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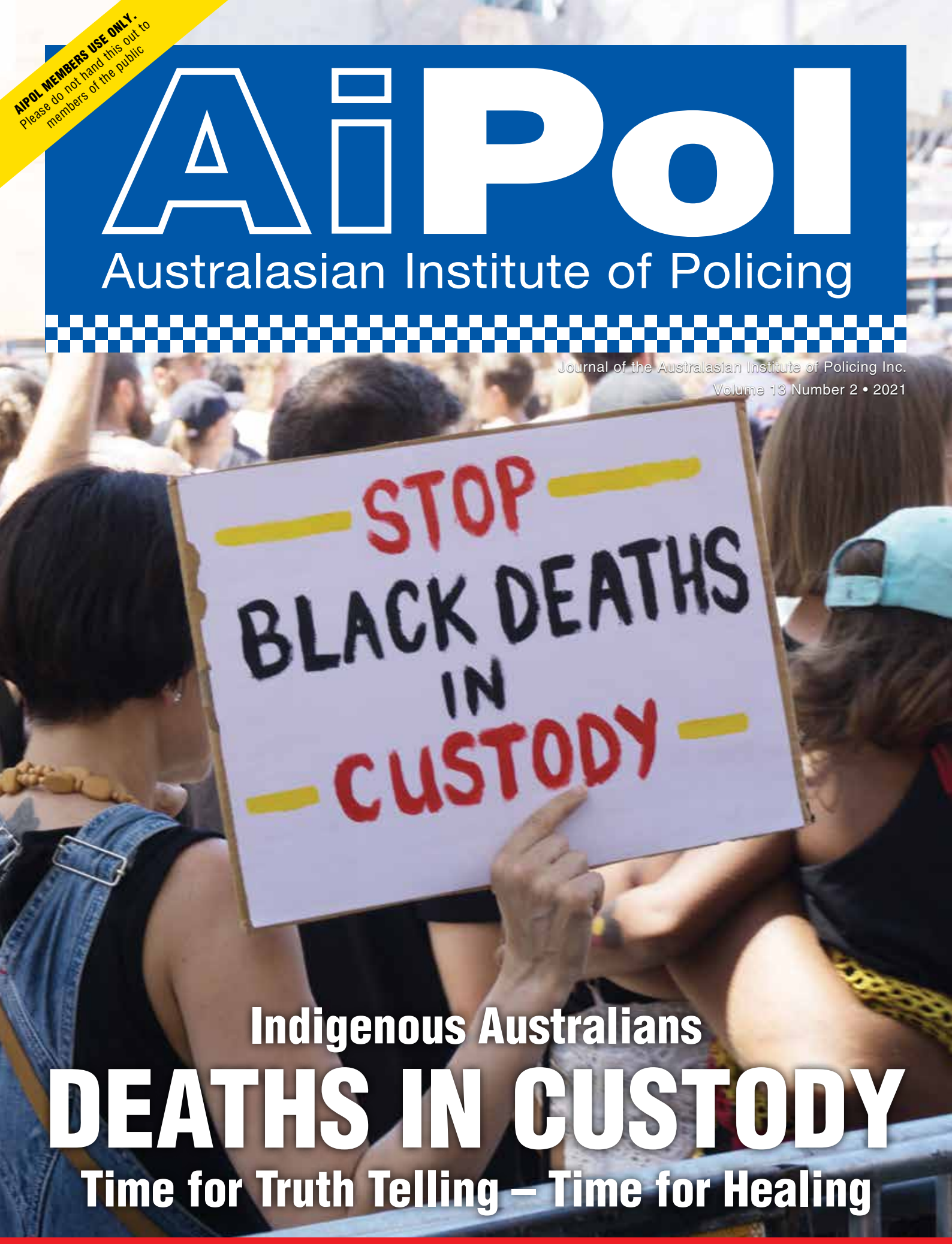

Indigenous Australians DEATHS IN CUSTODY

Time for Truth Telling – Time for Healing

Aboriginal and Torres Strait Islander readers are advised that this journal edition contains names and/or images of deceased people

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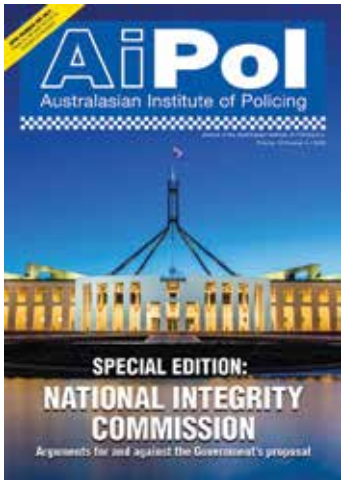

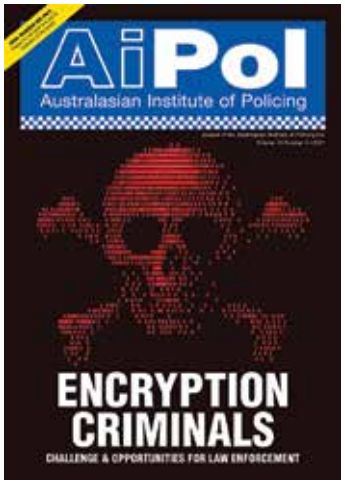

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Contributions

Articles on issues of professional interest are sought from Australasian police officers and police academics. Articles are to be electronically provided to the Editor, aipoljournal@aipol.org. Articles are to conform to normal academic conventions. Where an article has previously been prepared during the course of employment, whether with a police service or otherwise, the contributor will be responsible for obtaining permission from that employer to submit the article for publication to Australasian Policing.
Contributors are expected to adhere to the Journal's publishing guidelines. These guidelines are available in this Journal. All papers are peer-reviewed.

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Editorial

DR AMANDA DAVIES

Editor, Assistant Professor Policing and Security at the Rabdan Academy, Abu Dhabi

Importantly, there is collective recognition that to achieve positive outcomes requires a partnership between all parties – Indigenous stakeholders, Federal, State and Territory governments and respective agencies and community support groups.

Welcome to the 1st edition of a two part series focusing on Deaths in Custody. The Black Lives Matter Campaign (BLM) in the USA over the past 18 months, which has received sustained and centred global media attention, has similarly given a boost to an active campaign in Australia.

As discussed in the Aipol President's report, this heightened attention has advantages and disadvantages. The advantage, is it draws attention to the issue of Deaths in Custody, specifically of Indigenous persons and the current state of strategies to address this national tragedy. Unfortunately, negatively, key USA BLM campaign elements are being reflected in some Australian responses, targeting police with divisive harmful statements and actions.

The data indicates (see: Australian Institute of Criminology and BMC Public Health in this issue) there continues to be unacceptable incidents of Indigenous Australian Deaths in Custody. The articles in this edition highlight key areas for reform beyond the internal and external investigations of deaths in custody to include the Indigenous Australians families' experience with the judicial system, particularly in terms of notification, information and the provision of support following such tragedies. The BMC Public Health article highlights an important area of consideration, i.e. addressing the conditions which lead to suicide deaths in custody of Indigenous Australians.

Importantly, there is collective recognition that to achieve positive outcomes requires a partnership between all parties – Indigenous stakeholders, Federal, State and Territory governments and respective agencies and community support groups. This is recognised in the National Agreement which came into effect in 2020 underpinned by significant contribution and guidance from key Indigenous organisations and members. A comprehensive summary is provided in the President's Forward.

There is valuable research being undertaken to contribute to the development and implementation of strategies to progress positive impact on not only Deaths in Custody but also the associated factors reaching into the community, judicial, education and health systems.

This edition offers a selection of reports and articles which collectively articulates the current status of Deaths in Custody and associated influencing factors. This information provides valuable background from which to consider the goals of the National Agreement and monitor the impact of its application. Evaluation of the level of achievement of work progressed under the National Agreement will be evidenced in the reality of reducing the tragedy of Deaths in Custody and the trauma and heartbreak it brings to families and communities.

Australians all have a part to play in supporting the efforts of governments, organisations, and communities through supporting positive speech and actions and the work of the myriad of agencies, including police who are at the forefront in implementing measures to reduce the loss of life through Deaths in Custody.

I commend the articles in this edition to you as a comprehensive brief on the current status of Deaths in Custody and the development of policy and procedures designed for positive impact on this national dilemma.

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President's Foreword

JON HUNT-SHARMAN

President, Committee of Management, Australasian Institute of Policing

The Australasian Institute of Policing (Aipol) strongly believes that any death in custody is a tragedy for all involved and we hope that we can provide constructive suggestions to improve both the real and perceived views surrounding deaths in custody of our Indigenous Australians.

Aipol acknowledges that behind the statistics provided in this edition, is the sadness, pain, frustration and trauma that the families, friends and loved ones suffer at the loss of an Indigenous Australian who has died in custody. This pain, suffering and frustration is amplified within their communities with each death in custody. Each is a life lost in the most tragic of circumstances.

On behalf of Aipol, I extend my sincere condolences to those families, friends and loved ones of those who have died in custody and to their communities who have also suffered pain and loss.

Also, on behalf of Aipol, I pay my respect to the traditional owners of the lands and waters on which Australians live and work and pay respect to their Elders, past, present and emerging.

Elders within the Indigenous communities have called for *Truth Telling* as a way to heal the wounds of the past and to enable genuine reconciliation.

In terms of deaths in custody, Aipol acknowledge that due to the over-representation of Indigenous Australians in custody, the rate of deaths, while lower than what it was in the early 90's, is still unacceptably high.

Indigenous Australians are still far more likely to be in prison than non-Indigenous prisoners. This needs to be urgently addressed by Australian governments in partnership with Indigenous Australians.

In this article I want to focus the *truth telling* in relation to deaths in custody of our Indigenous Australians. In a follow up edition I wish to address *truth telling* in relation to the over representation of Indigenous Australians in custody. In both articles, Aipol will strive to provide practical recommendations for decision-makers to consider.

Truth Telling and the USA Black Lives Matter Movement in Australia

Truth telling requires facts, not fiction, accuracy not exaggeration, being un-bias not bias and as importantly - require genuine listening to all views and ideas.

As President of Aipol I have watched with concern the misconstruing of certain key campaign elements of the *USA Black Lives Matter* movement, as applying to the Australian indigenous environment. This misunderstanding and the resulting misinformation, unintentionally and intentionally, is being promulgated by some interest groups and subsequently sensationally reported by certain elements of the media.

This misunderstanding and the resulting misinformation is leading to the false categorisation of Australian police men and women into the same negative category as the US law enforcement officers accused of excessive violence and unlawful killings of African Americans.

The misconstruing of certain key campaign elements of the *USA Black Lives Matter* movement in Australia, is dangerous and reckless and risks causing violent responses against Australian police who are professional and, like the vast majority of non indigenous Australians, are sympathetic towards the challenges that Indigenous Australians face.

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A frightening example of the danger caused by this misinformation is the recent reaction of year 5 and year 6 students at Lindfield Learning Village where, as a class project, they produced posters supporting the *Black Lives Matter* movement in Australia, including some placards reading *"Stop Killer Cops"* and *"Pigs out of the country"*. This incitement of hatred towards Police is a direct reflection of the reckless commentary taking place.

Deaths in custody of Indigenous Australians is an extremely important issue to address together as Australians and must not be hijacked for radical motives, exaggerated for media profits or politicalised by minority political parties.

At the time of writing in April 2021, families of at least 20 Australian Indigenous men and women who died in custody, are awaiting coronial hearings in New South Wales (NSW), Western Australia (WA), Queensland (QLD), South Australia (SA) and Victoria (VIC). In addition to impending coronial hearings, there are two murder trials against police officers for shootings in the Northern Territory (NT) and WA. There is also one referral of NSW Corrective Services officers for manslaughter charges relating to a death in custody.

Unlike the USA, there is clear evidence that Australian police and Australian corrective service officers are not immune from investigation and prosecution and that there are strong oversight structures in place within all jurisdictions. This is not to say improvements can not and should not be made, to reduce deaths in custody and provide greater transparency of process. Aipol hopes to make a positive contribution in this area.

A number of interest groups and subsequent media outlets have been focusing on the total deaths in custody that have occurred over a thirty (30) year period since the *Royal Commission into Aboriginal Deaths in Custody* without looking at the cause of death, its relativity to non Indigenous deaths in custody or indeed the general reduction in deaths in custody of Indigenous Australians. It is quite misleading to quote figures based on national data and not exclude deaths from natural causes or suicide. This is giving the false impression to the public that the deaths in custody have been solely caused by inappropriate or indeed illegal action by police or corrective service officers. This is blatantly untrue and reckless.

The *USA Black Lives Matter* movement has highlighted the media's tendency to frame Indigenous Australian deaths in a negative and anti police way. Misrepresentation of Indigenous deaths in custody by certain elements in the media has potential to incite acts of harm against not just police and prison officers, but non-Indigenous nurses, doctors, ambulance officers and front line social workers.

Misinformation about deaths in custody also has the potential to traumatise families and the communities of people who have died in custody. Bereaved families are dealing with the loss of a loved one. Their anxiety should not been increased by conspiracy theories being aired through certain elements of the media without supporting factual evidence to support such claims. The myths and misinformation not just causes harm to all those involved and affected but can lead to division within our nation.

Misinformed and insensitive reporting unfairly portrays the vast majority of police, corrective service officers, and the men and women in health, welfare and support services who are working hard to reduce Indigenous Australian deaths in custody and those who support families when there is such a tragedy.

Truth Telling

The 1991 Royal Commission into Aboriginal Deaths in Custody

The 1991 *Royal Commission into Aboriginal Deaths in Custody* (Commission) made a large number of important recommendations- 339 in total. The recommendations covered a broad range of matters including policing issues, custodial safety, education, employment, cultural maintenance, government policy, customary law, health, self-determination and reconciliation.

The Commission found that Indigenous Australians died in custody at the same rate as non-Indigenous, but they were far more likely to be in prison than non-Indigenous people.

Importantly, the Commission found, and I quote:

1.2.2 The conclusions reached in this report will not accord with the expectations of those who anticipated that findings of foul play would be inevitable and frequent. That is not the conclusion which Commissioners reached. As reported in the individual case reports which have been released, Commissioners did not find that the deaths were the product of deliberate violence or brutality by police or prison officers.'

Whilst progress has been made to implement the Commissions recommendations in many areas, including the implementation of a *Custody Notification Service* in nearly all jurisdictions and the *Annual Reporting of Deaths in Custody* by the Australian Institute of Criminology, there is still a lot of work to be done by all governments, working in partnership with Indigenous Australians. This is evidenced by various ongoing inquiries, reports and academic reviews identifying general frustration by Indigenous Australians that various government agencies are not working together effectively in relation to Indigenous deaths in custody.

The National Deaths in Custody Program

The National Deaths in Custody Program (NDICP) monitors the extent and nature of deaths occurring in prison, police custody and youth detention from 1980 onwards. The NDCIP was established at the Australian Institute of Criminology (AIC) in 1992 in response to a recommendation made by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).

The types of deaths that require notification to the NDICP (Recommendation 41 RCIADIC 1991) are:

- a death, wherever occurring, of a person who is in prison custody, police custody or youth detention;
- a death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care, while in such custody or detention;
- a death, wherever occurring, of a person who dies, or is fatally injured, in the process of police or prison officers attempting to detain that person; or
- a death, wherever occurring, of a person attempting to escape from prison, police custody or youth detention.

Data utilised for the NDICP is based on two main sources: data provided by state and territory police services and corrections departments, and coronial records accessed through the National Coronial Information System (NCIS).

Deaths in Custody 1979-80 to 2018-19

There were 3,003 deaths in custody between 1979-80 to 2018-19. Of these, 1,918 were deaths in prison custody, 1,063 were deaths in police custody, 18 were deaths in youth detention and 4 were in another custody arrangement. Based on data from the *Australian Institute of Criminology's Statistical Report on Deaths in Custody in Australia 2018-19* there has been 455 Indigenous deaths in custody in the 28 years since the *Royal Commission into Aboriginal Deaths in Custody* – the deaths comprise of 295 in prison custody, 156 in police custody and 4 in youth detention.

Deaths in Prison Custody by Indigenous Status 1981-82 to 2018-19 (rate per 100 prisoners)

Death rates of Indigenous prisoners have been consistently lower than the death rate of non Indigenous prisoners since 2003-04.

Natural causes and hanging are the leading causes of death among Indigenous prisoners; however natural causes of death have exceeded hanging deaths since the early 2000's as a result of improved preventative measures being in place.

Death in Prison Custody by Indigenous Status 2018-19 (rate per 100 prisoners)

In 2018-19 there were 89 deaths in prison custody - 16 Indigenous prisoners and 73 non Indigenous. The death rate of Indigenous prisoners was lower than the death rate for non-Indigenous prisoners nationally. (0.13 and 0.23 per 100 prisoners respectively).

In 2018-19 there were 16 Indigenous deaths in prison custody nationally, with this 'accounting for 18% of all deaths in custody over the period'. All 16 were male prisoners, and 2 were aged between 25-39 years, 8 were aged between 40-54 years and 6 were 55 years or older.

The cause of death was recorded for 13 of the 16 Indigenous deaths in prison custody in 2018-19. Natural causes was the most common cause of death for Indigenous prisoners (85%).

The manner of death was 11 natural causes, 2 were self inflicted, 1 unlawful homicide by a prisoner and 1 justifiable homicide by a prisoner.

According to the Australian Institute of Criminology, the most common cause of death for both Indigenous and non-Indigenous prisoners was natural causes.

The Australian Institute of Criminology stated that the 'rate of natural cause deaths was higher for non-Indigenous prisoners than Indigenous prisoners (0.13 vs 0.09 per 100)'.

The Australian Institute of Criminology stated that the rate of hanging deaths was lower for Indigenous prisoners than non-Indigenous prisoners (0.01 vs 0.04 per 100).

The Australian Institute of Criminology stated that between 2017-18 and 2018-19 the death rate of indigenous prisoners was lower than the death rate of non Indigenous prisoners nationally (0.13 and 0.23 per 100 respectively).

Deaths in Police Custody and Custody Related Operations by Indigenous status 1989-90 to 2018-19

There were 257 shooting deaths in police custody and custody related operations between 1989-90 and 2018-19.

58% were police shootings and 42% were self inflicted. One further case involved a person shot by another person. 94% of the deceased were non Indigenous.

Between 1991-92 and 2016-17 there were 8 Indigenous Australians shot by police. During the same period there were 114 non Indigenous persons shot by police.

Based on data from the *Australian Institute of Criminology's Statistical Report on Shooting Deaths in Police Custody in Australia between 2003-04 and 2016-17* there has been 2 indigenous Australians fatally shot by police. During the same period there were 58 non Indigenous persons fatally shot by police.

The Australian Institute of Criminology stated that the shooting deaths in police custody (including police and self inflicted shootings) was lower for Indigenous Australians than non-Indigenous Australians for the reporting period.

Motor Vehicle Pursuit Deaths by Indigenous status 1989-90 to 2018-19

Motor vehicle pursuits is the most common method of detainment preceding Indigenous deaths in custody (51% of detainment related deaths). There were no motor vehicle pursuit deaths in 2018-19.

Deaths in Police Custody and Custody Related Operations by Indigenous status 2018-19

Of the 24 deaths in police custody in 2018-19, 4 were of Indigenous persons and 19 were of non-Indigenous persons.

In 2018-19 the cause of death of the 4 Indigenous Australians being 2 accidental deaths attributed to other/multiple causes, and 1 gunshot wound which was self inflicted. The cause of death was not recorded for the fourth death.

The National Deaths in Custody Program has found that Indigenous Australians die in police custody at a lower rate than non-Indigenous people.

Custody Notification Services

Custody Notification Services (CNS) are a 24/7 phone-line that police must call when an Indigenous person is brought into custody. The service provides cultural safe health and welfare checks and offers basic legal advice to Indigenous Australians as they come into contact with the justice system. CNS is delivered by the Aboriginal Legal Services to reduce the risk of death occurring in police custody.

The implementation of a Custody Notification Services (CNS) in all Australian States and Territories was recommendation no. 224 of the 339 recommendations of the 1991 Australian Royal Commission into Aboriginal Deaths in Custody report, but by 2018, only the Australian Capital Territory and New South Wales had such a service mandated by legislation. The majority of state have now mandated legislation, since the offer of three years of funding by the federal government in October 2016.

On 14 April 2021, the Australian Government announced that it is investing $2.4 million over three years to establish a new Custody Notification Service (CNS) in South Australia from 1 July 2021 and is increasing funding to the Northern Territory and Victoria service.

The 2018 Joint Council on Closing the Gap

In December 2018 the Council of Australian Governments (COAG) agreed to establish the *Joint Council on Closing the Gap* (the Joint Council). This was the first time that Indigenous Australians have been included as joint decision makers. The Joint Council is co-chaired by the Minister for Indigenous Australians, the Hon Ken Wyatt AM,MP, and the Lead Convenor of the Coalition of Aboriginal and Torres Strait Islander Peak Organisations (Coalition of Peaks),

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Ms Pat Turner AM. It includes ministers from each State and Territory, twelve members of the Coalition of Peaks, and a representative of the Australian Local Government Association (ALGA).

The 2020 National Agreement on Closing the Gap

In July 2020, after extensive engagement in 2019 with Indigenous Australians across the nation, for the first time, a *National Agreement on Closing the Gap* was developed in genuine partnership between Australian governments and the Coalition of Peaks.

On 27 July 2020, the National Agreement came into effect upon the National Agreement being signed by the First Ministers of all Australian governments, the Lead Convenor of the Coalition of Peaks and the President of ALGA.

The objective of the National Agreement is to enable Indigenous Australians and governments to work together to overcome the inequality experienced by Indigenous Australians, to achieve life outcomes equal to all Australians. The expertise and experience of the Coalition of Peaks and its membership have been central to the commitments made in the National Agreement.

As part of the implementation of the National Agreement, the views and expertise of Indigenous Australians, including Elders, Traditional Owners and Native Title holders, communities and organisations, continue to provide central guidance to the Coalition of Peaks and the Australian governments.

The Coalition of Peaks, the Commonwealth, States, Territories and local governments share accountability for the implementation of the National Agreement and are jointly accountable for the outcomes and targets under the National Agreement. There is an ongoing audit by the Commonwealth Productivity Commission to ensure effectiveness and accountability.

The National Agreement has 17 measurable targets across the following outcome areas:

Education; Employment; Health & Wellbeing; Justice, Safety, Housing, Land & Waters; and Languages.

Upon the signing of the National Agreement Prime Minister Scott Morrison said:

"The gaps we are now seeking to close are the gaps that have now been defined by representatives of Aboriginal and Torres Strait Islander peoples. This is as it should be. This creates a shared commitment and a shared responsibility. By focusing our efforts on these more practical and shared objectives we can expect to make much greater progress."

Upon the signing of the National Agreement the Lead convenor of the Coalition of Peaks, Ms Pat Turner AM, said:

"For the first time, First Nations people will share decision-making with governments on Closing the Gap. The National Agreement makes this a reality, not just for the Coalition of Peaks, but for all First Nations people that want to have a say on how things should be working in their communities."

If we are *truth telling*, this National Agreement is a significant and long awaited achievement.

Outcome 10 of the National Agreement on Closing the Gap

Outcome 10 of the National Agreement, amongst a number of positive goals, includes exploring options to measure and report on:

access to services in police custody

Aboriginal community controlled legal services, including data on police use of custody notification systems;

cultural competency training completed by police.

access to services in prison (disaggregated by sentenced/ unsentenced prisoners)

availability of and participation in culturally safe health and mental health services, including health and disability assessment on entering prison;

support provided to prisoners who are parents to keep engaged with family;

cultural competency training completed by corrections staff;

availability of and participation rates for prison-based programs, including vocational training, behavioural and specialist programs such as addiction.

access to services in police custody

rehabilitation and reintegration support, and building cultural strength.

The 2022 Justice Policy Partnership

The National Agreement establishes a *Justice Policy Partnership*, between all governments and Indigenous stakeholders. This is underway as one of five policy partnerships to be established by 2022. It has been recently prioritised by the Joint Council of Closing the Gap.

The *Justice Policy Partnership* will bring together all governments and Indigenous stakeholders to work on solutions to achieve the targets in a coherent and coordinated way.

Through the *Justice Policy Partnership*, Aipol looks forward to providing positive input in the lives of Indigenous Australians who have contact with the justice system.

Conclusion

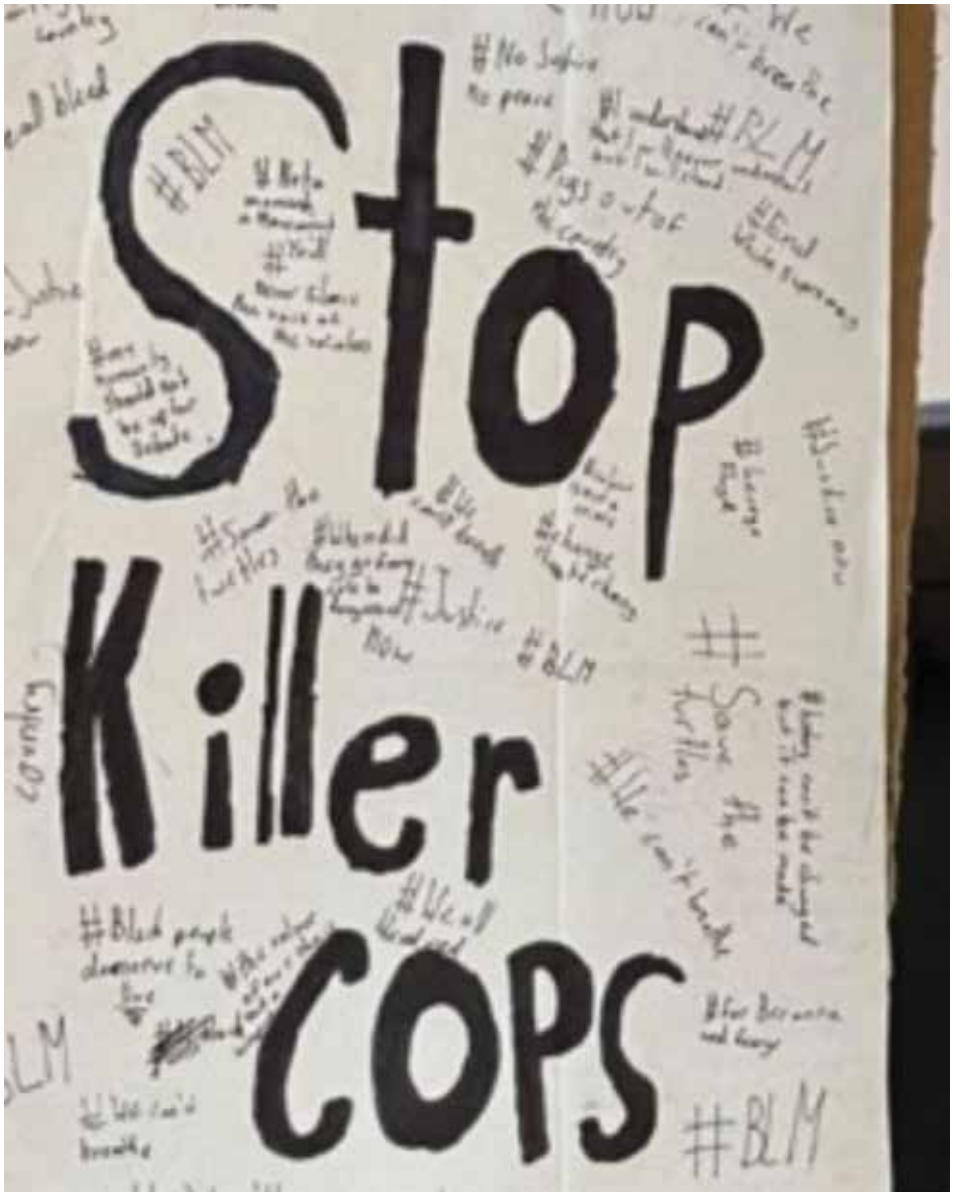
It can not possibly be argued that governments and relevant authorities, including police, corrective services and the judiciary have not made a considerable effort in successfully reducing the number of Indigenous deaths in custody. This should be recognised as a positive achievement since the Royal Commission.

What has not been successfully achieved is a reduction in the incarceration rate of Indigenous Australians. Aipol acknowledges the profound grief all families experience when losing a loved one whilst in custody, and that bureaucratic processes, insensitivity and lack of nationally consistent processes is compounding their trauma and loss. Clearly, access to counselling and support services is essential, as is the provision of timely and accurate information.

Aipol believes that it must be a priority of the *Justice Policy Partnership* under the *National Agreement on Closing the Gap* to establish a national approach to preventing deaths in custody and when such a tragedy occurs, a nationally consistent approach, particularly when it involves the death in custody of an Indigenous Australian. Compassion, consistency, and transparency will build trust and understanding.

Community trust can be built and frustration and anger can be minimised, through a nationally consistent approach for:

- preventing deaths in custody;
- oversight of death in custody investigations;
- notification of families and loved ones when there is a death in custody; and
- counselling and support services being immediately provided to families following a death in custody and then throughout the ongoing coronial process.



Posters displayed at Lindfield Learning Village school on Sydney's upper north shore.

Recommendations

Aipol believes that it would be beneficial for all Indigenous Australians if the *Justice Policy Partnership* considers recommending:

1. amendment to the legislation of the various Commonwealth, States and Territories police oversight bodies to expand the functions of those oversight bodies to oversight investigations in relation to all deaths in custody (police custody, prison custody and youth detention), with appropriate resourcing and support.
2. amendment to the legislation of the various Commonwealth, States and Territories police oversight bodies to include the ability to appoint a senior statutory Indigenous Australian to undertake engagement and oversight of investigations into an Indigenous death in custody.
3. that all States and Territories conduct an independent review into the provision and effectiveness of health screening services and treatment in correctional facilities, including consideration of alternative service models for Indigenous Australians with a focus on incorporating Indigenous community controlled health services.
4. that all States and Territories review mental health screening procedures for persons in custody, with particular attention given to the placement of prisoners with mental health conditions.
5. that all States and Territories:
   - engage with the National Disability Insurance Agency to establish timely, clear and comprehensive protocols for supporting people with a disability whilst they are in custody;
   - review current processes to ensure a more robust, holistic and comprehensive approach to support people with a disability to access the National Disability Insurance Scheme and other services whilst they are in custody.
6. that all States and Territories assess the current status of hanging points in all police stations and correctional facilities and develop a detailed plan and timetable for the removal of these points or the discontinued placement of vulnerable inmates in these cells, including Indigenous Australians.
7. that all States and Territories ensure police, corrections and youth detention agencies conduct a comprehensive review of internal processes following a death in custody, with a view to:
   - ensuring appropriate notification of death processes are in place
   - establishing a single point of contact for families
   - establishing clear communication protocols with families, including the provision of counselling and support services up to and including the coronial hearing
   - ensuring all staff within facilities receive training in culturally sensitive and trauma informed care, with training prioritised for staff in roles specific to the investigation or oversight of deaths in custody.
8. that all States and Territories allocate additional resources, including adequate funding and staffing, to ensure that their Coroners Courts can effectively prioritise the investigation of deaths in custody.
9. that all States and Territories amend their Coroners Acts so that the Coroner must also investigate and report on the quality of care, treatment and supervision a deceased received prior to their death in custody, with a view to preventing future custodial deaths..
10. that all States and Territories amend their Coroners Acts to ensure that the relevant government departments respond in writing within six months of receiving a Coroner's report, the action being taken to implement the recommendations, or if no action is taken the reasons why, with the response reportable under the National Deaths in Custody Program.

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Crime mapping technology and geospatial analytics are shining a spotlight on the dark side of humanity – and helping law enforcement leaders solve some of the world's most perplexing crimes.

As a renowned criminal investigator, Mike King has seen many extraordinary breakthroughs throughout his career.

For more than 40 years, the former police chief has worked with law enforcement agencies around the world and trained hundreds of investigators in the art of criminal profiling. He's been on the frontline in the hunt for serial predators and broken open some of the world's most perplexing cases, including the take down of one of the United States most notorious cults.

But ask this veteran investigator about the real turning point in his career, and he'll share it came while experimenting with geospatial technology in the investigation of a prolific serial killer whose final victim was murdered in his home state of Utah.

"I was researching the case of a notorious US predator known as the 'Truck Stop Killer', Robert Ben Rhoades," said King. "In the early 90's, Rhoades had been charged with three murders but only convicted of one – the murder of Regina Kay Walters – for which he is still in prison today.

"I suspected Rhoades was responsible for many more murders than he had initially been charged with, so I used geospatial technology to map and analyse his commercial trucking data – including every weigh station visit, fuel stop and recorded break logged – alongside information about missing persons and unsolved murder cases in the same areas at those same times.

"For the first time, we had a clear picture of the full extent of Rhoades' reign of terror and it supported the theory some FBI agents had that Rhoades may have killed as many as 300 victims."

Since making the chilling discovery, King has championed the use of crime mapping and geospatial analytics with law enforcement agencies around the world, working to establish Geographic Information System (GIS) technology as a foundational platform for contemporary investigations.

He cites groups including Singapore Police Force, New York City Police Department and UK National Fraud Intelligence Bureau as leaders in their application of geospatial technology – but indicated there is significant appetite from his Australian counterparts for expanding the use of GIS across the full spectrum of public safety operations.

"Understanding the element of 'location' is one of the most important pieces of the puzzle when it comes to law enforcement," said King. "Not only can it uncover answers to unsolved crimes, but it can also reveal insights that enable officials to put preventative measures in place to reduce the risk of similar crimes occurring again."

It's a concept King explores comprehensively in the breakout new Australian podcast, ***Mapping Evil*** – which he hosts alongside award-winning journalist Tory Shepherd. The series explores a number of unsolved Australian crimes, using King's trademark geographic analysis to shed new light on the cold cases.

"Being able to demonstrate in a very tangible way just how much insight this technology can provide to an investigation is very important, particularly as there's a growing need for geospatial capabilities, not just in law enforcement, but across the entire public safety domain.

"The challenges faced over the past few years have really brought home the importance of using maps and geospatial analytics to understand and get ahead of any public safety situation – whether it's monitoring the risk of COVID-19, tracking moving fire fronts or detecting criminal activity.

"The technology has also emerged as a valuable tool to support cross jurisdictional public safety efforts – as criminals and crises don't stop at geographic borders.

"Creating a common operating picture of all public safety threats – regardless of jurisdiction – is critical to ensuring quick and accurate decisions can be made to keep communities safe."

Season One of Mapping Evil with Mike King is available now at **mappingevil.com.au**

Register your interest to join a live, virtual Q & A with Mike King at **mappingevil.com.au/MikeKing**

Indigenous deaths in custody: 30 years since the Royal Commission into Aboriginal Deaths in Custody

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Abstract:

Thirty years has passed since the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). This paper examines the trends and characteristics of Indigenous deaths in custody since 1991-92, using data obtained through the National Deaths in Custody Program (NDICP).

NDICP data show Indigenous people are now less likely than non-Indigenous people to die in prison custody, largely due to a decrease in the death rate of Indigenous prisoners from 1999-2000 to 2005-06. Coinciding with this decrease in the death rate of Indigenous prisoners is a decrease in the hanging death rate of Indigenous prisoners.

Monitoring trends and characteristics of both Indigenous and non-Indigenous deaths in custody supports the development of proactive strategies addressing this important issue.

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established in 1987 in response to growing concern over the deaths of Indigenous people in custody. The RCIADIC (1991) found Indigenous people were no more likely than non-Indigenous people to die in custody but were considerably more likely to be arrested and imprisoned.

The RCIADIC (1991) recommended an ongoing program be established by the Australian Institute of Criminology (AIC) to monitor Indigenous and non-Indigenous deaths in prison, police custody and youth detention. In response, the National Deaths in Custody Program (NDICP) commenced in 1992.

Since then, the NDICP has collected comprehensive data on the extent and nature of all deaths in custody in Australia.

The purpose of this paper is to provide a picture of trends and characteristics of Indigenous deaths in prison and police custody in the 30 years since the RCIADIC. A key focus is to describe the circumstances of Indigenous deaths in custody and how these compare with those reported by the RCIADIC and over time.

What is a death in custody?

The final report of the RCIADIC outlined the types of deaths that would require notification to the NDICP (recommendation 41, RCIADIC 1991). They are:

- a death, wherever occurring, of a person who is in prison custody, police custody or youth detention;
- a death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care, while in such custody or detention;
- a death, wherever occurring, of a person who dies, or is fatally injured, in the process of police or prison officers attempting to detain that person; or
- a death, wherever occurring, of a person attempting to escape from prison, police custody or youth detention.

Deaths in police custody are further divided into two categories:

- category 1: deaths in institutional settings (eg police stations, police vehicles, or in hospitals, following transfer from an institution) and other deaths in police operations where officers were in *close* contact with the deceased (eg most raids and shootings by police).
- category 2: other deaths in custody-related police operations where officers were *not* in close contact with the deceased (eg most sieges, pursuits).

Methodology

Data used in this study were extracted from the NDICP database. The information held in the NDICP database is derived from two main sources: data provided by state and territory police and corrective service agencies; and coronial records (eg autopsy, toxicology and finding reports) obtained via the National Coronial Information System. For more detail on the NDICP and its methodology, see Ticehurst, Napier and Bricknell (2018).

Data were drawn from deaths occurring in prison and police custody across Australia between financial years 1991-92 and 2015-16. Excluded from the analysis are the small number of youth detention deaths recorded during the reference period (n=10) and five cases in which Indigenous status was not recorded. A total of 2,044 deaths in custody were included in the analysis.

Table 1: Deaths in custody by jurisdiction, custodial authority and Indigenous status, 1991-92 to 2015-16

	Prison				Police				Total			
	Indigenous (n)	Non-Indigenous (n)	Total (n)	Proportion (%) Indigenous	Indigenous (n)	Non-Indigenous (n)	Total (n)	Proportion (%) Indigenous	Indigenous (n)	Non-Indigenous (n)	Total (n)	Proportion (%) Indigenous
NSW	67	410	477	14	26	213	239	11	93	623	716	13
Vic	10	185	195	5	6	131	137	4	16	316	332	5
Qld	57	188	245	23	18	102	120	15	75	290	365	21
WA	58	123	181	32	45	60	105	43	103	183	286	36
SA	18	101	119	15	14	48	62	23	32	149	181	18
Tas	3	35	38	8	2	13	15	13	5	48	53	9
ACT	2	6	8	25	0	9	9	0	2	15	17	12
NT	32	8	40	80	35	17	52	67	67	25	92	73
Cth	0	0	0	0	0	2	2	0	0	2	2	0
Total	**247**	**1,056**	**1,303**	**19**	**146**	**595**	**741**	**20**	**393**	**1,651**	**2,044**	**19**

Source: AIC NDICP 1991-92 to 2015-16 [computer file]

Table 1 shows the breakdown of deaths in custody by jurisdiction, custodial authority and Indigenous status. It should be noted that custody populations vary greatly across the jurisdictions, which affects the number and distribution of deaths recorded.

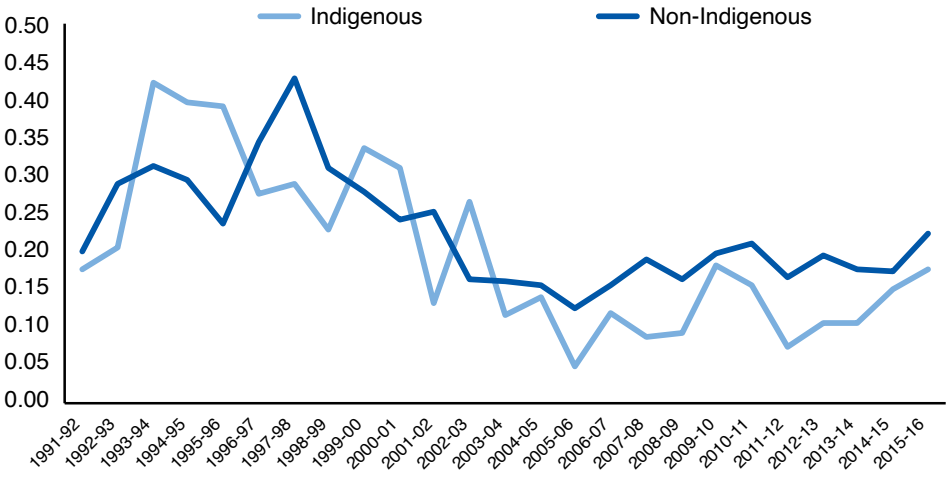
Indigenous deaths in prison custody

There were 247 Indigenous deaths in prison custody over the 1991-92 to 2015-16 period, accounting for 19 percent of all prison deaths (*n*=1,303; Table 1). Between 1991-92 and 2015-16, the number and proportion of Indigenous prison deaths fluctuated (range: 11% to 30% each year), while the number and proportion of Indigenous people in the prison population increased (from 14% to 27%; ABS 2000-2016). Since 2003-04, the proportion of Indigenous deaths in prison custody has been smaller than the relative proportion of prisoners.

Figure 1 shows prison death rates by Indigenous status. While there has been some variation, the death rate of Indigenous prisoners decreased overall by 85 percent from 1999-2000 to 2005-06 (from 0.34 to 0.05 per 100). Over the same period, the death rate of non-Indigenous prisoners decreased overall by 54 percent (from 0.28 to 0.13 per 100). Death rates of both Indigenous and non-Indigenous prisoners were notably lower in the second half of the reference period (2003-04 to 2015-16), compared with the first half (1991-92 to 2002-03).

The decrease in the death rate of Indigenous prisoners was proportionately greater than the decrease for non-Indigenous prisoners. This resulted in a widening in the gap between Indigenous and non-Indigenous prison death rates. For example, between 1991-92 and 2002-03, the average death rate of non-Indigenous prisoners was 1.1 times the Indigenous rate, increasing to 1.6 between 2003-04 and 2015-16. More recently, there has been a narrowing in this gap, largely due to an increase in the death rate of Indigenous prisoners (up 63% since 2013-14). Despite this, the death rate of Indigenous prisoners has been lower than that of non-Indigenous prisoners since 2003-04.

Figure 1: Deaths in prison custody by Indigenous status, 1991-92 to 2015-16 (rate per 100 relevant prisoners)



Source: AIC NDICP 1991-92 to 2015-16 [computer file]; rates calculated using ABS (2000-2016) prison population estimates

Legal status

Seventy-three percent (*n*=181) of Indigenous prison deaths between 1991-92 and 2015-16 involved sentenced prisoners, and 27 percent (*n*=66) involved unsentenced prisoners (Table A1). These proportions were relatively similar for non-Indigenous prison deaths (69% vs 31%).

Death rates by Indigenous status and legal status were calculated using available prison population data for the period 2004-05 to 2015-16 (ABS 2005-2016). Despite considerable variation,

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from 2004-05 to 2015-16, the death rate of Indigenous unsentenced prisoners decreased overall, from 0.26 to 0.16 per 100, while the death rate of non-Indigenous unsentenced prisoners decreased overall, from 0.37 to 0.17 per 100. On the other hand, from 2004-05 to 2015-16, the death rate of Indigenous sentenced prisoners increased slightly overall, from 0.11 to 0.19 per 100. The death rate of non-Indigenous sentenced prisoners also increased overall, from 0.11 to 0.25 per 100.

Since 2011-12, the death rate of Indigenous unsentenced prisoners has been lower than that of Indigenous sentenced prisoners. In comparison, the death rate of non-Indigenous unsentenced prisoners has generally been higher than that of non-Indigenous sentenced prisoners, with a narrowing in this gap in recent years.

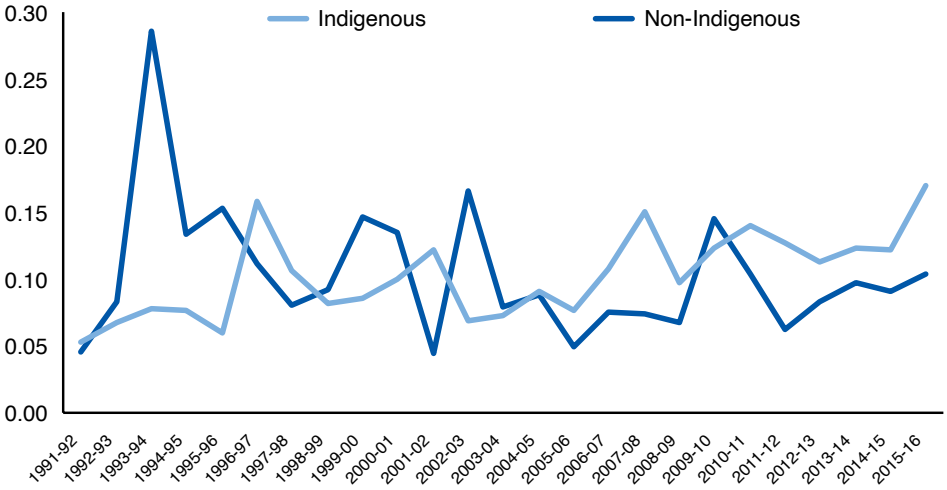
Demographic characteristics

Male prison deaths consistently outnumbered female prison deaths over the 1991-92 to 2015-16 period—96 percent (*n*=236) of all Indigenous deaths and 96 percent (*n*=1,018) of all non-Indigenous deaths (Table A1). The over-representation of males in prison deaths is representative of the gender composition of the wider prison population (ABS 2000-2016).

The age profile of Indigenous prison deaths was younger than non-Indigenous prison deaths. This reflects, in part, the younger age profile of Indigenous prisoners, compared with non-Indigenous prisoners (ABS 2000-2016). Over the period 1991-92 to 2015-16, the mean age at death for Indigenous prisoners was 37.8 years, compared with 45.3 years for non-Indigenous prisoners (Table A1). Eighty-nine percent of deaths among Indigenous prisoners occurred before the age of 55, compared with 69 percent of deaths among non-Indigenous prisoners. Almost one in five (18%; *n*=45) Indigenous deaths involved a prisoner less than 25 years of age.

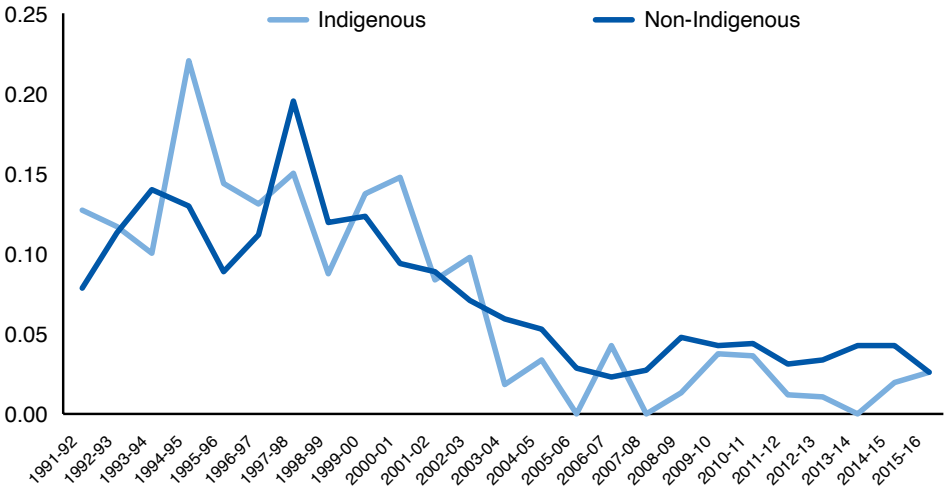
The mean age at death for Indigenous prisoners increased over the 25-year period, from 27.3 years in 1991-92 to 42.7 years in 2015-16. The mean age at death for non-Indigenous prisoners also increased, from 36.6 years in 1991-92 to 58.6 years in 2015-16. Increases in age at death for prisoners appear indicative of the ageing prisoner population (ABS 2000-2016; Baidawi et al. 2011).

Figure 2: Natural deaths in prison custody by Indigenous status, 1991-92 to 2015-16 (rate per 100 relevant prisoners)



Source: AIC NDICP 1991-92 to 2015-16 [computer file]; rates calculated using ABS (2000-2016) prison population estimates

Figure 3: Hanging deaths in prison custody by Indigenous status, 1991-92 to 2015-16 (rate per 100 relevant prisoners)



Source: AIC NDICP 1991-92 to 2015-16 [computer file]; rates calculated using ABS (2000-2016) prison population estimates

Cause of death

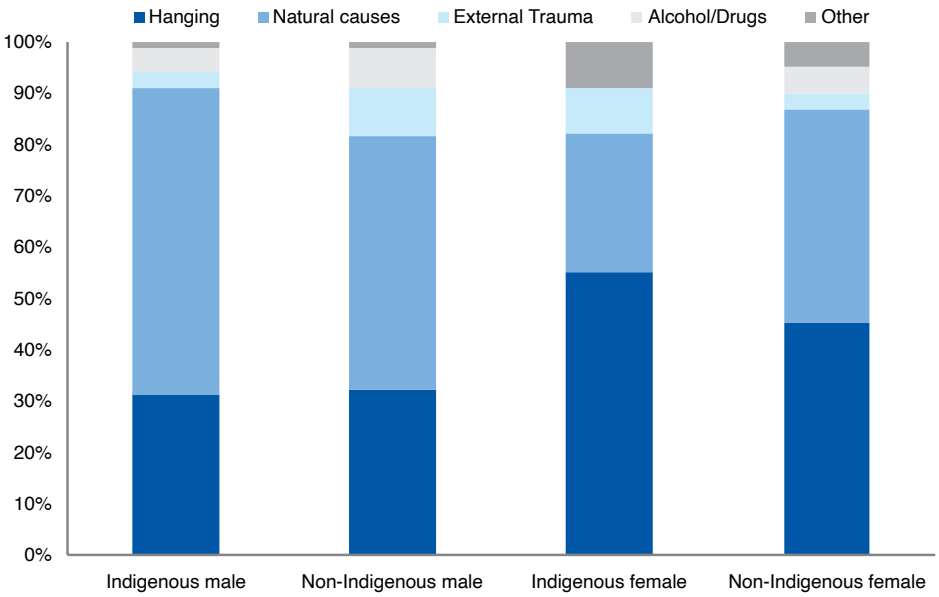
The majority of Indigenous prison deaths from 1991-92 to 2015-16 were due to natural causes (58%; *n*=140), followed by hanging (32%; *n*=78; Table A1). Twelve deaths (5%) were due to drugs and/or alcohol and nine (4%) were due to external trauma. For each year from 1991-92 to 2002-03, the leading cause of death among Indigenous prisoners was either natural causes or hanging. For each year from 2003-04 to 2015-16, deaths due to natural causes surpassed hanging deaths. This pattern was similar for non-Indigenous prison deaths.

Deaths from natural causes

Figure 2 shows natural death rates in prison custody by Indigenous status. Between 2003-04 and 2015-16, the natural death rate of Indigenous prisoners varied between 0.08 and 0.15 per 100 each year. The average natural death rate of Indigenous prisoners was 1.5 times the non-Indigenous rate between 1991-92 and 2002-03. From 2003-04 to 2015-16, the pattern reversed, with the average natural death rate of non-Indigenous prisoners 1.4 times the Indigenous rate.

The age profile of Indigenous prison deaths was younger than non-Indigenous prison deaths. This reflects, in part, the younger age profile of Indigenous prisoners, compared with non-Indigenous prisoners.

Figure 4: Deaths in prison custody by cause of death, Indigenous status and gender, 1991-92 to 2015-16 (%)



Notes: Excludes 10 cases where cause of death was not recorded. External trauma includes head injuries and gunshot wounds Source: AIC NDICP 1991-92 to 2015-16 [computer file]

Hanging deaths

As shown in Figure 3, hanging death rates among Indigenous and non-Indigenous prisoners present a very different picture. From 2000-01 to 2005-06, the hanging death rate of Indigenous prisoners dropped from 0.16 per 100 to zero deaths. The hanging rate of non-Indigenous prisoners also decreased during this time, from 0.10 to 0.03 per 100. From 2005-06, the hanging death rate for Indigenous and non-Indigenous prisoners remained at 0.05 or less per 100.

Hanging death rates decreased substantially among Indigenous prisoners, which resulted in changes to the rate ratio of Indigenous hanging death rates. For example, from 1991-92 to 2002-03, the average hanging death rate of Indigenous prisoners was 1.2 times the non-Indigenous rate, while from 2003-04 to 2015-16, the average hanging death rate of non-Indigenous prisoners was two times the Indigenous rate.

Indigenous hanging death rates by legal status were calculated using available prison population data for the period 2002-03 to 2015-16 (ABS 2003-2016). Despite considerable variation, from 2002-03 to 2015-16, the hanging death rate of Indigenous unsentenced prisoners decreased overall by 93 percent (from 0.41 to 0.03 per 100). Hanging death rates of Indigenous sentenced prisoners followed a more stable pattern over the period 2002-03 to 2015-16 (range: 0.06 to 0.00 each year). Since 2011-12, the hanging death rate of Indigenous sentenced prisoners has been similar to that of Indigenous unsentenced prisoners.

Cause of death by gender

Figure 4 shows the cause of prison death by Indigenous status and gender for the period 1991-92 to 2015-16. Similar proportions of Indigenous and non-Indigenous male deaths were caused by hanging—31 percent (*n*=72) and 32 percent (*n*=327) respectively. However, a larger proportion of Indigenous than non-Indigenous male deaths resulted from natural causes—59 percent (*n*=137) and 49 percent (*n*=494) respectively. Where the natural cause of death was recorded, Indigenous male deaths were more likely than non-Indigenous male deaths to be due to heart disease (56%; *n*=74 vs 37%; *n*=175), but less likely to be due to cancer (16%; *n*=21 vs 27%; *n*=128).

A larger proportion of Indigenous female deaths over the 1991-92 to 2015-16 period were due to hanging (55%; *n*=6 vs 44%; *n*=17 for non-Indigenous), while a larger proportion of non-Indigenous female deaths were due to natural causes (42%; *n*=16 vs 27%; *n*=3 for Indigenous; Figure 4). These differences, however, may only be apparent due to the small numbers of female prisoner deaths.

When comparing these findings with the wider prison population, data obtained from the Australian Institute of Health and Welfare (AIHW 2015) National Prisoner Health Data Collection indicate that, in 2015, just over half (51%) of prison entrants ever diagnosed with cardiovascular disease (eg heart disease, stroke, heart failure) reported still having cardiovascular disease, with Indigenous entrants most likely to still have the disease (7 out of 10). A small proportion of prison entrants (3%) were affected by cancer, with non-Indigenous entrants more likely than Indigenous entrants to have ever been told they had cancer (4% and 1% respectively).

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Cause of death by age

The leading cause of Indigenous deaths in prison custody varied depending on age. Over the 1991-92 to 2015-16 period, hanging was the leading cause of death among those aged less than 25, accounting for 76 percent (*n*=34) of such deaths. Among those aged 25 to 39 years, natural causes was the leading cause of death (48%; *n*=51), followed by hanging (36%; *n*=38). The majority of deaths among prisoners aged 40 to 54 years (83%; *n*=57) and those aged 55 years and over (96%; *n*=26) were from natural causes.

Manner of death

While the cause of death refers to the medical cause of the death, the manner of death refers to the accountability of the death or how the death came about. For example, if a person dies from natural causes (eg heart attack), the manner of death is also natural causes. If a person dies from other causes of death (eg external/multiple trauma), the manner of death is recorded as one of the following: self-inflicted, justifiable homicide, unlawful homicide, or accidental.

The manner of death in 58 percent (*n*=140) of Indigenous prison deaths was natural causes, equal to the 58 percent of Indigenous prison deaths attributable to natural causes (Table A1). A further 35 percent of deaths (*n*=86) were self-inflicted. Eight deaths (3%) were accidental, six (2%) were classified as an unlawful homicide, and one (<1%) was a justifiable homicide. For each year from 1991-92 to 2001-02, the leading manner of death was either natural causes or self-inflicted. For each year from 2002-03 to 2015-16, deaths from natural causes surpassed self-inflicted deaths as the leading manner of death. This pattern was similar for non-Indigenous prison deaths.

Self-inflicted deaths

Nearly all self-inflicted deaths among Indigenous prisoners over the period 1991-92 to 2015-16 were due to hanging (90%; *n*=77). Four were due to external/multiple trauma (5%) and three were due to drugs and/or alcohol (3%). Therefore, trends in self-inflicted deaths largely parallel trends in hanging deaths as described above. Almost half of Indigenous self-inflicted deaths (47%; *n*=40) during the 1991-92 to 2015-16 period were of persons who had previously attempted suicide, and almost one in three (30%; *n*=26) were of persons who had been identified as being at risk of self-harm or suicide.

The self-inflicted death rate of Indigenous prisoners decreased from 0.16 per 100 in 2000-01 to zero deaths in 2005-06. Over the same period, the self-inflicted death rate of non-Indigenous prisoners also decreased, from 0.11 to 0.05 per 100. The average self-inflicted death rate of Indigenous prisoners between 1991-92 and 2002-03 was 1.1 times the non-Indigenous rate, while from 2003-04 to 2015-16 the average self-inflicted death rate of non-Indigenous prisoners was 2.4 times the Indigenous rate.

In 1991, the RCIADIC concluded Indigenous people were no more likely to die in custody than non-Indigenous people but were significantly more likely to be arrested and imprisoned. The same remains true today.

Indigenous deaths in police custody

It should be noted that it is not currently possible to calculate rates of death in police custody, due to the absence of reliable data on the number of people placed in police custody each year and the number of people who come into contact with police in custody-related operations.

There were 146 Indigenous deaths in police custody over the 1991-92 to 2015-16 period, accounting for 20 percent of the total police custody deaths (*n*=741; Table 1). The number of Indigenous deaths in police custody each year was relatively small, with no clear trend over the reference period. The largest number (*n*=11) of Indigenous deaths occurred in 2002-03 and 2004-05, and the lowest (*n*=1) in 2013-14.

Just over half (56%; *n*=82) of Indigenous deaths in police custody during the 1991-92 to 2015-16 period were classified as category 2 deaths—that is, deaths in which officers were not in close contact with the deceased (Table A2). The remaining 44 percent (*n*=64) were classified as category 1—that is, deaths in which officers were in close contact with the deceased. A similar proportion of non-Indigenous deaths in police custody were classified as close and non-close contact deaths (44%; *n*=262 and 56%; *n*=333 respectively).

Demographic characteristics

Male deaths in police custody generally outnumbered female deaths in police custody over the 1991-92 to 2015-16 period, with male deaths comprising 86 percent (*n*=125) of all Indigenous and 95 percent (*n*=563) of all non-Indigenous deaths (Table A2). While police custody population figures are not available, this gender ratio is likely representative of the gender composition of the arrestee population.

The age profile of Indigenous deaths in police custody was younger than non-Indigenous deaths. Indigenous deaths in police custody most commonly involved those aged less than 25 years (40%; *n*=59), followed by those aged 25-39 years (38%; *n*=55; Table A2). Non-Indigenous deaths in police custody most commonly involved those aged 25-39 years (43%; *n*=256). The mean age at death for Indigenous persons in police custody was 29.9 years, compared with 34.6 years for non-Indigenous persons in police custody.

Cause of death

Over half (51%; *n*=74) of Indigenous deaths in police custody over the 1991-92 to 2015-16 period resulted from external/multiple trauma (Table A2), the majority of which were due to injuries sustained during motor vehicle pursuits (MVPs; 62%; *n*=46). Deaths resulting from MVPs accounted for almost one third (32%; *n*=46) of Indigenous deaths in police custody during the 1991-92 to 2015-16 period. This proportion was similar for non-Indigenous deaths in police custody (30%; *n*=176).

The next most common cause of Indigenous deaths in police custody over the period 1991-92 to 2015-16 was natural causes (21%; *n*=30; Table A2). Most of these were due to heart disease or related cardiac ailments (73%; *n*=22), as was the case for deaths in prison custody. A small number of deaths were due to stroke (13%; *n*=4), respiratory conditions (7%; *n*=2) and epilepsy (3%; *n*=1). Indigenous deaths from natural causes most commonly occurred among those aged 25-39 (43%; *n*=13) and 40-54 (37%; *n*=11). A higher proportion of Indigenous compared with non-Indigenous deaths in police custody resulted from natural causes (21%; *n*=30 vs 8%; *n*=47).

Less than 10 percent of Indigenous deaths in police custody over the 1991-92 to 2015-16 period were due to hanging (9%; *n*=13). No Indigenous hanging deaths have occurred since 2008-09. Non-Indigenous hanging deaths decreased, from 20 during the first half of the reference period (1991-92 to 2002-03) to nine during the second half (2003-04 to 2015-16). Similarly, no non-Indigenous hanging deaths have occurred since 2009-10.

The number of Indigenous deaths resulting from gunshot wounds was low over the 1991-92 to 2015-16 period (range: 0-2 per year). Of the total 13 Indigenous deaths resulting from gunshot wounds, eight (62%) were police shootings and five (38%) were self-inflicted. Nine percent of Indigenous deaths in police custody were caused by gunshot wounds, compared with 35 percent of non-Indigenous deaths.

Manner of death

Almost half (47%; *n*=68) of Indigenous deaths in police custody over the 1991-92 to 2015-16 period were accidental (Table A2), 57 percent (*n*=39) of which were due to MVPs and 19 percent (*n*=13) to some other type of pursuit (eg foot pursuit). The next most common manner of death was natural causes (21%; *n*=31), followed by self-inflicted deaths (19%; *n*=28). Less than 10 percent were due to justifiable homicide (7%; *n*=10) and unlawful homicide (5%; *n*=8).

Conclusion

In 1991, the RCIADIC concluded Indigenous people were no more likely to die in custody than non-Indigenous people but were significantly more likely to be arrested and imprisoned. The same remains true today.

Indigenous people are now less likely than non-Indigenous people to die in custody, largely due to a decrease in the death rate of Indigenous prisoners from 1999-2000 to 2005-06. Since 2003-04, non-Indigenous people have been, on average, 1.6 times more likely to die in prison custody than Indigenous people. More recently, there has been a narrowing in this gap, largely due to an increase in the death rate of Indigenous prisoners from 2013-14. Yet the death rate of Indigenous prisoners has been consistently lower than that of non-Indigenous prisoners since 2003-04. Coinciding with the overall decrease in the death rate of Indigenous prisoners is the decrease in the hanging death rate of Indigenous prisoners, falling below the natural death rate from 2002-03. Since 2003-04, the hanging death rate of Indigenous prisoners has been lower or the same as that of non-Indigenous prisoners. In contrast, the natural death rate of Indigenous prisoners has remained relatively stable across the years.
The mean age at death for Indigenous prisoners has been increasing over the years yet remains lower than that of non-Indigenous prisoners. Based on available prison population data from 2004-05 to 2015-16, the death rate of Indigenous unsentenced prisoners decreased overall, while the death rate of Indigenous sentenced prisoners increased slightly.

While less can be said about the trends for Indigenous deaths in police custody (due to the relatively small number of Indigenous deaths in police custody each year) and rates cannot currently be calculated, some clear patterns have emerged. Between 1991-92 and 2015-16, 146 Indigenous deaths in police custody occurred, representing 20 percent of all deaths in police custody. One in every two (47%) Indigenous deaths in police custody were classified as an accident, followed by deaths from natural causes (21%) and self-inflicted deaths (19%). One in two accidental deaths were due to MVPs and one in five were due to some other type of pursuit. The number of Indigenous hanging deaths in police custody was relatively small, with no Indigenous hanging deaths occurring since 2008-09. The number of Indigenous deaths resulting from gunshot wounds was also relatively small, and notably smaller proportionately than non-Indigenous deaths in police custody.
As with prison deaths, the age profile of Indigenous deaths in police custody was younger than that of non-Indigenous deaths in police custody.

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Appendix

Table A1: Deaths in prison custody by Indigenous status, 1991-92 to 2015-16

	Indigenous		Non-Indigenous		Total	
	n	%	n	%	n	%
Legal status						
Sentenced	181	73	724	69	905	70
Unsentenced	66	27	330	31	396	30
Gender						
Male	236	96	1,018	96	1,254	96
Female	11	4	38	4	49	4
Age group (years)						
Under 25	45	18	126	12	171	13
25-39	106	43	342	32	448	34
40-54	69	28	262	25	331	25
55+	27	11	326	31	353	27
Min/max		17/81		17/94		17/94
Mean (median)		37.8 (36)		45.3 (43)		43.8 (41)
Cause of death						
Hanging	78	32	344	33	422	33
Natural causes	140	58	510	49	650	50
External trauma	9	4	97	9	106	8
Alcohol/drugs	12	5	84	8	96	7
Other	4	2	15	1	19	1
Manner of death						
Self-inflicted	86	35	401	38	487	38
Natural causes	140	58	510	49	650	50
Unlawful homicide	6	2	58	6	64	5
Justifiable homicide	1	<1	4	<1	5	<1
Accident	8	3	68	7	76	6
Other	2	1	5	<1	7	1

Notes: External trauma includes head injury and gunshot wounds. Excludes cases with missing data. Percentages may not total 100 due to rounding
Source: AIC NDICP 1991-92 to 2015-16 [computer file]

Table A2: Deaths in police custody by Indigenous status, 1991-92 to 2015-16

	Indigenous		Non-Indigenous		Total	
	n	%	n	%	n	%
Category of death						
Category 1	64	44	262	44	326	44
Category 2	82	56	333	56	415	56
Gender						
Male	125	86	563	95	688	93
Female	21	14	32	5	53	7
Age group (years)						
Under 25	59	40	150	25	209	28
25-39	55	38	256	43	311	42
40-54	27	18	142	24	169	23
55+	5	3	46	8	51	7
Min/max	12/69	13/80	12/80			
Mean (median)	29.9 (28)	34.6 (32)	33.7 (32)			
Cause of death						
Hanging	13	9	29	5	42	6
Natural causes	30	21	47	8	77	10
Gunshot	13	9	207	35	220	30
External trauma	74	51	237	40	311	42
Alcohol/drugs	6	4	43	7	49	7
Other	10	7	28	5	38	5
Manner of death						
Self-inflicted	28	19	199	34	227	31
Natural causes	31	21	47	8	78	11
Unlawful homicide	8	5	6	1	14	2
Justifiable homicide	10	7	110	19	120	16
Accident	68	47	218	37	286	39
Other	1	1	11	2	12	2

Notes: External trauma includes head injury. Excludes cases with missing data. Percentages may not total 100 due to rounding
Source: AIC NDICP 1991-92 to 2015-16 [computer file]

Colonial Australia was surprisingly concerned about Aboriginal deaths in custody

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When the Royal Commission into Aboriginal Deaths in Custody's report was tabled in 1991, it was not the first official inquiry into this tragic phenomenon. The disproportionately high rate of mortality among Aboriginal convicts in colonial New South Wales had triggered an earlier investigation in 1850.

The problem is, of course, still with us. This year a Guardian investigation found 147 Indigenous people have died in custody over the past ten years, and 407 since the end of the Royal Commission.

In my research into the transportation of Aboriginal convicts in the 19th century, I uncovered a government circular, a formal letter, written in 1851. It set out detailed instructions about watching and reporting on the health of Aboriginal prisoners. And it recommended that if an Aboriginal prisoner's life was in danger, he might be released from gaol.

When Aboriginal convict Jemmy died in custody in 1850 soon after being transported to Cockatoo Island in Sydney, the Native Police Office wrote to let the colonial secretary Edwards Deas Thomson know. Thomson reacted by asking for a report of the number of Aboriginal convicts who had died on the island over the past five years.

It revealed that of the 19 Aboriginal men transported there between 1845 and 1850, 12 (63%) had died there or in Sydney's general hospital.

Jemmy, along with at least 60 other Aboriginal men from NSW (which at the time included Queensland and Victoria), was transported following his involvement in Australia's 19th century frontier wars. Some of these Aboriginal convicts were sent to Norfolk Island and Van Diemen's Land.

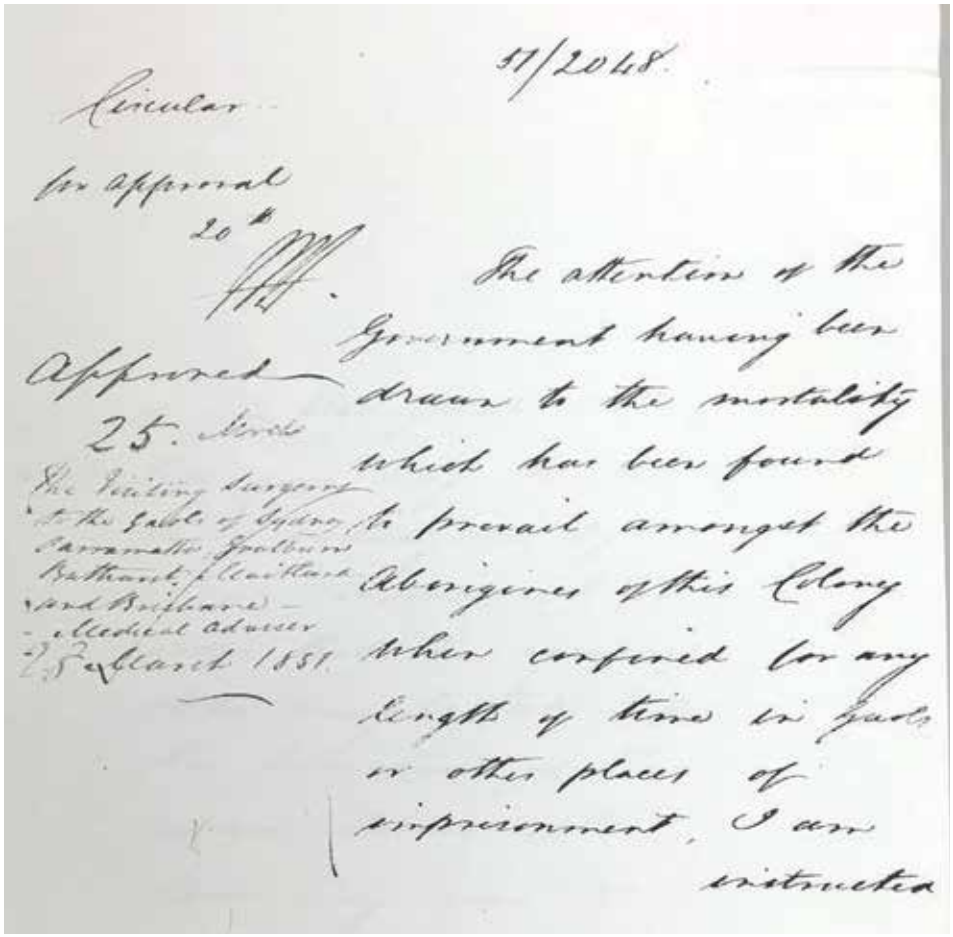
A portrait of Musquito, who was hanged in Hobart in 1825. National Library of Australia

Others languished on Goat Island, Sydney, and, later, Cockatoo Island. The most high profile Aboriginal captive was Musquito who was banished from NSW to Norfolk Island in 1805 and later hanged in Hobart in 1825.

Why the deaths?

Most Aboriginal convicts simply did not survive for very long in captivity. In their first year of incarceration, Aboriginal convicts died at ten times the rate of male convicts shipped to Van Diemen's Land from Britain. Speculation about this at the time mostly hinged around the idea that they died from pining for country.

Other contributing causes included untreated injuries following violent arrests and crowded, unsanitary living conditions, which led to chest infections.


51/2048.

Circular

for approval

20th

The attention of the Government having been drawn to the mortality which has been found to prevail amongst the Aborigines of this Colony when confined for any length of time in gaols or other places of imprisonment, I am instructed

Approved

25. June

The Visiting Surgeons to the Gaols of Sydney Parramatta Goulburn Bathurst Maitland and Brisbane – Medical adviser 25 March 1851

A detail from the circular that was sent around gaols. NSW State Archives and Records

The disturbing trend of high death rates amongst Aboriginal prisoners is evident in archival records from the early decades of the 19th century. Yet until the 1840s Aboriginal convicts were spread out across a range of different probation and penal stations.

Aboriginal poor health in custody was exacerbated by colonial diets and hard labour.

The disturbing trend of high death rates amongst Aboriginal prisoners is evident in archival records from the early decades of the 19th century. Yet until the 1840s Aboriginal convicts were spread out across a range of different probation and penal stations.

When Thomson heard how many Aboriginal convicts were dying in custody at Cockatoo Island, he set up a board of enquiry to consider alternatives to confining them there. This board comprised the medical adviser to the government Dr Patrick Hill, the surgeon at Cockatoo Island Dr O'Brien, and the island's visiting justice, H. H. S. Browne.

The response

The most significant outcome of the inquiry was a remarkable document that went beyond the 339 recommendations of the Royal Commission almost 150 years later. An official circular instructed surgeons visiting colonial gaols to report to justices any cases involving Aboriginal prisoners whose lives could be endangered by longer confinement.

The upshot of this was that, providing it was not considered contrary to the public interest, the suffering prisoner might be released from custody. With the restoration of his freedom, it was hoped he would return to full health.

While this initiative arose out of the convict system, the instructions were circulated more widely and applied to Aboriginal prisoners generally.

The gaol at Bathurst, a town north west of Sydney, was among the institutions to which the circular was sent in March 1851. In the early 1850s, Godfrey Charles Mundy visited Bathurst Gaol as part of a tour of NSW with his cousin, Governor Charles FitzRoy.

Mundy wrote about a man known as "Fish-hook", who had been locked up for cattle stealing and showed signs of reduced mental function. Returning a month later, Mundy noted a marked deterioration in Fish-hook's mental and physical wellbeing.

FitzRoy ordered Fish-hook's immediate release. When Mundy saw Fish-hook a third time, after the Aboriginal man had become a colonial servant, he wrote how the former prisoner's mental health had been perfectly restored.

Despite the transformative outcome for Fish-hook, it seems unlikely many Aboriginal prisoners were freed. To the contrary, some were considered too sick to be released, as it would almost certainly lead to their death.

The 1851 Circular and the 1991 Royal Commission into Aboriginal Deaths in Custody shared a common concern, to reduce the mortality rate of Aboriginal prisoners. The 19th century solution was to initiate, where possible, their early release. By the end of the 20th century, the Royal Commission's focus was on strategies to lower Aboriginal incarceration rates. However, many of its recommendations are yet to be implemented.

Identifying the prevalence and predictors of suicidal behaviours for indigenous males in custody

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Abstract

Background: High rates of suicidal behaviours among Indigenous Australians have been documented. Justice involved individuals are also at a higher risk for engaging in suicidal behaviours. This study sought to ascertain the prevalence and correlates of suicidal behaviours for 107 Indigenous adult males in custody in Victoria, Australia.

Methods: Participants undertook a structured interview comprising a psychiatric assessment. Information on suicidal behaviours (ideation and attempts), socio-demographics, environmental stressors, negative life events and mental health was obtained.

Results: A high proportion of Indigenous males in custody experienced lifetime suicidal ideation (63.7%) and over one half had attempted suicide (54.5%). A smaller, yet significant number of participants experienced ideation over the past 12 months (27.9%). Having a loved one pass away within the past 12 months predicted recent ideation; lifetime ideation and a diagnosis of Post-Traumatic Stress Disorder predicted a lifetime suicide attempt.

Conclusions: The prevalence of suicidal behaviours among Indigenous people in custody is remarkably high. Correlates of suicidal behaviours for Indigenous people in custody in this study likely manifest in the community, denoting an urgent public health response. Prevention must begin in communities at-risk for suicidal behaviours. The development of low intensity mental health service infrastructure in communities to promote awareness and provide accessible, least restrictive support and treatment is necessary. Correctional institutions must also continue to improve custodial suicide prevention and management initiatives.

Keywords: Indigenous population, Suicide, Prison, Mental illness, Aboriginal and Torres Strait islander health

Background

In a given year, almost 800,000 people die by suicide worldwide[1]. In Australia, suicide is the leading cause of death for people aged between 15 and 44 years[2]. Indigenous Australians (Aboriginal and Torres Strait Islanders) are at a higher risk for suicide compared to non-Indigenous Australians. Almost 6% of Indigenous Australian deaths are the result of suicide compared with less than 2% of non-Indigenous Australian deaths[2]. This disparity is more pronounced in early adulthood[2, 3], and among young people under 18 years[2]. The higher rate of suicide among Indigenous Australians has been linked to socio-economic disadvantage, racism, cultural disconnection, alienation and exposure to a concert of traumatic stressors and negative life events (e.g., incarceration, frequent preventable deaths of family and friends, child removal, family breakdown, sexual/physical abuse)[4-15]. These factors are often associated with other correlates of suicidal behaviours such as psychological distress, mental disorder, substance abuse, homelessness and 'social and emotional wellbeing'[5-7, 9, 13, 16-21], all of which are intensified in the absence of community support networks. Social and emotional wellbeing (SEWB) is an Indigenous Australian concept of health that encompasses physical, psychological, cultural, spiritual, familial and community dimensions[22]. The holistic nature of SEWB is believed to diverge from biomedical characterisations of illness which are described as having a more individualized emphasis[22]. The above risk factors, including low SEWB have been associated with criminal justice system contact[23-25]. Indigenous Australians are disproportionately incarcerated in every state and territory[26], which contributes to cycles of disadvantage, and risk for suicidal behaviours.

Rates of suicide are higher for adults who are incarcerated compared to the general community[27]. Detainees often present with numerous complex social and clinical needs[28, 29] which increase their risk for re-offending and also their risk for suicide[9, 30-32]. The custodial environment may increase levels of psychological distress, emotional breakdown, frustration and vulnerability

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to victimization[33]. As such, suicide is often the most common cause of death within correctional institutions after deaths due to natural causes[34]. Moreover, the risk for suicide is elevated during the immediate post release period[35-37]. This presents a heightened public health concern for some Indigenous Australians given the higher rates of incarceration in addition to higher rates of suicide in the broader community[3]. It is still unclear however, whether Indigenous Australians in custody are at a higher risk for suicide compared to non-Indigenous prisoners. The 1991 Royal Commission into Aboriginal Deaths in Custody discovered that rates of death (suicide or otherwise) are similar for Aboriginal and non-Aboriginal people in custody[8]. More contemporary reports indicate that rates of Indigenous deaths in custody (including self-inflicted deaths) have not increased alongside growing Indigenous imprisonment rates[34, 38]. In fact, death in custody rates for Indigenous prisoners may have decreased and now occur at lower rates compared to non-Indigenous prisoners[34].

Evidence suggests that Australian prison suicides have declined over time[38], presumably due to improved preventive initiatives in custody[39]. However, many inmates possess histories of suicidal behaviour and arrive in custody presenting with risk factors for suicide. It is estimated that around one-third of Australian prisoners have experienced suicidal ideation in their lives and approximately one-fifth have attempted suicide[40]. Higher percentages of ideation and attempted suicide have been identified among Indigenous prisoners[9, 41]. Despite this finding, risk for suicide on release from custody remains unchanged for Indigenous people[35]. However, this risk is still significantly greater than for those in the general population[14]. As such, there is a need to gain a better understanding of the drivers of suicidal behaviour for Indigenous people who find themselves in custody. Prior work has investigated the correlates of suicidal ideation and suicide attempts for the wider Australian prison population[9]. Yet no research has sought to identify correlates for Indigenous prisoners specifically. It is important for correctional and community health services to be able to identify and address the needs of justice-involved Indigenous people at-risk for suicide. This group potentially faces both multiple and unique factors that increase their risk for suicidal behaviours in custody and when transitioning back to the community.

This study aims to identify the prevalence and correlates of suicidal ideation and suicide attempts for a cohort of Indigenous people in custody in the Australian state of Victoria. We expect mental health factors, negative life events and custodial history to be associated with suicidal behaviours. Histories of psychiatric disorder and life stressors have previously been correlated with suicidal ideation in Australian prison populations. We also expect ideation to be associated with life-time suicide attempts, reflecting prior forensic and public health research.

Method

Recruitment setting

All remanded and sentenced male Aboriginal and Torres Strait Islander prisoners over 18 years from 11 regional and metropolitan prisons in the state of Victoria were approached to participate in the study. Participants were required to have their Aboriginal and Torres Strait Islander status formally registered with prison services. There was no recruitment from one correctional centre due to insufficient numbers of Indigenous prisoners. Participants placed in management at the time of interviews were not eligible to participate in the study. Over the course of recruitment, two prisoners declined to participate in the study once the researcher had explained the study to them.

Materials

Structured interview

A structured interview was conducted with each participant to obtain data on suicidal behaviours, mental health, environmental stressors and socio-demographic information. This encompassed information pertaining to a participant's area of residence prior to custody (rural and remote or urban), custodial status (sentenced or remanded), the total number of episodes in custody as an adult and the total number of days spent in custody for the current sentence or remand period.

Suicidal behaviours

Participants were asked to indicate (Yes/No) whether they had ever attempted suicide, whether they had ever had thoughts of suicide (ideation), and whether they had thoughts of suicide in the 12 months prior to the interview. In addition, participants were also asked about the locations (custody/community) in which they had attempted suicide or had suicidal thoughts.

Participants were also asked if a friend or relative had ever died by suicide and if a friend or relative had passed away (any cause) within the previous 12 months.

MINI international neuropsychiatric interview (MINI)

The Mini International Neuropsychiatric Interview (MINI) is a structured diagnostic interview designed by psychiatrists to assess the presence of psychiatric disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and the ICD-10 (International Classification of Diseases and Related Health Problems). The MINI comprises a series of yes/no questions across a number of clinical domains (e.g. major Depressive Episode, Dysthymia, Social Phobia). The presence of a disorder is indicated based on particular patterns of responses within each domain. The MINI has demonstrated concordance with other structured clinical interviews[42] and acceptable agreement with clinical diagnoses[43]. The MINI has previously been employed with Australian Indigenous populations[44].

Mood disorder

For the purposes of the present study, all MINI items related to a lifetime diagnosis of a mood disorder were included (i.e., presence of major depressive disorder, major depressive disorder with psychotic features, Bipolar I and II, Bipolar NOS, Bipolar I with psychotic features and Mood disorder NOS).

Substance use disorder

All MINI items indicating the presence of a substance use disorder were included (i.e., all items indicating the presence of alcohol dependence, alcohol abuse, substance dependence and substance abuse).

Anxiety disorder

MINI items indicating a diagnosis of social phobia, obsessive compulsive disorder, panic disorder and generalised anxiety disorder were collapsed into a single variable indicating the presence or absence of an anxiety disorder.

Psychotic disorder

MINI items indicating a diagnosis of psychotic disorder, psychotic disorder due to medical condition, substance induced psychotic disorder, brief psychotic disorder, schizophrenia, schizoaffective disorder and schizophreniform disorder were collapsed into a single variable indicating the presence or absence of a psychotic disorder.

Post-traumatic stress disorder

A diagnosis of PTSD based on the MINI was used as a variable to indicate the presence or absence of PTSD.

Procedure

The data for this analysis comprised the Koori Prisoner Mental Health and Cognitive Function Study (KPMHS) database sample. The KPMHS was conducted by the Centre for Forensic Behavioural Science under contract from the Victorian Department of Justice to investigate the mental health needs of Koori prisoners. Ethical approval to utilise the database was obtained from the Victorian Department of Justice Human Research Ethics Committee and Swinburne University Human Research Ethics Committee. The KPMHS study was overseen by a steering committee which included representation from the Victorian Aboriginal Community Controlled Health Organisation, the Victorian Aboriginal Legal Service and the Koori Justice Unit (Victorian Department of Justice).

As part of the KPMHS, participants undertook a structured interview and were administered a battery of mental health questionnaires in custody between January and October 2012. The development of the structured interview with Koori prisoners involved close consultation with the steering committee and advisory group. It was also reviewed by an Aboriginal psychologist with research expertise, as well as an Aboriginal psychologist with neuropsychological experience and a clinical neuropsychologist.

The interview was conducted by two mental health practitioners, one of whom was Aboriginal. Clients were initially informed of the study by Aboriginal Wellbeing or Liaison officers who provide support for Indigenous prisoners and cultural advice for prison staff. Aboriginal Wellbeing/Liaison Officers at each prison briefly informed participants of the details of the study. Those prisoners interested in participating in the study then met with the interviewers who provided them with an explanatory statement. The Aboriginal and Torres Strait Islander research officer verbally reviewed the explanatory statement with the prisoner and provided an opportunity for the prisoner to ask questions. Prisoners who wished to take part were asked to sign a consent form acknowledging their understanding of the study. All interviews were conducted in private rooms visible (though not audible) to custodial staff. Participation in the study was voluntary and participants could choose not to answer any questions, or terminate the interview at any time, if desired.

Statistical approach

The prevalence of suicidal ideation and suicide attempts across the lifetime, and suicidal ideation 12 months prior to baseline (time of interview) was estimated by calculating the proportion of participants who reported suicidal ideation and attempts in each of these categories. Confidence intervals were also calculated for the proportions of participants in each category. The median length of time in custody was examined between participants who reported suicidal ideation and those who did not report suicidal ideation in the 12 months prior to baseline. A Wilcoxon test was used to examine the average difference between those reporting suicidal ideation over the past 12 months and those who did not. Following the examination of time in custody, the custody status of participants was examined by reporting the proportion of participants who had been sentenced compared to the proportion who had been remanded.

To examine the correlates of suicidal ideation and suicide attempts, three multivariate logistic regression models were utilised. The model for lifetime suicidal ideation contained total number of times in custody, self-report of a close friend or relative dying by suicide, lifetime diagnosis of mood disorder, lifetime diagnosis of substance use disorder, lifetime diagnosis of anxiety disorder, lifetime diagnosis of a psychotic disorder, lifetime diagnosis of PTSD and the participant's region of residence outside of custody (rural/remote vs city).

The model for 12 month suicidal ideation was similar. However, rather than examining the total number of times in custody, this variable was replaced by the total amount of time in custody on the present occasion. This would help determine whether greater exposure to the prison experience is contributing to ideation. The report of a close friend or relative dying by suicide was replaced with a self-report variable indicating whether or not a friend or relative had passed away in the previous 12 months.

The same variables were used in the model for lifetime suicidal ideation. The only difference being that lifetime ideation was included as a variable in the lifetime attempts model. Odds ratios and associated 95% confidence intervals were presented for each variable adjusted for all other variables in the model and also in unadjusted form.

Results

The sample included 107 Indigenous males in custody. The sample size is representative of Indigenous prisoners in Victoria, which possesses the lowest proportion of Indigenous people in custody nationwide. The mean age of participants was 34.2 (*SD* = 10.4, range: 18-62) years. The sample comprised 100 (93.5%) participants who identified as Aboriginal and 5 (4.5%) who identified as Torres Strait Islander. A minority of participants were in custody on remand (*n* = 30, 28.0%), the remainder were undertaking a custodial sentence (*n* = 75, 70%). Data on specific Indigenous heritage (Aboriginal and/or Torres Strait Islander) and custody status was not available for two of the participants.

Prevalence of suicidal ideation and suicide attempts

Prevalence data for each of the outcome assessments used are presented in Table 1.

Suicidal ideation followed a decreasing pattern in relation to the time period examined, with the highest proportion reported for lifetime suicidal ideation, followed by ideation in the previous 12 months. Approximately 74% (*n* = 48) of participants who reported lifetime suicidal ideation also reported a suicide attempt.

Participants who reported lifetime suicidal ideation and lifetime suicide attempts were asked to provide follow up data relating to locations in which suicide attempts had been made and

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where thoughts of suicide had been worst. Of the participants that reported lifetime suicidal ideation and responded to the location question (*n* = 61), the majority (*n* = 37, 61%) reported that their worst thoughts of suicide occurred in the community, a smaller proportion identified custodial settings (*n* = 16, 26%), eight participants (13%) reported that their worst thoughts of suicide occurred in both community and custodial settings. The location of suicide attempts followed a similar pattern, with the majority of those who responded to the question (*n* = 47) reporting that their attempts took place in the community (*n* = 34, 72%), with far fewer reporting suicide attempts in custodial settings (*n* = 4, 9%), nine participants (19%) reported that suicide attempts occurred in both community and custodial settings.

All but two participants reported the number of times that they had served custodial sentences as an adult. The median number of custodial sentences was 4 (*IQR* = 2-6, *range* = 1-45) custodial sentences. The median number of sentences previously served was not significantly different for participants who reported suicidal ideation in the past 12 months (*Median* = 3, *IQR* = 1-5, *range* = 1- 20) compared with participants who reported no suicidal ideation in the same period (*Median* = 4, *IQR* = 1-6, *range* = 1-4), *W* = 770, *p* = .7. Similarly, participants reporting lifetime suicidal ideation (*Median* = 4, *IQR* = 2-5, *range* = 1-45) did not significantly differ from participants who reported no suicidal ideation (*Median* = 5, *IQR* = 1-6, *range* = 1-15), *W* = 1200, *p* = .6. Finally, participants reporting lifetime suicide attempts (*Median* = 4, *IQR* = 1-6, *range* = 1-45) did not differ significantly from participants who reported no suicide attempts (*Median* = 3.5, *IQR* = 2-6, *range* = 1-20) in terms of the number of times in custody as an adult, *W* = 980, *p* > .99.

The median number of days spent in the most recent time in custody was then examined between participants who had suicidal ideation in the past 12 months (*Median* = 9.5, *IQR* = 5-18.75, *range* = 1-180) compared to those who had not reported suicidal ideation in the same time period (*Median* = 17, *IQR* = 6-36, *range* = 0.6-114). The average time was slightly higher among those reporting no suicidal ideation. However, Wilcoxon's test indicated that the differences were not significant, *W* = 810, *p* = .4.

Finally, custody status was examined between participants who reported suicidal ideation in the past 12 months. Among those reporting suicidal ideation, the majority were serving custodial sentences (*n* = 17, 71%) rather than on remand (*n* = 7, 29%). Those who reported no suicidal ideation over the same period were mostly serving custodial sentences (*n* = 42, 70%) with a minority on remand (*n* = 18, 30%).

Table 1 Proportion of participants reporting self-harm behaviour

	n/N	%	(95% CI)
Suicidal ideation in previous 12 months	24/86	27.9	19-39
Lifetime suicidal ideation	65/102	63.7	54-73
Lifetime suicide attempts	49/90	54.4	44-65

Correlates of suicidal ideation and suicide attempts

Correlates of lifetime suicide ideation, suicidal ideation in the 12 months prior to baseline, and lifetime suicide attempts were examined through the use of three multivariable logistic regression models. Hosmer and Lemeshow tests for all three models were not significant (Lifetime Suicidal Ideation: $X^{2\,[8]} = 6.2$, $p = .6$; 12 Month Suicidal Ideation: $X^{2\,[8]} = 8.3$, $p = .4$; Suicide Attempts: $X^{2\,[8]} = 8.7$, $p = .4$) indicating a lack of evidence for poor model fit.

The total effect size for the lifetime suicidal ideation model was evaluated using Nagelkerke's R^2, a coefficient which ranges from 0 (equivalent to no predictive power) to 1 (with 1 equivalent to perfect prediction), the R^2 for the model was 0.24. Results are presented in Table 2.

The results of the model indicate that none of the variables was significantly associated with the outcome. The results of the 12 month suicidal ideation model are presented in Table 3.

Nagelkerke's R^2 for the total model was 0.34, indicating moderate explanatory power. The reporting of a close friend or relative passing away in the 12 months prior to baseline was significantly associated with suicidal ideation over the previous 12 months (adjusted odds ratio = 5.3, 95% CI = 1.6-20.9, *p* = .009). The results of the suicide attempts model are presented in Table 4.

Nagelkerke's R^2 for the total model was 0.62, indicating good explanatory power. Suicidal ideation (AOR = 58.2, 95%CI = 9.6-1159.6, *p* < .001) was significantly associated suicide attempts. No other variables were significantly associated with the outcome when adjusting for other variables. A diagnosis of PTSD was associated with suicidal attempts univariately (OR = 6.9, 95%CI = 1.7-46.5, *p* = .02).

Discussion

This is the first study to identify both the prevalence and correlates of suicidal behaviours for a cohort of Indigenous males in custody. The motivations for this analysis were underpinned by three key phenomena. First, offenders regularly possess numerous socio-historical and clinical factors that increase their risk for suicide. Second, Indigenous, and in particular Aboriginal, people are over-represented in custody. Third, Indigenous people are at a higher risk for suicide in the general community. Moreover, suicide is a leading cause of death in custodial settings, and prisoners are at a high risk for mortality on release from custody. An understanding of the predictors of suicidal ideation and suicide attempts for Indigenous people in custody is therefore overdue to help assist custodial and post-release mental health services detect and manage at-risk clients.

Prevalence of suicidal behaviours

Findings indicated that the majority of study participants with available data had engaged in suicidal behaviours. Approximately 64% of participants reported lifetime ideation and approximately 28% reported ideation during the past 12 months. More than half the sample (54.5%) had attempted suicide. These proportions are higher than previous Australian studies with male Indigenous prisoners (from New South Wales and Queensland) which range from approximately 18% to 35% for lifetime ideation and 12% to 25% for lifetime attempts[9, 39, 40]. The discrepancy between the prevalence of suicidal behaviours among Indigenous males in

Table 2 Correlates of lifetime suicidal ideation

	No suicidal ideation (*N* = 35)			Suicidal ideation (*N* = 61)				
	n	%	(95% CI)	n	%	(95% CI)	OR (95%CI)	AOR (95%CI)[a]
Number of times in custody	–	–	–	–	–	–	1.0 (0.9-1.1)	1.0 (0.9-1.2)
No suicide of close friend or relative	14	40	24-58	17	28	18-41	–	–
Suicide of close friend or relative	21	60	42-76	44	72	59-82	1.7 (0.7-4.2)	1.2 (0.4-3.1)
Non rural/remote	15	43	27-60	27	44	32-57	–	–
Rural/remote	20	57	40-73	34	56	43-68	0.9 (0.4-2.2)	1.2 (0.5-3.4)
No lifetime mood disorder	24	69	51-83	33	54	41-67	–	–
Lifetime mood disorder	11	31	17-49	28	46	33-59	1.9 (0.8-4.6)	2.1 (0.8-6.1)
No lifetime substance use disorder	11	31	17-49	18	30	19-43	–	–
Lifetime substance use disorder	24	69	51-83	43	70	57-81	1.1 (0.4-2.7)	0.8 (0.3-2.0)
No lifetime anxiety disorder	30	86	69-95	43	70	57-81	–	–
Lifetime anxiety disorder	5	14	5-31	18	30	19-43	2.5 (0.9-8.3)	1.7 (0.5-6.0)
No lifetime psychotic disorder	33	94	79-99	52	85	73-93	–	–
Lifetime psychotic disorder	2	6	1-21	9	15	7-27	2.9 (0.7-19.5)	3.5 (0.7-26.7)
No lifetime PTSD	33	94	79-99	48	79	66-88	–	–
Lifetime PTSD	2	6	1-21	13	21	12-34	4.5 (1.1-29.8)	4.1 (0.9-29.7)

[a]Odds ratios are adjusted for all variables listed in the model

Table 3 Correlates of suicidal ideation in previous 12 months

	No suicidal ideation (*N* = 60)			Suicidal ideation (*N* = 22)				
	N	%	(95% CI)	n	%	(95% CI)	OR (95%CI)	AOR (95%CI)[a]
Current length of time spent in custody	–	–	–	–	–	–	1.0 (0.99-1.02)	1.0 (0.99-1.02)
No close friend or relative passed away in previous 12 months	34	57	43-69	5	23	9-46	–	–
Close friend or relative passed away in previous 12 months	26	43	31-57	17	77	54-91	4.4 (1.5-15.0)**	5.3 (1.6-20.9)**
No diagnosis of PTSD	52	87	75-94	16	73	50-88	–	–
Diagnosis of PTSD	8	13	6-25	6	27	12-50	2.4 (0.7-8.1)	1.9 (0.5-7.8)
No lifetime mood disorder	38	63	50-75	11	50	31-69	–	–
Lifetime mood disorder	22	37	25-50	11	50	31-69	1.7 (0.6-4.7)	2.2 (0.7-7.9)
No lifetime substance use disorder	18	30	19-43	5	23	9-46	–	–
Lifetime substance use disorder	42	70	57-81	17	77	54-91	1.5 (0.5-5.0)	2.0 (0.5-9.1)
No anxiety disorder	48	80	67-89	14	64	40-82	–	–
Anxiety disorder	12	20	11-33	8	36	18-59	2.3 (0.8-6.7)	2.3 (0.6-8.6)
No psychotic disorder	53	88	77-95	19	86	64-96	–	–
Psychotic disorder	7	12	5-23	3	14	4-36	1.2 (0.2-4.8)	0.7 (0.1-3.7)
Non rural/remote	28	47	34-60	8	36	18-59	–	–
Rural/remote	32	53	40-66	14	64	40-82	1.5 (0.6-4.3)	2.8 (0.8-11.2)

[a]Odds ratios are adjusted for all variables listed in the model
[**]p < .01

custody in Victoria as documented in this study, and other jurisdictions are sizable. There may be methodological differences across studies (i.e., data collection approaches). This study comprised a wide-ranging and detailed interview that included cultural aspects and was conducted with an Indigenous well-being officer. It is possible that participants in this study felt particularly comfortable disclosing personal/sensitive information. A study from Western Australia which employed similar collection methods to this study, also discovered a higher than average prevalence of suicidal ideation and attempts for male and female Indigenous prisoners[45]. Although research from Queensland found much lower proportions of suicidal behaviours for male Indigenous prisoners using similar interview methods[46]. The higher proportions of suicidal behaviour in this study may also be a reflection of the poor health and social conditions experienced by some Indigenous males in Victoria, and particularly those who are justice-involved[47].
In line with prior research, the majority

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Table 4 Correlates of suicide attempts

	No suicide attempt(*N* = 40)			Suicide attempt (*N* = 45)				
	N	%	(95% CI)	N	%	(95% CI)	OR (95%CI)	AOR (95%CI)[a]
Number of times in custody	–	–	–	–	–	–	1.0 (0.96-1.1)	1.0 (0.96-1.2)
No suicide of close friend or relative	14	35	21-52	13	29	17-45	–	–
Suicide of close friend or relative	26	65	48-79	32	71	55-83	1.3 (0.5-3.3)	0.6 (0.1-2.4)
No diagnosis of PTSD	38	95	82-99	33	73	58-85	–	–
Diagnosis of PTSD	2	5	1-18	12	27	15-42	6.9 (1.7-46.5)*	5.1 (0.8-62.0)
No lifetime mood disorder	28	70	53-83	22	49	34-64	–	–
Lifetime mood disorder	12	30	17-47	23	51	36-66	2.4 (1.0-6.1)	2.7 (0.7-11.2)
No lifetime substance use disorder	15	38	23-54	10	22	12-37	–	–
Lifetime substance use disorder	25	62	46-77	35	78	63-88	2.1 (0.8-5.6)	2.7 (0.7-10.8)
No anxiety disorder	34	85	69-94	30	67	51-80	–	–
Anxiety disorder	6	15	6-31	15	33	20-49	2.8 (1.0-8.8)	1.5 (0.3-7.4)
No psychotic disorder	37	93	79-98	38	84	70-93	–	–
Psychotic disorder	3	7	2-21	7	16	7-30	2.3 (0.6-11.2)	1.4 (0.2-12.3)
No lifetime suicidal ideation	23	58	41-73	1	2	0-13	–	–
Suicidal ideation	17	43	27-59	44	98	87-100	59.5 (11.2-1107.1)***	58.2 (9.6-1159.6)***
Non rural/remote	16	40	25-57	22	49	34-64	–	–
Rural/remote	24	60	43-75	23	51	36-66	0.7 (0.3-1.6)	0.7 (0.2-2.8)

[a]Odds ratios are adjusted for all variables listed in the model
***p < .05; ***p < .001**

continued from page 27

of participants who reported suicidal behaviours endured these experiences in the community[46]. Access to suitable mental health services/interventions in the community may also be limited for some Indigenous Victorians at risk for suicide in the community. Furthermore, correctional health care services may also be limited in their capacity to identify/ manage/reduce risk factors for suicide for Indigenous people who frequently transition between custody and the community. The state of Victoria has one of the lowest imprisonment rates in the country and also hosts the smallest proportion of Indigenous prisoners of any Australian state or territory[26]. As such, Indigenous people in custody in Victoria may be more likely to possess numerous unmet health and social needs and pose a heightened risk for suicidal and offending behaviours.

Correlates of suicidal behaviours

For participants in this study, none of the variables significantly predicted lifetime suicidal ideation, while bereavement was associated with more immediate ideation. The presence of ideation generally, predicted a suicide attempt along with a diagnosis of PTSD. Substance use disorder, custodial history or community location were not predictive of suicidal behaviours for the cohort.

The sole predictor of recent (12 month) suicidal ideation in the multivariate model was having a close friend or family member pass away over the past 12 months. Cycles of bereavement are commonplace in communities where there are a high numbers of premature and preventable deaths[13]. Grief in these circumstances may be particularly heightened due to the regularity of death, particularly of younger friends and family members, the rates at which the deaths are by suicide and the importance and meaning many Indigenous people afford to family/ community connection[13]. For those who are incarcerated grief may be unresolved due to the lack of social support and distance from community during this time, prompting bouts of suicidal ideation.

There were no significant predictors of lifetime suicidal ideation in the model. However the odds of lifetime suicidal ideation occurring when a diagnosis of either PTSD or a psychotic disorder were present was particularly high compared to an absence of the disorders. Both PTSD[48, 49] and Psychosis[50] are commonly linked with suicidal behaviours in the general population. Moreover high rates of PTSD[51] and psychotic disorders[29, 40, 52] have been identified in correctional samples with PTSD/experiences of trauma associated with lifetime suicidal behaviours among prisoners[53, 54]. Rates of PTSD and links with suicidal behaviours are especially pronounced for Indigenous prisoners[55].

A diagnosis of PTSD was also one of two significant predictors of lifetime suicide attempts in this study, although this relationship was at the univariate level. High rates of violence (intimate partner violence, physical and sexual assault) have been reported in some Indigenous communities increasing the likelihood of experiencing various traumas. Indigenous prisoners' lives are often punctuated with numerous traumatic events including violence exposure, separation from family and personal loss[56, 57]. Moreover, a body of literature on Historical Trauma describes the downstream collective impact of past colonial injustices such as state sanctioned child removal, land dispossession, social exclusion, discrimination and forced acculturation on subsequent Indigenous

generations[4, 58-60]. Here, a personal sense of loss, grief and hopelessness is inextricably linked to collective experiences of trauma and despair[61]. While the nature and extent of the trauma witnessed by participants was unspecified in this study, its presence relative to its absence appears to significantly increase suicide risk. Indigenous male prisoners have been found to present with more traumatic symptomatology than non-Indigenous male prisoners[62]. The second, and strongest predictor of a suicide attempt was lifetime suicidal ideation. This finding was particularly salient. Almost three-quarters of participants reporting lifetime ideation had made a suicide attempt, indicating a pronounced link between these two actions in this sample. The ideation-attempt relationship has been established in prior forensic research, yet may be stronger in Indigenous populations[3]. This finding suggests that correctional institutions must make a concerted effort to carefully identify and monitor Indigenous clients who present with, or have histories of suicidal ideation.

Some caution is advised when generalising the findings to Indigenous men in custody in other regions of Australia, or women in custody as there are likely to be gendered issues for justice-involved men and women. Moreover, while the MINI has been administered to Indigenous populations in prior research, it is not known as to whether the assessment is culturally appropriate[63] or concordant with clinical diagnoses for such populations. It is also possible that mood and anxiety disorders may have been over-estimated by the MINI as has been found in prior research with general populations[43]. Estimates must also be considered in light of the small sample size. The present findings indicate considerable variability in confidence interval estimates, which is likely due to the low event per variable ratio in the current analysis[64]. Moreover the sample size did not allow for additional predictors to be added to the models. As such, we preferenced factors that we believed were most relevant in relation to suicidal behaviours. Further research should aim to identify which strength factors (i.e., resilience, cultural engagement, wellbeing etc.) lower the risk of suicidal behaviours.

Implications

The correlates of suicidal behaviours for Indigenous people in custody in Victoria likely manifest in the community, denoting a public health response. Such a response needs to be considered within an Aboriginal and Torres Strait Islander men's health and wellbeing framework. Trauma and bereavement are key factors, and point to the various social challenges faced by many Indigenous people. Surveys of the general Australian Indigenous population have discovered high rates family stressors and trauma exposure[65, 66]. In addition, the death of close family members and mental health problems are reported by a large minority[65]. Prevention must therefore begin in communities where these issues are particularly widespread and suicidal behaviour is high. The development of low-intensity mental health service infrastructure in affected communities to promote awareness and provide accessible, culturally informed support and treatment is required. This may include least-restrictive evidence based interventions that have flexible delivery and dosage options and can be administered or overseen by a range of service professionals. Moreover, community-based wellbeing workers could be trained to recognize risk factors, provide immediate aid and then link the individual with clinical services[67, 68]. Assistance to family members and peers who have recently been affected by suicide should be a part of any program. Seasonal variations in service intensity should also be considered given that suicidal behaviours in some Indigenous communities are increased during the hotter months. Evidently, accessible mental health services are just one component of a broader set of socio-economic and community factors underpinning suicidal behaviours. It is likely that such regions also undergo social and economic exclusion community dysfunction, family conflict and frequent law-breaking behaviour. Indigenous prisoners may disproportionately reside in such settings, often described as 'pathogenic' neighbourhoods[68]. As such, many Indigenous males in this study may have arrived in custody with pre-existing, unmet mental health concerns and some with unresolved anger, frustration and grief.

Although disconnection from family and community and the rigors of prison life may exacerbate these pathologies, evidence suggests that most Indigenous prisoners experience improved mental health and self-care during periods of incarceration[69, 70]. Better access to mental health care, general health care, daily routine and structure, and opportunities for social and cultural activities perhaps contribute to this outcome[70-72]. Nonetheless, correctional institutions should continue to improve custodial suicide prevention and management initiatives. Prison presents an opportunity to address the needs of vulnerable at-risk clients through therapy, improving coping skills and providing opportunities for meaningful activities. Screening for suicide-risk and the regular monitoring of clients with histories of suicidal behaviours and/ or current acute levels of distress are useful preventive mechanisms[33]. This requires that corrections staff are trained in mental health first aid and recognizing risk factors for suicidal behaviours. The evidence for an increased post-release suicide risk for Indigenous prisoners is equivocal. However, a return to a community with numerous social challenges and a communal high risk for suicide may increase the individual's risk for suicide on release. It is important that the predictors of suicidal behaviours identified in this study (mood disorders, exposure to trauma, bereavement) and their antecedents are addressed prior to, during and after re-entry. A dearth of treatment options in these spaces, particularly when transitioning back to the community, will ensure a continued risk for suicidal behaviours and possibly re-offending.

Conclusion

This study found that a high proportion of Indigenous men in custody in Victoria have experienced lifetime suicidal ideation and over one-half have attempted suicide. A smaller, though not insignificant number had experienced ideation over the past 12 months. Having a loved one pass away within the past 12 months predicted recent ideation. Lifetime ideation and a diagnosis of PTSD were significant predictors of a lifetime suicide attempt.

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Deaths in custody in Australia 2018-19 (Extract)

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Introduction

The National Deaths in Custody Program (NDICP) monitors the extent and nature of deaths occurring in prison, police custody and youth detention from 1980 onwards. The NDICP was established at the Australian Institute of Criminology (AIC) in 1992 in response to recommendation 41 of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC): that 'statistics and other information on Aboriginal and non-Aboriginal deaths in prison, police custody and juvenile detention centres, and related matters, be monitored nationally on an ongoing basis… within the Australian Institute of Criminology'. The final report of the RCIADIC outlined the types of deaths that would require notification to the NDICP (recommendation 41, RCIADIC 1991). They are:

- a death, wherever occurring, of a person who is in prison custody, police custody or youth detention;
- a death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care, while in such custody or detention;
- a death, wherever occurring, of a person who dies, or is fatally injured, in the process of police or prison officers attempting to detain that person; or
- a death, wherever occurring, of a person attempting to escape from prison, police custody or youth detention.

Box 1: Definitions of deaths in custody

Deaths in prison custody

Deaths in prison custody include deaths that occur in prison or youth detention facilities. This also includes the deaths that occur during transfer to or from prison or youth detention centres, or in medical facilities following transfer from adult or youth detention centres (RCIADIC 1991).

Deaths in police custody

Deaths in police custody are divided into two main categories:[a]

Category 1

(a) Deaths in institutional settings (eg police stations or lock-ups, police vehicles, during transfer to or from such an institution, or in hospitals following transfer from an institution).

(b) Other deaths in police operations where officers were in close contact with the deceased. This would include most raids and shootings by police. However, it would not include most sieges where a perimeter was established around a premise but officers did not have such close contact with the person to be able to significantly influence or control the person's behaviour.

Category 2

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

a: This definition of a 'death in police custody' is based on a resolution of the Australasian Police Ministers' Council in 1994. Category 1(a) deaths have been included in the NDICP since 1980, whereas police operational deaths (category 1(b) and category 2 deaths) have been collected by the NDICP since 1990

This report examines the extent and nature of deaths occurring in prison and police custody and custody-related operations in 2018-19, and compares these findings to long-term trends. Definitions of these categories are presented in Box 1.

Data used for the NDICP are based on two main sources: data provided by state and territory police services and corrections departments; and coronial records accessed through the National Coronial Information System (NCIS). For more information about the NDICP and its methodology, see *Appendix A*.

In the 28 years since the RCIADIC (1991), there have been 455 Indigenous deaths in custody (ie prison custody, police custody and custody-related operations and youth justice; see Table C2).

Deaths in prison custody

2018-19 findings

In 2018-19 there were 89 deaths in prison custody (see Table B1), 17 more than in 2017-18 (see Table D1). This is the highest number of deaths in prison custody since NDICP data collection began, attributable to the increasing prisoner population. The death rate also increased, from 0.17 to 0.21 per 100 prisoners (see Figure 1). The death rate in 2018-19 was higher than the average for the previous decade (0.17 per 100 for 2008-09 to 2017-18).

The largest number of deaths in prison custody occurred in New South Wales (*n*=33), followed by Victoria (*n*=19) and Western Australia (*n*=15; see Table

continued on page 34

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B1). Consistent with 2017-18, there were no deaths in the Australian Capital Territory. The death rate was highest in Tasmania (0.29 per 100), followed by New South Wales (0.25 per 100) and Victoria (0.23 per 100).

Between 2017-18 and 2018-19 there were increases in the number of deaths occurring in New South Wales (+6), Victoria (+2), Western Australia (+4), South Australia (+4) and Tasmania (+1; see Table D1). The number of deaths remained the same in Queensland (*n*=11), the Australian Capital Territory (*n*=0) and the Northern Territory (*n*=3). No jurisdiction recorded a decrease in the number of deaths.

Indigenous status

In 2018-19 there were 16 Indigenous deaths in prison custody (see Table B1), accounting for 18 percent of all deaths in prison custody over the period. In comparison, Indigenous prisoners made up 28 percent (*n*=11,866) of the Australian prisoner population at 30 June 2019 (Australian Bureau of Statistics (ABS) 2019b). The highest number of Indigenous deaths in prison custody in 2018-19 occurred in Western Australia (*n*=5), followed by New South Wales (*n*=4) and the Northern Territory (*n*=3; see Figure 2). No Indigenous deaths occurred in South Australia or Tasmania. There were 73 non-Indigenous deaths in prison custody in 2018-19, the highest number recorded since 1979-80. The highest number of non-Indigenous deaths occurred in New South Wales (*n*=29), followed by Victoria (*n*=17) and Western Australia (*n*=10).

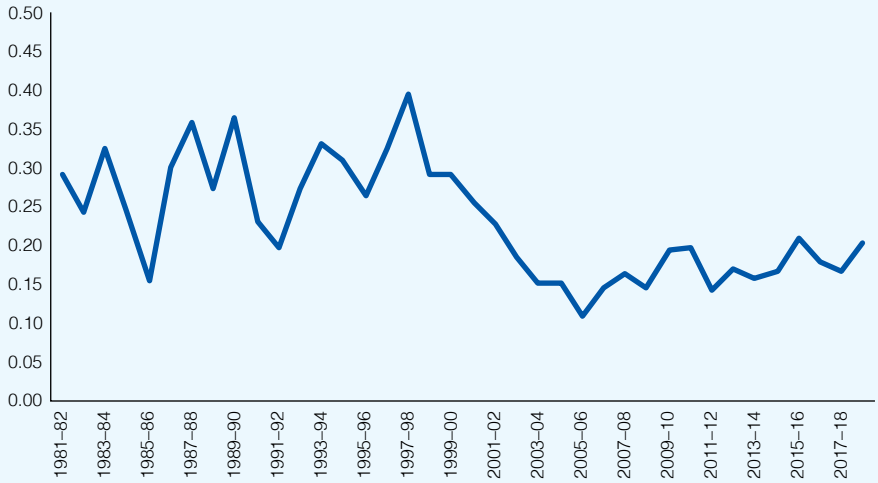
The death rate of Indigenous prisoners was 0.13 per 100 prisoners (see Table B1), and 3.11 per 100,000 Aboriginal and Torres Strait Islander population aged 18 years and over (see Table B2). The death rate for Indigenous prisoners was highest in Victoria (0.24 per 100 prisoners), followed by the Northern Territory (0.21 per 100 prisoners) and Western Australia (0.19 per 100 prisoners; see Table B1). Comparatively, the death rate of non-Indigenous prisoners was 0.23 per 100 prisoners (see Table B1), and 0.38 per 100,000 non-Indigenous population aged 18 years and over (see Table B2). It was highest for non-Indigenous prisoners in Tasmania (0.36 per 100 prisoners), followed by New South Wales and South Australia (0.28 per 100 prisoners for each; see Table B1).

Between 2017-18 and 2018-19, the number of Indigenous deaths in prison custody remained stable (*n*=16; see Table D2), while the number of non-Indigenous deaths in prison custody increased by 17 (from *n*=56 to *n*=73; see Table D3). Over the same time period, there was a small decrease in the death rate of Indigenous prisoners (from 0.14 to 0.13 per 100) and an increase in the death rate of non-Indigenous prisoners (from 0.18 to 0.23 per 100; see Table D5).

The death rate of Indigenous prisoners was lower than the death rate of non-Indigenous prisoners nationally (0.13 and 0.23 per 100 respectively), and in all jurisdictions except for Victoria (0.24 vs 0.23 per 100 prisoners) and the Northern Territory (0.21 vs 0.00 per 100 prisoners; see Table B1). Death rates of Indigenous prisoners have been consistently lower than the death rates of non-Indigenous prisoners since 2003-04 (see Figure 3).

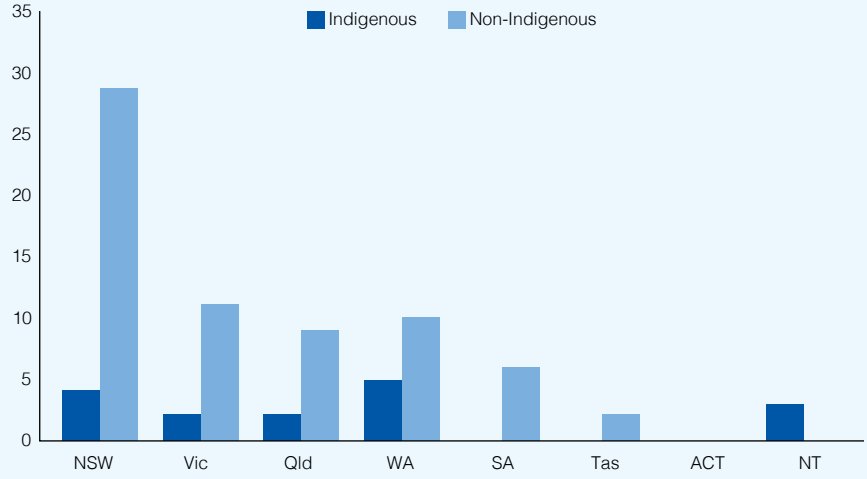
In 1991, the RCIADIC concluded that Indigenous persons were no more likely to die in custody than non-Indigenous persons, but were significantly more likely to be arrested and imprisoned. The same

Figure 1: Deaths in prison custody, 1981-82 to 2018-19 (rate per 100 prisoners)



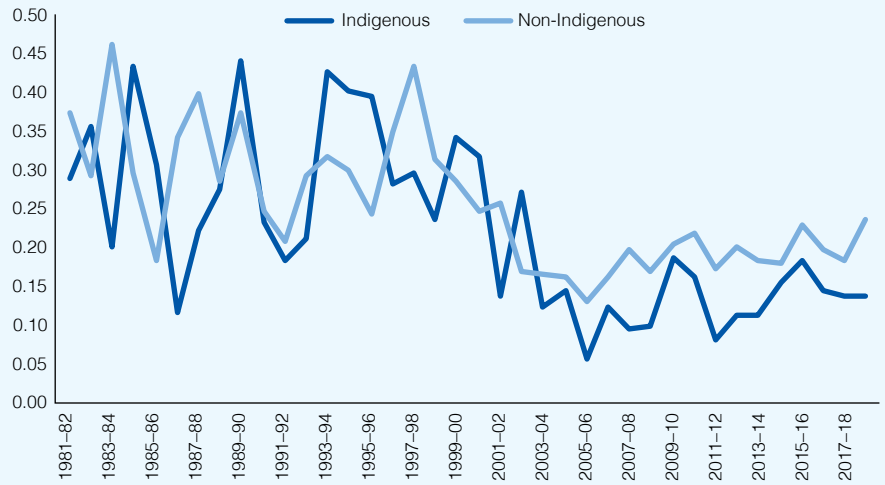
Source: AIC NDICP 1981-2019 [computer file]; see Table D5

Figure 2: Deaths in prison custody by jurisdiction and Indigenous status, 2018-19 (*n*)



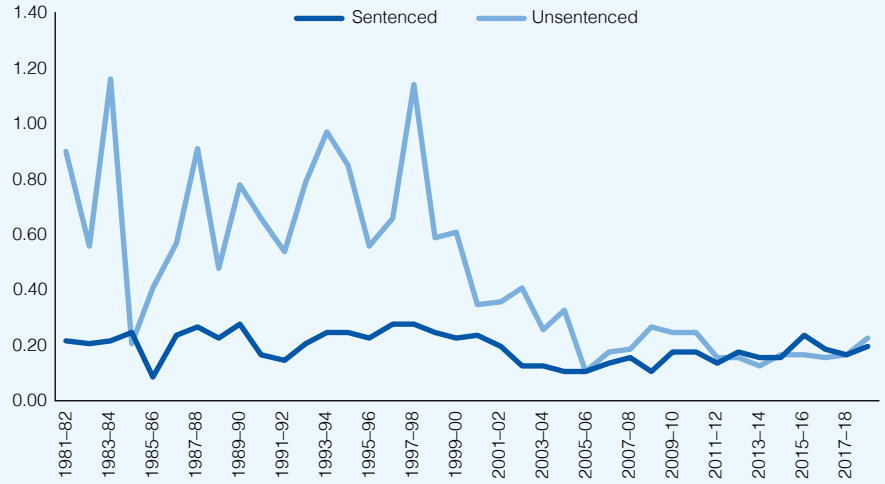
Source: AIC NDICP 2018-19 [computer file]; see Table B1

Figure 3: Deaths in prison custody by Indigenous status, 1981-82 to 2018-19 (rate per 100 relevant prisoners)



Source: AIC NDICP 1981-2019 [computer file]; see Table D5

Figure 4: Deaths in prison custody by legal status, 1981-82 to 2018-19 (rate per 100 relevant prisoners)



Source: AIC NDICP 1981-2019 [computer file]; see Table D12

remains true today. The most recent Australian census found that Aboriginal and Torres Strait Islanders comprise three percent of the Australian population (ABS 2017). In comparison, Indigenous prisoners made up 28 percent (*n*=11,866) of the Australian prisoner population at 30 June 2019 (ABS 2019b). Further, the Indigenous imprisonment rate was 12 times the rate for non-Indigenous prisoners in 2019, and has increased by 35 percent since 2009, compared to an increase of 26 percent for non-Indigenous prisoners (ABS 2019b).

In the 28 years since the RCIADIC (1991), there have been 295 Indigenous deaths in prison custody (see Table C2).

Gender

Eighty-seven males and two females died in prison custody during 2018-19, representing death rates of 0.22 and 0.06 per 100 prisoners respectively (see Table B1). The death rate for male prisoners increased by 22 percent between 2017-18 and 2018-19 (from 0.18 per 100 in 2017-18), while the death rate for female prisoners remained stable (see Table D6).

Of the 87 male prisoner deaths in 2018-19, 16 were Indigenous males and 71 were non-Indigenous males (see Table D4). This represents death rates of 0.15 and 0.25 per 100 male prisoners (see Table B1) and 6.30 and 0.75 per 100,000 relevant population respectively (see Table B2). Both female deaths in prison custody in 2018-19 were non-Indigenous women, representing a death rate of 0.09 per 100 non-Indigenous female prisoners (see Table B1) and 0.02 per 100,000 non-Indigenous female population (see Table B2).

The number of male deaths in custody has been consistently higher than the number of female deaths in custody since 1979-80 (see Table D4), reflecting the composition of the total Australian prisoner population (ABS 2000-2018, 2019b). For every female death in prison custody since 1979-80, there have been approximately 24.6 male deaths in prison custody. In comparison, for every woman imprisoned in Australia at 30 June 2019, there were approximately 11.3 men imprisoned (ABS 2019b).

Age

The median age at time of death for prisoners in 2018-19 was 49 years (see Table B1), while the median age of all prisoners in Australia at 30 June 2019 was 35 years (ABS 2019b). Indigenous prisoners had a lower median age at time of death than non-Indigenous prisoners (47 and 52 years respectively). In comparison, the median age of Indigenous prisoners was 32 years and the median age of non-Indigenous prisoners was 36 years (ABS 2019b).

The greatest proportion of deaths in prison custody occurred in prisoners aged over 55 (46%, *n*=41). This represents a death rate of 1.19 per 100 prisoners aged 55 years and over (see Table B1). Since 2017-18, the number of deaths of prisoners in this age category increased by 15 (see Table D7), and the death rate increased by 51 percent (from 0.79 per 100 in 2017-18; see Table D10).

Half of Indigenous prisoner deaths in 2018-19 were of those aged between 40 and 54 years (50%, *n*=8), whereas the death rate was highest for Indigenous prisoners aged 55 years and over (1.85 per 100; see Table B1). Since 2017-18, there has been an increase in the number of Indigenous prisoner deaths in both of these age categories (see Table D8). Nearly half of non-Indigenous prisoners who died were aged over 55 (48%, *n*=35), and the death rate was also highest for this age group (1.12 per 100; see Table B1).

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In each year since prison population data became available in 1981-82, the death rate has been the highest among prisoners aged 55 years and over (see Table D10).

Legal status

At 30 June 2019, 67 percent (*n*=28,721) of all prisoners in Australia were serving a sentence (ABS 2019b). In 2018-19, 63 percent (*n*=56) of deaths in prison custody were of sentenced prisoners. This represents a decrease in the proportion of deaths of sentenced prisoners compared to 2017-18 (67%, *n*=48; see Table D11).

In 2018-19, the death rate of sentenced prisoners was lower than that of unsentenced prisoners (0.19 vs 0.23 per 100; see Table B1). Among non-Indigenous prisoners, the death rate of sentenced prisoners was lower than that of unsentenced prisoners (0.22 vs 0.27 per 100), whereas for Indigenous prisoners the rates were comparable (0.13 and 0.12 per 100 respectively).

The death rate of unsentenced prisoners remained lower than the peak death rate recorded in 1983-84 (1.16 per 100; see Figure 4). Similarly, the death rate of sentenced prisoners has remained consistently lower than the peak of 0.28 per 100 prisoners recorded in 1989-90, in 1996-97 and in 1997-98 (see Table D12).

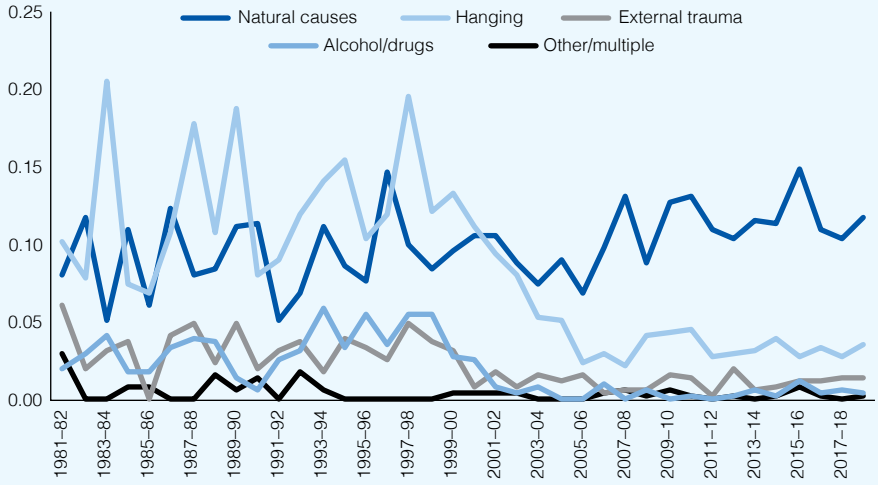
Cause of death

The cause of death was recorded for 75 of the 89 deaths in prison custody in 2018-19. Most of these 75 deaths were due to natural causes (68%, *n*=51; see Table B1). The remaining deaths were due to hanging and associated complications (all of which were self-inflicted; 20%, *n*=15), external trauma (8%, *n*=6), alcohol and/or drugs (3%, *n*=2) and other or multiple causes (1%, *n*=1). Prisoners aged over 55 accounted for almost two-thirds of natural cause deaths (63%, *n*=32), whereas prisoners aged under 55 made up the majority of hanging deaths (87%, *n*=13).

Three-quarters of natural cause deaths were of sentenced prisoners (76%, *n*=39), and the natural cause death rate was higher among sentenced prisoners than unsentenced prisoners (0.14 vs 0.08 per 100). Conversely, most hanging deaths were of unsentenced prisoners (73%, *n*=11), representing a death rate of 0.08 per 100 prisoners. This was higher than the rate of hanging deaths of sentenced prisoners (0.01 per 100).

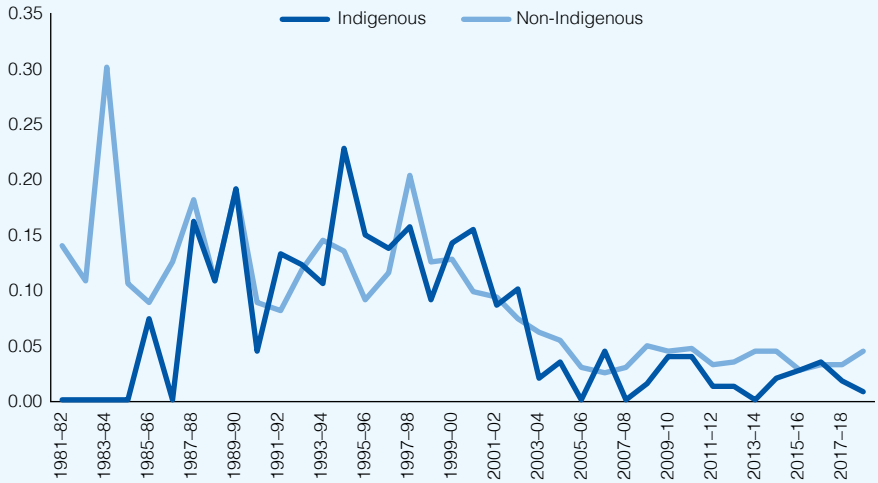
The cause of death was recorded for 13 of the 16 Indigenous and 62 of the 73 non-Indigenous deaths in prison custody in 2018-19. Natural causes were the most common cause of death for both Indigenous (85%, *n*=11) and non-Indigenous prisoners (65%, *n*=40; see Table B1). The rate of natural cause deaths was higher for non-Indigenous prisoners than Indigenous prisoners (0.13 vs 0.09 per 100). The specific cause of death was known in 10 of the 11 Indigenous deaths that were attributable to natural causes. Three of these deaths were from heart disease or related ailments, two were from cancer, two were from respiratory conditions and one was from each of infectious diseases, other conditions and multiple conditions. Of the 29 non-Indigenous natural cause deaths where the specific cause of death was recorded, most (52%, *n*=15) were from cancer, followed by respiratory conditions (21%, *n*=6) and heart disease or related ailments (14%, *n*=4).

Figure 5: Deaths in prison custody by cause of death, 1981-82 to 2018-19 (rate per 100 prisoners)



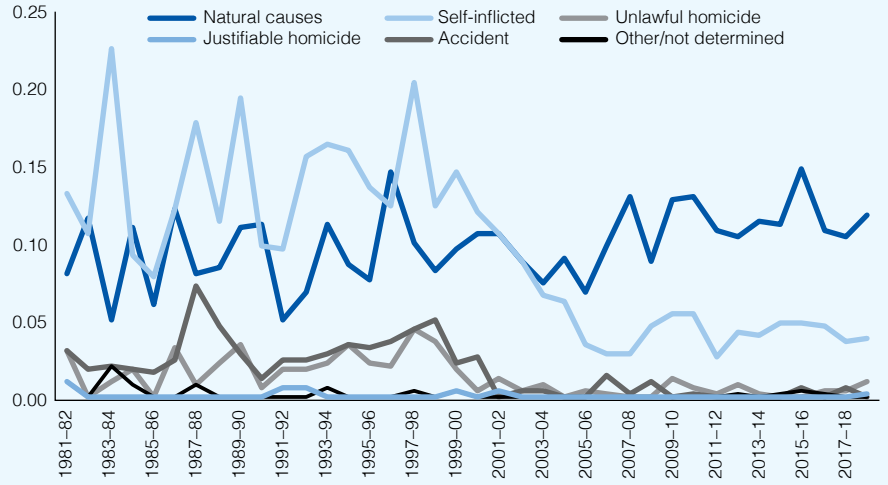
Note: External trauma includes head injuries and gunshot wounds
Source: AIC NDICP 1981-2019 [computer file]; see Table D16

Figure 6: Hanging deaths in prison custody by Indigenous status, 1981-82 to 2018-19 (rate per 100 relevant prisoners)



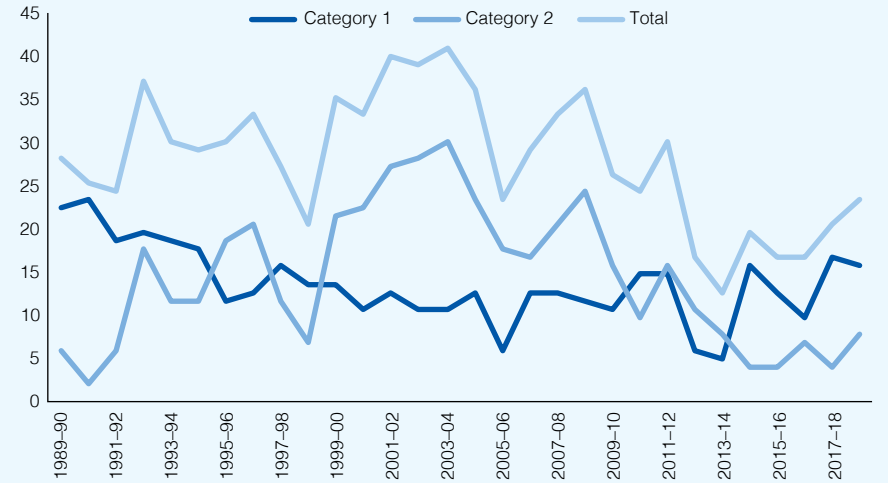
Source: AIC NDICP 1981-2019 [computer file]; see Table D17

Figure 7: Deaths in prison custody by manner of death, 1981-82 to 2018-19 (rate per 100 prisoners)



Note: Self-inflicted includes self-harm, whether intentional, unintentional or unknown intent, and accidental hangings
Source: AIC NDICP 1981-2019 [computer file]; see Table D21

Figure 8: Deaths in police custody and custody-related operations, 1989-90 to 2018-19 (*n*)



Note: For a definition of these categories, see Box 1 in the Introduction
Source: AIC NDICP 1989-2019 [computer file]; see Table E4

Of the 15 deaths attributed to hanging and associated complications, one was of an Indigenous prisoner and 14 were of non-Indigenous prisoners. The rate of hanging deaths was lower for Indigenous prisoners than non-Indigenous prisoners (0.01 vs 0.04 per 100). Consistent with previous years, most (53%, *n*=8) of the hanging deaths in prison custody involved the use of bed sheets. The most common hanging point was a cell fitting other than cell bars (60%, *n*=9), such as a cell door. Cell bars were used as a hanging point in one death. The number of hanging deaths in which cell bars were used as the hanging point has decreased since 2004-05, accounting for no more than three deaths per year.

The number of natural cause deaths has exceeded the number of hanging deaths since 2001-02 (see Table D13). Between 2017-18 and 2018-19, there was a slight increase in the number (45 vs 51; see Table D13) and rate (0.10 vs 0.12 per 100; see Table D16) of natural cause deaths. The rate of hanging deaths remained stable over this period (0.03 per 100 prisoners), representing an 86 percent decrease since the rate of hanging deaths reached its peak in 1983-84 (see Figure 5). The rate of Indigenous hanging deaths has remained the same or lower than the rate of non-Indigenous hanging deaths in all but one year over the last decade (see Figure 6).

Manner of death

The NDICP collects information on both the cause and manner of each death. Cause of death information relates to the direct cause of death, whereas the manner of death refers to the accountability or responsibility for the death (see *Appendix A*).

In 2018-19 the leading manner of death was natural causes (*n*=51), exceeding self-inflicted deaths (*n*=17) for the sixteenth year in a row (see Table D18). Five deaths were attributed to unlawful (prisoner-on-prisoner) homicide, the largest number of unlawful homicides in prison custody since 1998-99 (*n*=8). One death was classified as a justifiable homicide, the first to occur in prison custody since 2001-02. The manner of death was not recorded in a further 15 cases.

The death rate was highest for natural cause deaths (0.12 per 100), exceeding self-inflicted deaths (0.04 per 100; see Table B1). The death rate for natural cause deaths has exceeded that of self-inflicted deaths since 2004-05 (see Figure 7). The rate of death attributable to natural causes was higher for non-Indigenous prisoners than for Indigenous prisoners (0.13 vs 0.09 per 100), as was the rate of self-inflicted deaths (0.05 vs 0.01 per 100; see Table B1).

Of the 17 self-inflicted deaths, 15 were attributed to hanging and related complications, one was attributed to external trauma, and one was attributed to other/multiple causes (see Table B3).

Of the three unlawful homicides in which the cause of death was known, all were attributed to external trauma. Finally, the one justifiable homicide was attributed to external trauma.

Most serious offence

The NDICP collects information on the most serious offence (MSO) leading to custody (see *Appendix A*). Of the 89 persons who died in prison custody in 2018-19, most had been incarcerated for a violent offence (73%, *n*=65), followed by theft-related offences (11%, *n*=10; see Table B1). In comparison, just over half of all prisoners in Australia as at 30 June 2019 were incarcerated for a violent offence (56%, *n*=24,151), and 15 percent (*n*=6,665) were incarcerated for a theft-related offence (ABS 2019b). Violent offences were the most common MSO

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for both Indigenous (81%, *n*=13) and non-Indigenous (71%, *n*=52) prisoners who died in prison custody in 2018-19. Each year since 1993-94, violent offences have been the most common MSO recorded for those who died in prison (see Table D22).

Location of death

The most common location at time of death was a cell (47%, *n*=42), followed by a public hospital (28%, *n*=25) and a prison hospital (18%, *n*=16; see Table B1). Four Indigenous and 38 non-Indigenous prisoners died in a cell. Seven Indigenous and 18 non-Indigenous prisoners died in a public hospital. Since 1979-80, almost half of all prison deaths have occurred in a cell (49%, *n*=940; see Table D25).

Type of prison

In 2018-19, most deaths in prison custody occurred while the prisoner was in the custody of a government-run prison (80%, *n*=71), with fewer occurring while the prisoner was in the custody of a privately-run prison (20%, *n*=18; see Table B1). Based on prison population estimates from the Steering Committee for the Review of Government Service Provision (2020), the rate of death was the same in government-run and privately-run prisons (0.21 per 100).

Deaths in police custody and custody-related operations

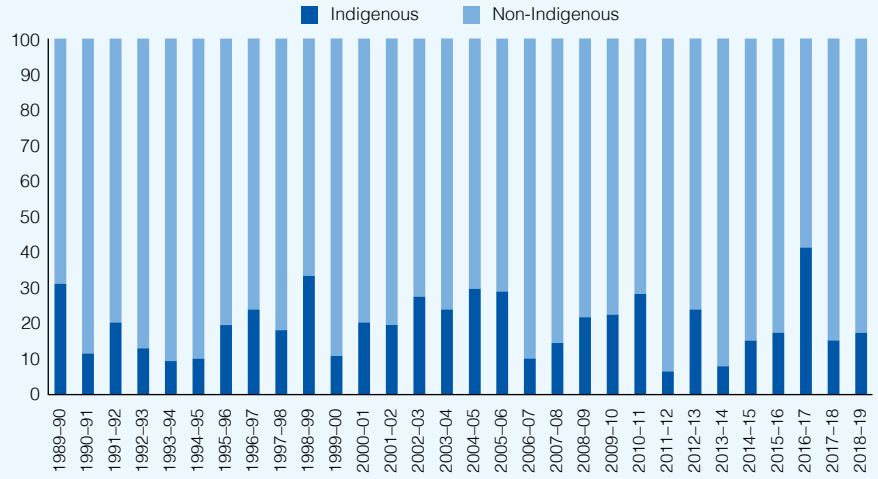
2018-19 findings

In 2018-19 there were 24 deaths in police custody and custody-related operations (hereafter referred to as police custody) in Australia (see Table B4), three more than in the previous year. The number of deaths in police custody fluctuates annually, which is attributable to the small number of deaths overall (see Figure 8). Death rates in police custody are not calculated due to the lack of national police custody population data. Instead, the death rate by Indigenous status and gender described below is calculated as a population rate.

The largest number of deaths in police custody occurred in Western Australia (*n*=6; see Table B4). There were five deaths in each of New South Wales, Victoria and Queensland, two in South Australia and one in Tasmania. No deaths in police custody were recorded in the Australian Capital Territory or the Northern Territory.

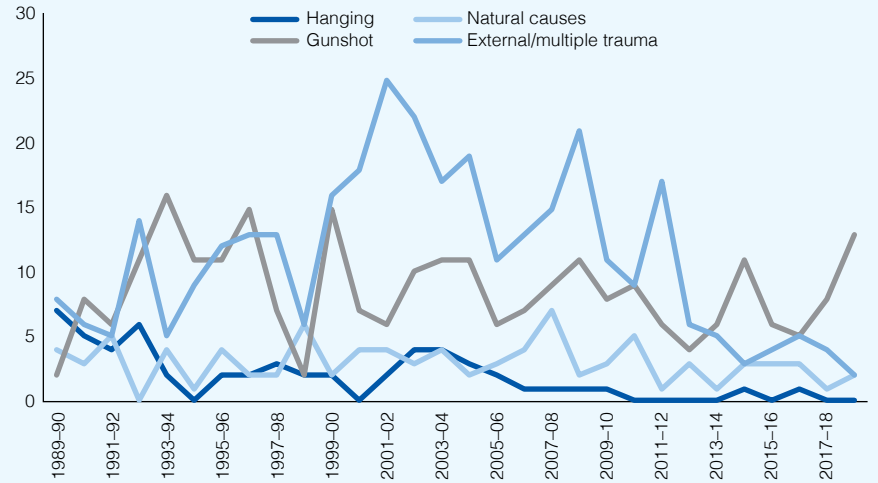
Sixteen of the 24 deaths occurring in police custody were categorised as category 1 deaths (see Table B4). Category 1 deaths are those occurring during close police contact with the deceased, including deaths in police stations, and most police shootings and raids (see *Introduction*). The remaining eight deaths were categorised as category 2 deaths, as they occurred during non-close police contact, such as foot pursuits or self-inflicted deaths in the presence of police after the commission of an offence.

Figure 9: Deaths in police custody and custody-related operations by Indigenous status, 1989-90 to 2018-19 (%)



Note: Excludes 2 deaths where Indigenous status was not stated or unknown
Source: AIC NDICP 1989-2019 [computer file]; see Table E5

Figure 10: Deaths in police custody by select cause of death, 1989-90 to 2018-19 (*n*)



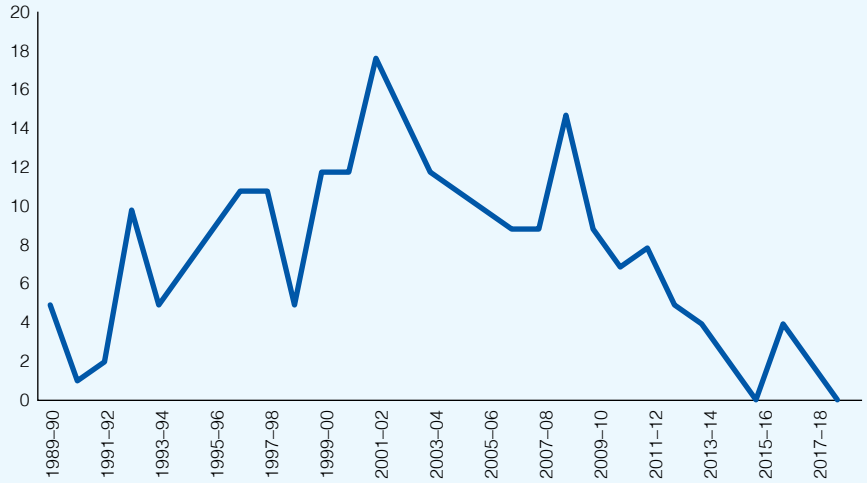
Note: External/multiple trauma includes head injuries. Excludes deaths caused by alcohol/drugs and other/multiple causes due to small numbers
Source: AIC NDICP 1989-2019 [computer file]; see Table E10

Indigenous status

Of the 24 deaths occurring in police custody in 2018-19, four were of Indigenous persons and 19 were of non-Indigenous persons (see Table B4). The Indigenous status of one deceased person was not recorded. The death rate of Indigenous persons in police custody was 0.61 per 100,000 Aboriginal and Torres Strait Islander population aged 10 years and over (see Table B5). The death rate of non-Indigenous persons in police custody was 0.09 per 100,000 non-Indigenous population aged 10 years and over.

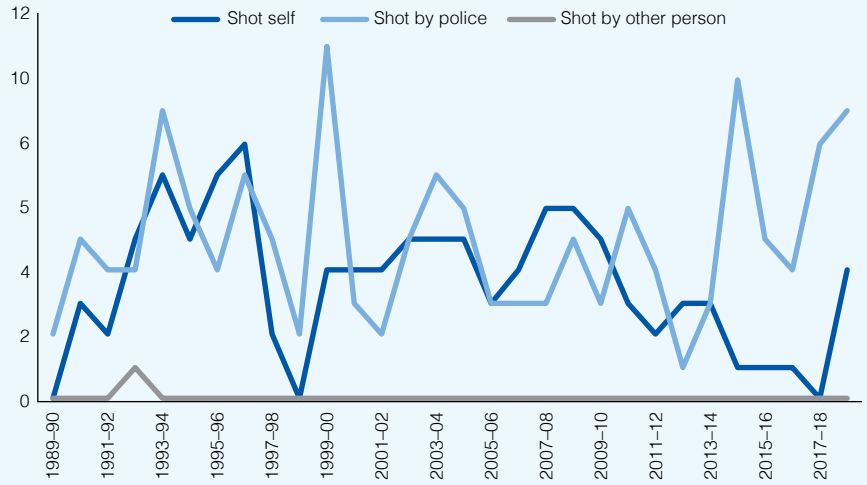
Consistent with all years of data on deaths in police custody (1989-90 onward), the number of non-Indigenous

Figure 11: Motor vehicle pursuit deaths, 1989-90 to 2018-19 (*n*)



Source: AIC NDICP 1989-2019 [computer file]; see Table E24

Figure 12: Shooting deaths, 1989-90 to 2018-19 (*n*)



Note: Excludes one case where shooting death status was not recorded
Source: AIC NDICP 1989-2019 [computer file]; see Table E25

deaths exceeded the number of Indigenous deaths (see Figure 9). Since 1989-90, Indigenous persons have comprised 20 percent (*n*=168) of deaths in police custody (see Table E5).

In the 28 years since the RCIADIC (1991), there have been 156 Indigenous deaths in police custody and custody-related operations (see Table C2).

Gender

In 2018-19, 21 males and three females died in police custody (see Table B4). The number of male deaths in police custody has exceeded the number of female deaths in police custody for all 30 years of deaths in police custody data (see Table E6). Of the four Indigenous deaths in police custody, three were male and one was female (see Table B4), with death rates of 0.92 and 0.30 per 100,000 relevant population respectively (see Table B5). Of the 19 non-Indigenous deaths in police custody, 17 were male and two were female (see Table B4), with death rates of 0.16 and 0.02 per 100,000 relevant population respectively (see Table B5). The Indigenous status was not recorded for one male death.

Age

The median age at time of death in police custody was 35 years (see Table B4). The median age at time of death was higher for non-Indigenous persons (36 years) than for Indigenous persons (22 years). Deaths in police custody most commonly involved persons aged 25-39 (*n*=10), and were least likely to involve persons aged 55 years and over (*n*=2). Since 1989-90, persons aged 55 years and over have been the least likely to die in police custody (7%, *n*=61; see Table E7).

Cause of death

The specific cause of death was recorded in 21 of the 24 deaths in police custody in 2018-19. Of these, most were attributable to gunshot wounds (*n*=13), followed by other/multiple causes (*n*=3; see Figure 10). Consistent with 2017-18, there were no hanging deaths in police custody. In 2018-19, two Indigenous persons died as a result of other/multiple causes and one Indigenous person died as a result of gunshot wounds (see Table B4). The cause of death was unknown in the remaining Indigenous death. Of the 19 non-Indigenous deaths in police custody, 12 were attributable to gunshot wounds, two to each of natural causes and external trauma and one to each of alcohol and/or drugs and other/multiple causes. The cause of death was unknown in the remaining non-Indigenous death.

In 2018-19, the number of deaths attributable to gunshot wounds (*n*=13) was the greatest since 1999-2000 (*n*=15; see Table E10). Of these 13 deaths, nine were police shootings and four were self-inflicted (see *Manner of death below*). Gunshot wounds or external trauma have been the leading causes of death in police custody since 1989-90.

Since 1989-90, the greatest proportion of Indigenous deaths in police custody have been attributable to external trauma (33%, *n*=55), followed by natural causes (22%, *n*=36) and head injuries (14%, *n*=24; see Table E11). In comparison, most non-Indigenous deaths in police custody have been attributable to gunshot wounds (36%, *n*=243) or external trauma (31%, *n*=208; see Table E12).

Manner of death

In 2018-19, nine of the 21 deaths where manner of death information was available were justifiable homicides. All nine of these deaths were caused by gunshot wounds from a police shooting (see Table B6). A further six deaths were

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self-inflicted, three were accidental, two were a result of natural causes and one had other/not determined recorded as the manner of death (see Table B4). Of the self-inflicted deaths, four were attributed to gunshot wounds, one to external trauma and one to alcohol and/or drugs (see Table B6). One accidental death was attributed to external trauma, and two were attributed to other/multiple causes.

Of the four Indigenous deaths in police custody, two were accidental deaths attributable to other/multiple causes, one was a self-inflicted death attributable to gunshot wounds, and one had no manner of death recorded (see Table B6). Of the 19 non-Indigenous deaths in police custody, nine were justifiable homicides, five were self-inflicted, two were attributable to natural causes, one was an accident and one had other/not determined recorded as the manner of death. The remaining non-Indigenous death had no manner of death recorded.

Since 1989-90, the greatest proportion of deaths in police custody have been accidental deaths (37%, *n*=314; see Table E13), and this is true for both Indigenous (see Table E14) and non-Indigenous persons (see Table E15). However, despite annual fluctuations, the numbers of accidental deaths have been generally decreasing over the last decade (from *n*=13 in 2009-10 to *n*=3 in 2018-19). Deaths resulting from unlawful homicides have remained consistently low since 1989-90, comprising just two percent (*n*=16) of all deaths in police custody (see Table E13).

Most serious offence

Of the four Indigenous persons who died in police custody in 2018-19, two were suspected of having committed theft-related offences, and one was suspected of having committed a good order offence (see Table B4). The MSO was not stated or unknown for the remaining Indigenous death. Non-Indigenous persons who died in police custody were most commonly suspected of having committed a violent offence (58%, *n*=11).

Since 1989-90, deaths of persons who were suspected of committing a violent offence have been more frequent than deaths of those suspected of committing other types of offences (34%, *n*=292; see Table E16). The number of deaths in police custody of persons suspected of committing drug-related offences has remained low since 1989-90, reaching a peak of three deaths in 1994-95, in 2004-05 and in 2005-06, and comprising three percent (*n*=23) of all deaths in police custody in which an MSO was recorded.

Since 1989-90, Indigenous persons who died in police custody have most commonly been suspected of having committed a theft-related MSO (33%, *n*=53) or a good order offence (24%, *n*=39; see Table E17). Over the same time period, non-Indigenous persons have most commonly been suspected of committing a violent offence (38%, *n*=255), or a theft-related offence (17%, *n*=113; see Table E18).

Location of death

The most common location of deaths in police custody was private property (*n*=9), followed by public places (*n*=8) and public hospitals (*n*=7; see Table B4). In 2018-19, no deaths in police custody occurred in a cell or other custodial environment. Of the seven deaths occurring in a public hospital, the location of the incident preceding the death was a private property in three cases, a public place in two cases, and a cell in one case. The remaining case was a police shooting that occurred in a public hospital.

Of the four Indigenous deaths in police custody, two occurred in a public place, one on private property, and the other in a public hospital. The location of death for the individual whose Indigenous status was not recorded was a public place.

Since 1989-90, the largest number of deaths have occurred in a public place (*n*=353), followed by a public hospital (*n*=221; see Table E19). Almost one in 10 deaths have occurred in a cell (9%, *n*=78).

Circumstances of custodial period

In 2018-19, 19 of the 24 deaths in police custody occurred while police were in the process of detaining or attempting to detain the individual (see Table B4). A further two deaths occurred in an institutional setting, and the remaining three deaths occurred in circumstances classified as 'other'. Two Indigenous deaths in police custody occurred while police were detaining or attempting to detain the individual, and two were in circumstances classified as 'other'. The individual whose Indigenous status was not stated or unknown died while police were in the process of detaining or attempting to detain them.

Deaths occurring while police were in the process of detaining or attempting to detain the individual have outnumbered deaths in any other type of custody since 1992-93 (*n*=634; see Table E20). Since 1989-90, the most common method of detainment has been a motor vehicle pursuit (36%, *n*=230), followed by a shooting or other circumstance (33%, *n*=208; see Table E21).

Motor vehicle pursuit deaths

In 2018-19, there were no deaths that resulted from a motor vehicle pursuit. This was the second year since NDICP data collection began that there have been no motor vehicle pursuit deaths (see Figure 11). The peak number of motor vehicle pursuit deaths occurred in 2001-02 (*n*=18).

Shooting deaths

In 2018-19 there were 13 shooting deaths in police custody, five more than in 2017-18 (see Figure 12). The highest number of shooting deaths occurred in Queensland (*n*=5), followed by New South Wales (*n*=3) and Western Australia (*n*=2). The remaining shooting deaths occurred in Victoria, South Australia and Tasmania (*n*=1 for each). Of the 13 shooting deaths in police custody, nine were police shootings, and four were self-inflicted shootings. Since 1989-90, there have been 148 police shootings and 108 self-inflicted shootings. Of the nine police shootings in 2018-19:

- All were of non-Indigenous persons. Police shootings of non-Indigenous persons have consistently outnumbered police shootings of Indigenous persons in all years since 1990-91.
- All involved males. Police shootings have been more likely to involve males than females in all years since 1989-90.
- Most were suspected of having committed a violent offence (*n*=7). The remaining two deaths involved persons suspected of committing a theft-related offence (*n*=1) or an offence categorised as 'other' (*n*=1). Since 1989-90, almost three-quarters (74%, *n*=111) of police shootings have involved persons suspected of having committed a violent offence.
- The location of the shooting was a private property in five cases, a public place in three cases, and a public hospital in one case.

In comparison, of the four self-inflicted shootings in 2018-19:

- Three involved non-Indigenous persons, and one involved an Indigenous person. Non-Indigenous self-inflicted shootings in police custody have consistently outnumbered Indigenous self-inflicted shootings since 1989-90.
- All involved males. Almost all (98%, *n*=106) self-inflicted shootings in police custody since 1989-90 have involved males.
- Two involved persons suspected of having committed a violent offence. Since 1989-90, most self-inflicted shootings in police custody have involved persons suspected of having committed a violent offence (60%, *n*=65).
- The location of the shooting was a private property in all four cases.

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The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line

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Abstract
This article explains the way that Australian coroners' courts often fail Aboriginal and Torres Strait Islander peoples. We discuss the gap between the expectations of families of the deceased and the realities of the process of the coroner's court. The discussion is illustrated with reference to real-life examples, drawn from the authors' experiences representing the families of the deceased.

Keywords
Coronial; inquest; death; Australia; Indigenous; Aboriginal.

Introduction

Well-functioning coroners' courts not only serve as important tools to hold our governments and their officials accountable, but they also have the power to drive reform and play a therapeutic role for the families of the deceased and their communities. Sadly, the traditional approach taken by most Australian coroners' courts, which focuses on the narrow cause and manner of death, is failing Aboriginal and Torres Strait Islander peoples on both counts. By and large, the families of the deceased want justice through the identification of wrongdoers and by holding them accountable and they demand systemic change and/or law reform to prevent similar deaths in the future. Despite recommendations made almost 30 years ago by the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) for coronial inquests to take on this broader scope, most coroners have not embraced the recommendations in practice.

Not only are the families and kin networks of deceased Aboriginal and Torres Strait Islander people being let down by the coronial system, it often inflicts its own special form of harm on them. Families seeking redress against acts of state violence—such as the death in custody of a loved one—can find themselves re-traumatised by a coronial system, which they feel does not listen to them, does not respect their culture and fails to address their demands for accountability and systemic reform. Those failures can be viewed as further perpetuating a form of state violence.

The authors are practitioners and advocates who work with families who have lost relatives in health care, inside prisons and at the hands of police. There has been relatively little academic attention paid to the functioning of coroners' courts in Australia, and the experience of First Nations peoples in those processes remains under-studied.[1] We share these insights from the field and our research to foster critical scholarship and law reform projects aligned to the interests of Aboriginal and Torres Strait Islander peoples who routinely encounter these systems of death review.

The article begins by situating Australia's coronial system in the context of a colonial legal system that was imposed on Aboriginal and Torres Strait Islander peoples. We then provide some background on the history of the coronial system and how it operates today in Australia. Next, we outline three areas in which the current system is failing Aboriginal and Torres Strait Islander families. First, we examine the structural and practical impediments to the effective participation of family and community members in inquests. Second, we critique the overly adversarial nature of the process. Third, we explore the ramifications of the reluctance to apportion blame or make recommendations for systemic change. We conclude with recommendations on how the system can be reformed. The purpose is not to examine the law in detail[2] but to identify the shortcomings of the lived experience of the law and how this can be improved.

Australia's Settler Legal System

Australia's coronial inquest system must be viewed in the context of a colonial legal system that is imposed on the lives and bodies of Aboriginal and Torres Strait Islander peoples. It not only governs them, but it also governs how they are described and understood. Inquests are not held in isolation from the general legal system and must be understood in terms of the institutional baggage they carry for Aboriginal and Torres Strait Islander peoples. Coronial

1. For notable exceptions to this, see among others Bray 2008; Watterson, Brown and McKenzie 2008; Whittaker 2018.
2. For detailed coverage of the law in New South Wales, see Abernethy et al. 2010.

inquests are an alien concept to Indigenous peoples:

> Indigenous programs [and systems] start with the collective Indigenous experience. Inevitably that involves an understanding of the collective harms and outcomes of colonisation, the loss of lands, the disruptions to culture, the changing of traditional roles of men and women, and the collective loss and sorrow of the forced removals of children. (Cunneen 2011: 322)

Inquests do not meet that aspirations or the basic needs of Aboriginal and Torres Strait Islander peoples. Instead, we argue that they are part of a broader claim of legalistic impunity for Aboriginal and Torres Strait Islander death. Eualeyai and Kamilaroi woman, Professor Larissa Behrendt articulates this as she writes about the colonial justice system in the following terms:

> The law concludes with a seemingly frustrated shrug that what is morally wrong is not always legally wrong. There are, as these cases bear out, lawyers' tricks to stop justice—definitions, intent, proof, evidence. Narrow formulations of questions facilitate the avoidance of the context and effects of legislation.
>
> This […] façade of neutrality, has also meant that expressions from an Indigenous point of view are sidelined. […] What seems to be more important from the Indigenous perspectives are the effects of the actions of the government—these actions have amounted to damage to Indigenous people, families and communities and they choose to use the word 'genocide' to describe it. This moves the discussion outside of the words of the statute to the side-effects and legacies of those sanctioned actions. (Behrendt 2001: 142)

This impunity relies on the kind of legal neutrality that retells the stories of Indigenous realities in its own terms, incentivising particular forms of participation from Aboriginal and Torres Strait Islander parties, writes Tanganekald and Meintangk woman Irene Watson:

> Australia like other colonising states has been successful in building a white nation, one based on our exclusion and inclusion. Inclusion occurs when our level of whiteness blends with their own. In saying this I am not speaking of a desire for inclusion, but of the failed acknowledgment of our existence and our laws. The power of the state to exclude or to make invisible is a universal phenomenon experienced by other colonised peoples. (Watson 2002: 263)

Watson's observations echo what Aboriginal and Torres Strait Islander activists have observed in the inquest system—that the system is complicit in their loved one's suffering and it tends to refuse a critical narrative of deaths in custody. Families and communities who have lost family members 'inside' often share these insights into how the death review system operates, but they are not always taken seriously by coronial research:

> It's traumatising yes, but it still needs to be put out there … They can't hurt us anymore, but they can traumatise us more by still holding back the truth … There will never be any justice unless there is truth and accountability. (Shaun Harris, quoted in Deathscapes 2017)
>
> I'd feel a lot more confident if there wasn't a police officer investigating my mum's death and if that police officer had actually obtained all the footage, which hasn't happened. There are pieces of the truth that we will never know. (Apryl Watson, quoted in Wahlquist 2019: para. 33)
>
> I would love us to be the last family to have to deal with this. But let's be honest. The system hasn't changed in 30-odd years. It's not going to change overnight, but we want to do our best. (Belinda Stevens, quoted in Wahlquist 2019: para. 35)
>
> Unfortunately the government had to be dragged to this point screaming and kicking every inch of the way. Every time there's been a breakdown in the procedure, the family and community on Palm Island are being subjected to more trauma, drama and unnecessary grandstanding by politicians. (Uncle Sam Watson, Sydney Morning Herald 2007: para. 12)

Background to the Coronial Inquest System in Australia

The office of the Coroner traces its origins to 1194. In the English legal system, it is only predated by the Sheriff's office. Initially, the Coroner's duties related to keeping the King's records and collecting his revenue. Modern coroners have quite a different role. They investigate deaths, and each Australian state and territory has its own laws governing the powers and the role of the Coroner's Court. This article does not focus on the differences in the laws,[3] but rather the general experiences of Aboriginal and Torres Strait Islander peoples who interact with Australian coroners' courts.

Broadly speaking, coroners' courts are magistrate-level specialist courts, which are often physically attached to institutes of forensic medicine (as is the case in Melbourne and Sydney). Coroners, the judges who oversee the jurisdiction, are arranged by seniority from the State/Territory Coroner, to the Deputy State/Territory Coroner, to generalist coroners and to generalist magistrates who can attend to some local matters by referral. As a rule, deaths in custody and more complex cases are overseen by either the State or the Deputy State Coroner.

Coroners' courts are inquisitorial and they are not supposed to operate in an adversarial manner. This is a character they share with other commissions of inquiry, such as Royal Commissions and the Independent Commission against Corruption. The primary purpose of a coroner's court is to answer questions about how a death occurred and how it might be prevented. It does not determine criminal or civil liability. In fact, coroners are barred from making any direct findings or remarks about criminal or civil liability. However, they can (and in some states, must) refer individuals to prosecutors or disciplinary bodies if there is sufficient evidence that an offence has been committed or that professional standards have been breached. As we discuss below, this is very uncommon in practice.

When is an Inquest Required?

The RCIADIC noted the importance of post-death inquiries and made 34 recommendations for reforming the coronial system (RCIADIC 1991). While many recommendations have not been acted on, most jurisdictions have implemented the key recommendation that inquests should be mandatory where individuals die in police custody, prison and youth detention (Amnesty International and Clayton Utz 2015). Whilst changes

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3. For such a comparison, see Vines and McFarlane 2000.

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have been made in law to allow coroners to investigate deaths in custody, the legislative changes do not reflect the systemic reviews that were envisaged in the RCIADIC recommendations. Coroners have close to absolute discretion to hold inquests referred to them where a death is not in custody or otherwise reportable.

The Role of Counsel Assisting, Procedures and Scope

Once an inquest is underway, coroners are guided in their inquiry by a Counsel Assisting. The ordinary rules of evidence are dispensed with at an inquest (most significantly, the rule of hearsay). However, procedural fairness rules apply, and protections are afforded for the compulsion of evidence that may incriminate a witness. The inquisitorial nature of the Coroner's Court means that coroners can ask questions themselves and can ask for evidence to be made available. Interested parties, such as the next of kin, have standing at the inquest, with human rights and community groups sometimes seeking leave to appear and interrogate witnesses, but they do not control what evidence is called. It is not uncommon for inquests to have close to a dozen interested parties representing individuals, organisations, families and government institutions.

Once an inquest has been called, coroners usually define the limits or scope of the subject matter of the inquest through a series of early interlocutory court hearings. Questions and evidence that stray from the scope of the inquest, and accordingly, from the relevant inquiry are disallowed. The scope of the inquest is principally confined to the cause and manner of death. Recently, some coroners have permitted the issue of systemic racism in the treatment of Aboriginal and Torres Strait Islander peoples, notably women, to be canvassed (e.g., *Inquest into the Death of Naomi Williams* 2019; *Inquest into the Death of Tanya Day* 2020). These cases represent a cultural shift in the Coroner's Court, mostly among those in the eastern states, to expand the scope to invite a race-critical analysis of morbidity and mortality. However, most coroners still tend to confine their inquiry to the cause of death, rather than to the manner, and they tend to avoid systemic issues such as systemic racism and neglect (Inquest into the Death of Jayden Stafford Bennell 2017).

Suppression Orders

During the inquest, coroners are commonly asked to issue suppression or non-publication orders for sensitive material, including the identities of interested persons and suicide methods. While the rules vary among states, coroners' courts are not courts of record and are subject to their own internal procedures on suppression and non-publication orders—fusing the open justice principles governing most suppression orders with the theoretically therapeutic mandate of the Coroner. Media and families can, and sometimes do, apply to release brief evidence or footage pertaining to the death (notably in the inquests into the deaths of Ms Dhu, David Dungay Jr and Aunty Tanya Day). These applications are often unsuccessful because of a high degree of Coronial discretion and a perception that families must be protected and the deceased are best dignified through privacy. A view that state actors are vulnerable if identifiable and conflicts within represented parties (like families) about what footage should be made public also contribute to this.

Findings, Recommendations and their Implementation

Coroners issue their findings and recommendations at the conclusion of the inquest. Depending on the state or territory, they may also issue other formal particulars about the death, such as the deceased's Indigenous status. Recommendations are limited to the scope of the inquest and are poised to answer preventative questions in the death that is the subject of the inquiry. In most states and territories, there is no obligation on the agencies to which the recommendation is made to heed or even respond to the recommendation.

Aboriginal Deaths in Custody and the Role of the RCIADIC's Recommendations

First Nations activists and advocates have coordinated an enduring movement against police and carceral violence against Indigenous peoples. Most recently, thousands took to the streets across Australia as part of the Black Lives Matter protests, rallying against First Nations deaths in custody. Other impactful recent campaigns emerged in response to prominent deaths like those of John Pat, TJ Hickey, Mulrunji Doomagee and Ms Dhu, and inquests into the circumstances of their deaths. What united each campaign, and the early movement that precipitated the early Aboriginal Deaths in Custody Watch Committee and the Committee to Defend Black Rights (Luckhurst 2006), was a cogent theory of change through culpability and accountability of state institutions or individuals. What was necessary, the campaigns put it, was at least an independent investigating body. This came from suspicion of the internal police investigations and infrequent coronial inquests, which appeared to permit collusion between police witnesses, exclude communities from participation and mask police violence.

Matters came to a head after the inquest into the death of Lloyd James Boney in 1987 concluded that his death was by suicide caused by ligature compression of the neck (he had been violently arrested 90 minutes prior while intoxicated). A public outcry prompted the Australian Government to establish the RCIADIC. The RCIADIC examined 99 Indigenous deaths in custody from the previous decade and issued 339 recommendations—from custodial health and safety to imprisonment as a last resort, and Indigenous self-determination, including a suite of 35 recommendations on post-death investigations.

The implementation of the recommendations has been patchy at best. Amnesty International Australia and Clayton Utz published a review in 2015 that concluded that most RCIADIC recommendations remained unimplemented, in what they referred to as a 'categoric fail[ure]' of state, territory and federal governments (Amnesty International and Clayton Utz 2015). In 2018, the Federal Government funded Deloitte Access Economics to monitor the RCIADIC's recommendations and their implementation. That review concluded that all but six per cent of the recommendations had been implemented or partially implemented (Deloitte Access Economics 2018). However, this assessment has been vigorously disputed by independent observers and researchers. They have argued that the implementation rate is substantially lower than what the Deloitte Access Economics report claimed and that the recommendations are qualitative and not easily quantified. A group of 33 academic and professional experts directly responded to the report, stating their concern with the 'scope … methodology …

and the substantive findings of the review' (Jordan et al. 2018: 1). They went on to say:

> At the time of writing this response … there are 14 Aboriginal deaths in custody awaiting a coronial hearing or findings in Victoria, South Australia, New South Wales, Western Australia, Queensland and the Northern Territory. These include deaths that occurred where Aboriginal women were incarcerated due to intoxication, Aboriginal men were denied adequate health care, and Aboriginal young people were on remand. All these circumstances are contrary to the recommendations of RCIADIC.

Since the RCIADIC, it is estimated that over 430 Indigenous people have died in custody (Allam, Wahlquist and Evershed 2020)—this represents a higher rate per the Aboriginal and Torres Strait Islander population than before the commission handed down its reports in 1991.

Key Failings of the Current System in Practice

In this section, we draw on our firsthand experience representing family members of deceased Aboriginal and Torres Strait Islander women and men who had died in custody to identify and explore three areas in which the current coronial inquest system is letting them down. First, we examine the barriers to family participation. We then critique the overly adversarial nature of proceedings, and finally, we examine the reluctance of coroners to apportion blame or make recommendations for systemic change.

Family Participation

Coroners' courts appear to encourage a façade of family participation—lamenting in findings when families have declined to participate (Whittaker 2018). While family members are encouraged to participate in the coronial system, their interventions are generally restricted to narratives about their loved one's life, rather than the cause or circumstances of their death. Given that the focus of the family members is usually on getting answers and their desire for accountability, stifling their meaningful intervention on those issues marginalises them. It adds to the perception that they are not being heard. It shuts out Indigenous participation in the storytelling of Indigenous death by making families authorities only on sentiment rather than substance, where they most urgently wish to be heard. Families who do attempt to intervene on narratives and findings surrounding the death of their loved ones find themselves subject to coronial scorn.

For example, in the inquest into the death of Robert Bropho, Coroner King rejected Bropho's daughter's evidence that her father complained of abuse in prison, including being denied medical care and food, as 'hearsay' and made 'with little notice to the court' (*Inquest into the Death of Robert Bropho* 2013: 12). Coroner King suggested, 'if there was any substance to the deceased's complaints … they would have been investigated and the results of the investigations attached to the Department's offender management file' (*Inquest into the Death of Robert Bropho* 2013: 13). These observations confirm the preference of the courts for state documentation over the testimony of family members of the deceased when considering state culpability. Moreover, Coroner King made the demeaning finding that the 'difficult and demanding' Bropho 'cried wolf' to 'elicit … attention' from his family (*Inquest into the Death of Robert Bropho* 2013: 15).

Existing approaches to including families in the process appear to be more about providing a veneer of moral endorsement to the inquest than addressing the more fundamental question posed by Aboriginal and Torres Strait Islander communities about state impunity (Whittaker 2018). Far from engaging families in their quest for justice, existing coronial practices often create new sites of trauma.

A lack of resources and support services also hamper family and kin network engagement in the coronial system. Free and low-cost legal resources for inquests are few and strained. Legal Aid NSW, for instance, has only two solicitor advocates in their inquest unit. Most Aboriginal Legal Services do not have a dedicated inquest practice. However, they do offer their services to Aboriginal and Torres Strait Islander clients or families of an Indigenous person who has died in custody. There are no clear procedures on how to obtain or even refer under-resourced families to coronial legal services or whom to approach. A lack of specialised practitioners operating in community legal centres, Legal Aid or Aboriginal Legal Services means that these services lack vital institutional knowledge for a unique jurisdiction or a shared strategic model for how to engage it. Organisations, such as the National Justice Project, do offer such specialised knowledge in selected cases. However, their service offering remains ad hoc, focused on strategic cases, and their limited capacity cannot meet the volume of cases that even overwhelms the coroners' courts.

Many Aboriginal and Torres Strait Islander families feel marginalised and excluded from the coronial process because of a lack of cultural sensitivity, a lack of institutional transparency and dissonance between the families' demands for justice and the statutory limits of the courts. Inquests ask a lot of family and community members, without offering much in return for their significant work under deep bereavement. This is particularly pronounced whenever there is a failure of a court or a coroner to accommodate cultural and religious concerns about the treatment of bodies of the deceased. Bodies are often subjected to an autopsy before the family can see the deceased or make decisions about them. Body parts, such as brains, sometimes need to be separated from bodies for forensic testing, and this can be traumatising for those families who seek to exert a religious or cultural authority to refuse an autopsy or require a more timely burial.

Coroners' courts in eastern states have recently made some concessions to Aboriginal and Torres Strait Islander families, kin networks and community groups who have worked for a more culturally secure treatment of their loved ones — such as allow them to participate in smoking ceremonies, conducting ceremonies and dances (Davidson 2019), demanding respectful treatment of evidence and exhibits in the process, changing hearing dates to accommodate Sorry Business (e.g., *Inquest into the Death of Naomi Williams* 2019). Some coroners have also accommodated the inclusion of objects of cultural, familial and personal significance in the court architecture—such as leaving sand from Dhungalla in front of the bench at the inquest into the death of Aunty Tanya Day to 'carry her footsteps' (McKinnon et al. 2019). Although these are welcome and necessary steps, coroners consider them supplementary to their jurisdiction and therefore outside of their substantive

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investigation. These practices do not amend a coroner's statutory, procedural or collegiate obligations to which Indigenous communities and families have so cogently objected for decades.

Coroners' courts often struggle with the plurality of personal and kinship interests that Aboriginal and Torres Strait Islander families hold, with a tendency to treat them as an essentialist and united unit. This has most publicly surfaced in the challenging of non-publication orders concerning the release of evidence on the deceased's final moments, as occurred in the inquests into the deaths of Yamatji woman Ms Dhu (Wahlquist 2016) and Dhungutti man David Dungay Jr (Mitchell 2018). In both inquests, families were split on this question and sought to arbitrate or advance distinct social and cultural concerns with how their loved ones will be exhibited in a public testament to their death. While these have been negotiated with sensitivity by those family members, the structure of the Coroner's Court leaves little room for what may be a necessary and private tension in bereavement.

Adversarial Nature

While coronial proceedings are ostensibly inquisitorial, they are increasingly run in an adversarial manner. The result is that families feel like they are on trial and that the process is more about suppressing their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice. The coroners' courts in every state and territory are formally inquisitorial forums. They are, as a general principle, not concerned with adjudicating disputes, causes of action or prosecutions, but to determine the cause and manner of a death and offer recommendations—an end to which those involved in a coronial inquiry are expected to contribute. But the parties engage with the process in line with their interests and strategies under the guidance of practitioners who are not commonly trained in the coronial jurisdiction, and this often gives rise to an adversarial mindset.

Moreover, when inquest findings might expose individuals or organisations to a civil or criminal penalty, coroners apply the Briginshaw standard when considering the evidence. This standard requires a higher degree of persuasion than otherwise applies in the coronial setting and makes controversial findings difficult when there are significant matters in dispute. Hence, while inquests are free from the ordinary rules of evidence (apart from procedural fairness), in deaths in custody matters where individual and institutional consequences in regulation, crime and insurance are at stake, the net and degree of formality tighten (Whittaker 2018).

The disparity between state and family resources for inquests is also significant. In a recent case, the family of Gomeroi man Tane Chatfield, were forced to fundraise for inquest attendance (Justice for Tane Chatfield, 2019).[4] When families are from remote, rural and regional communities, these expenses include accommodation and transport for often-lengthy inquests and often-large groups.

Families also find themselves outgunned not only by the quality of counsel but also by their quantity. State parties, both as institutions (police, corrections, hospitals) and individuals (police officers, corrections officers, doctors), are numerous and well-heeled. For example, consider the inquest into the death of Ms Dhu. After being arrested for outstanding fines, Ms Dhu died over three days in a police lock-up. She died in agony due to an untreated infection in her broken ribs after police were called to a family violence incident in which she was injured. Ms Dhu was repeatedly taken to a hospital, where after only perfunctory examinations, it was concluded that she was not suffering from a physical ailment. As a consequence she was discharged back into custody. At the inquest, Ms Dhu's family was represented by one Senior Counsel and two juniors (one acting separately for Ms Dhu's father). The family faced 11 lawyers acting for 29 interested persons and organisations, two of which were state parties. The polycentrism of proceedings, wherein up to a dozen actors each shift blame and liability somewhere else and enjoy heightened evidentiary standards, often means that the only valve for blame, even informal storytelling blame, lands on the deceased.

Worse than adversarial—to families so locked out of the process—the proceedings look biased, even insurmountably weighted against them. As Caroline Andersen, mother of Wiradjuri Kookatha and Wirangu man Wayne Fella Morrison (whose death in custody is currently pending findings) expressed to NITV News: 'I feel like I'm on trial. I'm his mum, you know what I mean? I feel pressure. My parenting skills. How I raised him. It's like I'm on trial for their lack of care' (Kurmelovs 2018). That one is 'on trial' is a common refrain among families who experience the inquest process and who sometimes become witnesses themselves—like the mother of Ms Dhu, who was cross-examined about whether her daughter was injured by an act of domestic violence (*Inquest into the Death of Ms Dhu* 2016).

Apportioning Blame and Failure to Address Wider Issues

Some coroners are reluctant to directly apportion blame for a death to a particular individual or to address issues of systemic racism. This is often disappointing for family members, who rightly view such findings as central to the purpose of coronial proceedings. In terms of individual culpability, as discussed, coroners have the power (and in some states a duty) to refer individuals to prosecutors on disciplinary bodies if there is sufficient evidence that an offence has been committed concerning a death. However, this rarely happens, and even when made, these findings are sometimes subsequently overturned. The inquest into the death of Mulrunji Doomagee is a telling example. Coroner Clements concluded that the death was the result of the deliberate actions of Queensland police officer, Senior Constable Chris Hurley (*Inquest into the Death of Mulrunji [No 1]* 2006). This was based on evidence uncovered during the investigation, including other documented instances where Senior Constable Hurley had been violent towards Aboriginal and Torres Strait Islander persons. Following Hurley's acquittal for the manslaughter of Mr Doomagee, the coronial findings were overturned by the Queensland Supreme Court. A new coroner oversaw new findings into the death. The strong findings of wrongdoing by Coroner Clements were replaced by new findings that there was not enough evidence to conclude that Officer Hurley intended to assault Mr Doomagee (*Inquest into the Death of Mulrunji [No 2]* 2010).

As discussed above, coroners frequently limit the scope and ambit of

4. Justice for Tane Chatfield, 18 November 2019: https://au.gofundme.com/f/justice-for-tane-chatfield

inquests to identifying the immediate cause and nature of the death, which frustrates the next of kin, families and community members who want the coroner to examine the wider and related circumstances that contributed to the death (Whittaker 2018). The need for a more expansive inquiry into Aboriginal deaths was highlighted in the RCIADIC's Recommendation 12, which advised that any coronial investigation of deaths in custody should include, as a matter of law, an investigation into the 'quality of the care, treatment and supervision of the deceased prior to death' (RCIADIC 1991). This recommendation has not been followed with adequate stringency. In South Australia, the legislation provides only that the 'causes and circumstances' of a death are to be examined (Coroners Act 2003 (SA): s 25(1)). Amnesty International observed that this means that there is no clear obligation to examine the quality of care, treatment and supervision where these are not directly related to the death (Amnesty International and Clayton Utz 2015: 40). In Victoria, New South Wales and Queensland, the power is discretionary (Coroners Act 2008 (Vic), s 67(3); Coroners Act 2009 (NSW), s 82; Coroners Act 2003 (Qld), s 46(1)).

Coroners often explicitly limit the ambit of the investigation and the questioning of witnesses to avoid broader systemic issues. For example, during the inquest into the death of Jayden Stafford Bennell in Western Australia, Coroner Linton ruled that the:

> questioning of witnesses, other than the lead police investigators, was generally to be limited to other relevant issues … [and] questioning directed towards any potential systemic issues and preventative comments/recommendations must relate to the particular circumstances of Jayden's death rather than extending into a broad-reaching inquiry into prison systems as a whole. (*Inquest into the Death of Jayden Stafford Bennell* 2017)

Coronial inquests often adopt a similarly 'narrow' approach to the potential scope of recommendations that can be made—and thus fail to address systemic failings that contribute to deaths. Recommendation 13 of the RCIADIC not only provided that coroners should be empowered to make 'recommendations as are deemed appropriate with a view to preventing further custodial deaths' but also that they should be enabled 'to make such recommendations on other matters as he or she deems appropriate' (RCIADIC 1991). The schemes in both the Northern Territory and Tasmania incorporate this recommendation, making such findings a mandatory requirement.[5] However, the power is discretionary in Western Australia (Coroners Act 1996 (WA) ss 22, 25(2)), New South Wales (Coroners Act 2009 (NSW) s 82), South Australia (Coroners Act 2003 (SA), ss 21(1)(a), 25), Victoria (Coroners Act 2008 (Vic) ss 67(3), 72(2)) and Queensland (Coroners Act 2003 (Qld) s 46(1)).

The former Western Australian State Coroner, Alistair Hope, took an expansive view of the Coroner's powers in the inquest into the death of Mr (Ian) Ward, endorsing the following quotation from Watterson, Brown and McKenzie (2008: 6):

> [The RCIADIC] provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.
>
> Unfortunately, Coroner Hope's approach of making findings on broader systemic issues is not being followed by his successors.

The findings of the recent inquest into the death of Ms Dhu illustrate the tendency towards narrow recommendations that avoid broader issues, even in the rare circumstances where systemic failings are identified. In her findings, Coroner Fogliani made multiple references to the RCIADIC. She highlighted persistent systemic failings in the criminal justice system that remain unremedied, particularly regarding jailing fine-defaulters—a causal factor in many of the death in custody cases in Western Australia (*Inquest into the Death of Ms Dhu* 2016: 785, 791-792). The Coroner endorsed the concept of 'institutional racism', defined in expert evidence by Professor Thompson as:

> societal patterns that have the net effect of imposing oppressive or otherwise negative conditions against identifiable groups on the basis of race or ethnicity. Institutional racism is manifested in our political and social institutions and can result in the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. (*Inquest into the Death of Ms Dhu* 2016: 857)

Despite findings that such institutional racism explained the racially biased conduct of police and medical staff without them necessarily being 'motivated by conscious deliberations of racism', and that this was a 'community-wide issue' requiring a 'seismic shift' in the collective cultural consciousness, no core recommendations were made to address such factors at an institutional level (*Inquest into the Death of Ms Dhu* 2016: 859-860). Instead, the Coroner limited her recommendations to improvements in the conditions and oversight of detention of Aboriginal and Torres Strait Islander peoples, including improving notification services, monitoring, cultural sensitivity training and higher staff levels at police lock-ups and in hospital emergency departments.

We see a similar approach in the inquest into the death of Jayden Stafford

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5. T legislation provides that the Coroner must, as they consider relevant, make recommendations to prevent similar deaths and can make comment on 'public health or safety or the administration of justice' (Coroners Act 1993 (NT) ss 26(2), 34(2), 124). In Tasmania, the Coroner must make appropriate recommendations to enable future prevention of deaths, comment on matters relating to the care, supervision or treatment of a person while in custody and comment on further connected matters (Coroners Act 1995 (Tas) s 28).

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Bennell, with Coroner Linton explicitly refusing to make recommendations about the implementation of the RCIADIC or 'in relation to those broader issues relating to deaths in custody and the treatment, care and supervision of Aboriginal prisoners, that do not relate to the specific circumstances of Jayden's death' (*Inquest into the Death of Jayden Stafford Bennell* 2017: 59).

Even where strong recommendations are made, in most Australian jurisdictions there is no requirement that responsible agencies (like state health departments, corrective services, state police forces or local area commands) read and respond to them. Even in Victoria, where there is a duty to read recommendations and report on a response to them, this does not translate into the implementation of reforms proposed by the coroner. A 2014 study found that only one-third of recommendations received by Victorian agencies were accepted and implemented (Sutherland et al. 2014).

Recommendations and Conclusion

The coronial inquest system is failing Aboriginal and Torres Strait Islander families and communities. At times, it appears to Aboriginal and Torres Strait Islander peoples as indistinguishable from a review and policy arm of the systems these families and communities accuse of violence. Many of the solutions for 'fixing' the system are already known—in particular, the unimplemented recommendations of the RCIADIC and the calls for reform from families and communities who disproportionately experience inquests into deaths in custody.

The proposed solutions are designed to make the coronial process culturally safe for Aboriginal and Torres Strait Islander families and communities. We do not believe they are all-encompassing, but they reflect the recommendations of the RCIADIC and the more recent demands for voice treaty and truth telling (The Uluru Statement from the Heart 2017).

The first and most crucial issue is to hear the voice of Aboriginal and Torres Strait Islander communities. One way would be to act on Recommendation 2 of the RCIADIC and establish independent Aboriginal Advisory Committees in each state and territory to advise on Aboriginal peoples' perceptions of criminal justice matters and the implementation of reforms.

The following additional reforms cannot address the broader colonial context of death review in a settler legal system. However, these reforms offer more transparency to families and communities and would mitigate some of the secondary and institutional trauma of the inquest for First Nations peoples. Specifically, we propose the following:

- Employing Aboriginal liaison officers in each jurisdiction who are trained in coronial practice to guide the coroner on Indigenous cultural practices and to guide Aboriginal and Torres Strait Islanders on coronial processes;
- Appointing Aboriginal and Torres Strait Islander coroners, counsel assisting and investigators with lived experience to undertake inquests into Aboriginal deaths in custody;
- Training forensic pathologists on Aboriginal and Torres Strait Islander peoples' cultural practices to do with bodies and how to respect those practices;
- Adequately funding Aboriginal and Torres Strait Islander legal services to represent the next of kin at inquests into the deaths of Aboriginal and Torres Strait Islander peoples or providing an experienced and well-resourced legal aid service;
- Amending the Coroners' Acts to require

(a) Coroners to make findings on whether the implementation of any, some or all RCIADIC recommendations could have reduced the risk of death in all cases where an Aboriginal or Torres Strait Islander person has died in custody, in or around a police action, or within 48 hours of attending or leaving a health facility or coming into contact with the police and

(b) Coroners to make recommendations to address any systemic problems that may be relevant to a death or the care and/or the treatment of an individual in the lead up to that death.

Moreover, the faith of family members in the coronial process and its ability to contribute to systemic change would be enhanced by implementing the following RCIADIC recommendations:

- Transferring investigative resources and authority over deaths in custody to an independent investigative body, away from police and corrections;
- Permitting Aboriginal and Torres Strait Islander peoples to view the body of the deceased if possible before tests are undertaken;
- Requiring annual reports to be laid before Parliament on all Aboriginal and Torres Strait Islander deaths in custody with all states and territories to report in a consistent manner to the Federal Parliament, so that outcomes can be compared and progress or lack thereof monitored.

Beyond the RCIADIC recommendations, further legal as well as simple practical changes to the way inquests are run could greatly enhance the engagement and participation of family members. This could be achieved by:

- Amending the Coroners' Acts to respect traditional Aboriginal and Torres Strait Islander kinship structures when granting leave for individuals to appear at coronial inquests to represent the interests of the deceased's family;
- Providing the next of kin of any Aboriginal or Torres Strait Islander person whose death is being investigated by the Coroner at an inquest with travel money and if required accommodation to attend the inquest hearing;
- Amending the Coroners' Acts to require that Aboriginal and Torres Strait Islander post-death practices are respected;
- Permitting activities such as a smoking ceremony or other ceremonies or cultural dances as part of an inquest process where an Aboriginal or Torres Strait Islander person has died;
- Allowing the family of a deceased Aboriginal or Torres Strait Islander person to perform an acknowledgement of country or a welcome to country as appropriate in the circumstances;
- Providing a private room of a suitable size for large families and supporters attending inquests into the death of an Aboriginal or Torres Strait Islander person;
- Amending the Coroners' Acts to mandate inquests where Aboriginal or Torres Strait Islander people die from acts of gender-based violence or unexpectedly in health care and to mandate *recommendations that seek to prevent future deaths and to address the impact of conscious or unconscious prejudice in similar circumstances*.

The changes we propose have the potential to transform the perception of coronial inquests among Aboriginal and

Torres Strait Islander communities from a place that perpetuates state violence against participants to a forum that holds to account the perpetrators of state violence.

The RCIADIC recommended that the Coroner's role should expand to become a formal means to ensure proper public accountability and to provide a system of review that draws from the general experience gained from all inquests held into Aboriginal and Torres Strait Islander deaths. State and territory governments have been reluctant to grant coroners such broad powers or the budget to effectively conduct such a function. Consequently, Aboriginal and Torres Strait Islander families are often disappointed when they ask coroners to broaden the scope of their inquiries, to hold state actors accountable and to make recommendations for systemic reform.

It may be that the coroners' courts are not the appropriate jurisdiction to provide justice for Aboriginal and Torres Strait Islander peoples and to implement the RCIADIC recommendations regarding independent investigation. Perhaps an Indigenous-run investigative organisation might better meet the RCIADIC objectives? In reality, governments are reluctant to subject themselves to independent scrutiny given the cost and embarrassment that would flow from the far-reaching findings and recommendations of an unconstrained well-funded investigatory body that respected the cultural safety of the families of the subjects of its inquisitorial powers.

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Shooting deaths in police custody

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Abstract
Shooting deaths in police custody (including police and self-inflicted shootings) account for 30 percent of all deaths in police custody. This paper uses National Deaths in Custody Program data and coronial records to examine the circumstances of these deaths between 2006-07 and 2016-17.

Shooting deaths in police custody were most likely to involve non-Indigenous men. Most decedents were in the process of being detained for a violent offence, were in possession of a weapon and had a history of mental illness. Almost half had used alcohol and/or drugs shortly before their deaths.

Introduction

Police and self-inflicted shooting deaths account for 30 percent of all deaths occurring in police custody since 1991-92. Gunshot wounds are the second most common cause of death among individuals in police custody, second only to external or multiple trauma (33 percent of all deaths). When police shootings or self-inflicted shootings in police custody occur, they are subject to intense media, public and legal attention.

Previous AIC research on police shootings found that decedents were likely to have consumed alcohol and/or drugs shortly prior to their deaths (Dalton 1998b) and that mental illness was a precipitating factor in 37 (Dalton 1998b) to 42 percent (AIC 2013) of deaths. A history of mental illness was further observed in more than two-thirds of decedents who shot themselves in police custody (Dalton 1998a). Finally, 85 percent of decedents were armed with a weapon at the time of the incident (AIC 2013).

The present study updates existing data on shooting deaths in police custody. It further examines and compares with previous data the circumstances of these deaths over the decade from 2006-07 to 2016-17.

Definition of a death in custody

The definition of a death in custody is derived from the final report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC), which outlined the types of deaths that would require notification to the National Deaths in Custody Program (NDICP) (recommendation 41, RCIADIC 1991). They are:

- a death, wherever occurring, of a person who is in prison custody, police custody or youth detention;
- a death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care, while in such custody or detention;
- a death, wherever occurring, of a person who dies, or is fatally injured, in the process of police or prison officers attempting to detain that person; or
- a death, wherever occurring, of a person attempting to escape from prison, police custody or youth detention.

Shooting deaths are included if they occurred while the decedent was in police custody, while police were attempting to detain the decedent, or where the decedent had attempted to escape police custody.

Shooting deaths include situations in which police shot an individual (police shootings), an individual intentionally or unintentionally shot themselves in the presence of police during or after the commission of a crime (self-inflicted shootings), or an individual was shot by another person in the above circumstances.

Methodology

Data used in this study were obtained from the NDICP database. The information contained in the NDICP database comes from two main data sources: data provided by state and territory police services and corrections departments, and coronial records including post-mortem reports, toxicology reports and transcripts of coronial inquests. Coronial records are accessed through the National Coronial Information System. For more information regarding the NDICP and data collection methods, see Gannoni and Bricknell (2019).

NDICP data were extracted for the financial years 2006-07 to 2016-17. Earlier data from 1991-92 were extracted to examine trends across time. For cases that met the criteria for a shooting death in police custody, coronial records were used to determine contextual factors associated with each death, including the presence of alcohol and/or drugs, diagnosed and undiagnosed mental illnesses and the presence of a weapon. Toxicology reports were used to determine whether or not licit or illicit substances were consumed prior to death in 59 cases (72%). Where these data were unavailable, post-mortem reports (13%, *n*=11) or coronial findings (6%, *n*=5) were used. Toxicology data were unavailable from any data source in seven cases (9%). Coronial findings

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(82%, *n*=67) and police incident reports (16%, *n*=13) were used to determine whether the decedent was in possession of a weapon. These data were unavailable from either source for two cases (2%). Data pertaining to a decedent's diagnosed or undiagnosed mental illness were obtained from coronial findings in 58 cases (71%). Where coronial findings did not provide this information, data were obtained from the NDICP database (11%, *n*=9). These data were unavailable in 15 cases (18%).

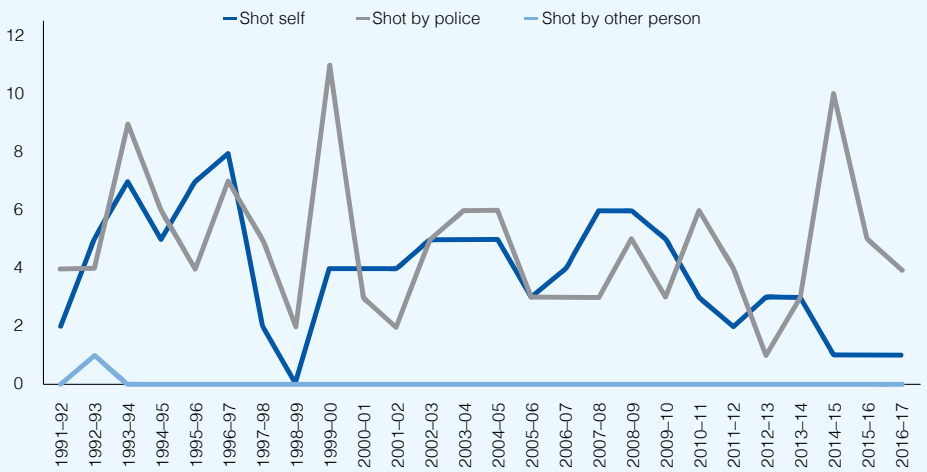
It is important to note that neither a history of mental illness nor the use of alcohol or drugs indicates that the behaviour of an individual during the incident resulting in their death was a consequence of these factors.

Results

There were 82 shooting deaths in police custody between 2006-07 and 2016-17 (see Table A1). Fifty-seven percent (*n*=47) of these deaths were police shootings, and 43 percent (*n*=35) were self-inflicted (see Table 1). All but three shooting deaths in police custody occurred as police attempted to detain the individual (see Table A2).

Consistent with previous years, 30 percent of all deaths occurring in police custody between 2006-07 and 2016-2017 were a result of shootings. The number of shooting deaths fluctuated annually, attributable to the small number of deaths occurring in police custody generally (see Figure 1). The greatest number of shooting deaths in police custody occurred in the three largest jurisdictions—28 in New South Wales, 18 in Queensland and 12 in Victoria (see Table A3).

Figure 1: Shooting deaths in police custody, 1991-92 to 2016-17 (*n*)



Note: Excludes one case where shooting death status was not recorded
Source: AIC NDICP 1991-92 to 2016-17 [computer file]; Table A1

Table 1: Shooting deaths in police custody by demographic characteristics, 2006-07 to 2016-17 (n)

	Shot by police (*n*=47)	Shot by self (*n*=35)	Total (*n*=82)
Gender			
Male	46	34	80
Female	1	1	2
Age (years)			
25 and under	8	6	14
25-39	17	12	29
40-54	20	10	30
55 and over	2	7	9
Indigenous status			
Indigenous	2	3	5
Non-Indigenous	42	32	74
Not recorded	3	0	3

Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Demographic characteristics

All but two of the 82 shooting deaths in police custody between 2006-07 and 2016-17 involved men (98%, *n*=80; see Table 1). Unlike all other age groups, decedents aged over 55 were more likely to have shot themselves (78%, *n*=7) than to have been shot by police (22%, *n*=2; see Table 1). Indigenous persons comprised six percent (*n*=5) of shooting deaths in police custody and non-Indigenous persons comprised 90 percent (*n*=74; see Table 1). The Indigenous status of three decedents was not recorded. Two of the five Indigenous decedents were shot by police and three shot themselves. Over half (*n*=42) of non-Indigenous decedents were shot by police. In each year since 1991-92 the number of Indigenous shooting deaths in police custody ranged from zero to two (see Table A4).

Location of incidents

Incidents resulting in a shooting death in police custody occurred in capital cities as frequently as they did outside of capital cities (see Table 2). Most incidents occurred on private property (59%, *n*=48). The majority of self-inflicted shootings occurred in or around a private residence (69%, *n*=24), whereas a similar number of police shootings took place in private settings (51%, *n*=24) and public spaces (49%, *n*=23).

Most serious offence

Three-quarters of persons (75%, *n*=56; see Table 3) who died from a shooting in police custody were in the process of being or had been detained for a violent offence. The violent offences most commonly recorded against this population were homicide-related offences (36%, *n*=20) and assaults (30%, *n*=17). A smaller proportion of individuals had their most serious offence listed as robbery (9%, *n*=5). Shooting deaths were most likely to occur on private property for those who had committed a homicide-related offence (60%, *n*=12), assault (71%, *n*=12) or another offence against the person (57%, *n*=8). Conversely,

Table 2: Shooting deaths in police custody by location of incident, 2006-07 to 2016-17

	Shot by police (*n*=47)		Shot by self (*n*=35)		Total (*n*=82)	
	n	%	*n*	%	*n*	%
Capital city	24	51	17	49	41	50
Other	23	49	18	51	41	50
Location						
Private property	24	51	24	69	48	59
Public place	23	49	10	29	33	40

Note: Excludes one death occurring in a custodial setting. Percentages may not total 100 due to rounding Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Table 3: Shooting deaths by most serious offence, 2006-07 to 2016-17

	Shot by police (*n*=41)		Shot by self (*n*=34)		Total (*n*=75)	
	n	%	*n*	%	*n*	%
Violent offences	37	90	19	56	56	75
Theft offences	1	2	2	6	3	4
Drug offences	0	0	1	3	1	1
Traffic offences	0	0	1	3	1	1
Good order offencesa	2	5	3	9	5	7
Firearms offences	1	2	6	18	7	9
Other offencesb	0	0	2	6	2	3

a: Good order offences include breach of orders, public order offences and offences against justice procedures b: Other offences related to trespassing
Note: Excludes four cases where most serious offence category was not recorded and three cases where police were responding to mental health welfare concerns. Percentages may not total 100 due to rounding
Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Table 4: Shooting deaths in police custody by possession of a weapon, 2006-07 to 2016-17

	Shot by police (*n*=45)		Shot by self (*n*=35)		Total (*n*=80)	
	n	%	*n*	%	*n*	%
Weapon	43	96	35	100	78	98
Firearm	14	31	34	97	48	60
Knife	21	47	0	0	21	26
Other	5	11	0	0	5	6
Multiple	3	7	1	3	4	5
No weapon	2	4	0	0	2	3

Note: Excludes two cases where possession of a weapon was not recorded. Percentages may not total 100 due to rounding Source: AIC NDICP 2006-07 to 2016-17 [computer file]

shooting deaths that occurred shortly after the commission of a robbery mostly occurred in public places (80%, *n*=4).

Thirty-nine percent (*n*=22) of all violent offences were family and domestic violence related. Further, in 63 percent (*n*=12) of self-inflicted shootings, the decedent's most serious offence was a violent offence involving family and domestic violence. This is an increase from the 42 percent of self-inflicted shootings that followed a family and domestic violence related incident reported by Dalton (1998a).

A further nine percent (*n*=7) of detainees were in the process of being detained or had been detained for firearms offences, including possession of a prohibited weapon and misuse of regulated firearms.

Possession of a weapon

In 96 percent (*n*=43; see Table 4) of police shootings between 2006-07 and 2016-17 the decedent was in possession of a weapon. The weapon most commonly possessed by decedents was a knife (47%, *n*=21), followed by a firearm (31%, *n*=14). Between 1989-90 and 2010-11, 85 percent (*n*=89) of fatal police shootings involved a decedent in possession of a weapon (AIC 2013). Since 2011-12, this has increased to 100 percent (*n*=26).

The proportion of incidents in which the weapon was used against responding police officers was higher in police shootings (88%, *n*=38) than self-inflicted shootings (34%, *n*=12). In police shootings, knives were most likely to be used against police, either to threaten (*n*=15) or injure (*n*=2) a police officer. Decedents who ultimately shot themselves were most likely to threaten (*n*=10) or kill (*n*=1) a responding police officer using the firearm ultimately used to shoot themselves. In one other self-inflicted shooting case, the decedent injured a police officer with a knife.

A larger proportion of police shooting incidents involving the possession of a firearm occurred on private property (57%, *n*=8) than in a public location (43%, *n*=6). Almost two-thirds (63%, *n*=5) of decedents shot by police while in possession of a firearm on private property had a mental illness. These decedents were most likely to have a violent offence (75%, *n*=6) recorded as their most serious offence.

Individuals shot by police while in possession of a knife were more likely to be in a public location (62%, *n*=13) than on private property (38%, *n*=8). Of those in possession of a knife in a public location prior to a police shooting, just over half (54%, *n*=7) had a mental illness, and 77 percent (*n*=10) had a violent offence recorded as their most serious offence.

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Overall, 60 percent (*n*=26) of those who died as a result of a police shooting who were in possession of a weapon also had a mental illness (either diagnosed, undiagnosed or both).

Mental illness

Sixty-one percent (*n*=50; see Table 5) of decedents either had a diagnosed mental illness (*n*=30), were suspected of having an undiagnosed mental illness (*n*=16) or had both a diagnosed and undiagnosed mental illness (*n*=4). Undiagnosed mental illnesses were included where the coroner explicitly stated their belief that the decedent, prior to their death, had been displaying symptoms indicative of a mental illness that had not been diagnosed. Depression was the most commonly diagnosed mental illness (*n*=16), followed by anxiety (*n*=8) and schizophrenia (*n*=6). Similarly, depression was the mental illness most frequently suspected to have occurred undiagnosed among decedents (*n*=6), followed by drug induced psychosis and schizophrenia (*n*=4 for each).

Around 60 percent of persons shot by police (62%, *n*=29) or who shot themselves (60%, *n*=21) had been diagnosed with a mental illness, or were suspected to have a mental illness. The proportion of decedents who had been diagnosed with a mental illness was higher for those who shot themselves (43%, *n*=15; see Table 5) than it was for those fatally shot by police (32%, *n*=15). The proportion of decedents suspected of having an undiagnosed mental illness was slightly higher among those fatally shot by police (21%, *n*=10) than those who shot themselves (17%, *n*=6). Decedents involved in self-inflicted shootings (31%, *n*=11) were more likely than those fatally shot by police (13%, *n*=6) to have no mental illness.

Substance use

Forty-nine percent (*n*=40; see Table 5) of decedents had consumed alcohol and/or drugs shortly prior to their death. Of these, most had used alcohol or methamphetamine (*n*=17 for each), followed by cannabis (*n*=13). Alcohol and/or drugs were consumed by around half of persons fatally shot by police (51%, *n*=24) and 46 percent (*n*=16) of those who shot themselves. A quarter (26%, *n*=12) of persons fatally shot by police had consumed one or more drugs prior to their death, and another 17 percent (*n*=8) had used alcohol and drugs. Among persons who shot themselves, 31 percent (*n*=11) had consumed one or more drugs and eleven percent (*n*=4) consumed only alcohol. No alcohol or drug use was recorded for 51 percent (*n*=18) of decedents from self-inflicted shootings compared with 36 percent (*n*=17) of decedents from police shootings.

Between 1989-90 and 2010-11, 51 percent (*n*=53) of fatal police shootings involved a decedent who had consumed alcohol and/or drugs prior to the incident resulting in their death (AIC 2013). Since 2011-12, this has decreased to 44 percent (*n*=12). Similarly, there has been a slight decrease in the proportion of decedents involved in a self-inflicted shooting who had consumed alcohol and/or drugs prior to their death (46%, *n*=16) since 1998 (48%; Dalton 1998a).

Table 5: Shooting deaths in police custody by mental illness and substance use, 2006-07 to 2016-17

	Shot by police (*n*=47)		Shot by self (*n*=35)		Total (*n*=82)	
	n	%	*n*	%	*n*	%
Mental illness						
Diagnosed mental illness	15	32	15	43	30	37
Undiagnosed mental illness	10	21	6	17	16	20
Diagnosed and undiagnosed mental illness	4	9	0	0	4	5
No mental illness	6	13	11	31	17	21
Not recorded	12	26	3	9	15	18
Substance use						
Alcohol	4	9	4	11	8	10
Drugs	12	26	11	31	23	28
Alcohol and drugs	8	17	1	3	9	11
None	17	36	18	51	35	43
Not recorded	6	13	1	3	7	9
Mental illness and substance use	**15**	**32**	**10**	**29**	**25**	**30**

Note: Percentages may not total 100 due to rounding Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Table 6: Police shootings by outcome of coronial findings, 2006-07 to 2016-17

	n	%
Coronial findings available	39	83
Justifiable shooting	37	95
Unjustifiable shooting	2	5
Coronial findings unavailable	8	17

Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Findings from coronial inquests

Where police shootings result in a death, coronial inquests examine whether the death was justifiable and whether police officers acted in accordance with relevant policies and procedures when discharging their firearm. Of the 39 fatal police shootings in 2006-07 to 2016-17 for which a coronial inquest had been completed and findings were available, 95 percent (*n*=37; see Table 6) were deemed justifiable shootings in which the decedent posed a significant threat to the lives of the police officers involved or to other individuals.

There were two cases in which the coroner determined that the shooting was not justifiable. In one of these cases, the coroner determined that the decedent had posed no threat to an attending police officer, and that the subsequent shot fired by the police officer was done so in a manner that was overly reactive. In the other case, the coroner determined that the attending police officer had accidentally fired their gun, mistaking it for their taser.

Context of public and private police shootings

Coronial findings were available for 19 of the 23 police shootings that occurred in public places. In 79 percent (*n*=15) of these cases, the police shootings occurred directly after the decedent had threatened, injured or killed an individual other than the responding police officer(s).

Of the 24 police shootings that occurred on private property, 20 had coronial findings available. Of these cases, 11 (55%) involved the decedent threatening or injuring another individual shortly prior to their death. Six of these cases (55%) involved the perpetration of family or domestic violence.

Recommendations

Recommendations were made in 39 coronial inquests (25 related to police shootings and 14 related to self-inflicted shootings). Most of these recommendations were directed to police agencies and were related to eight main themes: internal policies, training, audio and video recordings of police interactions, internal communication, communication with external parties (including relatives of victims and the media), critical incident procedures, post-incident procedures and investigative integrity. Recommendations were most frequently made in relation to mental illness (36%, *n*=14).

These recommendations included:

- incorporating mandatory mental health, de-escalation tactics and crisis response management into training for frontline and other police officers;
- embedding mental health workers within police operations;
- obtaining a mental health history of a high-risk offender when considering tactical options in respect of apprehending this offender;
- incorporating a mental health assessment into the firearm licence granting procedure;
- exchanging information relating to mental illness between police agencies and mental health treatment organisations;
- implementing systems in general practitioners' offices to identify and follow-up with patients who cease presenting themselves to receive their prescribed medication; and
- implementing mandatory suicide prevention and crisis management training for all medical practitioners.

Conclusion

The rate of shooting deaths in police custody has remained stable since the establishment of the NDICP in 1992, despite annual fluctuations. The majority of these deaths involved individuals who were non-Indigenous and male. Most decedents had a history of mental illness and almost half had used alcohol or drugs shortly before their death.

Shooting deaths in police custody were most likely to occur on private property, after the commission of a violent act and while the decedent was in possession of a weapon. Consequently, coroners have found the majority of police shootings to be justifiable, carried out by officers who were protecting themselves or others in the course of their duty.

In response to shooting deaths in police custody, coroners have made numerous recommendations as to how mental illness can better be dealt with by police and healthcare practitioners, how police policies and procedures can be revised, and how police training can be developed to ensure officers are best equipped to deal with the challenges they face while carrying out their duties.

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URLs correct as at November 2019

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Appendix

Table A1: Shooting deaths in police custody 1991-92 to 2016-17 (n)				
	Shot by police	Shot by self	Shot by other	Total
1991-92	4	2	0	6
1992-93	4	5	1	10
1993-94	9	7	0	16
1994-95	6	5	0	11
1995-96	4	7	0	11
1996-97	7	8	0	15
1997-98	5	2	0	7
1998-99	2	0	0	2
1999-2000	11	4	0	15
2000-01	3	4	0	7
2001-02	2	4	0	6
2002-03	5	5	0	10
2003-04	6	5	0	11
2004-05	6	5	0	11
2005-06	3	3	0	6
2006-07	3	4	0	7
2007-08	3	6	0	9
2008-09	5	6	0	11
2009-10	3	5	0	8
2010-11	6	3	0	9
2011-12	4	2	0	6
2012-13	1	3	0	4
2013-14	3	3	0	6
2014-15	10	1	0	11
2015-16	5	1	0	6
2016-17	4	1	0	5
Total	**124**	**101**	**1**	**226**

Note: Excludes one case where shooting death status was not recorded Source: AIC NDICP 1991-92 to 2016-17 [computer file]

Table A2: Shooting deaths in police custody by circumstances of custody, 2006-07 to 2016-17						
	Shot by police (*n*=47)		Shot by self (*n*=35)		Total (*n*=82)	
	n	%	*n*	%	*n*	%
Institution	0	0	1	3	1	1
Escaping	0	0	1	3	1	1
Detaining	46	98	33	94	79	96
Other	1	2	0	0	1	1

Note: Percentages may not total 100 due to rounding Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Table A3: Shooting deaths in police custody by jurisdiction, 2006-07 to 2016-17 (n)				
	Shot by police (*n*=47)	Shot by self (*n*=35)	Total (*n*=82)	Proportiona (%)
NSW	18	10	28	39
Vic	7	5	12	32
Qld	11	7	18	35
WA	4	4	8	17
SA	4	4	8	25
Tas	2	0	2	40
ACT	1	2	3	75
NT	0	3	3	13

a: Shooting deaths in police custody as a proportion of all deaths in police custody between 2006-07 and 2016-17 Source: AIC NDICP 2006-07 to 2016-17 [computer file]

Table A4: Shooting deaths in police custody by Indigenous status, 1991-92 to 2016-17 (n)						
	Indigenous shooting deaths			Non-Indigenous shooting deaths		
	Shot by police	Shot by self	Shot by other	Shot by police	Shot by self	Shot by other
1991-92	0	0	0	4	2	0
1992-93	0	0	0	4	5	1
1993-94	1	0	0	8	7	0
1994-95	2	0	0	4	5	0
1995-96	0	0	0	4	7	0
1996-97	0	1	0	7	7	0
1997-98	0	0	0	5	2	0
1998-99	1	0	0	1	0	0
1999-2000	0	0	0	11	4	0
2000-01	1	0	0	2	4	0
2001-02	0	1	0	2	3	0
2002-03	1	0	0	4	5	0
2003-04	0	0	0	7	5	0
2004-05	0	0	0	6	5	0
2005-06	0	0	0	3	3	0
2006-07	0	0	0	3	4	0
2007-08	0	1	0	3	5	0
2008-09	0	1	0	5	5	0
2009-10	0	1	0	3	4	0
2010-11	1	0	0	5	3	0
2011-12	0	0	0	4	2	0
2012-13	0	0	0	1	3	0
2013-14	0	0	0	3	3	0
2014-15	1	0	0	9	1	0
2015-16	0	0	0	4	1	0
2016-17	0	0	0	2	1	0
Total	**8**	**5**	**0**	**114**	**96**	**1**

Note: Excludes three cases where Indigenous status was not recorded, and one case where shooting death status was not recorded Source: AIC NDICP 1991-92 to 2016-17 [computer file]

In the lead-up to the 30th anniversary of the Royal Commission into Aboriginal Deaths in Custody, five deaths have happened in the last month. MickTsikas/AAP

Indigenous deaths in custody: inquests can be sites of justice or administrative violence

ALISON WHITTAKER

Research Fellow, University of Technology Sydney

Published courtesy of

THE CONVERSATION

Aboriginal and Torres Strait Islander readers are advised this article contains names and/or images of deceased people.

Five Aboriginal people have died in custody in the last month in Australia.

It's been 30 years since the 1991 Royal Commission into Aboriginal Deaths in Custody examined 99 deaths between 1980 and 1989 and made over 30 recommendations into how deaths in custody should be investigated.

A government-commissioned review of the royal commission's recommendations declared many had been implemented — but critics reject that characterisation as "misleadingly positive".

On the ground, little has changed — 474 Indigenous people have died in custody since the report was handed down.

Wayne Fella Morrison and Danny Whitton were babies when the royal commission conferred its report. Cherdeena Wynne was not yet born. All died in custody and have inquests that are expected to sit later this year.

Deaths in custody and inquests

The royal commission report issued 339 total recommendations aimed at preventing and addressing Aboriginal deaths in custody.

This included that families be involved at every stage of the inquest into a loved one's death. Aboriginal families continue to drive that advocacy, including with the recent launch of the Dhadjowa Foundation, which provides support to families whose loved ones have died in custody.

Every death in custody is mandatorily investigated through a coroner to determine how and why it occurred.

Recent inquests over the past year have occurred after:

- two young Aboriginal men died in the Swan River in 2018 during a police chase
- a 36-year-old Aboriginal man named Nathan Reynolds died in 2018 on a prison floor from an asthma attack (the NSW coroner found he was

Families have been sidelined by court procedures when they seek to offer evidence around the manner of their loved one's death. David Crosling/AAP

denied "at least some chance" of surviving due to an "unreasonably delayed" response from prison and health staff)

- Yorta Yorta woman Aunty Tanya Day died in a prison cell; the inquest into her death was the first to consider systemic racism

So, how effective are these inquests in preventing future deaths in custody, or getting justice for those we have lost?

Inquests can enable injustice

Inquest processes have been criticised in some quarters as enabling injustice. The royal commission found inquests: merely reflected the inadequacies of perfunctory police investigations and did little more than formalise the conclusions of police investigators.

In inquests, coroners are unable to suggest civil or criminal liability. They are also expected to rely on police and corrections personnel for their evidentiary briefs, while overseeing matters where police and corrections staff are parties with a stake in the case.

In some states, family statements at the end of an inquest are not considered evidence, but are reduced to commentary or personal information about the deceased.

While families can be closely involved in inquests, in many circumstances they cannot directly represent the legal interests of a person in the same way a custodial officer's lawyer might. This is because they are represented as next of kin, not as representatives of legal interests outside the inquest. They are not given standing for some of the most critical parts of accountability-seeking.

Some families report being sidelined by court procedures when they want more than a memorialising role.

Despite the royal commission's recommendation to investigate deaths in custody as potential homicides, the predominant narratives that now surround these deaths range from suicides to mysterious ill-health. This is the case with Indigenous deaths in custody in other countries, as well.

An example of this is the initial investigation of the death of David Dungay Jr. The implication that he died of natural causes in unsuspicious circumstances, despite him being pinned down until he was unconscious by five officers who ignored his panic about being unable to breathe, was rejected by his family.

A system that fails Indigenous people

Both weaknesses and the institutional design of the inquest system continue to fail Indigenous people. Some of these today were not even in the realm of contemplation for the royal commission 30 years ago.

Take, for example, the case of a South Australian deputy coroner looking into the death of Wayne Fella Morrison. The Supreme Court has ruled the deputy coroner will not, as one media report put it, "be able to make a finding of misconduct against corrections staff who restrained him, or compel them to give evidence."

This has potential to affect other inquests, and set a damaging precedent for other state agencies.

In the case of Ms Wynne, who died after losing consciousness while handcuffed, police have previously said they did not consider her death to be a "death in custody" and would not refer it to the coroner for the requisite inquest.

While the inquest is expected to proceed, establishing the obvious fact of a death in custody to get an inquest in the first place is a sizeable barrier that no family should have to face. The long-standing practice of mandatory referral risks being undermined by emboldened state agencies.

New tensions are also emerging in the role of coroners and when matters can be referred to prosecutors. At the time of the royal commission, coroners in some jurisdictions were able to directly set prosecutions in motion. Now, however, complex procedures and evidentiary thresholds govern when matters are referred to prosecutors to make that decision.

There has also been a surge in the use of suppression and non-publication orders in some jurisdictions, preventing evidence and names linked to an inquest or death in custody from being published.

Families of people who have died in custody are still pushing for CCTV footage, audio and photos linked to loved ones' deaths to be released publicly, having seen their potential in exerting public pressure and truth-telling as alternative paths to justice.

Inquests can be sites of justice or of administrative violence

Inquests are central to the violence of deaths in custody. For some who lose their loved ones in custody, they are a site of justice and change; for many, they are a site of fresh administrative violence.

Communities and families continue to push for justice, despite the immovable barriers placed in their path and even when, 30 years on from the royal commission, accountability for any death in custody seems distant or almost impossible.

Update: The piece was amended to remove descriptions of one of the cases currently before an inquest.

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Nyunggai Warren Stephen Mundine AO

Mundine calls BLM 'divisive liars'

Prominent Aboriginal leader Warren Mundine labelled Black Lives Matter divisive and untruthful during a major address in Sydney.

The former ALP national president told the internationally-affiliated CPAC forum that Australia was not a racist nation.

"BLM has exaggerated Aboriginal deaths in custody and is helping to spread historical misinformation," Mr Mundine said.

Rights

"From the arrival of the First Fleet, indigenous people were recognised as subjects of the British Empire – and had enjoyed all the rights of settlers including voting rights," he said.

"The status of indigenous people was never covered under the Flora & Fauna Act – that's just not true and is a long-repeated myth."

Mr Mundine, who has in recent years become an active member of the Liberal Party, told the gathering of 300 plus attendees that it was time to talk the truth.

"BLM talks about the 434 indigenous deaths in custody since 1991 as if there had been 434 killings by police and corrective services offices," he said.

"This is just not true. The vast majority of these deaths were not caused by officers.

Ignored

"Most died of natural causes or by their own hand or from accidents."

He said BLM also ignored there were 951 homicides with indigenous victims between 1989 and 2012 representing 12 per cent of homicides in Australia.

"Where's the outcry and marches for these black lives?" he asked.

"They ignore the fact that indigenous women are 35 times more likely to be hospitalised due to non-fatal family violence than any other Australian woman".

"Indigenous women are also five times more likely to be victims of homicide."

He said indigenous children were seven times more likely to be victims of substantiated abuse or neglect.

"I'm frustrated that people aren't telling the full truth about indigenous Australia and not acknowledging and dealing with the underlying problems of crime in their communities and within their families."

Mr Mundine said the indigenous population gained voting rights in the 1800s at exactly the same time as non-indigenous Australians – which included all men aged over 21 years and also included women in South Australia.

He said there had been a pause to indigenous voting rights in Queensland and Western Australia, but these had been re-stored by the mid 1900s.

"It's a myth that indigenous people didn't get the right to vote until 1962," he said.

"I can recall a polling booth being made available in my grand father's community.

"Australia is not a racist country. The truth has always been that black lives matter, blue lives matter and all lives matter."

Black Lives Matter protesters moved their protest to Hyde Park on Friday night at the last minute to avoid police, however they were moved-on by police and eventually dispersed. Picture: David Swift

For protesters not all black lives matter

CHRIS MITCHELL

Not all black lives matter equally to Australian protesters. A life lost in custody, even to natural causes, is apparently a more worthy cause than the thousands of lives lost to black-on-black violence in Aboriginal communities.

It's an issue blighted by a culture of forgetting. Those of us who were senior editors when the Royal Commission into Aboriginal Deaths in Custody report was handed down in 1991 have always known its flaw: the commission found death rates of indigenous people in custody were no higher than for white people.

Paul Kelly wrote that the 2017-18 report of the Institute of Criminology showed that year "the death rate of indigenous prisoners was 0.14 per 100 prisoners, compared with 0.18 per 100 for non-indigenous prisoners." Add to that the fact very few of these deaths are at the hands of police or prison guards — most are by natural causes or suicide.

Kelly said the different ways the ABC and Sky News treated the Black Lives Matter marches in Australia on the weekend of June 6 highlighted a "totally split culture" in media terms. "The ABC narrative was of the injustice of Aboriginal deaths in custody", while the Sky News "narrative was the irresponsibility of mass protests … given the health and political advice" in the middle of a pandemic. Especially so given that COVID-19 has not hit the indigenous community.

That dual media narrative highlights another problem, an issue that has plagued indigenous affairs for four decades — the left's preference for talking about race symbolism rather than dealing with actual murder rates, domestic violence, property crime, addiction and a lack of economic opportunity.

Long-term readers of the Australian newspaper will know it has been reporting the real situation on the ground in Aboriginal Australia for decades. Reporters such as Rosemary Neill, Paul Toohey, Tony Koch and Nicolas Rothwell have won Walkley Awards for gritty reporting on the rape of women and children by indigenous men, petrol sniffing, the killing on Palm Island of Cameron Doomadgee, foetal alcohol babies and murder rates many times higher than in the wider society.

Three Aboriginal thinkers were prepared to tell the truth last week. The always thoughtful Anthony Dillon, of the Australian Catholic University, in a letter wrote: "The best way of reducing Aboriginal deaths in custody is to focus on reducing the rates of Aboriginal deaths, full stop."

Alice Springs councillor Jacinta Price, always brutally honest, wrote that 70 per cent of indigenous people in jail were there for crimes of violence against their loved ones.

A protester in Sydney's Hyde Park.

The Aboriginal flag is seen during a Stop Black Deaths in Custody: Solidarity with Long Bay Prisoners vigil at Sydney Town Hall in Sydney on Friday.

Warren Mundine, in The Australian Financial Review, said governments could not fix Aboriginal disadvantage linked to over-imprisonment rates. Economic opportunity created by business investment was the only way forward.

Here is the real problem for the media. Many leftist journalists will not report the issue as it is. They will not look at the reality of the black lives they say matter. With a couple of notable exceptions — Russell Skelton at *The Age* a decade ago and Suzanne Smith at the ABC ahead of the NT Intervention in 2007 — the national broadcaster and the Fairfax papers (now owned by Nine) have not wanted to look at the issue beyond allegations of systemic racism.

In my 2016 book Making Headlines, I discuss the episode that first brought home to me how wilfully blind many journalists are to the facts of indigenous disadvantage. I was a young editor, and Paul Kelly was editor-in-chief.

I was at the Melbourne Walkley Awards in 1994 when this paper's Rosemary Neill won best feature for a piece about black women and children victimised by black husbands and fathers. After the presentation, a group of Fairfax editors rounded on our table to criticise the decision to publish Rosemary's piece. They thought the issue should be off limits and the piece "profoundly racist".

Three decades later, not much has improved in the indigenous world, and the media is worse. Young reporters educated in the ways of identity politics are left to campaign on issues they have not yet reported honestly or begun to understand. Once, senior editors would have tested their work, but not many such positions remain as the business model for journalism continues to disintegrate.

None of this is to deny racism exists. The Colt With No Regrets, a new book by an old regional Australian newspaper editor, Elliot Hannay, includes fascinating discussions of his relationship with Eddie Mabo and being lobbied at the Townsville Bulletin by the local Ku Klux Klan. Young journalists should read it.

I worked for Elliot in the late 1970s when he ran a series of stories about local soldiers who had started throwing Molotov cocktails on to Ross River under the CBD bridge where Palm Islanders often slept on weekend visits to Townsville. Elliot faced down a backlash from local business leaders wanting the rough sleepers out of town.

Such racism should be exposed. But so should facts about black-on-black violence. Jacinta Price wrote in The Daily Telegraph "In 2018 in the NT alone, 85 per cent (4355) of Aboriginal victims of crime knew the offender. Half were victimised by partners. Aboriginal women made up 88 per cent (2075) of those victims."

Aboriginal children were 5.9 per cent of the population but five times more likely to be hospitalised after an assault than non-indigenous children. "Between 2007 and 2011, 26 per cent of all deaths among Aboriginal children … were … (from) abuse injury," she wrote. "The leading cause of child death between 2014 and 2017 … was suicide. This is a quarter of all child suicides in Australia (85 of 357).

"Realising that there are fundamental connections between child neglect, child sexual abuse, Aboriginal victims of crime and the high rates of incarceration will allow us to address these critical issues effectively."

But most left-wing media don't want to know.

The Australian Institute of Criminology, in a paper by Jenny Mouzos, says that from 1989 until 2000, 15.1 per cent of all homicide victims nationally were Aboriginal, as were 15.7 per cent of all homicide offenders — and yet Aboriginal people were less than 3 per cent of the population.

Campaigners against law enforcement agencies who say "defund police", even neo-Marxist ANTIFA protesters, should look at a Chicago Sun Times report published on June 8 2020, : "18 murders in 24 hours: inside the most violent day in Chicago in 60 years."

From 7pm on Friday, May 29, to Sunday, May 31, 25 people were killed in the city and another 85 wounded by gunfire, all in the name of protesting against the police killing of George Floyd. The victims and perpetrators were almost all African-American.

Australian indigenous communities need to be able to trust police will protect them. Of course Aboriginal actor Nakkiah Lui was right on Q+A when she said "Just don't kill us". But she and the wider ABC, especially hosts such as Q+A's Hamish McDonald, need to report why Aboriginal Australians need police more than any other group — to protect them from black offenders.

Last word to Mundine in The Daily Telegraph: "We won't see change unless indigenous kids go to school, indigenous people are working in real jobs and there are real economies in indigenous communities."

Overwhelming support for independent First Nations body to investigate deaths in custody

BY RACHAEL KNOWLES

The New South Wales Parliamentary Inquiry into Indigenous deaths in custody has heard collective calls for independent oversight and investigation into Aboriginal and Torres Strait Islander deaths in custody.

The NSW Upper House inquiry received 120 written and video submissions. Many of these submissions supported the establishment of an independent First Nations body to oversee investigation and enforce accountability.

NSW's Bar Association and the nation's first Indigenous silk Tony McAvoy SC told the inquiry an independent Indigenous commissioner could work alongside coroners in investigations.

"If there is an independent investigation body established elsewhere that is a vast improvement on the current system," he said.

"The coroner must be resourced to do its job—that would mean resourcing the coroner's court with the investigative powers to do the investigation independently."

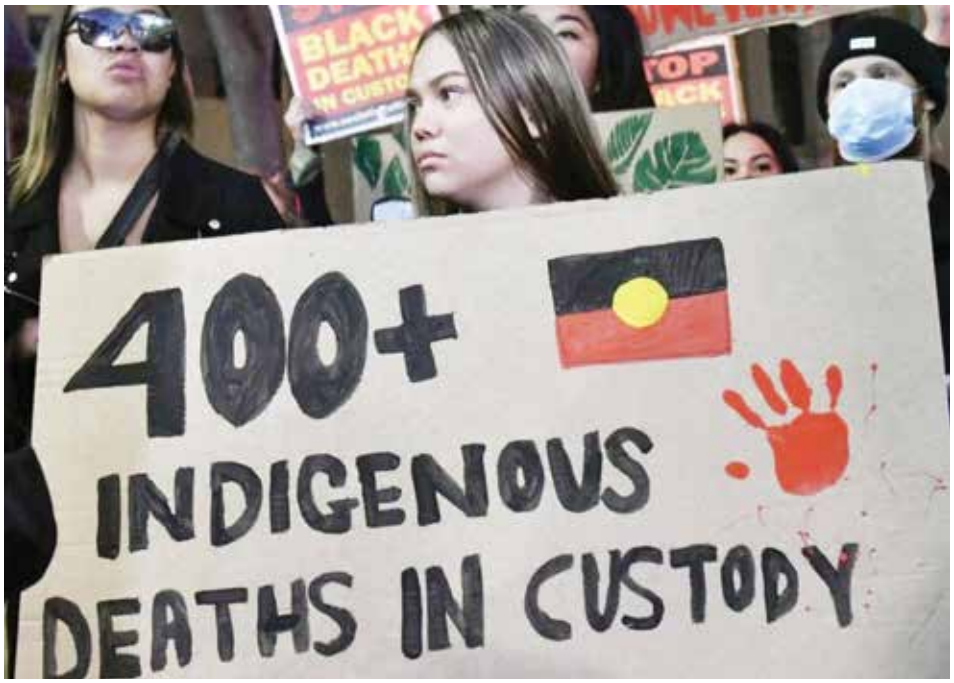
McAvoy also identified other recommendations.

"There are a number of things that might be done. Including Amendment of the bail laws, investment of community based diversionary and prevention programs, Indigenous specialist courts."

Colin and Nikola Chatfield, parents of Tane Chatfield who died in custody in 2017, told the commission about their desire for justice.

"I am devastated with the way the government has run corrective services, with investigating their own. Police investigating police, corrective services investigating corrective services," said Colin Chatfield in a video submission to the inquiry.

The Chatfields also supported independent investigations.



"We would like to see independent investigations coming through, an independent body to investigate each and every death in custody since the start," said Nikola Chatfield.

"You really need to look in this backyard and change your policy and procedures. Build healing centres, not prisons."

Aboriginal community-led not-for-profit organisation Deadly Connections raised the need for self-determination in inquiry recommendations.

"We strongly urge this Inquiry to place Aboriginal self-determination at the centre of its recommendations and recognise that systemic racism underlies the overrepresentation of First Nations people in the justice system which culminates in disproportionate Aboriginal deaths in custody," they wrote in their submission.

"There is also a significant need for greater support for family following deaths of a family member in custody. This should include a central access point for meeting, sharing and healing. Deadly Connections is committed to establishing this cultural, community, healing and social justice hub. We need support and resources to achieve this."

Calls for self-determination were echoed in Ngalaya Indigenous Corporation's submission. Ngalaya is the peak body representing over 750 First Nations lawyers and law students across NSW.

Ngalaya enforced the importance of Walama Court.

"The Walama Court is an opportunity for the NSW Government to demonstrate its commitment to the Closing the Gap justice targets. The over-incarceration of First Nations people in New South Wales requires urgent and decisive action. We strongly recommend the Walama Court as a keystone policy for reducing the over-incarceration of First Nations people," they wrote.

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The Bathing Buddha Festival is once again upon us. This year, the Festival will take place on 19 May.

Bathing Buddha Festival is a day when Buddhists celebrate and commemorate the birth of Prince Siddhartha Gautama, who later became known as Holy Sakyamuni Buddha. He founded Buddhism and brought us the philosophy of living with compassion and wisdom, looking beyond oneself, and implementing the teachings of universal love for all beings.

As the Festival follows the lunar calendar, it is often very close to the Australian Mother's Day. The coincidence is inspiring as the Festival itself is also a celebration of the Buddha's mother and all females. Many pivotal moments in Buddhism, including the birth of the Prince and introduction of Bhikkunis into the Buddhist ordained community, were a result of the outstanding contributions of females.

May the lotuses which sprouted from the Buddha Prince's steps continue to keep us pure and kind.