Australian Deaths in Custody & Custody-related Police Operations 1996

Australian Institute of Criminology
Research and Public Policy Series
No. 10

Vicki Dalton

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Introduction

The information presented in this report covers deaths which occurred while people were in the custody of Australia's police, prisons and juvenile justice authorities during the twelve-month period 1 January to 31 December 1996. It also includes deaths which have occurred during custody-related police operations. The report's central findings can be summarised as follows.

Total Numbers

- During the twelve months to 31 December 1996, 80 deaths in custody were reported throughout Australia. The 80 deaths comprised 15 Aboriginal people and 63 non-Aboriginal people. For the first time ever, there were two Torres Strait Islander deaths in custody reported during the year. One Aboriginal woman died in prison custody; she was the only female to die in custody during the period under review. One youth died in juvenile detention.
- Fifty-two of the deaths (65 per cent) occurred in prison custody while 27 deaths (34 per cent) occurred in police custody or in custody-related police operations; the remaining death occurred in juvenile detention. Of the 27 deaths in police custody, nine occurred in an institutional setting and the remaining 18 in custody-related police operations while police were in the process of detaining the individuals concerned.

Age and Cause and Manner of Death

- The ages of those who died ranged from 13 to 75 years, averaging 36 years. The most frequent cause of death for both non-Aboriginal and Aboriginal people combined was hanging, followed in frequency by death from illness and death from injuries. Contrary to earlier years when disease accounted for a larger proportion of Aboriginal deaths in custody, during the current year deaths from hanging and disease were similar in number.

Offences and Legal Status

- The largest number of people to die during the year were in custody for a sex offence (12 cases), followed by robbery (11 cases) and homicide (10 cases); the majority of these being prison deaths. Overall, the five most serious categories of offences, namely homicide, assault, sex offences, robbery and other offences against the person, accounted for 43 (or more than 53 per cent) of the 80 cases.
- In one-third of the deaths in police custody, however, the last and most serious offence committed was either the theft of a motor vehicle, drink driving or another traffic offence.
- During 1996, 12 (or 23 per cent) of the people who died in prison were being held on remand. This proportion is high when compared with the prison population as a whole where, as at 1 September 1996, 13.5 per cent of the prison population was held on remand.

Trends

- The number of deaths during the year (80) is lower than that reported for each of the previous three years (85 in 1995, and 81 in both 1994 and 1993).
- The number of Aboriginal and Torres Strait Islander deaths (17) is lower than the previous year (21), but higher than all previous years since 1990.
- The total number of deaths of Aboriginal and Torres Strait Islander

people in all forms of police custody (institutional settings (e.g. lockups) or in close contact custody, as well as in custody-related police operations (e.g. pursuits) has remained relatively stable for the period 1990 to 1996. A closer look also highlights the relatively low level of deaths in police institutional settings during the 1990 to 1996 period. This is in sharp contrast to the high numbers of deaths in lockups observed during the 1980 to 1989 period. There was one Aboriginal death in a police lockup during 1996 compared to 15 such deaths in 1987. It should be noted here that deaths in close contact custody (other than in lockups) have also decreased noticeably, reflecting the decrease over the last two years in the number of people shot and killed by police officers.

- A closer examination of the data also highlights that considerably greater numbers are dying in community settings, for example when police are in the process of detaining, or attempting to detain someone suffering from self-inflicted gunshot wounds in a siege situation or is suffering from injuries sustained in a motor vehicle crash. In the year under review, 11 people died in police pursuits; one shot himself during the course of the pursuit. This is by far the highest number of such deaths recorded over the six-year period for which data are available; more than twice that number recorded in 1990 and nearly four times that recorded in 1994.
- There has been a reduction in both Aboriginal and non-Aboriginal deaths in Australian prisons over the last 12 months, from 58 to 52 deaths. However, during 1995 the number of deaths in Australian prisons rose to the highest number recorded since 1980. The 17 Aboriginal deaths during that year was also the highest number ever recorded. There is therefore still a high level of prison custody deaths.

Over-representation

- Aboriginal people are heavily over-represented in all forms of custody and this has not dropped during the nine years since the Royal Commission was established, nor since the Royal Commission's final *National Report* was tabled in Federal Parliament on 9 May 1991. This suggests that many of the 339 recommendations emanating from the Royal Commission which were aimed at minimising the numbers of Aboriginal and Torres Strait Islander people being placed into police custody, prisons and juvenile detention centres, are not working.
- During 1996, Aboriginal people were 19 times more likely to die in custody than non-Aboriginal people. While they comprise only 1.4 per cent of the national adult population, they accounted for 21 per cent of all deaths in custody. The risk of dying for those in prison custody was 22 times greater than for non-Aboriginal people and 17 times that of non-Aboriginal people in police lockups.
- When measuring deaths in prison against the total prison population, the risk of death for Aboriginal people is 1.3 that for non-Aboriginal people. This difference in relative risk is related to the fact that Aboriginal and Torres Strait Islander people continue to be over-represented in the prison population —a level of over-representation that has been gradually increasing since 1988.

  Addressing this is a policy issue of the highest order.

Adam Graycar
Director

1

Deaths in all Custodial Settings

Introduction

This report presents information on deaths which occurred in police, prison and juvenile justice custody throughout Australia during the twelve months to 31 December 1996, as well as summary data which covers the period since 1980. The report aims to provide policy makers, the managers of custodial facilities and the public with information which will enable them to remain aware of trends in custodial deaths, both nationally and at the State and Territory level. In doing so, the Australian Institute of Criminology (AIC) is implementing Recommendation 41 of the Royal Commission into Aboriginal Deaths in Custody which addressed the need for the monitoring, on an ongoing basis, of Australian deaths in custody. This report is the latest in a series of Australian Institute of Criminology publications on the topic.

This report covers the incidence of 1996 deaths in all custodial settings combined, and then discusses deaths in police custody and custody-related police operations separately, followed by prison deaths. The report concludes with a discussion of trends in custodial deaths.

The second part of the report provides excerpts from the most recently completed coroners' inquests into deaths in custody. It documents all of the 1994 and 1995 cases for which the Australian Institute of Criminology has received Coroners' Findings since publication of the 1995 calendar year report (Dalton, Brown & McDonald 1996). In addition to outlining details about the date, place and circumstances of each death, and when, where and by whom the inquests were conducted, some of the coroners' comments, findings and recommendations, are presented.

Methodology

As recommended by the Royal Commission into Aboriginal Deaths in Custody [Rec 41] the Australian Institute of Criminology:

a) maintains a statistical data base relating to deaths in custody of Aboriginal and non-Aboriginal persons (distinguishing Aboriginal people from Torres Strait Islanders);
b) reports annually to the Commonwealth Parliament; and
c) negotiates with all custodial agencies with a view to formulating a nationally agreed standard form of statistical input and a standard definition of deaths in custody (*see* Royal Commission into Aboriginal Deaths in Custody 1991, pp. 189-90).

Since 1992, the Australian Institute of Criminology has prepared and disseminated regular reports covering deaths that have occurred in both calendar and financial years. Although the present report covers the 1996 calendar year, detailed information on the 1995-96 financial years period can be found in two recent reports prepared by the Australian Institute of Criminology (Australia, ATSIC 1997; Dalton 1996).

The data presented in the AIC's reports since the Program's inception updates Royal Commission data covering

the period 1980 to the end of 1989. Briefly, the methodology used in this project involved each of Australia's eight police services, corrections authorities and juvenile justice or juvenile welfare authorities being asked to provide information, in a standard format, on all deaths in custody which occurred within their area of responsibility during the year to 31 December 1996. This information included details on the personal characteristics of those who died, their custodial and legal status, and the cause and manner of their deaths. To enable comparisons to be made, it was necessary that the information collected be compatible with that collected by the Royal Commission from 1980 to the end of 1989.

Information on deaths was also obtained from other sources, including media reports and community organisations; these were checked against the custodial authorities' lists. In addition, each State Coroner or equivalent was asked to review custodial authorities' lists and check them for completeness. Once the findings of coronial inquests are received those reports are used to confirm and supplement information received from the custodial authorities.

What is a death in custody?

Consistency in definitions and counting rules is especially important in this type of project which aims to provide information on trends. The AIC's deaths in custody monitoring program has adopted the definition of a "death in custody" which was recommended for this purpose by the Royal Commission into Aboriginal Deaths in Custody and which has been agreed to by all governments. In Recommendations 6 and 41 the Royal Commission expressed the view that the definition of a death in custody:

... should include at least the following categories:

(i) the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

(ii) the death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;

(iii) the death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and

(iv) *the death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention* (Royal Commission into Aboriginal Deaths in Custody 1991, p. 190).

McDonald & Howlett (1993) discussed the complexities involved in defining a custodial death for the purposes of this monitoring program and post-death investigations. In summary, it was pointed out that the definition quoted above is broader than that used in the past by some custodial authorities. Prior to 1990, some custodial authorities (particularly the police services) took the view that a "death in custody" was limited to a death which occurred in a lockup, prison, juvenile detention centre, etc., or in a hospital after an inmate was transferred there directly from such a facility. Deaths which occurred in other forms of police custody (for example in a community setting), and deaths occurring while police or prison authorities were attempting to detain a person (for example in a pursuit), were often not categorised and dealt with as custodial deaths.

As mentioned above at (c), one of the main responsibilities of the Program has been to "negotiate with all custodial agencies with a view to formulating a nationally agreed standard form of statistical input and a standard definition of deaths in custody". The recommended definition is applied systematically to determine whether or not to treat a particular death as a "death in custody" for the purposes of national monitoring. While there were no cases during the current year where disputes arose about whether or not a death was a "death in custody", there were a number of

additional deaths which came to our attention that might fall within the definition of a death in custody but which have been excluded from the data set pending the outcomes of coronial inquests. These type of "borderline-type cases" may include persons who died following a police pursuit, those who died from self-inflicted gunshot wounds or other instances where the exact details of the circumstances and events surrounding the death are not made clear until the inquest has been completed.

The Incidence of Deaths in Custody

Eighty people are reported to have died in all forms of custody in Australia between 1 January and 31 December 1996. Table 1 and Figure 1 provide details on the number of custodial deaths by State/Territory and Aboriginality for the 1996 calendar year.

- Fifty-two deaths (65 per cent) occurred in **prison** custody while 27 deaths (34 per cent) occurred in **police** custody or in custody-related police operations; and one juvenile died while in the custody of **juvenile** justice authorities.
- The 17 Aboriginal and Torres Strait Islander deaths represent just over 21 per cent of all custodial deaths during this period whereas Aboriginal and Torres Strait Islander people comprise less than 2 per cent of the Australian population.
- Twelve of the 17 Aboriginal & Torres Strait Islander deaths (70 per cent) occurred in **prison** custody and five (30 per cent) in **police** custody. This is similar when compared with 22 of the 63 non-Aboriginal deaths (35 per cent) occurring in police custody and 40 (63 per cent) occurring in prison custody. Twelve (or 23 per cent) of the 52 prison deaths were of Aboriginal and Torres Strait Islander people.
- Thirty-two (40 per cent) of the total number of deaths occurred in New South Wales, followed by Queensland with 15 deaths (19 per cent). The two Torres Strait Islander deaths both occurred in prison custody in Queensland.

Table 1: *Australian Deaths in Custody 1996*
Jurisdiction, Aboriginality and Custodial Authority

	Police			Prison				Juvenile			Total			Grand
State	Ab'l	Other	Total	Ab'l	TSI	Other	Total	Ab'l	Other	Total	Ab'l	TSI	Other	Total
NSW	-	12	12	3		17	20				3		29	**32**
Vic.	-	1	1	-		7	7				-		8	**8**
Qld	1	3	4	3	2	6	11				4	2	9	**15**
WA	2	3	5	2		4	6				4		7	**11**
SA	-	1	1	1		4	5				1		5	**6**
Tas.	-	1	1	-		1	1				-		2	**2**
NT	2	1	3	1		-	1				3		1	**4**
ACT	-	-	-	-		1	1		1	1	-		2	**2**
Aust.	**5**	**22**	**27**	**10**	**2**	**40**	**52**		**1**	**1**	**15**	**2**	**63**	**80**

Figure 1: *Australian Deaths in Custody 1996*
Jurisdiction and Aboriginality

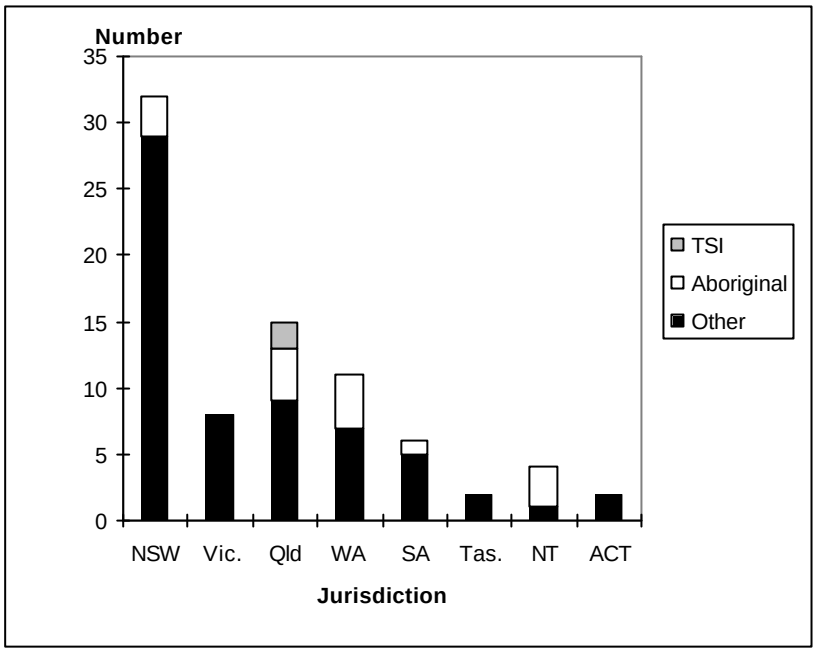
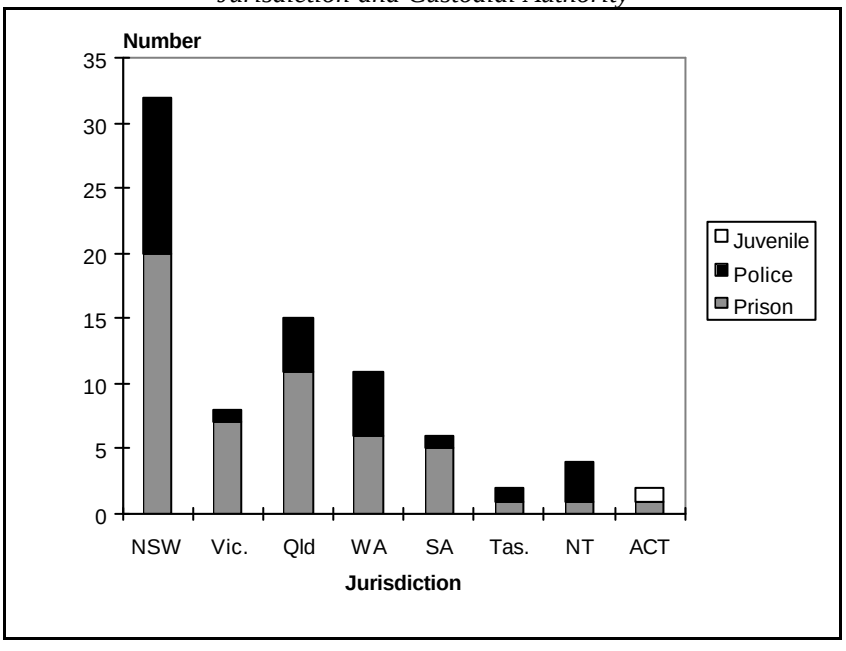


Figure 2: *Australian Deaths in Custody 1996*
Jurisdiction and Custodial Authority



The Circumstances of Deaths in Custody

As already noted, the definition of a "death in custody" as established by the Royal Commission into Aboriginal Deaths in Custody is quite broad. The 80 deaths which occurred during 1996 are summarised in Table 2 using the following three categories:

- deaths in **institutions** (prisons, police lockups and juvenile detention centres), or during transfer to or from an institution (for example in a police vehicle), or in hospital following transfer from an institution; and
- deaths which occurred while police or prison officers were in the process of **detaining** or attempting to detain the person; and
- deaths which occurred during the process of the person escaping or attempting to escape from police or prison custody or juvenile detention.

A fourth category recommended by the Royal Commission, deaths which occur while police were in the process of **escorting** those detained under State or Territory mental health legislation to a psychiatric institution, is not relevant here as no such deaths were reported during the year.

- Sixty-one deaths (or more than 76 per cent) occurred in institutional settings. Of the nine deaths in **police** custody that took place in an institutional setting, one was of an Aboriginal person. While this number is significantly lower than the numbers of deaths that occurred in institutional settings during the period of the Royal Commission, it has more than doubled from the previous year when four deaths in police custody occurred in institutional settings.
- It is notable that most of the deaths in **police** custody occurred whilst police were in the process of detaining, or attempting to detain, the individuals concerned. They accounted for 18 (or two-thirds) of the 27 deaths and occurred in circumstances such as sieges (in which the deaths were either self-inflicted or inflicted by police), or motor vehicle pursuits which ended in a fatal crash, etc. More specifically, 11 people died from injuries received in a motor vehicle crash in the course of, or immediately following, a police pursuit. Five deaths resulted from self-inflicted gunshot wounds (one during a police pursuit), one from a self-inflicted stab wound and the remaining two were shot by police.
- The one case classified as "escaping" occurred in Western Australia. The decomposing body of a male prisoner was found in bushland near the prison visitor's car park at Wooroloo Prison Farm. The prisoner had escaped on 29 July and the body was located on 4 September.

One **juvenile** was reported to have died in the custody of the juvenile justice authorities during the year. A brief description is provided below:

Table 2: *Australian Deaths in Custody, 1996*
Circumstances of Death, Aboriginality and Custodial Authority

	Police			Prison			Juvenile			Total		
Circumstances (*)	**Ab'l**	**Non-Ab'l**	**Total**	**Ab'l & TSI**	**Non-Ab'l**	**Total**	**Ab'l**	**Non-Ab'l**	**Total**	**Ab'l & TSI**	**Non-Ab'l**	**Grand Total**
Institution	1	8	9	12	39	51		1	1	13	48	**61**
Detaining	4	14	18							4	14	**18**
Escaping					1	1					1	**1**
Total	**5**	**22**	**27**	**12**	**40**	**52**		**1**	**1**	**17**	**63**	**80**

* See text for definitions

- In the Australian Capital Territory, a young male aged 17 years, died on 21 September at the Canberra Hospital, several days after being transferred there from the Quamby Juvenile Detention Centre. Earlier in the week the youth had been found hanging by a bed sheet in his cell. This occurred the day after he was refused psychiatric treatment by Canberra Hospital. He had a history of previous suicide attempts, including an attempt less than 24 hours before this occasion. He was being held in custody for malicious wounding.

Only one **female** died during the year under review:

- In Queensland, an Aboriginal female aged 31 years died on 23 October 1996 at the Townsville Correctional Centre from natural causes, apparently heart-related. She had been suffering from a heart complaint for some time and was on medication. She was a convicted prisoner, sentenced to a period of seven year's imprisonment for the offences of manslaughter and assault occasioning bodily harm.

In 1996 two **Torres Strait Islander** deaths were recorded; the first time a Torres Strait Islander person has died in custody since 1980. Both of these deaths occurred in prison custody; both in Queensland. A brief description of these two cases is provided below:

- In Queensland, a male aged 30 years died on 28 October 1996 at the Sir David Longland Correctional Centre as a result of self-inflicted hanging. He was a convicted prisoner, sentenced to a period of 16 year's imprisonment for the offence of sexual assault. He had previously attempted to commit suicide. A suicide note was located in his cell.
- In Queensland, a male aged 34 years died on 7 December 1996 at the Townsville General Hospital from natural causes. He had been transferred there from the Townsville Correctional Centre on 27 November after complaining of chest pains, dry coughing and difficulty in breathing. His condition subsequently deteriorated. He was a convicted prisoner, sentenced to life imprisonment for the offence of murder.

Cause and Manner of Death

Information on the cause and manner of death is obtained from custodial authorities and coroners. The cause of death for those who died in custody in Australia during 1996 is summarised in Table 3 and displayed at Figure 3(a) and the manner of death is displayed at Figure 3(b). It should be borne in mind when interpreting the information presented in this report on manner of death that, for drug-related deaths, unless the coroner clearly states that the death was intentional (i.e. suicidal), these deaths are treated as "accidental".

- A more detailed breakdown of the causes and manner of deaths for those who died in custody during 1996 can be found in the separate sections for each custodial authority later in this report . Hanging was the most frequent cause of death, accounting for 25 (or 31 per cent) of all deaths. It can be seen that nearly all of these deaths occurred in **prison** custody. While the three deaths from hanging in **police** custody is an increase over the number for the last two years, this figure needs to be highlighted when compared to the extremely high number of 22 hangings that occurred in police custody in 1987.
- Of the 23 deaths from natural causes (illness), 15 resulted from heart disease, one from cancer, one from respiratory problems, one from digestive problems, one from multiple causes. The type of illness resulting in four deaths is as yet undetermined.

Table 3: *Australian Deaths in Custody, 1996*
Cause of Death, Aboriginality and Custodial Authority

	Police			Prison			Juvenile			Total		
Cause	Ab'l	Non-Ab'l	Total	Ab'l & TSI	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l & TSI	Non-Ab'l	Grand Total
Hanging	1	2	3	6	15	21		1	1	7	18	**25**
Natural causes		2	2	5	16	21				5	18	**23**
Injuries	4	7	11	1	4	5				5	11	**16**
Gunshot		7	7								7	**7**
Drugs		2	2		5	5					7	**7**
Alcohol		1	1								1	**1**
Other		1	1								1	**1**
Total	**5**	**22**	**27**	**12**	**40**	**52**		**1**	**1**	**17**	**63**	**80**

Figure 3(a): *Australian Deaths in Custody 1996*
Reported Cause of Death in Custody by Custodial Authority

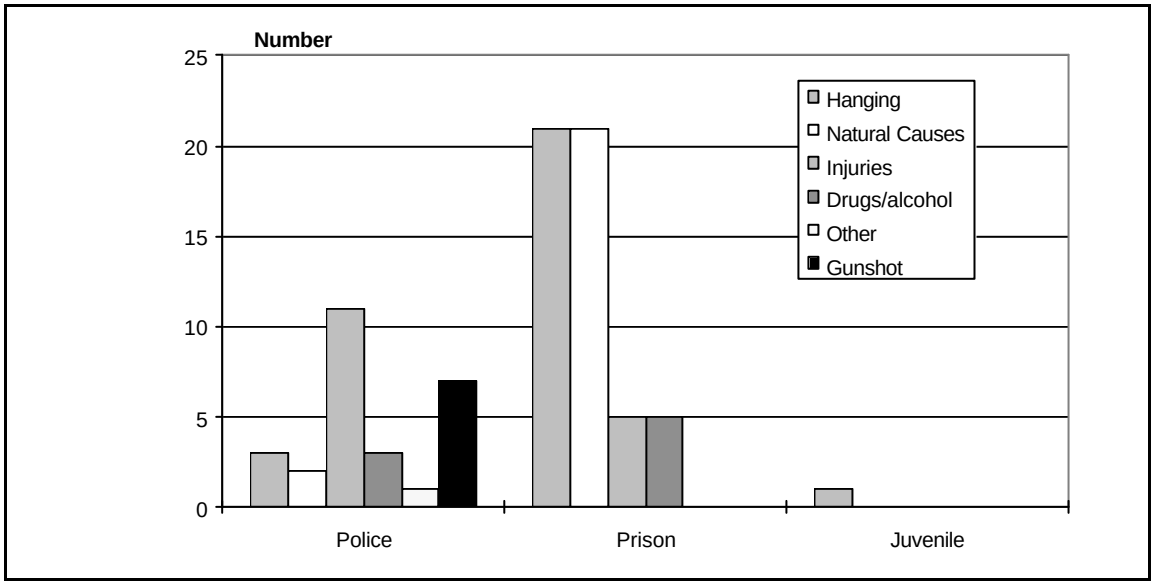
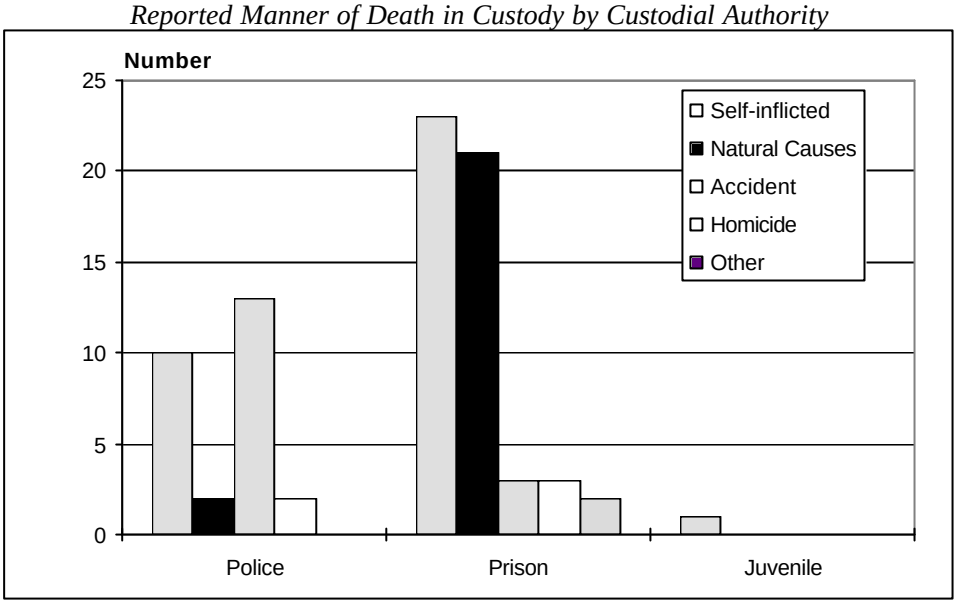


Figure 3(b): *Australian Deaths in Custody 1996*
Reported Manner of Death in Custody by Custodial Authority



- Figure 3(b) above displays the differences in the manner of death for those who died in police and prison custody and juvenile detention. It can be seen that 34 (or 44 per cent) of the 78 deaths for which information on the manner of death is available were self-inflicted; at the time of writing the manner of death is unknown in two cases.
- In 23 cases (or 29 per cent) the cause of death was illness (natural causes). Three people were the victims of homicide in **prisons**; and two justifiable homicides were recorded in **police** custody when both the offenders were shot by police.
- Sixteen deaths (or 21 per cent) were "accidental"; all but three occurred in **police** custody. A large number of these (10) were the result of external injuries received in a motor or motor vehicle crash in the course of, or immediately following, a police pursuit. The remaining six individuals died from either accidental drug or alcohol toxicity.
- One **youth** died from self-inflicted hanging whilst in the custody of juvenile justice authorities.

Offences

This section looks at the circumstances of those who died in custody. This includes details on the offences that led to the final period of custody, the legal status at the time of their death, as well as the reason for bail being denied for those in police custody.

Information is collected on the most serious offence relating to the final period of custody or police operation, regardless of the person's legal status. In some cases, for example police operations deaths, this would be the offence for which the person would most likely have been charged had he or she not died. In other instances the person may be held on remand awaiting a court hearing or may have died before even being liable to be charged (e.g. where held in protective custody for drunkenness in jurisdictions where such behaviour is not an offence). These offences are classified according to the Australian National Classification of Offences.

Table 4: *Australian Deaths in Custody 1996*
Most Serious Offence Leading to Custody, Aboriginality and Custodial Authority

	Police			Prison			Juvenile			Total		
Offence	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Total**	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Grand Total**
Homicide		4	4	2	4	6				2	8	**10**
Assault		3	3	2	2	4		1	1	2	6	**8**
Sex offences		1	1	4	7	11				4	8	**12**
Robbery					11	11					11	**11**
Other offences against person		1	1		1	1					2	**2**
Break, enter & steal	1	2	3	2	3	5				3	5	**8**
Fraud					3	3					3	**3**
Motor vehicle theft	3	3	6							3	3	**6**
Other theft					1	1					1	**1**
Property damage				2	1	3				2	1	**3**
Justice procedures												
Drunkenness		2	2								2	**2**
Other against good order		2	2		1	1					3	**3**
Possess and/or use drugs												
Deal/traffic drugs		1	1		1	1					2	**2**
Other drug offences					3	3					3	**3**
Drink driving		1	1		1	1					2	**2**
Other traffic offences		2	2		1	1					3	**3**
Other offences												
Mental Health legis.												
Protective custody intoxication*	1		1							1		**1**
Total	**5**	**22**	**27**	**12**	**40**	**52**		**1**	**1**	**17**	**63**	**80**

* Refers to a person taken into protective custody for drunkenness where drunkenness is not an offence.

Table 4 shows that the highest number of custodial deaths occurred among people whose most serious offence was a sex offence (12 cases). Robbery accounted for 11 cases and homicide for 10 cases. The majority of these occurred in prison custody.

Overall, the five most serious categories of offences, namely homicide, assault, sex offences, robbery and other offences against the person, accounted for 43 (or more than 53 per cent) of the 80 cases.

For those who died in police custody during 1996, the table clearly shows the large number whose last and most serious offence was the theft of a motor vehicle, reflecting again the high number who died during or following a police pursuit. The number of such deaths during the current year (6) is the highest figure recorded for the period for which data are available (i.e. since 1990) for deaths occurring in all forms of police custody, including police operations. If the two deaths from traffic offences and the one death from drink driving are included, then this total of nine deaths accounts for one-third of the total 27 police custody deaths during 1996.

It should also be pointed out, and can be seen in Table 5, that more than 20 per cent (n = 42) of the 203 deaths that have occurred in **police** custody during the period 1990-96 were deaths of people whose most serious offence was either motor vehicle theft (n = 23), drink driving (n = 5) or another traffic offence (e.g. failure to wear a helmet, etc.) (n = 14). In all but eight of these 42 cases, the person

Table 5: *Australian Deaths in Custody 1990-1996*
Most Serious Offence Leading to Custody, Aboriginality and Custodial Authority

	Police			Prison			Juvenile			Total		
Offence	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Total**	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Grand Total**
Homicide	1	18	19	7	46	53				8	64	**72**
Assault	5	23	28	15	26	41		1	1	20	50	**70**
Sex offences		6	6	12	43	55				12	49	**61**
Robbery		10	10	3	36	39		1	1	3	47	**50**
Other offences against person		11	11		2	2					13	**13**
Break, enter & steal	1	12	13	12	29	41		1	1	13	42	**55**
Fraud		4	4	1	9	10				1	13	**14**
Motor vehicle theft	12	11	23	2	8	10		2	2	14	21	**35**
Other theft	1	5	6		11	11				1	16	**17**
Property damage		3	3	4	5	9				4	8	**12**
Justice procedures	2	4	6	3	10	13				5	14	**19**
Drunkenness	4	23	27							4	23	**27**
Other against good order	1	7	8		4	4				1	11	**12**
Possess and/or use drugs		1	1	1	4	5		1	1	1	6	**7**
Deal/traffic drugs		2	2		13	13					15	**15**
Other drug offences	1		1		4	4				1	4	**5**
Drink driving		5	5		2	2					7	**7**
Other traffic offences	1	13	14	1	4	5				2	17	**19**
Other offences	1	2	3	1	2	3				2	4	**6**
Mental Health legis.		5	5								5	**5**
Protective custody intoxication*	2	6	8							2	6	**8**
Total	**32**	**171**	**203**	**62**	**258**	**320**		**6**	**6**	**94**	**435**	**529**

* Refers to a person taken into protective custody for drunkenness where drunkenness is not an offence.

Table 6: *Australian Deaths in Custody 1996*
Legal Status, Aboriginality and Custodial Authority

	Police			Prison			Juvenile			Total		
Legal status	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Total**	**Ab'l**	**Other**	**Total**	**Ab'l & TSI**	**Other**	**Grand Total**
Sentenced [(a)]				9	31	40				9	31	**40**
Remand [(b)]		4	4	3	9	12				3	13	**16**
Protective custody [(c)]	1		1							1		**1**
Questioning		4	4								4	**4**
Child Welfare Legislation								1	1		1	**1**
Other	4	14	18							4	14	**18**
Total	**5**	**22**	**27**	**12**	**40**	**52**		**1**	**1**	**17**	**63**	**80**

(a) Includes "under sentence: no appeal current" and "under sentence: awaiting determination of any appeal (verdict or sentence)".
(b) "Unconvicted: awaiting court hearing/trial extradition" and "convicted, awaiting sentence".
(c) Protective custody for drunkenness where not an offence.

concerned died during the course of, or following, a police pursuit. Almost 31 per cent (n = 13) were Aboriginal people.

Between 1990 and 1996, 35 people have died in police custody after being arrested for the offence of drunkenness or after being taken into protective custody for intoxication. This number has remained at a relatively low number over the last four years, with 3 deaths in 1996 compared to 12 such deaths during 1990. It is, however, interesting to note that out of the 35 people in this category who have died in police custody during this six-year period that only eight died after being taken into protective custody for intoxication. The remaining 27 deaths where people were arrested for being drunk occurred in Victoria (12), Queensland (13) and Tasmania (2) where drunkenness is still an offence. Six of the 35 deaths here were of Aboriginal people.

Between 1990 and 1996, 32 Aboriginal people died in police custody. As mentioned above 13 died because they were being pursued by police after having stolen a motor vehicle or committed another traffic offence; six died after being arrested for drunkenness or while in protective custody for public intoxication; and five died after assaulting or attempting to assault either police officers or other individuals. In the remaining cases, the offences varied including attempted murder, obscene language and fine default, cultivate prohibited drug, trespassing and resisting arrest, behaviour offences only, unlawful entry and stealing.

For those who died in prison custody during 1996, 11 were incarcerated for a sex offence, 11 for a robbery offence and six for a homicide offence. More than 17 per cent (55) of the 320 deaths that have occurred in prison custody during the period 1990-96 were imprisoned for sex offences, just under 17 per cent (53) for homicide offences, 13 per cent for break and enter offences (41), and 13 per cent (41) for assault offences.

Nineteen per cent (62) of the 320 prison deaths that occurred during the period 1990-96 were of Aboriginal or Torres Strait Islander people. The largest number (15) were imprisoned for the assault offences; 12 each for sex offences and break and enter offences; seven for homicide offences; four for property damage; three each for robbery and justice procedures; two for motor vehicle theft; and one each for fraud, possess and/or use drugs, other traffic offences and one other offences.

Legal Status & Bail

Table 6 shows the legal status of the people who died in custody during 1996. It can be seen that a substantial number (40) or 50 per cent of the deaths were of people who had been sentenced to a period of imprisonment at the time of their death. Another 16 were on remand at the time of death; all but one of these were unconvicted, being held in custody awaiting trial. In the other case, the person had been convicted and was awaiting sentencing.

It is interesting to note the manner of death for sentenced prisoners compared to those prisoners on remand. Eleven of the 12 remandee deaths were self-inflicted, compared to 12 of the 40 sentenced deaths; the manner of death for the remaining remandee is currently unavailable. Twenty-one of the 40 sentenced prisoners died from natural causes; 12 were self-inflicted deaths; two resulted from unlawful homicide and two from accidents; one is unknown.

Australian and overseas research has demonstrated an over-representation of custodial deaths among remandees compared with sentenced prisoners (Biles & McDonald 1992; Liebling 1992). During 1996, 12 (or 23 per cent) of the people who died in prison were held on remand. This proportion is high when compared with the prison population as a whole where, as at 1 September 1996 (the latest period for which figures are available), 13.5 per cent of the prison population was held on remand (ABS 1997). This produces a relative risk (an odds ratio) of 1.92 which means that the

proportion of deaths among this group of prisoners is nearly twice what one would expect from their proportion in the prison population.

Of the 27 deaths in police custody or police operations during 1996, there were only five cases where it would have been possible for police officers to have released the person on bail. Bail was not applicable in the other cases. They cover a variety of circumstances, such as people in custody where no offence was involved (e.g. protective custody), or where the person died prior to being charged with an offence (e.g. in transit to a police station or during the process of being detained). In two of the five cases where bail was an option, the detainees were reported by police to have been too intoxicated to be released. These two deaths occurred in Queensland and Tasmania where public drunkenness remains an offence. Police did not have the power to release the remaining three detainees who had been remanded in custody, one pending extradition to another State.

Death Rates

The rates of custodial deaths may be measured in two different ways: in terms of the ratio of the number of deaths to the number of people in the community; or, as the ratio of the number of deaths to the number of people in custody. Using the first of these approaches, it is observed that the 1996 crude death rate for police and prison custody and juvenile detention combined was 0.44 per 100 000 of the total Australian population. This means that for every 228 614 people in Australia, one person died in custody during 1996. When we consider only the population aged 15 years and above, to enhance comparability with the age structure of the custodial population, the death rate was 0.55 per 100 000.

Population data estimated by the Australian Bureau of Statistics enable comparisons to be made between the rates of custodial deaths of Aboriginal and non-Aboriginal people. Details are presented in Table 7. Although 21 per cent of the deaths were among Aboriginal people, the fact that they comprise only 1.4 per cent of the adult population (15 years and above) means that their adult crude death rate was more than 19 times that of non-Aboriginal people.[1]

In relation to the first type of measure, using figures for the different forms of custody, for the 1996 period the adult (15 years and above) crude death rate for prison custody was .36 per 100 000 of the Australian population. The adult crude prison death rate for Aboriginal people was 6.15 per 100 000 of the Australian Aboriginal population, whereas the prison death rate for non-Aboriginal people was .28 per 100 000 of the non-Aboriginal Australian population. Therefore, during the period covered by this report, the risk of death occurring in prison experienced by all Aboriginal and Torres Strait Islander people during this time was almost 22 times that experienced by non-Aboriginal people.

Turning now to police custody death rates, a similar pattern is observed. The adult crude death rate for all types of police custody (including police operations in community settings) for 1996 was .19 per 100 000 of the Australian population. The adult crude police custody death rate for Aboriginal people was 2.56 per 100 000 of the adult national Aboriginal population, whereas the corresponding death rate for non-Aboriginal people was .15 per 100 000 of the Australian population. This means that the risk of death in all forms of police custody for adult Aboriginal people during this time was over 17

1 The measures used in this section are rate ratios and odds ratios. The rate ratios are the ratio of the two rates. When actual rates are not available, the odds ratio is sometimes used. This estimate of relative risk is the ratio of two odds, for example, the odds of the death being of an Aboriginal person (21 divided by 79) divided by the odds of a person in the community being Aboriginal (1.4 divided by 98.6).

Table 7*: Australian Deaths in Custody 1996*
Police and Prison Custody and Juvenile Detention Death Rates
Denominators: Aboriginal, Non-Aboriginal and Total 15 yrs+ Populations Respectively

Aboriginality	Population 1996[a]	Persons 15 yrs+[a]	Deaths in custody 1996	Deaths per 100 000 population 15 years+
Aboriginal[b]	319 213	195 099	17	8.71
Non-Aboriginal[c]	17 969 929	14 211 986	63	0.44
Total	**18 289 142**	**14 407 085**	**80**	**0.55**

(a) Source: Population estimates provided by the Australian Bureau of Statistics.
(b) Includes Torres Strait Islanders.
(c) Includes "not stated".

Table 8: *Australian Deaths in Custody 1996*
Prison Custody Death Rates
Denominators: Aboriginal, Non-Aboriginal and Total 15 yrs+ Populations Respectively

Aboriginality	Population 1996[a]	Persons 15 yrs+[a]	Deaths in custody 1996	Deaths per 100 000 population 15 years+
Aboriginal[b]	319 213	195 099	12	6.15
Non-Aboriginal[c]	17 969 929	14 211 986	40	.28
Total	**18 289 142**	**14 407 085**	**52**	**.36**

(a) Source: Population estimates provided by the Australian Bureau of Statistics.
(b) Includes Torres Strait Islanders.
(c) Includes "not stated".

Table 9: *Australian Deaths in Custody 1996*
Police Custody Death Rates
Denominators: Aboriginal, Non-Aboriginal and Total 15 yrs+ Populations Respectively

Aboriginality	Population 1996[a]	Persons 15 yrs+[a]	Deaths in custody 1996	Deaths per 100 000 population 15 years+
Aboriginal[b]	319 213	195 099	5	2.56
Non-Aboriginal[c]	17 969 929	14 211 986	22	.15
Total	**18 289 142**	**14 407 085**	**27**	**.19**

(a) Source: Population estimates provided by the Australian Bureau of Statistics.
(b) Includes Torres Strait Islanders.
(c) Includes "not stated".

times that experienced by non-Aboriginal people.

As mentioned above, the other approach for displaying the rates of deaths in custody is in terms of the number of deaths compared to the number of people in custody. Using this method, the crude death rate for prison custody during 1996 was 3.16 per 1 000 of the prison population (Table 10). The crude death rate for Aboriginal prisoners was 3.89 per 1 000 prisoners whereas the death rate for non-Aboriginal prisoners was 3.00 per 1 000 of the prison population. Therefore the relative risk of death in prison custody for Aboriginal prisoners (compared with non-Aboriginal prisoners) was 1.3 (that is 3.89 divided by 3). This means that the risk of death for Aboriginal prisoners was approximately 1.3 times that of non-Aboriginal prisoners when their death rates are expressed in this manner.

It should be recalled, however, that this seemingly low relative risk of Aboriginal deaths in the prison setting is in contrast to the corresponding relative risk of 22 times where the numbers of Aboriginal and non-Aboriginal prison deaths are compared with the relative sizes of the Aboriginal and non-Aboriginal populations in the community at large. The difference between these two estimates of relative risk is explained by the continuing over-representation of Aboriginal people in the prison population, as detailed elsewhere in this report.

Data from the August 1995 National Police Custody Survey have been used to develop estimates of the police population. The Survey found that there were 22 060 occasions during the month of August 1995 which corresponded to 18 781 distinct persons in custody. Of these, 5 514 were Aboriginal people and 13 267 non-Aboriginal people. On average, each person spent 19.1 hours in police custody; for Aboriginal people the average time was 26.4 hours, while for non-Aboriginal people it was 16.5 hours. This resulted in a total of 199 person/years of exposure in a twelve-month period for Aboriginal people, compared to 300 person/years of exposure for non-Aboriginal people. Therefore, the crude death rate for *police custody* deaths during 1996 was 16.03 per 1 000 of the police custody population.[2] The crude death rate for Aboriginal people during this time was 5.0 per 1 000 of the police custody population and for non-Aboriginal people it was 23.3. This means that during the year the relative risk of death in police custody experienced by Aboriginal people compared with that of non-Aboriginal people, was .21. In other words, the non-Aboriginal death rate was close to five times that of Aboriginal people. (This calculation is based on one Aboriginal death and seven non-Aboriginal deaths either in police lockups or in hospital following transfer from a lockup.)

The broad similarity in the rates of death of Aboriginal and non-Aboriginal people in police lockups during 1996 does not mean that the disproportionate over-representation of the number of Aboriginal people dying in police custody (compared with the number of non-Aboriginal people) has disappeared. Indeed, as noted above, the fact that there were five deaths of Aboriginal people during the year in all forms of police custody means that the risk of death experienced by Aboriginal people in police custody was at a rate more than 17 times that of the non-Aboriginal population. (This conclusion is based on a comparison of the numbers of Aboriginal and non-Aboriginal police custody deaths, respectively, with the relative sizes of the Aboriginal and non-Aboriginal populations in the community at large.)

2 These rates are calculated using only deaths in police lockups or in hospital following transfer from a lockup as the numerators and person x days in custody, annualised, as the denominators. It does not include deaths in other institutional circumstances (e.g. police vans) as well as deaths in non-institutional forms of police custody (e.g. raids) or in other police operations (e.g. pursuits).

Table 10: *Australian Deaths in Custody 1996*
Prison Custody Death Rates
Denominators: Aboriginal, Non-Aboriginal and Total Prison Populations Respectively

Aboriginality	Prison population[(a)]	Deaths in prison custody 1996	Deaths per 1 000 prison population
Aboriginal[(b)]	3 083	12	3.89
Non-Aboriginal[(c)]	13 346	40	3.00
Total	**16 429**	**52**	**3.16**

(a) The prison population used as the denominator of these rates is the average of the total prisoner population count taken on the first day of each month for the period October 1995 to September 1996. Source: National Correctional Statistics: Prisons, September Quarter 1996, ABS, Canerra.
(b) Includes Torres Strait Islanders.
(c) Includes "not stated".

Table 11: *Australian Deaths in Custody 1996*
Police Custody Lockup Death Rates
Denominators: Aboriginal, Non-Aboriginal and Total Police Lockup Populations Respectively

Aboriginality	Police lockup population[(a)]	Deaths in police police lockup 1996	Deaths per 1 000 police lockup population
Aboriginal[(b)]	199	1	5.0
Non-Aboriginal[(c)]	300	7	23.3
Total	**499**	**8**	**16.03**

(a) Estimate of person/years of custody in a twelve-month period.
Source: National Police Custody Survey 1995 (forthcoming), Australian Institute of Criminology.
(b) Includes Torres Strait Islanders.
(c) Includes "not stated".

2

Police Custody and Custody-related Deaths

Table 12 provides numbers of persons who died in all forms of police custody during the 1996 calendar year. As agreed by the Australasian Police Ministers' Council, the following definitions describe the two categories for a death in police custody:

Category 1: (a) deaths in institutional settings (e.g. police stations/ lockups, police vehicles, etc.; or during transfer to or from such an institution; or in hospitals, etc. following transfer from an institution); and (b) other deaths in police operations where officers were in close contact with the deceased. This would include most raids and shootings by police. It would not include most sieges where a perimeter was established around a premises but officers did not have such close contact with the person as to be able to significantly influence or control the person's behaviour.

Category 2: Other deaths during custody-related police operations. This would cover situations where officers did not have such close contact with the person as to be able to significantly influence or control the person's behaviour. It would include most sieges as described above and most cases where officers were attempting to detain the person, e.g. pursuits.

Table 12 shows that 11 of the 27 people died in either an institutional setting or in close contact custody. The remaining 16 people died during other custody-related police operations. A breakdown of these deaths follows.

Category 1: Deaths in institutions and other forms of close custody

- Nine of the 11 deaths occurred in an institutional setting (Table 12). Five of these occurred in police lockups, two from hanging, one from alcohol toxicity, one from a drug overdose and one after the person choked on vomit. Three of the remaining four deaths occurred in hospital following transfer from a police lockup; one from a drug overdose, one from multiple natural causes and one from hanging. In the remaining case the person died from a heart attack in the rear of a police van.
- The remaining 2 deaths that occurred in this category were deaths in *non-institutional settings*, where police were able to exert a substantial degree of influence over the behaviour of the person who died. In both cases the death was a result of gunshot wounds inflicted by police while they were in the process of detaining, or attempting to detain, the individuals concerned.
- One of the 11 deaths was of an Aboriginal male who died after hanging himself in a police cell in the Northern Territory.

Category 2: Deaths in Other Custody-related Police Operations

- Sixteen deaths occurred in situations where police were involved but had little capacity to significantly influence or control the person's behaviour. In all cases police were in the process of detaining, or attempting to detain, the individuals who died (Table 12).
- Ten of the 16 deaths resulted from external injuries received in a motor vehicle crash in the course of, or immediately following, a police pursuit. All of the ten who died were young, ranging from 13 to 27 years of age.
- The four young Aboriginal males who died were all being pursued by police; they were aged 13, 13, 14 and 17 years.
- The remaining six deaths were all self-inflicted, five by gunshot wounds to the body (one during the course of a police pursuit), and one from a stab wound to the heart.

The people who died in police custody were mostly young, ranging from 13 to 62 years, with a mean age of 32 years. The median age (the point above and below which half of the cases fell) was 26 years. For Aboriginal people, the mean age was 20 years, compared to a mean of 35 years for non-Aboriginal people and a median of 31 years. The ages of the five Aboriginal people who died in police custody were 13, 13, 14, 17 and 42 years.

Table 12: *Australian Deaths in Custody 1996*
Police Custody and in Custody-related Police Operations
Jurisdiction and Aboriginality

	Category 1 - Institutional or Close Contact Custody			Category 2 - Other Custody-related Police Operations			Total		Grand
Jurisdiction	**Ab'l**	**Other**	**Total**	**Ab'l**	**Other**	**Total**	**Ab'l**	**Other**	**Total**
NSW		4	4		8	8			**12**
Vic.		1	1						**1**
Qld		2	2	1	1	2			**4**
WA		1	1	2	2	4			**5**
SA					1	1			**1**
Tas.		1	1						**1**
NT	1	1	2	1		1			**3**
ACT									
Aust.	**1**	**10**	**11**	**4**	**12**	**16**	**5**	**22**	**27**

3

Prison Custody Deaths

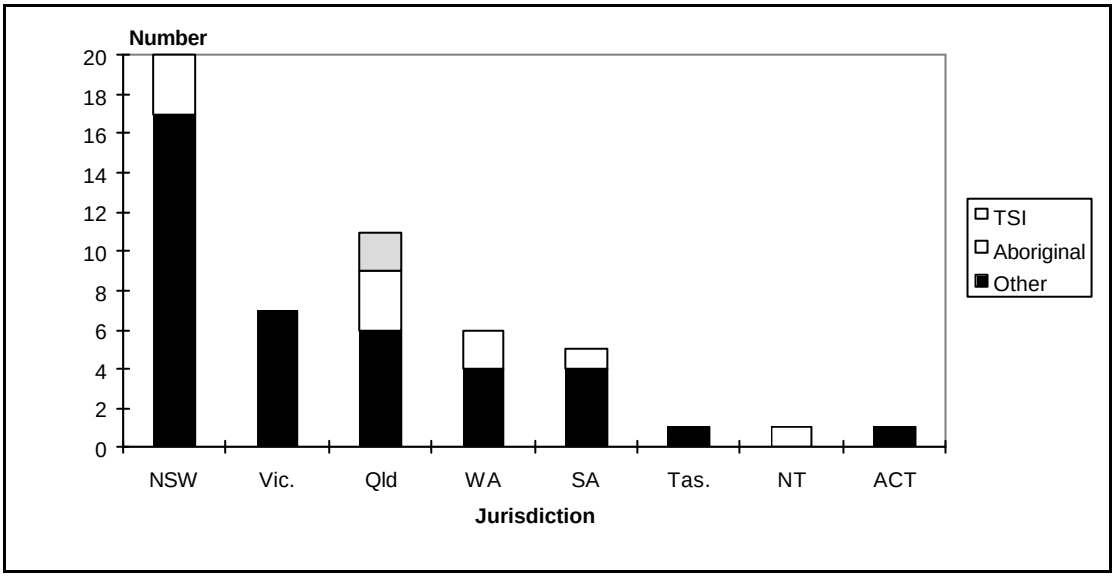
Table 13 and Figure 4 provide information on the number of persons who died in prison custody during the 1996 calendar year.

- More than one-third (20) of the deaths in prison custody occurred in New South Wales; three of those were Aboriginal.
- As stated earlier, two Torres Strait Islander people died in prison custody during 1996; the first two such deaths to occur. Both of these deaths occurred in Queensland. The only female to die in prison custody during the year also died in Queensland.
- As can be seen from Table 3, equal numbers of prisoners died from hanging (21 deaths) and from illness (21 deaths), while five were the result of injuries and five drug-related. Three of the five deaths from injuries were homicides, the result of the deceased either being bashed or stabbed and in another case it is not known if the deceased's cut throat was also the result of a homicide or whether it was self-inflicted. In the remaining case where the deceased died after setting himself alight with petrol, it is not known whether his intention was suicidal or accidental.
- In the five drug-related deaths, all were self-inflicted, three the result of accidental drug overdoses, one intentional (i.e. suicide) and the intention is unknown in one case.
- Fourteen of the 21 deaths from natural causes (illness) were from heart disease. Cancer, respiratory problems and digestive problems accounted for another three deaths. In the four remaining deaths, the type of illness is as yet undetermined.
- Five of the 12 Aboriginal and Torres Strait Islander deaths resulted from illness. Four of these were from heart disease and one from respiratory problems. All but one of the remaining seven deaths were from hanging. In the remaining case the deceased was stabbed.
- The people who died in prison custody ranged in age from 21 to 75 years, with a mean age of 39 years. The median age (the point above and below which half of the cases fell) was 35 years. For Aboriginal people, both the mean and median age was 31 years, compared to a mean of 41 years for non-Aboriginal people and a median of 38 years.

Table 13:*Deaths in Prison Custody 1996*
Jurisdiction and Aboriginality

Jurisdiction	Aboriginal	TSI	Other	Total
NSW	3		17	20
Vic.			7	7
Qld	3	2	6	11
WA	2		4	6
SA	1		4	5
Tas.			1	1
NT	1			1
ACT			1	1
Aust.	**10**	**2**	**40**	**52**

Figure 4*: Australian Deaths in Prison Custody, 1996*
Jurisdiction and Aboriginality



4

Trends 1980 to 1996

This section presents information on trends in custodial deaths during the period 1 January 1980 to 31 December 1996. The figures for the period 1980 to the end of 1989 are based on data received by the Royal Commission into Aboriginal Deaths in Custody's Criminology Unit from the custodial authorities.[1] It is likely that the definition of a death in custody used over this period varied both between the jurisdictions and over time. For this reason, too much emphasis should not be placed on small variations in numbers. The AIC now applies the new and expanded Royal Commission definition of a custodial death, detailed above, to all cases which have occurred since 1 January 1990.

Table 14 and Figure 5 show the number of deaths in institutional settings only. This includes prison custody deaths and, in the case of police and juvenile justice custody deaths, only deaths in detention facilities (e.g. police lockups and juvenile detention centres) and deaths which occurred while people were being transported to or from such facilities, or in hospitals etc. following transfer from lockups and other detention facilities. They do not include deaths in police operations, such as attempting to detain a person, even though such deaths have fallen within the definition of a "death in custody" with effect from 1990. Omitting these deaths enables direct and accurate temporal comparisons to be made over the full period 1980 to 1996.

- Substantial increases in both Aboriginal and non-Aboriginal deaths in 1987, compared to relatively low numbers during the period 1980-86, was a key factor in precipitating the appointment of the Royal Commission into Aboriginal Deaths in Custody. After this extreme level in 1987 (95 deaths), the number of institutional deaths dropped to 64 in 1988 and continued to drop steadily until 1992 when 47 persons died in institutional settings.
- Since 1992, the number of deaths increased each year, reaching 64 deaths in 1995. During 1996 this figure fell to 61 and this same trend occurred for Aboriginal and Torres Strait Islander people (from 6 deaths in 1992 to 17 deaths in 1995 to 13 deaths in 1996).
- From 1987 until 1995 there was a 93 per cent reduction (from 41 to 4) in the number of institutional deaths in police custody. However, during 1996 this figure has increased for the first time since 1987 (from 4 to 9).
- During the same period, the number of prison deaths fluctuated from 53 in 1987 to 33 in 1990, back up to 58 deaths in 1995. The 1995 figure of 58 deaths was the highest number of deaths recorded during the last 16

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1 While the data set from which these figures were derived contains all the cases reported to the Royal Commission's Criminology Unit, it is possible that it is not a *complete* list of all 1980 to 1989 deaths in custody. As a result, the figures presented here may slightly under-estimate the number of deaths which occurred during that period.

Table 14: *Australian Deaths in Custody 1980-96**
*Year of Death, Custodial Authority and Aboriginality, Institutional Settings Only***

	Police			Prison				Juvenile			Total			Grand
Year	Ab'l	Other	Total	Ab'l	TSI	Other	Total	Ab'l	Other	Total	Ab'l	TSI	Other	Total
1980	5	7	12	5		25	30	1	-	1	11		32	43
1981	3	12	15	1		27	28	1	-	1	5		39	44
1982	4	15	19	4		21	25	-	-	-	8		36	44
1983	6	10	16	5		26	31	-	1	1	11		37	48
1984	3	12	15	4		27	31	-	-	-	7		39	46
1985	6	16	22	4		22	26	-	-	-	10		38	48
1986	8	13	21	1		16	17	-	1	1	9		30	39
1987	15	26	41	5		48	53	-	1	1	20		75	95
1988	7	14	21	6		36	42	1	-	1	14		50	64
1989	10	11	21	4		36	40	-	1	1	14		48	62
1990	1	17	18	5		28	33		1	1	6		46	52
1991	3	14	17	8		31	39				11		45	56
1992	4	9	13	2		32	34				6		41	47
1993	2	7	9	7		42	49		1	1	9		50	59
1994	1	6	7	11		42	53		1	1	12		49	61
1995		4	4	17		41	58		2	2	17		47	64
1996	1	8	9	10	2	39	51		1	1	11	2	48	61

* Some of the figures in this table differ from those previously published, reflecting information which subsequently became available on deaths in custody which were not previously identified as such. The corresponding tables in reports prior to February 1995 are not directly comparable with this table as they covered deaths in all settings, whereas (for consistency in the time series) this table covers only deaths in institutional settings.

** Deaths in prisons, police lockups or juvenile detention facilities, during transfer to or from them, or in medical facilities following transfer from detention facilities.

Figure 5: *Australian Deaths in Custody 1980-96*
Year of Death and Aboriginality, Institutional Settings

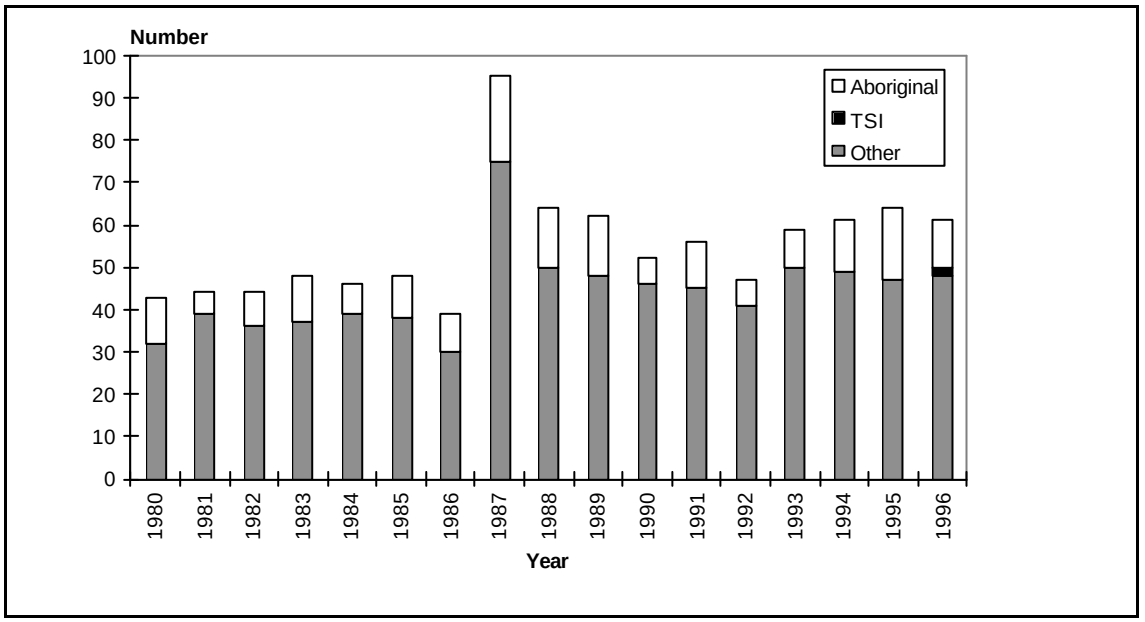


Figure 6: *Australian Deaths in Police Custody 1980-96*
Year of Death and Aboriginality

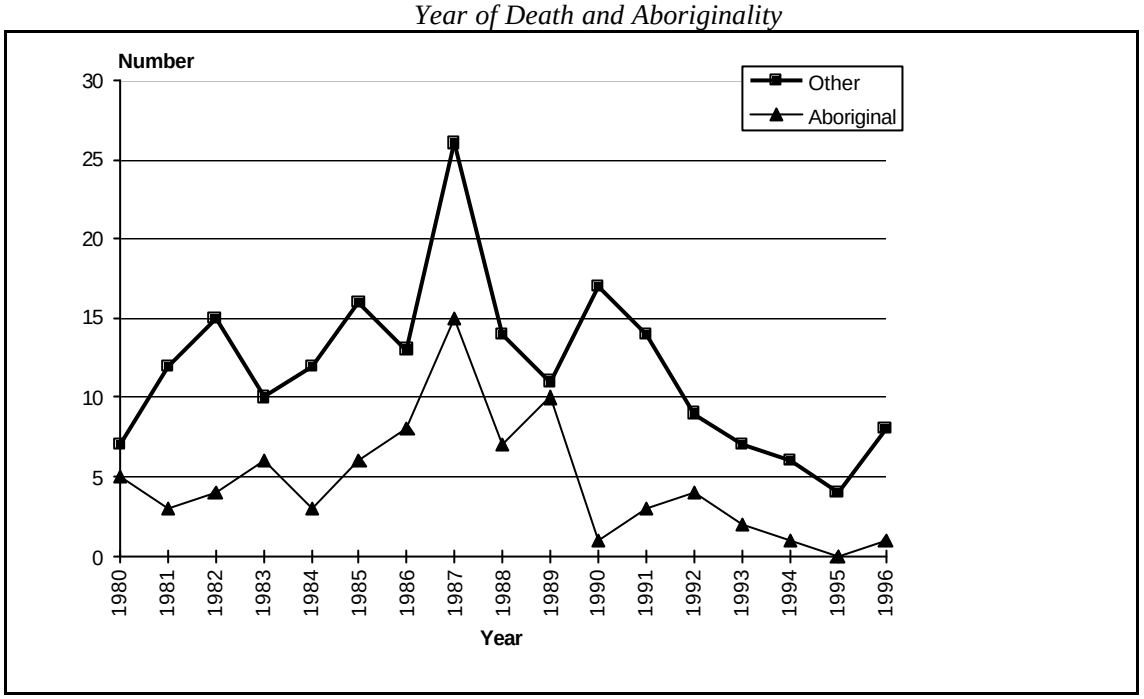
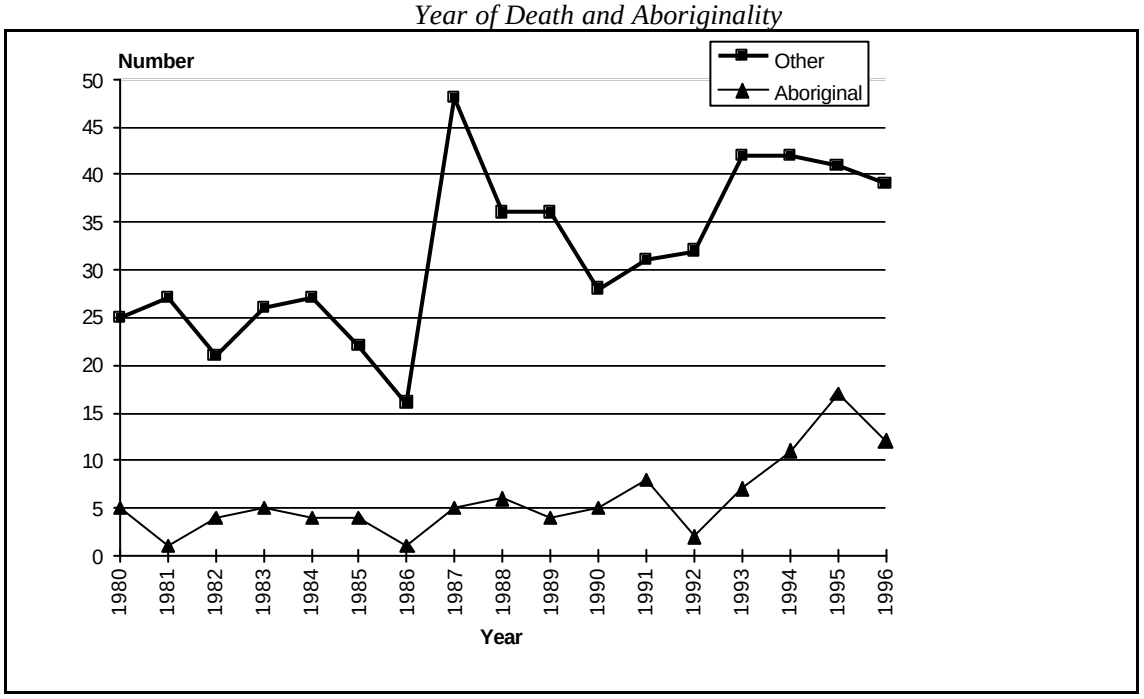


Figure 7: *Australian Deaths in Prison Custody 1980-96*
Year of Death and Aboriginality



years and almost double that recorded in 1980. However, during 1996 this figure decreased from 58 to 51 deaths.

- 17 Aboriginal people died in prison custody in 1995 which was the highest number recorded since 1980. While the number of deaths in 1996 has decreased to 12 (10 Aboriginal and two Torres Strait Islander), this number is still higher than any other year since 1980 (except 1995).

Table 15 shows deaths that occurred in *all custodial circumstances* from 1990 to 1996. All of these cases are covered by the post-Royal Commission definition of a "death in custody", which includes both deaths in institutional settings and in community settings, such as police sieges, shootings and pursuits.

Table 16 provides information on custodial deaths that occurred in *non-institutional* settings from 1990 to 1996, in accordance with the post-Royal Commission definition of a custodial death. Most of these deaths occurred in pursuits, raids, sieges and police shootings. It can be seen that the number of deaths has remained relatively stable over this six-year period

- Table 16 shows that, of all deaths to occur in all forms of custody over the 1990 to 1996 period, between one-fifth and just under one-third occurred in non-institutional settings.

Trends in Patterns of Prison Custody

Table 17 and Figure 8 provides information on deaths in prison custody in all jurisdictions for the period 1980 to 1996.

- A total of 643 people have died in Australian prisons during the 1980-96 period. Twenty-five of these deaths were female and 618 were male. More than 15 per cent (101) of these deaths were of Aboriginal and Torres Strait Islander people.
- More than one-third of these deaths (241) occurred in New South Wales; New South Wales has 34 per cent of the Australian population. One hundred and thirty people (20 per cent) have died in Queensland prisons; Queensland has 18 per cent of the Australian population. The pattern is similar for the remaining States and Territories.

Figure 9 provides information on the causes of death in prison custody for the period 1980 to 1996. It can be seen that hanging (268 or 42 per cent) accounts for the largest number of deaths during this period, followed by deaths from illness (210 or 33 per cent). However, the causes of death for the 101 Aboriginal and Torres Strait Islander people who have died in prison custody is in contrast to this. Thirty-eight (or 28 per cent) of these deaths were from hanging compared to 49 (or 49 per cent) from natural causes.

Figures 9a and 9b display the pattern of causes of death for the period 1980 to present for both Aboriginal and non-Aboriginal people.

Table15: *Australian Deaths in Custody 1990-96*
Aboriginality and Custodial Authority
Deaths in all custodial circumstances

	Police			Prison				Juvenile			Total			Grand
Year	Ab'l	Other	Total	Ab'l	TSI	Other	Total	Ab'l	Other	Total	Ab'l	TSI	Other	Total
1990	5	26	31	5		28	33		1	1	10		55	**65**
1991	5	26	31	8		31	39				13		57	**70**
1992	7	24	31	2		34	36				9		58	**67**
1993	3	28	31	7		42	49		1	1	10		71	**81**
1994	3	24	27	11		42	53		1	1	14		67	**81**
1995	4	21	25	17		41	58		2	2	21		64	**85**
1996	5	22	27	10	2	40	52		1	1	15	2	63	**80**

Note: Some of the figures in this table differ from those published in past reports. This reflects information which subsequently became available on deaths in custody which were not previously identified as such.

Table 16: *Australian Deaths in Custody 1990-96*
Aboriginality and Custodial Authority
Deaths in non-institutional settings only (a)

	Police			Prison			Total		Grand	% of all
Year	Ab'l	Other	Total	Ab'l	Other	Total	Ab'l	Other	Total	Deaths
1990	4	9	13				4	9	**13**	**20**
1991	2	12	14				2	12	**14**	**20**
1992	3	15	18		2	2	3	17	**20**	**30**
1993	1	21	22				1	21	**22**	**27**
1994	2	18	20				2	18	**20**	**25**
1995	4	17	21				4	17	**21**	**25**
1996	4	14	18		1	1	4	15	**19**	**24**

(a) Deaths other than those in police lockups, prisons, juvenile detention centres, or during transfer to or from such institutions and in hospitals following transfer from such facilities (e.g. in a community setting while police or prison authorities were attempting to detain a person).

Table 17: *Australian Deaths in Prison Custody, 1980-96*
Jurisdiction and Aboriginality

Jurisdiction	Aboriginal	TSI	Other	Total
NSW	30		211	241
Vic.	2		109	111
Qld	25	2	103	130
WA	20		49	69
SA	14		48	62
Tas.	1		16	17
NT	7		4	11
ACT			2	2
Aust.	**99**	**2**	**542**	**643**

Figure 8: *Australian Deaths in Prison Custody 1980-96*
Jurisdiction and Aboriginality

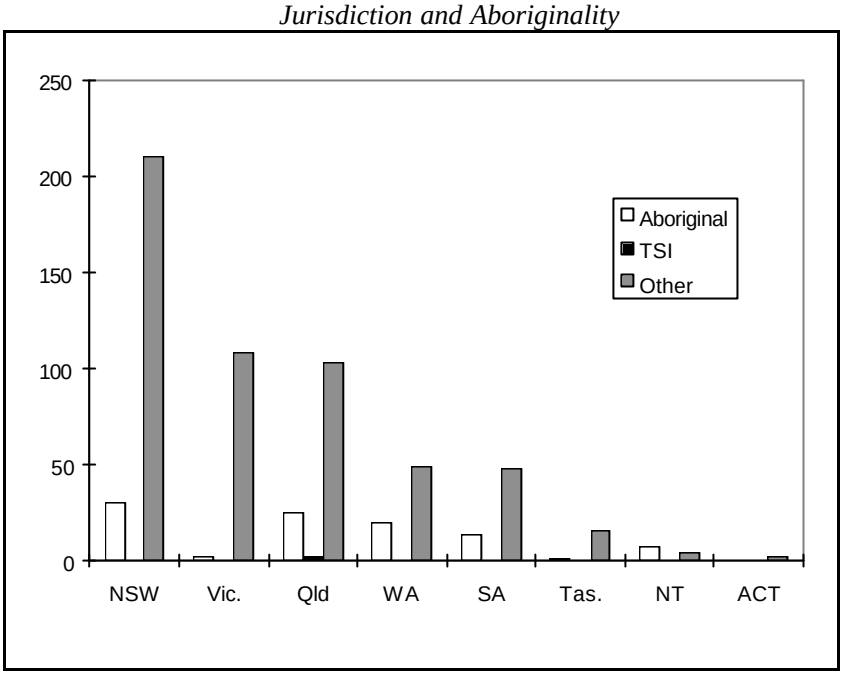


Figure 9: *Australian Deaths in Prison Custody 1980-96*
Causes of Death

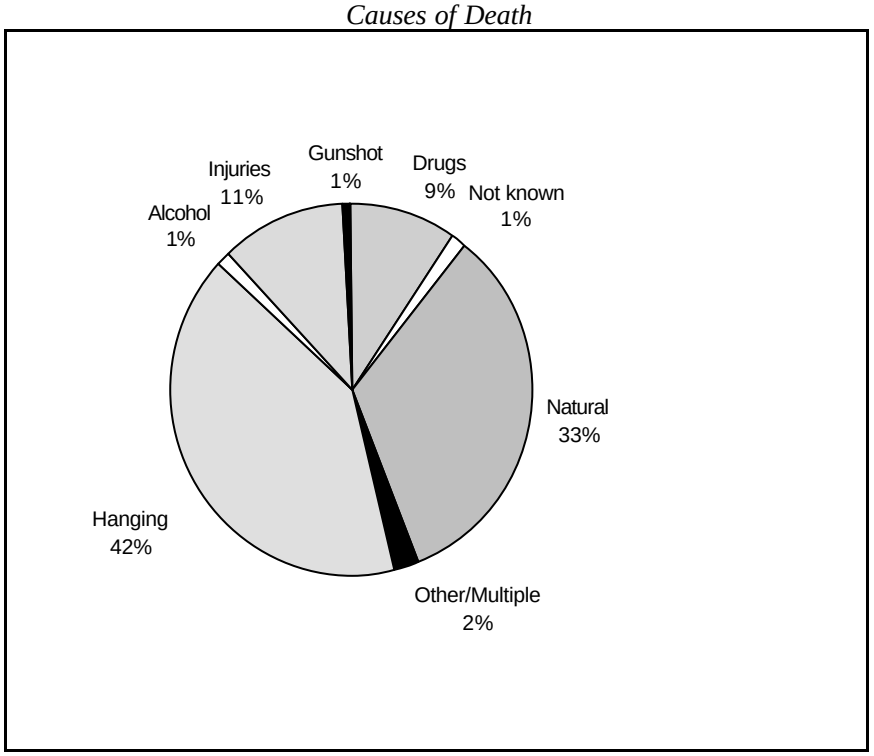


Figure 9a: *Aboriginal Deaths in Prison Custody 1980-96*
Causes of Death

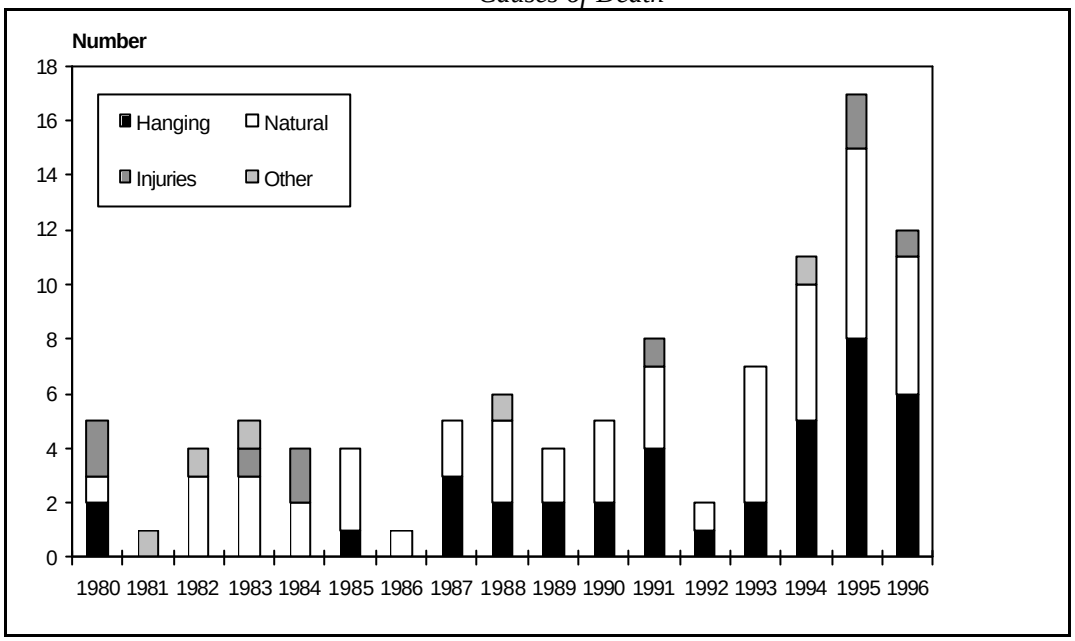
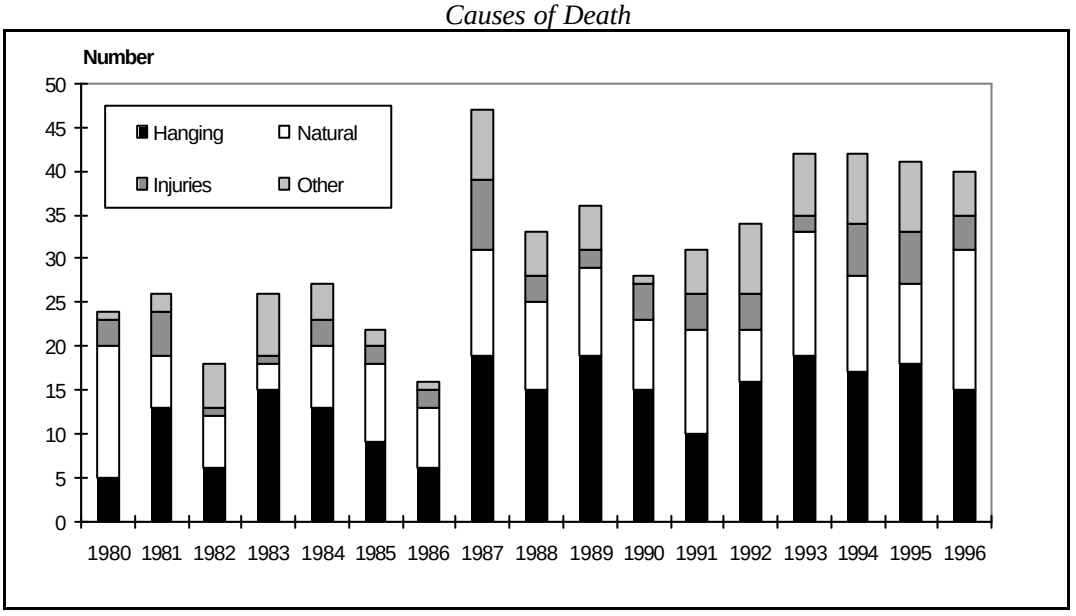


Figure 9b: *Non-Aboriginal Deaths in Prison Custody 1980-96*
Causes of Death



Trends in Patterns of Police Custody & Custody-Related Deaths

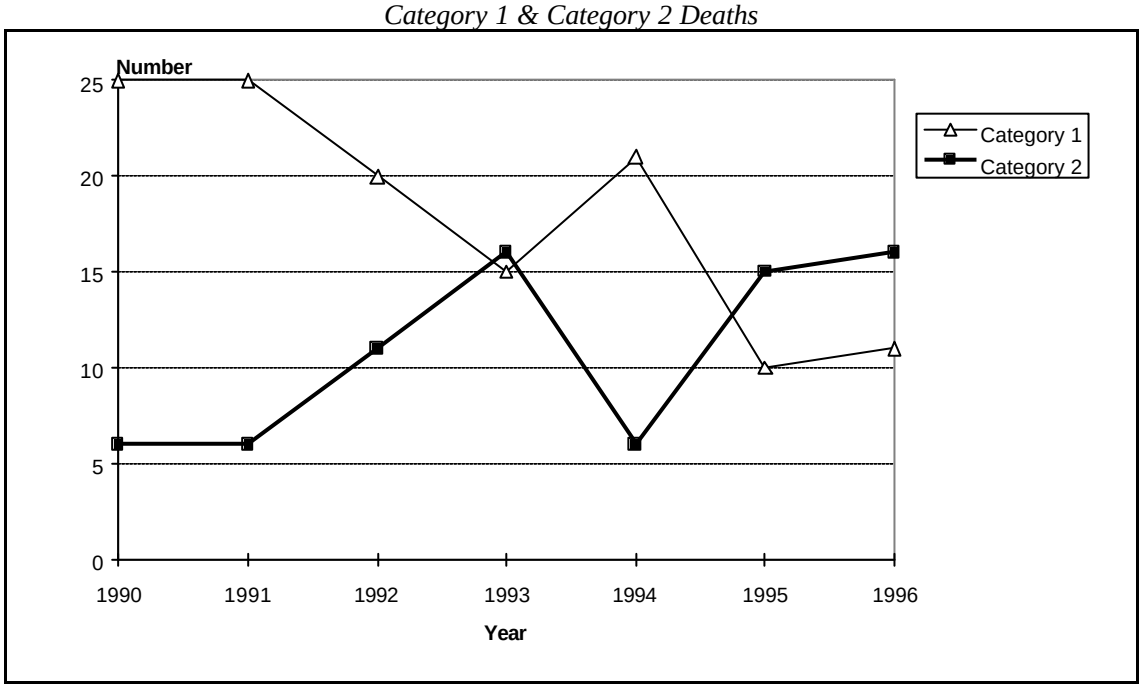
Table 10 provides information on deaths in police custody and in related police operations for the period 1990 to 1996. It is based on the two categories referred to earlier in the report.

- Between 1990 and 1996, 32 Aboriginal people died in police custody. The highest number of deaths occurred in Western Australia (10), followed by Queensland (7), New South Wales (5), Northern Territory (4), Victoria (3), South Australia (2) and Tasmania (1).
- The annual number of deaths has decreased marginally over this six-year period from 31 deaths in each of the years 1990-94 to 27 deaths in 1996.
- The data show that, during the period 1990-96, **Category 1** deaths (i.e. deaths in lockups and other situations where police could exercise a considerable degree of control over the deceased) have decreased markedly by more than 50 per cent from 25 deaths in 1990 to 11 deaths in 1996. The exception here was in 1994 when 21 people died, reflecting, in the main, the number of people shot and killed by members of the Victoria Police while they were attempting to detain the people or prevent the commission of an offence.
- Between 1990 and 1996 a total of 40 people (or 32 per cent of all deaths) have died as a result of gunshot wounds, 35 as a result of being shot by police and five were self-inflicted. Twenty-one (or 53 per cent) of these deaths occurred in Victoria; all but two were a result of a police shooting. The greatest number of gunshot deaths occurred in 1994 when 13 people died from gunshot wounds; only one of these was self-inflicted. It should be highlighted that during 1996 only two people died from gunshot wounds, both inflicted by police. Another 25 (or 20 per cent) died from hanging; 21 (or 17 per cent) were drug related; 17 (or 13 per cent) died from natural causes (illness).
- On the other hand, **Category 2** deaths (i.e. cases where police had little or no capacity to control the behaviour of the deceased) have increased noticeably by 63 per cent from 6 deaths in 1990 to 16 deaths in 1996 (except for 1994 with 6 deaths).
- Fifteen (or 20 per cent) of all Category 2 deaths (n = 76) spanning the 1990-96 period were of Aboriginal people compared to 17 (or 13 per cent) of Category 1 (n = 127) deaths being of Aboriginal people. Nine of these 15 deaths occurred in Western Australia, in all cases as a result of a police pursuit. In all but one of the remaining six cases the individuals concerned also died as a result of injuries sustained from a crash during or following a police pursuit.
- A breakdown of the causes of death of the 76 people who died in this category reveal that 48 died from injuries, 24 from gunshot wounds and four from other/multiple causes.
- Seven of the 48 deaths from injuries were self-inflicted. Three people inflicted stab wounds to their bodies in police presence; one drove his motor vehicle into a tree; one drove his motor vehicle over a cliff following a pursuit and siege situation; one jumped from a bridge to his death; and the remaining person self-detonated a home-made bomb during a siege situation.
- The majority (41) of the 48 deaths from injuries were accidental; 14 (or 34 per cent) were Aboriginal; 16 (39 per cent) occurred in New South Wales and 10 (24 per cent) in Western Australia. Most (37 or 77 per cent) occurred in a motor vehicle/motorcycle crash during or immediately following a police

Table 10: *Australian Deaths in Police Custody and in Related Police Operations 1990-96 by Aboriginality*

Year	Category 1 - Institutional or Close Contact Custody			Category 2 - Other Custody-related Police Operations			Total		Grand Total
	Ab'l	Other	Total	Ab'l	Other	Total	Ab'l	Other	
1990	2	23	25	3	3	6	5	26	**31**
1991	4	21	25	1	5	6	5	26	**31**
1992	4	16	20	3	8	11	7	24	**31**
1993	3	12	15		16	16	3	28	**31**
1994	3	18	21		6	6	3	24	**27**
1995		10	10	4	11	15	4	21	**25**
1996	1	10	11	4	12	16	5	22	**27**
Total	**17**	**110**	**127**	**15**	**61**	**76**	**32**	**171**	**203**

Figure 10: *Australian Deaths in Police Custody 1980-96 Category 1 & Category 2 Deaths*



pursuit. Often, during the course of a police pursuit, it is the passenger who dies and the driver of the vehicle who is charged with unlawful homicide. At the time of writing, there have been at least seven of these cases where the driver of the vehicle has been charged over the death of the deceased passenger.

- Twenty-two of the 24 deaths from gunshot wounds were self-inflicted, usually occurring in a public place or at a private residence during a siege situation. In two of these cases the deceased shot himself while driving a motor vehicle that was being pursued by police. In one of the remaining two cases the deceased female was shot by her husband during a siege situation with police; in the other case the coroner found that the death arose by misadventure and was unable to determine who fired the fatal shot.
- Three of the four deaths from other/multiple causes resulted from drowning; in the remaining case the cause of death was unable to be determined by the coroner.

Deaths since the Royal Commission

- A total of 435 people have died in all forms of police, prison and juvenile justice custody since the tabling of the Royal Commission's final *National Report* on 9 May 1991. Seventy-eight of these deaths were of Aboriginal people, two of Torres Strait Islander people and 355 of non-Aboriginal people.
- This represents an average of 14.16 Aboriginal and Torres Strait Islander deaths each year since that date. This is a noticeable increase when compared to the figure at 31 December 1994 of 42 Aboriginal deaths since the tabling of the *National Report*, representing 11.5 Aboriginal deaths each year.
- Institutional deaths since the tabling of the report accounted for 323 (about three-quarters) of the 435 deaths; 63 Aboriginal and two Torres Strait Islander. The figure of 11.51 Aboriginal deaths per annum since the tabling of the Royal Commission's report is similar to the average number of Aboriginal deaths each year for the period covered by the Royal Commission of (10.5).

Since 31 May 1989, the cut-off date for the deaths investigated by the Royal Commission a total of 573 people have died in all forms of custody. Of these, 101 were Aboriginal people, two were Torres Strait Islander people and 470 non-Aboriginal people. This is an average of 13.58 Aboriginal deaths each year.

5

Conclusion

While there has been a minimal reduction in the total number of deaths in the year under review, the alarming trends reveal that in recent years the number of Aboriginal and Torres Strait Islander people in our nation's prisons is continuing to increase, as is their level of over-representation in custody.

Following on from this, there are critically high numbers of Aboriginal and Torres Strait Islander people hanging themselves or dying from heart disease in prison custody. An optimistic future here is dependent upon concerted implementation of key recommendations of the Royal Commission into Aboriginal Deaths in Custody, focussing on minimising the numbers of people being held in prison and providing high quality care for those who do find themselves incarcerated within the prison system.

While the number of deaths in police custody are down slightly, there has been an increase in the number of deaths occurring in police lockups or in hospital following transfer from a lockup over the last 12 months (from 4 to 9).

It needs to be emphasised that over the last two years the number of Category 1 police custody deaths in institutional settings and close contact custody (e.g. lockups and police vehicles, as well as police shootings) has decreased significantly for both Aboriginal and non-Aboriginal people (from a total of 21 in 1994 to 11 in 1996).

However, the number of people who died during the year in custody-related police operations (Category 2) has almost tripled during the same period, 1994-96. During 1996, 11 people died from injuries received in a motorcycle or motor vehicle crash in the course of, or immediately following, a police pursuit. As highlighted in a number of recent inquests, the need exists for some police services to address procedures relating to situations such as police pursuits and sieges where police are in the process of detaining, or attempting to detain, the individuals who died.

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6

Coroners' Inquests into Deaths in Custody

The last report in the Deaths in Custody, Australia series (No. 12: *Australian Deaths in Custody & Custody-related Police Operations, 1995*) introduced this new section which provides excerpts from the most recently completed Coroners' Inquests into Deaths in Custody, both Aboriginal and non-Aboriginal.

This report documents all of the 1994 and 1995 cases for which the Australian Institute of Criminology has received Coroners' Findings since publication of the earlier report in May 1996. In addition to outlining details about the date, place and circumstances of each death, and when, where and by whom the inquests were conducted, some of the coroners' comments, findings and recommendations are presented below. The amount of information available from the Coroners' Findings vary depending on the nature of a death and the complexity of the issues surrounding the death.

The excerpts chosen reflect the circumstances and issues involved in each particular death in custody, highlighting where the authorities and the criminal justice system have been successful or where they have failed in some way. The next publication in the series will focus on 1996 cases.

1994
Deaths In Police Custody Or Custody-related Police Operations For Which Coroner's Findings Have Been Received (State By State)

Victoria

Case 9403	**Female aged 38 years, died 2/1/94, intersection of Wyndham & High Streets, Shepparton, Victoria.**
Circumstances of Custody or Police Operation	The deceased had seated herself close to the centre of the above cross-intersection. When police attended the scene, the deceased produced a knife and threatened one officer who retreated. Another officer drew his revolver and asked the deceased to drop the knife. The deceased was shot as she advanced towards the officer, the knife out in front of her.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Jacinta Mary Heffey Coroner's Court, Shepparton 21/7/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 1st January, 1994 at Shepparton from gunshot wound to chest." "I formally find that no other person or persons contributed to the cause of death."

Comments on Case 9403

[Prior to departing for and seating herself at the intersection, the deceased had had a verbal altercation with a man with whom she had previously boarded. She had been told to leave the house. The post mortem revealed that the deceased had a blood alcohol level of 0.15% which was consistent with her having been drinking earlier in the day.]

"In respect of [the police officer who shot the deceased] a finding of contribution might be appropriate if I were to find that he had acted precipitately, unreasonably used excessive force in the circumstances, or conducted himself in a manner significantly contrary to the training he had received in respect of management of situations which pose a risk to public safety including the safety of the person posing the risk and the safety of other police members.

"The preponderance of the evidence of eye witnesses was that [the officer concerned] shot [the deceased] in lawful self defence. The assessment of all but one was that from the moment [the deceased] turned her attention to the divisional van and advanced towards it the driver of the van was in a position where he had no alternative but to discharge his firearm to save himself from death or serious injury.

"[The two police officers concerned] were confronted with a close to unmanageable situation in my view. [The deceased's] presence in the intersection demanded an urgent response at least for her own safety. The time that would have been required to learn further information about her, to mobilise other members to cordon off and contain the intersection, to more fully assess the risk she posed could have produced equally catastrophic consequences in the form of her being killed or seriously injured by a vehicle or by her stabbing and injuring another member of the public.

"Also understandable but regrettable, was the shifting of the divisional van after the shooting and before the arrival of crime scene personnel. It would appear also that [the deceased's] pillow and back pack were moved and placed near her body. Both these actions rendered the task of reconstructing the event forensically a very difficult task particularly when eye witness accounts were so disparate. Preservation of a scene should be an automatic response ...

"It will never be known what stresses drove [the deceased] to behave as she did on the day of her death. ... Nevertheless I am satisfied that she was given ample opportunity to put down the knife and leave the intersection which she failed to do, instead assuming an aggressive role and threatening the lives of the two men obviously doing no more than lawfully and professionally performing their duty. In so doing she was killed by an officer defending himself in lawful circumstances and so contributed to her own death."

Case 9405	**Female aged 39 years, died 19/3/94, at Geelong Police Station, Victoria.**
Circumstances of Custody or Police Operation	The deceased was remanded in custody on 15 March, due for sentencing on 24 March. She was depressed as she expected a long sentence and was worried about her children. She was on medication and mentioned suicide several times to her cell mate.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Ian Maxwell von Einem Coroner's Court, Geelong 12/1/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 19th March, 1994 on a bed in cell of Geelong Police Station cells, Geelong, Victoria 3220 from combined drug toxicity (morphine, oxazepam, amytriptyline and doxepin. "And I further find that I am unable to conclusively say whether any person other than the deceased contributed to the cause of death."

Comments on Case 9405

"I am of the very firm opinion that no individual police officer has contributed to the death of the deceased. Firstly, it seems to me that the drugs prescribed for the deceased had been properly administered to the deceased. Secondly, it is my view that all rules and regulations were complied with in respect to the search of the deceased and her cell. If in fact a more thorough search of the deceased is required, then that is a matter for legislators which I will comment upon later. As to actual surveillance of the deceased, I do not think it is reasonable or practical to expect police officers to observe the various monitors 24 hours per day ...

"... none of the medications prescribed ... contributed to the death of the deceased ..."

Case 9406	**Male aged 34 years, died 26/3/94, at Watson Street, Wodonga, Victoria.**
Circumstances of Custody or Police Operation	Police were called to a burglary at the VicRoads Office. They observed the deceased leaving the building carrying a miner's pick. The deceased fled and was located by two other officers. After being asked not to move, the deceased walked towards one of the officers, making growling noises and raised the pick above his head. The deceased was shot after repeated requests by police to put the weapon down, the officer fearful of the deceased advancing with the raised pick.
Coroner **Location of Inquest** **Date of Inquest / Findings**	John William Doherty Coroner's Court, Wangaratta 19/6/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 26th March, 1994 at Wodonga, Victoria 3690 from bullet wound to chest."

Comments on Case 9406

"Photographs taken indicate the position of the deceased on the roadway and it is obvious that there was very little distance between the deceased and [the police officer who fired the shot] immediately prior to the first shot.

"Was the shooting justified? In my opinion it clearly was. I have no doubt [the police officer] acted justifiably in her own self-defence. If she had not it is my firm view that she would have been killed herself or at least suffered serious physical harm.

"The investigation in this matter has been thorough and detailed."

Case 9408	**Male aged 32 years, died 23/4/94, at Bairnsdale Police Station, Victoria.**
Circumstances of Custody or Police Operation	The deceased was remanded in custody on 19 April when his bail was revoked and he was ordered back into custody.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Keith William Lewis Coroner's Court, Bairnsdale 30/3/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 23rd April, 1994 from compression of the neck. I find that death occurred at the police cells, Bairnsdale Police Station ..."

Comments on Case 9408

[Following revocation of bail the deceased was distressed. The deceased was found hanging from the roof in the shower room several days later. A letter was found in his cell which displayed concern about the manner in which he was coping with his incarceration. A toxicology examination detected the presence of various drugs in the blood of the deceased, however, it was found that the presence of these were not a contributing factor to his death.]

"It is, in my view, undesirable that only one member, namely the watchhouse keeper, be on duty and in attendance at the police station and particularly when there is or are prisoners in the police cells. The circumstances here suggest that it was unreasonable to expect [the police officer] being the lone watchhouse keeper to be able to fully comply with force directives as they apply, and particularly to prisoners and the checking of prisoners.

"The evidence tells me that for reasons of privacy persons inside the shower recess with the door closed are unable to be seen by monitor or otherwise. Whilst for privacy reasons this is understandable, nevertheless it affords the opportunity to misadventure as occurred here; thus it seems to me, necessitating investigation of alternative means to monitor persons when out of view in the shower recess; whilst continuing to afford them privacy.

"During the five years preceding this incident, ... tells me that the Bairnsdale cells have been continually reviewed and upgraded in an endeavour to eliminate any areas where prisoners could injure, and including hang, themselves. As the deceased proved here and as ... inspection found, such earlier endeavours have not been entirely successful. ... some 20 areas in the external Bairnsdale cells requiring attention, not all but some of which might be considered critical to prisoners' safety and security. ... I would recommend that the works needed to correct the deficiencies highlighted ... be undertaken sooner rather than later.

"More importantly though I feel is the need to ensure that nil anchorage points exist or are available in the shower recess or cell block area generally from which such articles might be hung.

"It is of some concern that one of the towels relevant here ... was not what might be called an ordinary bath towel, in part due to its length which appeared to be in excess of two metres. ... towels of this type are not suitable for use by prisoners.

"... whilst I am of the view that the deceased ... contributed to his death, I cannot determine whether or not he intended that end, that is, to take his own life or whether his intentions were otherwise, that is, to achieve a result that stopped short of his death but assisted his apparent desire to abort his trial.

"... there is no evidence ... that would enable me to say that any person or persons either individually or collectively, or indeed organisation, has contributed either directly or indirectly ... to the death of the deceased ..."

Coroner's Recommendations

"Finally I suppose by way of recommendation, it seems to me, on the evidence, unnecessary to allow a prisoner to have access to a shower recess for an extended period; that the shower recess ought be unlocked and subsequently relocked allowing reasonable time for a prisoner or prisoners to utilise the shower in privacy and I note the evidence would suggest now two members be directed to be present when a prisoner is showering."

Cases 9409 & 9410	**Two males aged 18 and 35 years, died 16/5/94, at Somerville Road, Hampton Park, Victoria.**
Circumstances of Custody or Police Operation	Both males were fatally wounded when shot by members of the Victoria Police Special Operations Group. Shortly prior to the shooting the two deceased were about to enter the real estate agency to commit an armed robbery. One was armed with a loaded sawn off single barrelled shotgun.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Graeme Johnstone Coronial Services Centre, South Melbourne 11/8/95
Coroner's Formal Findings on Cause of Death	"The deaths of ... and ... occurred on 16th May 1994, outside Finning's Real Estate Agency, 82 Somerville Road, Hampton Park both from multiple gunshot injuries ..."

Comments on Case 9409 & 9410

[Police had received information that one of the deceased may have been involved in two armed robberies. Based on this information, a surveillance operation commenced on 2 May. Police were being assisted with information from an acquaintance of one of the deceased, including details of the intention to rob the real estate agency. Five SOG officers were watching from a van when the two deceased arrived and parked in front of the agency. They alighted from the van and challenged the two deceased, who were subsequently shot. Four of the officers fired in total 17 shots from their shotguns.]

"[The two deceased] contributed to both their own deaths and to each other's death by attempting to undertake an armed robbery. [The younger deceased's] contribution must also be seen in the context of him being young, probably immature, intellectually slow and 'led' by the far more mature and experienced career criminal [the older deceased].

"The shooting by the members of the Victorian Special Operations Group was lawful and justified in that all members fired after being put in reasonable fear that their own lives were at risk by both [the deceased]. The fact that [one of the deceased] was later discovered not to be armed, does not, of itself, alter the view of the police response at the moment of the shooting.

"No other person contributed to the deaths."

Coroner's Recommendations

Recommendation 1:

The Victoria Police review the practice of using the Special Operations Group for surprise raids in long term planned operations. Any review should consider whether the nature of the type of tactics used in this operation accords with the principles of "harm minimisation" as evidenced in "Beacon". One of the questions to be considered — do the tactics allow sufficient opportunity for rational choice by an offender.

It is not intended that this recommendation is directed at excluding the tactics completely as there may be rare occasions where there is no satisfactory alternative.

Also this recommendation is not intended to apply to tactics used in breaking sieges or incidents following negotiations. However, lessons learnt from this case may be useful in other areas.

Recommendation 2:

Where planned operations occur and there is risk to the public associated with the use of firearms every endeavour should be made to reduce the incursion of the public into the potential danger area. This issue also has occupational health and safety implications.

Where time permits a detailed risk management plan should be prepared.

Recommendation 3:

The investigators delegate an officer to identify and secure all documents, briefing notes, reports, information reports, diaries, witness notes, etc., relating to an operation with a view to providing the material with the brief for the coroner. The relevant material should be identified and secured at the earliest possible time in an investigation.

Documents with "public policy", security or privilege arguments may have to be dealt with separately.

Recommendation 4:

The force examine the "de-briefing" procedures to consider any improvements. Also any critical incident review should examine issues raised in the matter of Balzan as they may apply to shooting incidents involving police.

Any "critical incident review" document should be made available to the Coroner. In that process it is recognised there may be a need for a degree of confidentiality.

Recommendation 5:

The management structure for this type of operation be reviewed to ensure that the safety issues are dealt with at the highest practical level of police command.

Also direct operational management should be designed to ensure that the officer in active command should be senior to those operating the individual squads (ie, the chief investigator or the Special Operations Group).

Recommendation 6:

Where planned operations are dealing with a known offender a detailed "offender profile" should be considered for the assistance of police tasked with managing and reducing risk. Professional assistance should be considered in developing the profile.

The "profile" should be used to find the best way of managing an offender with the aim of effecting an arrest to minimise the risk of injury.

Recommendation 7:

Those in charge of an operation should have sufficient detail of the operation and offender's history available and ensure the appropriate level of information is given to any bailing officer. The information should provide the bailing officer with the necessary knowledge to make appropriate decisions when the offender is charged with an offence during the currency of an operation.

Case 9470	**Aboriginal female aged 41 years, died 23/9/94, at 22-28 Fitzroy Street, St. Kilda, Victoria.**
Circumstances of Custody or Police Operation	Police attended the Hanover Welfare Services Centre at the above address in response to a call from a social worker at the centre. The deceased, who had a prior history of mental illness and alcohol abuse, was armed with a tomahawk. She was shot by police as she was running at an officer with the weapon raised.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Iain Treloar West Coronial Services Centre, South Melbourne 3/11/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 23rd September, 1994 at 22-28 Fitzroy Street, St. Kilda, Victoria 3182 from multiple gunshot injuries to chest. "[The deceased] contributed to her cause of death by consciously ignoring the lawful directions of [the police officer] and intentionally threatening him with the hatchet she had in her possession. The evidence does not

	satisfy me that her actions were undertaken with the intention of committing suicide. "... neither [the two police officers] contributed to the cause of death."

Comments on Case 9470

[The deceased was well known to staff at the Hanover Centre. She had a history of psychiatric problems and alcohol abuse and had previously expressed suicidal and homicidal thoughts and attempted to take her life on numerous occasions. On the day in question, she attended the Centre in an intoxicated state, carrying a hatchet and behaving strangely. Two police officers attended. The deceased screamed and yelled at police who repeatedly asked the deceased to put the hatchet down. She yelled "shoot me, shoot me" and advanced toward one officer swinging the hatchet causing the officer to retreat. She then raised the weapon and ran at an officer who, believing he was going to be killed, fired at the deceased.]

"I am satisfied that ... the actions of the police in confronting the deceased and persistently requesting that she put down the hatchet, were appropriate and that their actions in failing to wait for the back up that had been requested, should not be the basis for criticism.

"The evidence satisfies me that the circumstances existing immediately before the deceased was fatally shot by [the police officer], necessitated him shooting her in self defence. ... At the time he shot the deceased, [the police officer] was entitled to assume that he and [the second police officer] were in immediate danger of attack and in these circumstances he was justified in firing at her, in self defence.

"I am also satisfied that no realistic opportunity presented itself, for [the police officer] to attempt to disarm the deceased."

Coroner's Recommendations

"That a critical evaluation be undertaken as to the merits of a firearm being the only effective weapon to counter an attack by an assailant using an edged weapon. While I am satisfied that such a response was appropriate in this case, I am concerned that there appears to be a universally held belief among operational members, that all edged weapons should be treated equally and that in defence from attack, it is necessary to shoot until the threat is neutralised, regardless of the circumstances and in all probability, having the effect of killing the assailant. As the inquest finding will be referred to the Ministerial Task Force on Police Shootings, it is requested that they ensure the identification of an appropriate independent investigator to make such evaluation, in conjunction with the Victoria Police Policy Unit or its nominee.

"That consideration be given to establishing with the Police Force, a specialist professional unit, appropriately trained, and equipped so that its members are in a position to take over from operational members during high risk crisis situations. The existing CAT teams are not in a position to meet this need, nor are the police negotiations from the Protective Services Group.

"That members attached to the L.E.A.P. Management Project remain vigilant in ensuring that as far as possible, the computer system maintains complete, accurate and up to date entries.

"That police members, directly involved in a death resulting from contact between police and the public, have their interview pursuant to paragraph 3.4 of the Standard Operating Procedures, either video or tape recorded. Just as the position held by a Police Officer, carries with it rights and privileges, it also carries the obligation of accountability. In being called to account, the officer and the community are entitled to the most accurate record of explanation.

"That when preparing the inquest brief involving a death resulting from contact between police and the public, investigators ensure appropriate background material concerning the member's police service is included in the brief.

"That the responsible officer from the Police Internal Investigation Department, be vigilant in actively overseeing the investigation into a death resulting from contact between police and the public.

"I adopt the recommendation made by the State Coroner in previous inquests involving a death resulting from contact between police and the public, (the most recent being Skews and Crome 1304 and 1305/94) of the need for 'Critical Incident Review' of each incident. This is

essential in order to assist the Police Force to identify potential areas for improvement and for the coronial investigation process."

Case 9471	**Male aged 45 years, died 5/12/94, at Tyrrell Crescent, Fawkner, Victoria.**
Circumstances of Custody or Police Operation	The deceased went on a shooting rampage, discharging two firearms at houses, people and passing motor vehicles. When asked by police to drop the rifle, the deceased refused and pointed the weapon at one of the police officers. He was subsequently shot by an officer of the Special Operations Group.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Jacinta Mary Heffey Coronial Services Centre, South Melbourne 20/2/96
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 5th December 1994 at Fawkner from a gunshot wound to the chest ... "I am satisfied and I find that [the police officer] killed the deceased lawfully in self defence and that no blame whatsoever should be attached to him either in the plan that he devised or the manner in which he sought to implement it. "I am satisfied that [the deceased] and no other person contributed to his death."

Comments on Case 9471

[The deceased had severe financial problems. He had been involved in a bitter dispute with his elder brother arising out of a partnership. An employee of Melbourne Water provided evidence that the deceased had threatened to kill their next employee who came to cut off the water to their home. When the employee had attended the home due to non-payment of rates and excessive volumes of water usage, the deceased had pointed a rifle at him, threatening to kill him. He had never reported the incident to police.

On the morning in question, the deceased told his wife to get out as he was going to kill her. The wife and two children fled down Tyrrell Crescent and sought shelter in a nearby friend's house. The deceased took two firearms from the house, walked outside, stood in the middle of the road, and started firing shots. He then fired two shots at a woman through her lounge room window and continued to fire shots at anything that moved into his view over the next 80 minutes. He was heard by numerous people to be calling out "come and get me".

"... I conclude that nothing that they [the police] did or failed to do can be said to have contributed to the death of the deceased ..."

Coroner's Recommendations

"I recommend that at management level in each of these utilities guidelines should be drawn up and brought to the attention of employees requiring a report of any incident like that which occurred to [the Melbourne Water employee] to be given to their superiors.

"I further recommend that upon receiving a report of a threat directed either to an employee personally or to him or her about any other person or persons, and particularly where a firearm is either produced in the presence of the employee or reference is made to a firearm as part of the threat, (but not exclusively in that circumstance), that the superior give urgent and serious consideration to bringing the matter to the attention of the appropriate authority, namely the Victoria Police.

"... a great deal of attention was directed to the question of whether any plan could have been instituted to alert residents within the cordon to the danger in the area and to give directions to them for their safety. ... The other suggestion that appealed was that of the use of an armoured vehicle. This would have enabled both the warning of the residents and the ability

to approach the gunman with minimal risk. I understand from the evidence that there is such a vehicle on order presently and confine myself therefore to the recommendation that the vehicle when available be deployed in any future street siege like the present.

"I recommend that the evidence of [a police officer], a person who has been involved in training members of the Special Operations group in recent years be closely examined by Police Command and any other body charged with investigating the phenomenon of police shootings in this State to determine the extent to which it represents an attitudinal feature within the Force. It's greatest danger, in my view, is that it could conceivably have the potential to inform the manner in which these situations are approached, in particular the value to be attached to the life of an offender who poses a risk to the public, a risk that police are charged to remove. Having said that, I want to stress that *there is no evidence whatsoever* that the consideration of and subsequent rejection of the option to shoot [the deceased] in this manner in any way influenced the conduct of [the officer who shot the deceased] who, as I have said, acted in the only way he could have in the circumstances.

Western Australia

Case 9474	**Male aged 22 years, died 23/9/94, at Capes Street, Osborne Park, Western Australia.**
Circumstances of Custody or Police Operation	Police received a phone call to attend the above address where the deceased had broken into a vehicle. The deceased fled and was pursued by a police officer. The deceased struggled and punched the officer. The officer pulled him to the ground and attempted to restrain him. The deceased persisted to struggle and a second officer came to assist. In the ensuing struggle the deceased produced a screwdriver and a knife and wounded the first officer. The deceased was eventually pulled to the ground and handcuffed.
Coroner **Location of Inquest** **Date of Inquest / Findings**	David Arnold McCann Coroner's Court, Perth 4/7/95
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that [the deceased] died on 23rd September, 1994, at 26 Cape Street, Osborne Park as a result of asphyxia in association with amphetamine effect. "I find that the death arose by way of misadventure in that the circumstances surrounding the death involved a lawful intentional act which unforeseeably led to the death."

Comments on Case 9474

"A medical examination was made of the deceased after his death. There were superficial grazes to various parts of the body consistent with being sustained during a struggle in a gravelled area. There were also superficial marks to the skin of the neck.

"The deceased had had a decorative chain around the neck and the pattern on the skin was similar to the design of the chain. These marks indicated that some force had been applied to the left side of the neck. However the only injury to the neck was to the skin surface. ...

"Analysis of a blood sample taken shortly after death revealed a level of 0.6mg per litre of methylamphetamine ... This level is considered to be very high and lies within the range associated with death from drug intoxication.

"The high blood levels of amphetamines, together with the evidence of intravenous use of the drug in the hours preceding death, indicate that the deceased was intoxicated with amphetamines at the time of his death.'

"The presence of amphetamines has an effect on the heart and makes it susceptible to potentially fatal disturbances of heart rhythm. Such a fatal disturbance of heart rhythm could

be precipitated by vigorous exercise, or a physical struggle, or by hypoxia resulting from interference with breathing.

"... it has been suggested there is some conflict in the accounts of the struggle given by the police officers ... I am satisfied that the evidence of the second police officer, in particular, was truthful.

"... the hold applied by the second police officer was not that which is referred to as a 'choker' ... I accept that the intention was not to render the deceased unconscious but to restrain him and to prevent further injury to his colleague or to himself.

"It should also be noted that the two police officers involved in the struggle were each armed with a firearm but they did not draw them. It is to their credit that they did not consider that the matter should be resolved by shooting the deceased.

"... the degree of force used by the police officers was reasonable."

1994
Deaths In Prison Custody
For Which Coroner's Findings Have Been Received (State By State)

New South Wales

Case 9452	**Male aged 23 years, died 23/12/94, at Goulburn Correctional Centre, Goulburn, New South Wales.**
Prison	The deceased was an inmate at Goulburn Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	John Abernethy Coroner's Court, Goulburn 24/9/96
Coroner's Formal Findings on Cause of Death	"I find that [the deceased] died on or about the twenty third day of December, 1994 in cell 44 of 'A' wing, Goulburn Correctional Centre, Goulburn by hanging, self-inflicted with the intention of taking his own life."

Comments on Case 9452

[The deceased had been diagnosed as psychopathic during his teenage years. He was transferred to Goulburn because it offered special Intensive Case Management programs for prisoners like him. He had indicated to a prison official at a previous prison that the 23rd of December was significant and that information had been passed on to authorities at Goulburn. The authorities felt that the deceased was more likely to be a danger to others than to himself.]

"It can be seen that Corrective Services had a prisoner who was something of a management problem, though docile in prison. In the circumstances I am of the view that the course it took in preparing for 23 December, was reasonable. ... the Department did not know just what the deceased was planning. At no stage could he have been termed suicidal though he attempted suicide on earlier occasions.

"I have no criticism of the Department of Corrective Services or the Corrections Health Service in their handling of the death in custody."

Victoria

Case 9429	**Female aged 27 years, died 30/5/94, at St Vincent's Hospital, Melbourne, Victoria.**
Prison	The deceased was an inmate at Fairlea Prison who was transferred to St. Vincent's Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Iain Treloar West State Coroner's Office, South Melbourne 12/5/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 30th May, 1994 at St. Vincent's Hospital from 1(a) hypoxic organ damage following prolonged

	cardiac respiratory arrest 1(b) toxic effects of drugs. "I further find that the deceased contributed to the cause of death, by self administration of non-prescribed drugs, however as the source of those drugs cannot be determined, a finding as to the identity of any other person contributing cannot be made."

Comments on Case 9429

[On 29 May, the deceased received a visit from a female friend. Not long after the deceased was observed by fellow inmates to be in a drugged state, admitting to having taken some Rohypnol tables and two "hits" of heroin. Shortly after the deceased was found not breathing and cyanosed.]

"The evidence does not permit a finding as to how the deceased came to be in possession of illicit drugs. ... It is possible that a drug transfer took place from mouth to mouth, at this time, however after the visit concluded and the deceased was thoroughly searched there was no evidence of transfer or anything that aroused further suspicion.

"With the benefit of hindsight it may well have been prudent to closely monitor her, however the prison officers making the observation were not satisfied that such a breach had occurred.

"I am further satisfied that the actions of the deceased's fellow prisoners in failing to get assistance at an earlier stage, does not amount to contribution to the cause of death. The tragic outcome that occurred in this case was not anticipated, with her friend's primary concern being to protect the deceased in her drugged state, from being discovered by the prison officers.

"... illicit drugs are going to find their way into the prison system ... I am satisfied that the authorities are aware of the need to maintain vigilance in preventing as far as is possible, the introduction of such contraband. There has been a strategy plan in place since 1991 to address this issue, as well as to provide opportunities for prisoners with substance abuse difficulties to establish and maintain drug free lifestyles.

"Finally the evidence satisfied me that appropriate emergency protocols were carried out by prison staff..."

Case 9455	**Male aged 40 years, died 14/9/94, at Metropolitan Reception Prison, Pentridge, Coburg, Victoria.**
Prison	The deceased was an unsentenced inmate in the Acute Assessment Unit at Metropolitan Reception Prison. He had been remanded in custody to the Shepparton police cells and subsequently transferred to the Carlton Watchhouse before being transferred to the Melbourne Reception Prison.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Jacinta Mary Heffey State Coroner's Office, South Melbourne 15/5/96
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 14th September, 1994 at Metropolitan Reception Centre - 'G' Division - A.A.U. Pentridge, Coburg, Victoria from hanging."

Comments on Case 9455

[While in the police cells the deceased was closely observed as a suicide risk. His risk was reassessed at Pentridge and he was transferred to the Acute Assessment Unit. During interviews with a psychiatric medical officer he admitted to earlier suicidal thoughts but denied any present ideas. On 14 September the deceased was very upset and crying and asked a fellow prisoner how he would go about committing suicide after which the deceased proceeded to practice tieing knots in an electrical jug cord. It was the view of all the professional staff who assessed the deceased from the time of his arrival that he was not entertaining *present* suicidal thoughts. When the deceased was found hanging later that evening, entry to the cell was delayed because the prison officer did not have keys to the cells and had to telephone to another officer outside the unit about 30 metres away where the keys both to the unit and to the cells were kept.]

"... an internal inquiry was conducted into the incident by... of the Department of Justice. ... Various recommendations were made ... Issues that have been addressed include shortening the cords attached to the electric jugs and the calico bags that are issued to prisoners. ... the keys to the cells are now placed in a fire-break box with breakable glass in the front. This would enable earlier access to the cells in such a situation as occurred here. There is no evidence in this case that earlier access might have saved [the deceased's] life.

"After considering in some detail all of the evidence heard in this tragic case I am of the view that no person other than the deceased contributed to his death and I so find."

Coroners' Recommendations

"I can only re-iterate the comments and recommendations which I made in the case referred to, namely that the current method of recording observations be changed so that each staff member recording such entries be required to note the exact time at which he or she made the observation.

"It is of concern that the thirty minute observations were not rigidly adhered to. I have commented in other Inquests on the practice of prenoting thirty minute intervals on observation sheets at every half hour on the hour (see Kelly Burnett deceased Case 255/1995).

"I recommend that a system be introduced to ensure that all information obtained by investigating police regarding a prisoner's suicide potential which would in accordance with Police Circular Memo 95-2-1 be required to accompany the prisoner during transfers between police cells be applied to transfers to any facility operated by the Office of Corrections and thereafter be handed to officers accompanying a prisoner between Divisions at such a facility.

"In another case of John Gerard Oakley (Case 329/1993) concern was expressed about the failure of communication in relation to that deceased's suicide potential as evidence by previous suicide attempts when in a cell. The failure largely related to the method of noting on the computer system within the police department to which other police members could have recourse when receiving the prisoner into their police cells. It was noted that the LEAP system now in place sufficiently alerts users to protective concerns in this respect and a form known

as the Prisoner Information Record must accompany a prisoner during transfers. It is unfortunate in this case that the history of the deceased's recent attempts at suicide was not brought to the notice of [the psychiatric medical officer at the prison] in a documentary form."

Queensland

Case 9433	**Female aged 18 years, died 23/3/94, at Princess Alexandra Hospital, Brisbane, Queensland.**
Prison	The deceased was an inmate at Brisbane Women's Prison who was transferred to Princess Alexandra Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Gary M. Casey Coroner's Court, Brisbane 12/12/95
Coroner's Formal Findings on Cause of Death	"I find that she died in the Princess Alexandra Hospital, Brisbane, on 23 March 1994 from hypoxic brain injury and that the cause of her death was hanging. I further find that on the morning of 22 March 1994 a custodial correctional officer discovered the deceased in an unconscious state in cell 34 of upper C block of the correctional centre. The deceased had used her bed sheet tied at one end to an air vent situated above the door to the cell and the other end around her neck to suspend herself."

Comments on Case 9433

"There is no evidence upon which any person could be committed for trial ...

"... it could be accepted that she had suffered from what was described as a borderline personality disorder. ... Had she had an identifiable psychiatric illness ... she would have had the opportunity ... to be treated as a psychiatric patient. Her condition prevented her from receiving long-term hospitalisation which may have assisted her in a successful rehabilitation.

"... she was inevitably assessed as a management and not a medical problem. ... In any event, had there been adequate facilities available at the centre to treat her condition, then effective treatment would probably have been hindered by the prospect of her being incarcerated for a short period of time."

Coroner's Recommendations

"I have attempted to glean from the evidence the inadequacies which existed at the correctional centre in respect to management practice generally and, in particular, so far as those practices relate to persons with a condition similar to the deceased. A number of positive initiatives have been implemented or are intended by the correctional centre which could have been the subject of a recommendation. They include the alteration of cells in which inmates are housed who are suspected of having disposition to inflict self harm or attempt suicide, the proposed conversion of the hospital ward at the centre into observation cells with closed circuit camera surveillance, the provision of trained staff to ensure the fulfilment of the previously mentioned proposal, an arrangement whereby medical files of an inmate held at hospitals in Queensland outside the centre are made available to medical staff at the centre within a reasonable time, the implementation of case management teams involving all relevant health professionals within the centre, the introduction of revised Correctional Services Commission rules dealing with the identification of at risk inmates and the appropriate management of them, including procedures for early intervention by custodial correctional officers.

"The official Investigation Report, Exhibit 36, dated 21 April 1994, conducted by the inspectors appointed under section 27 of the Corrective Services Act of 1988, made a number of recommendations contained in section 10 of that report. I agree in principle with those recommendations, particularly in regard to having adequate staff available to perform the functions of the centre.

"I would like to urge the Commission to again look at the level of psychiatric and psychological counselling services available within the centre. The evidence strongly suggests that there is an urgent need to increase the intensity of those services at the centre. Where applicable I would also urge the Commission to adopt, insofar as the Brisbane Women's Prison is concerned, those recommendations made in respect of an inquest held into the cause and circumstances of the death of Mervyn Patrick which were delivered in Brisbane on 13 October 1995."

Case 9435	**Male aged 21 years, died 17/4/94, at Wacol Correctional Centre, Brisbane, Queensland.**
Prison	The deceased was an inmate at Wacol Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Gary M. Casey Coroner's Court, Brisbane 13/10/95
Coroner's Formal Findings on Cause of Death	"I find that the deceased ... died in Brisbane on 17 April 1994 and that the cause of his death was hanging."

Comments on Case 9435

[At the time of his death the deceased was confined to the detention unit because of an incident on 15 April. He was placed on a continuous observation routine which was unfortunately altered on the relevant Suicide Watch Log to read 15 minutes.]

"I am satisfied that there is insufficient evidence upon which any person could be committed for trial with respect to an offence arising from the deceased's death.

"... there was a generally held view that ... the detention unit was perceived, by various levels of correctional staff from both the operational and program sections ... to have been an unsatisfactory facility to achieve continuous observations of any inmate ...

"His condition, identified as a border line personality disorder, was in the context of an ill-equipped custodial infrastructure, ultimately to lead to the tragic outcome.

"The condition ... meant that he was unsuitable for treatment in the normal correctional hospital setting or hospital for those suffering from a psychiatric illness ... Nor was he suitable for placement in a mainstream prison environment or in the detention unit.

"... there was virtually no place to which he could be transferred to achieve a successful treatment of his condition."

Coroner's Recommendations

"Accordingly, I recommend that serious consideration be given to acknowledging that a small proportion of the prison population has the misfortune to suffer from the condition which afflicted the deceased, and that suitable accommodation in an appropriate rehabilitative setting be established to treat those inmates afflicted with such condition.

"It is also recommended that should the aforementioned recommendation be deemed inappropriate, then additional psychiatric staff be employed to augment the services provided by a crisis support unit or correctional hospital, bearing in mind the evidence that sufferers of border-line personality disorders require long-term care, as compared to the short-term objectives of crisis support units or correctional hospitals.

"To reiterate what has been recommended in previous inquests, it is again recommended that additional medical and psychiatric services be provided to correctional institutions. The evidence at the inquest is indicative of a shortage of such services and the obvious need for those professionals currently employed within the correctional centres to devote more time to individual patients and to the attendants of associated administrative functions.

"It is additionally recommended that management formulate workable initiatives to integrate exchange of information and cooperation relevant to the care and treatment of

inmates between psychiatry, psychology, nursing personnel and custodial correctional staff. Furthermore, it is considered necessary that clear and unequivocal lines of communication be encouraged between counselling staff and particularly between psychiatrists and psychologists when it is considered that a change in frequency of observations of any inmate is necessary.

"It is recommended that procedures be formulated to ensure that all observation sheets or Suicide Watch Log forms be fully completed by custodial correctional officers and contain the endorsement of the shift supervisors in accordance with the tenure of the form.

"It is considered that regardless of what form of observation facility is provided for 'at risk' inmates, it is essential that cameras be installed to continually monitor inmates and that nursing staff, preferably with formal psychiatric credentials and correctional officers know exactly what is expected of them in relation to the professional performance of their respective functions.

"In view of the evidence given by [a doctor] concerning the appropriateness of periodic observations of potentially suicidal inmates, a review of the principles upon which such protocols are formulated is recommended.

"It is also recommended that an appropriate direction be given to ensure that all relevant information is provided to the operational support for the compilation of the operational planning matrix. Consideration could also be given to having a designated officer ensure that the matrix is fully relevant to the centre's operations on weekends.

"It is recommended that the Corrective Services Commission ensure that all official visitors to correctional centres are formally notified of the protocols for obtaining access to reports and other documentation relevant to an inmate's management and care. The information could also include precise guidelines of preferred hierarchal format for the lodging of official applications and complaints. It is also suggested that official visitors be encouraged to exchange information on a regular basis and be provided with access to a suitable facility to fulfil that purpose.

"It is also recommended that all exercise yards and cells in the detention unit at Wacol Correctional Centre be provided with identical locks to ensure that access to an inmate by correctional officers is provided in a most expeditious manner practicable.

"It is also recommended that management and professional medical staff be consulted before the Corrective Services Investigation Unit involve any 'at risk' inmate in covert surveillance or evidence gathering operations. Similar consultation should take place before any intended interview of such 'at risk' inmate."

Case 9457	**Male aged 49 years, died 5/8/94, at Rockhampton Correctional Centre, Queensland.**
Prison	The deceased was an unsentenced inmate at Rockhampton Correctional Centre. He had been remanded in custody from Bundaberg Magistrate's Court and refused bail.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Black Coroner's Court, Rockhampton 26/2/96
Coroner's Formal Findings on Cause of Death	"I find that a male person ... died on 5 August 1994 at the Rockhampton Correctional Centre ... and I duly certify the cause of death to be compression of neck."

Comments on Case 9457

"There was nothing in [the deceased's] demeanour in any interview or contact with correctional staff which would have or should have ignited a suspicion that he was a person at risk of self-harm.

"There is no evidence any other person contributed to [the deceased's] death. There is no suggestion of criminal negligence which would require that any person be committed for trial for any offence arising out of the death and no person is committed."

Western Australia

Case 9436	**Aboriginal male aged 30 years, died 22/1/94, at Canning Vale Prison, Western Australia.**
Prison	The deceased was an inmate at Canning Vale Prison.
Coroner **Location of Inquest** **Date of Inquest / Findings**	David Arnold McCann Coroner's Court, Perth 14/6/95
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that the deceased ... died on 22nd January, 1994, at Caning Vale Prison as a result of acute opiate toxicity. "I find that the death arose by way of unlawful homicide."

Comments on Case 9436

[On 22 January, a visitor to the prison passed to another inmate a package containing heroin. The inmate was told that the package was for two named inmates, and after taking some of the powder, passed it on to one of the two. He than obtained a syringe and the three shared the substance. The deceased insisted to one of the three that he be given some of the substance. One of the inmates eventually agreed and carried out the injection himself, the deceased being unable to do so. Two inmates carried the deceased back to his cell just before lock-down. While he couldn't be roused, he was still breathing.]

"Subsequent to the death of the deceased another person was convicted of the unlawful killing of the deceased.

"Some evidence was given about the difficulty of detecting persons who were under the influence of a substance. In my view it is not practicable to provide effective training to prison officers to enable them to detect that inmates might be under the influence of a specific drug."

Case 9437	**Aboriginal male aged 34 years, died 25/1/94, at Geraldton Regional Hospital, Geraldton, Western Australia.**
Prison	The deceased was an inmate at Greenough Regional Prison who was transferred to Geraldton Regional Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Robert Keith Black Coroner's Court, Geraldton 19/9/95
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that the deceased ... died on the 25th January 1994, at Geraldton Regional Hospital as a result of cardiac arrest consequent upon an acute myocardial infarction. "I find that death arose as a result of natural causes."

Comments on Case 9437

[On 20 January, the deceased complained to a prison nurse of central chest pain and feeling unwell. He was taking medication for pre-existing conditions of hypertension and diabetes. The following day he was observed to be coughing and expectorating yellow sputum and prescribed an antibiotic. He was transported to hospital that evening after the alarm was raised that he was observed suffering from pains to the chest area. Tests concluded that the pain was likely to be due to oesophagytis after which the deceased was discharged and returned to Greenough Prison. It was arranged for him to attend the prison medical clinic on Monday 24th. On the morning of the 24th, the deceased again complained of feeling unwell and the nurse arranged for him to rest in bed until the doctor's clinic that afternoon. After lunch the deceased was found in his cell coughing and expectorating pink sputum and expressing fear of dying in the prison. The deceased was taken to the clinic to await the doctor's arrival. Once the doctor arrived and found the deceased to be very unwell, he arranged the expeditious transfer to Geraldton Hospital. The following morning (25th), shortly after arrangements were made to transfer the deceased to Perth, he developed serious ventricular tachycardia which reverted to ventricular fibrillation.]

"The evidence establishes that the deceased was in a high risk category with regard to suffering of coronary artery disease. He was of Aboriginal descent, he had non-insulin dependent diabetes mellitus, he was obese, he suffered from hypertension, he was a smoker and had consumed alcohol to excess prior to his admission to prison. The authorities were aware of his existing medical condition ... prison medical authorities may not have been totally aware of the treatment that the deceased had received prior to his incarceration and at other times when he was not incarcerated.

"... it would be helpful to both the prison medical authority and a prisoner if at the time of the initial taking of any medical the prisoner was invited to sign a release or releases in relation to his medical history directed to any and all medical practitioners he has been treated by.

"The second matter that arises is in relation to the medical file kept by the Prison Health Service in respect of each prisoner. As a result ... of confidentiality that file does not ... leave the prison sick bay or infirmary. ... if a prisoner is transferred to a hospital that that file does not go with him for the benefit of any medical practitioner treating a prisoner at that hospital. ... procedures should be put in place to ensure that that file goes with that prisoner."

Case 9462	**Male aged 19 years, died 5/9/94, at CW Campbell Remand Centre, Canning Vale, Western Australia.**
Prison	The deceased was an unsentenced inmate at CW Campbell Remand Centre. He was remanded in custody from the Perth District Court and bail had been refused.
Coroner **Location of Inquest** **Date of Inquest / Findings**	David Arnold McCann Coroner's Court, Perth 21/6/95
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that the deceased ... died on 5th September, 1994, at CW Campbell Remand Centre, Canning Vale as a result of ligature compression of the neck. "I find that the death arose by way of suicide."

Comments on Case 9462

[Prior to appearing in court on 25 August and being refused bail, the deceased had told his mother that if bail was not granted he was going to hang himself. His mother relayed this information to the Senior Social Worker at the Remand Centre who later that day found the deceased to be depressed, withdrawn and somewhat uncommunicative. He revealed past suicide attempts and expressed thoughts of self-harm. It was agreed that because he did not want to be placed in an observation cell that he would share a cell with another inmate. The following day a medical officer noted that the deceased was suffering from anxiety depression and insomnia and requested that the deceased be reviewed on 30 August but this review did not take place. The deceased was expecting a visit from his mother on 5 September. When she had not arrived he requested permission to make a phone call which was abruptly refused. A fellow prisoner said he was upset and responded "I'm going to string myself up". He was found hanging later that afternoon.]

"Attached ... are further comments relating to this death and the death of another person in prison custody.

"There is clear evidence that persons detained on remand in prison custody may be distressed and upset by their circumstances and are particularly vulnerable in the first hours and days of such custody.

"... there appears to have been little to distinguish the form of custody of a sentenced prisoner and that of a person who was unconvicted of the offence with which he was charged and who was, as a matter of law, innocent.

"... the opportunity of making a telephone call appears to have been unduly restrictive.

"Evidence was given that a new system for telephone calls by inmates was planned to be tested later in 1995.

"It is hoped that the means for inmates on remand to communicate with their families has, by now, improved."

1995
Deaths In Police Custody Or Custody related Police Operations For Which Coroner's Findings Have Been Received (State By State)

Victoria

Case 9519	**Male aged 43 years, died 11/2/95, at Prahran Police Station, Victoria.**
Circumstances of Custody or Police Operation	The deceased, armed with a knife, held up a pharmacy in Prahran. He was chased by one of the customers who had been threatened and during the ensuing chase attempted to commandeer one car and break into another. He also held a knife to the throat of a pedestrian he took as a hostage. Following civilian arrest, the deceased ingested a quantity of white powder from one of the bottles stolen from the pharmacy. Police attended and arrested him. He was examined by ambulance crew who advised police that he seemed to be functioning normally and they had no concerns about the police transporting the deceased in a van to the police station for interview. At the Station, police spoke by phone with a police surgeon who, after being informed of the substance ingested, advised police to call an ambulance. Whilst this conversation was taking place the deceased started to have convulsions.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Jacinta Mary Heffey Coronial Services Centre, South Melbourne 27/05/95
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on 11th February, 1995 at Prahran Police Station, Prahran, Victoria 3181 from Combined Drug Toxicity. "I am satisfied that all the ambulance officers conducted themselves appropriately and professionally in the circumstances. I have perused the Victoria Police Operating Procedures in relation to the welfare of prisoners who present with illness or injuries. I am satisfied that there was never within observation of any of the police officers who dealt with the deceased on that day any suggestion that the deceased's conscious state was impaired in any way, thus bringing into operation the protocols and directions set out therein. I am further satisfied that once the gravity of the situation became known the police acted entirely appropriately. "Finally, I am satisfied that the deceased and no other person contributed to the cause of his death."

Comments on Case 9519

"I am satisfied that during transit and on arrival at the station the deceased's welfare was enquired about on a number of occasions and he responded that he was not feeling ill. ... He did not appear to be exhibiting any signs of ill-health. A call had been put through to a forensic physician [Doctor] via D24. [Doctor] received the call at about [the same time the deceased had arrived at the station] and he was asked to attend Prahran Police Station. As he was some distance away and in a busy shop at the time of the first call [Doctor] called the Prahran Police Station directly approximately 10 minutes later to ascertain the nature of the problem. He was told of the ingestion of white powder for the first time. The officer he spoke to went to retrieve the container and upon learning the nature of the substance, [Doctor] advised the officer to call an ambulance and to have the deceased conveyed to the Alfred Hospital. During the course of this conversation however he was told that the deceased was having a fit and that an ambulance was being called.

"It would appear that the deceased started to have convulsions whilst police were absent from the Interview Room into which he had been placed. As soon as his condition was observed, an ambulance was called and officers commenced to attempt to resuscitate him by giving CPR. The ambulance crew who attended shortly after found the deceased to be in

asystole and they were unable to find a pulse.

"Located in the deceased's stomach were two unbroken glass ampoules containing morphine sulphate and five further intact ampoules containing the same substance were found in his rectum. Toxicological analysis of body tissue found the presence of cocaine in extremely high concentration, opiates, codeine and morphine and benzodiazepines. In terms of the clinical picture that such a combination of drugs would be likely to present, the medical witnesses were unable to be very precise due to the unknown factors such as tolerance and the times of ingestion of the various substances. They considered it was at least possible that the sedative qualities of the opiate drugs may have influenced the clinical response one would otherwise expect from such a large quantity of cocaine which is a stimulant. They pointed out that overdoses of cocaine were very rare but one would expect in the absence of other features and substances that the person who had orally consumed such a quantity of cocaine would expect to show signs of severe agitation and flushing in about 10 to 15 minutes. Elevated blood pressure and quickened heart rate would also be likely leading to cardiac arrhythmia and possibly death.

"I am satisfied that notwithstanding these comments as to what a likely clinical picture might have been that none of these features were present at any time the deceased was being examined by ambulance personnel at the scene of the deceased's apprehension."

Case 9559	**Male aged 38 years, died 15/11/95, at Geelong Hospital, Victoria.**
Circumstances of Custody or Police Operation	Police were conducting covert surveillance inside the residence of 2 Gurr Street, East Geelong, in an effort to apprehend a persistent burglar who had broken into approximately 50 houses in the immediate area over a 10 week period. Two police officers were present when the deceased forced a side window and entered the premises. He was confronted by one of the officers, who was stabbed in the arm with a knife being wielded by the deceased. The officer, fearing for his life, fired a single shot from his revolver which struck the deceased in the upper chest.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Graeme Johnstone Coronial Services Centre, South Melbourne 4/11/95
Coroner's Formal Findings on Cause of Death	"The death of [the deceased] occurred on the 15th November 1995 at 2 Gurr Street, East Geelong from a gunshot injury to the chest."

Comments on case 9559

"In order to decide the issue of contribution it is necessary to determine whether or not the shooting was justified.

"The issue of contribution in this case is complex. Not being able to determine whether [the first police officer's] explanation on the origin of his injuries is correct creates difficulties for determining the issue of contribution to [the deceased's] death. There is the possibility that his version about the knife wounds (either in part or as a whole) is correct. If that is the case then the shooting may have been justified and he would not have contributed to the death. Alternatively, he may have self-inflicted all of the injuries. If so, then other, unexplained scenarios, may have occurred which either justify and explain the shooting or do not. In the end, while there may be a level of disquiet about what happened, we do not know.

"On the available evidence, in spite of the conclusions of [the first police officer's] involvement in disturbing the scene, it is not possible to determine whether or not the shooting was justified. Thus the issue of contribution vis-a-vis [the first police officer] remains unanswered.

"It is trite to say that [the deceased] clearly placed himself in a position of potential danger by continually breaking into houses in the East Geelong area. He was also capable of inflicting injuries to [the first police officer] and was affected by drugs. Whether he did inflict

the injuries is another matter. As it is not possible to ascertain the exact circumstances of the shooting, it is not possible to determine his level of contribution to his own death.

"There is no evidence to suggest that [the second police officer] contributed. No other person contributed to the death.

"The fact that we may never know what actually occurred in the bedroom of 2 Gurr Street is, of itself, disturbing. Where an incident occurs involving police using lethal force it is important for a society to be confident that all of the facts become publicly evident.

"Where, even following a lengthy inquiry, we do not know what actually happened, this must leave our society with some degree of disquiet. We do not know precisely how [the deceased] met his death. We do not know why there has been inadequate initial information provided by the officers to explain the event. ...

"Some aspects of the forensic investigation are of concern. This will need addressing to ensure that a continuing high quality of expert evidentiary material is put before our courts."

Coroner's Recommendations

Recommendation 1:

"The Victoria Police consider, as part of the development of the 'Ethical Standards Department', establishing an 'Ethics Committee' with an appropriate level of community and professional membership to assist in dealing with the more difficult and developing ethical issues constantly facing a modern police force.

"The evidence in this case illustrates the need for coordinated education and training on ethics rather than relying on a code for that guidance. ...

Recommendation 2:

"The Victoria Police consider including, as part of core responsibilities in position descriptions — operational/occupational health & safety.

"The officers directly involved in this incident remained at the scene and in the house for a period in excess of an hour after the event. It is essential, for the integrity of an investigation, to ensure that police officers involved in shooting incidents by separated at the earliest possible time (see also the comments of Coroner Jacinta Heffey in Helen Merkle - CN: 3306/95).

Recommendation 3:

"Victoria Police consider a system of "random audits" of routine, low level (and other) police operations to ensure equipment and management issues are monitored...

"Because of the lack of an "Operation Order" and equipment management issues it may be necessary to consider random audits of police operations to ensure there is some degree of monitoring in this area.

Recommendation 4:

"Victoria Police consider the installation of a time recording system for 'Intergraf'. This should be for the purpose of accurately identifying the time sequence of events. Where running transcripts of 'D24' radio conversations are provided it would be useful in cases where time might be an issue for a regular recorded time to correspond (where applicable) to the details of the conversations between the operator and the responding unit.

One of the potential difficulties in understanding the time factors of the events through the 'D24' Operator and the responding units was the difficulty in linking a time to the various conversations.

Recommendation 5:

"The Victorian Forensic Science Centre consider developing a protocol for attendance of the Assistant Director (Crime Scene) at all police shooting scenes. The role of the Assistant Director would be to oversee the management of the scene.

"One of the problems in this investigation related to initial sampling in areas such as blood and gunshot residue by forensic scientists. The identification of areas of expertise on the

question of whether the wounds were self-inflicted also needed to be addressed at a far earlier stage in the investigation.

"Clearly, some difficulties in any complex investigation cannot be envisaged in any protocol, no matter how well developed. Practicality demands a balance between what is achievable and what is not. This case has identified some problems which only come to light during a lengthy inquiry. All agencies (including the Coroner's Office) may benefit from a reconsideration of the protocols.

"Many of the comments mirror recommendations in the recent inquest into the death of Archie Butterly (CN: 804/93).

Recommendation 6:

"The Victorian Forensic Science Centre consider developing a protocol for attendance of an Assistant Director (Scientific) at all police shooting scenes. The role of the Assistant Director would be to oversee forensic sampling and testing. This recommendation should be considered in addition to Recommendation (5).

Recommendation 7:

"The Victorian Forensic Science Centre (with the Victorian Police Homicide Squad) consider developing investigatory protocols to:

(a) sample swab GSR from all relevant clothing (and persons) either at the scene or at the nearest convenient location. Such sampling should occur as soon as practicable after the incident.

"Consideration should be given to protocols designed to limit possible contamination or transference. Ideally protocols should also consider limiting travelling of officers (or other persons) involved.

(b) scene examiners secure all relevant equipment for sufficient time for scientific (or other) investigations to ensure that an issue is either eliminated or included. This may take some time.

Recommendation 8:

"The Victorian Forensic Science Centre consider developing procedures to ensure that all recovered evidence is inspected for forensic material. Where material is discovered that should be noted and immediately drawn to the attention of the investigators.

Recommendation 9:

"The Victorian Forensic Science Centre consider developing procedures to ensure that all expert statements are supplied with a list of the supportive material on which the opinion is based (ie: notes,- test results, drawings, plans, photographs, etc.).

"The statement (with the list) and copies of the supportive information should be provided at the earliest possible time before the hearing.

(It is not satisfactory to provide the supportive information on the day of the hearing. Nor is it desirable to inform the coroner during a hearing that another expert completed the relevant tests.)

Recommendation 10:

"The National Institute of Forensic Science (with the Victorian Forensic Science Centre) consider the benefits (or otherwise) of laboratory control studies to benchmark scientific evidence in the GSR area.

"The recent case of Butterly and this matter serve to highlight the need for more structured scientific evaluation in the area of GSR.

"For this recommendation to be effective (if considered scientifically valid) resources would need to be made available.

Recommendation 11:

"Victoria Police (Homicide Squad), Forensic Science Centre and the Institute of Forensic

Medicine (with the Coroner's Office) explore the development of protocols for the case management of police shootings. The role of case management meetings should be to assist with the proper assessment of forensic evidence and the obtaining of appropriate experts.

"In addition to case management protocols the appointment of a scientific liaison officer may be useful for the development of expert evidence (pathologists, forensic clinicians, forensic scientists, etc.) and scientific testing in appropriate cases.

Recommendation 12:

"Victorian Forensic Science Centre consider including in relevant statements riders on forensic test methods and any limits. Any explanations need to be clear and unambiguous.

Recommendation 13:

"Practically, it must be recognised that the Victorian Legal Aid Commission has increasing pressure as a result of budgetary constraints. However, where aid has been granted in an inquest, and it is proposed to withdraw that aid, it may be necessary to advise the Coroner hearing the matter to ensure the issue is discussed and appropriately managed. It also must be recognised that in some cases this protocol may not be appropriate."

Case 9563	**Male aged 64 years, died 6/12/95, outside the Salvation Army Gill Memorial Hostel, Melbourne, Victoria.**
Circumstances of Custody or Police Operation	The deceased, who had suffered from alcoholism for a number of years, returned home and collapsed on the front porch of his unit. He appeared to be drunk and ill and his wife called an ambulance. As he did not wish to be taken to hospital and his wife did not want him back in the house, the police were called. They returned to the Broadmeadows Police Station and decided to arrange alternative accommodation at the Gill Memorial. Upon arrival, as he was alighting from the rear of the police van, the deceased collapsed into the arms of both police officers.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Graeme Johnstone Coronial Services Centre, South Melbourne 1/10/96
Coroner's Formal Findings on Cause of Death	"I ... find ... that death occurred on the 6th December 1995, outside the Gill Memorial from 1(a) Hypolvolaemic cardiac arrest, 1(b) Chronic gastrointestinal haemorrhage, 1(c) Oesophageal ulceration with contributing factors, 11 Coronary artery atherosclerosis and left ventricular hypertrophy. "That no person contributed to the death."

Comments on Case 9563

"The ambulance officers observed blood about the deceased's head. It was believed that he may have had some trauma to his nose. His clothing was observed to be dishevelled and soiled. The ambulance officers apparently advised attending police that he may have had a broken nose.

"[The Ambulance Officer] stated the deceased did not explain as to how he had received the injury not did he give any indication of pain. In addition [the Ambulance Officer] stated 'he appeared alert and aware of his surroundings and what he was being asked.

"He was not placed in the cells. [A police constable at Broadmeadows Police Station] observed the deceased to be asleep but when woken he responded to questions. He made his own way into the police divisional van.

"They left for the Gill Memorial at about 7.40 pm. They arrived at about 8 pm, after stopping en route to check on his welfare. As he was alighting from the rear of the police van the deceased collapsed into the arms of [two police officers].

"[The pathologist] stated in his report, 'The injuries on the right side of the deceased man's forehead are superficial in nature and have features of injuries produced by non-specific blunt trauma.' In evidence he indicated the injuries could have occurred from either a fall or blow.

"The police officers involved, acting on earlier advice from the ambulance officers, took appropriate and compassionate steps to manage the deceased. The later discovery of the natural disease process is indicative of the difficulty for police in assessing and managing persons who appear to be intoxicated."

Coroner's Recommendations

"A careful examination of all of the material in this case— as has been provided by the police 'Critical Incident Report' [not publicly available] indicates some of the difficulties for police in assessing and managing the apparently 'intoxicated' individual. Accordingly, it may be useful to consider drawing on the issues in this case for the purpose of police and ambulance training [see also: Maxwell Williams, deceased - Case number 3326/94 - finding attached]."

Tasmania

Case 9574	**One male (age undetermined - incident involved two males, one aged 16 years and one aged 17 years), died 24/9/95, King Street, Sandy Bay, Tasmania.**
Circumstances of Custody or Police Operation	A motorcycle, with driver and pillion passenger, was observed by police travelling in King St with no indicators. Police indicated to the driver of the motorcycle to stop. The motorcycle slowed, then accelerated away through a red light and collided with another vehicle. (NOTE: Police were attempting to detain the driver of the motor cycle, not the pillion passenger. Therefore, while two deaths resulted from the incident, only one case is included here. Driver and age of driver undetermined because coroner unable to determine who was driving the motorcycle.)
Coroner **Location of Inquest** **Date of Inquest / Findings**	Ian Roger Matterson Coroners Court, Hobart 25/9/95

Coroner's Formal Findings on Cause of Death	"... That [the first deceased], died on the 24th day of September 1995 at the Royal Hobart Hospital at Hobart in the State of Tasmania from multiple injuries received when the motorcycle he was travelling on with [the second deceased] , collided with a Toyota Highlux, which was being properly driven by [driver], at the intersection of Regent and King Street, Sandy Bay. I am unable on the evidence before me to find who was driving the motorcycle which I find went through a red light. "I further find that the said [the first deceased] single, a trainee at ANM, was born at Hobart on the 29th November 1977 and was aged 17 years. "... That [the second deceased], died on the 24th day of September 1995 at Sandy Bay in the State of Tasmania from multiple injuries received when the motorcycle he was travelling on with [the first deceased] , collided with a Toyota Highlux, which was being properly driven by [driver], at the intersection of Regent and King Street, Sandy Bay. I am unable on the evidence before me to find who was driving the motorcycle which I find went through a red light. "I further find that the said [the second deceased] single, a student at Rosny College, was born at Hobart on the 17th January 1979 and was

	aged 16 years."

Comments on Case 9574

"The questions about the perceived attitude of police towards young motorcycle riders of course were put on the basis that it is something that is done by all police officers. Whether other officers do have those attitudes, is of course not a matter for Inquest to make a finding. ... I will limit the findings that I make about any attitudes to inference of [the police officer] who was the one to whom the matters were directed.

"I don't think that there was anything in the evidence that showed that he [the police officer] necessarily evinced anti-youth attitude on the road.

"It wasn't in fact until it was noted on the motorcycle that there were no indicators at all, the decision was then made to pull it up in King Street and to my mind that suggests that it was just pure co-incidence and that it wasn't a situation of 'let us get this motorcycle because there are two young blokes on it.'

"The one thing that I noted from the comments made today was that the parents of both of the deceased boys firmly believe that had their son been the driver of the motor bike that they would have obeyed the police directive to pull over.

"A. Was the behaviour of the police in the police vehicle following the motorcycle appropriate at that time; and B. Which of the two deceased was actually in control of the motorcycle, —who was the driver?

"As to A. ... I believe that it was quite appropriate for the police to pull the motorcycle up, at least find out why there were no indicators and nothing has come out of the evidence to suggest there was anything other than that question initially on the mind of the police officers. They kept some short distance back from the motorcycle, they only put on the flashing lights ... Perhaps the more so because they seem to be lulled into some false sense of expectation that the motorcycle was going to stop. So accordingly, there was no need for overkill situation with the sirens and horns to be going. ...the acceleration of the motorcycle away from the vicinity of the pole at King Street took the police officers completely by surprise. This is not a chase situation, in the manner that sometimes unfortunately does arise where one has a high speed chase with allegations that could be put then, that the police have put the individual drivers in even more danger because of the speed involved. There is nothing along these lines that suggests other than the police were following what I would regard as an appropriate procedure under the circumstances and I can see they have done nothing to exacerbate the situation other than their desire to properly pull up a vehicle that was — to all intense purposes — defective.

[Turning to B.] "Why the police officers didn't note the position of the person wearing the dark helmet and the person wearing the light helmet, can't really be explained. ... One can only assume that they just didn't ever consider that the colours of the helmets were going to be ever a consideration.

"My hunch is that [one of the two deceased] was probably in charge of the bike, but there isn't enough evidence of a satisfactory nature that would enable me to make a finding of fact on that basis, to do so would really just be contrary to the evidence that I have, which really is unsatisfactory. ... it is not appropriate to make findings purely on speculation. As unsatisfactory as it is going to be for both families, I believe the only appropriate finding I can make looking at the evidence in the best possible light, is that both deceased were on the motor cycle, but without making any findings to who was the driver."

New South Wales

Case 9576	**Aboriginal male aged 22 years, died 23/11/95, Prince of Wales Hospital, Sydney, NSW.**
Prison	The deceased was an inmate at Goulburn Correctional Centre who was transferred to the Goulburn Base Hospital and later to the Prince of Wales Hospital Intensive Care Unit.
Coroner **Location of Inquest** **Date of Inquest / Findings**	John Birley Abernethy State Coroner's Court, Glebe 18/12/96
Coroner's Formal Findings on Cause of Death	"... I formally find that [the deceased] died on 23 November 1995 at Randwick. I terminate this Inquest pursuant to S 19 of the Coroner's Act 1980."

Comments on Case 9576

[Coroner reading from the police form (Report of Death to the Coroner)]: "At about 11.30am on 16 November 1995, the deceased was in the front yard of the Goulburn Correctional Centre when he was involved in an altercation involving five other inmates, yet to be identified. As a result he received serious head injuries. He was then transferred to Prince of Wales Hospital for further treatment. The deceased never regained consciousness.

"On the evidence before me I must ask, in effect, could a person be convicted of an indictable offence? That is really what I have to consider, and I emphasise the word 'could'.

"I am satisfied that there is a prima facie case made out against a known person and it is inappropriate that I say more than that in this forum. Of course it follows that my reasons for holding a case in the name of a known person will be forwarded to the Director of Public Prosecutions in due course."

Recommendations

"That any prison officer who undertakes duty in a monitor room of any New South Wales correctional facility be fully and competently trained in the effective use and control of monitoring equipment prior to commencing such duty.

"That whenever an incident occurs in a New South Wales correctional facility which involves a police investigation, the relevant day's security monitor video tapes be retained by a senior prison officer and handed to investigating police at the time of initial attendance by police at the prison.

"That there be a standard instruction, as opposed to a 'local order', setting minimum guidelines relating to the movements of prisoners within any prison. Such instructions should encompass especially movements of differing categories or prisoners within an institution and the mixing thereof.

"That the Department of Corrective Services reviews its training procedures to ensure that all prison officers are fully trained in how to place a prisoner in a cell or yard containing other prisoners and how to remove a prisoner from such cell or yard."

Victoria

Case 9520	**Male aged 56 years, died 1/3/95, at H.M. Prison Morwell River, Boolarra, Victoria.**
Prison	The deceased was an inmate at Morwell River Prison.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Edwin Charles Batt Coroner's Court, Moe 13/9/95
Coroner's Formal Findings on	"I ... find ... that the death occurred on the 1st March, 1995 at Morwell

Cause of Death	River Prison, Boolarra, Victoria 3870 from coronary artery disease. "And I further find that no other person contributed to the death."

Comments on Case 9520

"The deceased suffered from natural disease in the form of coronary artery disease. ... Whilst walking there at about 6.10 pm he collapsed suddenly and injured his face falling. Appropriate attempts to revive him by prison staff and ambulance officers failed."

Case 9526	**Male aged 20 years, died 13/4/95, at H.M. Prison Pentridge, Coburg, Victoria.**
Prison	The deceased was an inmate at H.M. Prison Pentridge.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Iain Treloar West Coronial Services Centre, South Melbourne 8/5/96
Coroner's Formal Findings on Cause of Death	"I ... find ... that the death occurred on the 13th April, 1995 at Cell 34, A Division. H.M. Pentridge Prison, Coburg from hanging."

Comments on Case 9526

[When received at the prison, the deceased related a history of drug abuse which included recent use of cannabis, benzodiazepine and heroin, resulting in him obtaining treatment for symptoms of narcotic withdrawal. On 8 April the deceased cut his left forearm with splinters of glass. At that time he told a Prison Medical Support that he wanted to be dead. Shortly after being treated, and after being refused a cigarette, the deceased reopened the wound, stating he would continue to do so unless given a cigarette. While being interviewed by the prison psychologist on 9 April, the deceased expressed considerable anger towards his girlfriend who, he believed, was having an affair with his brother. On 10 April the deceased inflicted injuries to his elbow with a portion of a razor blade. While receiving treatment at Geelong Hospital he indicated to staff he was extremely angry with his de facto and wanted to see a psychologist. Back at Pentridge he presented as emotionally stable, without symptoms suggestive of mental illness and was assessed as non-suicidal. On 12 April he was returned from the Acute Assessment Unit back to the mainstream prison and arrangements were put in place for ongoing review by members of the Forensic Psychiatry Unit. The deceased was found hanging at 7.15 am on 13 April. A suicide note was located in the deceased's cell.]

"The evidence satisfied me, that the deceased's medical treatment and assessment, was indeed, appropriate. ... I am further satisfied that he was appropriately transferred back into the prison mainstream, as his assessment gave no indications that would justify keeping him longer in 'G' Division.

"As to the question of supervision ... While authorities should never exclude the possibility of suicide where there is a history of self-harming behaviour, they must also take into account explanations for the behaviour, that are inconsistent with suicide. ... it should not be said that staff failed to take all reasonable steps to secure his well being. I am satisfied that he acted impulsively in hanging himself and that this action overtook the possibility of ongoing review by members of the Forensic Psychiatric Unit staff.

"The evidence in this case, satisfies me that the deceased contributed to the cause of death by intentionally taking his own life and that no other person, so contributed."

Queensland

Case 9507	**Male aged 24 years, died 24/1/95, at the Sir David Longland Correctional Centre, Brisbane, Queensland.**
Prison	The deceased was an inmate at Sir David Longland Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Gary M. Casey Coroner's Court, Brisbane 5/12/95
Coroner's Formal Findings on Cause of Death	"I find that he died in his cell, at that Centre on the afternoon of Tuesday 24 January 1995 and that the cause of his death was hanging. He had earlier that afternoon been placed in his cell, with a quantity of approved property and wearing apparel, which included pairs of sox. The deceased, when he was discovered by custodial correctional officers at about 3.15 p.m. was suspended by the throat, from a towel rail in the toilet/shower recess area by means of sox, knotted end to end and tied to the rail."

Comments on Case 9507

"On 23 January 1995, the deceased, who had been participating in a period of sponsored leave of absence from the work outreach camp, Wacol, was collected from the address at which he was spending his leave and conveyed to the Moreton Correctional Centre, where he was confined that evening. A decision had earlier been made by management personnel at the work outreach camp, that the deceased's leave be revoked and ordered his return to secure custody, pending investigation by Corrective Services staff.

"The allegations of impropriety on the part of the deceased, involving the theft of moneys from a fund established for the benefit of inmates. On the morning of 24 January 1995 the deceased was confronted with the allegations referred to and subsequently was transferred to Sir David Longlands Correctional Centre, pending further investigations by the Corrective Services Investigation Unit. ... On the evidence before me, I'm satisfied that there is no evidence upon which any person could be committed for trial for an offence in respect to the death of the deceased."

Case 9508	**Aboriginal male aged 20 years, died 1/2/95, at Sir David Longland Correctional Centre, Brisbane, Queensland.**
Prison	The deceased was an inmate at Sir David Longland Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Gary M. Casey Coroner's Court, Brisbane 28/2/96
Coroner's Formal Findings on Cause of Death	"I find that ... he died at Brisbane on 1 February 1995 and that the cause of his death was hanging. "I find that he has of his own volition tied one end of a skipping rope to bars above the left-hand side of his cell and the end around his neck for the purpose of ending of his life. ... suffice to say that there is no evidence upon which any person could be committed for trial."

Comments on Case 9508

"So far as making a recommendation, however, I wish to put on record that I am satisfied that the deceased at the time of his death was disturbed by a relationship which existed whilst he was in prison between his de facto wife and his brother. I am satisfied that that was the cause of the depression.

"I do not propose to make any formal recommendations in the form of a rider, but I would like to go on record supporting particularly recommendations 2.1, 2.2 and 2.3 of the Internal Investigators Report, Exhibit 17, as they have made recommendations which I have previously made in respect of other inquests."

Case 9510	**Male aged 37 years, died 4/2/95, at Rockhampton Correctional Centre, Rockhampton, Queensland.**
Prison	The deceased was an unsentenced inmate at Rockhampton Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	K. P. Lynn Coroner's Court, Rockhampton 18/7/96
Coroner's Formal Findings on Cause of Death	"I do find that ... died on 4 February 1995 at Rockhampton Correctional Centre, Etna Creek, Rockhampton. He was found at approximately 7.04 p.m. on 4 February 1995 hanging by his neck in a cell at the Detention Unit."

Comments on Case 9510

[On the evening of 3 February the deceased threatened to self-harm. He said he was depressed about family problems but did not specifically threaten to take his own life. He was put under hourly observations and dressed in an anti-suicide kit. About 10 am the next morning, 4 February, he cut his forearm with a piece of glass and after treatment was subsequently moved for self-protection to the Detention Unit where he was found hanging later that evening. After lunch the deceased asked to be taken off observations. He made the same request again at about 5.30 p.m. and was advised that it would be reviewed on Monday. A correctional officer says that the deceased did not appear to be depressed and gave no indication that he intended to do further self-harm.]

"Just some comments in relation to the suicide resistance sheet. ... There was a tear in the sheet commencing near a seam and perpendicular to it. ... The evidence does not disclose how the tear occurred in the sheet. ... there is no evidence to indicate that there was any detailed inspection of the anti-suicide gear before it was handed to the deceased or at any time while it was in his possession. Obviously, however, he was able to cut his forearm at a time when the anti-suicide gear was in his possession and presumably at some time would have had the opportunity to make an incision in the sheet which would then enable it to be torn.

"In relation to the death of the deceased, there is no evidence before me of criminal negligence on the part of any person, no evidence on which any person can be committed for trial for an offence. However, I do add a rider to my findings. I add these comments ... When he did threaten to self harm and subsequently did so, it was after hours and weekend off time for health professionals in the mental health field who might otherwise have spoken to the deceased and assessed him or assisted him, which one officer saw as a continuing problem within the system. It was not felt by staff at the time that the deceased was at immediate risk of suiciding and he was placed on hourly watches only but had the self harm incident occurred during normal working hours, he may have benefited from counselling or other intervention by a psychologist. When an act of self harm is carried out it is recommended that appropriate mental health professionals be given early access to the inmate concerned.

"The detention unit is now said to be only used for detention of persons at risk of self harm or who are considered to be at risk of suicide when placed under continuous observation. There have been some structural modifications and security cameras have been installed. The evidence indicates that the detention unit can be an effective means of isolating an inmate from the general correctional centre population and to prevent his access to foreign objects, or at least restrict it. However, it does place an at risk inmate who may have feelings of hopelessness, which I understand is a state frequently associated with suicidal behaviour, in a very bleak and isolated environment which is regularly used to house inmates who are high risk inmates for security reasons. The system of having an officer in the unit full time was not in place when this deceased was there.

"However, the evidence indicates that monitoring officers will need to keep a close watch on high risk security inmates and the presence of the latter may well be a distraction for monitoring officers who are placed in the detention unit for the purpose of suicide watches.

References were made in evidence to proposals for building more appropriate accommodation and it is recommended that such proposals be accorded priority."

Case 9516	**Male aged 52 years, died 17/3/95, at Numinbah Correctional Centre**
Prison	The deceased was an inmate at Numinbah Correctional Centre, Numinbah Valley, Queensland.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Webber Coroner's Court, Southport 27/3/96
Coroner's Formal Findings on Cause of Death	"... I will find that ... died at the Numinbah Correctional Centre on 17 March 1995. "The post-mortem examination report shows the cause of death as a haemorrhage arising from incise wounds to the arms. "I am satisfied that the injury which resulted in the death was self-inflicted and that in this case the deceased took his own life. "I am satisfied that no other person was involved. There was no indication from the deceased's behaviour that a reasonable person would be expected to be alerted of the deceased's actions and therefore I find that no person is to be committed for trial ...".

Case 9521	**Aboriginal male aged 27 years, died 20/4/95, at Borallon Correctional Centre, Ipswich, Queensland.**
Prison	The deceased was an inmate at Borallon Correctional Centre.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Bloxsom Coroner's Court, Ipswich 24/11/95
Coroner's Formal Findings on Cause of Death	"I find that ... died on the 20th day of April 1995 at the Borallon Correctional Centre and the cause of death was hanging."

Comments on Case 9521

[The deceased had been taking medication for ulcers as well as an antidepressant that was used to modify aggressive behaviour. Prison records dated July 1994 noted that his emotional stability was abnormal, however there was no concern that the deceased would cause self harm. Shortly before his death the deceased's wife failed to visit him. He was concerned his wife was involved with another man and about to leave him. On 19 April the deceased was informed that he would not be allowed to contact his wife at the telephone number where she was residing with her mother. Some time later that evening the deceased wrote a letter to his wife indicating his intention to kill himself and placed in it the mailbox.]

"He had a prior history of suicide attempts ... None of this information was provided to prison authorities by the deceased or by members of his family, and would not have been discoverable on the prison records.

"I am satisfied that these matters occurring whilst he was in custody without any opportunity for input into these situations, has deepened any depression that he had at that time. It has caused him to be so depressed that both prison officers and other prisoners were concerned for his well being, ... As a result, a prison officer, ... has requested the prison psychologist to speak to the deceased. ... the psychologist has formed the opinion that he did not present a threat to himself ... That psychologist did not have regard to the medical file and was not aware of all details in that file when making that assessment. Because of her assessment, no arrangement was made for the monitoring of the deceased.

"After lock down [10.30 p.m.] all keys were secured in a key safe in the movement control office and the key to that safe was lodged with the operations manager, who is stationed some 50 metres approximately from B block. Each cell in B block has an intercom system connected to the movement control office. After lock down it is usual to switch that intercom system through to master control. The intercom system allows prisoners to make contact with the control office and also allows the control the monitor prisoners.

"On the night of 19 April, that intercom was not switched through to the master control and after 10.30 p.m. prisoners in B block were not able to make contact until it was rectified after discovery of the deceased. After lock down at 10.30 p.m. there were no prison officers on duty in B block and the only monitoring of prisoners was by an external patrol, who checked the prisoners through the external window approximately two times per night. It was this patrol that located the deceased hanging from a sheet near his cell door at about 12.40 a.m. on 20 April 1995.

"An emergency was called in on the radio which had the effect of causing a phone call to be made to the nurse on duty. Members of the patrol had to run to the office of the operations manager to get the key to the safe in B block. They then had to go back to B block and gain entry, open the safe, obtain the unit and cell keys from that safe, which finally allowed them access to the cell of the deceased. This caused delay of some minutes before they were able to get to the deceased.

"I am satisfied he has intentionally hanged himself ... There is no evidence before me upon which any person could be committed to take their trial in relation to the death of the deceased."

Coroner's Recommendations

"In about 1988 I dealt with a similar death in custody at the Etna Creek Gaol near

Rockhampton. At that time I made a recommendation that all possible anchor points such as window bars, should be covered to prevent sheets or ropes being attached to them. That recommendation appears to have had little effect, but I again make that recommendation that any such anchor points should be covered in some way to prevent ties being made to them.

"There should be someone in attendance or a more effective monitoring system put in place during the hours of lock down in all cell blocks.

"The intercom system should be upgraded so that it includes a fail safe backup to ensure it is open and monitored at all times. I recommend also a system of checks to ensure that it is working at all times.

"I recommend a change to the security system in relation to the keys to cell blocks and cells, so as to make them more readily available should emergencies arise.

"I recommend that the medical or psychological staff have regard to all information available when making assessments on mental instability. If all information is not available at the time they are making the assessments, then they should institute precautionary monitoring until they are able to have regard to all files, both medical and otherwise."

Western Australia

Case 9542	**Male aged 32 years, died 10/3/95, at Fremantle Hospital, Fremantle, Western Australia.**
Prison	The deceased was an inmate at Casuarina Prison who was transferred to Fremantle Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Robert Brian Lawrence Coroner's Court, Perth 30/1/96
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that the deceased ... died on 10 March 1995, at Fremantle Hospital as a result of bowel obstruction due to intra abdominal spread of carcinoma of the colon. I find that the death arose by way of natural causes. "The medical care and treatment given to the deceased during his illness by both the medical staff at Fremantle Hospital and Casuarina Prison Hospital was responsible and appropriate in the circumstances."

Case 9545	**Male aged 71 years, died 5/7/95, at Fremantle Hospital, Fremantle, Western Australia.**
Prison	The deceased was an inmate at Casuarina Prison who was transferred to Fremantle Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	David Arnold McCann Coroner's Court, Perth 28/11/95
Coroner's Formal Findings on Cause of Death	"Upon inquiry I find that the deceased ... died on 5th July, 1995, at Fremantle Hospital as a result of coronary arteriosclerosis. I find that the death arose by way of natural causes. "I conclude from the evidence that the medical and nursing attention given to the deceased at the infirmary was appropriate and caring."

Tasmania

Case 9566	**Male aged 42 years, died 13/12/95, at Royal Hobart Hospital, Hobart, Tasmania.**

Prison	The deceased was an unsentenced inmate at Risdon Prison who was transferred to Royal Hobart Hospital due to illness.
Coroner **Location of Inquest** **Date of Inquest / Findings**	Ian Roger Matterson Coroner's Court, Hobart 13/12/95
Coroner's Formal Findings on Cause of Death	"... the [deceased] died on the 13th day of December 1995 at the Royal Hobart Hospital in the State of Tasmania of I(a) gastro-intestinal haemorrhage, I(b) bleeding oesophageal varices, I(c) cirrhosis of the liver, probably due to alcohol plus Hepatitis C and II portal vein and splenic vein thrombo-embolism. "I find that death was due to natural causes."

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During 1996, Aboriginal people were 19 times more likely to die in custody than non-Aboriginal people. While they comprise only 1.4 per cent of the national adult population, Aboriginal people accounted for 21 per cent of all deaths in custody.

Whilst trend data reveal that the number of deaths of both Aboriginal and non-Aboriginal people in institutional or close contact custody (i.e. shootings) has decreased in recent years, the number of deaths occurring in custody-related police operations, such as pursuits, has increased significantly.

The statistics contained in *Australian Deaths in Custody & Custody-related Police Operations 1996* provide a base for concerted policy to address an issue of very serious magnitude. The number of people dying in prison has been increasing, and more Aboriginal people in prison are now dying from heart disease and from hanging than during the 1980s.

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