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AUSTRALIA

Too many open questions: Stephen Wardle's death in police custody

Introduction

Amnesty International is concerned that many suspicious circumstances surrounding the 1988 death in police custody of Stephen Wardle have never been fully and independently investigated.[1] The organization believes that he may have been ill-treated in custody and that he was subject to lack of care to such a degree that it constituted cruel, inhuman or degrading treatment which had fatal consequences. This concern is heightened by alleged police harassment and intimidation of his family following media reports about the findings of a coronial inquest. The family have considered these as attempts by police to discourage them from pursuing a thorough investigation.

Amnesty International urges the Western Australian State Government to respond positively to a recommendation made in June 1996 by a Legislative Council Select Committee on the Western Australian Police Service to grant a thorough and fully independent, judicial inquiry into both Stephen Wardle's death and subsequent alleged police harassment and intimidation of his family.

Such an inquiry should, in Amnesty International's view, be conducted according to the United Nations Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions[2]. The organization believes that the UN principles provide a useful and appropriate basis upon which to conduct death in custody inquiries. In Amnesty International's view, previous inquiries into the death of Stephen Wardle fell short of the standards set by these principles. Amnesty International's concerns about the case are based on the following facts and circumstances.

1. A suspicious death in custody

1Previous Amnesty International publications on the death in custody of Stephen Wardle include:
- "Amnesty International Supports Death in Custody Inquiry Call", Amnesty International, 24 June 1996,
  AI Index: ASA 12/09/96;
- Appendix A, "Non-Aboriginal deaths in custody", in *Australia: A Criminal Justice System Weighted Against*
  Aboriginal People, Amnesty International, February 1993, AI Index: ASA 12/01/93;
- "Worldwide Appeals: Australia-Stephen Wardle", in *Amnesty International News*, Vol. 26, No. 9, September
  1996, p. 7.

2Adopted by the United Nations Economic and Social Council in Resolution 1989/65 of 24 May 1989 and welcomed by the General Assembly on 15 December 1989 in Resolution 44/159. Subsequently referred to as UN principles. Published as appendix 4 in *Prescription for change: Health professionals and the exposure of human rights violations*, Amnesty International, May 1996, AI Index: ACT 75/01/96.

Stephen Wardle died, aged 18, at the East Perth Police Station, Western Australia, within hours of his arrival there on the night of 1 February 1988. According to the police, he was "arrested [...] for his own safety" on suspicion of drunkenness at the Entertainment Centre in Perth at about 9.30pm. Following formal registration at the police station at 9.40pm he was detained in a police cell some time after 10.40pm. When he was processed for reception in the cell block, police recorded "No Visible Injuries" upon him. Fears for his health, for example when he could not be roused, were repeatedly expressed by several people in the police station during the night, yet no action was taken. At 5.05am the next morning, Stephen Wardle's dead body was discovered in a cell with rigor mortis well established, and bruises, bumps and abrasions clearly visible.

1.1Found dead with several injuries

Western Australia's Chief Forensic Pathologist, Dr. John Hilton, did a first examination of the body in the cell about an hour later and found "marked suffusion of the face, neck and upper chest." He instructed investigating police officers to arrange for the body to be taken to the mortuary "as soon as possible for tests" and advised them that a post-mortem examination would be conducted later that day (at the Queen Elizabeth II Medical Centre Mortuary).

Stephen Wardle's mother saw the injuries on the same morning and became suspicious when police attempted to explain the death of her son as the result of a drug overdose. A Coroner's inquest later established that there was no evidence to support the police's suggestion that Stephen Wardle had a history of intravenous drug abuse. The Coroner also stated in his report that "[t]he medical evidence is consistent with this position."

1.1.1Family doctor effectively prevented from attending autopsy

Stephen Wardle's mother arranged for the family doctor - who knew her son well - to witness the post-mortem examination scheduled for 2pm on the same day. When the doctor arrived at the mortuary at about 1.45pm on 2 February 1988, he was told that the autopsy had been postponed until the following morning. However, when he arrived at the mortuary on the following day at the scheduled time, the post-mortem examination had already been completed. It had been carried out in the presence of at least seven police officers at 2.15pm on 2 February 1988.

The family doctor and the Chief Forensic Pathologist then conducted a re-examination of the body. However, due to the autopsy having been completed, it was no longer possible to examine a head injury about which Stephen Wardle's mother had expressed some concern to a police officer assisting the Coroner. According to the post-mortem report no X-rays were taken of any part of the body. The Chief Forensic Pathologist later recorded the re-examination in an annex to the post-mortem report and stated that on that occasion two more areas of bruising on the scalp had been discovered.

1.1.2Inquest fails to explain injuries

Following the post-mortem examination and prior to analysis of body samples conducted at the State Health Laboratory Services' Forensic Division, investigating police were advised by the Chief Forensic Pathologist that the cause of death was "undetermined." A summary of the post-mortem findings includes "[m]ultiple minor abrasions, bruises etc." and "[m]arkedly congested oedematous lungs" which resulted in the lungs being two to three times the normal post-mortem lung weight in a healthy young man. A laboratory examination conducted on 26 February 1988 at the Royal Perth Hospital's Department of Neuropathology concluded that Stephen Wardle's brain was "congested."

A series of 26 photographs taken by police in the cell and at the mortuary highlight many of the injuries, bruises and abrasions mentioned in the post-mortem report. In some of the photographs traces of "bloody froth" are visible "issuing from the nose and mouth" (post-mortem report). In a photograph taken inside the police cell several stains which would be consistent with these traces are visible on the bed sheet.

The Coroner's inquest, concluded after long delays more than a year later on 10 March 1989, did not result in any explanation of many of the marks or injuries observed on Stephen Wardle's dead body or the unusual state of his organs.

1.1.3Inquest unable to explain possible moving of the body

A photograph of the body lying on the cell bed, as well as several witness statements suggest that the body may have been moved after the death into the position in which police claimed to have found it. The Coroner's inquest examined this issue at some length, and the inquest report notes contradictory statements of police officers and other witnesses but does not offer a conclusive explanation.

Following the inquest, a former inmate at the East Perth Police lock-up claimed that at approximately 1.45am on the morning of 2 February 1988 he was placed into the cell (then numbered G.73) in which Stephen Wardle allegedly died. He said he had been shown photographs of Stephen Wardle lying in the cell and was certain that no such prisoner had been in cell G.73 at that time of the night.

1.1.4Police record of arrest time challenged

Another former inmate of the lock-up who was interviewed by police officers investigating the death later alleged to have seen and heard Stephen Wardle being questioned about medication by police in a room adjacent to the charge room. This prisoner witness was reportedly recorded by police to have been discharged from the lock-up some 20 minutes before they claim to have arrested Stephen Wardle outside the concert hall at 9.30pm.

Although the family made a request for him to give evidence at the Coroner's inquest, he was not called upon to do so. To Amnesty International's knowledge, the list of witnesses to give evidence at an inquest is compiled by a police officer assisting the Coroner and is at the

discretion of the Coroner. If the allegations of this witness were found to be true, this might have some implications for the assessment of forensic medical evidence and other available clues about the time of death (cf. 1.9 below).

In August 1988 the *Report of Ad Hoc Committee for the Review of the [Western Australian] Coroners Act* expressed the view that "one of the few strengths of the present system in Western Australia is that it is the practice for the Coroner to determine who shall be called as a witness" (p.23). However, the report also quotes from a submission made by the Aboriginal Legal Service suggesting that all Counsel to a coronial inquest be allowed to call witnesses:

It is our experience that in cases where a person has died in custody, the family may have available many witnesses as to facts which may not have come to light during the police investigation. This may be because the witnesses prior experience with police make them reticent about coming forward and giving information to police, whereas they are willing to provide that information to the family of the deceased.(p.14)

1.2Police unable to find missing photographic evidence at inquest

A police photographer stated under oath that he took four photographs in the police cell and another 22 at the mortuary during post-mortem examination. However, during the inquest police were unable to locate certain photographs taken at post-mortem of the head injuries which the family doctor had wished to examine. When Stephen Wardle's parents later approached the police with a request to purchase copies of all photographs taken by them, the negatives of the missing head injury photographs had allegedly disappeared along with the prints. The family managed to obtain three of the four photographs taken in the police lock-up, and 21 of the 24 photographs taken at the mortuary.

1.3Coroner's inquest critical of police

The Coroner's inquest found that Stephen Wardle's death resulted from the toxic effects of prescribed drugs (propoxyphene[3] and benzodiazepine [4]) and alcohol, "aggravated by lack of care". The Coroner also found "many unexplained discrepancies arising from the statements of the police officers [on duty] and the evidence of persons detained in the cells on that night and from the documentary records made during the same period." For example, "the evidence would seem to indicate that the body of the Deceased may have been moved after being found at 5.05 a.m. and before the photographs were taken, despite [...] other evidence to the contrary." Further evidence related to unexplained circumstances and the Coroner's criticism of police conduct will be examined below. The Coroner was also critical of police for their apparent lack of response to concerns expressed by several people in the lock-up about Stephen Wardle's health while in custody (cf. below 1.6).

3Sold to Stephen Wardle as Doloxene.

4Sold as Valium.

The Coroner found that "a number of questions" concerning the death remained unanswered since all 17 police officers on duty that night refused to be questioned during the inquest. Instead they tendered written statements after having received legal advice that they risked self-incrimination if they were subjected to cross-examination. This effectively prevented Stephen Wardle's family from having any of their questions put to key police witnesses and investigators and caused them considerable suffering (cf. conclusion).

1.4Police altered records after finding dead body

In his report, the Coroner noted that hand-written police records related to events immediately following the discovery of Stephen Wardle's body had been tampered with. For example, "corrections have been made by using white paint and the next entry in the [Occurrence] Book bears a time before the [preceding] entry, in other words the entries have not been made contemporaneously." The inquest failed to find an explanation of this interference since all police officers involved refused to be questioned in the Coroner's court and could not be compelled to answer questions under existing legislation.

Upon reception at the lock-up, police recorded Stephen Wardle's personal property in a hand-written inventory form which had several carbon copies. All copies of the form, including the original, bear the entry "No Visible Injuries" in the box entitled *Condition Of Prisoner (Describe if suicidal, injured, ill. etc.)*. However, the carbon copy given after his death (at 8.45am on 2 February 1988) to a brother of Stephen Wardle has an additional entry under the same heading: "Very intoxicated." Again, none of the official investigations into the case explained this alteration of police evidence, or if they did, the family was not informed of the findings.

1.5Police fail to record medication found upon Stephen Wardle

When Stephen Wardle was arrested, police officers said they found prescribed drugs upon him, namely "two part used foil packets of tablets marked 'Rohypnol'", as well as cholera and diphtheria vaccine for injections. However, the only medication police recorded in his *Inventory Of Property Taken From Prisoner* was "1 x Packet of Codiphen (7 tablets [sic]." It appears from the following that this record was either not tendered in evidence or, if it was subject of any questioning at the Coroner's inquest, did not result in any satisfactory conclusion. Again, for the inquest to resolve this discrepancy it would have been necessary to ask the police officers involved for an explanation.

According to the Coroner's report, none of the medication found in Stephen Wardle's possession upon arrest was recorded "in any document relating to the Deceased which was kept at the lock-up," although the arresting Police Sergeant had questioned him extensively about the drugs, both at the scene of arrest and at the police station. According to a written statement, submitted in accordance with police regulations, the Sergeant had formed the opinion that Stephen Wardle had "obtained [the tablets] illegally". The Sergeant then discussed the drugs with other police officers at the charge counter and made telephone inquiries about

their legality with another officer at the CIB Duty Sergeant's Office. The CIB officer in turn consulted with other police and then advised the Sergeant that the tablets were a "fairly common" drug, and that there was no offence unless they were obtained without a prescription. The Sergeant then mentioned to several other officers that he "would make further inquiries at a later date."

According to his mother, Stephen Wardle suffered from painful back and bone complaints including Scheuermann's Disease which required prescription painkillers.

1.5.1Missing drugs found in possession of arresting Police officer

On the day of Stephen Wardle's death, investigating police at the lock-up were unable to find the Rohypnol tablets found upon him by the arresting police officers. When the Sergeant who had arrested him the night before reported for work that afternoon, he had already been informed that Stephen Wardle was dead. However, it was not until two days after the death that the tablets were recovered from this Sergeant, on sick leave that day, who said "he had put them in his pocket and forgotten about them."

This Sergeant worked yet another afternoon shift on 3 February 1988, based at the same police station, while police investigations into the death were continuing and television news continued to report about it. He claimed to have "completely forgot[ten]" that he took the tablets home, until on 4 February the Police Constable who had arrested Stephen Wardle with him "called around to see how I was and he mentioned the drugs and I suddenly remembered." Following the rediscovery of the tablets in his trousers the Sergeant called the police union's lawyer to seek legal advice.

1.6Lack of care and failure to seek medical attention

A Justice of the Peace (JP) attending the Police Station at the time Stephen Wardle was in the charge room saw a person sitting on the floor of the charge room at about 10.12pm. This person did not appear well. At the same time, the JP overheard two police officers discussing "tablets", and heard one officer telling the other to "throw those away." According to the Coroner's inquest "it was the mention of 'tablets' which caused [the JP] to be concerned about the person sitting on the floor. [...] it seems likely, to the point of certainty, that it was the Deceased who was then sitting on the floor of the charge room."

The JP raised his concern about the health of this person with the Police Sergeant then in charge of the lock-up who later "assured him that he would pass on that concern to the next shift sergeant." There is no evidence that either Police Sergeant took any action upon the JP's concern. The Coroner's report states that "[i]t is to be noted that neither sergeant had occasion to mention such an expression of concern in the [written] statements made by them."

In a summary of medical evidence on the immediate cause of death, the Coroner's report describes the fatal effect of a large dose of propoxyphene on the body and concludes that

Stephen Wardle's life might have been saved if he had received medical treatment: "[i]f a patient suffering from an overdose [of propoxyphene] was delivered to a hospital while breathing then there was a likelihood of survival."

Western Australia's Chief Forensic Pathologist later responded to media enquiries about his investigations into Stephen Wardle's death and was quoted as saying "[i]f the police had called in expert medical advice, instead of simply dismissing the kid as a drunk, he would still be alive. My view is that all these deaths in custody are preventable. [...] There's no point in retaining people who are at risk of dying in a police cell" (*Bulletin* 4 July 1989).

1.7Police investigation finds "no suspicious circumstances"

A team of police officers headed by a Detective Sergeant attached to the Perth General Crime Squad conducted an "exhaustive enquiry into this death." They found "no suspicious circumstances" and concluded that there was "no evidence under the criminal code to sustain a charge in this matter." In this context, Amnesty International notes the 1991 Royal Commission into Aboriginal Deaths in Custody report on the many cases investigated by the Commission "in which a lack of care by custodians was found to have contributed to death:"

Police investigations which are confined to the search for criminal misconduct are, by their nature, inadequate to detect those factors which were frequently found to contribute to the deaths inquired into by Commissioners.
(National Report, Vol. 1, section 4.2.10).

In June 1989, the Western Australian Police Department's internal investigations branch reportedly opened an inquiry into alleged breaches of police discipline at the East Perth Police lockup. These followed the department's earlier investigation of complaints about the original police investigation into the death of Stephen Wardle at the lockup (cf. "Police probe jail breach claims", *West Australian*, 29 June 1989).

Following media reports about a politician's request for a Royal Commission into the case, the then Western Australian Police Commissioner was quoted as saying "[w]e conducted our internal investigation and we found no breaches of discipline. That is why no action was taken against the officers. On the evidence before me I see no need for a royal commission."

1.8Coroner complains about lack of independence in investigations

Several months before Stephen Wardle's death, a national Royal Commission had been established to investigate a disproportionate number of Aboriginal deaths in custody. As a result, the issue of deaths in police and prison cells was very much a part of public and expert debate at the time of the investigations into his death. Stephen Wardle's death, however, was not covered by the terms of reference of the Royal Commission because he was not an Aboriginal person.

The Coroner investigating the death in custody of Stephen Wardle referred to this Royal Commission in the introduction to his inquest report in which he commented adversely on the lack of independence of his investigative powers, the lack of support staff and the delay of over a year between the death of Stephen Wardle and the completion of the inquest. He expressed the view that this was unsatisfactory both for the families of victims of deaths in custody who suffered from the uncertainty surrounding the circumstances of such deaths, and for police officers involved who did not know whether they would be criticised for their part in those circumstances.

The Coroner also commented on this matter in his statements before the Royal Commission into Aboriginal Deaths in Custody, as reflected, for example, in the chapter on the adequacy of previous post-death investigations (National Report, Vol 1, chapter 4). In its Regional Report on Western Australia, the Commission quoted from the inquest report into the deaths of Stephen Wardle and three others:

... while some individual police officers perceive their duty to be to investigate the death on behalf of the Coroner, and this approach is re-inforced by Routine Orders issued by the Commissioner of Police, it is clear that the police force generally see this to be a police investigation out of which comes a report to the Coroner, and not an investigation by the Coroner in which the individual police officer acts as an agent for the Coroner.

It has been usual for the police reports to the Coroner to be received some two months to six months, or even more, after the death. By the time an Inquest is commenced, the Coroner is able to do little more than to call witnesses identified by the enquiring police officer. The Coroner, after so great a lapse of time, is usually unable to exert any influence on the actual investigation of the death [...] and to that extent it might be said that the Coroner's Inquest is not in reality an independent inquiry by an impartial judicial officer. (Regional Report, vol. 2, s. 6.1)

1.8.1Inadequacy of Police investigations into deaths in Police custody

According to the Royal Commission report on Western Australia, in almost two thirds of "cases investigated in this State the coronial/sudden death investigation conducted by the police was found by Royal Commission investigations to have been inadequate, in some instances seriously so" (*Regional Report of Inquiry into Individual Deaths in Custody in Western Australia*, Vol 2, 6.1.2.[5]). The report summarizes some of the main areas for criticism as follows:

-Lack of independence of investigation by police of deaths in police custody.
-Lack of scrutiny of police/prison officer version of the circumstances of death.
-Lack of experience of investigating officers.
-Narrow focus of police investigation.

5This report will subsequently be referred to as the Royal Commission Regional Report.

The Royal Commission report also quotes from the inquest report into the deaths of Stephen Wardle and others on significant delays in the completion of investigations:

If there is a criticism to be made generally [regarding police coronial investigations], then it is that there will be a delay between the date of death and the date upon which the inquiry file is received by the Coroner.

This delay is usually occasioned ... by the fact that the inquiry is a police inquiry by a police officer, who reports to senior police officers and not directly to the Coroner. Reports are often delayed because police officers senior to the enquiry police officer intercept the report and return it for further inquiries. This action is no doubt well meant but those senior officers are presuming that their views, including the question of relevance, are the views of the Coroner. (Royal Commission Regional Report, Vol 2, 6.1.2, section 2).

1.8.2Reform of the Western Australian *Coroner's Act 1920-1979*

The Western Australian *Coroner's Act 1920-1979* under which the inquiry into the death of Stephen Wardle was conducted, has since been the subject of legislative review and is about to be replaced. At the time of Stephen Wardle's death, the Perth City Coroner who conducted the inquest was a member of a committee assessing coronial law reform which was expected to report its recommendations in July 1989. As of October 1996, Western Australia retained its *Coroner's Act 1920-1979* while a new *Coroner's Act 1996* has been enacted but not yet put into effect. Amnesty International believes that the new Act, while not going as far as some recommendations stated in the Royal Commission report, nevertheless contains some legislative improvements relevant to the criticism made in relation to the death of Stephen Wardle.

The old Act of 1920 has been criticised for a variety of reasons in the Royal Commission into Aboriginal Deaths in Custody report (cf. Royal Commission Regional Report, Vol. 2, Part Six). One of the key critical issues relevant to previous inquiries into the death of Stephen Wardle is, in Amnesty International's opinion, the issue of insufficient independence. To date, irrespective of Western Australia's coronial legislation, police officers have always been placed in the role of investigating other police officers in a death in police custody.[6]

In this context the Royal Commission report states that "[a] Coronial Investigation cannot, in all truth, be called such unless the office of Coroner has the power to conduct and direct its own investigation into deaths" (Regional Report, Vol.2, s. 6.1.4). The report notes that the "inadequacies of past police investigations of deaths in custody [...] and the possible perception of a lack of impartiality on the part of police investigators when investigating the conduct of fellow officers, provides support" for the Perth City Coroner's recommendation that a body of civilian investigators be established under the direction and control of the Coroner (s. 6.1.4).

The new *Coroners Act 1996,* however, makes "[e]very member of the Police Force of the State

6Cf. s. 4.2.18, Royal Commission into Aboriginal Deaths in Custody, National Report, Vol. 1.

[...] contemporaneously a Coroner's investigator" (s. 14, 2). Under the new Act, Police officers assisting a Coroner are not required to carry out a direction of a Coroner "if that direction is inconsistent with a direction of the Commissioner of Police" (s. 14, 4).

While the Act also permits the Attorney General, on the recommendation of the State Coroner, to appoint civilian persons to be "Coroner's investigators" (s. 14, 1), current practice as well as Police concerns about their "autonomy" in the investigation of deaths make it unlikely that a body of trained civilian investigators will in the near future take over functions of Police officers in such inquiries (Royal Commission Regional Report, Vol. 2, s. 6.1.4).

Another issue Amnesty International considers relevant in the case of Stephen Wardle relates to the Coroner's lack of sufficient powers to summon and compel witnesses to give evidence in an inquest. As stated above, all 17 Police officers on duty during the night of Stephen Wardle's death refused to give oral evidence in the coronial inquest (cf. 1.4). A written statement of 23 February 1988 made by the Police Sergeant who arrested Stephen Wardle begins with the following sentence:

In accordance with the Police Regulations, I submit the following statement, but it is provided not of my own free will, but pursuant to an obligation placed upon me, and the statement is tendered, and questions I answer, on the basis that it and they will not be used in evidence in any action brought against me.

Under the new *Coroners Act 1996*, the Coroner may summon a person to appear as a witness at an inquest, and may order a witness to answer questions. Non-compliance with such a summons or order carries a penalty of A$ 2,000 (s. 46). A separate provision requires any "member of the Police Force who has information relevant to an investigation [to] report it to the Coroner investigating the death" (s. 18, 2). This provision carries a potential penalty of A$ 1,000.

Another section of the new Act allows an "interested person" to "appear, or be represented by a barrister or solicitor, at an inquest and examine or cross-examine witnesses" (s. 44, 1). However, section 47 gives some protection against the use of a witness' statement in possible criminal proceedings against that same witness if

-the witness initially declined to answer a question at an inquest on the ground that the answer will criminate or tend to criminate him or her, and if,
-after being compelled by the Coroner to answer the question,
-the witness complies with the order to the Coroner's satisfaction.

If it appears necessary for the ends of justice, a Coroner may offer a certificate to a such a witness. With such a certificate issued, any statement made by the witness in such a situation is not admissible in evidence in criminal proceedings against the witness "other than on a prosecution for perjury committed in the proceedings" (s. 47, 3). Once such a certificate has been offered, the witness is "no longer entitled to refuse to answer questions on the ground that his or her answers will criminate or tend to criminate him or her" (s. 47, 2).

These provisions reflect some of the key concerns expressed by Stephen Wardle's family over

the inability of the coronial inquest into their son's death to explain unresolved circumstances. They do not, however, provide for anyone found in an inquest to have contributed to a death in custody and who received a certificate under section 47, to be prosecuted for his or her contribution to the death on the basis of statements made in compliance with a Coroner's order under section 47.

1.9Medical evidence disappeared after autopsy

Under both the old and the new Coroner's Act, tissue samples from autopsy may be ordered by the Coroner to be preserved for possible further forensic tests. In the case of Stephen Wardle, several samples had been placed under preservation at the Western Australian State Mortuary Forensic Department, including blood samples, brain and liver tissue which would have been crucial in determining, for example, the time of ingestion of the fatal dose of the drugs. This factor could be relevant in the context of allegations that Stephen Wardle may have been dead hours before police claim to have found his body.

However, by April 1992 the blood and liver specimens were reportedly found to have disappeared without trace when the family requested them from the hospital for laboratory tests to be conducted by Professor Dr Bryan S. Finkle, then Associate Director and Research Professor of Pharmacology, Toxicology and Pathology of the Centre for Human Toxicology at the University of Utah in the United States.

Professor Finkle's interpretation of forensic tests in June 1992, conducted on the remaining brain tissue specimens, "points to a rapid death, perhaps 30 minutes to 2 hours," after administration of the fatal dose of propoxyphene. While this was "not established scientific fact", he concludes that "it is NOT reasonable that [Stephen Wardle] would be coherent 2 hours after the dose of PX [propoxyphene; emphasis in original]." The fact that Stephen Wardle was in police custody for more than seven or eight hours before police recorded the discovery of the body therefore leads to further questions about the time of death and the police's claim that he was still alive during early morning cell checks up to 4.30am. When the pathologist who conducted the post-mortem examination in the case was requested to comment upon the possible time of death at the inquest, he did not even offer a rough estimate.

1.9.1Conflicting evidence about forensic experts' opinions

Professor Finkle's conclusions were subsequently suggested to be questionable in a letter to Stephen Wardle's family by the Western Australian Director of Public Prosecutions (DPP). The DPP had initiated further investigations into the case after allegations had been made in the Western Australian Parliament on 29 December 1992 of a cover up of murder or manslaughter of Stephen Wardle.

The Commissioner of Police was requested by the DPP to undertake the investigation on his behalf, pursuant to Section 22 (2) (b) of the *Director of Prosecutions Act* 1991. According to the DPP's letter, tests were carried out on behalf of the Western Australian Police Service by the

Forensic Science Laboratory Chemistry Centre of Western Australia and interpreted by the Chief Forensic Pathologist for Western Australia, Dr Clive Cooke. Excerpts from the interpretation of these tests, quoted in the letter, suggest that they were aimed at showing that storage of brain tissue in formalin fixative may alter the forensic data in tests carried out before and after such storage, making interpretation of such data inconclusive.

Again according to the DPP's letter, Professor Finkle was informed about these findings "by telephone in April 1994" and "in the course of the conversation [...] indicated that he may reappraise his opinion if he were supplied with the data." The letter states that all relevant material was sent to Professor Finkle in May 1994. However, Professor Finkle informed Amnesty International in September 1996 that he never received the material. He understood from a telephone conversation with the Forensic Science Laboratory in Perth that a retired police officer would visit him in the United States to discuss the matter. On 24 August 1994 he sent a faxed response to inquiries made by the family and stated

I have not spoken with any police or law enforcement official [in Western Australia], or the retired officer appointed as special investigator.
I spoke several weeks ago to Dr. Ian Campbell at the Perth Forensic Toxicology laboratory but the discussion did not in any way refute my previously stated opinions.
I still hold the same opinions concerning the death of Steven [sic] Wardle and you have them in the form of a written report.

1.9.2New forensic opinion raises questions about time of death

Further forensic opinion offered in July 1995 and September 1996 by Professor Olaf Drummer, Assistant Director of the Victorian Institute of Forensic Pathology, and Honorary Associate Professor in Forensic Medicine at Monash University, Melbourne, takes into account that the interpretation of the brain tissue data for propoxyphene is difficult, as suggested by Dr Cooke.

Professor Drummer's opinion also takes into account that Stephen Wardle at about 10.40pm on 1 February 1988 was still awake and "conversing" while in, or near, the police station charge room. Professor Drummer's interpretation of the toxicological data on the case indicates that "[t]he absence of effects consistent with an overdose of propoxyphene in combination with alcohol at this time (10:40 pm) either suggests that ingestion occurred long after 8:30 pm or that the observed behaviour of Stephen Wardle at 10:40 pm [in the police station] was not accurate."

On the basis of information made available to him in 1995, Professor Drummer said that, if Stephen Wardle had taken the drug about an hour before police say they first observed him at approximately 9.30pm, he "would expect a significant, if not maximal effect from an overdose of propoxyphene to have been elicited by 10:40 pm, particularly in that the alcohol concentration was still very high at this time." Such effects have been described by the Coroner, summarizing medical evidence, as "to depress breathing, [...] there is a loss of consciousness, so that the person will appear to be asleep but will be unrousable."

Considering police records which claim that Stephen Wardle was not arrested before 9.30pm

and thus might have taken the overdose shortly before that time, Professor Drummer, in a letter to Amnesty International of September 1996, would "still expect [him] to exhibit significant signs of the effects of alcohol and propoxyphene one hour (i.e. 10.30 pm) after consumption of Doloxene tablets (assuming he took tablets shortly before his arrest)."

This interpretation further points to questions about the time Stephen Wardle took the fatal dose of the drugs and about police observations that he was still breathing during early morning cell checks. The police Cell Check Book for the morning of 2 February 1988 records these checks to have been carried out at 12.30am, 1am, 1.51am, 2am, 2.30am, 3.30am, and 4.30am. The officer responsible for taking prisoners' fingerprints recorded at 2.05am and again at 4am that Stephen Wardle "[c]ouldn't be woken".

In the light of these interpretations it appears that Stephen Wardle may have been dead before police claim to have last observed him alive in his cell - even if their records of the time of arrest and reception at the cell block were correct. Alternatively, he may have ingested the fatal dose of drugs while inside the Police station.

2.Ombudsman inquiry

In 1989-1990 the Western Australian Parliamentary Commissioner for Administrative Investigations (Ombudsman) conducted "an extensive inquiry" into the death of Stephen Wardle. Under state legislation governing the Ombudsman's office such an inquiry is considered to be a "last resort."

2.1Conflicting statements on the powers of an Ombudsman inquiry

According to the Minister for Police, "[f]or the purposes of his investigation the Ombudsman had *the powers of a Royal Commissioner*" (letter to an Amnesty International member dated 18 May 1993; emphasis added). This assertion appears to be at odds with a letter sent on 13 December 1989 by the Ombudsman to the family of Stephen Wardle. The Ombudsman's letter points out some of the legislative restrictions and procedures governing a his investigation. One of the limitations of such an inquiry listed by the Ombudsman is that "*[u]nlike the position with a Royal Commission*, no person is required to give any evidence or produce any documentation to me that he could not be compelled to give or produce in proceedings before a court" (emphasis added).

2.2Family not allowed to examine new Police evidence

Notwithstanding this key difference between the powers of a Royal Commission inquiry and an Ombudsman investigation, all police officers who had refused to give evidence at the inquest into Stephen Wardle's death gave sworn oral evidence in private to the Ombudsman. However, the parents and a brother of Stephen Wardle who were also interviewed during this inquiry were not permitted to examine, witness or question any of the statements made by the police officers. According to Stephen Wardle's mother, the Ombudsman also declined a request to advise the

family about specific questions they would have liked to put to the police officers.

Among other witnesses interviewed by the Ombudsman were a number of police officers involved with the internal police investigation of the case and the State's Chief Forensic Pathologist. However, witnesses whom the family had requested to be called upon to give evidence at the inquest and who were not included in the coronial inquest witness list, were apparently also not asked to give evidence in the Ombudsman inquiry. In his report on the case of which only excerpts were made available to Stephen Wardle's parents, the Ombudsman states

Bearing in mind it was not my function to conduct a further inquest, I did not consider it necessary or appropriate to interview all witnesses who gave evidence at the Inquest and who were the subject of cross-examination by the Complainant's counsel.

2.3Ombudsman finds Stephen Wardle's death was *unnecessary*

After completion of the inquiry, the Ombudsman invited Stephen Wardle's family to his office to advise them about his findings and to tell them that he did not recommend any action to be taken against any of the police officers on duty at the East Perth Police lock-up on 1-2 February 1988. In his view, allegations made by the family about the unanswered questions relating to their son's death were "without substance" and "resulted from an exacerbation and transference of the Complainant's natural grief beyond the actual cause of death."

However, "[n]otwithstanding this, [the Ombudsman held] the view that the death of Stephen Wardle was an unnecessary death in custody. It might well have been avoided if there had been in place in the Lock-up a full-time nurse, a better system of inspections of detainees and increased awareness of the part of the officers."

According to a letter sent by the Western Australian Minister for Police to an Amnesty International member in May 1993, "a nursing post has been established in the East Perth Lock-up [which] operates from 8pm until 4am on Thursday, Friday and Saturday nights." To Amnesty International's knowledge, this nursing post did not continue in operation for more than a few weeks after its establishment.[7]

3Alleged police harassment and intimidation of victim's family

Amnesty International believes there are further grounds for concern in this case due to the fact that Stephen Wardle's family have been the target of many police investigations since publication of the inquest findings in regional and national media reports during 1989. For example, numerous petty charges have since been laid against Ray Tilbury, Stephen Wardle's stepfather; until July 1996 almost all have resulted in acquittal. A few resulted in small fines.

7In this context, cf. the detailed recommendations on medical examinations for detainees and prisoners in chapter 5 of *Prescription for Change: Health professionals and the exposure of human rights violations,* Amnesty International, May 1996, AI Index ACT75/01/96.

Ray Tilbury was convicted on 12 July 1996 on charges of perjury and attempts to pervert the course of justice. He was sentenced to three years' imprisonment and is currently at Wooroloo Prison, Western Australia. Following the trial he was initially taken to the East Perth Police lock-up where, despite his pleading not to do so, police made him spend one night in the cell in which his stepson allegedly died.

3.1Search raids on the family home

Between August 1994 and September 1995, armed plainclothes police have carried out four early morning raids on the isolated family property outside Perth, which Stephen Wardle's family considered to be acts of harassment and intimidation. According to the search warrants for the first three raids, police were looking for various documents, including a shopping receipt, photographs, address books, as well as some bottles of vitamin tablets related to a shoplifting charge against Ray Tilbury. Another raid was executed on the business premises of Mr Tilbury's lawyer; the search warrant for this raid, issued on 9 August 1994, also related to an alleged shoplifting offence by Mr Tilbury of three bottles of vitamin tablets.

3.2Video recording of police raid screened on television

The last raid on the Tilbury family home, begun in the family's absence and filmed by their concealed video camera, was carried out on 7 September 1995. Five armed police drove approximately 30 kilometres in two unmarked cars to execute a search warrant regarding the alleged unlawful possession of a lawn mower they had already investigated in a previous raid. Several weeks later portions of the family's video recording were broadcast on television; a day after the broadcast, police charged Ray Tilbury with unlawful possession of the lawn mower.

3.3Family with similar surname protests police harassment

Following the television screening of the raid, a family with a similar surname (Tilbrook) complained about police harassment and intimidation and said they had repeatedly been called "Mr and Mrs Tilbury" by police. They also alleged that police officers had referred to Mr Tilbrook as "Ray." Following formal complaints and a subsequent internal police investigation, various charges laid against members of this family were dropped.

These developments increased the Tilbury family's suspicion that police may have visited their property in the family's absence without a search warrant on previous, unacknowledged occasions. In October 1995 Ray Tilbury went to court in an effort to obtain a restraining order against the Western Australian Police Service which would have prevented officers from entering or damaging the family home without lawful, valid reasons. The court found that restraining orders can only be issued against named individuals, not against the entire police service. The judge suggested the family attempt such a restraining order against one or a few individual officers; however, the family felt they could not afford the expected fees.

Amnesty International is concerned that the real reason for the large number and the scale of

police investigations concerned with Ray Tilbury may not always have been the legitimate pursuit of criminal offences, but rather a response to the family's unceasing and often well-publicized efforts to have a judicial inquiry into the death in custody of their son.

4Parliamentary Committee calls for judicial inquiry

In June 1996 the Western Australian Legislative Council Select Committee responsible for investigations into alleged corruption in the Western Australian Police Service tabled its *Interim Report* in Parliament. One chapter of the Committee's report deals with the death in custody of Stephen Wardle and subsequent alleged police harassment and intimidation of his family. It summarizes the evidence put before the Committee and finds that it is "a matter which can be resolved only by independent judicial inquiry."[8]

Conclusion

Amnesty International believes that the death in custody of Stephen Wardle may have resulted from lack of care to such a degree that it constituted cruel, inhuman and degrading treatment. The organization is concerned that this treatment may be found in violation of Australia's obligations under Article 7 of the International Covenant on Civil and Political Rights which states that "[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment".

Amnesty International believes that many of the grounds for suspicion in the case have never been satisfactorily and independently investigated. The organization is further concerned that Stephen Wardle may have been ill-treated in custody and that previous investigations failed to explain many of the injuries found upon his body. In Amnesty International's view there are serious doubts about official explanations of the precise time and circumstances of his death - despite previous inquiries into the case.

The organization further notes that police officers played a central role in all official inquiries conducted into Stephen Wardle's death. Under existing legislation, police officers have been able to influence the scope and direction of internal police and coronial investigations, as well as the list of witnesses and the presentation, and omission, of evidence at the Coroner's court.

Amnesty International notes a significant lack of independence and investigative powers of the Coroner's inquest and the fact that a new *Coroner's Act* has since been enacted, but not yet put into operation, which takes into account some, but not all, of the criticism made in relation to the inquest into Stephen Wardle's death and the relevant findings of the Royal Commission into

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8In a news release on 24 June 1996, Amnesty International welcomed the committee's recommendation and urged the Western Australian State Government to grant a fully independent judicial inquiry into the case; cf. "Amnesty International Supports Death in Custody Inquiry Call", Amnesty International, 24 June 1996, AI Index: ASA 12/09/96

Aboriginal Deaths in Custody.

The human rights organization further notes that police, coronial and Ombudsman inquiries failed to explain many unresolved circumstances raised by the observations made in this report. Some of these circumstances relate to the contradictions and inconsistencies in the evidence and in the statements made by police and other witnesses about the time of death.

Some of the questions resulting from the observations in this report are:

-How can the eye-witness report on Stephen Wardle's presence in the police station prior to the recorded time of arrest be explained?

-Why has this eye-witness not been allowed to give evidence at the inquest?

-How can the injuries observed on Stephen Wardle's body be explained in the light of police records stating "no visible injuries" at the time he was placed into his cell?

-Why were at least seven police officers present at the autopsy while the family doctor was effectively prevented from attending?

-Why did police fail to respond to concerns expressed over his health while he was in their care?

-Why did police fail to record any of the drugs they said they found upon him and why did they record different medication in his property list?

-Why have some of the drugs mentioned in police statements and records on the case not been tendered in evidence at the inquest given that the immediate cause of death was a drug overdose?

-Why did police alter some copies of Stephen Wardle's prisoner property sheet and the lockup Occurrence book?

-Was Stephen Wardle or his body moved between cells in the lock-up, and if so, why?

-Why have photographic evidence of injuries and body samples from the autopsy disappeared?

-Why was the issue of the missing photographs never followed up when it was discovered at the inquest?

-Has the family of Stephen Wardle been misled by the authorities about a possible reappraisal of Professor Finkle's interpretation of forensic data he never received?

-How can the scale and number of police operations related to Stephen Wardle's family be explained?

Recommendations

While the first of these recommendations deals specifically with the death of Stephen Wardle, all others are relevant for deaths in custody generally and should be taken into account by all Australian State and Territory Governments when dealing with deaths in custody or deaths occurring as a result of police operations.[9]

1)Amnesty International concludes, in support of the recommendation made in June 1996 by the Legislative Council Select Committee into the Western Australian Police Service, that a fully independent, judicial inquiry should be initiated to investigate the death in custody of Stephen Wardle, as well as the alleged police harassment of his family. The inquiry should make all efforts to find satisfactory answers for the questions raised in this report.

2)Such an inquiry should take into account the findings of the Royal Commission into Aboriginal Deaths in Custody on "the adequacy of previous investigations"[10].

3)The inquiry should be guided by the principles annexed to the United Nations Manual on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (Annex I)[11]. These principles are part of the United Nations Economic and Social Council's Resolution 1989/65 adopted on 24 May 1989 after years of consultations with experts from various countries and were welcomed by the General Assembly on 15 December 1989 in Resolution 44/159.

In the context of these consultations on international standards the United Nations Special Rapporteur on Summary or Arbitrary Executions in 1986 recommended that

A death in any type of custody should be regarded as prima facie a summary or arbitrary execution, and appropriate investigation should immediately be made to confirm or rebut the presumption.[12]

Amnesty International believes that the principles contained in the United Nations Manual provide a useful and appropriate basis upon which to conduct death in custody inquiries.[13]

9For a definition of what constitutes a death in custody or a death in police operations cf. David McDonald, C. Howlett, V. Dalton, *Australian Deaths in Custody 1992*, Deaths in Custody Australia No. 4, Canberra, Australian Institute of Criminology, August 1993, p. 1-3.

10Royal Commission into Aboriginal Deaths in Custody, National Report, Vol 1, chapter 4. The relevant recommendations (no 6-40) relate to coronial and police investigations and, apart from recommendations 19, 20, 21, and 39, apply to both Aboriginal and non-Aboriginal deaths.

11Subsequently referred to as United Nations Manual.

12Report of the Special Rapporteur on Summary or Arbitrary Executions to the Commission of Human Rights, E/CN.4/1986/21, quoted from United Nations Manual, p.7.

13Apart from the principles mentioned, the manual also contains a detailed Model Protocol for a Legal Investigation of Extra-legal, Arbitrary and Summary Executions as well as a Model

The organization notes that clause 11 of these principles calls upon Governments to pursue investigations through an independent commission of inquiry in such cases where the established investigative procedures have been inadequate, and where there have been complaints from the family of the victim about these inadequacies or other substantial reasons.

Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any institution, agency or person that may be the subject of the inquiry.(Clause 11 of UN principles)

4)In line with clause 10 of the UN principles, an inquiry into this death, and in all deaths in custody, should have at its disposal all the necessary budgetary and technical resources for effective investigation.

5)The inquiry should also have the authority to oblige any witness to appear and testify (clause 10 of UN principles). Where relevant witnesses are in custody, all interested parties, including the family of the victim or their legal representative, should have a reasonable opportunity to interview those witnesses as they would were they not in custody.[14]

6)According to clause 16 of the UN principles, the family of a death in custody victim should "be informed of, and have access to, any hearing as well as to all information relevant to the investigation", and should be entitled to present other evidence. In order for these rights to become effective in the inquiry, and in order for them to become satisfied that all efforts are made to answer unresolved questions in the case, Stephen Wardle's family should be allowed to have adequate legal representation, examine evidence, raise relevant questions and suggest witnesses to be interviewed. If necessary for these entitlements to be effective, sufficient funding for adequate legal representation during the inquiry should be made available to them. Amnesty International notes that free legal counsel was made available to all families of Aboriginal victims of deaths in custody investigated by the Royal Commission into Aboriginal Deaths in Custody.

7)In line with clause 17 of the UN principles, a written report should be published within a reasonable period of time on the methods and findings of the inquiry. The report should be made public immediately and should include the scope of the inquiry, procedures and methods used to evaluate evidence, as well as conclusions and recommendations based on findings of fact and on applicable law. In describing the specific events that were found to have occurred, and the evidence upon which the findings were based, the report should aim to satisfactorily answer all of the questions listed above, and to give reasons where this may not be possible.

8)The inquiry should also have the power to ensure that anyone found responsible for any circumstances which are found to have contributed to a death in custody is brought to justice, as recommended by clause 18 of the UN principles.

Autopsy Protocol.

14Cf. section 4.6.39, Royal Commission into Aboriginal Deaths in Custody National Report, Vol 1.

9)All Australian State and Territory Governments should ensure that, in future, investigations into deaths in custody or in police operations comply with the UN Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions. In terms of the specific Australian conditions, such investigations should also take into account the findings, and comply with the recommendations, made on "the adequacy of previous investigations" by the Royal Commission into Aboriginal Deaths in Custody, most of which apply for both Aboriginal and non-Aboriginal prisoners. The Federal Government should encourage and facilitate, where possible, any measures to be taken by State or Territory Governments to achieve these standards.

10)The Australian State and Territory Governments should further ensure that relatives and friends of victims of deaths in custody are protected from any form of police harassment or intimidation, in line with clause 15 of the UN principles. Complaints of such harassment or intimidation should be taken seriously by the relevant authorities, and a protocol of accountability for the way such complaints are dealt with should be strictly enforced.