director of Public Prosecutions to appear to assist the Coroner if the Director so wishes. The Committee has intentionally avoided including such a provision in the draft legislation. (Report p.24) Both the Ad Hoc Committee and Mr McCann have agreed that it is not appropriate that the DPP be involved because of the role of that functionality in criminal prosecutions and the criminal justice system. They

have stated that the coronial system should be quite separate from the criminal justice system and have noted the possible danger in the DPP using the inquest proceedings for its own purposes. I agree with their position and agree with the non-inclusion in the draft legislation of a provision allowing the DPP to assist the coroner.

The State Coroner in South Australia was of the view that he would be greatly assisted by a person with legal training on his staff who could not only assist at the hearing but also in the supervision of the investigation. The submission of ALS to the Ad Hoc Committee has also recommended the establishment of a permanent legal officer in the Coroner's Office (p. 18). The Perth Coroner is also of the view that a legal officer, working within the Coroner's office, would be his preferred option (McCann, Coronial Conference 31.8.90,T73).

This appears to be a sensible option with the provision for the Coroner to brief independent counsel as the coroner determines, e.g. in deaths in custody cases and complex or difficult inquests.

Juries

Should juries be retained as part of the Inquest proceedings?

The Western Australia Act provides for juries to be called in the following circumstances: if the Coroner considers it desirable to have a jury; if the Attorney General directs, if the death was due to an explosion or accident in a mine or factory. Otherwise inquests are to be held without juries (s.9).

Juries at inquests have been abolished in Queensland. According to the Ad Hoc Committee Report, the Victorian State Coroner, the New South Wales State Coroner and ex officio Coroners in Western Australia held the view that juries provide no practical benefit at Inquests (p.29).

The Ad Hoc Committee Report states:

> *It is the view of the Committee that the Coroner is capable of making rational findings as to facts and making recommendations, and that the addition of a jury to this process confers no additional advantages* (page 29).

However it has also been argued that the provision of juries is a clear manifestation of the public interest in deaths investigated at an inquest and that potentially juries provide a significant check on the Coronial process (see Public Interest Advocacy Centre paper 'Preliminary Note to the Attorney General of New South Wales: Review of the Coronial System in New South Wales', April 1988 pp. 9-10).

Use of Interpreters at Inquests

The desirability of utilising interpreters at Inquests arose in two cases investigated by the Royal Commission (McGrath and Harris).

In a letter to the Royal Commission in the Harris case Mr McCann made these observations about the availability of interpreters in Aboriginal languages:

> *'There is an abysmal lack of competent interpreters in European and Asian languages let alone competent interpreters in Aboriginal languages. Please*

advise me if you know of any!" and "Interpreters in Aboriginal languages appear to be non-existent. Competent interpreters would be even more so, if that is possible". (RCIADIC W25,25)

In a previous section of this Report I have discussed the difficulties in obtaining interpreters in Aboriginal languages in court proceedings and the current options available. It is clear that additional resources need to be allocated so that adequate interpreter services are available to courts and the Coroner, especially in relation to Aboriginal languages.

Venue of Inquests

In two of the cases investigated by the Royal Commission the inquest was heard, or partly heard at a prison. (Robert Walker at, Fremantle Prison and Harris at Canning Vale Prison).

In Robert Walker, Counsel Assisting submitted that it was inappropriate in an inquest into the death of a prisoner for the inquest to be heard at the prison where he died. Mr McCann, the Coroner who held the Inquest, took counsel's point but explained that the absence of other venues and the need to commence the Inquest as soon as possible left little alternative. He said the question of security of prisoners was also a matter for concern. He noted that the court accommodation at Canning Vale Prison was very poor (letter to the Royal Commission dated 30.1.90). The Coroner's position is appreciated given the lack of facilities at the Coroner 's Court and the difficulties in obtaining alternative facilities with adequate security.

However, as a matter of principle, it would seem inappropriate for inquests into prison deaths to be held in a prison and such a course should be avoided unless no other alternative can be found.

It has also been my practice in conducting hearings into deaths in custody to try to obtain hearing facilities other than a court room. I have pursued this course in order to conduct the hearing in a neutral place for Aboriginal witnesses, community members attending the heating, police and prison officers as well as the other witnesses and members of the public. It is worth noting that court houses may hold very bad memories for many Aboriginal people, including the relatives of the deceased and they may be very reluctant or uncomfortable about giving their evidence in that location. Mr McCann expressed the view that he would not be averse to conducting an inquest in an alternative location, e.g. municipal hall or old school house, and suggested that it was a matter that could be raised at a pre-inquest hearing (Coronial Conference 31.8.90, T3 1).

6.4.7 JUDICIAL REVIEW

Section 14 of the Western Australian Act provides where the Supreme Court or a judge upon application made by or under the authority of the Attorney General is satisfied that a coroner refuses or neglects to hold an inquest which ought to be held or an inquest has been held but by reason of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry or is otherwise necessary or desirable in the interests of justice that another inquest should be held then the court or judge may order an inquest to be held or where an inquest has been held quash the finding.

The provisions in the draft legislation are considerably broader in that any person may apply to the Supreme Court for an order that some or all of the findings of an inquest are

void s.50(l). Under these provisions the Supreme Court may order a new inquest or re-open the inquest if it is satisfied that it is necessary or desirable because of fraud, consideration of evidence, failure to consider evidence, irregularity of proceedings or insufficiency of inquiry; or there is a mistake in the record of the findings; or it is desirable because of new facts or evidence; or the findings are against the evidence and the weight of the evidence (s.50(3)).

Counsel Assisting the Royal Commission in the South Australian office has suggested additional areas in which a right of an appeal should be considered:

(a) right of appeal in relation to the performance of an autopsy
(b) the decision whether or not to hold an inquest
(c) the decision to grant or refuse leave to a person to appear before an inquest
(d) the decision to grant or refuse access to coronial documents relating to a particular case
(e) the decision to refuse to call a witness requested by a party appearing before an inquest.

The Perth Coroner's view is that the coronial proceedings ought not to be delayed with preliminary appeals and that one ought to let the court hear the matter and come to a conclusion and then for parties to be able to appeal the finding or the conduct of the inquest. I appreciate this argument in relation to matters that arise during the course of the inquest, e.g. refusal by the coroner to call a witness, but in relation to preliminary matters a right of appeal should be available at an earlier stage in the proceedings. I agree with suggestions of Counsel Assisting in South Australia, and support the fight of appeal being available to parties in relation to matters (a) and (e) listed above. In particular I suggest that the right of appeal in relation to matters (a) to (d) be available before the completion of proceedings.

6.4.8 CORONERS' FINDINGS

Ambit of the Findings

In Western Australia, as in all other jurisdictions, a Coroner is bound following an inquest to make certain findings and certify it in writing setting out who the deceased was and how, when and where the deceased came by his death (s. 1 1(3)).

It would appear that under the current legislation the Coroner does not have a duty to make findings if his inquiry does not proceed to inquest.

In Victoria the Coroner has a duty to make findings in relation to au reportable deaths whether or not an inquest is held (s.19). The proposed draft legislation for Western Australia imposes a duty in the same terms on Coroners in Western Australia (see s.24(l)). Imposing such a duty on coroners seems to have considerable merit.

The draft legislation provides that a coroner must find if possible:

a) the identity of the deceased, and
b) how death occurred; and
c) the cause of death; and
d) the particulars needed to register the death under the Registration of Births Deaths and Marriages Act 1961; and
e) the identity of any person who contributed to the cause of death.

Is the ambit broad enough?

Subsection (2) of the draft legislation empowers the Coroner to comment on any matter connected with the death including public health or safety or the administration of justice.

This provision would appear to provide the Coroner with considerable scope to address issues beyond the immediate cause and circumstances of death.

In Western Australia, as in all other jurisdictions, the Coroner is not entitled to make any findings in relation to the criminal liability of any person. This restriction is also included in the proposed draft legislation.

In the current Act, the Coroner is also prohibited from making findings as to civil liability however this prohibition has not been included in the draft legislation.

Distribution of Findings

In Western Australia, no provision is made under the current legislation or the proposed legislation for the distribution of a Coroner's finding.

It would appear appropriate that procedures ensuring the distribution of Coroners' findings be included in the coroner's guidelines.

Power to Make Recommendations

As mentioned previously, under the Western Australian Act the Coroner has power to express an opinion in the form of a rider which is designed to prevent the recurrence of similar occurrences s.43(l)(i)(a).

In eight cases investigated by the Royal Commission the Coroner attached a rider to his finding designed to prevent deaths in similar circumstances in the future (McGrath, Blankett, Wongi, Walley, Barnes, Cameron, Morrison, Samson). However in many cases in which recommendations could well have been made the Coroner omitted to do so.

The provision in the proposed legislation s.24(2) noted above provides the Coroner with wider powers to make recommendations.

It is clear that the making of recommendations with a view to preventing the occurrence of a death in similar circumstances is an important function of the Coroner. In both the current Act and the draft legislation, the power to make recommendations is discretionary. I suggest that the coroner should have a more positive duty to make such recommendations and that his finding should include:

a) the reasonable precautions, if any, whereby the death and the incident resulting in the death might have been avoided; and
(b) the defects, if any, in any system of working which contributed to the death or to such incident resulting in the death.

Followup and Enforcement of Recommendations

It would appear that the value of the Coroner's power to make recommendations lies in the implementation of these recommendations.

The Coroner has no power under the Act or under the proposed legislation to monitor the implementation of his recommendations.

In the Inquest finding into the deaths of Cameron, Wardle, Morrison and Samson (three of which were investigated by the Royal Commission), it is with dismay that one reads the previous recommendations of Coroners as listed by Mr McCann and the fact that generally they appear to have been ignored. This situation has caused Mr McCann to note that few lessons have been learnt by the police from past tragedies.

Counsel Assisting in South Australia has submitted that the Coroner should have the power to monitor all of his recommendations and, where no satisfactory response has been made to him within a prescribed period he could:

(i) refer the matter to the Attorney General and/or, in the case of government departments, to the Ombudsman, and

(ii) on a regular basis publicize his recommendations and those where no appropriate consideration to response has been given to them.

The Royal Commission has directed specific inquiries to the Department of Corrective Services about the way in which they implement recommendations by the Coroner. The procedures established by the Department for the review of the Coroner's recommendations is discussed in section 6.2.

As was noted in section 6.2 the Department has expressed opposition to any proposed system whereby the Coroner would have power to direct the Department to report back to him at some specified time on action taken or not taken on his recommendations and the reasons for so doing. The Department's view is that it is the responsibility of the Government authority concerned to pursue those recommendations.

Mr McCann has expressed the view that the coroner's duty should be finished when he completes the inquest and makes the finding and recommendations and he should then be free to commence the next one. He has noted however that there are provisions in the draft legislation which require the Coroner to report to the Attorney-General each year and which states he may make recommendations to the Attorney-General on any matter concerning a death which the coroner has investigated (s. 26(l) and (2)). He believes this section provides the 'sting in the tail' and it is unreasonable to expect the coronial system to do more than that. He argues that there should be other responses in the system (Coronial Conference 31.8.90, T74-75).

6.4.9 COUNSELLING SERVICES

There appears to be a need for a service which provides information and counselling services to meet the needs of the family and friends of deceased persons whose deaths are being investigated by the Coroner. This would seem to be particularly necessary in relation to deaths in custody.

It is envisaged that such a service could:

- assist in notifying the family of the death
- provide information to relatives about the procedures in the coronial system
- advise families of their rights in regard to the coronial process
- provide appropriate counselling services, referrals, education and support.

It is understood that such a service has been established within the coronial system in New South Wales.

It should also be noted that the needs of specific cultural groups, including Aboriginals, should be recognised.

I suggest that resources be provided to the Coroner's office to enable the provision of a counselling service and proper liaison with existing services elsewhere.

NAME	GARLETT, Darryl Horace
Date of Death	26.5.80
Case No	W/7
Gender	Male
Age at Death	26 years
Place of Birth	Tammin
Custodial Authority	Wooroolloo Prison Farm
Location of Death	Wooroolloo District Hospital
Cause of Death	Coronary artery disease
Condition on Apprehension - Police Custody	N/A
Most Serious Offence leading to Last Detention	DUI
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	Prison - 2 months
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Occasionally employed
Childhood Separation	Not known
Age of First Recorded Criminal Charge	17 years
Most Serious Offence in Life	DUI
Number of Convictions Alcohol Related ***	5
Number of Prior Convictions	12
History of Problematic Alcohol/Drug Use	Heavy alcohol use
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	No
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	DOOLER, Wayne John
Date of Death	19.6.80
Case No	W/4
Gender	Male
Age at Death	19 years
Place of Birth	Carnarvon
Custodial Authority	Carnarvon Police Station Lockup
Location of Death	Carnarvon Police Station Lockup
Cause of Death	Acute alcoholic poisoning
Condition on Apprehension - Police Custody	Rain sodden clothes, apparently unconscious, no apparent injuries, unable to be roused. Intoxicated.
Most Serious Offence Leading to Last	Drunk

Detention	
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 3/4 hour
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	0.614%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Nil
Age of First Recorded Criminal Charge	13 years
Most Serious Offence in Life	Unseemly Behaviour
Number of Convictions Alcohol Related ***	9
Number of Prior Convictions	10
History of Problematic Alcohol/Drug Use	Excessive alcohol use
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	No
Wardship/Guardianship	Committed to care of CWD

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.
** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	JONES, Christine Lesley Ann
Date of Death	18.10.80
Case No	W/3
Gender	Female
Age at Death	21 years
Place of Birth	Carnarvon
Custodial Authority	Midland Police Station Lockup
Location of Death	Midland Police Station Lockup
Cause of Death	Died by fastening cardigan sleeve around neck, partial suspension, compression of neck. No intention to kill herself. Self-inflicted hanging.
Condition on Apprehension - Police Custody	Mildly intoxicated. Mood variable - co-operative and jovial on arrest, became distressed at Police station.
Most Serious Offence Leading to Last Detention	DUI/Fine Default
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	47 minutes
Resuscitation Attempted/Adequacy	Yes - No mouth to mouth attempted. Inadequate
Post Mortem Blood Alcohol Level	0.25%
Legal Status	Serving sentence warrant in default
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	14 years
Most Serious Offence in Life	Disorderly Conduct, Re-enter Licensed Premises
Number of Convictions Alcohol Related ***	4
Number of Prior Convictions	9
History of Problematic Alcohol/Drug Use	History of alcohol use. Drinking from age of

	14. No treatment.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	DOUGAL, Albert
Date of Death	9.12.80
Case No	W/11
Gender	Male
Age at Death	24 years
Place of Birth	Beagle Bay
Custodial Authority	Broome Police Station Lockup
Location of Death	Derby Regional Hospital
Cause of Death	Brain damage caused by head injury.
Condition on Apprehension - Police Custody	Highly intoxicated, unconscious.
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Police custody - 11 hours, 30 minutes Hospital - 4 days, 3 hours, 15 minutes
Resuscitation Attempted/Adequacy	N/A - in hospital
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged with drunkenness - not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	22 years
Most Serious Offence in Life	Stealing
Number of Convictions Alcohol Related ***	0
Number of Prior Convictions	2
History of Problematic Alcohol/Drug Use	Alcohol abuse problem
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.
** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WALKER, Roy Norman
Date of Death	2.4.81
Case No	W/32
Gender	Male
Age at Death	62 years
Place of Birth	Unknown
Custodial Authority	Kalgoorlie Police Station Lockup

Location of Death	Royal Perth Hospital
Cause of Death	Subdural haemorrhage. The head injury being caused by a fall.
Condition on Apprehension - Police Custody	Unconscious with blood on nostril. Considered intoxicated. Unable to be roused.
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	8 hours, 30 minutes
Resuscitation Attempted/Adequacy	Nil - taken to hospital
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Pensioner
Childhood Separation	Mission
Age of First Recorded Criminal Charge	39 years
Most Serious Offence in Life	Stealing
Number of Convictions Alcohol Related ***	39
Number of Prior Convictions	45
History of Problematic Alcohol/Drug Use	Drank a bottle of wine a day.
Other Known Chronic Health Conditions	Arthritis, cardiac problems
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	BLANKETT, Nita
Date of Death	14.1.82
Case No	W/10
Gender	Female
Age at Death	41 years
Place of Birth	Narrogin
Custodial Authority	Bandyup Womens Prison
Location of Death	Rear of prison van outside surgery of St Andrews Medical Centre
Cause of Death	Acute bronchial asthma
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	DUI
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	2 days
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	29 years
Most Serious Offence in Life	Assault
Number of Convictions Alcohol Related ***	4

Number of Prior Convictions	31
History of Problematic Alcohol/Drug Use	Alcohol problem, all arrests associated with alcohol.
Other Known Chronic Health Conditions	Asthma and otitis media
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	VICENTI, Ricci John
Date of Death	31.3.82
Case No	W/27
Gender	Male
Age at Death	19 years
Place of Birth	Perth
Custodial Authority	Canning Vale Remand Centre
Location of Death	Royal Perth Hospital
Cause of Death	Shot in head.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Break and Enter
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	19 days
Resuscitation Attempted/Adequacy	Yes
Post Mortem Blood Alcohol Level	Nil
Legal Status	Convicted, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Fostered to a white woman
Age of First Recorded Criminal Charge	16 years
Most Serious Offence in Life	Break, Enter and Steal
Number of Convictions Alcohol Related ***	0
Number of Prior Convictions	9
History of Problematic Alcohol/Drug Use	Self-reported alcohol problem - no other evidence.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	BARNES, Faith Marilyn
Date of Death	27.10.82
Case No	W/30
Gender	Female
Age at Death	Approx. 27 years

Place of Birth	Unknown (Kalgoorlie)
Custodial Authority	Kalgoorlie Police Station Lockup
Location of Death	Royal Perth Hospital
Cause of Death	Acute subdural haematoma from injury to the head. Open finding as to cause of head injury.
Condition on Apprehension - Police Custody	No injuries seen, unconscious, unable to be roused or walk, smelt of alcohol.
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	5 hours, 20 minutes
Resuscitation Attempted/Adequacy	Taken to hospital
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Invalid Pensioner
Childhood Separation	Mother deceased, raised by aunt and uncle
Age of First Recorded Criminal Charge	17 years
Most Serious Offence in Life	Assault
Number of Convictions Alcohol Related ***	40
Number of Prior Convictions	48
History of Problematic Alcohol/Drug Use	Chronic alcoholic
Other Known Chronic Health Conditions	Diabetes and hypertension
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	The man who died at Sir Charles Gairdner Hospital***
Date of Death	25.2.83
Case No	W/9
Gender	Male
Age at Death	25 years
Place of Birth	Roebourne
Custodial Authority	Fremantle Prison
Location of Death	Sir Charles Gairdner Hospital
Cause of Death	Tuberculous meningitis.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Rape
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	4 months
Resuscitation Attempted/Adequacy	Not relevant
Post Mortem Blood Alcohol Level	Nil
Legal Status	Sentenced
Employment Status on Entry to Custody	Employed
Childhood Separation	Hostel while attending school
Age of First Recorded Criminal Charge	16 years

Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	73
Number of Prior Convictions	90
History of Problematic Alcohol/Drug Use	High use of alcohol since mid teens.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of DCW

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	ANDERSON, Robert
Date of Death	28.2.83
Case No	W/16
Gender	Male
Age at Death	26 years
Place of Birth	Wiluna area
Custodial Authority	Wiluna Police Station Lockup
Location of Death	Wiluna Police Station Lockup
Cause of Death	Epilepsy.
Condition on Apprehension - Police Custody	Very intoxicated
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 39 hours
Resuscitation Attempted/Adequacy	Nil - beyond resuscitation
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Employed (CDEP)**
Childhood Separation	Mission
Age of First Recorded Criminal Charge	17 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	16
Number of Prior Convictions	30
History of Problematic Alcohol/Drug Use	Heavy user of alcohol, weekends only.
Other Known Chronic Health Conditions	Epilepsy
Inquest by Coroner	No
Wardship/Guardianship	Not known

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WODULAN, Hugh
Date of Death	19.7.83
Case No	W/12
Gender	Male
Age at Death	30 years

Place of Birth	Liveringa Station, West Kimberley
Custodial Authority	Broome Police Station Lockup
Location of Death	Broome Police Station Lockup
Cause of Death	Compression of the carotid arteries as a result of self inflicted hanging.
Condition on Apprehension - Police Custody	Highly intoxicated, crepe bandage wound around burn injury to head.
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 2.5 hours
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	0.26%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission, Juvenile institution
Age of First Recorded Criminal Charge	15 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	22
Number of Prior Convictions	76
History of Problematic Alcohol/Drug Use	Chronic alcoholic
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	PAT, John Peter
Date of Death	28.9.83
Case No	W/19
Gender	Male
Age at Death	16 years
Place of Birth	Roebourne
Custodial Authority	Roebourne Police Station Lockup
Location of Death	Roebourne Police Station Lockup
Cause of Death	Closed head injury.
Condition on Apprehension - Police Custody	Bleeding, no visible injuries, possibility that was unconscious.
Most Serious Offence Leading to Last Detention	Aggravated Assault
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Not determined 0 - 2 hours
Resuscitation Attempted/Adequacy	Not determined medical evidence of resuscitation but denied by police
Post Mortem Blood Alcohol Level	0.23%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed

Childhood Separation	Nil
Age of First Recorded Criminal Charge	15 years
Most Serious Offence in Life	Aggravated Assault (police)
Number of Convictions Alcohol Related ***	4
Number of Prior Convictions	7
History of Problematic Alcohol/Drug Use	Not medically significant but reflected in his criminal history.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	UGLE, Ronald Mack
Date of Death	12.12.83
Case No	W/28
Gender	Male
Age at Death	53 years
Place of Birth	Tamala Station, Shark Bay
Custodial Authority	Broome Regional Prison (following transfer from Geraldton Prison)
Location of Death	Broome District Hospital
Cause of Death	Heart Attack.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Manslaughter
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	13 months
Resuscitation Attempted/Adequacy	Yes - Adequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Employed
Childhood Separation	Nil
Age of First Recorded Criminal Charge	18 years
Most Serious Offence in Life	Manslaughter x 2
Number of Convictions Alcohol Related ***	13
Number of Prior Convictions	24
History of Problematic Alcohol/Drug Use	Extensive alcohol abuse; numerous hospital admissions for alcohol related illness and injury.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	No
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	FARMER, Paul
Date of Death	11.7.84
Case No	W/5
Gender	Male
Age at Death	33 years
Place of Birth	Gnowangerup
Custodial Authority	Albany Regional Prison
Location of Death	Albany Regional Prison
Cause of Death	Deceased used razor blade to cut his throat with intention to take his own life.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Rape
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	2 years, 5 months
Resuscitation Attempted/Adequacy	Nil - beyond resuscitation
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Juvenile institution
Age of First Recorded Criminal Charge	10 years
Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	0
Number of Prior Convictions	27
History of Problematic Alcohol/Drug Use	Drank excessively when released to freedom.
Other Known Chronic Health Conditions	Schizo-affective/depressive order
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WALKER, Robert Joseph
Date of Death	28.8.84
Case No	W/2
Gender	Male
Age at Death	25 years
Place of Birth	Port Augusta
Custodial Authority	Fremantle Prison
Location of Death	Fremantle Prison
Cause of Death	Asphyxia resulting from compression of the chest.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Rape
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	22 months
Resuscitation Attempted/Adequacy	Yes
Post Mortem Blood Alcohol Level	Nil

Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Juvenile institution
Age of First Recorded Criminal Charge	12 years
Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	3
Number of Prior Convictions	25
History of Problematic Alcohol/Drug Use	Drug abuse
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of DCW

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.
** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	MICHAEL, Charles Sydney
Date of Death	9.10.84
Case No	W/1
Gender	Male
Age at Death	31 years
Place of Birth	Wandering
Custodial Authority	Bartons Mill Prison
Location of Death	Bartons Mill Prison
Cause of Death	Mycardial infarction.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Rape
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	3 years, 8 months
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	12 years
Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	4
Number of Prior Convictions	63
History of Problematic Alcohol/Drug Use	Heavy alcohol use
Other Known Chronic Health Conditions	Depression
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.
** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	POLAK, Kim Rodney

Date of Death	28.3.85
Case No	W/18
Gender	Male
Age at Death	28 years
Place of Birth	Leonora
Custodial Authority	Kalgoorlie Police Station Lockup
Location of Death	Kalgoorlie Police Station Lockup
Cause of Death	Alcohol withdrawal or acute hepatitis.
Condition on Apprehension - Police Custody	Highly intoxicated.
Most Serious Offence Leading to Last Detention	Street Drinking/Fine Default
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	2 days
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Sentenced (& cutting out warrants)
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission & hostels Juvenile institution
Age of First Recorded Criminal Charge	12 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	15
Number of Prior Convictions	120
History of Problematic Alcohol/Drug Use	Chronic alcoholic for approximately last 10 years of life.
Other Known Chronic Health Conditions	Diabetes and epilepsy
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.
** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	NIANJI, Jimmy
Date of Death	22.5.85
Case No	W/8
Gender	Male
Age at Death	Approx. 55 years
Place of Birth	Unknown (Gibson Desert)
Custodial Authority	Port Hedland Police Station Lockup
Location of Death	Port Hedland Regional Prison
Cause of Death	Asphyxia due to laryngeal oedema
Condition on Apprehension - Police Custody	Highly intoxicated.
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	2 days
Resuscitation Attempted/Adequacy	N/A - was in intensive care
Post Mortem Blood Alcohol Level	N/A
Legal Status	Sentenced
Employment Status on Entry to Custody	Invalid Pensioner

Childhood Separation	Not known
Age of First Recorded Criminal Charge	Approx. 34 years
Most Serious Offence in Life	Unlawful wounding
Number of Convictions Alcohol Related ***	22
Number of Prior Convictions	31
History of Problematic Alcohol/Drug Use	Period heavy alcohol use in last 15 years of life
Other Known Chronic Health Conditions	Diabetes
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WELLS, Milton
Date of Death	6.8.85
Case No	W/33
Gender	Male
Age at Death	30 years
Place of Birth	Kalgoorlie
Custodial Authority	Kalgoorlie Police Station Lockup
Location of Death	Kalgoorlie Regional Hospital
Cause of Death	Lobar pneumonia and acute meningitis
Condition on Apprehension - Police Custody	Shivering, mucous running from nose, not entirely coherent, unsteady on feet. Alcohol smelt on breath, assumed intoxicated.
Most Serious Offence Leading to Last Detention	Wilful Damage
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 13 hours
Resuscitation Attempted/Adequacy	Yes, ICU staff at hospital
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Nil
Age of First Recorded Criminal Charge	15 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	12
Number of Prior Convictions	37
History of Problematic Alcohol/Drug Use	Regular user of alcohol
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	GREEN, Dixon
Date of Death	19.11.85
Case No	W/24
Gender	Male
Age at Death	25 years
Place of Birth	Halls Creek
Custodial Authority	Broome Regional Prison
Location of Death	Broome Regional Prison
Cause of Death	Ischaemic heart disease.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Rape
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	18 months
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Employed
Childhood Separation	Not known
Age of First Recorded Criminal Charge	13 years
Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	2
Number of Prior Convictions	20
History of Problematic Alcohol/Drug Use	User of alcohol - no evidence of problem.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	BATES, Bobby
Date of Death	2.6.86
Case No	W/31
Gender	Male
Age at Death	33 years
Place of Birth	Warburton Range Warburton
Custodial Authority	Eastern Goldfields Regional Prison
Location of Death	Sir Charles Gairdner Hospital
Cause of Death	Bronchopneumonia.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	DUI/Fine Default
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	1 month, 4 days
Resuscitation Attempted/Adequacy	N/A - in hospital
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Employed (CDEP)**
Childhood Separation	Juvenile Institution

Age of First Recorded Criminal Charge	13 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	10
Number of Prior Convictions	32
History of Problematic Alcohol/Drug Use	History of heavy alcohol use
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WAIGANA, Misel
Date of Death	4.3.87
Case No	W/14
Gender	Male
Age at Death	39 years
Place of Birth	Saibai Island, Queensland
Custodial Authority	East Perth Police Station Lockup
Location of Death	East Perth Police Station Lockup
Cause of Death	Delirium tremens.
Condition on Apprehension - Police Custody	Assumed to be intoxicated. Distressed - calling out that someone was trying to kill him.
Most Serious Offence Leading to Last Detention	Disorderly Conduct
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 2 hours, 45 minutes
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Invalid Pensioner
Childhood Separation	Not known
Age of First Recorded Criminal Charge	24 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	13
Number of Prior Convictions	26
History of Problematic Alcohol/Drug Use	Chronic alcoholic since late 1970s
Other Known Chronic Health Conditions	Epilepsy
Inquest by Coroner	Yes
Wardship/Guardianship	Not known

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	MICHAEL, Steven Glen
Date of Death	23.5.87

Case No	W/26
Gender	Male
Age at Death	29 years
Place of Birth	Beverley
Custodial Authority	Canning Vale Prison
Location of Death	Fremantle Hospital
Cause of Death	Heart disease.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Break, Enter and Steal
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	2 years
Resuscitation Attempted/Adequacy	Yes - Adequate
Post Mortem Blood Alcohol Level	N/A
Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Juvenile institution
Age of First Recorded Criminal Charge	9 years
Most Serious Offence in Life	Break, Enter and Steal
Number of Convictions Alcohol Related ***	4
Number of Prior Convictions	187
History of Problematic Alcohol/Drug Use	Heavy alcohol use
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	BROWN, Stanley
Date of Death	27.6.87
Case No	W/13
Gender	Male
Age at Death	42 years
Place of Birth	De Grey Station Pilbara
Custodial Authority	Broome Police Station Lockup
Location of Death	Broome Police Station Lockup
Cause of Death	Self inflicted hanging as a result of compression of the carotid artieries.
Condition on Apprehension - Police Custody	Very intoxicated
Most Serious Offence Leading to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Less than 3 hours
Resuscitation Attempted/Adequacy	Nil - Inadequate. Didn't consider it
Post Mortem Blood Alcohol Level	.270%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Nil
Age of First Recorded Criminal Charge	17 years

Most Serious Offence in Life	Assault Occasioning Bodily Harm
Number of Convictions Alcohol Related ***	43
Number of Prior Convictions	72
History of Problematic Alcohol/Drug Use	Chronic alcoholic
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	MCGRATH, Bernard Albert
Date of Death	15.11.87
Case No	W/17
Gender	Male
Age at Death	20 years
Place of Birth	Kalgoorlie
Custodial Authority	Kalgoorlie Police Station Lockup
Location of Death	Kalgoorlie Police Station Lockup
Cause of Death	Hanging.
Condition on Apprehension - Police Custody	Distressed, not apparently intoxicated (despite positive finding).
Most Serious Offence Leading to Last Detention	Warrant (Breach of CSO)
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 40 minutes
Resuscitation Attempted/Adequacy	Nil - beyond resuscitation
Post Mortem Blood Alcohol Level	.223%/.217%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Juvenile institution (short period)
Age of First Recorded Criminal Charge	10 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	2
Number of Prior Convictions	26
History of Problematic Alcohol/Drug Use	Regularly used alcohol and marijuana
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	HARRIS, Donald James
Date of Death	10.3.88
Case No	W/25
Gender	Male

Age at Death	29 years
Place of Birth	Kalgoorlie
Custodial Authority	Canning Vale Remand Centre
Location of Death	Fremantle Hospital
Cause of Death	Acute pancreatitis.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence Leading to Last Detention	Break and Enter with Intent
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	2 months, 8 days
Resuscitation Attempted/Adequacy	N/A - was in intensive care
Post Mortem Blood Alcohol Level	Nil
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	15 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	7
Number of Prior Convictions	43
History of Problematic Alcohol/Drug Use	Heavy alcohol use
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	SAMSON, Ginger
Date of Death	30.3.88
Case No	W/23
Gender	Male
Age at Death	44 years
Place of Birth	Millstream Station Pilbara
Custodial Authority	Roebourne Police Station Lockup
Location of Death	Roebourne Police Station Lockup
Cause of Death	Epilepsy resulting from a closed head injury and excessive alcohol consumption.
Condition on Apprehension - Police Custody	Highly intoxicated, unable to walk and could not speak coherently, semi-conscious.
Most Serious Offence to Last Detention	Drunk
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 8-9 hours
Resuscitation Attempted/Adequacy	Nil - beyond resuscitation
Post Mortem Blood Alcohol Level	0.05%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Not known
Age of First Recorded Criminal Charge	18 years
Most Serious Offence in Life	Aggravated Assault
Number of Convictions Alcohol Related ***	88

Number of Prior Convictions	128
History of Problematic Alcohol/Drug Use	Chronic alcoholic for at least last 8 years of life
Other Known Chronic Health Conditions	Epilepsy
Inquest by Coroner	Yes
Wardship/Guardianship	Nil

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	MORRISON, Benjamin Wilson
Date of Death	6.4.88
Case No	W/15
Gender	Male
Age at Death	55 years
Place of Birth	Pinjarra
Custodial Authority	Fremantle Police Station Lockup
Location of Death	Fremantle Police Station Lockup
Cause of Death	Asphyxia due to self inflicted hanging.
Condition on Apprehension - Police Custody	Abrasions to knuckles, bleeding face, intoxicated, aggressive, threatening, yelling.
Most Serious Offence Leading to Last Detention	Disorderly Conduct
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	1 hour, 10 minutes
Resuscitation Attempted/Adequacy	Yes - prompt and competent
Post Mortem Blood Alcohol Level	0.20%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission
Age of First Recorded Criminal Charge	19 years
Most Serious Offence in Life	Assault Occasioning Bodily Harm
Number of Convictions Alcohol Related ***	121
Number of Prior Convictions	Approx. 275
History of Problematic Alcohol/Drug Use	Chronic alcoholic
Other Known Chronic Health Conditions	Psychiatric disorder
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of DCW

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	CAMERON, Edward Charles
Date of Death	8.7.88
Case No	W/20
Gender	Male
Age at Death	23 years

Place of Birth	Carnarvon
Custodial Authority	Geraldton Police Station Lockup
Location of Death	Geraldton Police Station Lockup
Cause of Death	Asphyxia due to self inflicted hanging.
Condition on Apprehension - Police Custody	Small cut on right cheek, cuts to hands.
Most Serious Offence Leading to Last Detention	Break, Enter and Steal
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Between 10 and 20 minutes
Resuscitation Attempted/Adequacy	Nil - Inadequate
Post Mortem Blood Alcohol Level	In excess of .20%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Not known
Age of First Recorded Criminal Charge	15 years
Most Serious Offence in Life	Break, Enter and Steal
Number of Convictions Alcohol Related ***	2
Number of Prior Convictions	14
History of Problematic Alcohol/Drug Use	Binge drinker of alcohol
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WALLEY, Graham Trevor
Date of Death	23.10.88
Case No	W/22
Gender	Male
Age at Death	21 years
Place of Birth	Northam
Custodial Authority	Greenough Regional Prison
Location of Death	Greenough Regional Prison
Cause of Death	Self inflicted hanging.
Condition on Apprehension - Police Custody	N/A
Most Serious Offence to Last Detention	Break and Enter
Adequacy of Assessment on Admission to Police Custody	N/A
Duration of Custody Prior to Death	6 months
Resuscitation Attempted/Adequacy	Yes - Adequate
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Juvenile institution
Age of First Recorded Criminal Charge	9 years
Most Serious Offence in Life	Rape
Number of Convictions Alcohol Related ***	3
Number of Prior Convictions	145
History of Problematic Alcohol/Drug Use	Committed offences while intoxicated, considered himself to have an alcohol

	problem.
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of Department

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	CHATUNALGI, Donald
Date of Death	15.12.88
Case No	W/29
Gender	Male
Age at Death	27 years
Place of Birth	Alice Downs Station East Kimberley
Custodial Authority	Halls Creek Police Station Lockup
Location of Death	Halls Creek Police Station Lockup
Cause of Death	Epilepsy
Condition on Apprehension - Police Custody	Good
Most Serious Offence Leading to Last Detention	DUI/Fine Default
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	Approx. 8 hours
Resuscitation Attempted/Adequacy	Nil - beyond resuscitation
Post Mortem Blood Alcohol Level	Nil
Legal Status	Serving sentence default on unpaid fines
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Nil
Age of First Recorded Criminal Charge	14 years
Most Serious Offence in Life	Driving under Influence of Alcohol
Number of Convictions Alcohol Related ***	2
Number of Prior Convictions	12
History of Problematic Alcohol/Drug Use	Binge drinker of alcohol
Other Known Chronic Health Conditions	Epilepsy
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of Department

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME	WONGI***
Date of Death	31..12.88
Case No	W/21
Gender	Male
Age at Death	28 years
Place of Birth	Kalgoorlie
Custodial Authority	Geraldton Police Station Lockup
Location of Death	Geraldton Police Station Lockup

Cause of Death	Asphyxiation as a result of self strangulation.
Condition on Apprehension - Police Custody	Right wrist bandaged, intoxicated but not drunk, aggressive.
Most Serious Offence Leading to Last Detention	Attempted Break and Enter
Adequacy of Assessment on Admission to Police Custody	Inadequate
Duration of Custody Prior to Death	1 hour, 20 minutes
Resuscitation Attempted/Adequacy	Yes
Post Mortem Blood Alcohol Level	0.16%
Legal Status	Charged, not sentenced
Employment Status on Entry to Custody	Unemployed
Childhood Separation	Mission, Juvenile institution
Age of First Recorded Criminal Charge	14 years
Most Serious Offence in Life	Robbery in Company
Number of Convictions Alcohol Related ***	21
Number of Prior Convictions	107
History of Problematic Alcohol/Drug Use	Chronic alcoholic
Other Known Chronic Health Conditions	Nil
Inquest by Coroner	Yes
Wardship/Guardianship	Committed to care of CWD

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME
Date of Death
Case No
Gender
Age at Death
Place of Birth
Custodial Authority
Location of Death
Cause of Death
Condition on Apprehension - Police Custody
Most Serious Offence to Last Detention
Adequacy of Assessment on Admission to Police Custody
Duration of Custody Prior to Death
Resuscitation Attempted/Adequacy
Post Mortem Blood Alcohol Level
Legal Status
Employment Status on Entry to Custody
Childhood Separation
Age of First Recorded Criminal Charge
Most Serious Offence in Life
Number of Convictions Alcohol Related ***
Number of Prior Convictions
History of Problematic Alcohol/Drug Use
Other Known Chronic Health Conditions
Inquest by Coroner
Wardship/Guardianship

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME
Date of Death
Case No
Gender
Age at Death
Place of Birth
Custodial Authority
Location of Death
Cause of Death
Condition on Apprehension - Police Custody
Most Serious Offence to Last Detention
Adequacy of Assessment on Admission to Police Custody
Duration of Custody Prior to Death
Resuscitation Attempted/Adequacy
Post Mortem Blood Alcohol Level
Legal Status
Employment Status on Entry to Custody
Childhood Separation
Age of First Recorded Criminal Charge
Most Serious Offence in Life
Number of Convictions Alcohol Related ***
Number of Prior Convictions
History of Problematic Alcohol/Drug Use
Other Known Chronic Health Conditions
Inquest by Coroner
Wardship/Guardianship

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** CDEP: Community Development Employment Programme
*** Name suppressed from publication.

NAME
Date of Death
Case No
Gender
Age at Death
Place of Birth
Custodial Authority
Location of Death
Cause of Death
Condition on Apprehension - Police Custody
Most Serious Offence to Last Detention
Adequacy of Assessment on Admission to Police Custody

Duration of Custody Prior to Death
Resuscitation Attempted/Adequacy
Post Mortem Blood Alcohol Level
Legal Status
Employment Status on Entry to Custody
Childhood Separation
Age of First Recorded Criminal Charge
Most Serious Offence in Life
Number of Convictions Alcohol Related ***
Number of Prior Convictions
History of Problematic Alcohol/Drug Use
Other Known Chronic Health Conditions
Inquest by Coroner
Wardship/Guardianship

* For the purpose of this chart an 'alcohol related offence' may be any of the following: Driving under the influence (DUI), Refuse to leave licensed premised (LP), Drunk, Road drinking, Streat/Park/Reserve drinking, Re-enter, Provide liquor to native, Drink liquor in townsite, Take liquor onto Reserve, Under influence of liquor on native Reserve, Receive liquor, Prohibited person on LP.

** CDEP: Community Development Employment Programme

*** Name suppressed from publication.

APPENDIX 2 GENERAL SUBMISSIONS - WESTERN AUSTRALIA

No.	Author	Title
G/W/1	D.W. McLeod	Letter to RCIADIC dated 5.11.87 enclosing Papers on Strelley Community/Nomads Group & other general issues (especially re the Pilbara) & Historical papers
G/W/2	Dr D. Pocock, retired forensic pathologist	Letter to RCIADIC dated 28.10.87 re assessment of deaths in custody
G/W/3	Dr J. Spencer, former Director of Clinical Services, WAADA	Submission dated 24.3.88 on Suicide, Depression & Alcohol in relation to deaths in custody
G/W/4	Prison Officers Association of Australia	Submission dated 10.7.87 of Aboriginals & the Criminal Justice Systems
G/W/5	Jennifer Searcy	Submission dated 20.7.87 on Non-Aboriginal Deaths in Custody
G/W/6	Lionel Frank Shaw	Submission dated 18.8.87 on the Criminal Justice System
G/W/7	Broome Regional Aboriginal Medical Service (Dr E. Hunter)	Submission dated 22.1.88 on Suicide in the Kimberley Region
G/W/8	R.I. Connell, JP	Submission dated 18.1.88 on Conditions of Aboriginals in Custody
G/W/9	Rosemary O'Grady,	Submission dated 20.2.88 on Provision of

	Barrister & Solicitor	Legal Services to Aboriginal people
G/W/10	Dr Ernest Hunter, Psychiatrist	Submission on Deaths in the Kimberleys
G/W/11	Sister Bernadine Daly, Sister of Mercy	Submission dated April
G/W/12	Senator Noel Crichton-Browne	Submission dated 30.6.88 on Cell Conditions in Halls Creek
G/W/13	Michael D. Breen	Submission dated July 1988 on Stress Management
G/W114	Brian Tennant, Social & Law Reform campaigner	Submission dated 2.2.88 on Cell Architecture
G/W/15	D.S. Trigger	Submission dated 20.10.88 on Death in Doomadgee, Queensland
G/W/16	Stephen Noon	Submission to RCIADIC
G/W/17	William Hernstadt	Submission dated 4.8.88 on Aboriginal deaths in custody
G/W/18	Special Government Committee on Aboriginal/Police and Community Relations	Submission on Corrective and Preventative approach to reduce likelihood of further deaths
G/W/19	Vanessa Read,Head Education Officer, Milliya Rumurra, Aboriginal Alcohol Rehabilitation Centre	Submission to Interim Inquiry into Aboriginal Deaths in Custody dated 11.2.88 on Deaths in Custody in Broome
G/W/20	David Eldridge	Submission dated 11.8.88 on Race Relations in Kimberley Region
G/W/21	Australian Medical Association	Submission dated 11 10.88 on Aboriginal Health Issues
G/W/22	Mr G.P. Campbell	Submission on North America
G/W/23	Police Federation of Australia & New Zealand	Submission dated 23.1.89 on Use of Custodial Facilities for Sentenced or Remand Prisoners
G/W/24	Mrs Duyker & Mr Sullivan	Submission dated 15.3.89 on Aboriginal Deaths in Custody and the Australian Montessori Society
G/W/25	Jennifer Searcy	Submission dated 9.4.89 on the Death of the Man who died at Sir Charles Gairdner Hospital

G/W/26	Gerry Benson-Lidholm, Anthropologist	Submission dated 14.2.90 on Leprosy in North-West of Western Australia
G/W/27	John Rando, Solicitor	Submission dated 4.1.89 on Avoiding Suicide in Police Custody, Pending Bail
G/W/28	Sister Bernadine Daly	Submission of 16.11.89 on The Design of Cells & Juvenile Delinquency
G/W/29	Special Government Committee on Aboriginal/Police and Community Relations	Review of Aboriginal Police Aide System
G/W/30	Murdoch University (G. Lansdell & Professor R. Simmonds)	Submission dated 27.6.90 on Training of law students: Aboriginal Culture and Law
G/W/31	WA Police Department (B. Bull)	Submission of WA Police Department to the RCIADIC dated May 1990 on Structure, Power & Authority, Control & Management, Deaths in Custody, Police Administration, Aboriginal-Police Relations, Community Policing Initiatives
G/W/32	Submission by Centre for Aboriginal Studies, Curtin University of Technology (P. Dudgeon & Dr E. Stringer)	Submission dated 18.7.90 on Police Training in Aboriginal Affairs
G/W/33	Tom Baban, Head, Institute of Applied Aboriginal Studies, Western Australian College of Advanced Education	Submission dated 7.9.90 on Training of Police Recruits in Relation to Aboriginal Issues
G/W/34	Crown Law Department, Western Australia	a) Responses of Crown Law Department to questions of RCIADIC b) Responses by the Crown Law Department to additional questions of RCIADIC dated 20.8.90
G/W/35	WA Police Department a&b	a) Responses of Police Department to questions of RCIADIC dated July 1990 together with annexures A to W b) Responses by the Police Department which the RCIADIC would like clarified dated 31.8.90 (with attachments)
G/W/36	WA Police Department a, b & c	a) Letter from B. Martin, Police Royal Commission Liaison Unit, 4.10.90 re Police Recruit Training

		b) Course Standard, Police Recruits, September 1990 c)Aboriginal Issues Programme - Police Recruit Training (provided by Department of Corrective Services 1990)
G/W/37	Stephen Cordner, Chairman, Victorian Institute of Forensic Pathology	Letter dated 8.10.90 re Resolution of Royal College of Forensic Pathologists Supporting Concept of Statewide Coronial systems
G/W/38	Aboriginal Education Liaison Unit, Ministry of Education, WA	Submission dated 26.9.90, on Provision of Training to Police Recruits and Non-Commissioned Officers
G/W/39	Western Australian Alcohol and Drug Authority	Submission dated 9.10.90 on Sobering Up Centres in Western Australia
G/W/40	Terry Velterop	Submission dated 18.10.90 on Compensation for Aboriginal People

APPENDIX 3 GENERAL EXHIBITS - SUBMITTED DURING HEARINGS COMMISSIONER D.J. O'DEA

No.	Exhibits	Location	Hearing	Date
GO/I	Police Routine Orders & extracts from Police Gazette	Perth	Jones	15.12.88
GOA	Submissions by Perth Coroner McCann to RCIADIC	Port Hedland	Njanji	3.4.89
GO/3	Report by D.I. Smith, N.H. Singh and H. Singh titled *'Survey of Aboriginal Alcohol Consumption and Related Problems at Wiluna, WA'*	Perth	SCGH	11.5.89
GO/4	Report by D.I. Smith & S. Skowran titled *'Survey of Homelessness, Alcohol Consumption and Related Problems in the Hedland* Area' dated August 1986	Perth	SCGH	11.5.89
GO/5	WA Police Routine Orders (current as at June 1989)	Perth	Waigana	4.9.89

GO/6	Paper by Professor S. Cordner titled *'Forensic Pathology Aspects of the Royal Commission into Aboriginal Deaths in Custody'* (including a protocol for suspicious deaths and homicides)	Perth	Waigana	6.9.89
G0/7	a) Visitors Resource Manual - Aboriginal Visitors Scheme, May 1989 b) Project Officer's Manual - Aboriginal Visitors Scheme. Aboriginal Affairs Planning Authority	Perth	Waigana	6.9.89
GO/8	A Study of Attitudes in Roebourne *'They Get Heaps'* by M. Edmunds, Australian Institute of Aboriginal Studies	Perth	SCGH	6.12.89
G0/9	*'Aboriginal/Police Relations in* the Pilbara', a Study of Perceptions *by a* Special Cabinet Committee on Aboriginal/ Police & Community Relations. Perth 1986	Perth	SCGH	6.12.89
GO/10	*'Improving Aboriginal/ Police Relations'* - the Roebourne Research Project by a Special Cabinet Committee on Aboriginal/Police & Community Relations. Perth 1988	Perth	SCGH	6.12.89
GO/11	*'Roebourne and the Juvenile Sub-Cult by* F. Donovan, 4.8.75	Perth	SCGH	6.12.89
G0/12	*'Decentralised Aboriginal Housing-Roebourne' - A* Demographic & Sociological Study prepared on behalf of the State Housing Commission Compiled by J.H. Imrie, August	Perth	SCGH	6.12.89

	1975			
G0/13	*'Murchison/Gascoyne Land Needs Study' by* N. Green & P. Sullivan, August 1988 with annexure: Description of Yulella Programme	Geraldton	Cameron, Wongi, Walley	11.4.90
G0/14	Submission to RCIADIC by Special Government Committee on Aboriginal/ Police & Community Relations with annexures: A Aboriginal Deaths in Custody B Submission to the Commissioner of Police on Procedures Governing Police Interview of Juveniles C Summary of 1984 Aboriginal Police Relations Summit D Submission to the State Working Party on the Design of Police Lockups	Perth		26.4.90
G0/15	Statement of Dr H.F. Oxer, Director of St John Ambulance & Chairman of the Australian Resuscitation Council, dated 25.11.88	Perth	Jones 15.12.88	9.5.90
G/16	Statement of Professor German, Professor of Psychiatry, University of Western Australia, dated 7.12.88	Perth	Jones 8.2.89	9.5.90
GO/17	Directives for the Guidance of Aboriginal Police Aides issued by the Police Department	Perth	Dooler 9.2.89	9.5.90
GO/18	Statement of David John Spencer, Consultant Psychiatrist, former Director of WA Alcohol	Perth	Dooler 8.2.89	9.5.90

	and Drug Authority dated 31.1.89			
GO/19	Statement of Ronnie Sampi, Manager of Milliya Rumurra Alcohol Rehabilitation Centre, dated 17.6.89	Broome	Brown 3.7.89	9.5.90
GO/2O	Statement of Ted Wilkes, Director Perth Aboriginal Medical Service Inc., dated 20.9.89	Perth	Waigana 21.9.89	9.5.90
GO/21	Statement of P.J. Prosser, Co-ordinator, Aboriginal Visitors Scheme, Aboriginal Affairs Planning Authority	Perth	Waigana 21.9.89	9.5.90
GO/22	Letter: B. Bull, Commissioner of Police to Crown Law Department 29.12.88 re Recruit Training Programme - First Aid & Resuscitation	Perth	Morrison 22.9.89	9.5.90
GO/23	Police Department Custodial Care Manual	Perth	Morrison 10.10.89	9.5.90
GO/24	Statement of A.H. Middleton, Advisor, Ngangganawili Aboriginal Community	Wiluna	Anderson 24.10.89	9.5.90
GO/25	Statement of W.J. Lapham, Former Justice of the Peace, Wiluna, Dated 15.11.89	Perth	Anderson 16.11.89	9.5.90
GO/26	Report of Dr W.M. Carroll, Head of Department of Neurology, Sir Charles Gairdner Hospital, dated 31.8.89	Perth 30.10.89	Anderson	9.5.90
GO/27	Statement of Maureen Kelly, Community Development Officer, WAADA, dated 4.4.89	Port Hedland	Njanji 5.4.89	9.5.90
GO/28	Statement of Snowy Judamia, Tribal Elder, Head of Warralong	Port Hedland	Njanji 3.4.89	9.5.90

GO/29	Submission by Concerned Aboriginal People on Juvenile Crime to Cabinet Sub-Committee on Crime Prevention January 1990, forwarded to the RCIADIC by S. Gordon, Magistrate	Perth		9.5.90
GO/30	List of all Sudden Deaths in Custody since 1.1.80, with Inquest Findings attached - forwarded to the RCIADIC by the Perth Coroner, Mr McCann	Perth		9.5.90
GO/31	Annual Reports from Department of Corrective Services for the period 1980-1990	Perth	Vicenti	16.5.90
GO/32	Unconvicted Prisoners in Australia: A study of the structure of remand populations in eight jurisdictions, by David Biles, Australian Institute of Criminology	Perth	Vicenti	5.7.90
G0/33	The Outcomes of Remand in Custody Orders by John Walker, Australian Institute of Criminology	Perth	Vicenti	5.7.90
G0/34	a) Commentary on Implementation of the Western Australian Report of the Interim Inquiry into Aboriginal Deaths in Custody by Western Australian Government Agencies (the Vincent Report) b) Commentary on Implementation of the Interim Report of the Royal Commission into Aboriginal Deaths in Custody (the Muirhead Report)	Perth		27.7.90
G0/35a)	Response of		Perth	13.8.90

I.C. Hill, Executive Director, Department of Corrective Services, in reply to RCIADIC questions, dated 6.8.90		
b)Further Responses of Department of Corrective Services in reply to RCIADIC Questions dated 17.9.90	Perth	10.10.90