CORONERS COURT OF WESTERN AUSTRALIA

INQUEST INTO THE DEATH OF MR WARD (File No 8008/08)

SUBMISSIONS OF THE HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION

INTRODUCTION

1. The evidence in this matter demonstrates a range of systemic failures that contributed to Mr Ward's death. It is vital that these failures be clearly identified so that they may be corrected. The evidence also demonstrates a lack of respect for the humanity and inherent dignity of Mr Ward on the day he died. His death was the direct result of the failure to take adequate care to protect his life.

2. These submissions address:

   (a) The relevance of human rights law to this inquest generally (Part A) and the specific human rights that the Commission regards as relevant (Part B)

   (b) The discretion and duty of the Coroner to make comments (Part C)

   (c) The denial of bail by Officer Timmers and Mr Thompson JP (Part D)

   (d) The quality of the supervision, treatment and care of Mr Ward whilst in police custody (Part E)

   (e) Key systemic deficiencies with the system of prisoner transport in Western Australia that preceded and contributed to Mr Ward's death, namely:

      (a) the design and condition of the vehicle fleet, particularly the relevant Mazda van (Part F),

      (b) relevant policies and procedures relating to prisoner transport (Part G)

      (c) the standard of training and instruction (Part H)

   (f) The particular matters in connection with the transportation of Mr Ward on 27 January 2008 which were inconsistent with his human rights (Part I)

   (g) The adequacy of the police investigation into Mr Ward's death (Part J)

   (h) Permission for the parties to make their submissions public (Part K)

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(i) Comments that should be made by the Coroner (Part L).

3. The Commission has had the benefit of reading the submissions of Counsel Assisting the State Coroner in this matter. The Commission accepts that those submissions accurately recite the key factual matters in the inquest. The Commission also adopts the findings and recommendations put forward in those submissions. The Commission does not wish to replicate unduly the matters covered in those submissions. Rather, the Commission seeks to supplement those submissions by contributing its perspective on certain key issues arising in the inquest, as well as to suggest additional comments that should be made by the Coroner.

4. In making these submissions, the Commission has drawn on relevant international human rights instruments and jurisprudence, as well as the findings and recommendations of the Royal Commission Into Aboriginal Deaths in Custody ('RCIADIC') and Reports No 3 and 43 of the Office of the Inspector of Custodial Services ('OICS'). The Commission submits that the RCIADIC and OICS reports are of particular relevance and utility to this inquest as they highlight matters of ongoing concern in the administration of justice and provide useful guidance on the appropriate treatment of persons in custody.[1]

5. At the time of filing these submissions, transcripts for the final three days of the hearing had not yet become available. Transcript references have therefore not been provided in respect of the evidence of Professor Harding, Mr Hughes and Mr Doyle.

PART A: RELEVANCE OF HUMAN RIGHTS TO THIS INQUEST

6. The Commission submits that human rights instruments and jurisprudence are relevant in assisting the Coroner in making comments in the present inquest.

7. First, human rights are a legitimate influence on the exercise of the Coroner's statutory discretions and obligations. It is a well settled principle of statutory construction that, to the extent of any ambiguity, all domestic statutes should be applied as far as practicable so as to conform with Australia's obligations under international law.[2] It is also an accepted principle that human rights law is a valid influence on the development and interpretation of the common law.[3]

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[1] As to the significance of the RCIADIC in informing coronial inquests, see eg Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006), p 667: 'In addition, a number of inquests have sought to reinforce the findings of the [RCIADIC].'

[2] *Kartinyeri v Commonwealth* (1998) 195 CLR 337, 384 (Gummow and Hayne JJ).; *Jumbunna Coal Mine N/L v Victorian Coalminers' Association* (1908) 6 CLR 309, 363 (O'Connor J). This principle applies to all statutes, not just those statutes that seek to implement Australia's treaty obligations: *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J); *Chu Kheng Lim v Minister for Immigration, Local Government and Ethnic Affairs* (1992) 176 CLR 1, 38 Brennan, Deane and Dawson JJ; Pearce and Geddes, *Statutory Interpretation in Australia* (5th ed, 2001), [5.14]. 'Ambiguity' in this context is to be construed broadly: *Minister for Immigration and Ethnic Affairs v Teoh*

8. Second, the terms of the contractual and policy framework applicable to the transportation of prisoners in Western Australia directly incorporate relevant human rights standards.[4] The *Standard Guidelines for Corrections in Australia,* to which Western Australia is a party, also expressly incorporate Australia's international obligations in respect of the treatment of persons in custody.[5]

9. Third, the Commission notes that international human rights law provides practical assistance in assessing whether the standard of care shown to Mr Ward was adequate. This was a point acknowledged by Professor Harding, who agreed in his evidence that in assessing prisoner transport standards as part of his role as Inspector of Custodial Services, international human rights law provided a useful comparative benchmark.[6] Similarly, the Victorian Court of Appeal has recognised that:

> the provisions of an international convention to which Australia is a party can also serve as an indication of the value placed by Australia on the rights provided for in the convention and, therefore, as indicative of contemporary values.[7]

PART B: RELEVANT HUMAN RIGHTS

10. Australia has a number of specific international legal obligations that are relevant to this inquest, particularly under the *International Covenant on Civil and Political Rights*[8] ('ICCPR').

Right to Life

11. The Commission submits that comments by the Coroner in this inquest are an important part of meeting Australia's positive duty under international law to protect life. Such comments may help to identify the systemic failures that contributed to Mr Ward's death and may assist in minimising the possibility of similar deaths and hardships in the future. A broad approach to the discretion and duty to make comments under the *Coroners Act 1996* (WA) ('Coroners Act') should therefore be preferred.

12. The right to life is provided for by article 6(1) of the ICCPR as follows:

(1995) 183 CLR 273, 287 (Mason CJ and Deane J). See further Wendy Lacey, *Implementing Human Rights Norms: Judicial Discretion & Use of Unincorporated Conventions* (2008), esp Chapters 4 and 5.

[3] *Queensland v Mabo (No 2)* (1991) 175 CLR 1, 42 (Brennan J).

[4] For example, Clause 5.3.1 of Schedule 2 to the *Contract for the Provision of Court Security and Custodial Services* (January 2000) provides: 'Persons in custody shall be treated with humanity, dignity, care, and sensitivity. No person in custody shall be exposed to torture or to cruel, inhumane or degrading treatment of punishment.' This requirement is further reflected in Policy 6.104 (Duty of Care) of the AIMS Operational Procedures Manual at [6-104.5]. As discussed below, this terminology incorporates the relevant standards applicable under international law.

[5] *Standard Guidelines for Corrections in Australia* (Revised 2004), Preface.

[6] See also OICS Report No 43, pp 26-7 and Exhibit 103 (OICS Media Release), p 2.

[7] *Royal Women's Hospital v Medical Practitioners Board of Victoria* (2006) 15 VR 22, [77] (Maxwell P).

[8] Opened for signature 16 December 1966, 999 UNTS 171 (generally entered into force 23 March 1976, article 4 entered into force 28 March 1978).

> Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

13. Consequent upon the obligation to protect life, there is a positive duty to prevent death.[9] In addition, a particular duty is owed to persons in detention.[10] In *Lanstova v Russian Federation,* for example, the United Nations Human Rights Committee ('UNHRC')[11] observed that 'the essential fact remains that the State party by arresting and detaining individuals takes the responsibility to care for their life.'[12] Similarly, the European Court of Human Rights has observed:

> Person in custody are in a vulnerable position and the authorities are under a duty to protect them. Consequently, where an individual is taken into police custody in good health and is found to be injured on release, it is incumbent on the State to provide a plausible explanation of how those injuries were caused. The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent where that individual dies.[13]

14. A further element of this duty is to provide appropriate training of personnel, such as police and custodial officers, to ensure that the right to life is adequately protected.[14]

15. In addition to the positive obligation to protect life, there is a further obligation on States to fully, publicly and effectively investigate the circumstances surrounding a person's death in State custody.[15] The House of Lords has relevantly said:

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[9] For example, the UNHRC has stated that: 'the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures': General Comment 6, *Article 6: The Right to Life* (1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994), [5]. See further Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), Chapter 8, especially [8.01], [8.39]-[8.64]. The same interpretation has been applied to the equivalent right to life under the European Convention on Human Rights, see eg *LCB v UK* (1998) 4 BHRC 477, 456 [36]; *Osman v UK* (1998) 5 BHRC 293, 321 [11]; *Keenan v UK* (2001) 10 BHRC 319, 348-9 [88]-[90].

[10] Camille Giffard, 'International Human Rights Law Applicable to Prisoners' in David Brown and Meredith Wilkie (eds), *Prisoners as Citizens: Human Rights in Australian Prisons* (2002) Chapt 11.

[11] The UNHRC was established under Part IV of the ICCPR and is the authoritative body for interpreting the ICCPR.

[12] Communication No 763/1999, UN Doc CCPR/C/74/D/763/1997 (2002), [9.2]. See also *Fabrikant v Canada,* UNHRC Communication No 970/2001, UN Doc CCPR/C/79/D/970/2001 (2003); *Dermit Barbato v Uruguay,* UNHRC Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982).

[13] *Salman v Turkey* (2002) 34 EHRR 425, 482 [99] (footnotes omitted). See also *R (Amin) v Secretary of State* [2003] 4 All ER 1264, 1283 [41] (Ld Slynn).

[14] See Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), [8.39] 181. There is also an overarching obligation on States under the ICCPR that 'administrative and judicial authorities should be aware of the obligations which the State party has assumed under the Covenant … and steps should be taken to familiarize the authorities concerned with its contents as part of their training.' General Comment 3, *Article 2: Implementation at the national level* (1981), U.N. Doc. HRI/GEN/1/Rev.1 at 4 (1994), [2].

[15] In respect of the equivalent right to life under the European Convention on Human Rights, see eg *McCann v UK* (1996) 21 EHHR 97, 163 [161]; *Yasa v Turkey* (1998) 28 EHHR 408, 447-8 [98]; *R (Amin) v Secretary of State* [2003] 4 All ER 1264.

> The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrong-doing (if justified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others.[16]

16. The House of Lords has further held that, consistent with the State's obligations in respect of properly investigating deaths in custody, the powers of a coroner to make comments should be construed broadly.[17]

Right to humane and dignified treatment

17. Article 7 of the ICCPR provides that 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.' The aim of article 7 is to protect the dignity and the physical and mental integrity of the individual.[18] The prohibition under article 7 has been further articulated under the *Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment* ('Convention Against Torture'),[19] to which Australia is also a party.

18. In addition to the prohibition against torture and cruel, inhuman and degrading treatment or punishment, article 10(1) of the ICCPR imposes further positive obligations which are directed specifically at the rights of detained persons. Article 10(1) provides:

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

19. The purpose of article 10(1) is to impose on States a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty.[20] Respect for the dignity of such persons must be guaranteed under the same conditions as for free persons. That is, persons deprived of their liberty enjoy all the rights prescribed in the ICCPR, subject to the restrictions that are unavoidable in a closed environment.[21]

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[16] *R (Amin) v Secretary of State* [2003] 4 All ER 1264, 1281 [31] (Ld Bingham).

[17] *R (Middleton) v West Comerset Coroner* [2004] 2 All ER 465. See also *R (Amin) v Secretary of State* [2003] 4 All ER 1264, 1272 [18] (Ld Bingham, Lds Slynn, Steyn, Hope and Hutton agreeing)

[18] UNHRC, *General Comment No. 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment (Art 7)*, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994), [2] and [5].

[19] Opened for signature 21 December 1984, 1465 United Nations, *Treaty Series* 85 (entered into force 26 June 1987).

[20] See, eg, Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), p 275 [9.132].

[21] UNHRC, *General Comment 21: Replaces general comment 9 concerning humane treatment of persons deprived of liberty (Art 10)*, (Forty-fourth session, 1992) U.N. Doc. HRI/GEN/1/Rev.6 at 153 (2003) [3]-[4].

20. The State's duty under international law to provide adequate care to persons deprived of their liberty is non-delegable,[22] as under the Australian common law.[23] The UNHRC and the United Nations Committee Against Torture have long expressed concerns in this context over the privatisation of prisons and prisoner escort services, emphasising the need for States to provide effective training and monitoring to ensure that human rights standards are met by contractors.[24]

Right to be free from arbitrary detention

21. Article 9(1) of the ICCPR provides:

> Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

22. 'Arbitrariness' is not to be equated with 'against the law' but rather must be interpreted more broadly to include elements of inappropriateness, injustice and lack of predictability.[25] In relation to remanding persons in custody, the UNHRC has stated that:

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[22] See, eg, *Cabal and Bertran v Australia,* Communication No 1020/2001, 19 September 2003, UN Doc. CCPR/C/78/D/1020/2001, [7.2]: 'The Committee considers that the contracting out to the private sector of core State activities which involve the use of force and the detention of persons does not absolve a State party of its obligations under the Covenant, notably under articles 7 and 10.' See also *B.d.B. v Netherlands* Communication No. 273/1989 (30 March 1989), U.N. Doc. Supp. No. 40 (A/44/40) at 286 (1989), [6.6]; Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd ed, 2005), pp 183-4 [42].

[23] See, eg, *New South Wales v Bujdoso* (2005) 227 CLR 1, esp at 13-4 [44] (Gleeson CJ, Gummow, Kirby, Hayne, Callinan and Heydon JJ).

[24] See, eg, UNHRC, *Concluding Observations (United Kingdom),* UN Doc CCPR/C/79/Add.55 (1995): 'The Committee is concerned that the practice of the State party in contracting out to the private commercial sector core State activities which involve the use of force and the detention of persons weakens the protection of rights under the Covenant. … The State party should ensure that all those who are involved in the detention of prisoners be made fully aware of the international obligations on the State party concerning the treatment of detainees.' See further Dr Bronwyn Naylor, 'Prisons, privatisation and human rights' Paper delivered at the 'Human Rights and Global Challenges Conference', 10 – 11 December 2001, Melbourne. See also UNHRC, *Concluding Observations (United Kingdom),* UN Doc CCPR A/33/40 (1978), [423], [431]; *Concluding Observations (New Zealand)* (2002) UN Doc. CCPR/CO/75/NZL, [13]; Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), pp 275-7. In respect of privatisation of prisoner transport in Western Australia, see Cliff Holdom, 'Extreme Transport: Custodial Transport in Western Australia & Beyond' (2008) *Proceedings of the 2nd Australian & New Zealand Critical Criminology Conference* 107, 108: 'History suggests that contract management in itself cannot be relied upon to safeguard human dignity and safety'

[25] *Mukong v Cameroon,* Communication No 458/1991 (21 July 1994), UN Doc GAOR A/49/40 (vol II), [9.8]; *Van Alphen v The Netherlands,* Communication No 305/1988, UN Doc CCPR/C/39/D/305/1988, [5.8]; *A v Australia* Communication No 560/1993, UN Doc CCPR/C/59/D/560/1993, [9.2]. See also Alex Conte and Richard Burchill, *Defining Civil and Political Rights: The Jurisprudence of the United Nations Human Rights Committee* (2nd ed), (2009), pp 113-4.

> remand in custody pursuant to lawful arrest must not only be lawful but reasonable in all the circumstances. Further, remand in custody must be necessary in all the circumstances…'[26]

23. In addition, a person's detention that is initially not unlawful or arbitrary may come to breach article 9(1) by reason of subsequent events which change the nature of the detention. This might occur, for example, where the person is subjected to a further and serious deprivation of their liberty beyond what is reasonable and proportionate in the circumstances.[27]

24. International law also creates a presumption in favour of granting bail. Article 9(3) of the ICCPR states:

> It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should the occasion arise, for execution of the judgment.[28]

Prohibition on systemic racial discrimination

25. Article 26 of the ICCPR requires States to 'guarantee to all persons equal and effective protection against discrimination on any ground such as race'. The prohibition against racial discrimination is articulated further by the *International Covenant on the Elimination of All Forms of Racial Discrimination*,[29] to which Australia is also a party.

26. The obligation to prevent discrimination extends beyond mere legal prohibition. It includes an obligation to take positive steps to address systemic forms of discrimination that disproportionately impact on particular racial groups.[30] The UNHRC, for example, has observed:

> …the principle of equality sometimes requires States parties to take affirmative action in order to diminish or eliminate conditions which cause or help to perpetuate discrimination prohibited by the Covenant. For example, in a State where the general conditions of a certain part of the population prevent or impair

[26] *Van Alphen v The Netherlands,* Communication No 305/1988, UN Doc CCPR/C/39/D/305/1988, [5.8]; *A v Australia* Communication No 560/1993, UN Doc CCPR/C/59/D/560/1993, [9.2].

[27] See, generally, HREOC, *Inquiry into Complaints by immigration detainees against the Commonwealth of Australia (Department of Immigration and Citizenship, formerly the Department of Immigration and Multicultural and Indigenous Affairs) and GSL (Australia) Pty Ltd,* [2009] HREOC Report No 40, [90]-[92] (and the authorities referred to therein).

[28] See further *Hill and Hill v Spain,* Communication No. 526/1993, U.N. Doc. CCPR/C/59/D/526/1993 (2 April 1997), [12.3]. In the European context, see eg *Tomasi v France* (1992) 15 EHHR 1, [84]; *Clooth v Belgium* (1991) 14 EHRR 717, [44].

[29] Opened for signature 21 December 1965, 660 United Nations, *Treaty Series* 195 (entered into force 4 January 1969 except Article 14 which came into force 4 December 1982).

[30] See, eg, CERD, *General recommendation XXXI on the prevention of racial discrimination in the administration and functioning of the criminal justice system,* CERD doc A/60/18 (2005), esp at [5(i)].

their enjoyment of human rights, the State should take specific action to correct those conditions.[31]

27. The obligation on States with respect to eliminating racial discrimination also extends to ensuring that law enforcement personnel are appropriately trained on human rights standards.[32]

28. Professor Harding observed in his evidence that Aboriginal persons bear the disproportionate burden of the failures and deficiencies in prisoner transport identified in OICS Reports 3 and 43.[33] This represented, in his view, a form of 'systemic racism' which was unreasonable and would not be tolerated by any other racial group of Western Australia.[34] Like Professor Harding, the Commission does not submit that the circumstances surrounding Mr Ward's death were prompted by deliberate racism.[35] However, the notion of racial discrimination is not so limited. Rather, it encompasses practices and policies which have a disproportionately adverse impact on a particular racial group which cannot be justified as being reasonable in all the circumstances.[36]

29. The Commission does not seek to make submissions on whether Mr Ward's death was a consequence of discrimination. Rather, the Commission notes its concerns over systemic racial discrimination to highlight the need for urgent action to address the widespread problems with prisoner transport in Western Australia. In the Commission's view, the failure to take such urgent action potentially puts Australia in breach of its international obligations with regard to achieving substantive equality and taking positive steps to protect vulnerable racial groups against known risks.

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[31] General Comment 18, *Non-discrimination* (Thirty-seventh session, 1989), U.N. Doc. HRI/GEN/1/Rev.1 at 26 (1994), [10].

[32] The UN Committee for the Elimination of Racial Discrimination, for example, has stated: 'The fulfilment of these obligations [under ICERD] very much depends upon national law enforcement officials who exercise police powers, especially the powers of detention or arrest, and upon whether they are properly informed about the obligations their State has entered into under the Convention. Law enforcement officials should receive intensive training to ensure that in the performance of their duties they respect as well as protect human dignity and maintain and uphold the human rights of all persons without distinction as to race, colour or national or ethnic origin.' CERD, *General Recommendation XIII (Training of law enforcement officials in the protection of human rights),* (Forty-eight session, 1996), [2].

[33] See also Exhibit 103 (Media Release of OICS).

[34] See also Exhibit 103 (Media Release of OICS).

[35] See also Exhibit 103 (Media Release of OICS).

[36] See, eg, *Althammer v Austria,* Communication No. 998/2001, UN Doc CCPR/C/78/D/998/2001: 'a violation of article 16 [non-discrimination] can also result from the discriminatory effect of a rule or measure that is neutral at face value or without intent to discriminate … if the detrimental effects of a rule or measure exclusively or disproportionately affect persons having a particular race…' The same is true with respect to indirect discrimination under Australian law, such as pursuant to s 9(2) of the *Racial Discrimination Act 1975* (Cth). See, generally, Australian Human Rights Commission, *Federal Discrimination Law Online,* available at: http://www.humanrights.gov.au/legal/FDL/index.html

Right to an effective remedy

30. The ICCPR also imposes an obligation to provide an 'effective remedy' in the case of a violation of human rights.[37] Vital to providing an effective remedy is the prompt and impartial investigation of allegations of breaches of human rights by a competent authority.[38]

31. The coronial process is an important part of providing an effective remedy for breaches of human rights. A coronial inquest should therefore, as far as possible, seek to provide a thorough investigation with a broad scope so that any breaches of human rights revealed in the course of the inquiry may be identified and addressed.

PART C: POWER AND DUTY OF THE CORONER TO MAKE COMMENTS

32. Pursuant to s 25(2) of the *Coroners Act 1996* (WA) ('Coroners Act'), the Coroner is permitted to comment on any matter connected with Mr Ward's death including 'public health or safety or the administration of justice'. In addition, given that Mr Ward was a 'person in care'[39] at the time of his death, pursuant to s 25(3) the Coroner 'must comment on the quality of the supervision, treatment and care of Mr Ward while in that care.'

33. However, pursuant to s 25(5) of the Coroners Act, the Coroner 'must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence'. It is nevertheless within the power of the Coroner to make findings as to the factual circumstances surrounding such matters as the denial of bail to Mr Ward, the standard of care shown to Mr Ward and the level of relevant knowledge of the Department of Corrective Services ('the Department') and GSL (Australia) Pty Ltd ('GSL'). The fact that legal conclusions as to the legality of such matters may be drawn by others from such findings of fact does not alter this: 'the coroner is to find the facts from which others may, if necessary, draw legal conclusions'.[40]

34. As noted above, relevant human rights principles highlight the need for a comprehensive approach to the making of findings and comments so that future deaths might be avoided in similar circumstances. Similar observations have also been made in Australia of the role of Coronial inquests.[41] The need for a broad

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[37] Article 2(3) of the ICCPR provides that: 'Each State Party to the present Covenant undertakes: (a) To 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.'

[38] *Herrera Rubio v Colombia*, UNHRC Communication No 161/1983, UN Doc CCPR/C/OP/2 at 192 (1990), [10.5]; *Dermit Barbato v Uruguay*, UNHRC Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982); *Aktas v Turkey*, ECHR 24351/94, 23 April 2003, [331]-[333]. See also UNHRC, *General Comment No. 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment (Art 7)*: 10/03/92, [14].

[39] Coroners Act, s 3.

[40] *Keown v Khan* [1998] VISC 83, 10 (Callaway J).

[41] See, eg, Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(SE2) *Australian Indigenous Law Review* 45, Rebecca Scott Bray, 'Why This Law?: Vagaries of Jurisdiction in Coronial

approach is particularly important in respect of systemic failures affecting a broad class of persons.

PART D: THE DENIAL OF BAIL

Powers and duties under the Bail Act

35. Under s 6A(3) of the *Bail Act 1982* (WA) ('Bail Act'), an authorised officer[42] who is considering an accused person's case for bail for an initial appearance in a summary court on a charge of a simple offence **must** order that the person be served with a court appearance notice and released unless not releasing the person is justified on reasonable grounds. Those grounds are set out in s 6A(4), including that the accused may commit an offence, continue or repeat the offence with which they have been charged, endanger a person's safety or property, interfere with witnesses or the course of justice, or because their safety would be endangered.

36. If the person is not released on a court appearance notice or summons,[43] the officer must then consider bail irrespective of whether an application is made by or on behalf of the accused.[44] Section 8(1) also imposes certain procedural requirements that the accused is given:

> (a) such information in writing as to the effect of this Act as is prescribed for the purposes of this paragraph;
>
> (b) an approved form for completion, designed to disclose to the judicial officer or authorised officer all information relevant to the decision.[45]

37. The 'information in writing' referred to in (a) above is prescribed under the *Bail Regulations 1998* (WA) and comprises several pages setting out various matters relevant to the rights of an accused in respect of bail.

38. Schedule 1 to the Bail Act then sets out various questions that the authorised officer must consider in deciding whether to grant bail,[46] including whether there is any

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Reform and Indigenous Death Prevention' (2008) 12(SE2) *Australian Indigenous Law Review* 27; Boronia Halstead, 'Coroners' Recommendations and the Prevention of Deaths in Custody' (1995) 10 *Australian Institute of Criminology: Australian Deaths in Custody;* Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest* (2006), pp 543, 654. See also *Perre v Chivell* [2000], SASC 279, [4].

[42] Pursuant to s 3 of the Bail Act, an 'authorised officer' is defined to include a police officer who holds the rank of sergeant or higher or is for the time bring in charge of a police station or lock-up.

[43] Pursuant to s 6A(1), an authorised officer considering an accused's case for bail for an initial appearance in a summary court on a charge of an indictable offence that is not a serious offence may order that the person be served with a summons and released.

[44] Bail Act, s 6(3).

[45] Bail Act, ss 8(1)(a) and (b).

[46] Bail Act, Schedule 1, Part C, s 1.

bail condition that could reasonably be imposed to ameliorate the relevant concerns over releasing the person from custody.[47]

Relevant principles for the exercise of police discretion regarding bail

39. One of the clear messages of the RCIADIC was that a reduction in the unacceptable rate at which Aboriginal people were dying in custody required a reduction in the rates of arrest, detention and imprisonment of Aboriginal people. Commissioner Johnston observed that the unacceptably high rates of Aboriginal deaths in custody

> occurs not because Aboriginal people in custody are more likely to die than others in custody but because the Aboriginal population is grossly over-represented in custody. Too many Aboriginal people are in custody too often.[48]

40. The RCIADIC report accordingly found that:

> The highest possible priority needs to be placed by governments and corrections authorities on measures to significantly reduce the number of Aboriginal people in custody.[49]

41. Similarly, in the separate regional reports of the RCIADIC relating to Western Australia, a number of pertinent criticisms were also made of the attitude of many police officers towards the granting of bail to Aboriginal persons. For example, Commissioner O'Dea observed:

> I am left with the clear impression that numerous police officers in the State regarded bail as a privilege to be conferred upon Aboriginal arrestees if and when they felt disposed to summon the effort to do so.[50]

42. Commissioner O'Dea also found that a 'troubling number of those who died in custody would not have been in custody if a more intelligent approach had been taken [to bail].'[51]

43. The Final Report of the RCIADIC recommended that police adopt the principle of arrest being treated as an option of last resort,[52] and that accused persons should as a general rule enjoy an entitlement to bail.[53] This also reflects the position under international law that arrest and detention must not only be lawful, but necessary.[54]

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[47] Bail Act, Schedule 1, Part C, s 1(e).
[48] RCIADIC, *National Report*, v 1, p 6 [1.3.3].
[49] RCIADIC, *National Report*, v 3, p 3.
[50] RCIADIC, *Regional Report of Inquiry into Individual Deaths in Custody in Western Australia* (1991), v 1, p 314.
[51] RCIADIC, *Regional Report of Inquiry into Individual Deaths in Custody in Western Australia* (1991), v 1, p 309. See also Aboriginal and Torres Strait Islander Social Justice Commissioner, *Indigenous Deaths in Custody: 1989 to 1996* (1996), p 87.
[52] RCIADIC, *National Report*, v 5, Rec 87.
[53] RCIADIC *National Report*, v 5, Rec 89.
[54] ICCPR, Article 9(1).

This requires a consideration of whether there were available 'less invasive means of securing the same ends'[55] and that bail shall not be ordinarily refused except where serious risks exist to make the refusal of bail necessary.[56]

44. Likewise, Australia courts have long cautioned against arbitrary infringements on a person's liberty under police powers of arrest and detention. As Deane J stated in *Donaldson v Broomby*:

> A police power of arbitrary arrest is a negation of any true right to personal liberty. A police practice of arbitrary arrest is a hallmark of tyranny. It is plainly of critical importance to the existence and protection of personal liberty under the law that the circumstances in which a police officer may, without judicial warrant, arrest or detain an individual should be strictly confined, plainly stated and readily ascertainable.[57]

Police refusal of bail was inappropriate

45. The Commission acknowledges that the Bail Act confers very broad discretions and the Commission does not make submissions on the lawfulness of the police refusal of bail to Mr Ward. However, for the following reasons the Commission submits that the Coroner should find that the refusal of bail to Mr Ward was an inappropriate exercise of police discretion in the circumstances.

46. First, the Commission submits that the evidence of Officer Timmers failed to demonstrate that he approached the consideration of Mr Ward's bail on the basis of a presumption in favour of Mr Ward being released on a court attendance notice and/or that refusal of bail be treated as an option of last resort.[58]

47. Second, the Aboriginal Legal Service ('ALS') was not contacted in respect of Mr Ward's eligibility for bail, contrary to the recommendations of the RCIADIC.[59] Indeed, no effort was made to contact any person who may have been able to assist in assessing Mr Ward's eligibility for bail. The Commission acknowledges that the evidence indicates that Mr Ward did not request that ALS or anyone else be

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[55] *C v Australia,* Communication No 900/1999, UN Doc CCPR/C/76/D/900/1999, [8.2].

[56] *Hill and Hill v Spain,* Communication No. 526/1993, U.N. Doc. CCPR/C/59/D/526/1993 (2 April 1997), [12.3]; *WBE v The Netherlands,* Communication No. 432/1990, U.N. Doc. CCPR/C/46/D/432/1990 (1992), [6.3]-[6.4]; *Van Alphen v The Netherlands,* Communication No 305/1988, UN Doc CCPR/C/39/D/305/1988, [5.8]. See further The Law Commission (UK), *Bail and the Human Rights Act 1998,* (2001), esp at pp 19-21, 27-30. See also Alex Conte and Richard Burchill, *Defining Civil and Political Rights: The Jurisprudence of the United Nations Human Rights Committee* (2nd ed), (2009), p 122; Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), pp 328-9.

[57] (1982) 60 FLR 124, 126.

[58] The Commission also notes that the evidence suggests that all persons with a blood alcohol reading were arrested as a matter of course in Laverton, rather than being released on a court attendance notice or summons: Transcript p 30.1 (Kopsen).

[59] RCIADIC, *Final Report,* v 5, Rec 90. The Commission also notes that a similar requirement is imposed under the *Standards for Police Cells* (pp 9-10), developed by the Victorian Office of Police Integrity to ensure compliance by police with their obligations under the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

contacted on his behalf,[60] but that he simply wanted to go to sleep.[61] However, in circumstances where a person is intoxicated and therefore less likely to be able adequately to represent their own best interests in making a case for bail, the need for notifying the ALS is arguably stronger. In any event, there is no evidence that this issue was revisited by the officers the following morning when Mr Ward was no longer intoxicated.

48. Third, the Commission acknowledges that Mr Ward's history of antecedents was an important consideration in respect of whether to grant bail and that Officer Timmers gave evidence that he took into account 'many factors' when assessing bail.[62] Nevertheless, the Commission submits that insufficient, if any, weight appears to have been given to the following relevant matters in support of Mr Ward's case for bail:

    (a) Mr Ward was employed on a full time basis and had work and family commitments in Warburton, including caring for four children.

    (b) Mr Ward was a person of considerably high standing in his community,[63] was well known to the police in Warburton and posed no serious flight risk. He was also described by GSL and police officers with whom he came into contact prior to his death as compliant and co-operative.[64]

    (c) The charges against Mr Ward were relatively minor. The severity of his offence was arguably mitigated further by the fact that, at the time of his arrest, Mr Ward was driving on either a bush track or otherwise crossing over a very short stretch of bitumen road to traverse from one bush track to another.

    (d) Whilst Mr Ward had six previous breaches of bail recorded on his criminal history, these convictions spanned a period of 18 years, with the most recent being approximately six years earlier.[65]

    (e) By the Sunday morning Mr Ward no longer posed a safety risk in driving.

    (f) The next Magistrates sitting in Warburton was only approximately one week away.[66]

[60] Exhibit 56 (Underlying record of lock-up assessment): 'Do you wish to contact the ALS? No. // Do you wish the ALS to represent you? Yes.'
[61] See, eg, Exhibit 54 (Statement of Const. Kopsen), [24]; Exhibit 2 (Statement of Snr Const. Sliskovic), [19].
[62] Transcript p 97.7 (Timmers).
[63] See, generally, the statements from members of Mr Ward's community (Exhibits 46, 46, 48, 51 and 52).
[64] See, eg, Transcript pp 10.3, 14.1, 22.4 (Kopsen); 67.5 (Timmers), 118.5, 124.8, 153.1 (Chammings), 826.9 – 827.1 (Powell).
[65] Transcript p 56.9 (Timmers).
[66] Transcript p 1122 (Denness).

49. In addition, the Commission submits that the Bail Act is sufficiently broad for Officer Timmers to have taken into account cultural factors weighing in favour of granting bail to Mr Ward.[67] For example, various law reform bodies and commentators have argued that refusal of bail can impose additional spiritual hardship on Aboriginal persons by keeping them off country, particularly where it also results in the person being transported far away from their country as was the case with Mr Ward.[68]

50. Fourth, Officer Timmers took into account Mr Ward's non-appearance in response to bail in a matter in June 2007 in which Officer Timmers was a prosecution witness, notwithstanding that that non-attendance had not resulted in any sanction by the court.[69] The Commission submits that this was an irrelevant consideration in assessing Mr Ward's bail.

51. Fifth, the evidence discloses no serious consideration being given by Officer Timmers to possible bail conditions. The main reason for refusing bail on the Saturday evening appears to have been because Officer Timmers considered that Mr Ward was likely to try and drive home to Warburton.[70] However, this could have been addressed by imposing bail conditions prohibiting Mr Ward from driving and by the police impounding his car until the morning. Alternatively, Mr Ward could have been detained overnight and then released the following morning on bail with conditions to return immediately to Warburton and report to the police station in Warburton at a designated time. However, Officer Timmers appears to have disregarded the use of bail conditions altogether based on a generalised belief that bail conditions were often not complied with.[71] This is clearly contrary to Parliament's intent in imposing a requirement that possible conditions must be considered by the officer when assessing bail.[72]

52. To the extent that Officer Timmers also expressed a concern that Mr Ward might commit further offences, such as taking alcohol to Warburton,[73] the Commission submits that this should be rejected. There was no cogent evidence to support this suspicion and Mr Ward was not carrying a supply of alcohol at the time of his arrest.

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[67] See, eg, Law Reform Commission of Western Australia, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture – Final Report,* Project No 94 (September 2006), p 165: 'Although the Bail Act is silent on Aboriginal customary law and other cultural issues, there is no reason why these matters could not be taken into account if relevant to the question of bail.'

[68] See, eg, RCIADIC, *Final Report,* v 3 [25.3.1] – [25.3.2]; Law Reform Commission of Western Australia, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture – Final Report,* Project No 94 (September 2006), pp 165-6; Cliff Holdom, 'Extreme Transport: Custodial Transport in Western Australia & Beyond' (2008) *Proceedings of the 2nd Australian & New Zealand Critical Criminology Conference* 107, 116; OICS Report No 43, p 26.

[69] Transcript pp 55.5, 69.8 – 70, 97.6 (Timmers).

[70] Transcript p 57-8 (Timmers).

[71] Transcript p 96.8 (Timmers).

[72] Bail Act, Schedule 1, Part C, s 1(e).

[73] Transcript p 58.1 (Timmers).

53. Sixth, the relevant procedural requirements imposed under ss 8(1)(a) and (b) of the Bail Act were not complied with. Mr Ward was not provided with the prescribed information outlining his rights in respect of bail and no approved form was completed to ensure that all relevant information relevant to Mr Ward's case for bail was properly disclosed.[74] The Commission submits that these procedural obligations are not simply inconsequential formalities; they are designed to ensure a fair and proper bail hearing for the accused.

54. Seventh, available records indicate that the time given to considering Mr Ward's eligibility for bail was cursory at best. The 'Evidential Breath Analysis'[75] recording Mr Ward's alcohol breath test shows that the results of Mr Ward's breath test became available at between 10.01 - 10.03pm. And yet, the 'Inventory of Property Taken from Person'[76] in respect of Mr Ward records that the Form 5 refusal of bail form[77] had been typed and recorded on his inventory of property by 10.03pm.

55. The Commission submits that the combined effect of the above factors renders the exercise of police discretion to refuse bail inappropriate - and particularly so by the morning of 27 January 2008. The Commission further submits that the inadequacies associated with the refusal of bail to Mr Ward were indicative of broader systemic problems. Officers Denness and Chammings, for example, both believed that Mr Ward was ineligible for bail due to having breached a suspended sentence;[78] a plainly incorrect reading of the Bail Act.[79] Similarly, none of the officers who gave evidence was familiar with the relevant procedural obligations under the Bail Act[80] or the relevant recommendations of the RCIADIC regarding bail.[81]

Court session conducted by Mr Thompson

56. The Commission submits that the court session convened by Justice of the Peace ('JP') Barrye Thompson also raises a number of serious concerns.

57. First, pursuant to reg 8 of the *Magistrates Court Regulations 2005* (WA), a JP can only be asked to convene a country court by a Registrar or by a Deputy Registrar directed to do so by a Magistrate or Registrar. In this case, Mr Thompson appears to have been asked to convene the court session by Officer Chammings,[82] who was neither a Registrar nor Deputy Registrar. To the extent that Officer Denness gave evidence that, in his absence, the acting Officer in Charge had delegated authority to act in his place as a Deputy Registrar,[83] this evidence should be treated with

[74] Transcript pp 44 – 45 (Kopsen), 93 (Timmers).
[75] Exhibit 1 (Report of Det. Sgt. Robinson), Annexure 4
[76] Exhibit 9.
[77] Exhibit 1 (Report of Det. Sgt. Robinson), Annexure 5.
[78] Transcript pp 146.5 (Chammings), 1115.9, 1121.3, 1123 (Denness).
[79] With the exception of murder, in respect of which only a Supreme Court judge can grant bail (s 15), the Bail Act does not treat any charge as automatically rendering an accused ineligible for bail.
[80] See, eg, Transcript pp 44 – 45 (Kopsen), 93 (Timmers), 153 (Chammings).
[81] See, eg, Transcript pp 43 – 44 (Kopsen), 94 (Timmers).
[82] Transcript p 128.2 (Chammings).
[83] Transcript p 1128 - 1129 (Denness).

caution. There was no evidence of a formal instrument of delegation to this effect. Furthermore, the terms of reg 8 indicate that requests to a JP to convene a country court session can only be made by a Deputy Registrar at the direction of a Magistrate or Registrar, which was not the case here.[84] Officer Chammings was also not the acting Officer in Charge at the time he contacted Mr Thompson.[85]

58. Second, the hearing by Mr Thompson was conducted on a Sunday, in direct breach of the prohibition against Sunday court sessions under the relevant Instrument of Delegation of Magistrate Sharratt.[86] None of the officers at Laverton appear to have been aware of this prohibition.[87]

59. Third, the ALS (or anyone else) was again not contacted on Mr Ward's behalf, contrary to the recommendations of the RCIADIC discussed above. Mr Thompson in fact gave evidence that he considered it to be in Mr Ward's best interests to be transferred to Kalgoorlie to enable him to access legal services.[88] The Commission regards it as alarming that a JP would regard imprisonment far away from Mr Ward's country, community, family and employment as in his best interests in circumstances where no attempt was made to contact the ALS or ascertain from Mr Ward what his preferences were.[89]

60. Mr Thompson's assumption that legal services were not available in Laverton was in any event incorrect. The ALS provided regional services to Laverton and Warburton,[90] as well as via a free telephone number. Indeed, the regional ALS court officer was in Laverton on 27 January 2008 and has stated that he would have attended the police station to represent Mr Ward if he had been contacted on his mobile phone (the number of which was known to Laverton police).[91]

61. Fourth, the procedural requirements under the Bail Act to provide Mr Ward with prescribed information and complete an approved bail form were again not complied with.[92] The requirement under s 26(2) of the Bail Act that the judicial officer prepare 'a record of the decision and of the reasons therefor' was also not complied with, nor were any notes of the hearing made.[93] In addition, the hearing was conducted in the police cell, despite the adjoining courtroom being available

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[84] The evidence of Officer Dennes indicates that this requirement was rarely, if ever, complied with: Transcript p 1129 (Denness).
[85] See, generally, Transcript pp 1138 – 1139 (Denness).
[86] Exhibit 40 (Instrument of Delegation re court sittings on Sundays).
[87] See, eg, Transcript pp 71.3 (Timmers), 114.1 (Chammings), 1112 (Denness).
[88] Transcript pp 1072.5, 1077.5, 1100 (Thompson).
[89] Transcript p 1072.7 (Thompson).
[90] See, eg, Exhibit 64 (Statement of Mr Wyatt), [4]-[5].
[91] Exhibit 64 (Statement of Mr Wyatt), [6]-[10]. Officers Timmers and Denness agreed that they knew Mr Wyatt and had access to his mobile telephone number: Transcript pp 73.3 (Timmers), 1149.5 (Denness). Officer Chammings also agreed that Mr Wyatt was likely to have attended if contacted (p 135.9), although was not aware that his mobile number was known to police at Laverton (p 137.5).
[92] Bail Act, s 8(2).
[93] Transcript pp 1068.4, 1078 (Thompson). The failure to provide written reasons is also inconsistent with human rights jurisprudence regarding refusal of bail. See, eg, The Law Commission (UK), *Bail and the Human Rights Act 1998* (June 2001), pp 23, 83-91, 115.

which would have provided a more suitable environment for conducting the hearing.

62. Fifth, Officer Chammings does not appear to have outlined the case for bail on Mr Ward's behalf. Mr Thompson was not aware of any of Mr Ward's personal circumstances relevant to bail[94] or even that he was required to consider bail at all unless requested to do so by Mr Ward.[95] Rather, he regarded his role as being limited to checking that the charges were not of a frivolous nature.[96] The evidence also indicates that the hearing lacked procedural fairness, given that relevant parts of the hearing were conducted between Officer Chammings and Mr Thompson whilst Mr Ward was either not present or still asleep.[97]

63. Sixth, the pre-arrangement of the GSL transport van the previous evening was likely to,[98] and appears to have in fact,[99] exerted additional pressure on Mr Thompson to remand Mr Ward to Kalgoorlie. In the Commission's submission, the convenience of a nearby transport van should not have been treated as a relevant factor for denying bail.

64. Seventh, when it was discovered that Monday 28 January 2008 was a public holiday, the remand warrant was simply extended by Officer Chammings with approval from Mr Thompson over the telephone.[100] Mr Thompson did not return to the station or provide Mr Ward with any opportunity to make submissions, even though this extension effectively doubled the period of Mr Ward's remand.[101]

65. In light of the above factors, the Commission submits that the hearing conducted by Mr Thompson did not meet acceptable standards, was procedurally defective and failed to consider adequately or at all Mr Ward's case for bail.

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[94] Transcript pp 1072.9 – 1073, 1085 (Thompson).

[95] Transcript p 1090.4: 'Your understanding is that you weren't attending for conducting a bail hearing at all? --- No.' See also p 1068 (Thompson).

[96] Transcript pp 1073.8, 1085 (Thompson).

[97] See, eg, Transcript p 147.2 (Chammings): 'Part of the discussion with the justice took place outside the cell.' See also p 1070.3 (Thompson): 'Where did this conversation occur (re the circumstances of the arrest and charge)? --- That was in the police station itself prior to going to the cells. // Was this information something that you took into account when making your decision? --- Yes it was.' See also p 1075.1.

[98] The Commission notes that concerns have long been raised over Justices of the Peace bowing to police preferences in refusing bail. See, eg, the speech of the Hon Wayne Martin, Chief Justice of Western Australia, to the Custodial Transport Forum, 7 August 2008, extracted at Annexure MC 8 to Exhibit 76 (Statement of Mr Corbett): 'Experience tells us that in cases in which the police are opposed to the grant of bail, it is very unlikely that the local Justice of the Peace will grant bail over police opposition.' (p 13).

[99] Mr Thompson stated that he treated the proximity of the GSL van as a relevant consideration in signing the remand warrant: Exhibit 7 (Statement of Mr Thompson), [17]. See also Transcript p 1084 (Thompson).

[100] Transcript pp 132.5 (Chammings), 1076 (Thompson).

[101] Officer Denness agreed that Mr Thompson should have been asked to return to the station to reconsider the matter afresh: Transcript p 1125 (Denness).

Broader systemic concerns regarding JP court hearings

66. Aside from the above concerns with the manner in which Mr Ward's hearing was conducted by Mr Thompson on 27 January 2008, the Commission agrees with the observations of Counsel Assisting that Mr Thompson's evidence reveals a number of broader systemic concerns in relation to court hearings by JPS, particularly in respect of the standard of training of JPs.

67. Mr Thompson acknowledged that he commenced in the position of JP without having undergone any training at all.[102] He was also allowed to continue in the role despite failing to complete the relevant TAFE course or associated assessments.[103] The Commission submits that Mr Thompson lacked any familiarity with his obligations or role under the Bail Act, as highlighted by the fact that Mr Thompson did not even appreciate that he was required to consider bail at the time he remanded Mr Ward into custody. [104]

68. The Commission also notes with concern that Officer Chammings gave evidence that officers at Laverton had not received any training in how they were supposed to prosecute bail hearings before Justices of the Peace.[105] Likewise, Officer Denness gave evidence that he never received any training in respect of his role as deputy registrar[106] and had never seen the relevant letter of appointment or statement of duties.[107]

69. The Commission submits that these are legitimate matters for comment by the Coroner in this inquest, as they relate to the administration of justice. The deficiency of Mr Thompson's training contributed to his failure to properly convene the court session with Mr Ward. Irrespective of whether Mr Ward's transfer of custody to GSL was ultimately still lawful without a signed remand warrant, the adequacy of the hearing conducted by Mr Thompson remains relevant. The evidence makes clear that, as a matter of practical reality, the Laverton police and GSL Kalgoorlie staff all operated on the mutual understanding that Mr Ward would not have been transferred into the Mazda van without a signed remand warrant.[108]

Absence of video-conferencing facilities

70. The Commission agrees with Counsel Assisting that the circumstances surrounding Mr Ward's transportation to Kalgoorlie have also highlighted the need to improve

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[102] Transcript p 1067.4 (Thompson): 'So at the time of your appointment as a JP what training had you had in total? --- Nil.' See also pp 1065 – 1067, 1083.
[103] Transcript pp 1101 - 1102 (Thompson).
[104] Transcript pp 1067 – 1069, 1072 – 1075, 1093 – 1094 (Thompson).
[105] Transcript p 132.7 (Chammings).
[106] Transcript p 115.2 (Denness).
[107] Transcript p 1109 (Denness).
[108] See, eg, Transcript p 1141.9 (Denness): 'So what was the purpose of the justice of the peace coming and conducting a court session? --- Well, you still have to get them remanded into custody so the GSL can do the escort.' See also Transcript pp 1115 - 1116 (Denness), 18 (Kopsen), 58.5 (Timmers),

access to video conferencing facilities at police lock-ups for bail hearings and the like to minimise the need for prisoner transports. This has previously been recommended by the OICS,[109] Western Australian Chief Justice,[110] Hooker Inquiry,[111] Law Reform Commission of Western Australia,[112] Officer Denness[113] and by similar reviews of prisoner transport conducted in the United Kingdom,[114] New Zealand[115] and Victoria.[116]

71. Regrettably, however, progress towards the expansion of video-conferencing facilities in Western Australia appears to have stalled. Certainly, video-conferencing facilities remain unavailable at Laverton[117] and no evidence was led to indicate substantive progress at other locations. Pending the availability of video-conferencing facilities at relevant locations, the Commission further submits that greater use should be made by police of telephone conferencing to minimise the need for long prisoner transports, at least in respect of bail hearings and minor appearances.

PART E: QUALITY OF SUPERVISION, TREATMENT AND CARE DURING POLICE CUSTODY

72. The Commission submits that the Coroner is required to comment on several additional matters relevant to the quality of Mr Ward's supervision, treatment and care whilst in police custody.

Supervision

73. The Commission acknowledges that regular checks were performed on Mr Ward throughout his time in police custody. Of concern, however, is that for approximately the first two hours after being placed in the police cell, all checks of Mr Ward were performed remotely via CCTV. At no stage during this period did any officer physically check on Mr Ward to assess his state of health.[118]

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[109] OICS Report No 43, Recommendation 6.
[110] See, eg, OICS Report No 43, p 13.
[111] R Hooker, *Inquiry into the Escape of Persons Held in Custody at the Supreme Court of Western Australia on 10 June 2004* (2004), p 89.
[112] Law Reform Commission of Western Australia, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture – Final Report,* Project No 94 (September 2006), pp 163-5.
[113] Transcript p 1126.
[114] OICS Report No 43, p 28. See further Her Majesty's Inspectorate of Prisons, *Thematic Review: The joint inspection of prisoner escort and court custody in England and Wales* (June 2005), pp 26-7.
[115] Chief Ombudsman and Ombudsman of the Department of Corrections (New Zealand), *Investigation by John Belgrave, Chief Ombudsman and Mel Smith, Ombudsman of the Department of Corrections in Relation to the Transport of Prisoners* (2007), p 25.
[116] Ombudsman Victoria and Office of Police Integrity (Victoria), *Conditions for Persons in Custody* (July 2006), p 26.
[117] See, eg, Transcript pp 37.9 (Kopsen), 152.4 (Chammings).
[118] Transcript p 44.5 (Kopsen).

74. The RCIADIC reported on numerous deaths that occurred in police lock-ups in circumstances where adequate police supervision might have averted the death. The report stated: 'The importance of frequent and thorough checking of prisoners cannot be overstated',[119] particularly in the first two hours of custody.[120]

75. The report went on to recommend that during the first two hours of detention, a detainee should be checked at least every 15 minutes and thereafter every hour.[121] The recommendations also emphasised the importance of such checks being conducting physically, rather than merely remotely:

> Notwithstanding the provision of electronic surveillance equipment, the monitoring of such persons in the periods described above should at all times be made in person. Where a detainee is awake, the check should involve conversation with the person. Where the person is asleep the officer checking should ensure that the person is breathing comfortably and is in a safe position and otherwise appears not to be at risk.[122]

Treatment and Care

76. The Commission notes with concern the police practice regarding warnings recorded on Custody Handover Sheets. The relevant Sheet for Mr Ward,[123] for example, prominently listed warnings that he may carry a weapon, assault police and resist arrest. However, the evidence indicates that these warnings were no longer relevant, but had simply been automatically generated by the computer based on Mr Ward's antecedents.[124]

77. It is unclear the extent to which, if any, the above warnings on Mr Ward's custody handover sheet impacted on his treatment by Officers Stokoe and Powell.[125] Nevertheless, the Commission submits that this practice is inappropriate. Given the risk that persons with strong warnings might be subjected to additional forms of restriction or hardship during their transport, such as denial of toilet stops at unsecured locations, it is incumbent on police to ensure that warnings remain current.

78. The Commission also expresses its concern that the only food provided to Mr Ward throughout his time in police custody consisted of meat pies. This is not of sufficient nutritional value and most likely contributed to Mr Ward's level of dehydration at the time he was escorted. The Commission notes that Officer Denness stated that re-heated pies were the only food available at Laverton station,

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[119] RCIADIC, *National Report*, v 3, [24.3.56]. See also [24.7.4]-[24.7.5]; v 1, [3.3.40].
[120] RCIADIC, *National Report*, v 3, [24.3.63]
[121] RCIADIC, v 5, Rec 137(b).
[122] RCIADIC, v 5, Rec 137(c). See also Recommendations 138 and 139.
[123] Exhibit 9.
[124] See, eg, Transcript pp 22.4 (Kopsen), 152.9 (Chammings).
[125] The Commission notes, however, that Nurse Stewart gave evidence that she was told by Ms Stokoe that Mr Ward was 'dangerous' (Transcript pp 188.7, 194.5), which she also recorded in the hospital notes: Exhibit 1 (Report of Det. Sgt. Robinson), Annexure 20, p 2.

which he did not regard as adequate.[126] Likewise, Professor Harding expressed his concern that pies were not an appropriate standard of nutrition.

79. The Commission also notes with concern the evidence of Officer Denness that the exercise yard of the Laverton police lock-up did not comply with the relevant recommendations of the RCIADIC, as it had 'a million and one hanging points'.[127]

80. The Commission submits that the above matters are relevant to the quality of supervision, treatment and care of Mr Ward in detention, as well as being generally relevant to public health and safety and the administration of justice.

PART F: PRISONER TRANSPORT VEHICLES

Human rights standards relevant to prisoner transport vehicles

81. International human rights law makes clear that persons deprived of their liberty are entitled to be treated at all times humanely and with respect for the inherent dignity of the human person.[128] As noted earlier, this requirement reflects the particular vulnerability of persons in custody, who are reliant on the State to care for their wellbeing. In the context of prisoner transport, this obligation requires that appropriate levels of safety, amenity and dignity are maintained at all times. For example, Rule 45(2) of the *Standard Minimum Rules for the Treatment of Prisoners*[129] provides:

> The transport of prisoners in conveyances with inadequate ventilation or light, or in any way which would subject them to unnecessary physical hardship, shall be prohibited.

82. Similarly, in their 2007 joint review of prisoner transport, the New Zealand Chief Ombudsman and Ombudsman of the Department of Corrections observed that conditions of discomfort in vehicles could be sufficient to breach the New Zealand *Bill of Rights Act 1990* and article 10(1) of the ICCPR in respect of treating persons in detention with humanity and dignity.[130] The report concluded:

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[126] Transcript p 1116.2 (Denness).
[127] Transcript p 1127.1 (Denness).
[128] ICCPR, Art 10(1).
[129] Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. The purpose of the Standard Minimum Rules is to elaborate on the obligations under art 10(1) of the ICCPR, to provide guidance to administrators and personnel responsible for the care of detained persons to ensure that they are treated with dignity and humanity.
[130] Chief Ombudsman and Ombudsman of the Department of Corrections (New Zealand), *Investigation by John Belgrave, Chief Ombudsman and Mel Smith, Ombudsman of the Department of Corrections in Relation to the Transport of Prisoners* (2007), p 18.

> This is not a matter of providing prisoners with luxury transport. Hard wood or metal benches for journeys of many hours in small cages without proper windows does not constitute a humane standard of transport.[131]

Condition of the prisoner transport fleet

83. As set out in the submissions of Counsel Assisting,[132] OICS Reports No 3 and 43 made a number of scathing criticisms in relation to the level of safety, amenity and dignity of prisoner transport vehicles in Western Australia. Specific concerns with the design and condition of the air-conditioning in vehicles were also raised in the OICS reports.

84. Similar criticisms had emanated from a range of sources in the several years leading up to Mr Ward's death. For example, by letter to Minister Quirk dated 30 November 2006, the ALS attached a detailed submission outlining its concerns and recommendations in respect of prisoner transport following the 'Sandfire' incident.[133] Likewise, evidence from GSL officers indicates that problems with the vehicles were widely known amongst GSL staff[134] and that concerns were repeatedly raised with supervisors and management.[135]

85. Similarly, Officer Denness gave evidence that he voiced his concerns over the condition of the vehicle fleet to GSL staff and management,[136] as well as to Minister Quirk.[137] He also understood that similar concerns had been raised by Officers in Charge at other locations.[138] The evidence of other police officers at Laverton also indicates clearly that the poor condition of the vehicles was well known and self-evident.[139]

86. The Department's contract monitors also appear to have been well aware of the widespread deficiencies with the transport fleet.[140] The regional reports for the six months prior to Mr Ward's death, for instance, show that almost all vehicles required significant repairs or replacement.[141]

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[131] Chief Ombudsman and Ombudsman of the Department of Corrections (New Zealand), *Investigation by John Belgrave, Chief Ombudsman and Mel Smith, Ombudsman of the Department of Corrections in Relation to the Transport of Prisoners* (2007), p 91.
[132] Submissions of Counsel Assisting, pp 22-8.
[133] Exhibit 105 (Additional materials from ALS), Tab 8.
[134] See, eg, Transcript pp 298.5 (Akatsa), 427.8 (Jenkins); 462.6, 478.7 (Stokoe). See also Exhibit 68 (Statement of Ms Corcoran-Sugars), [20], [29]; Exhibit 36 (Statement of Mr Prempeh), [13]; Exhibit 66 (Statement of Mr Akatsa), [8]-[17], [23]; Exhibit 69 (Statement of Ms Collins), [16]-[17].
[135] See, eg, Transcript pp 299 – 300 (Akatsa) 392.7 (Collins), 428, 431-3 (Jenkins), 808 – 809 (Powell). John Hughes also agreed in his evidence that there was 'robust discussion' at the 2007 supervisors conference arising from the general dissatisfaction with the vehicles raised by supervisors.
[136] Transcript pp 1117 – 1118, 1136 – 1137 (Denness).
[137] Transcript pp 1160 (Denness).
[138] Transcript pp 1136.2 (Denness).
[139] See, eg, Transcript pp 18.7 (Kopsen), 63 (Timmers).
[140] See, eg, Transcript p 809 (Powell).
[141] Exhibit 76 (Statement of Mark Corbett), Annexure MC6.

Problems with the design of the Mazda 2500 vans

87. Aside from concerns referred to above with the prisoner transport fleet generally, specific concerns had also been raised with the design of the Mazda 2500 vans. As noted by Counsel Assisting, specific design deficiencies with the air-conditioning of the Mazda vans had been brought to the attention of AIMS and the Department by the report of Car Air Wholesales Pty Ltd dated 13 September 2001.[142] The Commission agrees with the conclusion of Counsel Assisting that the recommendations in that report were ignored by AIMS and the Department.[143] The Commission also agrees with the evidence of Professor Harding that that report should have been brought to his attention.

88. The Commission submits that the rear pods of the Mazda are inhumane and unsafe, particularly on long escorts, on account of the following deficiencies:

(a) the design deficiencies with the air-conditioning system (referred to above)

(b) the almost total lack of ventilation[144]

(c) the lack of any grab rails or padding[145]

(d) the minimal degree of natural light and external vision

(e) the lack of seat belts

(f) the failure of the CCTV monitoring system to completely cover the rear pod[146] or record footage

(g) the wholly inadequate design of the duress alarm (prior to Mr Ward's death),[147] as well as the lack of any signage to that alarm

(h) the absence of any means of two-way communication with the rear pod

(i) the lack of remote temperature monitoring capabilities (prior to Mr Ward's death)

(j) the lack of any form of music or entertainment to make the uncomfortable conditions more bearable

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[142] Exhibit 77 (Statement of Mr Doyle), Annexure 9, p 2.
[143] Submissions of Counsel Assisting, p 25.
[144] The danger arising from the lack of ventilation and back-up cooling systems in pod-style vehicles was also highlighted in OICS Report No 43, p 90.
[145] In relation to the need for padded seats to ensure humane transport over long distances, see eg Chief Ombudsman and Ombudsman of the Department of Corrections (New Zealand), *Investigation by John Belgrave, Chief Ombudsman and Mel Smith, Ombudsman of the Department of Corrections in Relation to the Transport of Prisoners* (2007), pp 40-1, 91.
[146] See, eg, Transcript pp 467.9 – 468.2 (Stokoe), 838 (Powell).
[147] See, eg, Transcript pp 224.5 (Norman), 305 (Akatsa), 469.7 (Stokoe), 813, 874.4 (Powell).

(k) the lack of an external escape hatch.[148]

89. The unsuitability of the Mazda vans for long escorts also appears to have been a view shared amongst GSL staff at Kalgoorlie, including Ms Jenkins.[149] The Commission therefore notes with concern the evidence that the Mazda would sometimes be used for long haul escorts with up to eight men in the rear pod.[150]

Additional problems with the particular Mazda van in which Mr Ward died

90. In addition to the general problems noted above, the Department and GSL were on notice of on-going problems with the particular Mazda in which Mr Ward died,[151] including with the air-conditioning,[152] CCTV monitor[153] and the absence of a spare tyre (which had been missing for several months).[154] Indeed, the affidavit of Mr Doyle confirms that servicing or repairs were carried out on the Mazda 45 times in the two and a half year period prior to Mr Ward's death - an average of once every three weeks.[155] As noted by Counsel Assisting,[156] the poor condition of the Mazda was also immediately apparent to the investigating officers involved in the reconstruction of Mr Ward's escort.

91. The Mazda was taken to Sealys Auto Electrical Pty Ltd on 7 January 2008 due to reported problems with the air-conditioning. Whilst not clear what checks were done by Sealys, the relevant invoice indicates that Sealys reported to GSL that no fault could be detected.[157] The Commission submits that it was incumbent on GSL at this point to ensure that all Kalgoorlie staff were aware that faults had been reported with the air-conditioning system by GSL drivers which could not be explained by Sealys. Staff should have been instructed that particular care was therefore required to ensure that the air-conditioning was working before and during all escorts, particularly over long distances in hot conditions.

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[148] This was raised as an issue of concern in OICS Report No 3, p 17 [2.35].
[149] See, eg, Transcript pp 298.5, 311.2 (Akatsa), 438 – 439 (Jenkins), 812.5 (Powell).
[150] Transcript pp 285.9 – 286.5 (Akatsa).
[151] Transcript pp 285.1 (Akatsa): 'I must have done heaps of trips in the Mazda and in most cases there was always a problem.' See also pp 299 (Akatsa), 432-9 (Jenkins).
[152] Transcript pp 436.8 - 437 (Jenkins): 'There's always been problems with the airconditioning.' See also p 478 (Stokoe): '…that vehicle (the Mazda) has been in and out of Sealys getting fixed for air-conditioning problems since I've ever remembered being there.' See also pp 321.1 (Akatsa), 388 (Collins).
[153] Transcript pp 295.8 (Akatsa), 435.8 (Jenkins), 464.9 – 465 (Stokoe).
[154] Transcript pp 296 (Akatsa), 394.2 (Collins), 433.9 (Jenkins), 464.8 (Stokoe).
[155] Exhibit 77, (Statement of Mr Doyle) [43].
[156] Submissions of Counsel Assisting, p 18.
[157] Exhibit 26 (Bundle of service records and invoices). The invoice stated: 'Unable to fault system. Advise Customer.'

The response of the Department to deficiencies with the vehicle fleet

92. The Commission agrees with the submissions of Counsel Assisting that the response of the Department to the known deficiencies with the vehicle fleet was inadequate and contributed to Mr Ward's death.[158]

93. The evidence makes clear that the Department's response was fixated on a long term fleet replacement strategy, without giving adequate consideration to interim modifications to improve the existing vehicles pending arrival of the new fleet, such as installing permanent or temporary padding.

94. As a minimum interim measure, the Commission submits that the Department should have reviewed all relevant operational policies and procedures to ensure that, as far as possible, they adequately addressed OICS recommendations. The Department should also have ensured that effective mechanisms were in place to ensure that the Mazda vans, which according to Mr Doyle were only ever intended for short runs, were not being used for long haul escorts.[159]

95. Moreover, the Commission submits that the fleet replacement strategy was itself fundamentally flawed due to the Department's failure to make adequate budgetary allocations. The Department decided as early as 2003 that it would assume ownership of the vehicle fleet, which occurred in 2005. By that stage the Department was well aware, or at least should have been, that the vehicle fleet urgently required replacement. However, at no stage prior to the current 2009/10 budget was any budgetary allocation made for vehicle replacement.[160] Accordingly, despite outward assurances that the existing fleet would be replaced, the Department failed to ensure that the funds were available to make this happen.

The response of GSL to deficiencies with the vehicle fleet

96. The Commission agrees with the submissions of Counsel Assisting that the response of GSL to the known deficiencies with the vehicle fleet was also inadequate and contributed to Mr Ward's death.[161]

97. The Commission notes that Mr Hughes gave evidence that the only action taken by GSL in response to the various problems identified with the vehicle fleet was to direct staff not to use pods and/or vehicles if they were not mechanically or electronically sound. However, this was never put into writing and relevant policies were not reviewed at the time GSL took over the Court Security and Custodial

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[158] Submissions of Counsel Assisting, pp 22-31.

[159] The Department was clearly on notice that Mazdas were regularly being used for long hauls in hot regions. For example, contract monitor regional reports for Geraldton and Carnarvon in the months prior to Mr Ward's death show that only Mazdas were available at these locations: Exhibit 76 (Statement of Mr Corbett), Annexure MC6. At Geraldton, for example, the contract monitor raised a concern with one of the Mazda vans being used for long haul escorts, but only because it was not fitted with a long range fuel tank. No concern was raised with the other Mazda at the site continuing to be used for long haul escorts.

[160] Exhibit 77 (Statement of Mr Doyle), [63] – [65].

[161] Submissions of Counsel Assisting, pp 20-22, 30.

Services contract ('CSCS contract') to ensure that they adequately reflected this requirement.

98. In addition, this direction was not realistic. GSL officers in regional locations were under pressure to continue running escorts[162] and had only a limited pool of vehicles to use, all of which had mechanical problems to one degree or another. The evidence also makes clear that, even after a vehicle had been repaired, it would typically break down again a short time later.[163] Accordingly, a vehicle which commenced an escort with no apparent mechanical problems nevertheless carried a significant risk of breakdown or malfunction en route. Officers would also be understandably reluctant to refuse to use vehicles if this would mean missing out on a shift (if only one vehicle was available) or out of a fear of having their shifts reduced in future.[164]

99. Furthermore, this alleged directive did not adequately address the duty of care issues raised by the OICS and others. For example, no effort was made to ensure that GSL employees were briefed on the findings and recommendations of the OICS (or other relevant reports),[165] such as the recommendations made in OICS Report No 43 relating to the need for comfort breaks every 2 - 2 ½ hours and an adequate supply of fresh water.[166]

100. The Commission also notes with concern that the Mazda in which Mr Ward died was replaced after his death with a virtually identical Mazda which also experienced similar on-going problems.[167] Whilst officers were instructed to limit the use of the Mazda to journeys of two hours or less,[168] the Commission regards journeys of such lengths to still be highly inappropriate in light of the Mazda's apparent condition and the various design deficiencies referred to earlier.

PART G: POLICIES AND PROCEDURES RE PRISONER TRANSPORT

101. As outlined by Counsel Assisting, the death of Mr Ward immediately highlighted a number of deficiencies with GSL policies relating to prisoner transport, particularly in respect of regular welfare checks and pre-departure vehicle checks. In addition to these matters, the Commission seeks to make submissions relating to specific

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[162] See, eg, Transcript p 394 (Collins): 'I mean, if there's only one vehicle, I mean, people used to complain if you wouldn't go and do it. I mean, we had police on our back, everything you know.' And further: 'So you were under some pressure to go anyway? --- Yes, very much so. Very much.'
[163] See, eg, Transcript pp 432.7 (Jenkins): 'they were just continuously breaking down. … [T]he vehicles can go in to be fixed and they are given the all okay; we can use them the next day and they will break down.' See also p 794.7 (Powell): 'If there was a problem with it, you'd fix one problem, and then on the next trip out, something else would go wrong. It was never ending.'
[164] See, eg, Transcript p 464.3 (Stokoe): 'If we didn't take the vehicle out the supervisor would have got two other people to take that vehicle out.'
[165] Transcript pp 239.5 (Norman), 411.9 (Collins), 905.6 (Powell).
[166] OICS Report No 43, Recommendations 1 and 28.
[167] Transcript pp 236.6 (Norman), 403.7 (Collins), 611.2 (Jenkins), 810 (Powell).
[168] Transcript p 732.9 (Jenkins).

policy deficiencies in respect of toileting arrangements, the preference for the rear pod over the middle pod and the provision of food and water.

Toileting arrangements

102. The Commission notes with concern the policies and practices of GSL in respect of toileting during long haul escorts. This was also raised as an issue of concern in OICS Reports No 3[169] and 43.[170] Many long-haul vehicles, such as the Mazda, lack on-board toilets. The evidence reveals that, in the absence of a secure location, male prisoners would often be provided a bottle or plastic container to urinate in or would simply urinate on the floor, often in view of other prisoners.[171] In the case of female prisoners, Officer Stokoe gave evidence that if the police station at Leonora was not open on an escort from Laverton to Kalgoorlie, 'they had to hold onto it until we got to the prison or the cop shop at the other end'[172] (approximately 234km away[173]). In the Commission's submission, these practices are inadequate and fail to adequately respect prisoner dignity and humanity.

103. Mr Hughes gave evidence that GSL officers had discretion to allow prisoners out of vehicles to use public toilets if the need arose. However, this is not clearly stated in any written policies and does not appear to have been communicated to staff in Kalgoorlie given the practices described above. For example, Mr Akatsa noted that 'we never risked opening the back and taking them out [to go to the toilet]'.[174] He also stated that he had been instructed that prisoners could not even be let out of the vehicle in the event of a fire or an accident, but should be simply moved to the middle pod through the internal escape hatch.[175]

104. The Commission submits that the lack of any clear policy in respect of toilet breaks contributed to the failure by Officers Stokoe and Powell to conduct a welfare stop between Laverton and Kalgoorlie.

Rear pod vs middle pod

105. The middle pod of the Mazda is a plainly safer and more humane option than the rear pod, given that it has padded seats, seat belts, forward facing seats and better ventilation, light, views outside and capacity to communicate with the driver's cabin.

106. The evidence makes clear, however, that Mr Ward was placed into the rear pod due to the GSL policy that all persons collected from a police lock-up are automatically

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[169] OICS Report No 3, pp 20-1
[170] OICS Report No 43, p 59.
[171] Transcript pp 289.5, 298.2 (Akatsa), 377.3 (Corcoran-Sugars), 459.4 (Stokoe), 644.5 (Jenkins), 919.8 (Powell).
[172] Transcript pp 462.1 (Stokoe).
[173] Exhibit 1 (Report of Det Sgt. Robinson), Annexure 18.
[174] Transcript p 289.4 (Akatsa).
[175] Transcript p 289.7 (Akatsa).

classed as a maximum security prisoner.[176] This policy remains in force[177] and was known to the Department prior to Mr Ward's death.[178]

107. As noted earlier, the prohibition against arbitrary detention under international law encompasses a requirement that prisoners not be subjected to a further and serious deprivation of their liberty beyond what is reasonable and proportionate in the circumstances. Likewise, the requirement that persons deprived of their liberty be treated with humanity and dignity requires that the manner of detention be proportionate with the person's security status and that 'security measures to which prisoners are subject should be the minimum necessary to achieve their secure custody.'[179] Likewise, the *Standard Guidelines for Corrections in Australia* state:

> Transportation of prisoners should take place in a safe and efficient manner, under conditions appropriate to the level of security for those prisoners.[180]

108. The Commission submits that the GSL policy regarding the security rating of persons collected from a police lock-up is inconsistent with these human rights principles. The policy is applied without any regard to individual characteristics or circumstances such as age, gender, health, seriousness of offence or charge, behaviour or positive assurances from police.[181] The Commission also agrees with the suggestion by Professor Harding in his evidence that this security policy was geared to apply a higher degree of security than was necessary primarily to minimise the risk of GSL being fined under the contract for prisoner escapes.[182]

109. The Commission acknowledges that there may be situations where an absence of information requires a cautious approach to assessing a person's security risk. However, the inflexibility of the policy is liable to lead to unjust and unfair outcomes, as Mr Ward's case plainly illustrates.[183]

110. The Commission submits that the GSL policy in respect of security classifications contributed to Mr Ward's death, by resulting in his placement in the rear pod.

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[176] It was also GSL policy that all medium and maximum security prisoners were transported in the rear pod due to it being more secure: See, eg, Transcript pp 286.9, 309 (Akatsa), 357.1 (Corcoran-Sugars). The evidence of Mr Akatsa suggests that even minimum security prisoners would be placed in the rear pod except with permission of the supervisor (p 286.9).

[177] Transcript p 732 (Jenkins).

[178] See, eg, Exhibit 67 (Statement of Mr Corbett), Annexure MC7, p 4.

[179] International Centre for Prison Studies, *A Human Rights Approach to Prison Management: Handbook for Prison Staff* (2002), p 62.

[180] *Standard Guidelines for Corrections in Australia* (Revised, 2004), [1.81].

[181] See, eg, Transcript pp 212 – 213 (Norman), 309 (Akatsa), 834.1, 868.1 (Powell).

[182] This view is consistent with the evidence of Ms Stokoe regarding the relevant GSL policy: 'We've been told that they don't want an escape and it's more of an escapable area in the middle pod' (p 477.6).

[183] The evidence makes clear that Mr Ward was co-operative and compliance at all times and was not regarded by police or Officers Stokoe and Powell as presenting a security risk. See, eg, Transcript pp 10.3, 14.1, 22.4 (Kopsen); 67.5 (Timmers), 118.5, 124.8, 153.1 (Chammings), 826.9 – 827.1 (Powell).

Provision of food and water

111. The Commission submits that GSL policies failed to ensure an adequate supply of food and water to detainees.[184] The evidence from police and GSL officers makes clear that they each regarded this as the other's responsibility.[185] Whilst Mr Hughes gave evidence that bottled water was supplied by GSL to its regional locations, this is not consistent with the evidence given by GSL officers in Kalgoorlie.[186]

112. To the extent that GSL appears to have had an informal policy of reimbursing drivers if they purchased food or water with their own money, the evidence demonstrates that the reimbursement process was lengthy, inconvenient and rarely pursued.[187] In any event, the Commission considers that it was incumbent on GSL to have had adequate arrangements in place to ensure that food and water was provided without relying on officers to use their own money.

113. The Commission submits that the lack of a clear GSL policy in respect of provision of water contributed to Mr Ward's death, by depriving Mr Ward of an adequate water supply and/or by failing to ensure that appropriate stops were made during the escort to replenish his water supply.

GSL on notice of additional reports raising concerns with its standards of detainee transport

114. The Commission submits that the failure of GSL to ensure that prisoner transport procedures were satisfactory is of particular concern given that GSL was already on notice of similar policy deficiencies following an incident involving the transfer of five immigration detainees from Maribyrnong to Baxter on 17 September 2004. This incident prompted the appointment by the Federal Government of an independent inquiry conducted by Keith Hamburger of Knowledge Consulting. This inquiry identified a range of deficiencies with GSL policies that had contributed to the inhumane and undignified treatment of the detainees.[188]

115. Moreover, the President of the Commission subsequently conducted an inquiry into the incident and found serious breaches of the detainees' human rights, including that they had been subjected to degrading treatment and a lack of respect for their humanity and dignity.[189]

116. In the course of that inquiry, the Commission was advised that, in response to the Knowledge Consulting Report, GSL had created a 'Detention Services Escort Log'

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[184] See, eg, Transcript p 447.4 (Jenkins).
[185] See, eg, Transcript pp 116.6 (Chammings), 222.8 (Norman), 294.8, 322.9 (Akatsa), 481 – 482 (Stokoe), 803 (Powell), 1158.2 (Denness).
[186] See, eg, Transcript p 833 (Powell): 'The company never supplied water of anything like that for the van.' See also p 448.2 (Jenkins).
[187] See, eg, Transcript pp 322.3 (Akatsa), 376.8 (Corcoran-Sugars), 447.3 (Jenkins).
[188] Exhibit 109 (Knowledge Consulting Report). See esp Findings 1, 8, 12, 22 and 24.
[189] Exhibit 109 (HREOC Report No 39). See esp pp 7-8 [10] for an overview of the circumstances that contributed to this finding.

that 'stipulates that the driver takes rest breaks every two hours and provides a recording of the breaks and driver changes in the log'.[190] This log also documents pre-departure briefings with detainees,[191] and that 'client's needs such as access to nourishment, opportunity for the toilet and exercise at regular intervals are met during an escort trip'.[192]

117. In addition, the Commission notes that in 2006 the Victorian Ombudsman and Office of Police Integrity issued a joint report, entitled *Conditions for Persons in Custody,* which included a review of prisoner transportation provided by GSL. The Report relevantly concluded:

> Inadequacies have also been identified in the way prisoners are transported. Insufficient attention is given to the conditions under which prisoners are transported, often without basic amenities for long trips and lack of consideration of alternatives to transporting prisoners, such as expanding the use of video conferencing between prisons and courts.[193]

118. The report also referred to the findings of a 2005 report by the Victorian Corrections Inspectorate which had previously outlined deficiencies in prisoner transport provided by GSL in the areas of:

> …incomplete staff refresher training, poor record keeping, no regular reviews or updating of emergency management procedures, little adherence to servicing and maintenance requirements for the vehicle fleet, high breakdown levels of electronic surveillance equipment in the vans compounded by poor quality vision, broken lights and 'blind spots', inoperative communications equipment which prevent prisoners from speaking with the driver and an inadequate emergency duress monitoring system.[194]

119. The Commission submits that GSL should have taken steps to ensure that the lessons learned from the Maribyrnong – Baxter incident and the above Victorian reports were incorporated into a review of GSL policies when it took over the CSCS contract, and that operational staff and management were adequately briefed on these matters.[195]

120. The Commission acknowledges that the various GSL operations in Australia are conducted by separate corporate entities. However, the Commission submits that this should not be permitted to mask the reality that the various companies are closely related entities under a single GSL brand. For example, Mr Doyle gave

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[190] Exhibit 109 (HREOC Report No 39), Annexure D, p 87.
[191] Exhibit 109 (HREOC Report No 39), Annexure D, p 85.
[192] Exhibit 109 (HREOC Report No 39), Annexure D, p 86.
[193] Ombudsman Victoria and Office of Police Integrity (Victoria), *Conditions for Persons in Custody* (July 2006), p 108.
[194] Ombudsman Victoria and Office of Police Integrity (Victoria), *Conditions for Persons in Custody* (July 2006), p 105, referring to the report by the Corrections Inspectorate, *Review of Victorian Prisoner Transport Services* (Dept of Justice, 2005).
[195] None of the GSL officers who gave evidence were familiar with these reports. See, eg, Transcript pp 241 (Norman), 384.1 (Corcoran-Sugars), 412 (Collins).

evidence that the GSL head office in Melbourne provided corporate support to the GSL operation in Western Australia and that all GSL policies relating to the CSCS contract required sign-off from the GSL head office. GSL also no doubt traded on the combined experience of its various related companies in its negotiations with the Department to secure approval for the novation of the CSCS contract from AIMS to GSL.

PART H: TRAINING AND INSTRUCTION OF GSL OFFICERS

121. The Commission agrees with Counsel Assisting that the standard of training and instruction of GSL officers was inadequate and contributed to Mr Ward's death.

122. The evidence shows that the standard six week induction[196] lacked any practical or seminar-based training in respect of the matters covered in the various policy folders (other than in the use of force and restraints).[197] Furthermore, the Commission submits that a fair reading of the evidence in respect of on-the-job training and instruction at Kalgoorlie is that it was ad hoc, unstructured, informal and inconsistent. As noted by Counsel Assisting,[198] the lack of consistent training and instruction is illustrated by the widely different accounts given by GSL officers as to relevant transport policies and procedures.

123. It also does not appear to be in dispute that GSL officers did not receive any formal refresher training, other than in respect of first aid and the use of force and restraints.[199] Indeed, even after Mr Powell was reinstated shortly after having been summarily dismissed in 2007 for various policy breaches, he still did not receive any refresher training other than in first aid and the use of force and restraints.[200]

124. The Commission notes that the lack of refresher training is especially concerning given the findings of OICS Report No 43 that many staff had expressed frustration at the lack of refresher training.[201] The Report had also recommended that the Department ensure that a program of refresher training for all transport staff be considered a core budgetary component of any contract for custodial transport.[202]

125. The evidence also shows that staff were not briefed on the findings and recommendations of OICS Reports 3 and/or 43. There is also little evidence of formal meetings between GSL site supervisors and senior management, aside from an annual conference. In respect of the November 2007 supervisors' conference, Mr Doyle agreed that 'robust' concerns were raised by supervisors about the state

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[196] Mr Hughes agreed in his evidence that training did not change in any material way after GSL took over the CSCS contract. Likewise, GSL officers who gave evidence indicated that very little changed after GSL took over the contract. See eg Transcript pp 203.6 (Norman),

[197] See, eg, Transcript p 281.4 (Akatsa): 'And the only practical training you received was in relation to the use of force and restraints? --- That's correct.' See also pp 456 – 457 (Stokoe), 864 – 866 (Powell).

[198] Submissions of Counsel Assisting, pp 5-6.

[199] See, eg, Transcript pp 203.9 – 204 (Norman), 789.8 (Powell).

[200] Exhibit 108 (2 volumes of additional GSL documents), Tab 8B.

[201] OICS Report No 43, p 103.

[202] OICS Report No 43, Recommendation 32.

of the vehicles, including a warning by Ms Jenkins to the effect that someone would get seriously hurt.[203] However, little appears to have been done to address these concerns, other than await the roll-out of a replacement fleet. Rather than alleviating the supervisors' concerns, as suggested by Mr Doyle,[204] this response appears to have reinforced the view of Mr Jenkins, shared by GSL staff in Kalgoorlie, that it was pointless to raise concerns with the vehicle fleet as nothing would ever get done.[205]

PART I: TRANSPORTATION OF MR WARD

126. The Commission submits that the transportation of Mr Ward from Laverton to Kalgoorlie on 27 January 2007 was cruel, inhuman and degrading, in breach of his rights under article 7 of the ICCPR.[206] Mr Ward was also not treated with humanity or with respect for the inherent dignity of the human person, in breach of article 10(1) of the ICCPR. This was a result of the harsh conditions of the Mazda van, compounded by inadequate practices and policies of GSL and the failure of Officers Stokoe and Powell to exercise adequate care on the day.

127. In particular, the Commission's notes the following key deficiencies in the standard of care shown by Officers Stokoe and Powell:

    (a) the failure to perform adequate pre-departure checks at Kalgoorlie, particularly of the air-conditioning

    (b) the failure to provide Mr Ward with adequate water

    (c) the failure to perform adequate pre-departure checks at Laverton

    (d) the failure to adequately monitor Mr Ward during the journey or conduct welfare stops.

128. The Commission also submits that there were a number of steps that ought to have been taken by Officers Stokoe and Powell following Mr Ward's collapse.

Pre-departure checks at Kalgoorlie

129. It is not in dispute that Officers Powell and Stokoe did not check that the air-conditioning unit was functioning as part of their pre-departure vehicle check. It also does not appear to be seriously disputed that this should have occurred.[207]

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[203] See, eg, Transcript p 431.1 (Jenkins).
[204] Exhibit 111 (Supplementary statement of Mr Doyle), [27].
[205] See, eg, Transcript p 311.9 – 312.3 (Akatsa), 619.5 (Jenkins).
[206] ICCPR, Art 7. See further the Convention Against Torture.
[207] To the extent that Officer Stokoe justified the failure to check the air-conditioning on the basis that she lacked specialist mechanical training and because checking the air-conditioning was not included on the Motor Vehicle Sign Out Report, this justification should be rejected. Checking the air-conditioning on such a hot day was a matter of common sense. It also would not have involved any substantial delay,

130. Given the poor condition noted with the CCTV monitor and the absence of a spare tyre,[208] the vehicle also should not have departed without approval from Ms Jenkins.[209] This was not only a GSL policy requirement,[210] but a matter of common sense.

131. In addition, no attempt was made prior to departure (or at any time thereafter) to telephone ahead to Leonora police station to advise of an approximate time they would be passing through with Mr Ward to ensure that the station would be attended. This was the only secure stop for providing Mr Ward with a toilet break and the station was known to be frequently unattended unless prior arrangements were made, especially on Sundays.[211]

Provision of water

132. The only water provided to Mr Ward for his transport to Kalgoorlie was a 600ml bottle provided by Officer Chammings. The Commission submits that this was plainly inadequate, given the length of the journey, the temperature of the day, Mr Ward's dehydrated condition at the time and the warnings given in OICS Report No 3 regarding the need to provide fresh drinking water at all times.[212]

Pre-departure checks at Laverton

Air-conditioning

133. The evidence is not clear whether the air-conditioning in the rear pod was already switched on prior to when Officers Stokoe and Powell arrived at Laverton.[213] Nevertheless, the Commission submits they should have ensured that the air-conditioning was switched on for a reasonable period **prior** to their departure from

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inconvenience or expertise and was routinely done by other GSL officers: see, eg, Transcript p 821 – 822 (Powell).

[208] Exhibit 1 (Report of Det. Sgt. Robinson), Annexure 22.

[209] This section of the Motor Vehicle Sign Out Report was left blank: Exhibit 1 (Report of Det. Sgt. Robinson), Annexure 22.

[210] GSL Policy Document 2.114 (Vehicle Management and Security): 'Any issues affecting the reliability of mechanical, electrical and communications systems must be flagged with your Supervisor prior to the vehicle departing.' See Exhibit 112 (Internal Investigation Unit Report), Attachment 7.

[211] See, eg, Transcript pp 459.4 (Stokoe), 644.9 (Jenkins), 988 (Powell).

[212] OICS Report No 3, p 22 [2.55]-[2.56].

[213] Officers Stokoe and Powell both appear to have told GSL's internal investigators that the air-conditioning was switched off on the drive up to Laverton, to minimise strain on the engine (Exhibit 108, Tab 2). However, Officer Stokoe gave evidence that they never touched the air-conditioning controls as staff had been instructed never to do so (Transcript pp 471, 516). By contrast, Officer Powell told police and the inquest that he turned the air-conditioning from around midway to full as they departed Laverton (Transcript p 910). The evidence that Ms Stokoe said to Mr Ward words to the effect that 'the sooner you get in, the sooner the air-conditioning will kick in' suggests that the rear of the van was not cool at the time Mr Ward was placed inside.

Laverton, to pre-cool the rear pod. The statements of other GSL drivers indicate that this was relatively standard practice.[214]

134. The Commission further submits that, given the high temperatures of the day and the known problems experienced with the Mazda in the past, Officers Stokoe and Powell should have checked the air-conditioning prior to departing Laverton.[215]

Health checks

135. Officers Stokoe and Powell both observed Mr Ward to be moving slowly when he was loaded into the van in Laverton.[216] In the Commission's view, given their duty of care to Mr Ward, this observation should have prompted Officers Stokoe and Powell to make preliminary inquiries of Mr Ward as to his state of health and fitness to travel.[217]

136. The Commission notes that the issue of preliminary health checks by police was discussed by the RCIADIC. The report acknowledged that 'police officers cannot and should not be expected to make a diagnosis of a prisoner's medical condition'.[218] However, the report recommended that officers should nevertheless be trained and expected to 'make a preliminary assessment of the detainee's physical and mental condition based on information known to them and upon their own observations' and to seek medical assistance if left in any doubt as to the person's state of health.[219]

Pre-departure briefing

137. The Commission also considers that it was inadequate in the circumstances that neither Stokoe nor Powell provided any verbal briefing to Ward prior to their departure from Laverton, such as in respect of how to operate the duress button, how to get their attention,[220] when toilet breaks would be taken and any relevant emergency procedures.

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[214] See, eg, Exhibit 69 (Statement of Ms Collins), [11]; Exhibit 66 (Statement of Mr Akatsa), [22]; Exhibit 36 (Statement of Mr Prempeh), [23]; Exhibit 68 (Statement of Ms Corcoran-Sugars), [26]. See also transcript pp 303.1 (Akatsa).

[215] Officer Powell agreed that this should have occurred: Transcript pp 909 – 910 (Powell).

[216] See, eg, Exhibit 80 (Statement of Mr Powell), [55]; Exhibit 73 (Statement of Ms Jenkins), [26].

[217] The Commission acknowledges that the custody handover documentation included a health assessment questionnaire completed by Officer Kopsen the previous evening which disclosed no health concerns. In the circumstances, however, the Commission queries how reliable that assessment was, given Mr Ward's level of intoxication at the time. For example, the hospital file for Mr Ward indicates that he was known to have diabetes yet this was not disclosed on his health assessment. In any event, Officers Stokoe and Powell owed their own duty of care to Mr Ward and could not solely rely on a medical assessment conducted by others the previous day given their own observations at the time.

[218] RCIADIC, *National Report*, v 3, [24.3.4].

[219] RCIADIC, *National Report*, v 3, [24.7.3].

[220] The Commission notes that Officers Stokoe and Powell appear to have regarded it as simply a matter of common sense that a prisoner would bang on the sides of the van if they wished to attract their attention. However, this neglects the widely reported reluctance of many Aboriginal persons to challenge persons in

Monitoring of Mr Ward during journey

138. The Commission agrees with Counsel Assisting that there are various inconsistencies in the evidence of Officers Stokoe and Powell regarding the conduct of the escort such that the Coroner cannot be satisfied that events unfolded as they described.[221] Nevertheless, even on the evidence given by Officers Stokoe and Powell, the Commission submits that the quality of supervision of Mr Ward during the journey was inadequate in several respects.

Physical welfare checks

139. The Commission submits that Officers Stokoe and Powell should have conducted physical welfare checks of Mr Ward at Leonora and Menzies. As noted earlier, the RCIADIC emphasised the need for physical welfare checks of detainees, rather than relying on electronic technology for remote checks alone. Officer Stokoe's purported reliance on Mr Ward to bang on the sides of the van if he wanted their assistance is also at odds with the fact that she was wearing headphones listening to music virtually the entire journey to Kalgoorlie.[222]

140. To the extent that Ms Stokoe indicated that they did not stop at Leonora because Mr Ward was asleep, this justification should be rejected. This is contrary to the evidence of Mr Powell that, as they were approaching Leonora, Ms Stokoe advised that Mr Ward was sitting up and looking around.[223] Given the quality of the CCTV monitor, it is also impossible that Ms Stokoe could have been positively satisfied that Mr Ward had his eyes closed,[224] let alone that he was in fact asleep rather than simply lying down and resting. The failure by Officers Stokoe and Powell to telephone ahead to the police station at Leonora to make arrangements to use the toilet facilities also suggests that they never planned to make a stop at Leonora.[225] In any event, the temperature of the day, Mr Ward's minimal water supply and the conditions of the rear pod made a physical welfare check essential regardless of whether Mr Ward appeared to be asleep. Moreover, the Commission submits that Officers Stokoe and Powell should have stopped at Laverton to rest and change drivers for reasons of safety.

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authority and the understandable fear of facing some form of reprisal for disrupting the escort. See generally Chris Cunneen, *Conflict Politics and Crime: Aboriginal Communities and the Police* (2001), esp Chapter 5; Law Reform Commission of Western Australia, *Aboriginal Customary Laws: The interaction of Western Australian law with Aboriginal law and culture – Final Report,* Project No 94 (September 2006), p 192; Law Reform Commission of Western Australia, *Aboriginal Customary Laws: Discussion Paper,* Project No 94 (December 2005), pp 235-6; Phillip Vincent, 'Aboriginal people, criminal law and sentencing' Background Paper 15, Law Reform Commission of Western Australia, *Aboriginal Customary Laws – Background Papers* (2005) 549, 567-9.

[221] Submissions of Counsel Assisting, pp 12-13.

[222] Whilst Ms Stokoe disputed that she wore both ear plugs, Officer Powell was firm in his evidence that she did: Transcript p 905.3 (Powell) cf pp 508.8 – 509.2 (Stokoe).

[223] Transcript p 840.5 (Powell).

[224] Transcript 466.5 (Stokoe), 839.9, 923 (Powell).

[225] See, eg, Transcript pp 988 - 989 (Powell).

Removal of shirt

141. In his interview with police, Officer Powell stated that Officer Stokoe observed Mr Ward to remove his shirt during the escort. Whilst disputed by Officer Stokoe in her evidence, the Commission submits that Officer Powell's evidence to police on this matter should be preferred given the recentness of that evidence to the relevant events. The Commission further submits that this observation should have prompted Officers Stokoe and Powell to stop and check whether the air-conditioning was functioning in the rear pod.

Treatment of Mr Ward following his collapse

142. In times of medical emergency, tensions quickly rise and an optimal response can of course be difficult. However, the Commission considers that there were a number of steps that ought to have been taken by Officers Stokoe and Powell following Mr Ward's collapse, including:

(a) opening the inner door[226] to allow some of the heat to escape and to afford better access to Mr Ward

(b) climbing into the rear pod to assess Mr Ward's condition and perform first aid[227]

(c) driving immediately to the hospital, rather than waiting on the roadside for approximately two minutes after securing the rear doors with Mr Ward inside[228]

(d) having one of the officers riding in the rear pod en route to the hospital to monitor Mr Ward and perform first aid

(e) calling ahead to put the hospital emergency department on notice of their imminent arrival and Mr Ward's condition.

143. The Commission also notes that the Mazda van was not equipped with a fully automatic defibrillator as part of its first aid kit, which might have otherwise ensured that Mr Ward was administered appropriate cardiac treatment as soon as his heart stopped. Following Mr Ward's death, the Department's Internal Investigations Unit recommended that consideration be given to inclusion of

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[226] To the extent that Mr Powell in his evidence stated that, contrary to his earlier accounts, they in fact **did** open the inner door, this evidence should be treated with caution. This evidence is contrary to his interview with police (Exhibit 81, pp 9 – 10), statement to police (Exhibit 80) and notes prepared following the incident (Exhibit 82) as well as all the evidence of Officer Stokoe.

[227] The Commission notes that, despite the incorrect understanding of Officers Stokoe and Powell, opening the inner door was permitted under GSL policies if the situation was 'life threatening': Exhibit 76 (Statement of Mr Corbett), Annexure MC3, p 2.

[228] See, eg, Transcript pp 948 - 953 (Powell).

automatic defibrillators in remote area escort vehicles,[229] although this recommendation does not appear to have resulted in any changes being made.

144. The Commission acknowledges that the medical evidence indicates that the failure to take the above steps probably did not contribute to Mr Ward's death. Nevertheless, the Commission considers that comments on this issue are relevant to the quality of treatment and care of Mr Ward whilst in custody, as well as to public health and safety and the administration of justice.

PART J: POLICE INVESTIGATION INTO THE DEATH OF MR WARD

145. As noted earlier, as part of the State's international obligations to protect life and provide an effective remedy it is essential that deaths in custody are subjected to comprehensive and rigorous investigation. Likewise, the RCIADIC emphasised the importance of ensuring a high standard of police investigations of Aboriginal deaths in custody, noting that:

> The anguish and anger of the relatives, their fear and suspicion as to what may have happened inside a police or prison cell, demands an assurance that the circumstances of death will be thoroughly and fairly investigated.[230]

146. The RCIADIC was also highly critical of many of the police investigations it reviewed and concluded that: 'The inadequacies of post-death investigations throughout Australia must be addressed as a matter of urgency.'[231] The report went on to make a series of recommendations to ensure the 'thorough, competent and impartial'[232] investigation of all deaths in custody[233]

147. The Commission submits that Det. Sgt. Robinson displayed a lack of awareness with these recommendations and with the findings and recommendations of the RCADIC generally.[234] In the Commission's view, this is not satisfactory for a senior officer in charge of an investigation into an Aboriginal death in custody.

148. Det. Sgt. Robinson stated that he treated the investigation into the death of Mr Ward as if it was a homicide. In line with the recommendations of the RCIADIC,[235] the Commission agrees that this is the appropriate approach that should have been taken. The reality, however, fell far short.

149. On the night of Mr Ward's death, Officers Stokoe, Powell and Jenkins were all kept together and unsupervised in an unused office for several hours before being

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[229] Exhibit 112 (Internal Investigations Unit Report), p 14 [10.4].
[230] RCIADIC, *National Report*, v 1, Forward to Chapter 4, p 109.
[231] RCIADIC, *National Report*, v 1, [4.7.1]. Substandard police investigations also attracted criticisms in the follow-up review of Aboriginal deaths in custody conducted by the Aboriginal and Torres Strait Islander Social Justice Commissioner: *Indigenous Deaths in Custody: 1989 to 1996* (1996), pp 242-4.
[232] RCIADIC, *National Report*, v 1, Forward to Chapter 4, p 109.
[233] RCIADIC, v 5, Recs 6 – 40, esp Recs 32, 33, 35 and 36.
[234] Exhibit 114 (ALS notes from inquest at Warburton), p 11.
[235] RCIADIC, *National Report,* v 5, Rec 35(a).

interviewed.[236] Ms Jenkins was also allowed to remain present during the interviews of both Stokoe and Powell, notwithstanding that she was a material witness in the case.[237] The Commission submits that her relevance to the investigation should have been immediately apparent, if not at least strongly suspected, given her supervisory role[238] and her presence at the hospital at the time the police arrived. Her relevance was further confirmed as the interviews unfolded, yet at no stage was she removed.

150. The Commission submits that the investigation was also open to criticism in the following respects:

(a) Statements from the police officers at Laverton indicate that little care was taken to scrutinise properly the evidence of these witnesses. For example, many parts of the statements of Officers Sliskovic[239] and Kopsen[240] (the arresting officers) are almost identical. Likewise, Officer Timmers gave evidence that he and other officers conferred with one another in preparing their statements.[241] In addition, little attempt was made to clarify relevant details surrounding the denial of bail to Mr Ward by Officer Timmers and Mr Thompson.

(b) No follow-up inquiries appear to have been made with any of the witnesses after they provided their statements, including Officers Stokoe and Powell. As outlined by Counsel Assisting, there were various inconsistencies between the accounts of Stokoe and Powell which, in the Commission's submission, should have prompted further inquiries by police.

(c) No statement was taken from any of the Aboriginal witnesses to Mr Ward's arrest[242] or his time in police custody at Laverton, such as PE or Tyrone Ward.[243]

(d) No attempt was made to locate the CCTV footage of Mr Ward being loaded into the van at Laverton, despite such footage being apparently available at the time (but since destroyed).[244]

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[236] See, eg, Transcript pp 605, 643 – 644 (Jenkins), 856.8 (Powell). It is also unclear whether Officers Stokoe, Powell and Jenkins were even directed not to discuss the incident: Compare Transcript pp 605.5, 643 - 644 (Jenkins), 857.1 (Powell) and Exhibit 71 (Det. Sgt. Robinson running sheets), p 1.

[237] The evidence of Officer Stokoe also indicates that Ms Jenkins requested to be present for the interview, rather than Ms Stokoe asking that she be present as her support person: Transcript pp 507, 544 (Stokoe).

[238] The interviewing officers were clearly aware that Ms Jenkins was the supervisor to Officers Stokoe and Powell. See, eg, Exhibit 73 (Transcript of Stokoe interview with police), p 2.

[239] Exhibit 2.

[240] Exhibit 54.

[241] Transcript p 77.1 (Timmers).

[242] Officer Kopsen agreed that there were other persons in the car with Mr Ward at the time of his arrest: Transcript pp 9.3, 26.4 (Kopsen).

[243] The investigation running sheets do not reveal that any real attempt was made to speak with these witnesses: Exhibits 38 (Internal Affairs Unit running sheet) and 71 (Det. Sgt. Robinson running sheets).

[244] Exhibit 88 (Memo from Det. Sgt. Robinson re CCTV footage).

(e) The investigation suffered from significant delays. For example, hospital staff did not provide statements until almost seven months after Mr Ward's death and statements were not requested from other GSL drivers and Mr Thompson until approximately 12 months after Mr Ward's death. Moreover, at the time Dt. Sgt. Robinson submitted his report in 2009, a statement had still not been provided by Mr Hughes, Mr Thompson or anyone from within the Department.

(f) The documents produced through the investigation were also very limited in their scope and did not include, for example, highly relevant documents relating to the use of the Mazda in the weeks leading up to Mr Ward's death.[245]

(g) Det. Sgt. Robinson was not an appropriate choice to lead the investigation given his location in the region where Mr Ward died.[246]

151. The Commission submits that the above deficiencies are relevant matters for comment as they relate to the administration of justice in connection with Mr Ward's death.

PART K: MAKING WRITTEN SUBMISSIONS PUBLICLY AVAILABLE

152. At the conclusion of the evidence, the Coroner indicated that his usual practice was that parties would not be permitted to make written submissions publicly available, even after his findings were handed down. However, the Coroner indicated that the parties could address this issue in their written submissions.

153. The presumption in favour of open and public administration of justice has long been recognised as a cornerstone principle of the Australian legal system. In *Russell v Russell* (1976) 134 CLR 495, for example, Gibbs J explained the basis of this presumption as follows:

> It is the ordinary rule of the Supreme Court, as of the other courts of the nation, that their proceedings shall be conducted 'publicly and in open view' (*Scott v Scott*). This rule has the virtue that the proceedings of every court are fully exposed to public and professional scrutiny and criticism, without which abuses may flourish undetected. Further, the public administration of justice tends to maintain confidence in the integrity and independence of the courts. The fact that courts of law are held openly and not in secret is an essential aspect of their character. It distinguishes their activities from those of administrative officials, for 'publicity is

[245] Whilst a number of Motor Vehicle Sign Out Reports for the Mazda were ultimately produced during the inquest, the relevant reports for 2, 7, 9, 13, 14, 15, 16, 22, 24 and 26 January 2008 were never provided, despite occurrence log records for January 2008 showing that the Mazda was used on these dates: see Exhibit 70 (Bundle of Persons in Custody occurrence logs).

[246] RCIADIC, v 5, Rec 33.

the authentic hall-mark of judicial as distinct from administrative procedure' (*McPherson v McPherson*).[247]

154. Similarly, In *John Fairax Publications Pty Ltd & Anor v District Court of NSW & Ors* [2004] 61 NSWLR 344, Spigelman CJ (Handley JA and Campbell AJA agreeing) summarised the relevant principles as follows:

> It is well established that the principle of open justice is one of the most fundamental aspects of the system of justice in Australia. The conduct of proceedings in public … is an essential quality of an Australian court of justice. There is no inherent power of the Court to exclude the public. …
>
> It is also well established that the exceptions to the principle of open justice are few and strictly defined. It is now accepted that the courts will not add to the list of exceptions but, of course, Parliament can do so, subject to any Constitutional constraints.
>
> The entitlement of the media to report on court proceedings is a corollary of the right of access to the court by members of the public. Nothing should be done to discourage fair and accurate reporting of proceedings.
>
> From time to time the courts do make orders that some aspect or aspects of court proceedings not be the subject of publication. Any such order must, in the light of the principle of open justice, be regarded as exceptional.[248]

155. As noted earlier, the right to life and the right to an effective remedy under the ICCPR also impose positive obligations on the State to ensure that inquiries into deaths in State custody are public and accountable.

156. The Commission submits that parties should be permitted to make their written submissions public. This is an important component of open justice, particularly in this inquest given the numerous systemic issues of public interest and importance. The Commission also notes that, due to time constraints, the parties were unable to make oral submissions in the inquest. Accordingly, it is only through the parties being permitted to now make their submissions available that the content of those submissions can be publicly known.

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[247] (1976) 134 CLR 495, 520 (citations omitted).

[248] [2004] 61 NSWLR 344, [18] – [21] (citations omitted). See also *John Fairfax & Sons Pty Ltd v Police Tribunal of New South Wales* (1986) 5 NSWLR 465, 476-7 (McHugh JA): 'The principle of open justice also requires that nothing should be done to discourage the making of fair and accurate reports of what occurs in the courtroom. Accordingly, an order of a court prohibiting the publication of evidence is only valid if it is really necessary to secure the proper administration of justice in proceedings before it. Moreover, an order prohibiting publication of evidence must be clear in its terms and do no more than is necessary to achieve the due administration of justice. The making of the order must also be reasonably necessary; and there must be some material before the court upon which it can reasonably reach the conclusion that it is necessary to make an order prohibiting publication. Mere belief that the order is necessary is insufficient.'

PART L: COMMENTS OF THE CORONER IN THIS INQUEST

157. As indicated earlier, the Commission adopts the findings and recommendations proposed in the submissions of Counsel Assisting. The Commission also adopts the submissions made to this inquest by the OICS.

158. The Commission submits that the Coroner should also consider making the following additional comments in this inquest:

Denial of bail

(a) The refusal of bail to Mr Ward was an inappropriate exercise of police discretion in the circumstances.

(b) The evidence of police officers at Laverton discloses a general lack of awareness of relevant obligations under the Bail Act, *Magistrates Court Regulations 2005* (WA) and recommendations of the RCIADIC regarding bail. The Police Commissioner should consider whether this reflects upon police training generally or a need for further training of officers stationed at Laverton.

(c) The Police Commissioner should ensure that police operating manuals emphasise that bail should ordinarily be granted and that powers of arrest and refusal of bail should only be treated as measures of last resort.

(d) The Police Commissioner should consider introducing a requirement that when officers achieve the rank of sergeant[249] they are required to undergo refresher training on their obligations under the Bail Act.

(e) The hearing conducted by Mr Thompson did not meet acceptable standards, was procedurally defective and failed to consider adequately or at all Mr Ward's case for bail.

(f) The Department of Attorney-General should take steps to ensure that current Justices of the Peace who have not completed their required training and assessment are required to do so as a matter of urgency.

(g) The Department of Attorney-General should phase out within three years the current arrangements of having Justices of the Peace consider bail applications, to be replaced with having all bail applications considered by a judge or magistrate, either in person or via audio or video link-up.

(h) The Department of Attorney-General should take steps to ensure that video conferencing facilities are available and operational in all remote police stations within three years.

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[249] Pursuant to s 3 of the Bail Act, an authorised police officer for the purposes of granting bail is an officer who holds the rank of sergeant or higher.

Quality of supervision, treatment and care in police custody

(i) The evidence of police officers at Laverton discloses a lack of awareness of, and a failure to take into account, the recommendations of the RCIADIC relating to physical cell checks. The Police Commissioner should consider whether this reflects upon police training generally or a need for further training of officers stationed at Laverton.

(j) Particular attention should be given by the Police Commissioner to the training of officers working in Aboriginal communities. Such training should be provided prior to any service in Aboriginal communities and should deal particularly with relevant recommendations of the RCIADIC.

(k) The Police Commissioner should review current arrangements for the supply of food and beverages to persons in police custody to ensure that standards of nourishment, hygiene and variety are satisfactory, especially in remote locations. The Police Commissioner should also consider modifications to the police station exercise yard at Laverton to remove potential hanging points.

(l) The Police Commissioner should review current practices with respect to automatically generated historical warnings on Custody Handover Sheets, to ensure that warnings are not listed unless they remain current.

Prisoner transport fleet

(m) Pending the roll-out of a replacement vehicle fleet, the Department and G4S Custodial Service Pty Ltd (‘G4S’) (formerly named GSL) should take urgent steps to consider appropriate interim measures and modifications to address the level of safety, amenity and dignity of the current fleet, including permanent or removable padding in all vehicles used for long-haul escorts.

(n) In replacing the current vehicle fleet, the Department and G4S should also consider the greater use of coaches and air transport for prisoner transport, as well as vehicles specifically designed for minimum security prisoners.

Policies and procedures

(o) G4S should review its current policies in respect of toileting arrangements to ensure humane and dignified access to toilet facilities. G4S should also ensure that appropriate policies and protocols are in place to facilitate the use of police lock-ups for toilet stops during prisoner transports where appropriate.

(p) G4S should take urgent steps to review relevant policies of all related GSL / G4S companies in Australia that provide prisoner / detainee transport services in light of the lessons learned from this inquest.

Training and instruction

(q) In enhancing training for G4S staff, as recommended by Counsel Assisting, the Department and G4S should also consider developing a case study based on Mr Ward's death, to ensure that the lessons learned from this inquest are passed on to all current and future staff.

(r) G4S should review current arrangements for the exchange of information between management and site supervisors. These arrangements should ensure that supervisors are provided with appropriate briefing materials in respect of key reports and other matters relating to prisoner welfare and that concerns from supervisors are facilitated, encouraged and actioned.

Treatment of Mr Ward on 27 January 2008

(s) Mr Ward's treatment during his transportation from Laverton to Kalgoorlie on 27 January 2008 was cruel, inhuman and degrading. Mr Ward was also not treated with humanity or with respect for the inherent dignity of the human person.

(t) In carrying out their duties on 27 January 2008, Officers Stokoe and Powell should have but failed to:

- check that the air-conditioner was functioning prior to departure from both Kalgoorlie and Laverton
- notify Ms Jenkins prior to departure from Kalgoorlie to advise her of problems with the CCTV and that the vehicle was missing a spare tyre
- notify the police station at Leonora to advise of their arrival time, to facilitate access to toilet facilities for Mr Ward
- conduct a preliminary health check of Mr Ward at Laverton and provide him with a short briefing about the escort
- provide an adequate supply of water to Mr Ward
- perform physical welfare checks on Mr Ward and a change of driver during the escort.

(u) G4S should review its policy relating to the allocation of a maximum security rating to all persons collected from police lock-ups, to allow a more individualised assessment in appropriate circumstances.

(v) G4S should review its policies relating to medical emergency procedures during escorts. This review should ensure that local hospital emergency department contact numbers are prominently displayed inside transport vans and/or on transport documentation. G4S and the Department should also

consider the inclusion of fully automatic defibrillators on board all long-haul vehicles.

Police investigation into Mr Ward's death

(w) The failure to adequately separate Officers Stokoe, Powell and Jenkins prior to and during their interviews with police was inappropriate and undermined the integrity of the investigation. The investigation overall was also not sufficiently comprehensive, rigorous or prompt. The Police Commissioner should consider whether this reflects upon police training generally or a need for further training of officers who investigated Mr Ward's death.

(x) The Police Commissioner should review current procedures to ensure that in all deaths in custody:

- (i) the appointment of the officer in charge is made by the Chief Commissioner, a Deputy Commissioner or Assistant Commissioner of Police
- (ii) officers investigating the death are chosen from a region other than that in which the death occurred.

(y) The Police Commissioner should consider introducing a requirement that officers likely or wishing to be considered for appointment in charge of an investigation into an Aboriginal death in custody are first required to become familiar with the recommendations of the RCIADIC, particularly recommendations 6 – 40 regarding post-death investigations.

28 May 2009

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Brook Hely
Senior Solicitor
Human Rights and Equal Opportunity Commission