Submission No 122

INQUIRY INTO HIGH LEVEL OF FIRST NATIONS PEOPLE IN CUSTODY AND OVERSIGHT AND REVIEW OF DEATHS IN CUSTODY

Organisation: Indigenous Social Justice Association (ISJA)

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Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

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Tane Chatfield's mother, Nikola, echoed the sentiment of her family when she told the coroner directly, "Tane was killed by the prison system."

This submission is dedicated to the Chatfield family.

The Indigenous Social Justice Association (ISJA) would like to thank the NSW Legislative Council Select Committee for inviting it to make a submission to the inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody.

In considering the terms of reference, ISJA notes one focus is on the unacceptably high level of First Nations people in custody in NSW.

The Royal Commission into Aboriginal Deaths in Custody outlined in its 1991 report that indicators of disadvantage contribute to this over incarceration. These include the economic position of Indigenous people, their health, their housing situation and their lack of access to basic employment and education.[1]

These factors are a result of the long history of dispossession and genocide at the hands of the settler colonial nation, along with the impacting intergenerational trauma and systematic criminalisation of First Peoples within the Australian criminal justice system.

In this submission, ISJA will specifically address the question raised in the terms of reference around the suitability of oversight bodies and in particular, the NSW Coroner's Court. It will consider whether the coroner functions appropriately in its role of assessing the cause of First Nations deaths in custody and in turn, preventing future deaths.

Recommendation 11 of the Royal Commission was that deaths in custody be required by law to be the subject of a coronial inquiry which culminates in a formal inquest conducted by a coroner into the circumstances of the death.[2]

ISJA's submission will focus on the recent NSW coronial inquiry into the death of Tane Chatfield. This took place over the week beginning 13 July 2020. The inquest was overseen by NSW deputy state coroner Harriet Grahame.

As Magistrate Grahame noted during the inquest, "the role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death." Her Honour continued that a coroner may make recommendations that arise directly from evidence that will be of benefit to public health and safety in the future.[3]

According to the deputy state coroner, "the manner and circumstances around Tane's death required significant investigation", as no one had foreseen that he would attempt suicide as happened on 20 September 2017. "Trying to understand what happened, even when it seems inexplicable, is a crucial part of preventing future death", she added. But nobody moved a finger.

[1] Royal Commission into Aboriginal Deaths in Custody, Volume 1
[2] Ibid, Volume 5, Recommendations
[3] Inquest into the Death of Tane Chatfield, 26 August 2020, paragraph 21

A reasoned excuse

ISJA asserts that over the last decades, the function of the NSW Coroner in terms of how it deals with inquests into First Nations deaths in custody is to provide a detailed assessment of the facts in such a way that excuses those directly involved in the custody death incident, as well as ultimately absolving the entire criminal justice system that continues to produce recurring deaths in custody.

Take the 2004 inquest into the death of TJ Hickey. The police officer driving the main vehicle involved in the incident, Michael Hollingsworth, was excused from testifying on the ground that he might incriminate himself. Then NSW coroner John Abernethy found that while a police car was following the teenager on his bike, the officers weren't pursuing him. And he labelled the incident a "freak accident".[4]

More recent inquests have involved more of the same. Rebecca Maher was stuck in a prison cell whilst noticeably intoxicated and forgotten about. Correct procedures weren't followed, and she was found dead in her cell. While recommendations were made, there was no consideration of disciplinary measures.[5]

David Dungay Junior was held face down in the prone position by five Long Bay prison guards until he died. No recommendations for any significant reforms were made and nor was there any suggestion that charges be laid against the guards.[6] The inquest into the death of Patrick Fisher made no recommendations.[7] Eric Whittaker died whilst in a coma shackled to a hospital bed. Again, no substantial recommendations were made as a result of his inquest, including in terms of holding anyone to account.[8]

The inquest and the outcome into Tane Chatfield's death occurred at the height of a resurgence in the Stop Aboriginal Deaths in Custody movement. Coroner Grahame's findings were delivered on 26 August 2020.

Nioka Chatfield remarked on the day the report was tabled that it was the prison system that killed her son. And these sentiments were echoed by the coroner herself when she stated in the third last paragraph of the report:

"I am so sorry that Tane experienced such despair in circumstances which were unsafe for him. Given his history and lack of support in custody, I understand why he could not ask for help when he experienced despair that morning."[9]

The coroner's statement points directly to the heart of the matter that led Tane to take his own life, which is the constant neglect that First Nations people suffer at the hands of the NSW corrections system. Yet, she makes this statement as an afterthought. The coroner has already inquired into the death in custody, she's heard the evidence, recommendations have been made, no one is to be held to account and that's the finish of it.

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[4] Paul Gregoire, Calls for a Parliamentary Inquiry Into TJ Hickey's Death, Sixteen Years On, Sydney Criminal Lawyers, 12 February 2020 ,<www.sydneycriminallawyers.com.au/blog/calls-for-a-parliamentary-inquiry-into-tj-hickeys-death-sixteen-years-on/>

[5] Inquest into the Death of Rebecca Maher, 5 July 2019
[6] Inquest into the Death of David Dungay, 22 November 2019
[7] Inquest into the Death of Patrick Fisher, 23 August 2019
[8] Inquest into the Death of Eric Whittaker, 28 February 2020
[9] Inquest into the Death of Tane Chatfield, 26 August 2020, paragraph 148

ISJA contends that the NSW Coroner now functions as a cog in the deaths in custody process. As the criminal justice system incarcerates large numbers of First Nations people, some of them are killed as a result, either at the hands of employees or via their neglect. Corrective Services NSW subsequently announces there was nothing suspicious about the incident. The case goes before the NSW Coroner's Court. Families are barely heard. Recommendations are made. And then another Aboriginal death in custody occurs.

A system of neglect

The NSW Coroner concluded that Tane Chatfield took his own life, when he hung himself on the morning of 20 September 2017. He subsequently died in hospital two days later. By most accounts, he'd been in good spirits leading up to that date as recent court proceedings indicated that he was likely to be released, after having been remanded since 30 July 2015.

As the coroner sets out in the report, over those two years on remand, as he was separated from his partner and child, Tane received no sustained psychological care. Despite having a history of drug use and testing positive for illicit substances in prison, he received no treatment. The 22-year-old Gamilaraay, Gumbaynggirr and Wakka Wakka man was simply left without any substantial help.[10]

On the evening prior to his suicide, Tane suffered a number of unexplained seizures. He was taken to the hospital overnight. On arrival back at Tamworth Prison in the morning, Chatfield was taken to see the on duty Justice Health nurse Janeen Adams. And as per usual protocol, Ms Adams requested the discharge summary that should have been provided by the hospital from the officer watching over Tane.

However, the prison guard advised that no discharge summary had been supplied. So, Ms Adams then recommended Tane to be taken back to his cell to wait until his discharge certificate arrived. She claims she was unaware that he had suffered seizures and had she known she wouldn't have permitted him to be left in a cell by himself. An email from the evening before, which outlined that Tane had been taken to hospital due to seizures, had been sent to Ms Adams; however she claims she didn't read it until after he'd committed suicide.[11]

After identifying these main points of neglect, Coroner Grahame then went on to make a series of recommendations. These included removing all hanging points from cells at Tamworth Correctional Centre; although the reason this has not been done in the past is that the prison is heritage listed. Indeed, the removal of hanging points was a suggestion made by the Royal Commission in recommendation 165.[12]

It was also recommended that Corrective Services NSW implement new procedures regarding an inmate's next of kin being notified if they're taken to the hospital, even if they're not admitted, and that prisoners taken to hospital shouldn't be returned without a discharge summary. Although, the latter recommendation was obviously already part of protocol, which had been broken on the morning in question.

Further recommendations included that Justice Health shouldn't place an inmate returned from hospital in a cell on their own, or if they do, it should be an observation cell. And Corrective Services

[10] Ibid, paragraph 25
[11] Ibid, paragraphs 67-85
[12] Commission Royal into Aboriginal Deaths in Custody, Volume 5, Recommendations

NSW should actively hire Aboriginal health workers, which one might expect is already being done considering the high number of First Nations people in custody.

The final recommendation was that a transcript of Ms Adams' evidence be forwarded to the Nursing and Midwifery Board of Australia so it could consider whether the nurse's professional conduct should be reviewed.

ISJA observes that in the case of the inquiry into the death of Tane Chatfield, the coroner honed in on the way that the corrections system neglected the young man, and she then made a series of recommendations, some of which have already been made going back as far as the 1991 Royal Commission.

The NSW Coroner has done its job of considering the case. Nothing has changed. No one was held to account. And therefore, more Aboriginal deaths in custody will be forthcoming.

Systemic change

The role currently played by the NSW Coroner in regard to deaths in custody still provides a veneer of hope for the families as if significant change is possible. However, it's become such a regular part of the system that the coroner is now simply providing a rubber stamp at the end of the custody deaths process.

Instead of being the starting point to real reform, the coronial inquest has become the end point, providing closure from the perspective of the authorities, while for the families; the Coroner's Court leaves them with an open wound, which can't be healed, and no room for further legal recourse.

The key reason as to why the NSW Coroner has taken on this superficial role is that it never holds anyone to account. In a case of neglect such as Tane's, it suggested that the nurse's performance be assessed. But there's no suggestion that anyone in a managerial role should take some of the responsibility or be held accountable for the multiple examples of neglect under their watch.

While in the case of David Dungay Junior's death there was no suggestion from the coroner that any of the five guards who held him in the prone position, as he called out repeatedly that he couldn't breathe and eventually took his last breath, be held responsible for the death of this young Dunghutti man.

ISJA asserts that one of the chief roles of the imposed British justice system over the more than 230 years since it has been established in NSW has been to quell resistance from the local First Nations peoples, as the settlers usurp their land. A key way of doing this was to lock Aboriginal people up in prison to get them off country and out of the way.

Law enforcement, the courts and corrections have all been complicit in this project. And as the NSW Coroner's Court is part of the state's criminal justice system, there's no reason to believe that it would operate in any other way.

And unless the NSW Coroner's Court begins to recommend that individuals are held to account for specific deaths in custody, then police, prison and nursing staff will continue to act in a similar manner, because there's no reason for them not to.

Recommendations

ISJA makes the following recommendations:

1. The NSW Coroner's Court should commence making recommendations that lead to those responsible for First Nations deaths in custody being held to account.

2. Certain deaths, such as that of Tane Chatfield, should no longer be simply labelled suicide, or, as in other cases, an accident. Reasons for death, such as failure to provide duty of care, ignorance of cultural facts, racist attitudes and prejudice should be available to be recorded as causes of death. In the Tane's case, he was in prison for over 2 years and never was a serious investigation on his mental situation, nor were his records in power of JH at Tamworth. So little attention was given to Tane, when he was sent to the Hospital for the seizures, the doctor recommended an ECG, and never was done. The Coroner never asked the question:"Who was responsible for the lack of information of Tane's mental situation, which probably played a role in his death? JH, the jail authorities or Corrective Services? How many inmates are in Tamworth with not assessment made on their health? How many potential suicides are in there? Hopefully none. However it will be by chance but not because serious research by the authorities. The Coroner didn't pursue the case, not only Tane's, but for the rest of the inmates.

3. The role of the coroner in relation to deaths in custody should be reviewed. First, any inquest has to respond to the questions of the family of the victim and allow them to present all issues. After this the coroners should be encouraged to deliver findings that could lead to reforms, rather than simply support the status quo. They should made recommendations to change procedures, and follow up with the relevant and responsible authorities. It is absolutely incomprehensible the Royal Commission into Aboriginal Deaths in Custody recommended almost 30 years ago the removal of hanging point in cells, and Coroners are still putting recommendations for the removal. What is the point of the recommendations?

4. In the Tane's inquest, the coroner denied to family the possibility to submit their issues with the inquest. Finally the Tane Chatfield inquest has brought to the Coroners a new way to do inquests. The problem is that the family doesn't know and is under the false impression that would be as the others. The normal path would be 1st, a Brief of Evidence, (Chatfield Family received it 4 days before the starting the inquest) no much time to understand what the inquest would be about. 2nd the actual inquest. 3rd, The transcripts, that help the family to understand what was said in court, not many people can understand some things said in court, nor can be paying attention all the time, and need to be refreshed. 4th, sometime the Counsel assistant the coroner submission and, 5th, the family submission sometime late. This submission is very important because is the only opportunity for the Family to tell the Coroner what they are really waiting from him, supported by a better knowledge of the case. It should be a concern what this coroner did, stopping the transcript publication, ask the submissions to be given orally on the last day of the inquest. I don't know how many people knew this, and the worst part, the family had very limited time to present the submission, orally, at the end of a painful and traumatic week, it's very hard to present the real thoughts of the family. The actual recommendation is expressed in the paragraph 144:"

4. In the Tane's inquest, the Coroner denied the Family of the possibility to submit their issues to the Inquest. Finally, Tane Chatfield's inquest has brought to the

Coroner a new way of doing Inquests. The problem is that the Family didn't know this, and it was under the false impression that this Inquest would be as previous ones. The normal path would have been: * First, a Brief of Evidence (Chatfield Family received it four days before the beginning of the Inquest) with no much time to understand what this Inquest was going to be about. *Second, the actual Inquest. *Third, the Transcript that helps families to understand what it was said in Court. Not many people can understand things said in Court, nor can be paying attention all the time and need to be refreshed. *Forth, sometimes the Counsel Assistant to the Coroner makes submissions. *Fifth, the Family's submission comes later, which it is very important because it is the only opportunity for the Family to tell the Coroner what they are really expecting from him, supported by a better knowledge of the case. It should be of concern that this Coroner did – stopping the Transcript publication, to request that Submissions were presented orally on the last day of the Inquest. I don't know if many people were aware of this, and the worst part is that the Family had very limited time to prepare and present the submission at the end of a painful and traumatic week. It was very hard to present the actual thoughts of the Family (paragraph 144).

5. In relation to the Coroner's role, it is important that legal representation provided to Aboriginal families at death-in-custody inquests be complete, fair and honest. There needs to be guaranteed that quality representation is provided by lawyers willing to properly work in families' best interests. This is also a duty for the Coroner to be aware of the dynamics between the Family and their legal team.

This submission was prepared by Raul Bassi and Faith Black on behalf of the Indigenous Social Justice Association (ISJA).

Contact Raul Bassi in relation to this submission on or at

Raul Bassi

ISJA Secretary

DONIA LANDY-ARIEL

ISJA Spokesperson BATJALA / MERIAM

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