



Photo © Fee Plumley via Creative Commons. Rally calling for justice - at the very least answers for why Miss Julieka Dhu died in custody a year ago today. <http://www.deathsincustody.org.au/oneyearon>

## Reflections on the coronial inquest of Ms Dhu

Dr Amanda Porter

*This article was originally given as a speech at the University of Technology at a public forum on settler-colonialism and violence against Indigenous women in Canada and Australia on 7 April 2016.*

This is not an academic paper. I'm not going to talk today about statistics, neo-colonialism or the intersections of race and gender. Instead I wanted to share my personal reflections on the transcripts and testimonies emerging from the coronial inquest, which concluded last month and the findings of which will be handed down later this year.

But let me begin by saying a few words about the beautiful young woman who you may have seen in photos who is known, at the request of her family, simply as 'Ms Dhu'.

Ms Dhu was born in Geraldton, Western Australia in 1991. Her family describe her as caring, full of love and cheer, with a fierce sense of loyalty and generosity for close friends and family. She liked to paint and make artwork in her spare time and dreamed of one day travelling. She was loved by her parents Della Roe and Robert Dhu. She is missed by her grandmother, Carol Roe, by her uncle, Shaun, her brothers, sisters and extended family.

I wanted to begin by sharing these personal details about Ms Dhu for two reasons. Firstly because, I have always been struck by the discrepancy in how when a non-Indigenous person dies, we might hear in the mainstream media

about what kind of person they were or something about their dreams and aspirations. We might hear about how they liked horse-riding, for example, or that they were very popular in school. This honouring of the deceased rarely occurs when the death occurs in custody, especially when the deceased happens to be Aboriginal.

Secondly, I think that sometimes when we talk about deaths in custody, something important is lost in the language and the statistics, we risk reducing the memory of the deceased to a statistic. In particular, when we read about this death in custody we learn very little about Ms Dhu as a human being, but quite a lot about somebody else's perception of who she was.

And it is this denial of this basic humanity and the human dimensions of this tragedy that I wanted to speak to today.

So how do we get from this story about a creative young woman to one steeped in racism and in gendered stereotypes? Let me start at the beginning. I wanted to take you through the inquest in terms of a chronology and just by way of warning, it's hard for me to read this without getting emotional.

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From mid-2013 Ms Dhu was in a relationship with, Mr Dion Ruffin, 18 years her senior. Her family describe the relationship as physically abusive in nature. On the 2nd August 2014 at around 5pm, officers at the South

Headland police station were called to a domestic violence incident. Mr Ruffin was arrested for breaching bail on a domestic violence charge arising from a previous partner. Ms Dhu was arrested pursuant to a warrant for \$3,622 in outstanding fines.

Under Western Australian law, fine-defaulters can be gaoled and, under this policy “pay down” their fines in prison at a rate of \$250 per day in custody.

The findings of the state coroner, Ms Ros Fogliani, will be handed down later this year, and in the meantime I can’t say with certainty whether she was afforded due process. And by that all I mean is, we don’t know *for now* whether she was charged, whether her charges had been properly processed, whether they were signed off by a magistrate, and so on. What we do know is that when she arrived at South Hedland Police watch-house, she complained of severe pain, fever and paralysis.

On the 2<sup>nd</sup> of August at 9:15 pm, Ms Dhu was taken to the Hedland Health Campus. She was given a triage score of four, the second lowest. She was seen by the nurse on duty, Mrs Samantha Dunn, who testified that she found Ms Dhu’s behaviour and symptoms “*unremarkable*” and “*exaggerated*”. She was seen by the doctor on duty, Dr Anne Lang, who described her physical symptoms (which included being hunched over and limping) as “*a little bit attention-seeking*”. The doctor’s medical notes, which were tendered in court, describe a patient who had presented for *behavioural gain*. But Dr Lang said at the inquest: “*I would have made the same diagnosis if it had have been a middle aged white woman*”. Ms Dhu was deemed “*medically fit*” to be held in custody and returned to her cell.

On the 3<sup>rd</sup> of August just after 5pm, she was again taken to the hospital, again declared by the doctor on duty to be “*medically fit*” and again returned to police custody. The picture that emerges from the testimonies is that each time Ms Dhu returns from the hospital to the police lockup, the atmosphere at the station becomes increasingly *judgemental*, *sceptical* and *indifferent*.

There is recorded CCTV footage of Ms Dhu’s final days that was played at the

inquest. One of the most haunting aspects of this footage was *the sound*, the audio content. In the background to these recordings you can hear the voices of police officers laughing. They say, mockingly: “*Paracetamol! After all that!*”

There is also footage from the charge room, which is next to the cells. For the half an hour that it runs, Ms Dhu can be heard moaning, crying, asking for help, saying she can’t breathe and that she needs to go to hospital.

Two witnesses to the events, Mr Dion Ruffin and Mr Malcolm Wilson, confirm that Ms Dhu was in agony—vomiting, crying and at times begging on her knees for help.

At one point Ms Dhu complained her hands were turning blue. Sgt Rick Bond claimed he checked on her later and said that: “*she looked fine to me*”. Asked during cross-examination whether he believed at the time she was a junkie who was faking illness, he replied: “*I wasn’t confident that she was being truthful.*”

Constable Christopher Matier told the inquest that because Ms Dhu had been declared fit for custody twice he didn’t check what her complaint had been. He didn’t think it was relevant. He said that he offered her paracetamol.

On the 4 August 2014 just after midday, Senior Constable Shelley Burgess *transported* Ms Dhu on her third and final trip to the hospital. I say *transported* deliberately, because to say that she was *accompanied* would be a euphemism. Footage from security cameras shows Ms Dhu being dragged by one arm from her cell, as advocate Gerry Georgatos puts it, “*like a dead kangaroo*”. She was dumped inside the police van, and left alone.

Training manuals from Western Australian Police stipulate the procedure to follow when presented with a medical emergency. This is all on the public record. Police officers should keep the detainee stable and comforted; where no breathing or pulse is detected they should apply CPR; officers should call for an ambulance.

None of this occurred. There was a procedure but no professionalism, no duty of care and no compassion.

Even in Ms Dhu’s final moments as she was pulled out of the van and fell back in the wheelchair, Senior Constable Shelley Burgess testified that she thought Ms Dhu was “*pretending to faint to get quicker medical treatment*”.

Ms Dhu died on the 4<sup>th</sup> of August 2014 at 1:39pm shortly after her arrival at the Health campus. She died of septicaemia and pneumonia—caused by an infection in her fractured ribs that spread to her lungs. She died not surrounded by loved ones, but by people who until her last breaths, treated her with *absolute contempt*.

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I would like to ask you at this point to reflect on the last time *you* experienced significant pain and how it was dealt with. Did someone hold your hand and comfort you, did they tell you that everything was going to be alright? Were your complaints dealt with professionally by those around you? And if a family member called to see if you were OK, did staff actually check on you? Did they pass on accurate information to your loved ones?

These are all things we take for granted, but which Ms Dhu was denied, and which her family were denied. Until this point I have been talking about failures on the part of medical staff and of the state police, but I would also like to acknowledge the broader dimensions of this failure: a failure of human dignity, of basic human rights. These were failures at an institutional level and at a national level.

MS Dhu’s death is a national failure in the sense that this happened in Australia in the 21<sup>st</sup> century, a so called “*advanced liberal democracy*”. A failure to learn from past mistakes. It was an institutional failure to successfully implement the 339 recommendations from the Royal Commission into Aboriginal Deaths in Custody that would have prevented this tragedy. These include inter alia: recommendations 87 (arrest only when no other way of dealing with the problem), 92 (imprisonment as a sanction of last resort), 120 (Amnesty on the execution of warrants for unpaid fines), 121 (sentences of imprisonment should not be imposed in default of a payment of a fine), 128 (medical services provided to persons held in police watch-houses



should be of an equivalent standard to that available to the general public), 137 (careful and thorough checks of all detainees in police custody) and 161 (immediately seek medical attention if any doubt arises about a detainee's condition).

We knew all this in 1991. 25 years ago. These recommendations came from a report but from a much longer history of Aboriginal deaths in custody. Let me just give you a brief overview of several cases for context:

- **Mrs Nita Blankett**, a 41-year old mother of 5, who died in 1982 from an asthma attack en route from custody to St Andrews Medical Centre Midland. Like Ms Dhu, Mrs Blankett was “distressed, hysterical and crying” before her death, unable to convince authorities that she needed medical attention.
- **Ms Muriel Binks**, a 38-year old mother of two from Innisfail, near Cairns who died in a police watch-house from pneumonia in 1989. Her crime? Unpaid fines of \$30 for failing to lodge an income tax return ten years earlier.
- **Ms Christine Jones**, who was found hanged in a single cell at Midland Police Station in Perth in 1980. Like Ms Dhu, she was 22 year old and also like Ms Dhu, arrested on a warrant for outstanding fines.
- **Barbara and Fay Yarrie**, sisters from Brisbane, Qld. Barbara Yarrie, the eldest sister, died in custody at the Brisbane police watchhouse in 1986, aged 30. Barbara's sister Fay died two

years later in 1988 in a cell in the same watchhouse, aged just 29. Fay was placed in an unobserved cell with two other Aboriginal women and was assaulted so violently that she died some three hours later in Royal Brisbane Hospital. Both sisters were subjected to various forms of intervention by child welfare agencies from the ages of 11 and 13. The younger sister Fay was a mother of four children, and all four of her children were placed under welfare supervision.

What I think is remarkable when reading through these cases is that these are not stories of criminality or of serious wrongdoing. These are stories of inter-personal violence, of institutional violence. Some of the women were victims of ongoing violent assaults, domestic violence, and sexual assault. Some of the women who died in custody were removed from their families as children. Many were victims of the institutional violence inherent in the nature of government intervention.

Most involve fine default. And, let me remind you at this point that WA Premier Colin Barnett was elected on a public platform that he would “get tough on crime” and “clamp down on fine-defaulters”. But let us not forget, he was democratically elected.

I would like to conclude not by giving academic, legal or policy recommendations on the way forward (I will reserve my comments on these until the coronial findings are made public) but rather I would like to conclude simply by inviting you to reflect on the morality of all this. Ms

Dhu owed \$3000 in unpaid fines, a crime for which she paid the ultimate price: her life.

Think about this so-called crime in light of the greater context: in terms of how she was treated by medical staff who showed no compassion; by the state police who failed to follow procedure; but also think of those who think that gaoling fine-defaulters is a *humane* policy; and think of everyday Australians who continue to see Aboriginality—not in terms of an identity of proud and diverse peoples—but in terms of deficiency and criminality.

And most importantly, think about the family who wake up every morning adjusting to life without their daughter, without their granddaughter and niece. Think not only of the grief and anger they must be feeling right now, but of their strength in fighting this battle on the ground, while at every turn, being confronted with the ugly prejudice that their daughter's life was somehow worth less than someone else's.

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