IN THE CORONERS COURT OF VICTORIA **NO. COR 2017/6424**
AT MELBOURNE

INQUEST INTO THE DEATH OF TANYA DAY

SUBMISSIONS BY BELINDA DAY / STEVENS, WARREN STEVENS, APRYL WATSON AND KIMBERLY WATSON, THE CHILDREN OF TANYA DAY

A. INTRODUCTION

1 Tanya Day is our mother. We need you to tell the truth about what happened to her. Our children need you to tell the truth, so that they can try to make sense of why their grandmother died. We want you to listen to her story, to hear and to understand her story. We are therefore going to tell her story using her voice, which speaks in us.

B. TANYA DAY

2 *My name is Tanya Louise Day.*

3 *I am a proud Yorta Yorta woman. I am a mother, a grandmother, a sister, an Aunty and a respected member of my community.*

4 *I was born in Deniliquin on 8 September 1962, to proud Aboriginal parents. I am one of 10 siblings, raised on Moonacullah Mission. The hut my grandmother lived in was there, and it still is. I was full of mischief and fun. My favourite thing was to head out into the bush with my Dad and his hunting dogs. I remember going out on my Dad's shoulders, and everyone said I was his shadow. My big brothers looked out for me. I loved the tranquillity of the bush, spending time there and being surrounded with my family and community. A community where everyone looked after each other. Later, I would take my children and grandchildren out to Moonacullah, and they love it too, they feel their connection to their county, just like I did.*

5 *After my dad passed away, we moved to Echuca with my Mum, where I went to school. I stayed cheeky, as I grew up into a beautiful young woman. I was always proud of my brown skin and being a Yorta Yorta woman.*

6 *I was independent young. I got a job on the checkouts at Coles. I used to play netball and enjoyed spending time with my family and friends. I enjoyed getting dolled up and hitting the town for a good time.*

7 *Then Belinda was born when I was 18, and I started my own family. I loved my children so much. I taught them to laugh and have fun, and to be strong and proud of who they are, and to fight for what was right and against what was wrong. I am so proud of how they have grown up, as strong, courageous, resilient, cheeky, kind humans, who are proud to be Aboriginal. I am proud, too, of the way they have fought against the injustice of my death.*

8 *I loved my children so much when they were little and as they grew up. Each had their own unique personality and my cheeky streak was something that I passed on to them all. I loved to show my children off and whenever I had the opportunity, I would make sure people knew they were mine. My children blessed me with grandchildren that I absolutely adored. I was so proud of being a Nan, I enjoyed teaching them new things, how to bake a cake or how to throw a boomerang.*

9 *In 1984, I lost my son Luke, when he was only four months old to Sudden Infant Death Syndrome. I remember the day like it was yesterday, I had gone to play netball and upon returning home I went to check on Luke and found my precious baby boy was blue and wasn't breathing. The loss of my son destroyed me and I never recovered. I found it hard to talk about losing Luke and how it made me feel. Over the years I have suffered the loss of many family members including my Father, Mother, Grandmothers, Brother, Sister, Nephew and so many Aunties, Uncles and Cousins. One way I had of dealing with that trauma was to drink to numb the pain.*

10 *I travelled around Australia. I had many adventures and visited many different communities. I always felt a part of the communities I was in and did what I could to support them.*

11 *While I was in Sydney, I got hooked on the South Sydney Rabbitohs and the NRL. I kept following them throughout my life and I was so happy when my boys won the NRL premiership in 2004.*

12 *I was a deadly cook and loved to cook for my family and community. My favourite meal was a Sunday roast with all the trimmings and a wicked pavlova to finish with. I worked hard in the different cooking jobs I had, this ranged from cooking at Berrimba Child care for the children to starting my own catering company.*

13 *I was a beautiful woman, and I loved to dress up and look good. I looked really good in my fur coats and felt good in them. I loved wearing nice heels. It felt good, and made other people feel good too. I would pose for photos, and later, my grandchildren learned to pose too.*

14 *I loved my community, being with them and supporting them. I respected my Elders and looked out for the younger ones. I understood the importance of building strong communities. I loved to go where communities were organising and standing up for things that were important. I would cook good food to keep people strong, and provide moral support, and laughter.*

15 *I understood the importance and strength of Aboriginal people celebrating who we are, and what we have achieved, demanding justice and respect. This pride and strength were instilled in me by mother and grandmothers, proud and strong Aboriginal women who were the backbone of their families and communities.*

16 *My uncle, Harrison Day, died in custody when I was 19 years old. I always knew that police cells and prisons were not safe places for Aboriginal people, that we died there. And I knew that we were much more likely to end up there than other Australians. We didn't need the Royal Commission to tell us that, we knew from our own lives, from the stories of family and friends in our communities. As I got older, wiser and stronger, I realised I could do something more about fighting against this injustice. I supported communities who were grieving those who died. I spoke up and encouraged others to speak up. I always felt a need to help others and would do whatever I could to support others that were having a tough time.*

17 *When I woke up on 5 December 2017, I didn't know it would be the last day of my life as I knew it. I never imagined that something that I was so proud of, my Aboriginal heritage would be used against me to deny me my freedom, dignity and ultimately my right to life. I was feeling good because I was going to see my youngest daughter who was pregnant, and we were going to see about housing for when I moved to Melbourne. It was an exciting time for me, and after I bought my ticket, I decided to buy a couple bottles of wine to get me through the journey to Melbourne. I began drinking on the bus and when I arrived in Bendigo, I felt the effects of the alcohol and had a rest on the bench seat inside the station. When I boarded the train at Bendigo, I went and found my seat and got comfortable before falling asleep. I was woken sometime later by the train conductor asking to see my ticket, somehow, I had misplaced my ticket and despite my best efforts to find it, I couldn't find it. When the conductor left me, I fell back to sleep, only to be woken a second time by police officers. I was confused, embarrassed and didn't understand what was happening. I had a ticket and I wasn't bothering anyone, so I was horrified when the police officers forced me to get off the train. At first the officer tried to grab my arm and I told him 'Please don't', and I got up myself and walked off the train. I felt frightened because I hadn't done anything wrong. I was surrounded by four police officers on the station platform, everyone could see, it was so humiliating.*

18 *I was groggy and a bit confused. I realised that they wanted me to get off the train. I followed them on to the platform, and did my best to tell them who I was and where I was going. It was a bit hard to unlock my phone, because the screen was smashed and it was reflecting in the sunshine, but eventually the police got Kimberly's number. Then they took me to the divvy van. I had the most terrible sinking feeling. I knew what was going to happen now. Like my uncle Harrison, like so many of my people, I was going to be locked up in a police cell when I had done nothing wrong. I was going to be locked up for being Aboriginal. I knew how dangerous the cells were for me. Inside I was full of fear, but all I said was, "this again", because I knew there was no way I could explain it to them so they would understand. They put me in the back of the van and took me to the station.*

19 *Back at the station, one of the police told me they had talked to Kimberly and were trying to get someone to collect me. But then they started processing me into custody. I knew what was going to happen — they were going to put me in a cell. I was so scared. I knew how dangerous this would be. I was trying everything I could to stop them. I tried to be nice to them, laughing and joking. I pleaded with them, and tried to bargain with them to let me go. All of this was demeaning to me, but I had to try. But they wouldn't change their mind. I had to take off my shoes, my jacket, my jewellery. I was so upset and scared. I started crying a few times. I felt that same old feeling, that feeling Aboriginal people feel all the time, but white people can't believe in because they don't feel it. They couldn't see me at all. All they could see was a drunk Aboriginal woman. They just wanted to get me into the cell and forget about me. They walked me down the corridor and put me in the cell.*

20 *I was terrified, and I felt this terrible fear squashing me. Now that there was nothing else I could do, I felt disoriented and very scared. I can't explain to you how it felt to be in that cell, because only another Aboriginal person could really understand. The best way I can try to explain it is that it was like the most scary nightmare you can imagine, where you feel like the whole world is unsafe and there is nothing you can do, and the people around you are carrying on like nothing is wrong. I just wanted to go to sleep. I lay down. The officers kept trying to talk to me. One said she had to pat me down. Eventually I stood up. I was pretty wobbly, but a different officer held my arm while I was being patted down so I didn't fall over. The officers left and I lay down again. I felt very alone. I started feeling very woozy. I got up and moved around a couple of times. I tried the door — I knew it wouldn't open, but I had to try. As I moved around the cell I stumbled a couple of times.*

21 *After a while, as I was lying down, I heard a tap on the window. I wondered if I'd dreamed it. I got up to try to see what was going on.*

22 *I tripped and fell. I smashed my head on the wall. I kind of knew it would kill me. It didn't really surprise me, because I had felt so scared of dying in that cell. But the next few hours were so painful and scary. I knew it was really bad, that I was going to die, but everyone just kept acting like nothing was going on, like everything was normal and fine. I don't think you could understand what those last few hours were like, but please try. It is so important that you try. Eventually, it all started to quiet down, and I felt myself leaving. I felt peaceful to be rid of all that pain and fear, but so deeply sad that I had to leave behind my children, my grandchildren, my people and my country, and for nothing, for no reason.*

23 *I have told you my story because I want you to see.*

24 *I miss my children and my grandchildren. It is not right that I can't be around to see them grow up, and to help to raise them; I would have given my life to that. But my life was taken away from me and from them. You cannot know the grief and anger – the deep and irreversible trauma – that this causes my family and my community. Don't pretend you can, but please try your best. You must try your best, because you have the power to tell the truth and recommend changes that might prevent another Aboriginal family, and their community, from experiencing that trauma.*

25 *I need you to see, and to acknowledge, that my death was caused by the same system that killed my uncle, Harrison Day, the same system that dispossessed and killed so many of my ancestors and so many other Aboriginal people; that fractured our communities and culture, and caused deep intergenerational trauma. I need you to see that this is not past history, this is the ongoing story of our country.*

26 *I need you to tell the truth about this.*

27 *I also need you to hold those involved accountable, and to refer the people involved for a proper criminal investigation and trial.*

28 *You are a part of the same system, but you have the opportunity to transform it, by speaking the truth, and holding the system itself accountable.*

29 *It is not enough to change the law on public drunkenness. I need you to tell the truth about why the law was applied to me differently from the way it would have been applied to a white Australian grandmother, drunk and asleep on a train, on her way to Melbourne to visit her daughter; about why the police took me into a cell, rather than to hospital or home; about why the police treated me like a criminal and completely failed to care for me, even though they said they were imprisoning me for my own safety.*

30 *If you don't do that, nothing will change.*

C. THE TWO TANYA DAYS

31 Remember how Commissioner Wotton described the two Harrison Days? That showed his insight into the truth about the cause of Uncle Harrison's death, about a deep and systemic causal factor in all Aboriginal deaths in custody.

32 In trying to tell the truth about what happened to our Mum, we ask you to show the same sensitivity as Commissioner Wotton, and carefully consider the difference between the rich human being she really was and how she was seen by Shaun Irvine, the police officers, and Lisa Harrup.

33 We are so grateful to Sarah Holland and Emma Matheson. They were the first people the whole day who really saw Mum as a human being. Sarah said, "Initially, the story matched, that Ms Day was lying and behaving intoxicated but it was soon becoming apparent that there was something else going on and the situation that we were given was not accurate".[1] She considered the objective evidence, and looked hard to see what was really going on. As Stephenson explained, it was critical for paramedics to apply objective measures, such as the Glasgow Coma Scale, to ensure that they most accurately got at the truth of a patient's condition, and avoided the false pictures that might be created by unconscious biases. In his opinion, had Harrup properly applied that measure, she "would have had to" detect that there was something wrong with Mum, beyond intoxication.[2] She would have started to see our mum, instead of "an intoxicated person".[3]

34 We ask you to be like Sarah Holland. You have been told a range of stories about what happened, by the officers who are potentially implicated in Mum's death, following an inadequate and flawed investigation by other police officers. But you have objective evidence. You have the CCTV footage. You have the facts of the decisions that were made. You have the language used by Irvine and the officers, which tells you something about how they thought. And you have the data produced by Victoria Police under FOI, and the objective expert evidence of Professor Klein about how the mind works (which is consistent with documents prepared by Ambulance Victoria and Victoria Police), and of Thalia Anthony, documenting facts and studies about institutional racism in Victoria Police.

35 We ask you to be like Sarah Holland: to be sceptical about what you have been told by the officers, who have reason to tell a story that makes their conduct better than it actually was, and whose thinking was affected by stereotypes and ideas of which they are not conscious, and to look at the objective evidence in order to determine the truth.

36 Commissioner Wootten and Sarah Holland both came to their task in a position of authority, but had the courage and sensitivity to do what was not usually done, in order to get at the truth. Their courage to do what was needed, rather than what was usual.

D. YOUR TASK

37 Because Mum died as a result of being fatally injured in police custody (a police contact death), and because she was an Aboriginal woman, you have a unique and important function, when it comes to investigating her death. This has ramifications for the way you need to approach your task.

I. What we want you to do

38 The two most important things to us are:

38.1 That you notify the DPP under s 49(1) of the Act. As we talk about below, individuals are hardly ever referred to the DPP after an Aboriginal death in custody. There has to be accountability. On the evidence, it is possible that offences have been committed, which means that you need to notify the DPP.

38.2 That you make findings about systemic racism and unconscious bias. These issues are almost never talked about in inquests and other court proceedings. But they played a central role in our Mum's death. You cannot properly make findings about what happened without considering them.

II. An Aboriginal death in custody

<u>Death in custody — the right to life and a procedural duty</u>

39 In Victoria, Parliament has protected everyone's right to life.[4] It had to do that to keep Australia's promise to 73 other countries that it will protect that right.[5] When a government agrees to protect that right, "[t]here is a great responsibility on the police to ensure that the citizen in [their] custody is not deprived of [her] right to life".[6] Police therefore have to protect citizens in custody from harm, including from themselves.[7]

40 Also,[8] a country that has agreed to protect the right to life has a "procedural" duty, "requiring the initiation of an effective public investigation by an independent official body into any death where it appears that any of the state's substantive obligations has been or may have been violated and it appears that agents of the state are or may be in some way implicated".[9] Here, that comes from Australia's promise to actually protect that right, and to provide effective remedies where rights are not protected,[10] and from the Victorian Parliament's protection of the right to life.[11] If a person dies in police custody, especially where there is a question whether police might have caused her death, art 2 requires Australia to conduct an investigation that is "independent, impartial, prompt, thorough, effective, credible and transparent".[12]

41 Compliance with that procedural duty "must rank among the highest priorities of a modern democratic state governed by the rule of law".[13] As in the UK, in Victoria "an inquest is the means by which the state ordinarily discharges that obligation".[14] The Act is how Victoria upholds Australia's procedural duty, and should be interpreted in a way that allows that duty to best be fulfilled. It is also how Victoria's Parliament said the duty was being fulfilled in Victoria: "[t]he right to life is protected by section 9 of the charter. In other jurisdictions this right has been interpreted to include an obligation on government to ensure an effective investigation into certain deaths. As the most significant investigative mechanism into reportable and reviewable deaths, the coronial system gives effect to this right."[15]

42 In England, the highest court has said that a coronial inquest into a death involving the state needs to be more intensive to satisfy the procedural duty.[16] It has to be independent from "the state agents who may bear some responsibility for the death"; relatives must play an appropriate role; and the inquest "must be prompt and effective. This means that it must perform its essential purposes. These are to secure the effective implementation of the domestic laws which protect the right to life and to ensure the accountability of state agents or bodies for deaths occurring under their responsibility".[17] It requires not only an independent and thorough investigation (which, as you know, we don't think has happened here), but also a full determination of the circumstances, which — in this case — extends to determining whether the police conduct was lawful and whether it was affected by systemic racism.

43 Unless you determine lawfulness, how can you secure effective implementation of the domestic laws which protect life? And if systemic racism is at play, what will stop it killing again, if you don't call it out?

44 Section 49 of the Act is also very important. Riley's investigation into possible criminal responsibility was not independent or effective; it was bad. An effective investigation "must be capable of leading to the identification and punishment of those responsible". This inquest can satisfy that requirement, only if you refer the possible criminal conduct to the DPP.

45 For the reasons the VEOHRC gave you earlier in the year, in exercising inquest functions, you are a "public authority" under the Charter. So you must (s 38(1)) give proper consideration to, and act compatibly with, the right to life (s 9), liberty (s 21), substantive equality (s 8(3)) and culture (s 19(2)).

Aboriginal death in custody — the coroner's role

46 The requirement for you to be independent, to look into everything properly, and to refer possible criminal conduct to the DPP, is doubly important in Australia, where, since the beginning, the system of domestic laws has destroyed, and then failed to protect, the right to life of Aboriginal people.

47 In his report into the death of Harrison Day, Commissioner Wootten found that "[t]he police investigation in the present case was of a token nature, not independent of those whose conduct should have been investigated, and completely ineffective. As a result there was no scrutiny of the care taken of Harrison Day, there was no accountability and no lessons were learnt."[18] These kinds of failures led to recommendations about making the coronial process as independent as possible from police officers implicated in the death.[19] Those recommendations are consistent with the requirements of the right to life's procedural duty.

48 The Attorney-General said that the Act implemented recommendations of the Royal Commission.[20] The Royal Commission spent a lot of time considering the inadequacy of coronial investigations of Aboriginal deaths in custody.[21] This led to detailed recommendations about future coronial inquests.[22] One recommendation was that police be directed to approach investigations on the basis that the death may be a homicide.[23] Other

recommendations required a broader and more intensive investigation, including "[t]hat a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death"[24] and "[t]hat a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths".[25] This approach is consistent with your obligations under the Charter. This Court has held that in order to comply with the State's obligation to protect the right to life (s 9), an inquest "must address broader systemic and prevention issues that may have contributed to the death".[26] The fact that Mum was Aboriginal is particularly important: 19(2) can impose obligations on courts,[27] which must recognise the particular forms of "discriminatory disadvantage and vulnerability" faced by Aboriginal people.[28]

49 The Victorian Implementation Review said that "implementation of the Royal Commission Recommendations is impeded by a strong residual element of cultural ignorance, disrespect, lack of interest, and, at times, racism."[29] Those problems cannot be addressed unless they are identified and examined. As they say, "sunlight is the best disinfectant". That is why you need to make findings about *all* the relevant matters — including the difficult and taboo issues of systemic racism and unconscious bias — not just uncontroversial or obvious ones. That way, you will do what is required under the Act and the Charter, satisfy the procedural duty, and meet the recommendations, and the spirit, of the Royal Commission.

Aboriginal death in custody — the importance of language, and what it says about meaning

50 Alison Whittaker is a Gomeroi poet and law scholar. She undertook research at Harvard Law as a Fulbright and Roberta Sykes scholar, analysing the language used by coroners in reporting on Aboriginal deaths in custody. She has prepared a book manuscript on the subject, which she has kindly agreed to make available if you ask for it. However, she has succinctly summarised some of her key findings in a short Guardian article, which we ask that you read. It is Annexure 2 to these submissions. She explains why "the language coroners come to use about deaths inside is crucial", and how, based on her extensive research, the language they use reflects particular views about Aboriginal people and the systems that cause their death. She points out the use of words like "sad", "regrettable", "unfortunate". Please don't use words like that. We know it is sad that our mother died, we are sad. To put it bluntly, Aboriginal people are not helped by hearing about the sadness of non-Aboriginal people at the effects of a system that keeps killing us, even though everyone knows about it, and no-one does anything about it.

51 But the reason language is so important is that it shapes meaning and outcomes. She writes, "I spent a year researching 134 cases to find out why prosecutions and civil actions for deaths inside were so uncommon. I concluded that the problem starts earlier than the discretion to prosecute or pursue civil action. It begins in the state's coroner's court." She noted the use of language to blame the person in custody, and minimise the contribution of official actors. Please read it. It is really important to us, and for you to fulfil your function, that you think about what the language you use says about the meaning you are attributing to what caused Mum's death.

52 Our grandchildren will read this when they grow up. Not just what you say, but how you say it, is very important. The reports written by Commissioners Johnston and Wootten are enduring and powerful 30 years later, because of the sensitivity, insight and truthfulness with which they were written. We ask that you bring those same courageous values to bear on this task.

Aboriginal death in custody — the importance of referral for proper criminal investigation

53 Alison also notes that, of the 134 cases she researched, 11 were considered for referral, 5 were referred, and only two were taken up. It is a fundamental principle of the procedural obligation to provide an effective inquiry that it be capable of leading to prosecution. The *most* important thing for us is that you exercise the power under s 49 of the Act. This is a case where actions will speak louder than words.

III. Truth-telling and proof-barriers

Counsel Assisting's Submissions

54 Counsel Assisting's submissions, which effectively accept the overall story told by the officers, go something like this. The "tragic circumstances" illustrate in "distressing detail" why the public drunkenness law should be repealed. Systemic racism by Victoria Police against Aboriginal people exists and is connected to and reinforces unconscious bias in individual police officers.[30] Aboriginal women are 10 times more likely to be the subject of public drunkenness laws. Nevertheless, everything that happened in this case can be explained in a way without finding that any kind of systemic racism or unconscious bias occurred: sometimes what happened was quite reasonable, and complied with the applicable policies;[31] sometimes it was a result of a "culture of complacency" about dangers to "drunk persons" in custody.[32] And, "having regard to the principles of fact finding in coronial matters and to the jurisdiction of the Court, it is not possible to make findings that the decision making of any individual involved with Ms Day was as a result of their awareness of Ms Day's Aboriginality".[33]

55 In making those submissions, Counsel Assisting repeatedly refers to whether events were "surprising" or "unusual".[34] That is not the point. It is not "surprising" or "unusual" for people to act on their unconscious biases, for Aboriginal people to have disproportionate contact with the justice system, or for Aboriginal people to die in custody. That something is usual does not make it right. Systemic racism is so dangerous exactly because it is completely usual, and therefore hard to see for those who are not affected by it. Considering the events that led to our mother's death against a standard of what is "usual" assumes that "usual" = acceptable. Some of the worst things in history have been banal. "Usual" pre-emptively denies that anything needs to change. We ask you to look beyond what is "usual", and to look for the truth.

56 Further, while Counsel Assisting (correctly) submits that the Coroner should find that Mr Wolters and Ms Neale failed to conduct physical checks as required by the guidelines, she submits that "[i]t is now not possible to ascertain what would have or should have occurred in relation to Ms Day's time in custody if [a proper physical check] procedure was carried out correctly. It may be that she would not have fallen at all, it may be that she still would have fallen but received earlier medical intervention, it may be that there was no different result".[35] In one sense that is self-evidently true — one can never be certain about a counterfactual. But in reality, our mum died because police put her in a cell and neglected her. As explained below, the evidence shows that police failed to properly care for her and that as a result they failed to prevent her fatal fall and contributed to her death. That is the finding you should make. To say instead that "we just can't know what would have happened" is a cop out. Literally. It absolves police from responsibility.

Fact-finding under the Coroners Act

57 Section 67(1) of the Coroners Act says that "(1) A coroner investigating a death must find, if possible— … (a) the identity of the deceased; and … (b) the cause of death; and … … (c) … the circumstances in which the death occurred". That means you have to find the facts most likely to be true, even if that reflects badly on individuals involved.

58 Some judgments have talked about the case of *Briginshaw v Briginshaw*,[36] and said that "coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death".[37] *Briginshaw* was about the standard of proof for allegations in adversarial proceedings. In it, Dixon J talked about three "considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal": (1) "[t]he seriousness of an allegation made"; (2) "the inherent unlikelihood of an occurrence of a given description"; and (3) "the gravity of the consequences flowing from a particular finding".

59 The Supreme Court said that the "*Briginshaw* standard" applied to a coroner's finding under the old Coroners Act about "the identity of any person who contributed to the cause of death",[38] at least for medical professionals,[39] and to some extent police officers.[40] That was because of the consequences for that person: "[t]he extremely deleterious effect the finding has upon the plaintiff's character, reputation and employment prospects demand a weight of evidence that is commensurate with the gravity of the allegation".[41]

60 If you took that approach in this inquest, you would be prioritising the protection of police officers' reputations over finding the truth. You should not take that approach, especially to findings about unconscious racial bias, for at least seven reasons.

61 *One*. The relevant parts of the current Act are different to the old Act. In this Inquest, s 67(1)(b) and (c) require the Coroners Court to "find, if possible … the cause of death; and … the circumstances in which the death occurred". That doesn't leave any room for refusing to make a finding because of the possible consequences for a person involved in the death. Your duty is to make findings about the cause and circumstances of the death, not to decide an allegation in a civil proceeding. (Section 140 of the *Evidence Act 2008* (Vic), which reflects *Briginshaw*,[42] does not apply to the Coroner's Court.[43])

62 *Two.* The officers directly involved in Mum's death are not the only ones with an interest in your findings about the cause and circumstances of it. We have an equal interest in those findings.[44] The High Court said that *Briginshaw* is unhelpful or misleading when a "determination depends on a choice between competing and mutually inconsistent allegations of fraudulent conduct".[45] In the same way, the *Briginshaw* approach is wrong if you don't make a finding which would be in our interests, in order to protect a police officer's interests. Section 67 requires you to find the truth about the causes and circumstances of our mother's death, not to protect the interests of one interested party at the expense of those of another. Findings about individuals or organisations can be serious, but as Mortimer J said in *Wotton v State of Queensland (No 5)*, "the 'seriousness' of the circumstances in this case is not one-sided".[46] Our community lost another much-loved and important member, and we lost our Mum.

63 *Three*. As we said earlier, your role in investigating an Aboriginal death in custody requires a full, proper and independent investigation and for you to find the facts in a way that best tells the truth about why Mum died. To find facts using an approach that protected the officers involved would undermine the independence and completeness of your inquiry, and its ability to change anything.

64 *Four*. Coronial findings cannot create either civil or criminal liability. Section 49(1) requires you to notify the DPP if you believe "an indictable offence *may* have been committed", but you *must not* "include in a finding or comment any statement that a person is, or may be, guilty of an offence".[47] Coronial findings could not be used in civil or criminal cases,[48] and even evidence given in an inquest can be used in other cases only in very limited circumstances.[49]

65 *Five*. Even in adversarial civil cases, *Briginshaw* does not create a different standard of proof. The High Court has explained that when courts talk about the need for "clear", "cogent", or "strict" proof, they are "merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct".[50] The situation here is quite different. The expert evidence shows that every human being is affected by unconscious bias, that it is caused by evolutionary biology, and that it unconsciously affects everyone's decision-making.[51] The training documents prepared by Victoria Police and Ambulance Victoria show that they agree with this. Therefore *Briginshaw* can't apply to a finding of unconscious bias.

66 *Six.* In any event, the courts have said that *Briginshaw* does not attach to findings of non-deliberate racial bias.[52]

67 *Seven*. As Mortimer J said in *Wotton*:

> Most findings of unlawful discrimination, including those arising from a provision such as s 9 with its formula "based on race", will be based on inferences drawn from the evidence. Seldom is it the case that there is either an admission of the racial basis for conduct, or direct evidence of that basis. Some of the examples that could be given – a racially-based sign outside a cinema – are easy, but not especially realistic examples of direct evidence. In most cases dealing with a course of human conduct, the picture will be more complex, and the drawing of inferences will be required. All the more so when there are, as here, multiple actors.[53]

68 The first four points are strongly supported by the recent reasoning of the English Court of Appeal in *Maughan, R v Oxfordshire Senior Coroner*.[54]

Impact on fact-finding of flaws in the investigation

69 Despite what Counsel Assisting says,[55] the inadequacies in Riley's investigation have affected your ability to make important findings of fact in this inquest. To give just a few examples:

69.1 Within days of Mum's fatal fall, Riley had received the statements of Wolters and Neale, had reviewed the transcript of the 000 call, and had reviewed the CCTV footage.[56] He must have known that critical parts of Wolters's statement were wrong, that there were direct conflicts between the evidence of Neale and Wolters, and that Wolters had described to the 000 operator a fall that never occurred. But didn't try to re-interview Wolters or Neale to clarify any of those things.[57] He agreed that he "came up with an explanation" for Wolters's mistakes, instead of finding out what Wolters's actual answer was.[58] As a result, the issues were not explored until the evidence in the actual hearing, almost two years later.

69.2 In fact, Riley never re-interviewed any witness about any topic. He never asked Wolters about the conflict between the objective CCTV and the story the paramedics said he told them. He never asked Towns or Hurford about the obvious conflict in their accounts of the timing of the call to Kimberly.

69.3 He chose to only keep CCTV footage that showed Mum.[59] So there is no other footage available, for example showing the movements of police officers and paramedics elsewhere in the station. Sarah Holland describes a conversation with an officer in the cell corridor;[60] Riley did not preserve the CCTV that would have allowed a proper testing of her evidence. His failure to keep the CCTV footage is a really hard thing for us to accept. If he was investigating properly, why did he allow evidence to be destroyed before you, or anyone else, could see it?

69.4 He never made any inquiries about the lawfulness of Mum's treatment, such as whether she in fact had a V/Line ticket, or obtaining Hurford's phone records to establish when he called Kimberly.

70 There are many other examples, like the failure to test the blood found in Mum's cell, to conduct any investigation into the adequacy of her treatment by paramedics, or to establish what else was happening at Castlemaine police station that night. We don't believe that the investigation would be conducted this way if anyone other than police officers were implicated. Counsel Assisting is wrong to say the solution is "legislative recognition that the Coroner is directing the investigation".[61] The solution is to have a truly independent investigator for police contact deaths; not police investigating police.

E. WHAT KILLED TANYA DAY?

I. Systemic racism against Aboriginal people in Australia

71 The evidence of Thalia Anthony about the existence of systemic racism against Aboriginal people should be accepted. You found the definitions given during the scope argument helpful.[62] As the expert evidence of Professor Klein and Dr Anthony show, negative ideas about Aboriginal people are shared throughout Australian society; throughout institutions within that society, including Victoria Police; and in stereotypes causing unconscious bias in individuals.

72 To understand systemic racism and how it was a cause of Mum's death, you have to consider racism at different levels, systemically interconnected. Below, we talk about four levels at which Australian racism against Aboriginal people operates: society, law, administration of the law, and individual unconscious bias. They are connected, overlapping, and reinforce each other. Any non-Aboriginal Australian who has grown up here can test the obvious truth that socially shared ideas about Aboriginal people inform individual stereotypes, and are fed by individuals' stereotypes, by honestly considering their own ideas about Aboriginal people, and where those ideas have come from. Honest reflection by any person educated in Australia's true colonial history, who has grown up exposed to Australian society and culture, will show that the "system" in systemic racism is made up of multiple, reinforcing layers or levels, from culture down to individual thoughts.

73 During the hearing of this Inquest, we felt on many occasions the taboos that prevent discussion of systemic racism as it is shared by, and manifests in, individuals. It was palpable, especially to the Aboriginal people watching, when questions or ideas made people feel uncomfortable, like when Peter Morrissey asked if officers

had grown up hearing people talk about "boongs" and "abos". Why were those questions uncomfortable? Because they shone light on a shared system that ensures the ongoing over-incarceration of Aboriginal people without the need for any express law, policy or agreement, a system that operates in the darkness, away from the light of public discussion, or even the light of consciousness.

74 Please consider this very carefully, because the truth is that systemic racism at each and all of these levels was obviously involved in Mum's death; but we know it is hard, because of the taboos built into the system, for you to see or describe. You have the opportunity, the responsibility, to name and tell the truth – so obvious to us, and all Aboriginal people who sat in the Inquest, but so hard for you to explicitly name and pin down. Please try. Please do your best to tell the truth about this. That is how non-Aboriginal Australians can walk with us, by telling the truth about why we are still being dispossessed, denied and destroyed, in our own countries.

75 The only way for you to avoid a finding that systemic racism was a causal factor in Mum's death, is to perpetuate the highly improbable myth that, although public drunkenness laws are undoubtedly exercised against women on the basis of their Aboriginality at massively disproportionate rates, in our mother's case, her Aboriginality had nothing to do with anything.

Level 1 – A settler society

76 As the Royal Commission recognised, in order to properly understand systemic racism, and how it has caused the overrepresentation of Aboriginal people, including our mother, in Australian prisons, it is important to understand both the law and culturally shared ideas and assumptions about Aboriginal people in their historical and social context. That is a topic too long for these submissions, but it is discussed in the Royal Commission reports,[63] in Dr Anthony's report and a brief summary is contained in Chapter 2 of the ALRC's recent report, *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*.

77 *Burra Lotjpa Dunguludja* (Victorian Aboriginal Justice Agreement 4) gives this snapshot:

> The *Victorian Aboriginal Affairs Framework* explicitly recognises that the contemporary social and economic circumstances of Aboriginal people are inextricably linked to ongoing and previous generations' experiences of European colonisation. This recognition equally applies to Aboriginal overrepresentation in criminal justice. The exercise of power and control by European settlers resulted in dispossession of land, disruption of culture and kinship systems, removal of children, racism, social exclusion, institutionalisation and entrenched poverty for Aboriginal people. The consequences of colonisation are far-reaching and intergenerational, continuing to play out in Aboriginal peoples' interactions with the criminal justice system.[64]

78 Commissioner Johnston was right when he said, "Aboriginal people remember this history and it is burned into their consciousness."[65] It was burned into our mother's consciousness, and it was all there with her when she was taken down to Cell 1. That history acts in non-Aboriginal Australians as well. It is the backdrop against which you grow up and it inescapably informs your views, your ideas and your assumptions. Non-Aboriginal Australians are just as affected by history as Aboriginal Australians are; it is just that — unless you have made a special effort to learn and understand — you are usually less aware of it.

Level 2 – The Law

79 The British came to Australia with their law, which was immediately enforced by them over our people, our land and our culture, oblivious to the fact that we had lore. "While theoretically Aboriginal people were to be treated as British subjects, they 'suffered severe disabilities in the courts'. They were not given equality of legal status, yet were perceived as law-breakers".[66] At first, the law sanctioned dispossession of land (on the lie of terra nullius[67]), but prisons were unnecessary: Aboriginal people were killed or moved on, so there was no need to lock us up.[68] What Commissioner Johnston wrote in 1991 is still true, "little known is the amount of brutality and bloodshed that was involved in enforcing on the ground what was pronounced by the law."[69]

80 Then came the protection and assimilation laws that applied only to Aboriginal people and denied us almost every basic right protected for other Australians. As Commissioner Johnston explained, "Non-Aboriginal Australia has developed on the racist assumption of an ingrained sense of superiority that it knows best what is

good for Aboriginal people. With many people associated directly or indirectly with land settlement, the assumption was underpinned by economic interest".[70] Those laws were administered by police.[71]

81 By the time section 10 of the *Racial Discrimination Act 1975* (Cth) was passed, invalidating crudely discriminatory laws of the earlier kind, it didn't matter. Discrimination was built into the system, so that laws that look fair and neutral would still disadvantage Aboriginal people at a much higher rate.

82 As Commissioner Wootten explained in his three Victorian reports, including the report into the death of Uncle Harrison Day, public drunkenness laws look neutral, but they're not. Being highly discretionary, they are enforced in a systemically discriminatory way, despite looking like they apply to everyone equally. The systemic racism built into the institutions of justice and the powerful negative stereotypes about Aboriginal people shared throughout Australian society mean that those laws inevitably result in massive disproportion.

Level 3 – Institutional racism and the administration of the Law

83 *Burra Lotjpa Dunguludja* recognises that systemic racism persists in the Victorian justice system. This is also established by the unchallenged opinion of Dr Anthony, based on reports and inquiries including the Royal Commission. Please re-read her report. We rely on it, but we won't try to summarise it all here.

84 In 1991, Commissioner Wootten wrote in his *Regional Report of Inquiry in New South Wales, Victoria and Tasmania*, "The reason for the disproportionate number of deaths was not the rate at which Aboriginals were dying in custody, but the rate at which they were being taken into custody".[72] He noted that, in Victoria, Aboriginal people were 13 times more likely to be taken into police custody, and 12 times more likely to be in prison. As in his individual report about Uncle Harrison Day, he identified systemic racism as the cause, explaining how Aboriginal people are "criminalised", including by the administration of public drunkenness laws. He described the way racist theories and assumptions at the time of European arrival had been "built into the nation's attitudes and institutions and remain effective in a considerable measure today". He said:

> Few white Australians understand how racism continues to affect Aboriginals and what an all pervasive part of their experience it is. If there is to be a real change in the position of Aboriginals in Australian society the non-Aboriginal community has to develop an understanding of the widespread, insidious, dehumanising and debilitating effects of racism, and work to reduce its influence

85 In his *Report on the Inquiry Into the Death of Harrison Day*, he clearly described the institutional racism in the way public drunkenness laws are policed. As the data produced by Victoria Police show, that was still true at the time of Mum's death. Everyone knows that officers of Victoria Police don't wait outside CBD restaurants and bars to arrest the middle-class white people getting drunk there on the weekend, but those people are just as formally guilty, and just as morally undeserving of punishment, as Mum was.

Level 4 – Unconscious bias and the administration of the Law

86 Professor Klein explains that unconscious bias is the result of our shared evolutionary biology. This means that we all have unconscious bias, the same way we all get tired when we don't sleep. It is generally good. But it can be very harmful, especially when people are given power by the public to make decisions that can kill. The only way to stop unconscious bias causing harm is to try to become conscious of the underlying ideas, and the way unconscious bias operates, so that it doesn't control us. In the same way, the only way to reduce the risk of killing someone from falling asleep while driving is to learn to notice when we are getting tired. Because we all have ideas about people based on their appearance, including our perceptions about "race", this also means that we are all a bit racist. The only thing we can do to try to stop this from harming others is to become conscious of our ideas about people of different races so that we can catch those ideas before they influence our decision-making. The training documents prepared by Victoria Police and Ambulance Victoria seem to accept all of this.

87 The problem is that public drunkenness laws can't possibly be applied to everyone, and they give discretion to police officers to decide who to stop, fine or arrest. They choose based both on who they see as "drunk" and who they see as "criminal". This is a bad combination for Aboriginal people. In the 19th Century, when public drunkenness was first criminalised, European Australians openly believed and circulated racist theories about Aboriginal people being inferior by nature. With this came the belief that Aboriginal people were morally inferior

(by nature) and were therefore drunks and criminals.[73] When public drunkenness laws were enacted in the 19th Century, no-one in positions of authority in settler society would have found those ideas surprising. Like an old uncle who grew up when it was normal to be openly racist, and is now trying to learn not to say the wrong thing in front of the wrong people, both those laws and those ideas about Aboriginal people have survived; the ideas just can't be spoken any more. It is hard to explain, but in a way this makes it worse. People treat you differently because of your race, while pretending it's got nothing to do with that.

II. Systemic racism was a cause of Mum's death

1. Public drunkenness laws were much more likely to be applied to Mum, as an Aboriginal woman, making her more likely to be incarcerated, and more likely to die as a result

88 A fundamental point made by the Royal Commission was that Aboriginal people were more likely than you to die in custody because we are more likely to be locked up:[74] "Too many Aboriginal people are in custody too often".[75] That seems pretty obvious, but it was very important because it was the first time Australian institutions really started to focus on the harm that colonisation has caused our people. Because Mum was at least ten times more likely to be stopped for public drunkenness, it is just obvious that she was more likely to be arrested, more likely to be put in the cells, and therefore more likely to die, than a non-Aboriginal woman. That makes race a causal factor in her death.

89 If you play roulette, betting on red, on a wheel with ten times more black pockets than red, and the ball lands in a black pocket, it would be nonsense to say that the disproportion was not a causal factor in your loss.

2. The decisions that led to Mum's death were affected by shared, unconscious ideas about Aboriginal people as drunks and criminals

90 It is very obvious to us that systemic racism and unconscious bias were involved in our Mum being taken off the train, locked in the cell, and then treated with a complete lack of care and concern. When you try to break it up into particular decisions, it might be harder to see. But when you look at the whole course of events, it is very clear. Please ask yourself whether it is plausible that Irvine would have called the police on Cheryl McInerney if he found her drunk in the train. And why was the non-Aboriginal woman found "heavily intoxicated" not stuck in the van and taken to Cell 2? If the officers had found a good-natured, non-Aboriginal grandmother, drunk and sleeping on the train to visit her daughter in Melbourne, would they really have decided she was in a goldilocks zone where she was drunk enough to arrest "for her safety", but not drunk enough to require medical care?

91 Our counsel made oral submissions about the proper reasoning process; please accept them. "Induction" is "[t]he process of inferring a general law or principle from the observation of particular instances".[76] The law allows inferences to be drawn from particular facts. It also allows inferences about what a particular person did on a particular day to be drawn from general experience about how human beings ordinarily behave. For example, that is why the law presumes that people's actions are voluntary: the presumption is "merely a requirement that there be evidence to displace ordinary human experience".[77] The reasoning goes like this: a) ordinarily, when a human does an act, they do it voluntarily; b) this human did an act; therefore, c) unless there is something extraordinary here, they did the act voluntarily. (It is the opposite of the *Briginshaw* reasoning: that where something is very unlikely, greater care is required to be satisfied it occurred.)

92 We are just asking you to follow the same reasoning process. In this case, when it comes to unconscious bias, the reasoning goes like this: a) generally speaking, humans are affected by unconscious bias, which occurs when our intuitive judgments are affected, without conscious thought, by assumptions or stereotypes about other human beings having a particular characteristic (including race). This is established by Professor Klein's uncontradicted opinion and supported by the Victoria Police and Ambulance Victoria training material. From this, it can be inferred that b) each of the officers who gave evidence was affected by unconscious bias, unless there was some evidence to the contrary. (This also means that the *Briginshaw* reasoning doesn't apply unconscious bias, because it is very likely and nobody can be condemned for it.)

93 So what sorts of assumptions or stereotypes were the officers affected by? Obviously, there is no direct evidence about it. But you have plenty of circumstantial evidence and, from that, you can infer the answer. *First*, the public drunkenness data provided by Victoria Police shows Aboriginal women were at least 10 times more likely than

non-Aboriginal women to be the subject of public drunkenness powers. That is a massive disproportion. There must be a reason for it. The only reason rationally suggested by the evidence is that police officers are affected by unconscious bias, by ideas about Aboriginal people that more often makes them appear to be appropriate subjects for criminal law powers for public drunkenness. *Second*, Dr Anthony's uncontradicted opinion, on the basis of strong primary materials, is that Victoria Police is affected by systemic racism (a key part of which is shared assumptions and stereotypes about Aboriginal people) which can be seen in both qualitative studies and statistical data. The data produced by Victoria Police strongly support Dr Anthony's opinion. *Third*, as Professor Klein explains, biases inherent in an organisation inform and reinforce the unconscious bias of individuals.[78] The Royal Commission "warned of the danger of enforcing [public drunkenness] laws 'when based on stereotypes of Aboriginal people', which arise from 'institutional practices' irrespective of the intentions of the individual person".[79] *Fourth*, none of the evidence provides any other explanation for the disproportion (and nobody, including Victoria Police, has suggested one).

94 Therefore, the most probable inference to be drawn from the evidence is that the massive disproportion in the policing of Aboriginal women for public drunkenness is caused by shared negative assumptions or stereotypes connecting "Aboriginal" with "drunk" and "criminal" and maybe other ideas that are hard to write down or explain. Those ideas, which are shared throughout Australian society (for most of post-settlement history, openly and shamelessly) are reinforced and intensified by the culture within Victoria Police. This same process of police institutional bias has been recognised overseas. In his Report on the Stephen Lawrence Inquiry, Sir William Macpherson wrote that "unwitting racism" often "arises out of uncritical self-understanding born out of an inflexible police ethos of the 'traditional' way of doing things. Furthermore such attitudes can thrive in a tightly knit community, so that there can be a collective failure to detect and to outlaw this breed of racism. The police canteen can too easily be its breeding ground."[80]

95 So, on the evidence, the best inference is that negative assumptions or stereotypes about Aboriginal people are shared among officers of Victoria Police (including unconsciously). Then it is appropriate to reason from the general to the specific. The police officers made discretionary decisions to look after our Mum by locking her up for the crime of public drunkenness, rather than calling an ambulance, taking her to hospital or taking her home. Where there are indicators that their thinking was affected by unconscious bias, you can infer that it was at work. So too with the failure to take proper care for Mum while she was in custody.

96 This is how systemic racism works. It is not a concrete thing written down in a policy. It can only manifest through individuals. The evidence before you shows that systemic racism in this case manifested in, and was caused by, unconscious bias in individual officers (Level 4), working within an institution that polices Aboriginal people differently (Level 3), enforcing a facially neutral law with a massively discriminatory effect (level 2), each of which is a manifestation of colonial Australian society (Level 1). That systemic racism was a clear cause in police deciding to arrest Mum, and then fail to properly care for her in custody.

97 The police might say you shouldn't make any findings about systemic racism or bias. They might try to break up Mum's story into lots of little individual moments and at each moment say "look: there's no racism here". But to do that they would have to ignore the objective data, which they can't explain. They would have to ignore the lived experience of Aboriginal people.[81] They would have to ignore the expert evidence you have received. That ignorance would be either deliberate or caused by a total lack of insight and an unwillingness to think about hard questions. But we ask you to put on a different set of glasses. We ask you to try to see what is really there.

III. Into the system – removal from the train

<u>The truth about Mum's removal from the train</u>

Irvine's decision to call the police

98 When approached by Irvine, Mum was sleeping on the train. Apart from having her feet in the aisle, she was not disturbing anybody.[82] He interacted with her for no more than a minute,[83] but identified that she was Aboriginal[84] and thought she seemed "delirious".[85] At that point in time, he thought she posed no danger to herself or anyone else.[86] Then he asked the driver to call the police.

99 Why did he do that? In his statement,[87] and in the incident report he completed the next day,[88] he described Mum as being "unruly". That is a strange choice of words to describe a sleeping woman. Although V/Line procedure documents define an "unruly" customer,[89] such a person is distinguished from a customer who is "not in control":[90] A customer who is "not in control" is a customer who is "incapable of taking care of themselves whether by virtue of drugs, alcohol or illness", in which case conductors are directed to contact a relative or carer, an ambulance, or the police. A customer who is "unruly" is a person who "presents a danger to staff, other customers, themselves or property", in which case the procedures only refer to calling the police. On any objective assessment, Mum more appropriately fell into the first category than the second.

100 In his evidence, Mr Irvine suggested that he called the police because he was concerned for Mum's safety.[91] Yet after his very brief interaction with her, he did not keep Mum in his line of sight while she remained on the train.[92] Nor did he observe her while waiting for the police to arrive; instead he stood on the platform chatting to Gordon Bodie.[93] That behaviour is not consistent with a genuine concern for Mum's safety.

101 So how to explain his decision to call the police? We know that he identified her as Aboriginal. Professor Klein explains how our stereotypes are activated when we observe a person in a definable social category, influencing our judgments without our conscious knowledge.[94] Associate Professor Anthony explains that the word "unruly" has been applied to Aboriginal people since colonisation, and carries strong connotations of being "uncontrollable", "child-like" and "savage".[95] Faced with the unexplained gap between what Mr Irvine could observe and the language he used, on the evidence the only available inference is that he was influenced by a stereotype associating Aboriginal people with being "unruly". As a result, he put Mum in the category of "unruly", instead of seeing what was actually in front of him. As the procedures implicitly acknowledge,[96] a person who is "unruly" is potentially dangerous. The influence of this unconscious stereotype explains why he wanted her removed from the train.[97] It explains his otherwise unexplainable decision to call the police.

102 You should also find that his conduct, or decision, was unlawful under s 38(1) of the Charter: it limited Mum's right of freedom of movement, and her privacy, without any demonstrable justification. Irvine did not give proper consideration to those rights, or to her dignity as a human being.

Police attendance and removal from the train

103 In their initial callout over the radio, officers Thomas and Towns had been told there was an "unruly" person on the train.[98] When officers Towns and Thomas boarded the train, they decided that Mum was drunk.[99] By reference to the Medical Checklist in the Victoria Police Manual (**VPM**),[100] both officers agreed that when they first spoke to Mum on the train her best verbal response was "unintelligible".[101] According to the VPM, that required them to "send to hospital or seek urgent medical advice". They did not do so.

104 Instead, they told her she had to get off the train with them.[102] In doing so, they believed they had placed Mum under arrest (although they did not expressly explain this to her)[103] for the offence of being drunk in public under the Summary Offences Act.[104] Despite the nature of that power, the officers did not arrest Mum for the purpose of applying the criminal law. They said that if they believed a better option was available, they would not have arrested her, or even issued her with an infringement notice.[105] Rather, they exercised their power of arrest because they were worried about Mum's welfare.[106] Like Mr Irvine, they thought she should not be left sleeping on the train. So they placed her under arrest, compelled her to get off the train, and sat her on the platform. The train left without her.

<u>Why removal and arrest was unlawful</u>

105 The right to liberty is a cornerstone of the common law. As Blackstone explained, it can't be taken away except by law.[107] The common law has always insisted that a person who detains another must establish lawful authority, otherwise the detention is unlawful. That is the essence of the procedure on a writ of habeas corpus. It is also now reflected in ss 21 and 38 of the Charter which, read together, make it unlawful for a public authority to detain someone unless the public authority can establish that the detention is "under law".

106 It is for the Chief Commissioner (who appeared on behalf of all the police officers) to justify the lawfulness and proportionality of detaining Mum. If you decide not to consider s 15 of the *Summary Offences Act 1966* (Vic), and the Chief Commissioner doesn't try to persuade you it authorised Mum's arrest, then you must assume it

didn't. But you should consider and decide the argument made by our counsel. We were informed during the hearing that the lawfulness of police conduct was in scope. We and our lawyers ran the hearing on that basis. The unique nature of an inquest into an Aboriginal death in custody, having regard to the Royal Commission's recommendations (to which the Act gives effect) and the procedural limb of the right to life, requires that you include the lawfulness of police conduct in scope. As the law has not yet been repealed, that is also essential to the aspect of your function (again recognised by both the Royal Commission and cases about the right to life obligation) of preventing future deaths by making it clear that the public drunkenness laws are more limited than police think.

107 Police officers don't have power to detain someone just because they think they have that power.[108] Although the Attorney-General has announced an intention to repeal s 15, remember that a bill to repeal the offence was introduced after the Victorian Law Reform Commission's report in 1989, but did not pass. And anyway, that is irrelevant to whether the law sanctioned our mother's death. The law is supposed to protect citizens. Through Parliament, we give power to detain ourselves, but only where the law allows it. Working out whether our mother was detained in accordance with the law is much more important than working out whether she was detained in accordance with an internal police policy. The law is the most important policy. It would be perverse to consider details of the VPM, but not the law relied on, without which the VPM can authorise nothing.

108 Anyway, if s 15 did give police discretion to arrest Mum, the removal and arrest was incompatible with her rights. The only purpose they say they had was to keep Mum safe. The proper way of doing that, which would have been less restrictive on all of her rights, especially her rights to liberty and life, was to take her to hospital, or call an ambulance or other medical personnel. It doesn't matter if that is "not the done thing". Section 7(2) of the Charter asks what is demonstrably justifiable, not what is the done thing. Especially because she was an Aboriginal woman, ss 8(3) and 17(2) of the Charter[109] required them to do more to keep her out of custody. They also did not give proper consideration to her rights.

IV. Into Cell 1 – unlawful incarceration causing death

The truth about Mum's incarceration

109 On the platform, Thomas and Towns were joined by Hurford and Fitzgibbon. Fitzgibbon had very recently been appointed the Macedon Ranges Police Aboriginal Liaison Officer.[110] Both Fitzgibbon and Hurford believed that Mum was under arrest, although again neither of them told her so.[111]

110 The officers gave evidence that her condition improved while she was on the platform. However, she "kept saying random, incoherent things",[112] the officers were "unable to hold a conversation with her"[113] and she was "making no sense at all".[114] All four officers believed she was heavily intoxicated. And they were right: in fact, her BAC was about 0.313, a level which according to Dr Sungaila would ordinarily require immediate medical attention.[115] Thomas claimed to have made a positive decision that medical attention was *not* required;[116] none of the other officers even considered seeking medical advice.[117] Given what they saw, and that they knew nothing about Mum's medical history, they should have sought medical attention.

111 But they did not do that. Instead, they took her back to the station and placed her in the cells. The police witnesses said that they only did so because they had exhausted all the other options.[118] But in fact, they had only considered the two options specifically laid out in the VPM.[119]

112 *First*, the officers on the platform had made some attempts to contact Mum's family members to see if she could be picked up. Although there was some conflicting evidence about this, the truth is that Hurford called Kimberly as Mum was being led to the divisional van — that is, *after* the decision had been made to place her in the cells. That is consistent with the evidence of Towns,[120] the objective evidence of the CCTV,[121] and with Hurford's unchallenged evidence that he told Kimberly that Mum would be at the station for "at least 4 hours".[122] After they returned to the station, police answered calls from Mum's family members, who said that nobody could pick her up. That was the end of the matter. There is no suggestion that any officer suggested dropping Mum somewhere, or offered any other proactive solution.

113 *Second*, much was made of the fact that Fitzgibbon had called the ACJP, but nobody from the ACJP had attended. It is not clear how any of the officers could have believed there was any realistic possibility of the ACJP attending

to collect Mum. All were familiar with the ACJP; none had ever experienced the ACJP collecting an intoxicated person.[123]

114 Those were the only options the police considered for Mum. That same night, Towns and Thomas dealt with a different woman who was, according to Towns's note, "heavily intoxicated" at the Cumberland Hotel.[124] She was not arrested, placed in a cell or even given an infringement notice. Instead, Towns and Thomas offered to drive her to an address. When called away to another job during that process they told her to wait, attended to the job, then came back and dropped her off as promised.[125] The contrast is striking.

115 That woman was not Aboriginal.[126] The only other relevant differences identified in the evidence were that the woman identified an address near Castlemaine, and that she may have been less intoxicated than Mum.[127] That might explain why police did not take exactly the same actions with Mum. But it does not explain the obvious difference in effort and approach. To take just one example: when officers spoke to Mum's family, they asked whether someone could *pick her up*. There is no evidence they ever asked if there was somewhere they could *drop her off*.

116 There is no evidence that the police consciously decided to lock Mum up because she was Aboriginal. But most of the officers seem to have assumed that, unless some external force intervened, Mum was going to end up in a cell.[128] It was like a stream, into which she had fallen; unless someone had the courage to step in and pull her to the bank, she was going into the cells. That stream was explained by the officers as just the way they would treat "any drunk". The normality of it all — when history, reason and compassion should have been screaming at them, "do anything not to put this Aboriginal woman, who has done nothing wrong, in a cell" — shows how systemic racism and unconscious bias work. Please try to see that. Please don't miss the forest for the trees.

117 And when you look at the evidence carefully, there are many other suggestions. A small example: one indication of unconscious bias is interpreting ambiguous actions in a negative way.[129] In his statement, made the next day, Hurford described Mum "trying to turn away with the phone and dismiss what we were asking".[130] In oral evidence he conceded that, in fact, she "might have been turning away from the sun".[131] He interpreted an ambiguous action in a negative way. He also repeatedly referred to her as being just like "any drunk". But she was a good-natured grandmother, who had done nothing wrong.

118 And for all that, he denied any unconscious bias.[132] Indeed, the police witnesses generally denied that their judgments were affected by any unconscious bias. They may well have been sincere in that evidence. But the expert evidence demonstrates, and Victoria Police's own training acknowledges,[133] that they were wrong. Unconscious bias affects everyone. Only by becoming conscious of it can we reduce its effects. And it is the simplest and best explanation of the course of police decisions on that day — a course which could kill an innocent citizen — oblivious to the urgent alarm bell of history screaming in their ears.

Why incarceration was unlawful

119 Incarceration was unlawful because, at latest by the time the infringement notice was written, there was no power under s 15 of the *Summary Offences Act* to lock Mum up. Even if there was, locking an Aboriginal woman in a cell without appropriate care, without any criminal law justification, but for some ill-defined beneficent purpose, rather than taking her to hospital (if genuinely concerned for her health and wellbeing) or letting her go (if not), is about the worst breach of human rights that an Australian police officer could make. It cannot be justified under s 7(2) of the Charter.

V. Failure of care – an unlawful and preventable death

The truth about the police failure to care for Mum

120 When Mum was at the charge counter, they knew she was intoxicated. They did not offer to breathalyse Mum, which would have revealed how dangerously intoxicated she really was, because they had never seen it done before.[134] It wasn't usual. Nevertheless, they knew she was at significant risk of falling. They knew that intoxicated people could deteriorate rapidly. They should have sought medical attention at that stage.

121 At the charge counter she was able to stand unassisted, follow basic commands, and even "had the better of the members for a short period of time".[135] As soon as she entered the cell, her condition visibly deteriorated. She

lay down on the concrete bench and did not want to get up. When she eventually stood so that Neale could conduct a pat down search, Fitzgibbon had to hold Mum's hand to steady her.[136] Her visible deterioration at that stage should have prompted police to seek medical attention, or at least conduct a proper reassessment of her condition. They did neither of those things.

122 After the police left her alone in the cell, her condition got worse. On at least three separate occasions she stumbled around the room, clearly unbalanced and unable to move around the concrete cell safely.[137] On one occasion she tried to sit down, and fell off the bench.[138] All this was captured by the CCTV, which was displayed on large screens in the watch house and a smaller screen in the Sergeant's room. But Neale and Wolters said that they saw none of these incidents.[139] That is either untrue or it shows that they were not monitoring Mum in any meaningful way.

123 At 16:50 Wolters and Cairnes conducted a "physical check". Wolters was at the cell door for 6 seconds. He did not open the trap door. On Wolters's own evidence, Mum said only a single word to him: "yes".[140] Plainly, he could not conduct any meaningful assessment of her condition or identify her deterioration. The check was completely inadequate.[141] If they had done a proper physical check at that time, as required by their own policies, they *should* surely have realised Mum was in a bad way and required immediate medical attention.

124 Mum suffered her fatal fall at 16:51. If police had been properly monitoring that CCTV, or if they had conducted a proper physical check, they should have identified that Mum had suffered a significant deterioration in her condition since she was at the charge counter. They then could have — and on their evidence, would have[142] — taken further steps to care for her. If they had properly cared for her, they would have prevented the fall from occurring at all.

125 As well as being unlawful, the way police looked after Mum before the fatal fall was in breach of their own rules in the VPM and SOPs. You have heard lots of evidence about that, so we won't repeat it here. But remember their rules say a person in custody "MUST take precedence" over all other demands, a person "arrested for drunk must be given special attention", and medical attention must be sought where "the slightest doubt exists about their condition".[143] Detainees must be "treated as an individual, having regard to their specific risks and needs" and must be "continually monitored and assessed".[144] They didn't do any of those things for Mum.

126 The police care after the fatal fall was even worse. Neale and Wolters decided to reduce the frequency of checks, in contravention of the VPM and the Castlemaine SOPs. Wolters did not even comply with that wholly inadequate modified regime. In four hours, he spent a total of less than 20 seconds "observing" Mum at the cell door and, even accepting his evidence, she spoke just four words to him.[145] His entries on the custody module were misleading.[146] Neither he nor Neale noticed Mum's increasingly obvious hemiparesis on the monitor. He learned that Mum had an undisclosed medical condition, but did nothing with that information.[147] When police finally realised Mum was injured, Wolters gave the 000 operator and paramedics a self-serving and misleading account of what had occurred. The police behaviour meant that Mum had been injured for almost 3 and a half hours before paramedics arrived. Although Professor Laidlaw suggests Mum had limited chances of survival once she had sustained the fatal fall, every additional delay "would be expected to further worsen the small chance of survival".[148] Even when it became clear that something was very wrong, she was not treated with dignity, with respect, or with consideration of her human rights.

127 Why was the police care so careless? Again, the language the officers used provides a clue. Over and over again, Neale and Wolters said, in effect, that our mother presented just like any other drunk. The Royal Commission recognised the dangers of such stereotypes.[149] Marcia Langton traced the history of the stereotype of the "drunken Aborigine", and how it has been associated since colonisation with being mendicant, violent and degenerate.[150] The officers' evidence does not suggest merely "a culture of complacency".[151] It suggests the officers' judgments were significantly influenced by stereotypes. Those stereotypes both prevented them from seeing what was really happening ("she's behaving as a conscious breathing drunk"),[152] and led them to view our mother as someone who was not deserving of care.

Why the failure of care was unlawful

128 Again, s 15 did not authorise the police to lock Mum up at all, when they had already written the infringement notice.

129 The police officers who saw Mum's condition once they had taken her into the cell should have recognised that she was culturally unsafe and physically unsafe – that her life was in danger. Please don't just focus on the minute details of the police policies. Sections 8(3), 9, 10, 19(2), 21 and 22, with s 38(1) of the Charter, are a higher-order policy made by Parliament. Look at the CCTV footage. Given the risk to her life, and the absolute cultural unsafety of a police cell as a way to care for Mum, the decision to leave her there, without constant monitoring, cannot be justified. There is one simple explanation for it: they did not see Mum as a human being deserving of their care and compassion. They would not have treated someone they cared about, a relative or friend, in that way. If they had been able to see clearly that this was a very vulnerable human who had done nothing wrong, who needed either an ambulance, to be driven home, or to be freed, they would not have locked her up, at least not without watching her constantly. There is only one good explanation for how they could consider it so normal and everyday to do that. They couldn't see her clearly in that way. The ideas of "Aboriginal", "drunk" and "criminal" were powerfully coalescing under the surface to produce very simple conscious ideas directed to locking her up and forgetting about her.

VI. Underfunded Aboriginal organisations must not be scapegoated

130 Counsel Assisting describes the ACJP by quoting the Chief Commissioner's lawyers: that it is "a welfare check initiative … to ensure the safety and wellbeing of Aboriginal people taken into police custody".[153] Let's be clear. It is the responsibility of *police* to "ensure the safety and wellbeing" of Aboriginal people in custody. Even the most proactive ACJP volunteer is entirely reliant on police to contact them, to provide them with information, and to enable them to perform their role.[154] Any attempt to deflect attention or responsibility away from police must be rejected.

131 Sandra Owen is a volunteer, one of just three at that time working a 24/7 roster to cover an area stretching from Woodend to Echuca.[155] When the call came, she was at work, not on volunteer duty, but she took it anyway.[156] She never received the second call and another volunteer was rostered on duty.[157] Any conflict between Fitzgibbon and Owen's evidence about the call is easily resolved: there was a misunderstanding. A short conversation covered both whether Owen knew Mum and whether anyone was available to collect her. Fitzgibbon thought the two things were connected; Ms Owen's emphatic evidence was that they were not.[158] There is no need, and no reason, to prefer Fitzgibbon's evidence over Owen's.[159]

132 The VPM and the ACJP Policies and Procedures document anticipate that the ACJP will attend the majority of call-outs, including for intoxicated people. It is clear this does not occur in practice, at least in the Bendigo region. In light of those policies, Owen should have taken further steps to assist Mum. Counsel Assisting is therefore right to say that in practice the ACJP does not provide a proper protective measure.[160] But the ACJP is a purely volunteer organisation, with just three (now six)[161] volunteers to cover an enormous region with little funding or support. Any recommendation should not only be directed towards resolving the "disconnect" between Victoria Police and the ACJP, it should be directed towards ensuring the program is properly resourced and supported so that it can fulfil its objectives.

133 You also heard evidence about the VALS Custody Notification Service. Once again, Victoria Police, not VALS, are responsible for the safety of people in custody. CNS workers provide a telephone service only, and rely entirely on what they are told by police. However, we are concerned that a policy or practice apparently exists that CNS workers may not talk to intoxicated people in custody.[162] Intoxicated people are particularly vulnerable in custody. Not only are they are at greater physical risk, but they may have a lesser ability to communicate any welfare needs to police. Any recommendation about the CNS should include a recommendation that CNS workers speak to all people in custody, whether intoxicated or not.

134 What these two Aboriginal organisations need is better funding and support. It is very important they don't get scapegoated for the failures of Victoria Police.

F. REFERRAL TO THE DPP

I. The action that matters most

135 Please refer Danny Wolters and Edwina Neale to the DPP. That is what matters the most to us. Section 49 of the Coroners Act requires you to notify the DPP if you believe an indictable offence *may have been* committed in connection with the death. You do not need to believe, as you did under the previous Coroner's Act,[163] that an indictable offence *has* been committed.

II. An indictable offence may have been committed

136 For the following reasons, you should believe that the indictable offence of negligent manslaughter may have been committed by Wolters and Neale.

The elements of negligent manslaughter

137 The offence of manslaughter has four elements. The first is that the accused owed the victim a duty of care. The second is that the accused breached that duty by criminal negligence. This requires the accused's act or omission to have fallen so far below the standard of care a reasonable person would have exercised that the act or omission merits criminal punishment.[164] The third is that the act which breached the duty of care was committed consciously and voluntarily.[165] The fourth is that the accused's breach of the duty caused the victim's death.[166] The prosecution does not need to establish any element of malice,[167] nor does it need to prove that the accused's actions were in any way unlawful.[168]

The inadequate investigation

138 Riley was supposed to be conducting an investigation to determine whether a criminal offence had been committed, at least until some unspecified time in early January 2018 when it became a coroner's investigation.[169] Yet, as described at 69–70 above, his investigation was totally inadequate. He never followed up on glaring inconsistencies or apparently false statements made by police. He never even tried to conduct a suspect record of interview with Wolters or Neale.[170] He certainly didn't approach his investigation "on the basis that the death may be a homicide".[171] In those circumstances, you should be slow to decide you do *not* believe that an offence "may have been committed". Without a proper investigation, it remains a real possibility.

Danny Wolters and Edwina Neale may have committed negligent manslaughter

139 You should believe that an offence may have been committed because there is evidence that each element is made out.

140 *Duty*. Wolters and Neale owed a duty of care to Mum. It is well established that police owe a duty to exercise reasonable care for the safety of people in their custody.[172] In addition, a person owes a duty to provide competent care where they have voluntarily assumed a care of another and "so secluded the helpless person as to prevent others from rendering aid".[173]

141 *Breach*. You have ample evidence that Wolters and Neale breached that duty. We think that their conduct fell so far below the standard of care a reasonable person would have exercised (as well as those prescribed by the VPM and the SOPs) that it merits criminal punishment. You cannot determine that question, which is for a jury. But that finding would be open for at least the following reasons:

141.1 The police had no lawful authority to take Mum into custody in the first place.

141.2 Wolters and Neale both knew Mum was intoxicated, unsteady on her feet, and at significant risk of falling. Yet before the fatal fall they failed to obtain medical assistance, monitor her in any meaningful way, perform an appropriate physical check, or identify that her condition was deteriorating. Then, after the fatal fall, they reduced the frequency of physical checks and failed to notice Mum's drastically worsening condition, resulting in a delay of over three hours in getting medical assistance.

141.3 Neale was the supervising officer with ultimate responsibility for Mum's welfare. Further, in making her initial assessment she did not consider the medical checklist set out in the VPM[174] and did not consider

the risk of Mum falling at all.[175] Wolters, having failed to properly to perform his duties of monitoring, physical checks, and continual assessment, then made false statements to the 000 operator,[176] to the paramedics,[177] and to investigators,[178] which suggests a consciousness of guilt.

142 *Conscious and voluntary*. The actions of Wolters and Neale were conscious and voluntary.

143 *Causation*. As set out above, there is evidence that the breach of duty by Wolters and Neale caused our mother's death. Both officers said that had they seen Mum's behaviour before the fall, they would have entered the cell and assessed her.[179] Had they done so, they should have realised the danger she was in and taken appropriate steps to protect her. Then, the fatal fall would never have happened. But even if you thought that fall was inevitable, you should still refer. Professor Laidlaw's opinion, although relevant, does not conclusively decide causation. It also shows that the delay, caused entirely by police failures, further reduced her limited chances of survival. The DPP should consider the whole situation and decide what to do.

144 We don't have space to do a detailed analysis about this. But you know that the investigators never got any independent legal advice about the possibility of a crime, whether from the DPP or anyone else.[180] On the evidence you have, there is at least a real possibility that crimes have been committed. You should refer to the DPP so she can properly consider the issue.

145 Section 23 of the OHS Act creates an indictable offence with four elements: (a) the accused was an employer; (b) there was a risk to health and safety to non-employees; (c) the accused failed to take measures which would have eliminated or reduced the risk; and (d) it was reasonably practicable to take those measures. The prosecution does not need to establish that the employer's breach caused the accident.[181] In this case, the Chief Commissioner is an "employer".[182] There was a risk that an intoxicated person would fall and suffer catastrophic injury while in custody at Castlemaine Police Station. As the inquest has explored, there were a range of measures the Chief Commissioner could have taken to eliminate or reduce the risk (such as requiring all intoxicated persons to receive a proper medical assessment). Whether those measures were "reasonably practicable" is a question of fact, to be determined with regard to the relevant risks.[183] Again, you need only to believe that an indictable offence *may* have been committed. On the evidence you have heard, you should hold that belief and notify the DPP under s 49.

G. RECOMMENDATIONS

146 Annexure 1 to this Submission is a list of the recommendations that we ask you to make. We are very grateful for your early indication that you would recommend the repeal of the public drunkenness laws. We hope you will understand that we are sceptical about training and things like that. We think the problems are deeper and more fundamental than anything that a new training sheet can fix. However, please make whatever recommendations that you think might stop this from happening to someone else.

Dated: 15 October 2019

Belinda Day / Stevens

Warren Stevens

Apryl Watson

Kimberly Watson

[1] Ts 1293.18-22.

[2] Ts 1370.30–1371.3.

[3] Brief 623 [27].

[4] The right to life is protected by s 9 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the **Charter**). The right to life was also the first of the three cornerstone, "natural" rights of "the people of England": Blackstone, *Commentaries on the Laws of England* (1898), Vol 1, 129-134.

[5] Articles 2 and 6 of the *International Covenant on Civil and Political Rights* (the **ICCPR**).

[6] *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653 at [20] (Bingham LJ), quoting from *Nilabati Behera v State of Orissa* (1993) 2 SCC 746, 767 (Anand J).

[7] See, eg, *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, [21]; *Savage v South Essex Partnership NHS Foundation Trust* [2009] AC 681, [25]-[50]; *In the matter of an application by Geraldine Finucane for Judicial Review (Northern Ireland)* [2019] UKSC 7, [83].

[8] *In the matter of an application by Geraldine Finucane for Judicial Review (Northern Ireland)* [2019] UKSC 7, [86], [94]-[96].

[9] *R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, [22].

[10] Article 2(1) of the ICCPR requires Australia to "respect and to ensure to all individuals within its territory and subject to its jurisdiction" the rights, including the right to life, "without distinction of any kind, such as race…". Article 2(3)(a) provides "[e]ach State Party to the present Covenant undertakes … [t]o ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity".

[11] Charter, ss 9, 28-32 and 38.

[12] UN Human Rights Committee, *General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life* CCPR/C/GC/36, 30 October 2018, [27]-[27].

[13] *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [5] (Lord Bingham, giving the opinion of the House of Lords). While the House of Lords was referred to the UK's obligations under the European Convention, the observation is of equal force to the obligations under the ICCPR.

[14] *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182 at [20] (Lord Bingham, giving the opinion of the House of Lords).

[15] Statement of Compatibility to the Coroners Bill 2008, Victorian Parliamentary Hansard, Legislative Assembly, 9 October 2008 at p 4030 (Mr Hulls, Attorney-General).

[16] *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182.

[17] *Smith, R v Secretary of State for Defence* [2010] UKSC 29, [64] (Lord Phillips).

[18] *Royal Commission into Aboriginal Deaths in Custody: Report of the Inquiry into the Death of Harrison Day* (Report, August 1990) 34.

[19] Royal Commission, Recommendations 29-35.

[20] Victoria, *Legislative Assembly*, 9 October 2008, 4034 (R Hulls).

[21] Royal Commission, Vol 1, 4.5 "Coronial Inquiries";

[22] Royal Commission, Recommendations 6-40.

[23] Royal Commission, Recommendation 35(a).

[24] Recommendation 12.

[25] Recommendation 13.

[26] *Coronial Investigation of 29 Level Crossing Deaths - Ruling on the Interpretation of Clause 7(1) of Schedule 1 to the Coroners Act* (25 June 2010), p 19 [15].

[27] *Cemino v Cannan* [2018] VSC 535.

[28] *DPP v SE* [2017] VSC 13 at [28].

[29] Referring to the recommendations generally, not just in respect of investigations: Victorian Department of Justice (2005), *Victorian Implementation Review of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody: Review Report*, Volume 1, 1.5.5.

[30] Counsel Assisting Subs, [83]; Brief 852–3 [28]–[30]; Brief 935–943 [18]– [31].

[31] Counsel Assisting Subs, [23], [26], [28], [32], [35].

[32] Counsel Assisting Subs, [63].

[33] Counsel Assisting Subs, [85].

[34] See, eg, Counsel Assisting Subs, [18], [23], [29], [30], [62], [90].

[35] Counsel Assisting Subs, [57].

[36] (1938) 60 CLR 336.

[37] See, eg, *Inquest into the Death of Radev, Nikolai* (COR 2003 1166) [2016] VicCorC 146 (8 December 2016), [12] (Hinchey J, State Coroner).

[38] *Coroners Act 1985* (Vic) s 19(1)(e) (repealed).

[39] *Anderson v Blashki* [1993] 2 VR 89, 95-97 (Gobbo J); *Secretary for Department of Health and Community Services v Gurvich* [1995] 2 VR 69, 73-74 (Southwell J).

[40] *Commissioner of Police v Hallenstein* [1996] 2 VR 1, 19-20 (Hedigan J).

[41] *Anderson v Blashki* [1993] 2 VR 89, 96 (Gobbo J).

[42] *Karakatsanis v Racing Victoria Limited* [2013] VSCA 305, [32] (Osborn and Beach JJA).

[43] Coroners Act, s 62(1) (see *Karakatsanis v Racing Victoria Limited* [2013] VSCA 305, [33]-[34] (Osborn and Beach JJA)) and s 62(3).

[44] See s 56 of the Coroners Act; Royal Commission, Recommendations 21-25; *Annetts v McCann* (1990) 170 CLR 596; *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182, [18].
[45] *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170, 172 (Mason CJ, Brennan, Deane and Dawson JJ).
[46] [2016] FCA 1457, [115].
[47] Coroners Act, s 69(1).
[48] Evidence Act, s 91.
[49] Coroners Act, s 63(2).
[50] *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170, 171 (Mason CJ, Brennan, Deane and Dawson JJ).
[51] See the expert report of Professor Klein.
[52] *Victoria v Macedonian Teachers Association of Victoria* (1999) 91 FCR 47, [21] (O'Connor, Sundberg and North JJ); *Qantas Airways Ltd v Gama* (2008)_167_FCR_537, [127]-[139] (Branson J).
[53] [2016] FCA 1457, [117].
[54] [2019] 3 WLR 365; [2019] EWCA Civ 809, upholding the reasoning of Leggatt LJ in [2019] 1 All ER 561; [2018] EWHC 1955 (Admin).
[55] Counsel Assisting Subs [93].
[56] Ts 1502–1504.
[57] Despite this being best practice, as acknowledged by his superior Patrick: Ts 1574.8–14.
[58] Ts 1237.18–24.
[59] Brief 318.
[60] Ts 1298.7–24.
[61] Counsel Assisting Subs [97].
[62] Ruling on Scope [73].
[63] See, eg, Royal Commission, Vol 1, 1.4 "The Importance of History".
[64] Victorian Government, *Burra Lotjpa Dunguludja* (2018), 18.
[65] Royal Commission, Vol 1, [1.5.2].
[66] Royal Commission, Vol 2, [10.6.2].
[67] WEH Stanner, *After the Dreaming: 1968 Boyer Lectures*; Royal Commission, Vol 2, 10.3; *Mabo v Queensland (No 2)* (1992) 175 CLR 1.
[68] *Pathways to Justice*, [2.9]-[2.10].
[69] Royal Commission, Vol 1, [1.4.2].
[70] Royal Commission, Vol 1, [1.4.10].
[71] *Pathways to Justice*, [2.15].
[72] http://www.austlii.edu.au/au/other/IndigLRes/rciadic/regional/nsw-vic-tas/.
[73] See, eg, Anthony Report, [62]. Such views are openly expressed in the responses to survey questions to landholders, published by the Aboriginal Protection Boards in Victoria in the second half of the 19th Century. See for yourself: https://digitised-collections.unimelb.edu.au/handle/11343/21345.
[74] Anthony Report, [35].
[75] Royal Commission, Vol 1, 1.3.3 (Commissioner Johnston).
[76] *OED* online edition, meaning 7(a).
[77] *R v Falconer* (1990) 171 CLR 30, 61.
[78] Brief 852–853.
[79] Anthony Report, [28].
[80] *Stephen Lawrence Inquiry*, [6.17].
[81] See, eg, Ts 579.2–12; RCIADIC vol 2 (n 9) [12.1.26]–[12.1.27]; Harry Blagg, Neil Morgan, Chris Cunneen and Anna Ferrante (2005) *Systemic Racism as a Factor in the Over-representation of Aboriginal People in the Criminal Justice System*, Report to the Equal Opportunity Commission and Aboriginal Justice Forum.
[82] Ts 165.18–22; Ts 51.25–7.
[83] As Cheryl McInerney observed: Ts 163.28–164.5.
[84] As submitted by Counsel Assisting at [17], this must be so despite his evasive answers. For example, attending police were told on the platform that she was Aboriginal: Ts 262:2.
[85] Brief 63.
[86] Ts 100.16–28.
[87] Brief 63.
[88] Brief 66.
[89] Brief 454–5.
[90] Brief p448, 454.
[91] See, eg, Ts 70.21–5.
[92] Ts 95.5–12.
[93] Exhibit 9.
[94] Brief 849.
[95] Report of Thalia Anthony, Brief page 362–3.
[96] Such as through their focus on the conductor's "personal safety" when dealing with an unruly person: Brief 448.
[97] As Counsel Assisting submits at [17], his evidence that he did not have "a preference either way" should be rejected.
[98] Exhibit

99 Ts 274.12–27; 534.1–2.
100 Brief 236.
101 Ts 301.3–10; 373.9–15.
102 Ts 273.9–11; Ts 355.16–23.
103 Ts 274.12–13; 256.20–28.
104 Ts 274.28–31; 356.4–8 .
105 Ts 340.1–11; 384.25–385.
106 Ts 273.12–14; 384.20–385.3.
107 Blackstone, *Commentaries on the Laws of England* (1898), Vol 1, 134-135, citing *Magna Carta*, cl 39 ("No free man shall be seized or imprisoned … except by the lawful judgment of his equals or by the law of the land") and numerous ancient statutes.
108 That was the point of Lord Aitkin's dissent in *Liversidge v Anderson* [1942] AC 206, now universally accepted as correct: see, eg, *George v Rockett* (1990) 170 CLR 104. Blackstone said, at 135, that if personal liberty "were left in the power of any the highest magistrate to imprison arbitrarily *whomever he or his officers thought proper*, there would soon be an end of all other rights and immunities" (emphasis added).
109 See the VEOHRC Submissions.
110 Ts 442.14–24.
111 Ts 449.28; Ts 510.9–12.
112 Brief 89.
113 Brief 94–5.
114 Brief 101.
115 Ts 1456.
116 Ts 293.7–11; 313.4–8.
117 Ts 378.15–17; 413.19–21; 628.4–8;
118 See, eg, Ts 313.16–17; 386.25–27; 678.3–5; 811.18.
119 Brief 249.
120 Brief 90–1; Ts 380.
121 See Ts 628–36.
122 Brief 103.
123 See, eg, Ts 419.14–16; 677.8–15; 765.19–28.
124 Brief 15. Thomas co-signed the page describing the woman as "heavily intoxicated". That contemporaneous record should be preferred to his somewhat equivocal oral evidence as to her level of intoxication: Ts 295.29–31; 299–300.
125 Ts 369.28-370.3; Brief 82-83.
126 Ts 298.2–4.
127 Ts 367.8–23; 295.29–296.2.
128 See, eg, Ts 401.12–15; Ts 674.22–25; Ts 754.27–755.3; cf 625.7–15.
129 Brief 849.
130 Brief 103.
131 Ts 657.12–16.
132 Ts 637.11–14.
133 See, eg, Exhibit 93(n).
134 Ts 1023.14–26;
135 Ts 915.2–5.
136 Exhibit 51 from time stamp 15:38:38.
137 See Exhibit 51 from time stamps 16:07:15, 16:21:30, 16:44:45.
138 See Exhibit 51 from time stamp 16:21:30.
139 Ts 772.14; 1035.4.
140 Ts 932.28.
141 As even Neale acknowledged: Ts 827.5–7.
142 See, eg, Ts 772.14–19; Ts 1034.30–1035.3.
143 Brief 579–80, 601.
144 Brief 223.
145 Wolters claims she said "yes" three times when he was at the cell door, and once over the intercom: Ts 932.28; 933.4; 934.1; 952.30–953.1. However, his evidence is wholly unreliable: see Counsel Assisting Subs [56].
146 For example, by recording she was "moving around freely" when she was not: Exhibit 51 at time stamp 17:54:30-17:57; Exhibit 49; Ts 1070.21–1072.26.
147 Ts 1052.26–1054.1.
148 Exhibit 91, p5.
149 RCIADIC vol 2 (n 9) [13.4.15].
150 Marcia Langton, "Rum, Seduction and Death: 'Aboriginality' and Alcohol" (1993) 63 *Oceania* 3, 195.
151 Counsel Assisting Subs [63].
152 Ts 824.27–31.
153 Counsel Assisting Subs [37], quoting Exhibit 36. That description does not appear anywhere in the ACJP's own Policies & Procedures document: Exhibit 35.

154 For example, Sandra Owen referred to significant problems with police not understanding the ACJP's role and limiting access to people in custody: see, eg, Ts 545.20–28; 570.23–29.
155 Ts 564.17–25.
156 Ts 553.1–29.
157 Ts 542.7–11; 553.8–16; 559.12–18; 589.3–5.
158 See, eg, Ts 557.6–21.
159 Contra Counsel Assisting Subs [45].
160 Counsel Assisting Subs [43].
161 Ts 592.29.
162 See, eg, Ts 1482.1–25; Ts 1427.25–1428.10.
163 *Coroner's Act 1985* s 21(3) (rep).
164 *R v Shields* [1981] VR 717.
165 *R v Winter* [2006] VSCA 144.
166 *Cittadini v R* [2009] NSWCCA 302.
167 *R v Lavender* (2005) 222 CLR 67.
168 *Wilson v R* (1992) 174 CLR 313.
169 Ts 1501.18–1502.23.
170 Ts 1507 21-3
171 Royal Commission, Recommendation 35(a).
172 *Howard v Jarvis* (1958) 98 CLR 177.
173 *R v Taktak* (1988) 14 NSWLR 226 at 245 (Yeldham J, Loveday J agreeing); 250 (Carruthers J).
174 Ts 758.4–13.
175 Ts 759.27–8.
176 In his detailed but false account of a fall he had "seen".
177 In repeating that account to Harrup, and tacitly permitting her to relay it to Holland and Matheson.
178 In his sworn statement asserting "Whenever I conducted an in person welfare check on Tanya, I always had a discussion with her and family or other parties to her": Brief 119.
179 See, eg, Ts 772.14–19; Ts 1034.30–1035.3.
180 Ts 1526.16–23.
181 *DPP v Vibro-Pile* (2016) 49 VR 676 at 682 (Maxwell P, Redlich & Whelan JJA).
182 OHS Act, s 5.
183 *Downer EDI Works Pty Ltd v The Queen* (2017) 53 VR 1 at 11 (Maxwell P & Redlich JA).

ANNEXURE 1 - RECOMMENDATIONS

Victorian Government

1 That the Victorian Government decriminalise public drunkenness and repeal of sections 13 to 16 inclusive of the *Summary Offences Act 1966*.

2 That the Victorian Government prohibit the placement of intoxicated people - charged solely with an offence (or offences) under the *Summary Offences Act 1966* - in police cells.

3 That the Victorian Government work in partnership with Aboriginal and Torres Strait Islander organisations and communities, legal and health experts, Ambulance Victoria and Victoria Police to design, resource and implement a range of non-custodial, public health alternatives for the care and treatment of intoxicated persons.

4 That the Victorian Government publicly report, on an annual basis, on its progress towards implementing all of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody.

5 That the Victorian Government properly resource and fund the Victorian Aboriginal Legal Service's Custody Notification Service.

The Coroner

6 That the Coroner direct the principal registrar to notify the Director of Public Prosecutions that the Coroner believes an indictable offence may have been committed by Wolters and Neale, because they both owed Tanya a duty of care, consciously and voluntarily breached that duty and that breach of duty was causally connected to Tanya's death.

7 That the Coroner direct the principal registrar to notify the Director of Public Prosecutions that the Coroner believes an indictable offence may have been committed by Victoria Police, as an employer, for failing to ensure, so far as is reasonably practicable, that persons other than employees – like Tanya – were not exposed to risks to their health or safety.

8 That the Coroner recommend that the role of the Coronial Investigator receive legislative recognition in the *Coroners Act 2008*, and that it should also be stipulated in the *Coroners Act 2008* that, for a police contact death, the Coronial Investigator appointed to investigate the death should be an independent investigator (and not a currently serving police officer).

9 That the State Coroner undertake a review of the Coroners Court's processes and procedures to assess compatibility with the recommendations made by the Royal Commission into Aboriginal Deaths in Custody. To the extent that the Coroners Court's processes and procedures are not compatible, the Coroners Court should take steps to address those and engage in a co-designed process to ensure that the Coroners Court operates in a culturally safe and inclusive way.

V/Line

10 That senior management of V/Line take internal disciplinary action against Irvine for the actions he took that contributed to Tanya's death.

11 That senior management of V/Line review internal policy and training modules for V/Line staff regarding dealing with intoxicated passengers to require:

- that staff prioritise the safety and wellbeing of the passenger;

- that staff emphasise responses that will enable passengers to continue to their final destination where they do not pose a serious risk to the safety of staff or other passengers; and
- that requests for police assistance be as a last resort.

12 That senior management of V/Line review current training materials and provide compulsory, regular, detailed and ongoing human rights-focused training, developed in consultation with Aboriginal and Torres Strait Islander organisations, on racial discrimination, unconscious bias and the nature of racism, including its particular impact on Aboriginal and Torres Strait Islander people and communities, to all V/Line staff.

Victoria Police

13 That the Chief Commissioner of Police, in light of the evidence presented during the inquest, review and reconsider the internal disciplinary action taken against Wolters and Neale.

14 That the Chief Commissioner of Police publicly acknowledge that Victoria Police is an institution affected by systemic racism, that individual officers of Victoria Police have unconscious biases and that both of these interact and can have a real impact on decisions made by police.

15 That the Chief Commissioner of Police, having acknowledged the above, implement an anti-racist approach to service delivery and commit to organisational change. Victoria Police should develop an audit process to evaluate the effectiveness of organisational change. Part of the approach should include developing and delivering mandatory anti-racism programs for staff at all levels of Victoria Police, in partnership with Aboriginal organisations.

16 That the Chief Commissioner of Police review current training materials and provide compulsory, regular, detailed and ongoing human rights-focused training, developed in consultation with Aboriginal and Torres Strait Islander organisations, to new recruits and current police officers on racial discrimination, unconscious bias and the nature of racism, including its particular impact on Aboriginal people and communities. This training should be evaluated on an ongoing basis and police officers should only pass training if they demonstrate that lessons have been absorbed and retained.

17 That the Chief Commissioner of Police establish permanent data collection and retention systems to record human rights-based data, including the Aboriginal and Torres Strait Islander status of people approached by police. This data should be publicly reported by Victoria Police on an annual basis.

18 That the Chief Commissioner of Police review the adequacy of legislation, the VPM, standard operating procedures and training/refresher modules regarding dealing with intoxicated persons to require that police officers:

- consider and utilise alternatives to custody;
- consider arrest as a last resort and consider all alternatives before arresting a person, particularly in cases of minor offences;
- undertake individual health and risk assessments to determine whether the person requires medical attention or accommodations prior to taking a person into custody;
- if the intoxicated person is an Aboriginal or Torres Strait Islander person, consider that they may have experiences of intergenerational trauma, be more likely to have more complex health needs and may experience being detained in custody in a particularly negative and traumatic way; and

- provide adequate care and supervision of persons taken into custody to maintain their health, safety and wellbeing.

19 That the Chief Commissioner of Police review the adequacy of legislation, the VPM, standard operating procedures and training/refresher modules on reception and admission to custody to require police officers to:

- undertake individual health and risk assessments to determine whether the person is fit for custody or requires medical attention;
- complete a written questionnaire and record of visual observations and verbal responses which detail health and risk and welfare information and determinations made for the safety and management of the person once admitted to custody;
- in relation to an Aboriginal or Torres Strait Islander person taken into custody, to advise and assist the person to contact and communicate directly and confidentially with the Aboriginal Legal Service;
- in relation to an Aboriginal or Torres Strait Islander person taken into custody, consider that they may have experiences of intergenerational trauma, be more likely to have more complex health needs and may experience being detained in custody in a particularly negative way and traumatic way;
- reinforce the duty to provide adequate care and supervision of persons taken into custody to manage their health, safety and wellbeing;
- in relation to intoxicated persons taken into custody, provide that those persons should always be triaged as "Level 1 – High Risk" to ensure that they receive supervision commensurate with their at risk health status, and that they spend the least amount of time in custody as possible until arrangements can be made to transfer them out of police custody; and
- clarify that any physical checks cannot be effected simply by viewing CCTV footage and doing a visual assessment outside of the cell and emphasise the requirement for direct and meaningful communication with the intoxicated person within the cell in close proximity to the person.

Victorian Aboriginal Legal Service

20 That VALS review the adequacy of the Custody Notification Service protocol and Client Service Officer training to ensure that:

- welfare checks and requests for legal advice enable direct and private communications between the VALS Client Service Officer and the Aboriginal or Torres Strait Islander person taken into custody by police;
- welfare checks are conducted on all Aboriginal or Torres Strait Islander people in custody, irrespective of whether or not they are intoxicated; and
- there is effective collaboration between Victoria Police, the Aboriginal Community Justice Panel and other Aboriginal and Torres Strait Islander organisations to facilitate access to alternatives to custody for Aboriginal or Torres Strait Islander people.

Aboriginal Community Justice Panel Executive Committee

21 That the Aboriginal Community Justice Panel Executive Committee, in consultation with the Victorian Government, Victorian Police and Victorian Aboriginal Legal Service, review the adequacy of the current panel model including resourcing, training and staffing capabilities to meet the health and welfare needs of the Victorian Aboriginal and Torres Strait Islander population.

Ambulance Victoria

22 That senior management of Ambulance Victoria review internal guidelines and training to emphasise the requirement that paramedics act independently from police when called to assist a person in police custody, including that they obtain a detailed history, undertake an appropriate assessment and record objective observations.

23 That senior management of Ambulance Victoria continue to provide compulsory, regular, detailed and ongoing human rights-focused training, developed in consultation with Aboriginal and Torres Strait Islander organisations, on racial discrimination, unconscious bias and the nature of racism, including its particular impact on Aboriginal and Torres Strait Islander people and communities, to all Ambulance Victoria staff.

ANNEXURE 2

The Guardian

'Dragged like a dead kangaroo': why language matters for deaths in custody

Alison Whittaker

The coroner described the death of Ms Dhu as 'unfortunate' some 25 times. It was 'regrettable' 11 times, 'sad' 12 times

Sat 8 Sep 2018 06.00 AEST

When Coroner Ros Fogliani handed down her findings in the inquest into the death of Yamatji woman Ms Dhu, she released nearly three minutes of the footage of Ms Dhu's final moments. Activists described Ms Dhu, like John Pat before her, as being dragged "like a dead kangaroo" from her cell, down the corridor, to the hospital. The Australian legal system was the last to carry her like this, when a coronial inquest failed to deliver the "damning criticism" her family hoped for since her death.

Fogliani described those who carried Ms Dhu as "inhumane" and "unprofessional". CCTV vision of Ms Dhu being carried and dropped was "profoundly disturbing". The coroner

considered the matter “unfortunate” some 25 times. It was “regrettable” 11 times. “Sad”, 12 times.

Assessments like those delivered by Fogliani, addressing the conduct of third parties in deaths inside, are rare. More commonly, coroners blame ephemeral things like “disadvantage”. Even more commonly, they blame the deceased. Those who have died inside were “arrogant”, “verbally aggressive”, “difficult”, “drunk”, “brain damaged”, “impulsive”.

Outside of its pithiness and dehumanisation, the language coroners come to use about deaths inside is crucial. While coroners can’t impose any legal liability for the cases before them, they can and do use condemnatory language to express a sense of culpability - just like you and I might. That becomes important for advocates who seek justice for their loved ones.

The coroner’s court and its records are seen to achieve justice through storytelling and prevention. The inquest represents a crucial juncture in a case’s trajectory, between prosecution and the case’s end in the public record. Coroners are required to refer cases to prosecutors if they “form the opinion” that evidence points to a “known person” committing an offence in connection to the death, and that evidence could be “capable of satisfying a jury beyond reasonable doubt”.

Fogliani did not consider referring Ms Dhu’s case to prosecutors. Ms Dhu’s family fought for accountability in the coronial process to show that something “really happened” (a call they’ve since taken to the civil justice system), but were met with this in the inquest’s findings:

‘Unfortunately … the preponderance of … views’ that Ms Dhu was critically unwell ‘had the cumulative effect of obfuscating’ just how severely her life was ‘threaten[ed].’

Threatened by who? And how did that threat become her death?

To answer a common complaint of Indigenous families whose loved one has died inside - that they can find no justice in Australian law - I spent a year researching 134 cases to find out why prosecutions and civil actions for deaths inside were so uncommon. I concluded that the problem starts earlier than the discretion to prosecute or pursue civil action. It begins in the state’s coroner’s court.

Those courts produce an archive of death and public health data through which Guardian Australia combed to produce its Deaths Inside database. They can do so because, roughly since the royal commission into Aboriginal deaths in custody, they are mandated to hold inquests on every death inside and every death in connection with a police operation. The coroner’s court is also where most investigations conclude - “under-resourced” and “beset by delays” - with the production of findings and recommendations that are commonly unheeded.

Along with the legal structures I investigated (like heightened and inconsistent evidentiary standards, a glut of interested parties, a lack of impartial investigations), it was the coroner who ultimately directed the future of a case, decided if someone was blamed.

They had to see a “who”. And they had to see a “how”. In the 134 cases I researched, they saw both and then considered referring to prosecutors only 11 times. Of those 11, only five were referred to prosecutors. Of those, only two (the deaths of Mulrunji and Mr Jongmin) were taken up by prosecutors on the record. Mulrunji’s community “dragged … the government … every inch of the way” to that prosecution. Jongmin’s family “decided to leave it to white man’s law … but what did that give [us]? Nothing.” No one was convicted.

As the coroner's courts grew more conscious of the dignity and wellbeing of the bereaved before them, they tried to humanise their deceased subjects or understand their contexts. Sometimes, coroners described the cultural strengths of the deceased, their talents, their passions, their families, their lives. More often, coroners would begin with the deceased's first contact with police, their first alcoholic drink, first instance of abuse, first truancy. The attention was granular and humiliating.

While families whose loved ones died inside lamented that their loved one was on trial, coroners saw those dragged before them as tragic and deserving figures, fated to die of "natural causes". Coroners, in their long careers examining death, are trained to look for biomedical models. It is unremarkable that they find that most deaths inside are from natural causes. What they and we often fail to see is how designating a death as natural commonly misrepresents *how* someone died inside, implying that nothing caused or contributed to it.

Pathology became a way to avoid blame - disguising violence as disadvantage or doom. Canadian Aboriginal scholars suggest that inquests see Indigenous bodies in custody as "already dead" and their suffering as nothing but sad, timely deaths - "the only thing we can expect from a disappearing race." US scholars investigating police violence suggest that it "masks systemic harm", turning "systemic government misconduct" into "anecdotes".

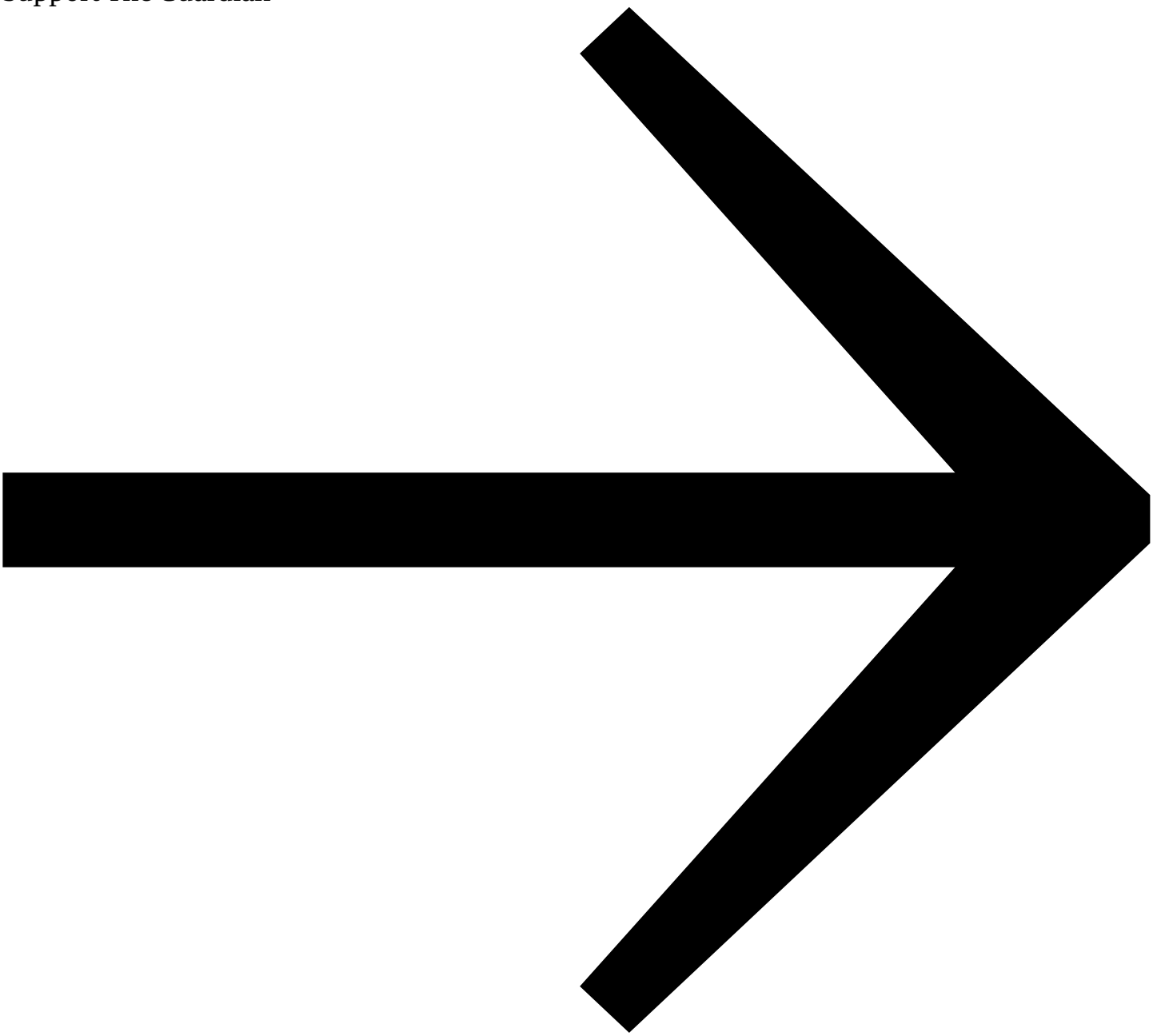
When state actors and systems *were* blamed through anecdotes, it was for their failure to intervene in tragedies that apparently spiralled out from nowhere. They were not blamed for deliberately depriving people of care nor for weaponising indifference in circumstances of total control. Perhaps unsurprisingly, no one was blamed for the policies that entrapped Indigenous people inside in the first place. Coroners contributed to the same blameless fatalism that has long underscored Australia's Indigenous policy. Indigenous death and suffering was naturalised, Indigenous people lived only by the benevolence of their gaolers.

When coroners blamed, they pointed to things going wrong in a system that routinely does Indigenous people wrong. Ms Dhu's carceral control - which Amnesty International described as akin to torture - became a series of "missed opportunities" for benevolent intervention. In cases similar to Ms Dhu's, conduct is "untimely", "unnecessary", "callous", "bureaucratic". In other cases, uses of force are "accidental", "unfortunate", "excessive", "undignified", "mild", "justified", "exacerbating an existing health issue", but never causative.

Indigenous people were restrained and suffocated by crowds of bystanders, police, and healthcare professionals who coroners merely described as "overzealous". Physical assaults by prison officers became "background stressors" in a man's "decision" to take his own life.

Coroners used this kind of language as a shorthand to "reject" allegations of "brutality or inhumanity". I cannot reject those allegations after I read that shorthand 134 times, about 149 people inside who can never come home. Australia's legal processes after a death inside are brutal and inhumane in their own right. They drag those who die inside down their corridors like dead kangaroos.

Alison Whittaker is a Gomeroi poet and law scholar. She undertook this research at Harvard Law as a Fulbright and Roberta Sykes scholar



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