Findings: Death of a Hope Vale Man in an Aboriginal Community Police Van

The Coroners Act 1958 provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of Desmond Mark Bowen who was known to his friends and family as Marky. However out of respect for the wishes of his family, he shall be referred to in these findings wherever possible as "the deceased".

Introduction

The deceased spent the afternoon of 28 April 2003 at his home in Hope Vale socialising with friends. As the evening wore on, the deceased became increasing intoxicated and a violent dispute erupted between he and his partner Paula resulting in the deceased being arrested by the Hope Vale Aboriginal Community Police.

They took him back to the community police station and contacted the state police in Cooktown who agreed that the deceased should be brought to Cooktown. The three community police therefore drove to Cooktown with the deceased in the back of the community police van. When they arrived at the Cooktown police station they found the deceased was dead. These findings seek to explain how that happened. They also contain recommendations aimed at reducing the likelihood of similar tragedies occurring in the future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Although the inquest was held in 2005, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the police officer who first became aware of the death considered it to be "*a violent or unnatural death"* within the terms of s7(1)(a)(i) of the Act, he was obliged by s12(1) to report it to a coroner. Section 7(1) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred, and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations[2], referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence,

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)
[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I turn now to a description of the investigation into this death.

Immediately the death was discovered, the officer on duty at the Cooktown police station called the officer in charge of the station who attended the scene. Arrangements had already been made to attempt to resuscitate the deceased. When it was apparent that they were unsuccessful, the Regional Crime Coordinator in Cairns was advised of the tragedy and he detailed the matter to the detective sergeant in charge of the Mossman Criminal Investigation Branch, Sgt Perham, for investigation.

That officer immediately drove to Cooktown and commenced the investigation. He interviewed all of those involved in the detention of Mr Bowen and arranged for the relevant places and the community police vehicle to be photographed. The physical exhibits were seized. The death was reported to the local coroner in Cairns.

The death was also reported to the Crime and Misconduct Commission and the Ethical Standards Command of the QPS. Officers from those organisations and the Regional Crime Coordinator overviewed the investigation.

The investigation report was conveyed to the local coroner on 4 March 2004. On 7 May 2004 I agreed to his request that I take over responsibility for the investigation as the undertaking of inquests imposes severe burdens on circuit magistrates.

Since that time further inquiries have been undertaken in relation to the recruitment and training of community police officers, the building of a police station in Hope Vale and various other matters

The inquest

A directions hearing was held in Cooktown on 15 October 2004. Mr Plunkett was appointed counsel assisting. Leave to appear was granted to the family

[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

of Mr Bowen, the Commissioner of the QPS the Hope Vale Community Council and the Aboriginal community police officers. Later, leave was also granted for the officer in charge of the Cooktown police station to be represented The inquest was then adjourned until 1 February 2005 but it was unable to proceed on that day. When it resumed, on 5 April, evidence was taken from 18 witnesses over two days and 78 exhibits were tendered.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Background

The deceased had been in a long standing relationship with Paula Fullagar. They had both lived in Hope Vale or nearby for all of their lives and had many extended family members in the area. In about January 2003, after their daughter was born, they moved from Starcke Station where they had been living with the deceased's parents, back into Hope Vale.

The deceased worked with the Community Development Employment Program but most of the money he made there went to servicing a car loan.

He regularly drank to excess and abused marihuana. He also engaged in domestic violence towards Paula and indeed in April 2003 there was in existence a domestic violence order, taken out in May 2002, that required the deceased to refrain from committing acts of domestic violence against her.

The events on the day of the deceased's death

Sadly, on the day of his death the deceased breached this order. On that day, he had been drinking at home with two friends; Neville Gibson, who lived next door and James Crawford. They started drinking at about 3 o'clock and by 8 or 9 pm they had nearly finished two cartons of stubbies each containing twenty four 260 ml bottles of beer. At this stage, the deceased became angry that Paula had not prepared an evening meal and went to wake her from their bedroom where she was sleeping with their baby daughter. Paula says the deceased punched her once, forcefully, to the forehead. Numerous other witnesses report having seen a lump on her head consistent with such a blow. A photograph of the injury taken by police the next day was tendered in evidence.

Paula went next door to borrow an onion to use in making the meal the deceased had demanded. While there some of the women noticed the injury to Paula's forehead and she told them the deceased had assaulted her. One of the women went to get Paula's mother, Grace Rosendale, who lived not far away.

When the messenger got to Grace's house, Grace asked her to call the community police and to arrange for the police to meet her at Paula's house. The officer who took that call, Bevan Bowen agreed to that request but said that he'd have to wait until the police van returned to the station.

Paula's mother, Grace, went to Neville Gibson's house which was next door to where the deceased and Paula lived. She sent one of the boys over to get Paula because she didn't want to become involved in a confrontation with the deceased. Unfortunately, it seems the person who took this message may have been suspected by the deceased of being involved in an illicit sexual relationship with Paula. He was not well received.

At about the same time the community police van carrying Bevan Bowen, Eric Harrigan and Neville Bowen arrived. They went into the house. A short time later, so did Grace, and they all confronted the deceased about his having assaulted Paula. The deceased denied that they had been fighting. Grace said she wanted to take Paula and the baby home and the deceased became upset. There was a noisy argument which the community police were unable to resolve. It became apparent that Paula was intending to leave with her mother but the deceased said they could not take the baby, that he would take her to his sister's house.

Thinking that would be a good way to defuse the tension, the community police agreed to drive the deceased and the baby the short distance to the house of the deceased's sister.

They then returned to Paula's house to see whether she wanted to be taken to the women's shelter. There is some discrepancy as to the order of events that then transpired. On some versions, Paula, her mother and the neighbours were still standing around outside Neville Gibson's house when the community police officers arrived and asked Paula again if the deceased had assaulted her and advised her that, if he had, they could call out the state police from Cooktown to come and arrest the deceased. However, as Paula had already arranged to go with her mother and a friend to the women's shelter, she declined any further assistance from the community police. That group and the community police were just about to leave the area when the deceased came running back towards them along the footpath. On other accounts, this happened before or just as the community police were arriving back at the Gibson residence.

It is not possible or necessary to resolve this conflict in the evidence. It is agreed by all of the witnesses (at least in their statements, if not their oral evidence) that the deceased was yelling at Paula and everyone present got the impression that he was intent on assaulting her. The female neighbour, Lee Ann Wortley said in her statement, " *I remember thinking that he would hit me because he was in such a rage. He was real agro towards Paula."*[9] She went back inside to avoid him. Paula in her statement said, *"That's when he*

[9] exhibit 26 para12

came running back and he wanted to hit me.…He was abusing Marcus and he was really drunk and aggressive."[10] Neville Gibson said*, "Marky came from nowhere and wanted to get stuck into Paula but I happened to be standing in front of the car……I remember seeing Marky running down Kernich street towards the car. He was swearing and saying 'where's his woman.' Marky was angry all right but he couldn't punch her because I had hold of him."*[11]

The deceased's arrest

Fortunately, as the above quoted passage makes plain, the male neighbour, Neville Gibson, saw that the deceased was intent on assaulting Paula and intervened. He grabbed the deceased around the arms in a bear hug. The community police, then wrestled the deceased into the police van. The witnesses say that the deceased was resisting the police and trying to avoid being put in the van but that no punches were thrown. Although it took a few minutes to get him in, no one says that any unnecessary force was used and no injuries indicating violence was done to the deceased were found on his body at autopsy. On some versions, after struggling for a few minutes, the deceased voluntarily got into the van when it was made clear that he was not going to be released.

As the police were driving away for the scene of the arrest, the deceased was abusing the police and making threats against them and those who had helped put him in the van.

The community police derive their powers from the *Hope Vale Aboriginal Council By-Laws 1994* which provide, so far as is relevant to this case, that a community police officer may arrest a person without warrant if he/she reasonably suspects that the person has committed an offence against the provisions of Division 2 of Part 2 of the by-laws and the continued liberty of the person would be likely to endanger the safety of any person.[12]

The offences contained within that part of the by-laws include assault[13] and offensive behaviour.[14]

I am of the view that the behaviour engaged in by the deceased justified his arrest. When they first attended at the house there was evidence that he had assaulted Paula that could have justified his arrest at that stage. The community police sensibly sought to defuse the situation by assisting the deceased leave the house. However, when the deceased came running back to where Paula and her mother were standing outside the Gibson's house, acting in a manner that led everyone there to conclude that he was going to assault his wife, the community police had to arrest him. The only reasonable conclusion that could be drawn from his attempt to attack Paula, his resistance to his arrest and his threats to the community police and others,

[10] Exhibit 22 para 14
[11] Exhibit 24 para 14 and 15
[12] Exhibit 46 Power of arrest - para 1.03
[13] Exhibit 45 para 2.07
[14] ibid para 2.09

was that unless he was arrested the deceased was likely to endanger the safety of others.

After the community police had arrested the deceased, as it was not possible to bring him immediately before a court having regard to the time of day, they needed to consider whether he should be granted bail.[15] The likelihood that he would endanger the safety of others was sufficient justification for refusing to release the deceased on bail. The threats he made while in the back of the police van re-enforce this view.

When that decision had been made, properly in my view, the community police were obliged by the provision of the by-laws to take the deceased to a watch house under the control of the QPS.[16]

If any further authority is needed for the actions of the community police, I am of the view that it is provided by the provisions of section 260 of the *Criminal Code* which authorises any person who witnesses a breach of the peace,[17] to use such force as is reasonably necessary to detain any person who appears likely to continue to breach the peace, for as long as is necessary to give the person into the custody of the police. For the reasons set out above, I am of the view that the community police could reasonably apprehend that the deceased was likely to continue to breach the peace. It follows, they could detain him for so long as it was necessary to deliver him into the custody of the state police.

The transfer of the deceased to Cooktown

At about 10.00 pm, community police officer Bevan Bowen rang the Cooktown police station, spoke with police liaison officer Anthony Gibson and explained the situation to him. Community police officer, Bowen, said that they wanted to bring the deceased to Cooktown because they didn't believe it was safe to release him. PLO Gibson telephoned the on call officer, Constable Liam Walker and advised him that the community police wanted to bring Mr Bowen into Cooktown. Constable Walker came back to the station, advised the officer in charge of what was proposed and sought his approval for the overtime that admitting Mr Bowen to the watch house would entail. Constable Walker then called Community Police Officer Bevan Bowen to confirm that it was appropriate for them to bring the deceased to Cooktown.

It is apparent that in making that decision, Constable Walker may not have received an entirely accurate description of the conduct of the deceased from the community police. However, I am satisfied that having been made aware that the deceased had allegedly assaulted his partner and that there was a domestic violence order in place in relation to him, there was ample justification for this decision, especially when it is recognised that the community police had, without success, already attempted the less interventionist response of taking the deceased to his sister's house. In view

[15] ibid para 1.04(2)
[16] ibid para 1.04(7)
[17] In R v Howell [1982] 1 QB 416 at 427 the court of appeal held that a breach of the peace occurred when ever harm is done or is likely to be done to a person

of the long over due change in attitude to domestic violence on Indigenous communities, I believe that had the community police not removed the deceased from the community that night they could have been rightly criticised. I do not accept that placing him into the custody of elderly or female relatives was an acceptable option; in view of the behaviour he had displayed that day and his state of intoxication.

None of the community police officers noticed whether the deceased was wearing a belt but no consideration was given to searching the deceased before transporting him to Cooktown. The officers involved say they have never been told that they should do so and it did not occur to them that the deceased would self harm. He was not only aggressive and clearly angry about being taken into custody but also making threats about what he would do when he got out. He gave no indication that he was contemplating suicide. Each of the men had known the deceased for many years and none of them thought he was suicidal. In evidence, Neville Bowen did say he was concerned that the deceased might endanger himself but went on to say that he did not think he would commit suicide. I took Neville Bowen's comments to mean that he was concerned that if released, the deceased was at risk of doing something that he would later regret.

The community police say that as they were driving out of Hope Vale the deceased was calling out, but by the time they reached the cemetery or the end of the bitumen he'd gone quiet and they assumed he was asleep. Although one of the officers looked back at one stage as they were driving along, as there was no light in the back of the van and only a small opening to look through, he could not really see what the deceased was doing. He said he thought he appeared to be lying up against the driver's side of the cage near the back of the driving compartment.

When the community police van reached the Cooktown police station at about 10.50pm, the community police went to enter the station as Constable Walker came out to meet them. The constable immediately noticed that the person in the cage on the back of the van was in an unnatural position and so checked him. Constable Walker saw that there was a ligature around the person's neck, the other end of which appeared fastened to the mesh of the van. He checked the deceased for a pulse, found none and felt him to be cold to touch. Constable Walker then ran into the station and called Sgt Cruise and the ambulance. While doing so he instructed PLO Gibson to attempt resuscitation.

PLO Gibson, with the assistance of the community police officers, removed the deceased from the vehicle. He checked for a pulse and on finding none commenced doing chest compressions in an attempt to restart the deceased's heart. No CPR mask was able to be located but Constable Walker immediately commenced mouth to mouth resuscitation. The ambulance arrived a few minutes later and the para-medics took over the resuscitation attempts. Sgt Cruise and his wife, a registered nurse, arrived at about the same time as the ambulance and she also assisted. A doctor from the

hospital also attended. The resuscitation attempts were unsuccessful and the deceased was declared dead.

A statement from an expert in resuscitation, Dr Victor Callanan [18] said that by the time asphyxiation causes a person's heart to stop beating their brain is usually irreparably damaged and the chances of reviving the person with CPR is less than 1%. If CPR is delayed more than a few minutes after the heart stops, death is inevitable. In this case it can not be established exactly when the deceased lost consciousness but it seems clear that by the time he reached the Cooktown Police Station his heart was no longer beating and his body was cold. He was probably already dead. I find that nothing more could have been done by those who attempted to save him.

The body of the deceased was transported to the mortuary at the Cooktown Hospital and then to Cairns where, on 30 April 2003, an autopsy was performed by Dr David Williams an experienced forensic pathologist.

The autopsy found no significant injuries to the deceased's body, other than abrasions around the neck and a vague band on each side of the neck. The pulmonary oedema and congestion in the lungs led Dr Williams to conclude the cause of death to be asphyxia caused by hanging. The absence of injuries to the hands of the deceased or other signs of foul play, when coupled with the bruising to the strap muscles of the neck and the fact that the laryngeal skeleton and hyoid bone were intact led him to conclude that death was more likely to have been caused by self inflicted hanging than homicidal strangulation. Dr Williams noted that the deceased was severely intoxicated and that there was in his blood evidence that he had been smoking cannabis. There is no evidence that contradicts Dr Williams' conclusions which accord with those of the investigating officer.

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death. As mentioned earlier, these are not criminal proceedings and I am therefore to apply the civil standard of proof when considering these issues.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings.

Identity of the deceased – the deceased was Desmond Mark Bowen

Place of death – he died in the back of the Hope Vale Community Police wagon at an unascertained place between Hope Vale and Cooktown.

Date of death – He died on 28 April 2003

[18] Exhibit 32

Cause of death – The cause of death was hanging. It was self inflicted with no evidence of the involvement of any other person.

Criminal charges – No person should be committed to stand trial

Issues of concern

They are the bare facts and findings in relation to this death but of course there are far deeper and troubling aspects of the matter that require some comment.

The tragic death of the deceased man in the circumstances that prevailed, must for all who knew him, or have since learned of them, raise profound questions about why the death occurred and whether it could have been prevented. The loving family of the deceased man will forever grieve his loss. His baby daughter will never know her father. The involvement of long standing friends and relatives in the detention and attempted resuscitation of the deceased will have a lasting traumatic impact on them. To all of those people I offer my sincere sympathy and condolences but of course that will do little if anything to ease their pain. Nothing can bring the deceased man back but this examination of the circumstances of his death does provide an opportunity to push for changes that might reduce the likelihood of similar deaths occurring in the future.

The issues I wish to mention in that context are:

- Suicide in Indigenous communities
- Alcohol abuse
- Policing in Indigenous communities

Suicide in Indigenous communities

The issue of suicide among Indigenous Australians has been studied at length. The facts revealed by those studies are alarming. For example, in one analysis it was demonstrated that the rate of suicide among Aboriginal men is twice that of the general population.[19] When it is realised that Australia has one of the worst rates of suicide among the general population in the world, the magnitude of Aboriginal suicide is drawn sharply into focus.

Attempts to explain these horrifying statistics have focussed on similar high rates among other post colonial Indigenous groups around the world and referred to the breakdown of traditional social control mechanisms and the material poverty and poor health that besets almost all of these populations. However, these attempts at drawing parallels provide no explanation for the

[19] Hillman S., Silburn, (2000) *Suicide in Western Australia 1986 to 1997*, Perth, Youth suicide advisory committee, University of Western Australia

frightening recent increase in Aboriginal suicide. Only three decades ago, suicide among Indigenous Australians was rare. To quote one expert who has worked extensively in Cape York, *"(S)uicide was, until the 1980s, extremely uncommon, indeed unknown in most Australian Indigenous communities"*[20]

It is, I would have thought, generally accepted that in that same period, greater attempts have been made to recognise and redress the harm done by the earlier treatment of the traditional owners of this land. Yet apparently, during the period when one might have thought the deleterious impacts of dispossession and domination were being ameliorated, the rate of suicide among Indigenous people has dramatically increased. Perhaps the seemingly trite title of a recent report is true – *"Aboriginal suicide is different."*[21] That study attempt to offer theoretical explanations for suicide rates and looks at common features, many of which were present in this case; domestic conflict, alcohol and marihuana abuse.

Suicide is undoubtedly a serious problem for the Indigenous communities around Cooktown. A basic review of police records for the Cooktown division for the period 1999 to 2004 showed 18 deaths – all but 2 by hanging. It is clear also that attempts have been made by the local community to address the phenomenon. Ms Norgard gave evidence of programs that had been implemented in Hope Vale aimed at identifying individuals who might be at risk and offering them counselling and support. She also spoke of the success of these strategies to address an outbreak of suicide attempts among the youth of Hope Vale when apparently 40 attempts were made over a three month period. However, the death investigated by this inquest is evidence that those programs have had only limited impact. For example, none of the local community police who gave evidence were aware of a "high risk list" that they could access to discover whether special precautions were needed in relation to a person in their custody and not even basic precautions were taken – an issue I will deal with later in connection with the training of community police. Further, even though the deceased had been referred to Ms Norgard for counselling by the local Life Promotions officer, who happened to be his mother, his death was not prevented.

Regrettably, after reviewing the evidence presented in this case and having considered the literature that is readily available to me, I have come to the conclusion that Indigenous suicide is too complex a question for me to make meaningful preventative recommendations about. I will therefore refrain but exhort those in positions of responsibly in this community to redouble their efforts to grapple with the problem.

Alcohol abuse on Aboriginal communities

How this death came about are in many respects is all too tragically familiar and all too obvious.

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[20] Hunter E.,(2004) *The protracted dawning of a "Bran Nue Day": Aboriginal suicide in social context* (as yet unpublished)

[21] Tatz C., (1999) A report to the Criminology Research council on CRC Project 25/96-7

Once incarcerated and alone in the back of the police van, this 27 year old man had the opportunity and means to take his own life with as little as his own belt and a hanging point from the wire mesh on the back of the community police van.

It is not without significance that the deceased was an Aboriginal male who lived on a Far North Queensland Aboriginal community, he was heavily intoxicated by alcohol and marihuana and was in a highly emotional state having just had a violent altercation with his partner and the Aboriginal Community Police.

Relevantly as far as the intoxicated state of mind of the deceased was concerned, it was observed of Queensland Aboriginal communities by Royal Commissioner Mr L F Wyvill QC some 15 years ago when reporting on deaths in other Indigenous communities [22]

> *The role of alcohol in triggering violence and creating a whole range of other social problems cannot be denied. The constant refrain of police on communities is that 90-95% of crime is alcohol related and the constant complaint of nursing staff is that 90-95% of health problems are alcohol related.*
>
> *…*
>
> *The central place of alcohol in the deaths of Noble, Hyde and Koowootha is self-evident. It, too, can be viewed as a problem with its roots in White society and the legacy of its invasion and ongoing impositions. Heavy reliance upon alcohol can be understood in terms of the lifestyle of many residents who have to contend with a wide range of stresses resulting from discrimination, unemployment, poor living conditions and a general lack of prospects. These stresses are particularly acute in the young.*
>
> *…*
>
> *Too frequently high levels of alcohol consumption are viewed simply as a cause, rather than an expression of social problems. Both professional and community members exhibited this attitude in reacting to self-injury and threats of suicide by Noble. Still, there has been a failure of both Aboriginal and European societies to come to terms with the problem of alcohol abuse, especially in the young. For Aboriginal societies the solution must ultimately strike at the deep seated causes.*
>
> *…*
>
> *Ultimately, the underlying causes of high alcohol consumption can only be addressed by the restoration to Aboriginal people of power and responsibility over their lives. In the meantime the issues cannot be ignored and alcohol availability and the existence and value of detoxification and rehabilitation centres must continue to be addressed at Yarrabah. Consideration must be given to the desirability of seeking to control alcohol related violence through the legal system or through more community oriented measures.*

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[22] *Royal Commission into Aboriginal Deaths in Custody Individual Report on Perry Daniel Noble, Richard Frank (Charlie) Hyde & David Mark Koowootha*, Part 7, Chapter 22 - Underlying And Other Issues

This death again highlights the strained social circumstances of Aboriginal people living on Aboriginal communities in Queensland and the destructive role of alcohol especially among young males. I am of course aware of recent attempts to again seek to address the problems caused by the abuse of alcohol on Cape York communities.

However, I feel obliged to observe in these findings that the fact that the deceased was an Aboriginal male living on an Aboriginal community contributed to his intoxication and his state of mind leading to him taking his own life. I have no doubt that had the deceased not been drunk on the day of his death he would not have acted as he did. Undoubtedly, his level of risk was exacerbated by his consumption of marihuana, a factor common to many Aboriginal suicides.[23] It is too simplistic to say that the deceased chose to drink to excess and could have chosen not to. The fact that many Aboriginal people don't abuse alcohol does not mean that those who do are simply weak willed. Such an analysis ignores the lack of choice Aboriginal people have in so many other aspects of their lives.

While Aboriginal communities in Queensland continue to suffer from the legacy of racism, social deprivation and under resourcing, Aboriginal people will continue to be at a greater risk of alcoholism, violence and suicide than other Australians.

Simply put, there have been too many words, studies and inquiries, too much dithering and delay, and not enough action to help Aboriginal people on Queensland communities deal with these problems. There is little I can constructively add to the ongoing debate about this issue but an account of the context of this death would be incomplete without reference to the problem of alcohol abuse among some residents of Hope Vale.

Aboriginal community police

When giving evidence at this inquest Inspector John Harvey and other QPS members acknowledged the invaluable contribution Aboriginal community police play across far northern Queensland. Aspects of that role mentioned were:

- Front line crime prevention,
- A first response in times of emergency,
- Intelligence gathering,
- Witness and suspect locating,
- Dissemination of information about law enforcement and public safety issues,

[23] Tatz O., (1999) op. cit at p73

- Developing cultural awareness in new state police and informants on local sensitivities and relationships.

The Cooktown police division provides a good example of the vital role these officers play. It stretches over 200 kms from the Bloomfield River in the south to Bathurst Bay in the north and contains such wild and rugged country that to drive from one end of the division to the other can take two days if weather allows land travel. It has an area of 11,850 square kms. Yet there is only one state police station situated in the township of Cooktown. The community police in Wujal Wujal and Hope Vale obviously provide essential augmentation to the delivery of policing services to the citizens of these communities. However, even a cursory examination of the support given by the government to this essential service demonstrates its gross inadequacy.

The facts of this case provide graphic evidence of this contention. The three community police involved in the arrest of the deceased man had been police officers for 4 months, 2 months and 3 weeks respectively. None had received any training. None had access to a mobile phone or a two way radio. They were not provided with hand cuffs, batons or any of the other accoutrements routinely issued to the state police. The van they were given to transport prisoners in had no internal light in the prisoner compartment and had numerous hanging points. It could not be adequately inspected from the passenger compartment. There was no watchhouse in which they could hold prisoners and when, as in this case, the Cooktown state police were not available to come to Hope Vale to take a person into their custody, the community police had to transport the prisoner into Cooktown, a distance of approximately 50 kms, much of it over unsealed roads.

Because of their lack of training, the officers did not think to search the deceased to remove his belt and did not think to keep a regular watch on him to ensure that he did not self harm. The QPS police liaison officer at Cooktown who spoke to the community police before the deceased was brought into Cooktown claims he may have suggested the community police "*keep and eye*" on the prisoner but this was denied by the community policeman concerned. In any event it didn't happen.

The community police in this case are employees of the Hope Vale Community Council. Similar arrangements exist in all but four of the 35 Aboriginal and Torres Strait Islander communities. It is therefore the responsibility of the community councils to recruit, train and equip the community police. The community councils are obviously ill-equipped to discharge this role. They have no expertise in what is clearly a very specialised function. Consider, for example, how Cooktown might fare if the QPS withdrew to Cairns and passed to the Cook Shire the responsibility for local policing. Further, as the Aboriginal community councils are totally dependent upon state government grants and have no power to raise funds by charging municipal rates as do mainstream local authorities they have dire funding shortages which results in health care, housing and other community services competing for funding with community policing. The only significant

alternative source of funding for the councils is licensed canteens but obviously such enterprises bring with them as many problems as the funds they generate might solve.

Although they have no statutory responsibility to do so, the QPS has commendably attempted to provide training for Aboriginal community police and has devoted considerable resources to this activity. It was suggested in the very competent and thorough report of Sgt Perham, that training was difficult to effectively deliver because of a high turn over among community police members. None the less, QPS witnesses sought to persuade me that the problem has eased, at least in this district, as a result of a more concerted effort on the part of the Police Service to deliver block training and greater stability among the Hope Vale community police contingent. That assurance was demonstrated to be illusory when the officer in charge of Hope Vale community police gave evidence. He told the inquest that the Hope Vale contingent now only consisted of himself and one other officer and that although he had received some training in crime prevention he knew noting about custody awareness issues. When questioned about the difficulty in recruiting and retaining suitable people to be community police officers that officer, Sgt Trevor Gibson, referred to the poor pay and the lack of any opportunity for career advancement. Other witnesses referred to the difficulty of policing in a community in which personal relationships between senior members of a community council might be used to undermine or over turn action taken by the community police.

I don't mean to suggest that nothing has been done to address the deficiencies highlighted by this death. The community police van was immediately replaced with a more suitable vehicle and training in custody awareness issues was provided to community police from Hope Vale and Wujal Wujal. However, none of the Hope Vale officers who attended that training remain in the community police service. Standard operating procedures were developed that are designed to ensure that prisoners are only transported by community police officers who have received custody awareness issues training. In view of the evidence of Sgt Gibson it is difficult to see how this could be complied with.

However, a solution to these problems, in so far as they apply to Hope Vale, seems to be at hand with the announcement that a QPS station will soon be built at that community; indeed earthworks commenced on the same day as this inquest. However, there remain four other Aboriginal communities[24] in which community police are the sole local providers of policing services.

When one looks at the history of the decision to commence building a police station at Hope Vale it is difficult to be confident that the needs of these communities will be addressed in the near future.

Recommendations to Government for the building of a police station at Hope Vale were made in the following reports:-

[24] Injinoo, Naprunam, New Mapoon and Wujal Wujal

- On 2 July 1987 in the *Powder-Law Report*, the results of independent inquiry by Messrs E J Law and P Powder into possible causes for Aboriginal suicides recommended a new police station at Hope Vale (recommendation 3 on page 6);

- In the early 1991 this recommendation in the *Powder-Law Report* was endorsed by Commissioner Lew Wyvill QC, Royal Commissioner into Aboriginal Deaths in Custody in the individual death report of Alistair Albert Riversleigh;

- On 25 August 1994 the *Queensland Police Service Review of Policing in Remote Aboriginal and Torres Strait Islander Communities* recommended the establishment of a two person station at Hope Vale (recommendation 5.6 on page 7 of the Executive Summary;

- In November 1998 the Indigenous Advisory Council sponsored Hope Vale Planning and Awareness Workshop held on 25 and 26 February 1998 recommended the upgrading of the Aboriginal Community police station and watch house (recommendation 13, page 6)

The history of recommendations for the proper resourcing of community police is equally tortured:

- In 1986 the Australian Law Reform Report Commission recommended that Aboriginal Police Aides should have a career path after necessary training in the regular police force, periodic review and adequate police powers and they should not be seen as a second hand police force;

- On 2 July 1987 in the *Powder-Law Report*, the results of independent inquiry by Messrs E J Law and P Powder into possible causes for Aboriginal suicides and suggested solutions sets out in detail the results of investigations into 14 Queensland Aboriginal communities. The first item listed in the 'Major Recommendations' called for "effective training and career paths for Community Police". (recommendation 1 on page 6);

- In 1988 the Aboriginal Co-ordinating Council recommended that consideration be given to the incorporation of Aboriginal Community Police as special constables of the Queensland Police Service and to consider ways to financially assist the Community Police such as providing them with uniforms, training, equipment and vehicles;

- In 1991 Commissioner Lew Wyvill QC, Royal Commissioner into Aboriginal Deaths in Custody in Individual Reports on:-

    - *Perry Daniel Noble, Richard Frank (Charlie) Hyde & David Mark Koowootha*, PART 7, Chapter 22 - Underlying And Other Issues;

    - *The Young Man Who Died At Aurukun on 11 April 1987* in Chapter 1. Police And Social Control;

- *The Young Man Who Died At Wujal Wujal on 29 March 1987* in *Chapter 1. Policing And Social Control*;

- *Alistair Albert Riversleigh*, Commissioner Wyvill QC in *Chapter– 9.1 Aboriginal Police*;

commented on the lamentable state of the under resourcing of Aboriginal Community Police in Queensland, the absence of a career structure, formal qualifications, character checks, and training and found that many of the deaths in custody would have been preventable if the Aboriginal Police had been properly trained.

- In 1991 the Royal Commission into Aboriginal Deaths in Custody, National Report, Volume 1, The Queensland Community LockUps, National Report, Volume 4, Aboriginal Police Aides, National Report, Volume 2, Queensland, further called for the resourcing and proper training of Aboriginal Community Police;

- The summary of *Review and Recommendations* of the Royal Commission recommended that :

  - "That Police Services in their ongoing review of the allocation of resources should closely examine, in collaboration with Aboriginal organizations, whether there is a sufficient emphasis on community policing. In the course of that process of review, they should, in negotiation with appropriate Aboriginal organizations and people, consider whether: a. There is over-policing or inappropriate policing of Aboriginal people in any city or regional centre or country town; b. The policing provided to more remote communities is adequate and appropriate to meet the needs of those communities and, in particular, to meet the needs of women in those communities; and c. There is sufficient emphasis on crime prevention and liaison work and training directed to such work" (Recommendation 88, page 28)

  - "That the question of Community Police in Queensland and the powers and responsibilities of Community Councils in relation to them be urgently reviewed" (recommendation 232, page 50)

- In 1991 the Legislative Review Committee in a *Final Report of an Inquiry into the Legislation relating to the Management of Aboriginal and Torres Strait Islander Communities in Queensland* , while not pre-empting community choice, welcomed a proposal for the policing of communities which involved the integration of the Community Police into the State Police Service (page 17);

- In 1993 the Aboriginal Co-ordinating Council Discussion Paper again called for substantial improvement in Community policing;

- In 1993 the Aboriginal Community Representatives Workshop in Cairns (13-15 April 1993) assessed that the expectations placed on Aboriginal Community Police were unrealistic;

- On 25 August 1994 the *Queensland Police Service Review of Policing in Remote Aboriginal and Torres Strait Islander Communities* found through extensive Aboriginal community consultations a lack of a clearly defined role for community police which affected the respect accorded by members of the community to them. It found that community police were hesitant to act in the absence of clear guidelines as to the their duties and powers. The other factors of lack of training, poor wages, lack of support from the State Police and Councils, conflicting family and work obligations and criminal history of some officers also affected their status in the community. The review reported that the issue of costs incurred by the QPS was the main reason given by State Police officers opposing employment of community police because of the assumption that it would come from the QPS budget and the need for additional funds being made available to QPS to enable a transfer of community police to the QPS. Nevertheless the review recommended that the Aboriginal Community Police be employed by the QPS contingent on additional funds being made available. The review also recommended that QPS officers be rostered at appropriate times to provide an effective, proactive and reactive policing service and to ensure adequate supervision of community police. The review recommended that individual protocols be developed between each community and the QPS to cover the roles and responsibilities of community and QPS officers. Another recommendation of the review was that the QPS provide formalised, structured and continual training to community police, with particular emphasis on watch house procedures and safe custody awareness.

- In April 1995 the Human Rights and Equal Opportunity Commission, Race Discrimination Unit, in its Mornington Island Review Report called for a substantial increase in resources and training for Aboriginal Community Police;

- In May 1996 the Office of Aboriginal and Torres Strait Islander Affairs, Brisbane in *The Local Justice Initiatives Program* [1996] AILR 86; (1996) 1 AILR sought improvements in Aboriginal Community Policing;

- In 1996 the *First Report of the Aboriginal and Torres Strait Islander Overview Committee (Queensland)*, *An Agenda for Action* [1997] AILR 29; (1997) 2 AILR 324, the Department of Families, Youth and Community Care, Brisbane, called upon the Queensland Government to delay the introduction of amendments to the Community Services Acts until after the delivery of effective training for community police, and the completion of community-wide consultation (recommendation 32). The Overview Committee called upon the Queensland Police Service to take responsibility for the supervision, training, and remuneration of Aboriginal and Torres Strait Island Council community

police officers, who must be trained in all aspects of community policing, including the administration and execution of relevant community law and order by-laws (Recommendation 38);

- In July 1997 the Aboriginal Co-ordinating Council in the *Kowanyama Customary Law Workshop* [1998] AILR 30; (1998) 3 AILR 466 recommended that the State Government ensure appropriate training, award conditions and career structure for Community Police (recommendation 23);

- In 1997 the Human Rights and Equal Opportunity Commission, *Bringing Them Home -National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families* [1997] AILR 36; (1997) 2 AILR 286 observed there was an urgent need for training of Aboriginal Community Police;

- In 2000 the *Aboriginal and Torres Strait Islander Women's Task Force on Violence Report* [2000] AILR 20 stated that if Aboriginal Community Police are retained, either under the current arrangements or through the collaborative jurisdiction of Queensland Police and Community Councils, their training program needs review. The Task Force said it must be an accredited program under Queensland Police and given before appointees are assigned to the workplace and then as an ongoing requirement;

- In early 2000 in response to the recommendation to *1994 QPS Review*, referred to above, the Queensland Aboriginal and Torres Strait Islander Police Project (QATSIP) began. Queensland Aboriginal and Torres Strait Islander Police were established in the three communities of Baduu Island, Yarrabah and Woorabinda. The Department of Aboriginal and Islander Policy has recommended that the Queensland Government give serious consideration to the allocation of sufficient resources to the QPS to allow the expansion of this program to all Deed-of-Grant-in- Trust (DOGIT) communities.

As Sgt Perham and Inspector Harris point out in their reports into this death, under current arrangements it will be highly unlikely that the QPS will be able to adequately train and supervise community police. I whole heartedly agree with their assessment.

So far as I have been able to discover, no action has been taken to implement the recommendations of the numerous expert reports cited above that are all highly critical of the current model of community police service delivery.

On 1 July 2004, the Department of Aboriginal and Torres Strait Islander Policy (DATSIP) ceased to be responsible for the provision of support and funding of Aboriginal communities. Prior to this date DATSIP provided funding to Aboriginal Councils under the State Government Financial Aid Program

(SGFA). DATSIP has advised the Court[25] that this funding was based on a formula that included a component for funding of community police.

DATSIP stated that Aboriginal Councils have for many years contended that SGFA funding was insufficient for Aboriginal Councils to provide the full range of services including community policing.

DATSIP say that since 1 July 2004 the Department of Local Government, Planning, Sport and Recreation assumed full responsibility for supporting Aboriginal Councils and now administers SGFA funding.

DATSIP advised the Court that while it was responsible for the administration of the *Aboriginal Communities (Justice and Land Matters) Act 1984* (formerly the *Community Services (Aboriginal) Act 1984*) and provided funds in recent years to the QPS for provision of training to community police, DATSIP now has no role in the employment of community police.

Conclusions

It is easy to conclude that the deprivations on the Aboriginal Communities in Queensland are the result of the failures of social engineering by successive Queensland Governments over the last two centuries. History has shown that the predecessor of DATSIP, the Department of Native Affairs overly and brutally administered the Aboriginal Communities akin to concentration camps.

At the outset of the 21st century, government policy appears to have moved to the other extreme of the spectrum where Aboriginal leaders complain of feelings of abandonment and abdication by Government of their responsibilities to the Aboriginal people.

The Aboriginal people, especially children and women, in these remote communities are entitled to the full protection of the law enabling them to enjoy the fundamental right to security of person. The residents of Aboriginal and Torres Strait Island communities have as much right to the provision of an adequate police service as do the citizens of any other Queensland community.

Aboriginal people on communities deserve to have a properly resourced police and justice system, especially when their need for the protection of the law in most respects is substantially greater than the better resourced urban non-Aboriginal communities elsewhere in the State.

Justice and the rule of law require an end to what had long been recognised by inquiry after inquiry as an inadequate police service, delivered “on the cheap” for Aboriginal communities.

For so long as governments hesitate to commit resources and effectively restructure responsibility for policing on Aboriginal communities, the parlous

[25] Exhibit 53B

state of Aboriginal police community policing will undoubtedly result in more deaths similar to the one investigated by this inquest.

The report of the Royal Commission into Aboriginal Deaths in Custody, written almost 15 years ago, noted the inertia that has historically characterised the development of an effective community policing service on Aboriginal communities. Aboriginal policing, from its outset in 1848, has meant Aboriginal people continue to be used for the most difficult, dangerous, or unsavoury tasks without training, without resources, on the cheap, as a pretend alternative to a genuine police service.

Unless the decade old *Queensland Police Service Review of Policing in Remote Aboriginal and Torres Strait Islander Communities* is fully implemented with the QPS budget adequately augmented to enable Aboriginal Community Police to be transferred to the QPS and properly resourced, trained and supervised, I anticipate that there will be similar deaths of Aboriginal deaths in custody as occurred on this occasion.

Recommendation

Pursuant to s43(5) of the Act I make the following recommendation:-

In accordance with the numerous reports of expert inquiries over many years, the responsibility for recruiting management and training and the funding of Aboriginal community police is transferred to the Queensland Police Service.

I close the inquest

Michael Barnes
State Coroner
Cooktown
7 April 2005