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AUSTRALIA
Deaths in custody: How many more?

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. [1]

1 INTRODUCTION

In July 1991, a joint forum of Australian federal, state and territory ministers agreed to formulate a "whole of Government" approach to combat a high incidence of Aboriginal deaths in custody. Since then, at least another 64 Aborigines[2] have died or sustained fatal injuries in prison or police facilities, and about 40 more in custody-related police operations, some of them in circumstances which Amnesty International believes amounted to cruel, inhuman or degrading treatment. Nineteen of 75 people recorded by the government to have died in all custody-related circumstances during the 12 months to 30 June 1996 were Aboriginal - a sharp increase over previous years. Although Aborigines represent only 1.4 per cent of the adult population, they accounted for more than 25 per cent of all custodial deaths.[3] In the prison system, Aborigines accounted for 18,5 per cent of all prisoners but 39 per cent of all those who died in prisons.

On 4 July 1997, a ministerial summit meeting, originally planned for January 1996, is scheduled "to address deaths in custody and the unacceptable level of Indigenous incarceration". Amnesty International welcomes the summit as a belated, but unique and important opportunity for all parties to initiate effective reforms. The organization submits this report to the summit participants in the belief that its recommendations, if adopted, could help eradicate some of the factors contributing to the high incidence of Aboriginal deaths in custody.

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[1] Article 10, International Covenant on Civil and Political Rights.

[2] In this report, the term Aborigines is meant to include the indigenous people of the Torres Strait Islands between Australia and Papua New Guinea who are usually not listed separately in official Australian reports on deaths in custody. There are about 300,000 Aborigines and Torres Strait Islanders in Australia, which has a total population of 18 million.

[3] Australian Institute of Criminology; cf. *Annual Report 1995-1996, Implementation of the Commonwealth Government responses to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, Canberra, February 1997, Vol I, p. 4.

Over the past decade the high incidence of Aboriginal deaths in custody has drawn considerable attention, both in Australia and internationally. A Royal Commission set up

in 1987 to investigate 99 Aboriginal deaths during 1980-1989 found that:

> *"Aboriginal people die in custody at a rate relative to their proportion of the whole population which is totally unacceptable and which would not be tolerated if it occurred in the non-Aboriginal community."*[4]

Ten years later the rate of Aboriginal deaths in custody remains at the same high level while the average annual death rate of other Australians in custody has fallen. Initiatives taken by government authorities in response to the Royal Commission have, on the whole, been ineffective in addressing this problem.

Amnesty International is concerned that in some cases ill-treatment, or lack of care amounting to cruel, inhuman or degrading treatment may have *contributed* to a death in custody. These concerns are compounded by a lack of promptness, thoroughness, independence and transparency of many investigations into deaths in custody, and by the harassment and intimidation by law enforcement officers of a number of relatives who did not accept official explanations of a death in custody.

The Royal Commission recommended a definition of deaths in custody which includes deaths within prison or police facilities as well as deaths occurring as a result of custody-related police operations such as police shootings or pursuits. The definition specifically includes deaths - wherever occurring - which have been caused, or contributed to, by traumatic injuries sustained in any form of detention or custody, or by a lack of proper care. Police fatal shootings and deaths during police pursuits were generally not investigated by the Royal Commission, but have been included in official statistics since 1994.

[4] Royal Commission into Aboriginal Deaths in Custody, *National Report*, Vol. 1, p. 6. Accessible on the Internet world wide web site *http:// www.austlii.edu.au/car/*.

The Royal Commission on deaths in custody made various recommendations in 1991 which, had they been properly implemented, could have resulted in a substantial drop in the numbers of custodial deaths. However, a national approach to deal with the situation has suffered, in the words of the Australian Government representative to the United Nations, from *"a lack of co-ordination between the Commonwealth and the State and Territory Governments regarding the implementation of the recommendations of the Royal Commission"*[5]. State and federal government ministers have on occasion blamed each other for their failure to stop the climbing rates of Aboriginal death in custody. Amnesty International considers that both federal and state authorities in Australia bear a collective responsibility to take action in accordance with international standards and with the principles of human rights treaties to which Australia has committed itself. This shared responsibility is expressed by Article 50 of the *International Covenant on Civil and Political Rights* which states that its provisions "extend to all parts of federal States without any limitations or exceptions."

This report outlines some of Amnesty International's main concerns in relation to deaths in custody as well as their investigation in Australia and makes specific recommendations aimed at the prevention and investigation of such deaths.

While the report's main focus is on deaths occurring in *custodial facilities*, it takes into account official Australian definitions of custodial deaths which include, for example, the death of a person who was in the care of a law enforcement officer outside the confines of a prison or police station, or who was shot by police.[6]

[5] Statement by the Australian representative to the United Nations in Geneva on behalf of the Australian delegation to the United Nations Working Group on Indigenous Populations, 14th session, Geneva, 31 July 1996, pertaining to item 5 of the agenda: *Review of Developments Pertaining to the Promotion and Protection of Human Rights and Fundamental Freedoms of Indigenous People*.

[6] In this report 'police custody' refers to the control exercised by police officers over a person's liberty, whether that person is inside a police cell, a police vehicle, in a police interview room or elsewhere. Facilities used by Australian police for detention include cells in police stations or separate buildings called lock-ups or watch-houses. Designed primarily for temporary detention prior to a prisoner's transfer to a court or prison, lock-ups or watch-houses are used in some locations as accommodation for convicted prisoners serving short-term sentences close to their home. Detainees held in court holding cells on the day of their appearance in court are generally in police custody, often following transfer from a prison remand centre.

On the other hand, 'prison custody' refers to institutions designed for prisoners serving a sentence of imprisonment or awaiting trial, including facilities for juvenile detention.

> *"The Royal Commission made 179 recommendations concerning the criminal justice and coronial systems after finding that: Aboriginal and Torres Strait Islander people were significantly over-represented in prisons and police lock-ups; many deaths were avoidable if custodial authorities had properly exercised their duty of care; and, the Royal Commission may have been unnecessary had coroners properly investigated deaths in custody by dispelling suspicion and making preventative recommendations.*"

While the Commissioners did not find that any of the deaths they investigated were the product of deliberate violence or brutality by police or prison officers, they stated that

> *"far too much police intervention in the lives of Aboriginal people throughout Australia has been arbitrary, discriminatory, racist and violent. There is absolutely no doubt* [...] *that the antipathy which so many Aboriginal people have towards police is based not just on historic conduct but upon the contemporary experience of contact with many police officers."*

Commenting on the circumstances of the deaths, the Commission stressed that

> *"... generally, there appeared to be little appreciation of and less dedication to the duty of care owed by custodial authorities and their officers to persons in custody. We found many system defects in relation to care, many failures to exercise proper care and in general a poor standard of care.* [...] *it can certainly be said that in many cases death was contributed to by system failure or absence of due care."*

Apart from a systemic failure to exercise proper care, the single main explanation offered by the Royal Commission as to why, in proportion to their share of the population, so many more Aborigines than other Australians died in custody was that

> *"... the Aboriginal population is grossly over-represented in custody. Too many Aboriginal people are in custody too often."*

Amnesty International believes that the continuing disproportionate rates of Aboriginal deaths in custody show that many of these deficiencies have not been effectively addressed by the Australian authorities.

2 TRENDS IN DEATHS IN CUSTODY

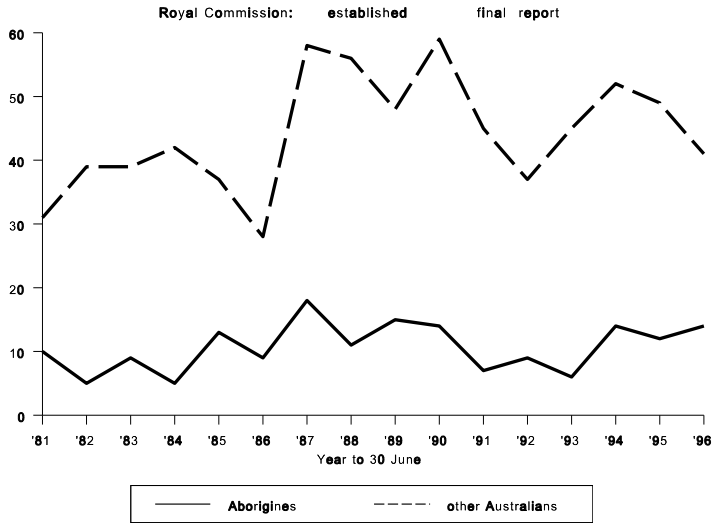
Using government statistics recorded by the Australian Institute of Criminology, Amnesty International has identified three significant trends in Australian deaths in custody since national figures were first recorded in July 1980.

I) Over the past 17 years, the average number of people, both Aborigines and other Australians, who died each year in custodial facilities has not significantly changed. Before and after the Royal Commission findings, an average of 55 people died in

custodial institutions every year.

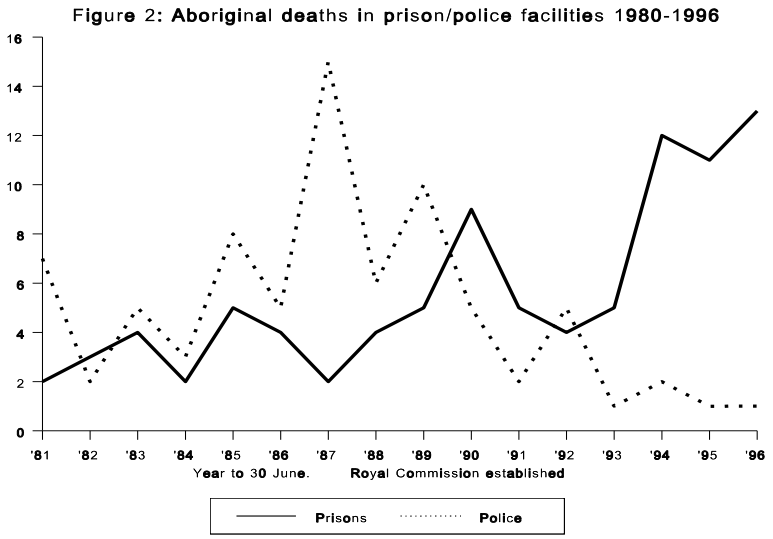
II) Significant long-term trends can be found in comparing Aboriginal and other Australian deaths in institutional prison and police custody. Since 1987, when the Royal Commission was established, there has been a downward trend among the number of *non-Aboriginal* people who died in both prison and police facilities, despite a temporary increase during 1993-1994. During the same 10-year period, the number of *Aborigines* who died each year initially dropped until the Commission published its final report in March 1991 [7]. However, since then the number of Aboriginal deaths has increased to an annual average of nearly 13, or almost the level of the late 1980s (see figure 1).

Figure 1: Deaths in custodial institutions 1980-1996



[7] From a record high number of 18 in the year ending 30 June 1987, to nine during the year ending 30 June 1992.

III) Looking specifically at *Aboriginal* deaths in prison and police detention facilities, the most significant change since the Royal Commission was established has been a shift away from police detention to prisons and juvenile justice institutions as the most frequent place of death (figure 2). Some police spokes--persons interpreted this trend as indicative of the success of police measures in dealing with the problem. Amnesty International believes that other factors have also influenced this change. For example, policy changes in most states have reduced the number of Aborigines being detained in police cells but have increased the number of Aborigines in the prison system.



Reviewing the latest trends of deaths in the prison system, a recent Federal Government report emphasized the difference between Aboriginal and other prisoners:

> *"While* [...] *the number of non-Aboriginal people dying in Australian prisons has decreased markedly, it is alarming that deaths of Aboriginal people in prison have continued to increase reaching the highest figure recorded for the 16 year period from 1980."*[8]

This statement refers to the 13 Aborigines and 33 other Australians who died in prison between 1 July 1995 and 30 June 1996. According to the report, Aborigines were 29 times more likely to die in prison than other Australians.

[8] Australian Institute of Criminology, cf. *Annual Report 1995-96, Implementation of the Commonwealth Government responses to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, Canberra, February 1997, Vol I, p. 28.

3 CAUSE AND CIRCUMSTANCES OF DEATHS IN CUSTODY

Deaths in custody occur for a wide range of reasons and in many different ways and settings. Official data on the number and causes of deaths in custody is usually based on police investigation reports and the findings of coronial inquests. These reports are fulfilling specific functions under domestic law which require establishment of the *medical* cause of death and possible criminal responsibility. Thus, they do not necessarily consider all the circumstances that may have *contributed* to the deaths, some of which may constitute a violation of human rights.

According to a report based mainly on coronial investigations, the largest proportion of the 79 Aboriginal deaths in all forms of custody between January 1990 and May 1996 were of natural causes (38%) and hanging or self-inflicted injuries (33%). Aborigines who died of illness were often very young: two-thirds of those who died of natural causes were less than 40 years old. By contrast, hanging or self-inflicted injuries (36%) were the most common causes of non-Aboriginal deaths in custody.[9] Health problems have increasingly impacted on the survival chances of Aboriginal prisoners. In the period July 1995 to June 1996, five out of 14 people who died in prison of natural causes were Aboriginal.

This may be partly explained by the fact that, generally, Aborigines have a very poor standard of health and live between 15 (women) and 18 (men) years less than other Australians. Recommendations made over the past decade in the course of investigations into deaths in custody have repeatedly highlighted the need for custodial authorities to take the specific health risks and medical needs of Aboriginal people into account. For example, Aborigines are more likely than other Australians to die at a young age from heart attacks and other serious medical problems, but are less likely to seek medical assistance in custody.

Ill-treatment in custody

[9] *Indigenous Deaths in Custody, 1989-1996*, a report prepared by the Aboriginal and Torres Strait Islander Social Justice Commissioner, Canberra, Aboriginal and Torres Strait Islander Commission, October 1996, p. 28-29.

While the immediate medical causes of custodial deaths have generally been thoroughly investigated, Amnesty International is concerned that other contributing factors, such as alleged ill-treatment during arrest or lack of proper care in custody, have often been neglected, ignored or dismissed. During recent years the organization received many reports of ill-treatment of Aborigines in custody. These have included kicking and beating of detainees by law enforcement officials. Some detainees have reportedly been hit on the head with truncheons or fists. Metal handcuffs have been applied very tightly around the wrists or ankles of detainees in such a way as to cause severe pain. Detainees have been forced face down on the ground and had a knee pushed into their backs while their hands were handcuffed behind their backs, restricting their ability to breathe freely. Once in custody, some detainees have allegedly been denied medical care, and medication, food or blankets have been withheld. Some people were said to have been threatened by police officers with prolonged incarceration or death. Examples of cases previously raised by Amnesty International in which such allegations were made include the deaths of Daniel Yock, Barry Turbane, and Darryl Cameron.[10]

Focussing on the immediate cause of death can be misleading when assessing harassment and ill-treatment as contributing factors in the context of deaths in custody. For example, a coronial investigation of a prisoner's suicide shortly after arrival in a prison does not necessarily take into account the manner and circumstances of the prisoner's arrest and treatment by police and prison guards: in March 1994 the coroner investigating the death of Barry Turbane in a prison cell said state legislation did not permit him to express an opinion on matters outside the scope of the inquest which focussed on criminal responsibility for the cause of death. Two days before he died, Barry Turbane had reportedly been beaten by police officers during his arrest and had subsequently been assessed as 'at risk of suicide'. He was denied a visit by his family at the Arthur Gorrie Remand and Prison Centre in Queensland and was found hanging from prison socks suspended from bars in his prison cell on 7 April 1993. The coroner did not investigate the circumstances of Barry Turbane's arrest or medical assessments in police and prison custody.

While allegations of ill-treatment did not always relate directly to the causes of deaths in custody, they were often communicated in the context of Amnesty International research into custodial deaths. Irrespective of whether they could possibly have contributed to a death in custody, such allegations should always be taken seriously and should be properly investigated.

[10] For a case study of a non-Aboriginal death in custody involving suspicions of ill-treatment, see *Australia: Too many open questions - Stephen Wardle's Death in police custody*, 17 October 1996, AI Index: ASA12/01/93.

Amnesty International believes that all allegations of ill-treatment made in the context of a death in custody should be thoroughly investigated. Police and other investigators should be required to follow up all allegations of ill-treatment of a person who died in custody even if these do not appear to be directly linked to the cause of death. Where legislation or guidelines governing coronial investigations may discourage the investigation of alleged ill-treatment which does not appear directly related to the medical cause of death, state governments should consider a review of the legislation.

The death of Daniel Yock

Daniel Yock, an 18-year-old Aboriginal dancer, was found dead inside a police van within 30 minutes of his controversial arrest on 7 November 1993. He was allegedly beaten or kicked by arresting officers, but died of a heart condition. Eye-witnesses testified that officers ignored attempts to alert them to his health condition following the arrest. While an inquiry did not find sufficient evidence that he died as a result of police ill-treatment, the case illustrates how provocative policing of Aboriginal juveniles and a lack of proper care can lead to an avoidable death in custody.

On the afternoon of 7 November 1993, Daniel Yock and several young Aboriginal companions allegedly reacted with obscene language and disorderly conduct to a police patrol who had observed and followed them for no apparent reason at Musgrave Park, central Brisbane, where the youth had been drinking. When he noticed that more police were arriving, Daniel Yock ran away but collided with a plainclothes police officer and fell to the ground. He struggled when the officer tried to restrain him, but was turned around face down on the ground and handcuffed with his hands on his back. Witnesses observing the struggle testified to a judicial inquiry that Daniel Yock was kicked or punched by the arresting officers, which was denied by police. Police officers noticed that he made noises indicating that he had difficulties with breathing while lying on the ground handcuffed. Several witnesses, including police, noticed vomit or fluid coming out of Daniel Yock's mouth, as well as body movements described as shaking or wriggling or adjusting his position. Evidence given to an investigation by the Queensland Criminal Justice Commission (CJC)[11] indicated that he was at best semi-rousable, and that a companion moved Daniel Yock's head to prevent him from swallowing his vomit.

A few minutes later Daniel Yock was unable to walk to a police van without the assistance of two officers, but police denied allegations made by eye-witnesses that he

[11] A body established under the Queensland *Criminal Justice Act 1989* to monitor the operation of the criminal justice system and to act as a complaints authority for the prison and police services.

had to be carried into the van. He was placed in the van face down with his hands still handcuffed behind his back and without any apparent concern for his health. A companion locked into the same vehicle testified that police ignored his complaints that Daniel Yock's handcuffs were too tight and that he did not respond to attempts to wake him up. Daniel Yock spent almost half an hour in the police van which kept circling the area for some 17 minutes before driving to the police watch-house. Although at the time of arrest several officers noticed symptoms suggesting that Daniel Yock may have been unwell and in need of medical attention, there was no evidence that they made any attempt to check his condition from the time he was being handcuffed to his arrival at the police watch-house. The CJC inquiry report describes this failure as a matter of some concern.

Upon arrival at the watch-house, Daniel Yock was found lifeless. Police attempted resuscitation, but his death was confirmed after transfer to a hospital. Two post-mortem examinations found that the immediate cause of death was cardiac arrythmia (Stokes-Adams attack). The doctor conducting the second autopsy on behalf of Daniel Yock's family stated that three "relatively minor" abrasions found on the head were consistent with the application of a type of force applied in a punch or kick but that the death was not the result of major trauma. He also concluded that "the subsequent treatment of Daniel Yock following his collapse would [have been] of supreme importance" for his chances of survival.

Queensland police initially refused to accept Daniel Yock's death as a death in custody, or custody-related police operations, and failed to report it to the government's death in custody monitoring unit for eight months. Due to considerable Aboriginal protests and public attention to the case, the CJC conducted an inquiry, instead of a coroner's inquest, which focussed on the question of criminal liability and official misconduct by police officers including neglect of duty in relation to the death. While the inquiry was critical of the "unreliable" and inconsistent evidence of some police officers involved, it did not find "sufficient evidence to support a prima facie case against any member of the Police Service." The investigating Commissioner discussed the appropriateness of the arrest given that it was triggered only by the youth's response to close police observation which the teenagers saw as a provocation. However, the Commissioner accepted police claims that they would have treated non-Aboriginal persons in the same way. This claim lacks credibility, given the wording of police radio calls which make specific reference to the youths' Aboriginality and the interest of a police patrol to deal with such a situation: *"There's 7 or 8 Aboriginal persons fairly, sort of giving us a few problems* ...[...] *I just thought you might be around 'cause you love that type of stuff ... You would have loved it."*[12]

[12] *A Report of an Investigation into the Arrest and Death of Daniel Alfred Yock*, Brisbane, CJC 1994, p. 29.

The CJC inquiry did not find it necessary to investigate a possible need for "changes [...] to Police Service policies, procedures, or operational instructions in relation to the apprehension and management of Aboriginal persons in similar circumstances" which was one of its terms of reference. However, it recommended further training for police officers to ensure that the condition of a prisoner is assessed at appropriate intervals following arrest and was critical of the use of handcuffs during transfer to the police watch-house.

In October 1995 a former Queensland police officer's claims that "police took part in regular officially sanctioned bashings of Aborigines in Brisbane" and that "a key police witness had lied at the Yock inquiry" led to a second CJC investigation which was conducted in private and placed under a publication-ban. This inquiry did not find sufficient evidence to support the claims.

Lack of care

In March 1996 Amnesty International delegates visited several police lock-ups and prisons in Western Australia. The state's geographic dimensions, sparse population and the remoteness of many towns and Aboriginal communities pose particular problems for the adequate care and custody of criminal suspects and prisoners. Amnesty International was encouraged by measures taken in some remote police lock-ups since an earlier visit to improve standards of care and attention to prisoners. [13] However, some improvements were not present in all police lock-ups. In two facilities Amnesty International was additionally concerned about the apparently casual attitude towards the health and well-being of prisoners displayed by individual police officers.

Western Australia Police custodial care handbook

A handbook first issued in 1989 highlights police officers' duty of care and the serious legal consequences they face if the life or health of a detainee has been affected as a result of a failure to provide the "necessities of life" which "include

[13] See *Australia: A Criminal Justice System Weighted Against Aboriginal People*, February

For example, the organization learned that at some remote police stations, where almost all detainees were Aboriginal, inmates have been left unsupervised for four to six hours during the night on a regular basis. This practice seriously compromises the safety of prisoners and means they may not have immediate access to necessary help in an emergency. One experienced police officer in charge of a remote police station responded to Amnesty International questions about the means available to detainees to seek assistance in emergencies at night by suggesting that they can shout for help, as his house was not far from the lock-up building.

1993, AI Index ASA12/01/93.

Amnesty International believes such an attitude to the health, care and safety of persons in detention is unacceptable for a police officer in charge of a police station. The organization also believes that detaining persons over night in custodial facilities which are left unsupervised for several hours is in breach of the United Nations *Standard Minimum Rules for the Treatment of Prisoners* which provides for "regular supervision by night". In addition, Amnesty International notes that both Western Australia police guidelines and international standards place a positive obligation on officers to "ensure the full protection of the health of persons in their custody"[14]. After raising the issue with senior police, Amnesty International learned that early in 1997 instructions were issued by district superintendents regarding the duty of care and the risks of unsupervised detention in remote locations. While instructions for the central police region around Kalgoorlie and Meekatharra no longer allow any unsupervised detention, discretion is granted to officers in charge of most Kimberley police stations whether to allocate officers to supervise persons detained in police cells overnight.

Police services in several other states are applying procedures to prevent unsupervised detention, for example by having detainees transferred to the nearest police station with 24-hour staff rotas. However, the underlying problem is apparently not unique to Western Australia. On 1 May 1996 a 42-year-old Aboriginal man was found hanging within hours of his arrest in a community police cell on Bathurst Island, Northern Territory, after community police officers had left the building to attend to an incident elsewhere. While community police operate with less training, powers and responsibilities than other police officers, they should have been properly trained to exercise their duty of care towards prisoners to the same high standards required of other law enforcement personnel. An earlier case of unsupervised detention of an Aboriginal detainee in a New South Wales police cell had led to a court decision in September 1995 to award damages to close relatives after a Royal Commission investigating the death had criticised issues involving lack of care by police and health officials involved (see p. 23).

While Amnesty International is not aware of cases since the Royal Commission where any law enforcement official was prosecuted for criminal responsibility in the death of a prisoner, coronial and other judicial inquiries into deaths in custody often highlighted unacceptable and sometimes serious deficiencies in the standard of care. In some cases these may either have contributed to a death or may have played a role in a prisoner's suicide. Common problems include: the lack of training in, or attention paid to, relevant custodial care guidelines and procedures by prison or police officers as well as prison medical staff; a failure to adequately assess a prisoner's health or risk of suicide; and a failure to properly record, forward or act upon information where such assessments were made. For example, a schizophrenic 19-year-old Aboriginal prisoner with a record

[14] See Article 6 of the United Nations *Code of Conduct for Law Enforcement Officials*.

of suicide attempts who had been treated in hospital for psychosis was transferred back to prison in November 1993 without his medical file. He had been under special supervision as a suicide risk during imprisonment earlier that year. When his medical file became available, the prison nurse reportedly did not check its contents. The prisoner was found hanging in his cell on 2 April 1994. No system had ever been established to ensure that medical files accompanied prisoners during transfer to prison from hospital and that the files were checked for information relevant to the care and custody of the prisoner. At an inquest prison representatives reportedly objected to any questions regarding the apparent lack of procedures on prisoner care which had been recommended by the Royal Commission.

Investigations into the circumstances of deaths in custody have frequently revealed that procedural reforms, made in response to the Royal Commission, had been ignored or were incomplete and not effectively implemented. For example, Brian Docherty, a 27-year-old mentally disturbed Aboriginal inmate at Lotus Glen prison near Cairns in far north Queensland arrived at Townsville Correctional Centre on 22 October 1992 while in transit to Rockhampton prison on the state's south coast. He had been granted transfer to Rockhampton to enable visits from his sister who lived in the area. Procedural and administrative failures, such as a delay in forwarding his prisoner file, led to delays in his transfer which should have been completed within two weeks. He was imprisoned at Townsville for almost six weeks until his death on 4 December 1992 when he was found hanging in his cell during routine cell checks.

Townsville prison staff - whose manager was unaware of his transit situation - failed to have his suicide risk and medical needs assessed even after receiving a psychiatric review from Lotus Glen prison which warned that Brian Docherty was a suicide risk. Following temporary closure of his prison unit, he was placed alone in a cell in a 100-year-old part of the prison where cell conditions had previously been described as in breach of international standards by the former Australian Human Rights Commissioner. When a prison guard found him hanging from a piece of mattress cover attached to cell window bars on the night of 4 December 1992, the guard did not have keys to the cell, nor was there an alarm system to call for assistance, even though Brian Docherty was in an observation cell that day.

The death of Kim Nixon

Kim Nixon, a 37-year-old Aboriginal man, died of a serious heart condition on 13 September 1994 at the East Perth Police lock-up. A coroner's report states that he was unlawfully detained at the time of death. The case illustrates problems encountered by police with indigenous people from remote desert communities whose first language is not English.

When Kim Nixon was received at the lock-up after arrest for breach of bail conditions on Monday, 12 September 1994, police computer records should have alerted lock-up officers that he had a heart condition, was prone to dizziness, fainting spells and alcohol abuse. Despite these records being available to police and his obvious language difficulties, officers denied him the opportunity fully to answer questions about his health by interrupting him with further questions. Upon reviewing video recordings of the procedure the coroner found that they "performed their duties in a most perfunctory manner" and did not follow up unclear answers. Officers failed to seek medical advice on his fitness for custody and assessed his health as "OK", although Kim Nixon answered 'yes' to routine questions about chest pains and other medical complaints, and gave confusing advice about his need for high blood pressure medication.

Visitors of the Aboriginal Visitor Scheme, an organization which regularly attends to Aboriginal detainees in the lock-up, met with Kim Nixon later that day and discussed his condition with an officer in charge of prisoner welfare. The officer then arranged for Kim Nixon to lie down in a cell with other inmates. Although the visitors reportedly advised police where the prisoner's medication could be found, no attempt was made to retrieve it. As the welfare officer was not aware of police records on the prisoner's health, no further steps were taken to ensure that any deterioration of his condition would be immediately brought to his attention. Officers recording 21 routine observations of Kim Nixon during the night did not note anything unusual, although a fellow inmate observed him vomiting several times and looking ill and weak. During and after breakfast several inmates saw him frequently go to vomit in the toilet. The coroner stated that, *"[i]n stark contrast to the evidence of the detainees only one of the police officers on duty who gave evidence during the inquest described having observed the deceased vomiting."* Lock-up visitors gave evidence that Kim Nixon was "very shaky", "freezing cold" and "shivering" in the morning, and a fellow inmate stated he told a police officer that Kim Nixon had vomited blood, felt unwell and needed his tablets. The officer denied this had happened.

In a court room next to the police lock-up on the morning of 13 September 1994 Kim Nixon was fined and, according to the coroner's report, ought to have been subsequently released. Instead, police returned him to the court holding cell within the police lock-up buildings where he was under direct supervision of a police officer who sat immediately outside his cell door. The police explanation for his post-trial detention was that they were fetching his personal belongings. After more than an hour in the cell Kim Nixon suddenly collapsed and was subsequently pronounced dead at a hospital.

The coroner's report is critical of the police's failure to properly assess, record and forward information relating to the deceased's medical condition. In Amnesty International's opinion, the case serves to illustrate how well-intentioned measures, such

as the use of questionnaires, computer records and an occurrence book with information about a prisoner's situation and medical condition, can become ineffective if officers involved in an inmate's custody are unaware of this information or fail to take action upon it. According to procedures agreed between the Aboriginal Visitors Scheme and the heads of police and prison services in Western Australia information on every prisoner visited must be recorded in the occurrence book and counter-signed by the officer in charge. Even if police assessing Kim Nixon's condition upon reception at the lock-up may have been justified in not seeking medical advice, the available information on his condition should have been brought to the attention of all officers in charge of his welfare and custody.

The coroner did not recommend any disciplinary or criminal proceedings against individual officers as a consequence of his findings, but instead focussed on recommendations for a thorough review of police training in custodial care, staff numbers at the lock-up, their functions and ability to provide proper care, as well as consultation with relevant Aboriginal organizations. He also recommended an extension of the limited period during which a nursing post at the lock-up is operational (on weekend nights) as it had not been staffed on the Monday and Tuesday Kim Nixon spent there[15]. As a result of its own investigations into the case, the Western Australia Police Service took immediate steps to remedy problems identified in police custody procedures - before coronial recommendations to that effect were issued. Western Australia police also advised Amnesty International that under new guidelines the cells in which Kim Nixon collapsed are only to be used in exceptional circumstances.

Deaths in the context of police pursuits

In Australia, the government's definition of deaths in custody now includes the death of a person who dies, or is fatally injured, in the process of attempts by police or prison officers to detain that person. Again, Aborigines are highly over-represented in the number of deaths resulting from police attempts to apprehend suspects. Since 1 January 1990, at least 17 Aborigines whom police were trying to apprehend were killed or died from fatal injuries sustained during a pursuit, most of them teenagers. The number of other Australians who died under similar circumstances is believed to have been less than double that figure. On 21 August 1996, the day after two Aboriginal teenagers died during a police car pursuit in Perth, Western Australia, the Australian Institute of

[15] The nursing post was only staffed from 10pm to 3am on Thursdays, Fridays and Saturdays and had been established partly in response to the controversial death from drug intoxication of Stephen Wardle at the same lock-up; see *Australia: Too many open questions - Stephen Wardle's death in police custody*, 17 October 1996, AI Index ASA12/13/96, p. 17.

Criminology published figures which revealed that Aborigines outnumbered other Western Australians in the number of deaths in police pursuits by nine to one. The institute concluded that, compared with their share of the population, the rate for Aborigines to die in police attempts to apprehend them was 318 times that of other Western Australians. This was three times the national rate.

The death of Michael Winmar

Michael Winmar's death on 9 February 1997 from injuries sustained in a car accident was the latest in a series of fatalities resulting from police car pursuits[16] during the past six years in which at least eight young Aboriginal offenders and two other Western Australian suspects were killed. Although more Aborigines died in such circumstances in Western Australia than in any other state or territory, and despite allegations that police beat some Aboriginal offenders involved in car pursuits, the Western Australia Government is refusing to initiate an inquiry into the problem.

On 6 February 1997 police in Perth, Western Australia, followed a stolen car driven by 16-year-old Aboriginal Michael Winmar after he failed to observe a stop sign. Police acknowledged that a pursuing police car collided with the boy's car immediately prior to an accident in which Michael Winmar sustained fatal head injuries, leading to his death in a hospital three days later. Media reports of the collision raised concerns that police officers may have forced the boy's car off the road in an attempt to 'pull him over'. Police advised Amnesty International that Michael Winmar had suddenly driven his car into a pole off the road when the officers identified themselves by flashing their signals. In a neighbouring suburb two Aboriginal teenagers died only six months earlier when their stolen car crashed into a pole seconds after a pursuing police car collided with their car at high speed.

While the circumstances of Michael Winmar's death are still being investigated, Amnesty International is concerned that some of these circumstances led to considerable trauma and distress for the relatives of Michael Winmar and his two juvenile companions who were also injured in the accident. For example, after Michael Winmar had been taken to hospital where he remained in police custody, an Aboriginal legal service officer was refused permission to take photographs of his injuries, although relatives had

[16] Western Australia Police Service advised Amnesty International in June 1997 that they do not regard Michael Winmar's death as a death resulting from a police pursuit. The police distinguish between high speed pursuits involving the use of police sirens and other occasions where police vehicles merely follow a suspect's car. Police therefore do not classify as 'pursuits' all events involving offenders who died in accidents after police followed their car. Police statistics identify seven people as Aborigines among nine suspected offenders who died in car pursuits since 1991.

requested that photographs be taken. The family were not given reasons why the legal service officer was denied access to the boy. A 15-year-old passenger and companion of Michael Winmar was treated in hospital for minor leg injuries which he claimed resulted from baton blows inflicted by police after he hesitated to obey orders to get out of the car. He told Amnesty International that he was confused and was cradling the bleeding head of Michael Winmar's unconscious body when police repeatedly told him to 'let him go'. A second juvenile passenger who sustained injuries to both ankles was arrested in hospital as soon he could be carried into a wheelchair.

According to the Western Australia State Coroner's office, no decision had been made by the end of May 1997 whether an inquest would be held to investigate the circumstances of Michael Winmar's death. In February the State Coroner had responded to media reports on the death by saying that an inquest was "likely".

Some community organizations acknowledge a higher Aboriginal offending rate in comparison to other sectors of the population, but also express suspicions that the Aboriginal death rate in Western Australia police pursuits indicates, in effect, discriminatory policing and reckless and unjustified use of force. Western Australia police statistics made available to Amnesty International indicate how the Aboriginal death rate in police car pursuits relates to the alleged Aboriginal involvement in offences leading to such pursuits. Among the known offenders involved in Western Australia police car pursuits, Aborigines are more than seven times more likely than others to die as a result of accidents during police pursuits. Police figures on identified drivers and passengers involved in car pursuits reveal that, between 1 January 1991 and 27 March 1997, seven Aboriginal suspects died in 432 car pursuits involving Aboriginal drivers, while only two other Western Australian suspects were killed in accidents involving 893 non-Aboriginal drivers.

According to media reports of 20 June 1997, Western Australia police acknowledged the need for reform of the policy on high speed car pursuits given the number of fatalities involved in the past five years. Deputy Commissioner Bruce Brennan was quoted as saying that "[p]eople have been killed in circumstances where it really hasn't been justified." A new Urgent Duty Driving Policy will restrict permission for high speed pursuits to cases of life-threatening situations or the pursuit of people suspected of being involved in serious crime.

Western Australia police advised Amnesty International that they were involved in a new working group involving 18 government authorities and community organizations described as "stakeholders in the area of Aboriginal car theft". The initiative reflects a widespread belief that one major factor in the frequent involvement of Aboriginal youth in police car pursuits is 'joy-riding' - stealing a car only for the purpose of driving it for a brief period. Amnesty International acknowledges that police appear to

be dealing with a social problem. However, the question remains why Aborigines accounted for three-quarters of all car pursuit fatalities but only a third of known drivers involved in such pursuits.

While patterns of a high incidence of fatal police shootings during arrests in Victoria - previously highlighted by Amnesty International[17] - have been subject to investigations resulting in a reform of police operations and fewer fatalities, the disturbing pattern of deaths in police car pursuit has not drawn comparable attention. The Western Australia State Government repeatedly dismissed calls by community organizations, made in response to car pursuit deaths, for an investigation into the pattern of such deaths, saying that each individual case was already investigated by police.

4 POST-DEATH INVESTIGATIONS

While the Royal Commission into Aboriginal Deaths in Custody prompted reform, it also recommended a continuing review of procedures, including improved post-death investigation systems which could be more effectively utilized to prevent deaths reoccurring under circumstances already identified in a previous investigation as a potential hazard. Amnesty International is concerned to learn that some coroners investigating deaths in custody after the Royal Commission have found that recommendations made at previous inquests towards preventing custodial deaths had not been implemented.

Deaths in custody in Australia are routinely investigated by police officers who in turn file a report to the coroner. These officers operate under the supervision of, and report to, the police commissioner. If a death occurs in prison, juvenile detention or other correctional facility, the government department responsible usually initiates an additional internal investigation. This practice involves a number of issues which are of concern to Amnesty International. While many of these issues were raised in the context of Aboriginal deaths in custody, they appear to be equally relevant for all Australian custodial deaths.

(I) Detailed findings of most investigations into deaths in custody are not normally made public. Access by the general public to investigation findings is generally limited to inquests or other judicial investigations. However, not all deaths in custody are investigated by inquests.

[17] *Indigenous Deaths in Custody, 1989-1996*, op. cit., p. 59. Cf. Amnesty International, *Annual Report 1995* and *1996*.

(II) Due to different state and territory legislation, there is no uniform approach to post-death investigations across Australia which would ensure that the same standards apply in decision-making, for example, about the kind of investigation (internal or public), about the manner, independence and thoroughness of the investigation, about the involvement of family members of the deceased, and about access by relatives and the general public to the findings of investigations.[18]

(III) Investigations into deaths in police custody are routinely carried out by police officers of the same police service in whose custody the death occurred.

(IV) Police officers are involved in so many aspects of coronial investigations into deaths in custody that they have been perceived by community organizations as effectively in control of the investigative process. This raises questions of impartiality and the level of independence of coronial investigations.

A recurring issue is the function of post-death investigations to dispel any suspicions about possible abuses, or deficiencies in the standard of care afforded to a prisoner before his or her death. Where witnesses or relatives have made allegations of ill-treatment or serious lack of care in the context of a death in custody, investigations have often failed to clarify the events and have sometimes left questions unanswered about a possible causal relationship between alleged ill-treatment and the death.[19] Transparent, thorough, fully independent and impartial investigations of all custodial deaths are important not only to determine possible criminal responsibility for alleged abuses, but also to ensure the authorities are aware of deficiencies which, if addressed, would help prevent further deaths under similar circumstances.

Policy, legislation and guidelines on police and coronial investigations, as well as their practical application, vary significantly between the different states. This can lead to a situation in which legislation in some states requires a full coronial inquest into a custodial death, while a death occurring under identical circumstances in another state may not be subject to an inquest or any other publicly recorded investigation. For example, the most recent coronial legislation in Australia, the Western Australia *Coroners Act 1996*, requires the coroner to hold an inquest if a death occurred in the custody, control or care of any institution controlled by a number of government

[18] Amnesty International is encouraged to learn that, as a first step towards a national approach to coronial investigations, a National Coronial Information System, initiated by the Australian Coroners Association, is expected to become operational during 1997 which will provide statistical information relating to investigated deaths throughout Australia.

[19] For an example, see *Australia: Too many open questions - Stephen Wardle's death in police custody*, October 1996, AI Index: ASA12/01/96, p. 20-22.

authorities, including police and prison services. By contrast, the Queensland *Coroners Act 1958* leaves the decision to hold an inquest to the "opinion" of the coroner or the coroner's chief executive officer (sections 7B and 16). Deaths in police custody are not even mentioned in provisions of the Queensland act concerning the circumstances of custodial deaths which could trigger an inquest (section 7B.(1)-(b)-(i)). Even where the Police Commissioner has requested that an inquest be held, Queensland coroners may decline the request.

Another significant difference between state coronial legislation relates to the interpretation of the coroner's function to comment on the treatment by police and prison guards of people who died in custody. While the Western Australia *Coroners Act* states that "a coroner must comment on the quality of the supervision, treatment and care of the [detained] person" (section 25 (3)), Queensland coroners are prevented by law from making such comments as part of their findings.[20]

Amnesty International is concerned that the Queensland *Coroners Act 1958* lacks adequate safeguards to ensure that all deaths in custody, including deaths in police custody or during police operations, are thoroughly and independently investigated. The legislation falls short of international minimum standards on the protection of detained persons which recommend that an inquiry be held by a judicial or other authority into the cause of the death of *any detained person* and that the findings be made publicly available, except where this would jeopardize an ongoing criminal investigation.[21] Amnesty International urges the Queensland Government to amend the *Coroners Act 1958* in such a way that all deaths in custody-related circumstances are required by law to be investigated by a fully independent and adequately resourced judicial authority whose findings will be made easily accessible to the public, subject to reservations about ongoing criminal proceedings. In addition, amendments should incorporate provisions which encourage investigations of, and coroner's comments on, the quality of care, including possible ill-treatment or lack of care of deceased detainees, even in cases where such treatment has not been the immediate cause of death.

[20] Section 43 of the Queensland *Coroners Act 1958:*
"(5) The coroner shall not express any opinion on any matter outside the scope of the inquest except in a rider which, in the opinion of the coroner, is designed to prevent the recurrence of similar occurrences. (5A) A rider shall not be or be deemed to be part of the coroner's finding but may be recorded if the coroner thinks fit. (6) No finding of the coroner may be framed in such a way as to appear to determine any question of civil liability or as to suggest that any particular person is found guilty of any indictable or simple offence." The scope of an inquest is limited to establish the identity of the deceased as well as "when, where, and how" death occurred, and to identify persons (if any) committed for trial (section 43 (2)).

[21] Principle 34, *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*.

Amnesty International also has concerns about the impartiality and independence of investigations into deaths in custody. Police officers are empowered by legislation to exert considerable control on custodial post-death investigations. For example, police officers usually inform and question close relatives about a family member who died in custody, are present at post-mortem examinations, collect evidence and conduct the investigation, select and interview witnesses and control the dissemination of documents to the relatives of the deceased. This includes cases where police are investigating the death of a person who died in the custody of police officers belonging to the same police service. Even where legislation provides for the appointment of independent investigators, established practice relies on the police service to conduct the investigation. In its comments on this practice, the Royal Commission considered it as a "major problem [...] that the investigation was often conducted by, or with the assistance of, officers involved in the initial apprehension and/or custody of the deceased."[22] The Commission found that police officers investigating deaths in custody frequently failed to see the need for the same scrutiny of evidence they applied to other cases. While some structural changes have been made to address this criticism, the fundamental problem remains.

Police investigators often take up to a year before submitting their investigation file to a coroner handling a death in custody. Responding to Amnesty International inquiries about the reasons for such delays, police officers explained that an investigation file could not be completed and sent to the coroner before all relevant witnesses, including fellow-detainees, had been located and interviewed. The Royal Commission found that such delays have an adverse effect on the ability of coroners to *independently* control the level of scrutiny and direction of post-death investigations. Amnesty International believes that the appointment in some jurisdictions, on an ongoing basis, of counsel assisting the coroner may be a step towards increasing the independence and impartiality of investigations into deaths in custody. In addition, coroners should have immediate access to all police investigation files concerning a death in custody at any stage of the police investigation. Coroners should not be expected to await completion of police investigations before commencing inquiries.

5 GOVERNMENT RESPONSE

[22] *Regional Report of Inquiry in Queensland,* Canberra, Royal Commission into Aboriginal Deaths in Custody, 1991, p. 86. See also *Regional Report of Inquiry in New South Wales, Victoria and Tasmania*, pp. 154-157.

A large number of initiatives have been taken over the past 10 years at all levels of government to address issues relating to deaths in custody, in particular to the high number of Aborigines who have died in custody. In response to the Royal Commission into Aboriginal Deaths in Custody the Australian Government made some A$400 million available until June 1997 for measures to implement the Commission's recommendations. Amnesty International has welcomed the breadth of these measures which go far beyond issues of arrest and detention and include steps to address post-death investigations as well as the specific social, welfare and health needs of Aboriginal people, both in the criminal justice system and in Australian society.

Examples of positive initiatives by state and territory governments include physical changes to detention facilities such as the removal of fittings, bars and rails in police and prison cells which could be used to commit suicide by hanging. Emergency alarm and camera surveillance systems have gradually been introduced in a number of new and existing police lock-ups and prisons. Other reforms include procedural changes to the assessment and treatment of detainees in both police and prison custody as well as the training of officers in charge of their care and custody. Examples include new and revised police and corrective services guidelines, such as the *Custodial Care* handbook of the Western Australia Police Service, to improve the standards of care and the supervision of prisoners found to be at risk of suicide or life-threatening illness. Numerous liaison and consultation groups were established involving government officials as well as Aborigines, and government departments at both state and federal level designated offices for the monitoring of deaths in custody and the implementation of Royal Commission recommendations. In the judicial system, improvements include more decentralized magistrates courts in remote areas, the recruitment and training of

To Amnesty International's knowledge, no criminal prosecution has been initiated against anyone involved in the care and custody of a person who died in custody since January 1990. The few court hearings concerning custodial deaths between 1980 and 1990 in which law enforcement officials were charged with criminal offences for their role in a death in custody ended in acquittal.

Amnesty International is aware of two cases in which courts ordered state government authorities to pay compensation to the relatives of Aboriginal people who died in custody. One of these involved 22 year-old Mark Quayle who was found hanged in the remote police lock-up of Wilcannia, New South Wales, on 24 June 1987. In the early morning hours of that day he had been taken by his family to the Wilcannia hospital where he was accepted as a patient but did not receive medical care. Subsequently hospital staff called police officers and arranged for Mark Quayle to be kept in the police station overnight for "safe custody" as they believed he was disorientated and might wander off. He was arrested without charge and left alone in a dark cell with no light switch. The officers then left the police station. When they returned the following morning they found him hanged by a strip of blanket from the cell door flap. Police officers later blamed the family for Mark Quayle's death. In September 1995, a New South Wales court awarded damages to his immediate family for the trauma they had suffered as a result of his death.

interpreters to assist Aboriginal suspects with a limited command of English, and training in Aboriginal culture for judges. Alternative options to arrest and incarceration were piloted to test ways of implementing Royal Commission recommendations to use arrest and imprisonment as a last resort, especially for children and minor offenders.

It appears that some of the more successful initiatives to avoid high levels of detention and imprisonment of Aborigines as an underlying factor for custodial deaths have been introduced at a local level by individual government and police officers, often in cooperation with local Aboriginal people. These include confidence-building projects between the Aboriginal communities and police as well as cooperation between Aboriginal organizations and the judiciary on alternatives to prison sentences.

The need for more action

While initiatives such as these are important and welcome, the trends and case studies on deaths in custody outlined above show how limited their effect has been. In Amnesty International's opinion, a major factor in the failure of many well-intentioned measures has been the lack of appropriate systems to ensure that relevant information on Royal Commission recommendations, as well as on the authorities' response, was disseminated to all police and prison staff, as well as to community organizations concerned with the care, welfare and custody of prisoners. It appears that at least in some states it was left to the initiative of police and prison officers to seek access to those Royal Commission findings and recommendations directly related to their work. Several years after Australian state and territory governments endorsed implementation of most Royal Commission recommendations, some senior prison and police officers told representatives of Aboriginal organizations they had never seen the Commission's reports and had not been required to make themselves familiar with those sections of the Commission's reports relevant to their work. Amnesty International notes in this context that the Royal Commission was funded and established by the Australian Federal Government, while the responsibility for implementing most of its recommendations referred to in this report rests with the state and territory governments. Government representatives have repeatedly acknowledged that cooperation between the various authorities on implementing the Commission's reforms has often not been satisfactory.

In addition, many reforms and improvements have been delayed for years or were incomplete, and some have not been systematically implemented across the country, or even within a state jurisdiction. For example, police officers at the Kununurra police station in Western Australia showed Amnesty International delegates in March 1996 how they had improvised to reduce suicide risks from hanging in a cell block and to increase fire safety while waiting for a new police lock-up to be built, which is due to be opened in November 1997. Since the delegation's visit, portable cells have been installed at

Kununurra as a temporary measure to raise detention standards and improve the safety of detainees. Amnesty International is concerned that the authorities appear to have been reluctant to improve detention conditions temporarily where they were planning to replace detention facilities in the future.

Another cause for concern is that many initiatives to curb deaths in custody were short-lived. Community groups and concerned individuals told Amnesty International that the reasons were often a lack of proper consultation and reliable funding, a lack of suitable staff to continue projects set up by people who then left the area or posting, and a lack of effectiveness due to inadequate training, cooperation and accountability of persons involved, both in government authorities and community organizations. Aboriginal people in rural and remote communities often complained about the transfer of police officers who had contributed to improved relations and cooperation with local Aboriginal organizations and spokes people. This had frequently led to problems with the continuation of projects which were based on mutual trust and the police officer's knowledge of the local Aboriginal community.

6 RECOMMENDATIONS TO THE SUMMIT MEETING

The death in custody summit on 4 July 1997 represents an important opportunity to resolve the concerns outlined above. For the summit to have an immediate and visible effect, Amnesty International believes ministers should adopt a series of measures which can be implemented with a minimum of delay. In Amnesty International's opinion, this could significantly contribute towards rebuilding trust among the general public, and particularly among Aboriginal communities, in the seriousness of the government's intention to make the reduction of deaths in custody a high priority. The implementation of the following recommendations, in addition to those already outlined above, would be a positive sign of the authorities' commitment to reduce the number of deaths in custody and the high incidence of such deaths of Aboriginal and Torres Strait Islander people.

Particular emphasis should be placed on measures found to have been effective in other jurisdictions, both within Australia and overseas. Amnesty International calls upon the federal authorities to play a leading role in making reforms effective in all jurisdictions. The organization urges the Federal Government to use its influence to initiate and support state government measures against deaths in custody, especially in the criminal justice system, and, where necessary, to provide state governments with the means for reform.

Amnesty International calls on all Australian State and Territory governments and on the Federal Government to implement the following recommendations for the

prevention of factors contributing to custodial deaths. Where some recommendations may already have been partially implemented in some jurisdictions, the effectiveness of the steps taken should be reviewed in the light of the concerns outlined above.

(1) Existing laws, guidelines and regulations pertaining to the treatment of detained persons should comply with relevant international standards, in particular the United Nations (UN) *Standard Minimum Rules for the Treatment of Prisoners*, the UN *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment,* and the UN *Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.*

(2) Prison and police officers as well as medical staff working in custodial facilities should be formally required to take proper notice of, and comply with the relevant laws, orders and guidelines pertaining to the care and custody of detainees in all places of detention, including during transfer, arrest and attempts to apprehend a person. Government authorities should enforce compliance through appropriate sanctions and regularly review the clarity and adequacy of instructions.

(3) Government departments should ensure that the latest guidelines and orders concerning the care and custody of detainees are available and easily accessible in print at all places of custody, that they are brought to the attention of relevant custodial staff, and that they are incorporated, on a regular basis, in staff training.

(4) Given that about two-thirds of Aborigines and almost half of other Australians who died in custody in recent years were found to have either committed suicide or died of natural causes, information pertaining to a possible need for medical care or close supervision, as well as the state of health and suicide risk of a detainee should be gathered and recorded formally on every occasion where a person is taken into custody. The records should at all times be accessible to every government officer responsible for a detainee's care and custody, including during the transfer of a prisoner to a court or a place of detention.

(5) All police and prison officers as well as medical staff responsible for a prisoner's custody should be instructed to actively ensure they are aware of all relevant information concerning the health and suicide risk of a prisoner, and of his or her possible need for medical care or extra supervision.

(6) Unambiguous and detailed instructions about appropriate extra care in cases where assessment or existing records on a prisoner's health and welfare point to a possible risk or a need for medical care should be available in all places of detention. In addition, effective and practical procedures should be in place to

ensure that any observations or directions made by a law enforcement official or an official visitor in relation to a prisoner's need for extra care is brought to the attention of all officers responsible for that prisoner, including those on a subsequent shift of duty or in charge of the transfer of the prisoner.

(7) Police, judicial and medical investigations of custody-related deaths should be guided by relevant international standards.[23] Australian governments should give adequate support to initiatives, such as those made by the Australian Coroners Association, towards improving the standards and the effectiveness of coronial investigations across Australia.

(8) In cases where coroners or other judicial investigators comment on any deficiencies in custodial care in their findings, or give specific recommendations about the way in which care could be improved, custodial authorities should be required to bring them to the attention of all staff responsible for the care of detainees. Coroners' findings and recommendations pertaining to the work of custodial staff should be incorporated, on a regular basis, into their training. Coroners' findings and any recommendations related to custodial care, as well as government-sponsored research into the trends, causes and circumstances of deaths in custody should systematically be brought to the attention of all officers in charge of custodial institutions and to government departments responsible for juvenile detention, prison, police and health services.

(9) In order to facilitate the identification of systemic deficiencies, coroners investigating custody-related deaths should be required to investigate, and to comment in their findings on, the circumstances of detention and death, the treatment of the detainee, the quality of care and any allegations of ill-treatment. Coronial systems should, where this is not already the case, present annual reports with summary recommendations and findings which enable custodial authorities in other jurisdictions to identify and address systemic problems in the care of detained persons. Where custodial authorities report annually to government ministers or to parliament, the implementation or otherwise of coroner's recommendations for the prevention of custodial deaths should be reflected in the report.

(10) Where legislation or guidelines governing coronial investigations may discourage coroners to examine and comment on alleged ill-treatment or any other circumstances not directly related to the medical cause of death, state governments

[23] See Appendices in *Prescription for Change: Health professionals and the exposure of human rights violations*, Amnesty International, May 1996, AI Index: ACT 75/01/96; and UN *Manual for the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions*.

should consider a review of the legislation.

(11) Monitoring and analysis of deaths in custody and respective post-death investigations, as well as legal representation at inquests of the next of kin should continue to receive special funding beyond the five-year period which ends in 1997 for which financial support has been provided in response to Royal Commission recommendations. Reports on deaths in custody such as those issued by the Australian Institute of Criminology should be made easily available to the general public.

(12) As soon as possible after a death in custody occurred, relatives should be made aware of the procedures of investigation, their rights in respect of information pertaining to the circumstances of the death, and the courses of action open to them in respect of post-death investigations, legal representation in coronial inquests, and the availability of counselling. This information should be brought to the attention of the relatives in a language and manner which is appropriate and easy for them to understand in a situation in which they often suffer considerable trauma and uncertainty.