Police silence and Aboriginal deaths in custody

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Snapshot

- The recent Black Lives Matter protests have demonstrated a public concern with First Nation deaths in custody and the effectiveness of existing legal mechanisms of accountability.
- The Coroner's office has a statutory function to investigate the manner and cause of deaths, and a statutory obligation to do so for First Nation deaths in custody.
- Two recent decisions in New South Wales and South Australia have examined the legal principles that apply to objections to give evidence by the officers involved.

The recent Black Lives Matter protests saw tens of thousands of Australians marching in support of the families of First Nation people calling for an end to First Nation deaths in custody and to the perceived lack of accountability of involved officers.

More than 400 Aboriginal and Torres Strait Islander people have died in police custody since the end of the Royal Commission into Aboriginal Deaths in Custody in 1991. During that time, only a handful of cases have resulted in prosecution, the most high-profile of which was the prosecution of Chris Hurley for the death of Mulrunji Doomadgee on Palm Island in 2004 (more recently charges have been laid in relation to the shooting death of 19-year-old Kumanjayi Walker in Yeundemu in November 2019 and the shooting death of 29-year-old Joyce Clarke in September 2019).

One obstacle to prosecution in such deaths is a reticence on the part of those involved (including police or prison witnesses) to give full and frank accounts of what happened.

To understand how that occurs, it is necessary to understand the steps that are mandated in law where a death in custody occurs, for which we will take New South Wales as a fair example. All deaths in police or corrective services custody must be reported to the Coroner (*Coroners Act 2009* (NSW), s 35(1)(a) and *Crimes (Administration of Sentences) Act 1999* (NSW), s 74). New South Wales Police then conduct an investigation on behalf of the State Coroner in accordance with the obligations set out in the NSW Police Force Critical Incident Guiding Principles (The author has written elsewhere about the problems inherent in such arrangements, see: theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838). As part of that investigation, inter alia, police attempt to interview the individuals involved in the death. Having collated the evidence, police present it to the Coroner and when the Coroner is satisfied the brief is sufficient, an inquest is conducted. Two recent decisions: the *Inquest into the death of Rebecca Maher* (4 March 2019) ('***Maher***') and *Bell v Deputy Coroner of South Australia* [2020] SASC 59 ('***Bell***'), demonstrate the tensions that can arise between the State's entitlement (on behalf of the public) to examine contentious deaths via the Coronial process and the attempts by witnesses to refuse to answer questions that could lead to negative consequences.

Inquest into the death of Rebecca Maher (4 March 2019)

Ms Rebecca Maher was a 36-year-old Wiradjuri woman who died in a cell at the Maitland police station on 19 July 2016 after being taken into 'protective custody' by police. Because Ms Maher had not been arrested for an offence, police were not obligated to advise the Aboriginal Legal Service Custody Notification Service ('**CNS**') - the telephone assistance service that was implemented in response to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody (see *Inquest into the death of Rebecca Maher,* 5 July 2019 at [210] ('**July Findings**'). It is worth noting that the CNS is a potentially life-saving service. Since its inception, no First Nation person had died in police custody in New South Wales, that is until Ms Maher, and in her case, police failed to notify the service. Ms Maher died in a police cell of 'respiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit' (July Findings at [272]), about five hours after being detained. The Coroner ultimately found, inter alia, that: given her level of intoxication Ms Maher should have been taken directly to hospital (July Findings at [259]); the police's failure to call an ambulance was in breach of NSW Police policy (July Findings at [257](e)) and Ms Maher 'would have survived' if an ambulance had been called (July Findings at [257](d)).

Police reluctance to participate in interviews for the Coroner

During the coronial investigation into Ms Maher's death, four police officers were identified as 'involved officers' (officers thought to have contributed to the incident under investigation). Those officers were directed by Senior Police (pursuant to clause 8(1) of the *Police Regulation 2015* (NSW)) to participate in recorded interviews with coronial investigators. The officers did so after reading prepared statements to the effect that they were only participating in the interviews because of the direction and not 'of their own free will', that they objected to the interviews being provided to anyone outside the Police Force or being admitted into evidence in any inquest, and that they claimed 'derivative' immunity (see: *Inquest into the death of Rebecca Maher - Decision on inclusion of directed interviews in brief* at [6]-[7], published 4 March 2019) ('**March Findings**'). Prior to the commencement of the inquest, the officers objected to the use of the interviews on the basis that, inter alia, it would be 'unfair' (March Findings at [48]).

Acting State Coroner O'Sullivan rejected that submission. Her Honour noted that the combined statutory framework of the *Coroners Act 2009* (NSW), the *Police Act 1990* (NSW), and the *Police Regulation 2015* (NSW) (along with the Police Critical Incident Guidelines), sanctioned both the directions and consequent interviews. Consequently, there could be no unfairness in their use (March Findings and applying *DPP v Attallah* [2001] NSWCA 171).

The *Maher* finding is a welcome one for public accountability. The Coroner's ability to investigate the circumstances of a death in custody depends on both the ability of coronial investigators to interview witnesses and on the public examination of their evidence during the inquest process. The alternative fails to give sufficient weight to the interest of the public in holding accountable those who exercise executive power on their behalf.

Bell v Deputy Coroner of South Australia [2020] SASC 59 ('*Bell*').

A related question arose recently in South Australia in relation to the death in custody of Wayne 'Fella' Morrison who died three days after being restrained and placed face-down in a prison van in September 2016. Mr Morrison was a Wiradjuri, Kookatha and Wirrangu man, who was being held on remand whilst awaiting a court appearance by video-link.

The seven guards inside the prison van all objected to giving evidence on the basis that 'no meaningful questions could be answered without fear of the prison guards incriminating themselves' (www.abc.net.au/news/2018-12-05/guards-fight-giving-evidence-at-wayne-morrison-inquest/10585126). The Coroner found that the privilege against exposure to a civil penalty ('**penalty privilege**') was not available under the *Coroners Act 2003* (SA). That finding was challenged in the Supreme Court as constituting jurisdictional error. What the Supreme Court ultimately had to determine, inter alia, was whether the penalty privilege was available under the *Coroners Act 2003* (SA). In his judgment, Blue J noted that, whilst ultimately the question will be one of construing the appropriate statute, what is less clear is whether one starts from the proposition that penalty privilege does not apply in non-curial settings unless the subject Act recognises or creates it, or, the penalty privilege applies in non-curial proceedings unless the subject Act abrogates it by 'express provision or necessary intendment' (at [156] citing *Pyneboard Pty Ltd v Trade Practices Commission* (1983) 152 CLR 328. See also his Honour's discussion at [135]-[195]). Holding that any tension in the authorities should be resolved by the High Court (at [163]), Blue J adopted the latter approach in his analysis, holding the *Coroners Act 2003* (SA) did not abrogate the penalty privilege by 'an express provision or necessary intendment' and that it therefore applied (at [195]). One can compare this approach with the characterisation (in obiter) of the Federal Court in *Trade Practices Commission v Abbco Iceworks Pty Ltd* (1994) 52 FCR 96 where it said:

'[I]f penalty privilege is to apply in a non-curial setting, it must be found to do so from the language of the provisions in question. Such a finding must be found in the face of the view of a majority of the High Court in *Daniel's* doubting that penalty privilege ordinarily applies in a non-curial setting at all' (at [52]).

With respect, in the author's view, Blue J's decision may create significant difficulties for the office of the Coroner in South Australia and points to a need to clarify the *Coroners Act 2003* (SA) as to the availability of the penalty privilege. The *Coroners Act 2003* (SA) contains no reference to, or definition of, 'civil penalty'. Where that term has been interpreted in this context in other jurisdictions however it has been held to include 'orders disciplining police officers, such as financial penalties, reductions in rank and dismissal from office (*Police Service Board v Morris* (1985) 156 CLR 397 at 403 and 408' (as cited in *Wallers Coronial Law and Practice in New South Wales* [61.6])).

In almost every First Nation death in custody the author has been involved with, there have been breaches of internal policies that could ground some form of disciplinary proceedings. In those circumstances, the consequence of *Bell* is that:

(a) Witnesses can simply refuse to answer investigators' questions on the basis of penalty privilege*. Given inquests can take three years or longer before they even commence, witness recollections could degrade substantially and the families of those who have died will be faced with silence for that time; and

(b) Inquests could take much longer and be more complex. Given the potentially broad range of consequences that could fall within the undefined concept of 'penalty', inquests could become 'bogged' down in numerous objections, submissions and rulings on whether the penalty privilege applies (particu-

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larly where, generally, global objections to giving evidence in inquests are not available (see for example, *Accident Insurance Mutual Holdings Ltd v McFadden* (1993) 31 NSWLR 412; *Correll v AG (NSW)* (2007) 180 A Crim R 212). Any increase in the length and complexity of inquests should be avoided given the substantial delay already evident in the Coronial jurisdiction.

Indeed the work of the Coroner's Court in South Australia may well 'grind to a halt' as reportedly foreshadowed by Deputy Coroner Jayne Basheer in her first instance decision (at [194]). One hopes this does not occur, given the impact that the already substantial delays have upon First Nation families (see: theguardian.com/australia-news/2019/aug/25/why-does-it-take-so-long-the-desperate-wait-for-answers-after-a-death-in-custody). Moreover, obvious and critical questions arise about the utility of accountability mechanisms that can take years to identify misconduct by police and prison officers who will, in the interim, continue to be responsible for people in custody.

Police and prison officers are amongst those who represent the physical manifestation of the State's lawful and coercive force. Officers should be required to answer questions about how they exercise such force, particularly when someone has died in their custody. The Coroner's inquest is one of the ways in which those answers are sought.

Why it matters

The 1991 Royal Commission into Aboriginal Deaths in Custody ('**RCIADIC**') noted the importance of proper investigation of deaths in custody to ensure that such deaths occur in the 'common course of nature' and not 'by some unlawful violence or unreasonable hardship put on him by those under whose power he was while confined. There should not be given an opportunity for asserting that matters with regards to deaths in public institutions are "hushed up"' (Report on the death of John Pilot by Commissioner Wyvill, cited at [4.7.2] of RCIADIC, National Report, Vol 1, 4.7 Conclusion). Police and prison officers are amongst those who represent the physical manifestation of the State's lawful and coercive force. Officers should be required to answer questions about how they exercise such force, particularly when someone has died in their custody. The Coroner's inquest is one of the ways in which those answers are sought. An officer should not be entitled to refuse to provide answers because of a threat of a civil penalty such as termination of employment. In *The Police Service Board and Another v Russell John Morris/Robert Colin Martin* (1985) 156 CLR 397, Brennan J (in another context) referred in his judgment to 'the incompatibility of a claim of privilege with the duty of a police officer to reveal information acquired in the course of his duty'. In doing so he references the following extract from a United States judgment:

'Duty required them to answer. Privilege permitted them to refuse to answer. They chose to exercise the privilege, but the exercise of such privilege was wholly inconsistent with their duty as police officers. They claim that they had a constitutional right to refuse to answer under the circumstances, but ... they had no constitutional right to remain police officers in the face of their clear violation of the duty imposed upon them.' (*Christal v Police Commission of San Francisco* 92 P.2d 416 (1939), at p 419).

This is the nub of the issue and something that is often raised by First Nation families who acutely recognise the hypocrisy of that position. In this writer's view, a more appropriate balance of these competing interests lies in provisions such as ss 58 and 61 of the *Coroners Act 2009* (NSW) which preserve the ability of the Coroner to compel evidence from witnesses, but do so on the condition, inter alia, of the provision of a certificate that prohibits such evidence being used in any NSW court. The protection is not complete. It does not prohibit its use in non-judicial forums (for example, in relation to some disciplinary offences). Nonetheless, it can be obtained whilst protecting the witness from criminal prosecutions. In contrast, at least in South Australia, the *Bell* decision means that the privilege, if founded, can be claimed as a complete objection to providing evidence.

Conclusion

Notwithstanding the fact that none of those prison guards who were with Mr Morrison during his last moments are facing charges, the consequence of the *Bell* decision is that when the inquest resumes some three or more years after Mr Morrison's death, those officers will more easily be able to insist (at least substantially) on silence as a response to both the families and the Coroner's demand for answers. To allow prison or police officers to avoid admitting to serious breaches of policy in order to protect them from disciplinary proceedings does little to instil confidence that the State is serious about tackling First Nation deaths in custody. **LSJ**

*On a related note, it was reported on 16 June that the lead applicant in *Bell* intends to claim penalty privilege as a basis for refusing to answer any questions at the inquest when it resumes (mobile.abc.net.au/news/2020-06-16/wayne-morrison-prison-guards-refuse-to-answer-questions/12360414).