

# AUSTRALIAN DEATHS IN CUSTODY

## No. 12 Australian Deaths in Custody & Custody-related Police Operations, 1995

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The information presented in this issue of the *Deaths in Custody, Australia* series 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 1995. Its central findings can be summarised as follows.

### Total Numbers

- During the twelve months to 31 December 1995, 86 deaths in custody were reported throughout Australia. The 86 deaths comprised 21 Aboriginal people and 65 non-Aboriginal people. There were no Torres Strait Islander deaths in custody reported during the year. Two juveniles died in the custody of juvenile justice/juvenile welfare agencies. Fifty-eight of these deaths (67 per cent) occurred in prison custody while 26 deaths (30 per cent) occurred in police custody or in custody-related police operations. Two women were among the 86 deaths.

### Age, Cause and Manner of Death

- The ages of those who died ranged from 16 to 75 years, averaging 33 years. The most frequent cause of death for both non-Aboriginal and Aboriginal people was hanging, followed in frequency by death from injuries and death from illness. 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.

### Trends

- Unfortunately, the number of deaths during the year (86) is higher than that reported for the previous year (80) and (using a consistent definition of a death in custody) was exceeded in only one of the 16 years for which data are available, namely 1987. While the total number of deaths in all forms of police custody have remained at the same level (26) as the previous calendar year, the same cannot be said for deaths in prison custody. The 58 deaths in prison custody during the year represents the highest number recorded.
- The number of Aboriginal deaths (21) is one and a half times the number reported for the previous year (14 deaths) and almost two-and-a-half times that reported in 1992 (9 deaths). The number of Aboriginal deaths in prison custody (16) has also increased markedly since 1992 when there were only two deaths and is the highest number ever recorded over the 16-year period since 1980.
- The number of Aboriginal deaths in police custody has remained at a similar number since 1992. On the positive side, no Aboriginal people died in police lockups during the year although five died in other forms of police custody.

Yet again, it is necessary to emphasise the fact that Aboriginal people were over-represented in the number of custodial deaths compared with the number of Aboriginal people in the community. Nearly 25 per cent of the 86 deaths in custody during the year were of Aboriginal people. Aboriginal people make up less than 2 per cent of the total Australian population which highlights the over-representation of these people in custody.

These new figures demonstrate the need for stronger action to be taken by all governments to implement the recommendations of the Royal Commission into Aboriginal Deaths in Custody, particularly the recommendations concerned with minimising the number of people held in prison and providing a high quality of care for those in prison custody.

Adam Graycar  
Director

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## INTRODUCTION

This paper presents information on deaths which occurred in police, prison and juvenile justice custody throughout Australia during the twelve months to 31 December 1995, as well as summary data on the whole period since 1980. The paper 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.

Details on the methodology used in this project were included in the first paper in this series. Briefly, each of Australia's eight police services, corrections authorities and juvenile justice or juvenile welfare authorities was 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 1995. 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. The information on trends presented towards the end of this paper updates that provided in earlier issues in this series. It incorporates new information on custodial deaths.

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## 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).*

The fourth paper in this series (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.

**TABLE 1**  
**Australian Deaths in Custody, 1995**  
**Jurisdiction, Aboriginality and Custodial Authority**

<i>Juris- diction</i>	<i>Police</i>			<i>Prison</i>			<i>Juvenile</i>			<i>Total</i>		<b>Grand Total</b>
	<i>Ab'l</i>	<i>Non- Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non- Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non- Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non- Ab'l</i>	
NSW	3	3	6	5	17	22	-	-	-	8	20	<b>28</b>
Vic.	-	9	9	-	6	6	-	1	1	-	16	<b>16</b>
Qld	-	4	4	3	9	12	-	1	1	3	14	<b>17</b>
WA	2	-	2	1	4	5	-	-	-	3	4	<b>7</b>
SA	-	-	-	6	5	11	-	-	-	6	5	<b>11</b>
Tas.	-	3	3	-	1	1	-	-	-	-	4	<b>4</b>
NT	-	1	1	1	-	1	-	-	-	1	1	<b>2</b>
ACT	-	1	1	-	-	-	-	-	-	-	1	<b>1</b>
<b>Aust.</b>	<b>5</b>	<b>21</b>	<b>26</b>	<b>16</b>	<b>42</b>	<b>58</b>	<b>-</b>	<b>2</b>	<b>2</b>	<b>21</b>	<b>65</b>	<b>86</b>

This report covers the incidence of 1995 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 also includes a discussion of trends in custodial deaths.

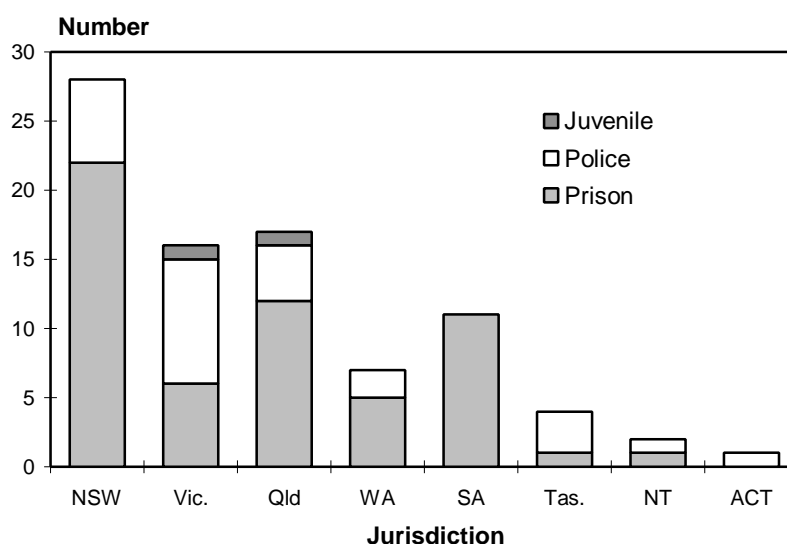
In order to provide a more detailed picture surrounding the issue of deaths in custody, a new section is included in this report which provides excerpts from the most recently completed coroners' inquests into deaths in custody. It documents all of the 1994 and 1995 cases for which the Australian Institute of Criminology has received coroners' findings. In addition to outlining details about the date, place and circumstances of each death, and about when, where and by whom the inquests were conducted, some of the coroners' comments, findings and recommendations, are presented. Subsequent publications will update this information as coroners' findings are received.

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## THE INCIDENCE OF DEATHS IN CUSTODY

During the twelve months to 31 December 1995, 86 deaths in custody were reported throughout Australia. Table 1 and Figure 1 provide details on the number of custodial deaths by State/Territory and Aboriginality for the 1995 calendar year.

**FIGURE 1**  
*Australian Deaths in Custody, 1995*  
*Jurisdiction and Custodial Authority*



Fifty-eight deaths (67 per cent) occurred in prison custody while 26 deaths (30 per cent) occurred in police custody or in custody-related police operations.

The 21 Aboriginal deaths represent almost 25 per cent of all custodial deaths during this period whereas Aboriginal people comprise less than 2 per cent of the Australian population.

Significantly, 16 (or 28 per cent) of the 58 prison deaths were of Aboriginal people. One-third (28) of the total number of deaths occurred in New South Wales.

## 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 86 deaths which occurred during 1995 are summarised in Table 2 using the following two 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.

A third category recommended by the Royal Commission, deaths which occur while a person is escaping from custody, is not relevant here as no such deaths have been reported during the year.

Sixty-four deaths (or more than 74 per cent) occurred in institutional settings. Significantly, there were only four deaths in police custody that took place in an institutional setting. None of those deaths were of Aboriginal people.

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 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.

Significantly, it is pleasing to note that not only have no Aboriginal or Torres Strait Islander people died in a police lockup during this calendar year, but for the first year since 1980 there have been no Aboriginal deaths in police custody other than where police were attempting to detain the person who died.

Two juveniles were reported to have died in the custody of the juvenile justice authorities during the year. Brief descriptions are provided below:

**TABLE 2**  
**Australian Deaths in Custody, 1995**  
**Circumstances of Death, Aboriginality and Custodial Authority**

Circumstances(*)	Police			Prison			Juvenile			Total		Grand Total
	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	
Institution	-	4	4	16	42	58	-	2	2	16	48	<b>64</b>
Detaining	5	17	22	-	-	-	-	-	-	5	17	<b>22</b>
<b>Total</b>	<b>5</b>	<b>21</b>	<b>26</b>	<b>16</b>	<b>42</b>	<b>58</b>	<b>-</b>	<b>2</b>	<b>2</b>	<b>21</b>	<b>65</b>	<b>86</b>

\*See text for definitions

- In Victoria, a young male aged 17 years died on 30 September at Cape Schanck as a result of drowning. At the time of his death he was on a supervised day outing with four youths from the Melbourne Juvenile Justice Centre. Three of the four youths were swept off an outcrop of rocks by a large wave, two being swept back onto the shore. The body of the deceased has not yet been found. He had been sentenced to 10 months detention for the theft of a motor vehicle and was seven days from being released. This case is classified as 'institutional' in Table 2 as he was under the direct supervision of institutional staff.
- In Queensland, a young male aged 16 years died on 24 December at the Sir Leslie Wilson Youth Detention Centre, Brisbane as a result of self-inflicted hanging. He was an unconvicted detainee, held on remand in relation to the alleged offence of possession of drugs. A psychologist's report compiled the day before the youth's death had warned that the youth was suicidal and that he was known to be upset over several deaths among his family and close friends.

## Manner of Death

The manner of death for those who died in custody in Australia during 1995 is summarised in Table 3. It should be borne in mind when interpreting the information presented in this paper 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'.

Hanging was the most frequent cause of death, accounting for 28 or 33 per cent of deaths. Almost half of the prison deaths were from hanging.

**TABLE 3**  
**Australian Deaths in Custody, 1995**  
**Cause and Manner of Death, Aboriginality and Custodial Authority**

<i>Manner</i>	<i>Police</i>			<i>Prison</i>			<i>Juvenile</i>			<i>Total</i>		<b>Grand Total</b>
	<i>Ab'l</i>	<i>Non-Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non-Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non-Ab'l</i>	<i>Total</i>	<i>Ab'l</i>	<i>Non-Ab'l</i>	
Hanging	-	1	1	7	19	26	-	1	1	7	21	<b>28</b>
Natural causes	-	2	2	7	8	15	-	-	-	7	10	<b>17</b>
Gunshot	-	9	9	-	-	-	-	-	-	-	9	<b>9</b>
Injuries	5	7	12	2	6	8	-	-	-	7	13	<b>20</b>
Drugs/alcohol	-	1	1	-	5	5	-	-	-	-	6	<b>6</b>
Other	-	1	1	-	-	-	-	1	1	-	2	<b>2</b>
Not known	-	-	-	-	4	4	-	-	-	-	4	<b>4</b>
<b>Total</b>	<b>5</b>	<b>21</b>	<b>26</b>	<b>16</b>	<b>42</b>	<b>58</b>	<b>-</b>	<b>2</b>	<b>2</b>	<b>21</b>	<b>65</b>	<b>86</b>

There was only one death from hanging in police custody; reflecting a significant downward trend from an extremely high level of 22 hanging deaths in police custody in 1987.

At the time of writing, the cause of death had not been determined for four prison deaths.

## Death Rates

In this section we present information on death rates during the 1995 calendar year for the Australian population. Death rates for police custody will be provided in the next report in this series as up-to-date data on the police custody population will be available then. The following discussion of prison death rates is based on the number of deaths in prison custody in relation to the number of people in prison custody.

**TABLE 4**  
**Prison Custody Death Rates, Australia, 1995**  
**Denominator: Aboriginal, Non-Aboriginal and Total Prison Populations**

<i>Aboriginality</i>	<i>Prison population<sup>(a)</sup></i>	<i>Deaths in prison custody 1995</i>	<i>Deaths per 1000 prison population</i>
Aboriginal <sup>(b)</sup>	2 909	16	5.50
Non-Aboriginal <sup>(c)</sup>	12 991	42	3.23
<b>Total</b>	<b>15 900</b>	<b>58</b>	<b>3.65</b>

- (a) **Source:** Prisoner populations taken on or near the first day of the month, Australian Bureau of Statistics (1996).  
 (b) Includes Torres Strait Islanders.  
 (c) Includes 'not stated'.

The crude death rate for *prison custody* during 1995 was 3.65 per 1000 of the prison population.<sup>1 1</sup> The crude death rate for Aboriginal prisoners was 5.50 per 1000 prisoners, whereas the death rate for non-Aboriginal prisoners was 3.23 per 1000 of the prison population; the relative risk of death in prison custody for Aboriginal prisoners (compared with non-Aboriginal prisoners) was 1.70 (that is 5.50 divided by 3.23). This means that the risk of death experienced by Aboriginal prisoners was approximately 1.7 times greater than that experienced by non-Aboriginal prisoners when their death rates are expressed in this manner.

<sup>1</sup> The prison populations used as the denominators of these rates are derived from Australian Bureau of Statistics (1996).

## POLICE CUSTODY AND CUSTODY-RELATED DEATHS

Table 5 provides numbers on persons who died in all forms of police custody during the 1995 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.

The total number of deaths in all forms of police custody have remained, for the second year running, at 26, the lowest figure reported for the six years for which these data are available.

In sharp contrast to previous years when deaths in close contact with police (Category 1) dominated, in 1995 almost two-thirds of the deaths occurred in other types of police operations, such as pursuits (Category 2).

**TABLE 5**  
**Australian Deaths in Police Custody and in Custody-related Police Operations, 1995**  
**Jurisdiction and Aboriginality**

Jurisdiction	Category 1 - Institutional or Close Contact Custody			Category 2 - Other Custody-related Police Operations			Total		Grand Total
	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	
NSW	-	-	-	3	3	6	3	3	6
Vic.	-	7	7	-	2	2	-	9	9
Qld	-	2	2	-	2	2	-	4	4
WA	-	-	-	2	-	2	2	-	2
SA	-	-	-	-	-	-	-	-	-
Tas.	-	-	-	-	3	3	-	3	3
NT	-	-	-	-	1	1	-	1	1
ACT	-	1	1	-	-	-	-	1	1
<b>Aust.</b>	-	<b>10</b>	<b>10</b>	<b>5</b>	<b>11</b>	<b>16</b>	<b>5</b>	<b>21</b>	<b>26</b>

The people who died in police custody were mostly young, with a mean age of 33 years. There were no significant age differences between the Aboriginal people who died in police custody and the non-Aboriginal people: the former had a mean age of 27 years compared to the mean age of 34 years for the latter.<sup>2</sup>

As can be seen from Table 3, injuries (12) and gunshot wounds (9) accounted for most of the deaths which occurred in police custody. Of the nine deaths resulting from gunshot, four were self-inflicted and the remaining five deaths were a result of gunshot wounds inflicted by police officers. Four of the deaths resulting from gunshot occurred in Victoria, all but one inflicted by police officers.

<sup>2</sup> There are differing age distributions of these two groups in the community but not in the custodial populations. Thus, the mean ages at death of Aboriginal and non-Aboriginal people, as we might expect, reflected the age distributions of their respective custodial populations but not their total populations in the community.

Overall, the five *most serious categories of offences*, namely homicide, assault, sex offences, robbery and other offences against the person, were the reasons for custody in 10 (38 per cent) of the 26 deaths in police custody. Motor vehicle theft was the alleged offence in an additional five cases, traffic and drunk/driving in four cases, break, enter/theft in four cases, public drunkenness in two cases and Mental Health Act matters were involved in one case.

In relation to the *legal* status of the deceased, in 22 of the 26 cases police were attempting to detain the individuals concerned. Of the four who were in an institutional setting, one person was on remand in police custody for the offence of drunkenness; one was a prisoner undergoing sentence at the time of his death; and one was being held for questioning. In the remaining case the person was intoxicated and being conveyed to a facility for the homeless for the night when he collapsed.

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

Seven of the 10 deaths occurred in Victoria, four as a result of gunshot wounds, all but one being self-inflicted.

Four deaths occurred in an *institutional setting*. Two of these deaths occurred in police lockups, one from natural causes and one from an accidental drug overdose. Of the two remaining deaths, one occurred in hospital following transfer from a police lockup as a result of self-inflicted hanging. In the remaining case, the person died after alighting from a police van at a home for the homeless after being conveyed there by police.

The remaining six deaths occurred in *non-institutional settings*, where police were able to exert a substantial degree of influence over the behaviour of the person who died.

Of particular concern is the fact that all six *non-institutional deaths* were a result of gunshot wounds. All but one of these deaths were a result of gunshot wounds inflicted by police while they were in the process of detaining, or attempting to detain, the individuals concerned. The remaining death was a result of a self-inflicted gunshot wound.

## **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.

It needs to be highlighted that seven of the 16 deaths resulted from external injuries received in a motorcycle or motor vehicle crash in the course of, or immediately following, a police pursuit. In New South Wales one death was as a result of a person being struck by a passing motorcycle while being pursued on foot by police. In Queensland a man died after he drove his vehicle over a cliff following a police pursuit and siege situation.

Three persons died as a result of self-inflicted gunshot wounds.

Three persons died as a result of either falling or jumping from bridges while police were attempting to detain them. Two died as a result of external injuries and one as a result of drowning. In another case a man died after falling from the eighth floor of a building whilst police were attempting to detain him.

**TABLE 6**  
**Deaths in Prison Custody, Australia, 1995**  
**Jurisdiction and Aboriginality**

<i>Jurisdiction</i>	<i>Aboriginal</i>	<i>Non-Aboriginal</i>	<i>Total</i>
NSW	5	17	22
Vic.	-	6	6
Qld	3	9	12
WA	1	4	5
SA	6	5	11
Tas.	-	1	1
NT	1	-	1
ACT	-	-	-
<b>Aust.</b>	<b>16</b>	<b>42</b>	<b>58</b>

## PRISON CUSTODY DEATHS

Table 6 provides information on the number of persons who died in prison custody during the 1995 calendar year.

More than one-third (22) of the deaths in prison custody occurred in New South Wales. Nearly one-third of those who died in New South Wales were Aboriginal. One female died in the State from self-inflicted hanging.

More than one-third (6) of the 16 Aboriginal prison custody deaths occurred in South Australia.

The people who died in prison custody were mostly young, with a mean age of 34 years. There were no significant age differences between the Aboriginal people and non-Aboriginal people who died in prison custody, the former having a mean age of 31 years compared to a mean of 35 for the latter.

As can be seen from Table 3, hanging was the most frequent cause of death in prison, accounting for 26 of the 58 deaths. Seven of the 16 Aboriginal prison deaths were as a result of hanging. At the time of writing, the cause of death was unknown in four cases.

Five of the six Aboriginal deaths from natural causes were from heart disease.<sup>3</sup>

It should be noted that 28 of the 54 deaths for which information on the manner of death is available were self-inflicted.

Overall, the five *most serious categories of offences*, namely homicide, assault, sex offences, robbery and other offences against the person, were the reasons for custody in 34 (or 59 per cent) of the 58 prison deaths. The highest number of prison custody deaths (15 out of the 58) occurred among people in prison for assault.

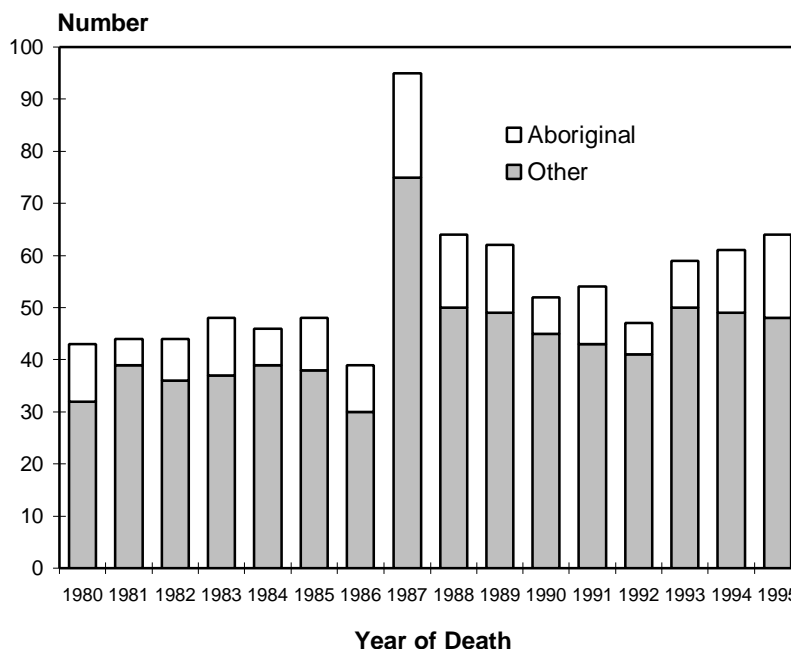
Nearly 71 per cent (or 41 of the 58 deaths) were of people who had been sentenced to a period of imprisonment at the time of death. The remainder (17, or 29 per cent) were on remand, i.e. unconvicted or convicted but awaiting sentence.

<sup>3</sup> The impact of cardiovascular disease in the Aboriginal population generally is being reflected in the custodial population (Australian Institute of Health and Welfare 1994, pp. 26-36).

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## TRENDS 1980 TO 1995

**FIGURE 2**  
*Australian Deaths in Custody, 1980 to 1995*  
*Year of Death and Aboriginality, Institutional Settings*



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This section presents information on trends in custodial deaths during the period 1 January 1980 to 31 December 1995. 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.<sup>4</sup> 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.

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<sup>4</sup> While the data set from which these figures are 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 7\***  
**Australian Deaths in Custody, 1980 to 1995**  
**Year of Death, Custodial Authority and Aboriginality, Institutional Settings\*\***

Year	Police			Prison			Juvenile			Total		Grand Total
	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	
1980	5	7	12	5	25	30	1	-	1	11	32	<b>43</b>
1981	3	12	15	1	27	28	1	-	1	5	39	<b>44</b>
1982	4	15	19	4	21	25	-	-	-	8	36	<b>44</b>
1983	6	10	16	5	26	31	-	1	1	11	37	<b>48</b>
1984	3	12	15	4	27	31	-	-	-	7	39	<b>46</b>
1985	6	16	22	4	22	26	-	-	-	10	38	<b>48</b>
1986	8	13	21	1	16	17	-	1	1	9	30	<b>39</b>
1987	15	26	41	5	48	53	-	1	1	20	75	<b>95</b>
1988	7	14	21	6	36	42	1	-	1	14	50	<b>64</b>
1989	10	11	21	3	37	40	-	1	1	13	49	<b>62</b>
1990	1	17	18	6	27	33	-	1	1	7	45	<b>52</b>
1991	3	12	15	8	31	39	-	-	-	11	43	<b>54</b>
1992	4	9	13	2	32	34	-	-	-	6	41	<b>47</b>
1993	2	7	9	7	42	49	-	1	1	9	50	<b>59</b>
1994	1	6	7	11	42	53	-	1	1	12	49	<b>61</b>
1995	-	4	4	16	42	58	-	2	2	16	48	<b>64</b>

\* Some of the figures in this table differ from those previously published. This reflects information which subsequently became available on deaths in custody which were not previously identified as such. The corresponding tables in reports prior to No. 8 in this series 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 2 and Table 7 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 1995.

Relatively low numbers of deaths were recorded during the period 1980 to 1986.

Substantial increases in both Aboriginal and non-Aboriginal deaths in 1987 (to 95 deaths) was a key factor in precipitating the appointment of the Royal Commission into Aboriginal Deaths in Custody. After this extreme level in 1987, the number of institutional deaths dropped to 64 in 1988 and continued to drop steadily until 1992 when 47 persons died in institutional settings. The number has increased each year since then.

Of particular importance is the fact that while institutional deaths in police custody have decreased markedly (by more than 90 per cent since 1987 (from 41 to 4), this is not the case for prison deaths. The highest number of deaths recorded during the last 16 years occurred in the 1995 calendar year when 58 persons died in prisons.

Deaths of Aboriginal people in prison custody have also increased markedly, with 1995 showing the highest number recorded for the 16-year period since 1980.

Table 8 shows deaths that occurred in *all custodial circumstances* from 1990 to 1995. 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.

It will be observed from this table that the 86 deaths which were reported for the year covered by this report reflect a 7.5 per cent increase on the previous year when 80 custodial deaths occurred.

The number of Aboriginal people who died in all forms of custody (21) is a 50 per cent increase on the number who died the previous year (14), consistent with the trend of Aboriginal deaths increasing since 1992. The number of non-Aboriginal deaths has remaining generally stable over the last two years.

The significant increase in prison deaths over the last six years is discussed below.

## Trends in Patterns of Prison Custody Deaths

**TABLE 8**  
**Australian Deaths in Custody 1991 to 1995,**  
**Aboriginality and Custodial Authority, Deaths in all custodial circumstances**

Year	Police			Prison			Juvenile			Total		Grand Total
	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	Total	Ab'l	Non-Ab'l	
1990	5	26	31	6	27	33	1	1	2	12	54	<b>66</b>
1991	5	25	30	8	31	39	-	-	-	13	56	<b>69</b>
1992	7	24	31	2	34	36	-	-	-	9	58	<b>67</b>
1993	3	26	29	7	42	49	-	1	1	10	70	<b>80</b>
1994	3	23	26	11	42	53	-	1	1	14	66	<b>80</b>
1995	5	21	26	16	42	58	-	2	2	21	65	<b>86</b>

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 9 provides information on deaths in prison custody in all jurisdictions for the period 1980 to 1995.

Of the 591 deaths that have occurred in prison custody during the 1980-95 period, 24 were female and 567 were male. More than 15 per cent (89) were of Aboriginal people.

More than one-third (or 37 per cent) of the total number of prison deaths occurred in New South Wales; New South Wales has 34 per cent of the Australian population.

Figure 3 provides information on the causes of death in prison custody for the period 1980 to 1995.

## Deaths since the Royal Commission

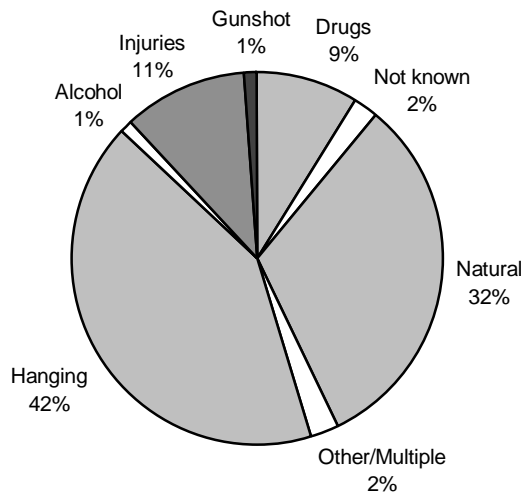
A total of 354 people have died in all forms of police, prison and juvenile justice custody since the tabling of the Royal Commission's final *National Report* on 9 May 1991. Sixty-three of these deaths were of Aboriginal people and 291 of non-Aboriginal people.

This represents an average of 13.6 Aboriginal deaths each year since that date. This is a noticeable increase when compared to the figure at 31 December 1994 of 39 Aboriginal deaths since the tabling of the *National Report*, representing 10.7 Aboriginal deaths each year.

When considering only institutional deaths, the figure of 11.0 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 492 people have died in all forms of custody. Of these 88 were Aboriginal people and 404 non-Aboriginal people. This is an average of 13.4 Aboriginal deaths each year.

**FIGURE 3**  
**Australian Deaths in Prison Custody, 1980 to 1995**  
**Causes of Death**



## CONCLUSION

It is alarming that deaths in custody, apart from deaths in police custody in institutional settings, continue to increase.

The number of persons to die in all forms of custody has risen by 30 per cent from 66 in 1990 to 86 in 1995.

For the second consecutive year, the total number of people who died in prison custody during 1995 is the highest figure recorded since 1980. It has almost doubled from 30 in that year to 58 in 1995.

**TABLE 9**  
**Australian Deaths in Prison Custody, 1980-95**

<i>Jurisdiction</i>	<i>Aboriginal</i>	<i>Non-Aboriginal</i>	<i>Total</i>
NSW	27	194	221
Vic.	2	102	104
Qld	22	97	119
WA	18	45	63
SA	13	44	57
Tas.	1	15	16
NT	6	4	10
ACT	-	1	1
<b>Aust.</b>	<b>89</b>	<b>502</b>	<b>591</b>

The deaths of Aboriginal people in prison custody has also increased markedly to the highest number recorded since 1980: from 5 in that year to 16 in 1995.

Action must be taken to fully implement the key recommendations of the Royal Commission into Aboriginal Deaths in Custody concerned with minimising the number of people being held in prison. The recommendations concerned with providing high quality care for those who are in prison also need to be addressed if we are going to significantly reduce the number of deaths in prison custody.

On the positive side, the number of deaths in police custody remains relatively low.

The number of deaths in police custody in institutional settings (e.g. lockups and police vehicles) has decreased significantly since 1987 to the lowest figure recorded since 1980, for both Aboriginal and non-Aboriginal deaths in this setting.

Unfortunately, while there have been improvements in the area of deaths in police custody in institutional settings, the number of people who died during the year in custody-related police operations has increased threefold over the previous year from 5 to 16 deaths. During the year seven people died from injuries received in a motor cycle 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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## **CORONERS' INQUESTS INTO DEATHS IN CUSTODY**

This new section of Deaths in Custody, Australia provides excerpts from the most recently completed Coroners' Inquests into Deaths in Custody, both Aboriginal and non-Aboriginal. This issue documents all of the 1994 and 1995 cases for which the Australian Institute of Criminology has received coroners' findings.

In addition to outlining details about the date, place and circumstances of each death, and about when, where and by whom the inquests were conducted, some of the coroners' comments, findings and recommendations, if any, 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 authors have chosen excerpts which 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.

Subsequent publications will update this information as additional coroners' findings are received.

**1994  
Deaths in Police Custody or  
Custody-related Police Operations  
for which Coroners' Findings have been received  
(State by State)**

*New South Wales*

<b>Case 9401</b>	<b>Male aged 62 years, died 31/03/94, at Woodvale Close, Plumpton, NSW.</b>
<b>Circumstances of Custody or Police Operation</b>	The deceased was armed and had been seen breaking and entering. A witness telephoned police to report the break-in. Other witnesses saw the deceased drive off and reported the car number to police who spotted the car, followed it and attempted to stop it.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	John Birley Abernethy Westmead Coroner's Court 16/09/94
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that the deceased on the 31/03/94 [in] . . . Woodvale Close, Plumpton in the State of New South Wales died of the effects of a shotgun wound to the head, self-inflicted with the intention of taking his own life.'

**Comments on Case 9401**

[The death occurred by self-inflicted shotgun wound to the head when the deceased finally stopped and got out of the car, despite being told by police to put down his gun.]

'There can be no doubt that [the deceased] somewhat unexpectedly took his own life and his decision to do so I have to find was not in any way due to pressure from Police, who, faced with an armed man, whose circumstances they did not know, had no option other than to take the course of action they took. I am able to say that [the deceased] was very depressed about his circumstances. It is fair to say that he felt his life was ruined or in tatters.

'I think the Police are entitled to hear from me that I formally indicate that I am able to say at all times that all Police involved in this matter should be commended and have acted lawfully and with a deal of maturity and discretion and no criticism is to be made of them by this court. It is refreshing for once to be able to do that.'

<b>Case 9467</b>	<b>Male aged 27 years, died 17/08/94, at Fairfield Police Station, NSW.</b>
<b>Circumstances of Custody or Police Operation</b>	The deceased was transferred to the Police Station at Fairfield from the Remand Section of Long Bay Gaol in order to attend the Fairfield Court.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	John Hiatt Westmead Coroner's Court 12/04/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that the deceased on the 17/08/94 at Cell 5, Police Station Fairfield in the State of New South Wales died from Acute Narcotism following self ingestion of Heroin then and there.'

### **Comments on Case 9467**

[It was procedure to search prisoners at the prison prior to transfer and again at the police station once prisoners had been transferred. Somehow the deceased had managed to obtain and retain a quantity of heroin and the necessary equipment in order to inject himself with the drug. While at Long Bay Gaol the deceased was placed on protection due to a history of heroin use.]

'Now in respect of the search at the prison the court has considered the evidence that has been placed before it, particularly evidence from prison officers . . . which disclosed that the search of the prisoner before he was placed on the prison van in the court's opinion was less than the standard required by the Commissioner for Corrective Services . . . There was no check on the contents of his pockets in the court's opinion having regard to the evidence. No removal or inspection of his shoes and socks, nor in the court's opinion use of a metal detector on the soles of the shoes. In the court's opinion there is doubt, having regard to the total evidence, that the metal detector was, in fact, used effectively, and the evidence establishes the search was perfunctory at the most.

'Further, when prison officers found a piece which is described as a piece of the finger of a rubber glove with the end tied, when that was found on the prisoner at that time in the court's opinion there was a clear indication that the officer-in-charge then and there should have conducted a strip search of the prisoner.

'The circumstances of this search and the practices adopted at a lower standard give rise to potential for danger to other members of the public and there should be an inquiry by the Department of Corrective Services to rectify the shortcomings exposed by the evidence in these proceedings.

'In respect to the search at the police station the court has considered the evidence that has been placed before it and it has in the court's opinion been shown to have been conducted in accordance with the then police standards. . . the evidence establishes that contraband was in fact found . . . no internal search was conducted either at Long Bay or in the Police Station at Fairfield.

' . . . in the court's opinion each of [the] officers should be commended in the way that they attempted to revive the deceased.

‘The evidence satisfies the court on the balance of probability that the deceased had received the heroin through a visitor . . .

‘There is sufficient evidence to satisfy the court on the balance of probability the deceased has secreted the heroin and needle in his anal passage at the Remand Section of Long Bay Gaol, that he removed the same on arrival at the police cells at Fairfield.

‘All persons who have custody of prisoners whether they be Police Corrective Services or other persons should constantly be reminded that their actions will continue to be subject to thorough scrutiny in circumstances such as this by reason of full investigation.’

### **Coroner’s Recommendations**

‘The court under provisions of s22A of the *Coroner’s Act 1980* as amended, makes the following recommendations:-

‘1. That the Minister for Corrective Services should instigate a formal inquiry within the Department of Corrective Services to establish -

a) Why the provisions of the New South Wales Corrective Services Procedural Manual, particularly (12) 11.1 body-searching; (12) 11.2 searching inmates to be escorted; and (12) 11.3 strip searching, were not properly carried out at the Remand Centre on 17 August 1994 in respect of the prisoner [the deceased].

b) Whether since police escorts to courts have been taken over by the Corrective Services Department there have been a lowering of standards in respect of all prisoners being so escorted.

c) The circumstances of such directive being given to lower the standard as set out in the Procedural Manual and as referred to by witnesses in these proceedings and,

d) Whether such directive was, in fact, given orally by [the] Superintendent of Court Transport, and if so whether such directive was justified in the public interest.

‘2. The court recommends to the Minister for Corrective Services that consideration be given to directing the ‘relevant Corrective Services officer’ to provide specific detail on orders accompanying prisoners to communicate to receiving officers the reason why prisoners are on protection. This more specific information in the court’s opinion is essential to assist custodians make proper assessment and determinations in respect of their continued custody. Where contraband has previously been found during a search of prisoners being transported to court information should be communicated to the receiving officers at police stations or courts.

‘3. The court recommends to the Commissioner for Police that consideration be given to issuing an instruction or notification to confirm the instructions, whichever is appropriate -

a) That all resuscitation equipment should be available in police stations. That such equipment be regularly maintained and appropriate officers ensure compliance.

b) Appropriate posters outlining resuscitation instructions and procedures and advice be displayed in charge rooms or other appropriate areas adjacent to police cells where prisoners are detained.’

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**Queensland**

<b>Case 9478</b>	<b>Male aged 42 years, died 19/09/94, at Breakfast Creek Road, Brisbane, QLD.</b>
<b>Circumstances of Custody or Police Operation</b>	Police were informed that a woman was in danger from the deceased who had gone to her flat. It was believed that he was in possession of a firearm. When police attended the woman's home, the deceased attempted to shoot one of the officers and fled. A pursuit on foot then followed.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Gary M. Casey Coroner's Court, Brisbane 27/09/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that he [the deceased] died in Brisbane on 19 September 1994 and that the cause of his death was a gunshot wound to the chest. I find that the wound was inflicted during an incident involving officers of the Queensland Police Service which occurred at approximately 8.30 pm on 19 September 1994.'

**Comments on Case 9478**

[During the pursuit the deceased shot at police. The police discharged rounds from their firearms without injuring the deceased. The deceased then fired at two unarmed police officers who were standing beside their police car. One of these officers then got out his gun and called at him a number of times to drop his weapon, which he did not do. He was then shot by the police.]

'On the evidence before me I am satisfied that the police officers had no option than to attempt to preserve their own lives as well as the lives of fellow officers and members of the public and the context of the very clear warnings given by them to the deceased and accordingly were justified at law taking the action they did which resulted in the demise of the deceased.

'Accordingly no person is to be committed for trial for any offence arising out of the fatal incident. It is apparent that fate intervened that evening to spare innocent persons from serious injury or death, and I include police officers in that comment.'

**Coroner's Recommendations**

'In so far as making a rider to my findings is concerned I have perused the national guidelines for the use of lethal force by police officers and relevant Queensland provisions applicable to the Queensland Police Service, and in the circumstances of this inquest, I can see no necessity to make any recommendations in relation to the matter of a summoning of special emergency response team members to a potential incident in view of the current review of such policies by the Queensland Police Service.'

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**Victoria**

<b>Case 9404</b>	<b>Male aged 23 years, died 03/01/94, at Scott Street, Elwood, VIC.</b>
<b>Circumstances of Custody or Police Operation</b>	The deceased's mother called the police for assistance when her son, [the deceased], who suffered from schizophrenia, had begun screaming and stabbing himself repeatedly with a kitchen knife, in his family home.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Wendy Anne Wilmoth Coronial Services Centre, South Melbourne 11/11/94
<b>Coroner's Formal Findings on Cause of Death</b>	'I . . . find . . . that death occurred on 3rd January, 1994 at . . . Scott Street, Elwood from a gunshot wound to the chest.'

**Comments on Case 9404**

[Police arrived at the home, and asked the deceased repeatedly to drop the knife and not move. He did not respond to the requests, continuing to move towards them with the knife. One of the officers shot him in self-defence.]

'It is clear that they [the police] had enough information to know what sort of incident they were attending. They knew [the deceased] was stabbing himself, that he had a psychiatric problem, and that neither drugs nor alcohol was involved. What they saw and heard immediately upon their arrival had the unequivocal signs of an emergency. There was no time for them to wait, either for other police to arrive and assist, or to formulate a plan to contain and isolate [the deceased]. From the outset, the police knew there were others in the flat with him. The screaming voices, both male and female, obviously suggested danger.

'I make no finding of contribution towards the cause of death by either [of the two policemen present]. Nor am I able to find that [the deceased], by his actions, contributed to his own death. [It was] submitted that [the deceased], whilst undergoing an acute schizophrenic attack, had no control whatsoever, and his mind could not have known what he was doing. Therefore, he could not be said to have contributed. No other person contributed to the death.

'When they left their vehicle, neither policeman thought to take his baton with him. Police are supposed to do, and it is reasonable for me to draw the inference that batons were not at the time regarded as important equipment in circumstances such as these. As it happened, it would have been most unlikely that either policeman could have used a baton against [the deceased].

' . . . However, it is still the case that the police should have taken batons with them; this should have been automatic on leaving the vehicle. By leaving them behind they denied themselves an option which could have been useful had the circumstances been different.

‘It is to be noted that evidence heard by Mr. Hallenstein [Coroner] in the police shooting inquests, dealt with the need to isolate and contain in order to avoid shooting. Isolation and containment was acknowledged as being impossible where the subject person’s actions pose an immediate threat of physical injury or death to police or others. Strategies such as isolation and containment are acknowledged to have very limited application to emotionally disturbed persons. The use of force and confrontation is a method of last resort, where there is immediate danger to innocent life.’

### **Coroner’s Recommendations**

‘I have already noted that it was not my intention to make recommendations regarding police training. I have referred to the evidence heard by Mr. Hallenstein in this regard. Experts from jurisdictions outside Australia described strategies used to avoid the last resort option of shooting. I refer here in particular to pages 134 and 135 of the finding in the case of Yap. The use of a specialist unit skilled in rescue and tactical functions, such as is used by New York City police, arises as a possible consideration . . . Even if the need is perceived for a specialist trained unit to attend an incident involving an emotionally disturbed person, time may not be on their side, as it was not in this case.’

<b>Case 9407</b>	<b>Male aged 21 years, died 28/03/94, The Ridge West, Knoxfield, VIC.</b>
<b>Circumstances of Custody or Police Operation</b>	Police had received a number of phone calls reporting that the deceased was armed with a sawn-off rifle and that a violent domestic dispute was taking place. They also knew the deceased and were aware of his violent nature and his dealings with drugs. They therefore decided to raid the deceased’s home.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Wendy Anne Wilmoth Coronial Services Centre, South Melbourne 11/11/94
<b>Coroner’s Formal Findings on Cause of Death</b>	‘I . . . find . . . that death occurred on 28th March, 1994 at The Ridge West, Knoxfield, Vic. from Gunshot Abdomen and Chest Injuries.  ‘I find that the deceased contributed to his own death by running from the lounge room when he saw the police arrive and by struggling with [the Sergeant] in the attempt to apprehend him. [It was during this struggle that the police sergeant’s gun was discharged, killing the deceased.]  ‘[The deceased] knew the police were in the vicinity well before the raid occurred, and might well have thought a visit from them was possible. At the time of the raid he was under the influence of cannabis and amphetamines, and for several years he had participated in a culture of drug use and dealing, involving possession of weapons, violence and crimes of dishonesty. He had developed a hatred of the police, of which he told others, and it appeared that this was escalating into the taking of violent action against police in the district.’

## Comments on Case 9407

‘All the evidence leads to the conclusion that the police, [the sergeant] in particular, were justified in conducting the raid as they did. It was planned to be a Level 2 raid, that is, a forced entry in the circumstances where speed and surprise were necessary because of the knowledge that [the deceased] was armed and likely to use his firearm, and that a female and maybe others were likely to be in danger. Indeed, this was found later to be true. [The deceased’s girlfriend] had been assaulted, threatened with death and put in fear, and the other occupants of the house were frightened of [the deceased] as he played with the gun and constructed the bomb.

‘I cannot reach a conclusion as to how, or by whom the firearm was discharged in this case. It is equally possible that it was discharged by [the deceased] or by [the sergeant], but in either case contribution to the cause of death was not by [the sergeant] but by [the deceased]. Nor did [the sergeant] contribute by his part in planning and leading the raid, nor indeed did any other police officer.

‘It is important to note that whilst police had become aware, by the time of the raid, of a significant amount of information about [the deceased], which gave him justifiable cause for planning the raid, they did not know until afterwards of [his] plans to shoot them, and to throw the bomb into the police station. After his death, [the deceased’s mother] found a song written in her son’s handwriting which expressed his violent feelings towards police, and a similar note was found by [a friend] at his house.

‘Whilst no cause for criticism of police actions, procedures or training has arisen out of this inquest, the circumstances of [the] death serve to emphasise the importance of regular training in respect of forced entry. Not all police who took part in the raid were trained as [the sergeant] was, and there is a clear need for the continuation of the training programme already in place.

‘. . . the parents of the deceased, both gave evidence at the inquest, and described their son as a boy whose activities and behaviour took him out of their control, despite their best efforts. In his middle teens, [he] had an apprenticeship but he did not complete it; he appears to have failed to find a direction for his life and replaced it with drugs, and the lifestyle which that involved led to his tragic death. The finding of contribution I have made should be seen in that context.’

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<b>Case 9411</b>	<b>Male aged 29 years, died 18/05/94, Parnell Street, Cheltenham, VIC.</b>
<b>Circumstances of Custody or Police Operation</b>	The deceased who had some psychiatric problems had consumed alcohol and some prescribed medication which had a 'cocktail effect' making him aggressive. His father phoned police as he had done in the past, and said that, '[His son] was not very well and [he] needed them to come down and have a chat to him, and help him, which they have done in the past.' The police decided they would attend. Apparently the police had assisted at the home in the past when the deceased was aggressive and had taken him into custody or transported him to hospital.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Graeme Johnstone Coronial Services Centre, South Melbourne 07/02/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I . . . find . . . that death occurred on the 18th May 1994 at . . . Parnell Street, Cheltenham from a gunshot injury to the head.  'I find the deceased contributed to his own death by continuing to place himself in a situation where there was a real risk he would be shot. In view of the combination [of the] deceased's alcohol/drug consumption, documented poor insight and comment to the officers seconds before he was shot, I am unable to say whether he actually intended the eventual outcome. No other person contributed to the death.'

### Comments on Case 9411

[On arriving at the home the deceased's mother told police that she thought her son was holding a gun. The deceased then yelled threats to police. The parents were removed from the home for their own safety. Police called out to the deceased to put down his weapon. (Because it was dark the police had difficulty in seeing what the weapon was, but apparently it looked like a firearm.) The deceased retreated but then came back still holding the weapon. He pointed the weapon at a policeman who then told him to drop the weapon. He was then told that if he didn't drop the weapon the police would shoot. He said words to the effect that he didn't believe it and pointed the weapon again at the policeman. He was then shot by the police.]

'This case involves an incident between police and a psychologically disturbed man with a long history of intermittent heavy drinking, therapeutic drug abuse and regularly being abusive towards his parents. He also had a documented medical history of suicide ideation and making death threats to people. He had army training and no doubt weapon skills. Whilst there are some limited contrary indications he apparently had no documented history of direct physical violence towards others.

'With the increasing number of persons with psychiatric [or psychological] related problems being integrated into the community it is important to develop structures to assist police in managing potentially dangerous incidents. It is recognised improvements in making information available to police or other authorities outside the normal medical management circles create difficulties in relation to patient confidentiality, civil liberties and related privacy problems.

‘There can be no criticism of the individual police officers involved in the incident. Each of the officers performed a difficult task with an appropriate degree of professionalism. The first officers to attend the scene, on discovering existence of a ‘firearm’ and threat to life removed those at risk from the immediate vicinity. An officer reconnoitred with the purpose of trying to ascertain the nature of the ‘firearm’. On arrival of [the sergeant] the scene was contained, reinforcements were requested and reports were made.

‘During the initial process of containment the deceased entered the incident cordon with what was then considered to be a ‘firearm’ and on posing a threat to another officer by refusing to desist was fatally wounded by [the sergeant]. [The sergeant] acted, on reasonable grounds existing at the time, to save a fellow officer’s life. Because of the circumstances and time constraints there was little opportunity to negotiate an injury free conclusion.’

### **Coroner’s Recommendations**

#### *‘Recommendation 1:*

That a review team under the auspices of the Health Department be established involving psychiatrists, psychologists, lawyers and police with a role to examine medical and police information on individuals involved in significant violent incidents with a view to identifying improvements in management. The medical and compensation files in this case could form the beginnings of a study of alternative methods of managing potentially violent individuals who may have a mental illness or behavioural problem.

The membership of the team could usefully include: operational police, a police psychologist, a clinical forensic medical specialist, a forensic psychiatrist, a psychiatrist from Corrections/Health, legal adviser, etc.

The review team would have responsibility to identify improvements in such areas as:

- Generally directing review of cases to ensure medical/psychological management and protocols to reduce the number of potential incidents requiring police management (or improve outcomes),
- Identifying the optimum time information needs to be available to police,
- Identifying improvements in the type of information available (and timeliness) to assist police in managing incidents,
- Identifying areas where police information could usefully assist in medical/behavioural management,
- Finding solutions to the confidentiality and privacy issues, and
- Recommending legislative changes.

#### *‘Recommendation 2:*

That management of an individual with personality disorders of potentially violent type include the family (where practical) to attempt to identify, explain and minimise problems (*see also* Coronerial Recommendations and comments in John Benny 3/6/91—Case No 588/89).

*‘Recommendation 3:*

That the ‘Leap’ System be reviewed to ensure input of the appropriate level of detail on individuals with mental/behavioural problems and potential for violence. The system needs to be user friendly. It is essential the information be timely and where practical give guidelines for management of particular individuals.

The ‘Leap’ System needs to be a major incident management tool and protocols need to be in place to ensure the information is available to operational police well before attendance at an incident.

Appropriate ‘audit’ procedures need to be instituted to ensure the information input to ‘Leap’ is correct.

Protocols to minimise concerns over confidentiality or privacy issues need to be developed.

*‘Recommendation 4:*

Reliance on ‘local’ knowledge or ‘station’ information, whilst it may be important, must be subject to regular checks to ensure its accuracy. An audited computer information system (‘Leap’) may be one of the checks and balances to local information. Without appropriate checks errors in the available information could lead to mistakes in management of incidents.

*‘Recommendation 5:*

That the police consider establishing a specialist trained unit combining rescue and tactical functions with negotiation skills to deal with the situations where the CAT (Crisis Assessment Treatment) Team’s deployment is not appropriate.

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***Western Australia***

<b>Case 9472</b>	<b>Male aged 29 years, died 04/08/94, approximately 16 kilometres West of Boyup Brook on the Donnybrook/Boyup Brook Road, WA.</b>
<b>Circumstances of Custody or Police Operation</b>	Australian Federal Police Officers had gone to the home of the deceased with officers from the Australian Taxation Office, to execute a search warrant. The deceased had voluntarily accompanied them in a police vehicle to go to Bunbury Police Station.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	K. T. Fisher No inquest, (Bunbury District Coroner) No inquest, (inquiry on 09/03/95)
<b>Coroner’s Formal Findings on Cause of Death</b>	‘I find that the deceased . . . came to his death at about 8.30 am on the 4th August 1994 approximately 16 kilometres West of Boyup Brook on the Donnybrook/Boyup Brook Road from Strychnine Toxicity.  ‘I find that the death arose by way of suicide.’

## Comments on Case 9472

'The evidence concludes that the deceased and his wife whilst together in the home observed the police officers approach as their vehicles travelled the lengthy driveway. Upon their arrival the deceased's wife answered the door whilst the deceased went to the main bedroom and there orally ingested a fatal quantity of strychnine crystals.'

[The deceased's condition began to deteriorate after travelling about 16 km. He held his chest and had what appeared to be a fit. The Police officers laid the deceased on the back seat to make him more comfortable and began to drive him to the hospital. His condition deteriorated further and the Police officers commenced CPR. He responded for a few moments but his condition worsened, losing pulse and respiration. The officers attempted CPR again but were unsuccessful.]

'At the time of his death the deceased was in the company of Australian Federal Police Officers; he had not been the subject of an arrest nor was he in law or fact in their custody.'

## Coroner's Recommendations

'I am satisfied that no further or better information is to be had with the holding of an inquest; and I propose that no inquest be held.'

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**1994**

## **DEATHS IN PRISON CUSTODY FOR WHICH CORONERS' FINDINGS HAVE BEEN RECEIVED (STATE BY STATE)**

### *New South Wales*

<b>Case</b>	<b>Male aged 22 years, died 10/01/94, Parramatta Correctional Centre, O'Connell St, Parramatta, NSW.</b>
<b>Prison</b>	The deceased was an unsentenced inmate at Parramatta Correctional Centre. He had been remanded in custody from Balmain Court and bail had been refused. He was transferred from Police custody to Prison Custody at long Bay, and then at Parramatta.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	John Birley Abernethy Westmead Coroner's Court 24/11/94
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that the deceased on the 10/01/94 at Cell 100 3 Wing Parramatta Correctional Centre, O'Connell St, Parramatta in the State of New South Wales, died when he hanged himself with the intention of taking his own life.'

## Comments on Case 9412

[According to the evidence given in this case, previous police records warned that the deceased may be suicidal. This warning was due to a suicide attempt in May 1993 at the Sydney Police Centre and was dated 22/5/93. A police officer then noted the deceased as 'may be suicidal' on the prisoner lodgement form which should have accompanied the prisoner to the Long Bay Correctional Centre. However, when received at the prison, the Corrections Health Service reception assessment recorded his 'current attitude towards suicide/self-harm' as 'no family history, not suicidal or self-harming at present'. A previous suicide attempt in 1992 in the Long Bay Remand Centre was noted. Because he was judged to fit the criteria for young offender's placement, the deceased was then transferred to Parramatta Correctional Centre. The receiving officer at this prison did not recall seeing any medical file or case management profile accompanying the deceased.]

'On the evidence I have before me I have to say it is quite likely that had all the data now before me been before the authorities at Parramatta, and I mean by that the prisoner health file, the medical file, and had that been before those health personnel who saw him, the prison authorities, this death in custody may still not have been prevented.

'Unfortunately, turning to the medical file, the wider issue, if I can put it that way. This inquest has been unable to learn yet how it was that the medical file did not accompany this prisoner. From October, it is clear from documentation, that it was mandatory that it should accompany him and that is set out in the document annexed to [the doctor's] statement . . . It wasn't even learned until this adjournment really, I think, that the prison medical file had to accompany prisoners at that time.'

[The coroner quoted a recommendation from a previous inquest conducted by His Worship Mr Hiatt:]

'Prisoner's medical files shall be forwarded with the prisoner when that prisoner is transferred from one gaol, institution or unit within the prison system to another. The court would recommend such procedure be made part of the prison regulations.

'There must be criticism of the prison medical service and the Department of Corrective Services that the file did not travel with this particular prisoner. I can put it no higher than that.

'I note also that the Corrections Health Service is now receiving funds to computerise sympathetically with the Department of Corrective Services computer system but not the same system, so that the two, whilst they will run separately, will still in a sense run in conjunction with each other and complement each other. In other words, prison officers will be able to get into aspects of the Health computer system, as I understand the evidence before me.'

## Coroner's Recommendations

'In view of the evidence I have heard today of the grant of funds by the government and the fact that I am satisfied that funds have been allocated and will be forwarded I propose not to make a formal recommendation about the computerisation of the prison medical system but I do intend to write to the Attorney-General, Minister for Corrective Services, . . . and the Minister for Health, . . . advising each of my view that these funds should be allocated as a matter of urgency and that full computerisation of the prison medical service be completed as soon as possible.'

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<b>Case 9413</b>	<b>Male aged 53 years, died 21/01/94, at the Prison Annex, Prince Henry Hospital, Little Bay, NSW.</b>
<b>Prison</b>	The deceased was an inmate at Long Bay Correctional Centre who was transferred to the Prison Annex, Prince Henry Hospital, Little Bay due to illness.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	John Birley Abernethy State Coroner's Court, Glebe 19/12/94
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that [the deceased] died on the twenty-first day of January, 1994 at the Prison Annex, Prince Henry Hospital, Little Bay of acute asthma associated with pulmonary tuberculosis due to atypical mycobacterial infection with chronic obstructive airways disease.'

## Comments on Case 9413

[It is clear that the deceased was chronically ill and that his death was due to the natural course of his condition.]

'I have no doubt [said the doctor] that the cause of . . . death was an acute severe asthma attack on a background of severe and irreversible lung damage caused by asthma and TB.

'The only things I'll say for the record are that I am satisfied that adequate procedures took place in respect of the care and treatment of this prisoner whilst he was being treated for his medical condition both at the Prince Henry Hospital, the Gaol and at the Auburn District Hospital where he was not long before he was returned—not long before his last hospitalisation at Prince Henry.

'I am also satisfied that the Police have conducted their investigation into his death in accordance appropriately, bearing in mind that it is in fact a death in custody.

'I can find absolutely nothing to criticise on the part of the Department of Corrective Services, the Prison Medical Service or indeed those at the Prince Henry Hospital and the Auburn District Hospital.'

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<b>Case 9415</b>	<b>Male aged 69 years, died 20/03/94, 1994 at Cooma District Hospital, Cooma, NSW.</b>
<b>Prison</b>	The deceased was an inmate at Cooma Correctional Centre who was transferred to Cooma District Hospital due to illness.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	John Birley Abernethy State Coroner's Court, Glebe 11/04/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that [the deceased] died on the twentieth day of March, 1994 at Cooma District Hospital of Metastatic Adenocarcinoma (Gastric or Pancreatic Primary), a significant condition contributing to the death but not relating to the disease causing it being ischaemic heart attack.'

### **Comments on Case 9415**

[It was known that this prisoner was suffering from cancer. He had been treated for it but it had got to the stage where it was incurable and he had been told that he only had another three to six months to live. His condition rapidly deteriorated resulting in his transferral to hospital, where he died.]

'Two prisoners gave evidence and attested that the deceased was, in their opinion, and I accept their opinion, very well cared for and compassionately cared for by both prison staff and prison medical staff. As I say I accept unreservedly their evidence about that.

'It's pleasing to be able to find therefore that no criticism can be made, or should be made either of the Department of Corrective Services, Prisoner Medical Service, the local hospital, or the Prince Henry Hospital in this case. On the contrary, all involved in the care and keeping of [the deceased] during his terminal illness, behaved at all relevant times with sensitivity and compassion. The nursing staff at Cooma, attached to the Cooma Prison or Cooma Correctional Centre I found to be most impressive.'

<b>Case 9419</b>	<b>Male aged 53 years, died 06/04/94, at Long Bay Hospital, Malabar, NSW.</b>
<b>Prison</b>	The deceased was an inmate at Maitland Gaol who was transferred to the Long Bay Hospital due to illness.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Gregory Charles Glass State Coroner's Court, Glebe 23/01/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that the deceased on the 06/04/94 whilst a prison inmate at the Long Bay Hospital Malabar, in the State of New South Wales died from a Natural Cause, namely Metastatic poorly-differentiated Adenocarcinoma.'

### Comments on Case 9419

'The evidence from the doctor who performed the post-mortem was that there was cancer found throughout his body. Therefore it was only a matter of time before this man died. There is nothing before me to indicate that he was given anything but satisfactory medical care and attention.'

<b>Case 9450</b>	<b>Male aged 55 years, died 20/11/94, Long Bay Correctional Centre, NSW.</b>
<b>Prison</b>	The deceased was an inmate at Long Bay Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Derrick Windsor Hand Coroner's Court, Glebe 10/04/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find that the deceased on or about 20/11/94 in Cell 39, 15 Wing Long Bay Correctional Centre, New South Wales, died of the effects of a natural cause, namely ischaemic heart disease.'

## Queensland

<b>Case 9430</b>	<b>Aboriginal Male aged 22 years, died 09/01/94, at Lotus Glen Correctional Centre, QLD.</b>
<b>Prison</b>	The deceased was an inmate at Lotus Glen Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Douglas Wayne Morton Coroner's Court, Mareeba 30/03/95
<b>Coroner's Formal Findings on Cause of Death</b>	'I find the cause of death to be:- a) acute myocardial infarction b) coronary thrombosis c) coronary atherosclerosis.'

### Comments on Case 9430

[On the day of his death the deceased had gone to the prison hospital and complained to the nurse that he had a sore shoulder and pain in the sternal area. His blood pressure and pulse were checked and appeared normal for his age and considering that he had just played football. The nurse later asked a correctional officer to check on the deceased, who reported that he did not want to see her. He was later found dead in his cell.]

'I find no criminal negligence on the part of any person and no person is committed for trial.'

### Coroner's Recommendations

'I do not intend to make any recommendations arising out of this death in custody.'

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<b>Case 9432</b>	<b>Male aged 23 years, died 10/02/94, at Rockhampton Correctional Centre, Rockhampton, QLD.</b>
<b>Prison</b>	The deceased was an inmate at Rockhampton Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	K.P. Lynn Coroner's Court, Rockhampton 26/10/94
<b>Coroner's Formal Findings on Cause of Death</b>	'The cause of death was certified by Dr Ansford after post-mortem by him on 10 February 1994 as hanging. 'I formally find that there is no evidence of criminal negligence by any person and close the inquest.'

### Comments on Case 9432

[The deceased, who was described by his mother as mentally backward and suffering from fits of depression, had previously been found with a self-inflicted wound and had later admitted that he had attempted suicide due to family problems. When he began his sentences at the Arthur Gorrie Correctional Centre in 1993 the deceased stated that he had no current thoughts about suicide. The interviewer however assessed him to be a medium risk prisoner and he was placed on the Suicide Watch Program. A psychologist who interviewed him a couple of days later noted that he was more settled, did not show any evidence of depression and denied suicidal ideation. He was taken off the Suicide Watch and on 10/11/93 was transferred to Rockhampton where no further assessments were made. On the day on which he died there was some trouble in the block in which the deceased had a cell and the inmates were questioned, but apparently the deceased was not directly involved. When questioned the deceased was reported to have been cooperative, showing no extraordinary behaviour. He was discovered hanging in his cell during a routine head count.]

‘It is clear that there was no possibility of other persons entering the cell prior to the deceased being found after lock-up as the cell remained under observation on the T.V. Monitor throughout that time and the video tapes had been retained.’

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<b>Case 9431</b>	<b>Aboriginal Male aged 32 years, died 12/03/94, at Rockhampton Correctional Centre, Rockhampton, QLD.</b>
<b>Prison</b>	The deceased was an inmate at Rockhampton Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	S. Bradley Coroner’s Court, Rockhampton 03/03/95
<b>Coroner’s Formal Findings on Cause of Death</b>	‘I find that the deceased, . . . died sometime between 7.15 am and 11.20 am on Saturday 12th March, 1994 in Cell 20 of Unit 6 at the Rockhampton Correctional Centre, Rockhampton. ‘I find, . . . that the cause of deceased’s death was coronary atherosclerosis.’

### Comments on Case 9431

[From the evidence it is clear that there was no indication that the deceased had a heart problem. He had never complained of anything which could have been related to a heart problem and nothing had been discovered during a physical examination which had taken place in May 1993.]

[The Doctor stated that]: ‘It is not uncommon in forensic practice to see persons who have died from coronary artery disease who have not complained of any relevant symptoms prior to their sudden death. Sometimes however a history of ‘indigestion’ is obtained which may have represented cardiac pain.

‘[The deceased] died of natural causes, he was given appropriate and adequate medical attention whilst in custody and his death from coronary atherosclerosis could not have been foreseen. He had been dead for some time prior to being discovered and it was quite apparent that any attempts to resuscitate him would have been futile.

‘His cell and body were properly secured after discovery and all proper investigations were carried out.

‘I can find no evidence of criminal negligence which can be attributed to any person in relation to the death of the deceased, and accordingly no person is committed for trial.’

<b>Case 9456</b>	<b>Aboriginal Male aged 35 years, died 04/07/94, at Harold Gregg Units, Townsville Correctional Centre, QLD.</b>
<b>Prison</b>	The deceased was an inmate at Townsville Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	G.J. Brennan Coroner’s Court, Townsville 29/08/95
<b>Coroner’s Formal Findings on Cause of Death</b>	<p>‘I find . . . [the deceased] died at about 6.58 am on 4 July 1994 in detention at unit cell 4, Harold Gregg Units, Townsville.</p> <p>‘The evidence is that the deceased was last seen alive at about 8.30 pm on 3 July 1994 when he was secured in that detention cell. At about 6.58 am he was found in that cell hanging from a ventilation grill by a piece of bed sheet material which was tied around his neck. There is no evidence any person had contact with the deceased during this interval and no evidence any other person was directly involved in his death.</p> <p>‘A post-mortem examination conducted on 5 July 1995 . . . established the clinical cause of death to be: Hanging.</p> <p>‘I find no criminal negligence attaching to any person and no person is committed for trial upon any charge arising out of this death.’</p>

<b>Case 9460</b>	<b>Male aged 33 years, died 24/12/94, at Sir David Longland Correctional Centre, Brisbane, QLD.</b>
<b>Prison</b>	The deceased was an inmate at Sir David Longland Correctional Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Gary M. Casey Coroner’s Court, Brisbane 18/07/95
<b>Coroner’s Formal Findings on Cause of Death</b>	‘I find that [the deceased] died in his cell in the evening of 23 December 1994 from morphine toxicity which was the result of a self-administration by use of a needle and syringe of the illicit drug heroin. There is no evidence of a criminal nature which may be imputed to any person and accordingly, no person is committed for trial as a consequence of the death of the deceased.’

## Coroner's Recommendations

'So far as the making of recommendations in the form of a rider designed to prevent the recurrence of similar incidents is concerned I have had the benefit of perusing the report of the independent investigators . . . dated 27 January 1995 and the subsequent report in the implementation of the recommendations contained in the inspector's report.

'I am satisfied that the recommendations contained in the subject report of 27 January 1995 contains most, if not all, of the substantive recommendations which were potentially and objectively available for me to do. I do not propose to elaborate on those recommendations which were, in my opinion, based on sound reasoning. I strongly support those recommendations. I do, however, make the following recommendations.

'In order to achieve the objectives defined in the draft joint Queensland Corrective Services Commission Police Drug Strategy that the Queensland Police Service increase its commitment to minimising the illicit drug trade in correctional centres by providing additional manpower to the Corrective Services Investigation Unit. The matter requires urgent consideration, in my view.

'In the report of the independent investigators there was identified the need to modify or introduce training procedures in the context of a structured training plan supported by intelligence outcomes. To fulfil that objective I also recommend that the management of Sir David Longland Correctional Centre, in furtherance of its drug strategy, include in any proposed training plan a course designed to assist correctional officers in the interpretation of and the practical day-to-day implementation of the relevant provisions of the *Corrective Services Act of 1988* and Regulations thereto and the General Manager's Rulings.

'I refer particularly to the provisions of sections 107 and 108 of the Corrective Services Act with respect to the search and arrest of visitors to the Centre. It has come to my attention that there appears to be a reluctance on the part of some correctional officers to enforce those provisions adverted to. If necessary, a legal opinion should be obtained by management to remove any doubt as to the efficacy of the provisions and if it is thought necessary urgent consultation with the appropriate Minister of the Government should take place in order that any perceived deficiency in section 107 particularly be rectified.

'If visitors who are reasonably suspected of committing an offence proscribed by section 104 or any other offence relating to the security or the management of the prison are permitted to leave the Centre whilst awaiting the arrival of a police officer to enforce the subject legislative provision then the potential to attain the strategies intended is frustrated or totally defeated.'

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## Tasmania

<b>Case 9440</b>	<b>Male aged 21 years, died 28/05/94, in the Remand Section of Risdon Prison, Hobart, TAS.</b>
<b>Prison</b>	The deceased was an unsentenced inmate in the Remand Section of Risdon Prison.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Michael Rodney Hill Coroner's Court, Hobart 17/05/95
<b>Coroner's Formal Findings on Cause of Death</b>	'The [deceased] came by his death as a result of asphyxia consistent with suicidal hanging on the 28th day of May 1994 in the remand section of Risdon Prison and that [the deceased] was. . . not attended by a medical practitioner at the time of his death.'

### Comments on Case 9440

[The deceased was charged and taken into Police custody by Devonport Police. He was then transferred to Launceston Gaol, and the prison authorities were informed by police that he was in a depressed state and had a foot injury which needed attention. The police officer who completed the reception form, said that the deceased was in a 'highly emotional/disturbed state of mind'. He was treated in the Launceston General Hospital for his foot injury. Bail was then granted with certain conditions imposed. The deceased was referred to a psychiatrist. After a few days the deceased was returned to custody at Launceston Gaol. He was apparently in reasonable spirits at that time. Bail was opposed and the deceased was transferred to Risdon Prison where he was assessed and allocated a cell in the remand centre where he was found dead a couple of days later.]

'May I say at the outset that I do not see any reason to criticise any of the persons involved, be they prison officers or police officers in the course of their dealings with the deceased. In some cases I may seek to criticise the system, but that is not necessarily a criticism of the persons who make up and partake in that system.

'I repeat the comment that it is obvious and important that the admission forms will only be of assistance if they follow the prisoner. I note in particular under the heading "PA and RA Form (Administrative Matters)" in the Policy Document No.12 of 1994, Recommendations and Direction D appearing on page 3 of that document that there appears the following Direction:

The form '(d)' shall after its completion in each case where a person in custody is to be transferred to a place of detention, be photocopied and a copy of the form forwarded with the person in custody for the information of supervisory personnel at the place of transfer.'

Compliance with this direction should ensure that the receiving custodian is fully apprised of earlier assessments of the prisoner.

'It seems to me that if the risk assessment form completed on the 15th May by [an officer] had been seen by the admitting official at Risdon Prison . . . it is unlikely the deceased would have been released from the Prison Hospital during his remand period.

'I have no reason to criticise the staff of Devonport or Launceston watchhouses on their treatment of the deceased once he was admitted to their custody.'

## Coroner's Recommendations

'I understand that copies of earlier risk assessment forms are not sent to the hospital. I would have thought that for that to occur in future a minor adjustment only would be required to the present system. It is my recommendation that this procedure be adopted if it has not been already.

'The risk of suicide amongst remandees is significantly higher than that in the normal prison population . . .

'That they are supplied with razors which they retain is an unacceptable risk. I would not have thought that daily supply and subsequent collection of razors and razor blades would present too much of a problem . . .

'There needs to be some system for the passing on of information concerning remandees from one prison officer to another. The evidence in this inquest revealed all that one prison officer knew of a remandee was what he had read in the press. It may be that the unit management system . . . will go some way towards addressing the problem.

'The system of checking remandees at night, in my view, needs to be closely examined. It seems to me that the pegging of the clock system has scope for abuse.

'No good reason was proffered why the prison officer in charge of the remand section was not in possession of a key to the cells when he made his rounds. I understand the security aspect of this, but the authorities should consider a system to allow prison officers immediate entry if untoward behaviour is observed.

'This cell presented to the deceased every opportunity to pursue his purpose of suicide. . . . if the design of the cell had been such so as to reduce the number of suspension points, the end result may have been different. Given the accepted increased risk of suicide among remandees, I suggest that urgent consideration be given to the design of at least some of the present cells.

'The final matter I wish to refer to . . . is the supply to the prison medical staff of thermometers able to read body temperatures below 35 degrees Celsius. The time of death is not so vital in this inquest as it may be in others, but I am sure that those charged with forming opinions on the likely time of death would be assisted by temperature readings capable of being recorded by those thermometers.'

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<b>Case 9441</b>	<b>Male aged 28 years, died 27/06/94, at Risdon Prison Hospital, Hobart, TAS.</b>
<b>Prison</b>	The deceased was an inmate at Risdon Prison.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Michael Rodney Hill Coroner's Court, Hobart 09/11/94
<b>Coroner's Formal Findings on Cause of Death</b>	'The [deceased] died on the 27th day of June 1994 at the East Wing of Risdon Prison Hospital at Risdon in the State of Tasmania, of asphyxia, suffered when he hanged himself with the intention of taking his own life . . . The deceased was not attended by a medical practitioner at the time of his death.'

**1994  
DEATHS IN JUVENILE DETENTION  
FOR WHICH CORONERS' FINDINGS HAVE BEEN  
RECEIVED**

*South Australia*

<b>Case 9443</b>	<b>Male aged 18 years, died 26/01/94, at Cavan Training Centre, Adelaide, SA.</b>
<b>Juvenile Detention Centre</b>	The deceased was a detainee at the Cavan Training Centre.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Wayne Cromwell Chivell Coroner's Court, Adelaide 06/12/94
<b>Coroner's Formal Findings on Cause of Death</b>	'I, the said coroner, do find that [the deceased] aged 18 years,. . . died on or about the 26th day of January, 1994 as a result of hanging.'

**Comments on Case 9443**

[From the evidence it is clear that the deceased had given 'hints' to various people at various stages that he may have been suicidal. However it is apparent that these 'hints' were not reported and therefore not collated in such a way that the deceased could have been formally assessed and classified as suicidal. It seems that the deceased usually displayed a cheerful manner.]

[A forensic psychiatrist concluded in his report that:] 'In my judgement, given the circumstances and the mechanisms in place, the unit and centre staff cannot be faulted for failure to anticipate this tragic event. Furthermore, taking into account the general demeanour of [the deceased], and the availability of information, there would not have been any particular need or urgency for unit staff, . . . to seek professional assistance with respect to the behaviour or mental state of [the deceased].

'Following [the deceased's] death, the Acting Executive Director - (Operations) of the Department of Family and Community Services, carried out a very thorough, objective and critical analysis of the events and the role of the Department in them, and her report has been of great assistance to me in consideration of these issues. I commend [that particular officer] and the Department for the professional and dispassionate way in which this investigation was conducted, and for the fact that the Department has taken such an open and self-critical approach to these events in an attempt to avoid a similar tragedy in future.

‘Ironically, room no. 9 in unit B [the deceased’s room], was equipped with a surveillance camera which could have enabled complete surveillance of [the deceased] throughout that night. However, the Department took the view, and I agree, that it is inappropriate to conduct such a surveillance on an inmate in the absence of any indication that he is at risk, since the surveillance constitutes a severe invasion of privacy, and would probably be counter-productive in relation to their attempts at rehabilitation.

‘Although [it] was clear that the night staff were required to check the boys every five minutes prior to midnight, and every 15 minutes after that, the practice . . . was far more casual than that . . . This represents a very unfortunate confusion and lack of communication between management and staff as to actual requirements.

‘Having inspected room 9 [the deceased’s room], it is apparent that much has been achieved to eliminate hanging points from the room as was recommended by the Royal Commission into Aboriginal Deaths in Custody.

‘. . . However, it would seem that a number of hanging points remain, and I would encourage the Department to continue in its efforts to minimise them where possible.

‘. . . However, I also agree . . . that it is virtually impossible to completely eliminate hanging points without turning the room into a cell. I agree that the only feasible approach is to try and maintain the delicate balance between the minimisation of such hazards and the preservation of some dignity and comfort for the inmates.’

### **Coroner’s Recommendations**

‘I recommend that the Department give consideration to the provision of a special cutting implement [which could be issued to the shift supervisor], which can be used in relation to removing the ligature in a hanging.

‘. . . I would suggest that it is good practice for officers to carry a radio at all times, both for their own safety and in order that instant communication can be achieved from any part of the institution should it be necessary.

‘I make the following recommendations pursuant to Section 25 (2) of the Coroner’s Act which I consider may prevent, or reduce the risk of a similar event:-

1. That the Department formulate and implement clearly to its staff a policy in relation to strict compliance with instructions regarding surveillance and monitoring of inmates, particularly in relation to frequency and thoroughness thereof;
  2. that the form in the Unit Log Book be changed to accord with any amended policy in that regard;
  3. that the Department implement a number of exercises or drills designed to provide training and experience in relation to emergency situations they may face, with particular regard to the use of radios, communication within and from the facility, resuscitation and first aid, preservation of scenes, liaison with emergency services agencies and the like.’
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**1995  
DEATHS IN POLICE CUSTODY OR  
CUSTODY-RELATED POLICE OPERATIONS  
FOR WHICH CORONERS' FINDINGS HAVE BEEN  
RECEIVED**

*Tasmania*

<b>Case 9524</b>	<b>Male aged 25 years, died 25/03/95, at Evergreen Terrace, Geilston Bay, Hobart, TAS.</b>
<b>Circumstances of Custody or Police Operation</b>	The deceased had entered his estranged girlfriend's home armed with a rifle while she was out, and indicated to baby-sitters, who subsequently called the police, that he might harm his daughter. He had earlier indicated that he would kill both his daughter and himself so that they could be a family in heaven. The police attended the scene, and the deceased subsequently shot himself.
<b>Coroner Location of Inquest Date of Inquest / Findings</b>	Ian Roger Matterson Coroner's Court, Hobart 15/12/95
<b>Coroner's Formal Findings on Cause of Death</b>	'... The [deceased] died on the 25th day of March 1995 at ... Evergreen Terrace, Geilston Bay in the State of Tasmania of a gunshot wound to the head, self-inflicted with the intention of taking his own life.'

**Comments on Case 9524**

'It is a difficult task that police face. They must weigh up the situation in the best interests of those immediately involved, the residents living in the area, their own personnel, and also family members who feel compelled to enter the residence and do what they could for him and who no doubt believe they could have stopped him from taking his own life.

'But what if they couldn't stop him and in the ensuing moments also died as a result of their efforts, who then would take responsibility for their death? Quite obviously the police would be answerable for a death that could have been prevented.

'I have considered the evidence before me and also the police operation in general. I commend the police for their efforts in containing a violent situation, in obtaining the release of the child and their efforts to try and pacify and talk the deceased into a peaceful resolution.'

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## POSTSCRIPT

After this publication had been prepared for printing, new information was received on the Aboriginality of one of the people who died in custody in 1995. This was the 20 April 1995 death by self-inflicted hanging of a man at the Borallon Correctional Centre, Queensland. He was previously considered to be a non-Aboriginal person as he had not identified as Aboriginal on admission to the prison. The Coroner who conducted the inquest into the death, the family of the deceased, and Aboriginal organisations all confirm that he was, in fact, an Aboriginal person. As a result, in the 1995 calendar year there were, nationally, a total of 22 Aboriginal and 64 non-Aboriginal deaths in custody and in custody-related police operations. In prison custody, there were 17 Aboriginal deaths and 41 non-Aboriginal deaths. The next publication in this series will provide corrected figures.

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### *Future Publications in this Series*

Please note that as from the next issue, the Deaths in Custody, Australia series will be published in the Australian Institute of Criminology's Research and Public Policy Series. For further information, contact the Publications Section of the Institute.



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