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Prisoners' Legal Service

UQ DEATHS IN CUSTODY PROJECT

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UQ Deaths in Custody

Project Report

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About the UQ Deaths in Custody Project

In 1991, the report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was published in response to the growing concern surrounding the number of Indigenous deaths in custody.

The University of Queensland Deaths in Custody Project was established in January 2016, almost 25 years after the publication of the Royal Commission report. Initially, it was formed to assist Sisters Inside, a community organisation that assists women in the criminal justice system, to keep a record of all deaths in custody. Our project now runs out of Prisoners' Legal Service (Qld).

Teams of UQ law students read and analyse all coroners' inquest reports that concern deaths in custody in Australia. Not all deaths in custody are publicly reported on, so the project is necessarily limited to deaths in custody for which a coroner's report is publicly available.[1]

1 Note also that the availability of findings from certain years differs between each State and Territory.

Death in Custody Definition

To ensure that the data remains consistent, the project adopted the definition of 'death in custody' that was used by the Royal Commission. 'Death in custody' is defined as a death wherever occurring of a person:

- who is in prison custody or police custody or detention as a juvenile;
- whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in custody;
- who dies or is fatally injured in the process of police or prison officers attempting to detain that person;
- who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.[2]

We include police operations for the purpose of preventing suicide where police are attempting to or are exercising a level of control over the person. We include these cases because it is sometimes difficult to ascertain whether the police were attempting to detain the person, or whether the person knew they were being pursued (and were attempting to escape).

We also include cases where coroners have classified the death as a 'death in custody'. However, we exclude cases where the person was on bail, parole, or home detention bail.

Scope and Limitations of the Project

This report analyses all coroners' inquest findings handed down between 1991 and 2023 where the death was classified as a death in custody (based on the definition above).[3]

Our data is solely retrieved from coroners' inquest findings that are made publicly available on the coroners' websites of each state. To ensure that our data is reliable, no sources of information outside of these reports are consulted.

Due to the differing rates of reporting between the coroners' offices in each State or Territory, there is no way for us to determine whether every finding for a given year has been made available.

2 *Royal Commission into Aboriginal Deaths in Custody* (Final Report, April 1991) vol 1, 4.5.45.
3 Database up to date as at 30 June 2023.

Deaths in Custody Data

As at 1 January 2024, our database included a total of 1059 cases, an increase of 445 cases since the publication of our last report in 2019.[4]

Table 1: Number of publicly available deaths in custody reports by date of finding (n=1059)

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
1991-1999	4	0	0	0	0	0	0	0	4
2000-2009	1	0	28	56	65	6	6	0	162
2010-2019	6	101	47	143	59	15	92	78	541
2020-2023	1	123	10	41	34	6	73	64	352
Total	12	224	85	240	158	27	171	142	1059

Of all reported deaths in custody, one-fifth were specified as involving an Indigenous person (20%, *n* = 210), less than one-fifth were specified as involving a non-Indigenous person (14%, *n* = 143), and approximately two-thirds (67%, *n* = 706) of reported deaths did not specify the Indigenous status of the deceased person. On 30 June 2023, Indigenous prisoners accounted for 33% of the prisoner population Australia-wide.[5]

Table 2: Indigenous, Non-Indigenous and Non-Specified prisoners by type of custody

	Indigenous	Non-Indigenous	Not Specified	TOTAL
Prison	132	104	447	**683**
Police cell	14	5	23	**42**
Police operation	49	29	211	**289**
Police station	3	1	4	**8**
Police vehicle	5	1	5	**11**
Courthouse	0	0	1	**1**
Juvenile detention	2	0	2	**4**
Hospital	0	1	5	**6**
Mental health facility	1	1	4	**6**
Other	4	1	2	**7**
Not Specified	0	0	2	**2**
TOTAL	**210**	**143**	**706**	**1059**

4 '2019 Project Report', *UQ Deaths in Custody Project* (Report, April 2020) <https://deaths-in-custody.project.uq.edu.au/docs/UQ_Deaths_in_Custody_Report_2019.pdf>.

5 Australian Bureau of Statistics, *Prisoners in Australia: 2023* (Catalogue No. 4517.0, 2024).

Deaths in custody most commonly occurred in prison (65% of deaths in custody, *n* = 687). The second most common type of custody was in the course of a police operation, accounting for 27% of deaths (*n* = 289).

Table 3: Type of custody by State/Territory

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
Police station; police vehicle; police cell; watch house	3 (25%)	7 (3%)	12 (14%)	18 (8%)	6 (4%)	1 (4%)	11 (6%)	4 (3%)	61 (6%)
Police operation	6 (50%)	54 (24%)	22 (26%)	76 (32%)	43 (27%)	6 (22%)	42 (25%)	40 (28%)	289 (27%)
Prison; youth detention	3 (25%)	159 (71%)	48 (56%)	145 (60%)	103 (65%)	18 (67%)	115 (67%)	96 (68%)	687 (65%)
Other (eg. mental health facility)	0	4 (2%)	3 (4%)	1 (0%)	6 (4%)	2 (7%)	3 (2%)	2 (1%)	22 (2%)
Total	12	224	85	240	158	27	171	142	1059

Table 4: Type of custody by Indigenous status

	Aboriginal and/or Torres Strait Islander	Not Aboriginal and/or Torres Strait Islander	Not specified
Police station; police vehicle; police cell; watch house	22 (10%)	7 (5%)	33 (5%)
Police operation	49 (23%)	29 (20%)	211 (30%)
Prison; youth detention	134 (64%)	104 (73%)	449 (64%)
Other (eg. mental health facility)	5 (2%)	3 (2%)	13 (2%)
Total	210 (100%)	143 (100%)	706 (100%)

Most prisoners who died in custody were over 25 years of age (88%). Around half had a pre-existing medical condition, and more than four in 10 were known to use drugs or alcohol. Close to 50% had been diagnosed with a mental health condition. Only 4% were female.

Table 5: Characteristics of deceased persons dataset, by State/Territory

	ACT (n=12)	NSW (n=224)	NT (n=85)	QLD (n=240)	SA (n=158)	TAS (n=27)	VIC (n=171)	WA (n=142)	Total
Aboriginal and/or Torres Strait Islander	8%	14%	75%	19%	11%	0%	8%	26%	20%
0-25 years of age	33%	13%	12%	12%	12%	22%	9%	8%	12%
Female	8%	2%	4%	5%	3%	0%	6%	8%	4%
Alcohol use	50%	26%	36%	34%	35%	37%	20%	39%	34%
Drug use	58%	46%	28%	43%	42%	30%	43%	55%	44%
Mental illness	58%	51%	22%	46%	46%	59%	50%	39%	45%
Medical condition	0%	49%	59%	50%	48%	44%	53%	65%	52%

Cause of Death

Overall, 'medical condition' accounted for the highest percentage all reported deaths in custody, 50% of the total number reported (*n* = 524). This was followed by suicide (23%, *n* = 248) and accident (12%, *n* = 131).

Medical condition was the most common cause of death across six of the states and territories: New South Wales (47%, *n* = 106), Queensland (49%, *n* = 118), Western Australia (58%, *n* = 82), South Australia (46%, *n* = 73), Northern Territory (59%, *n* = 50) and Victoria (49%, *n* = 84). In the remaining two states and territories, Australian Capital Territory and Tasmania, the leading cause of death was suicide (ACT: 42%, *n* = 5; TAS: 56%, *n* = 15).

Figure 1: Cause of death by State/Territory

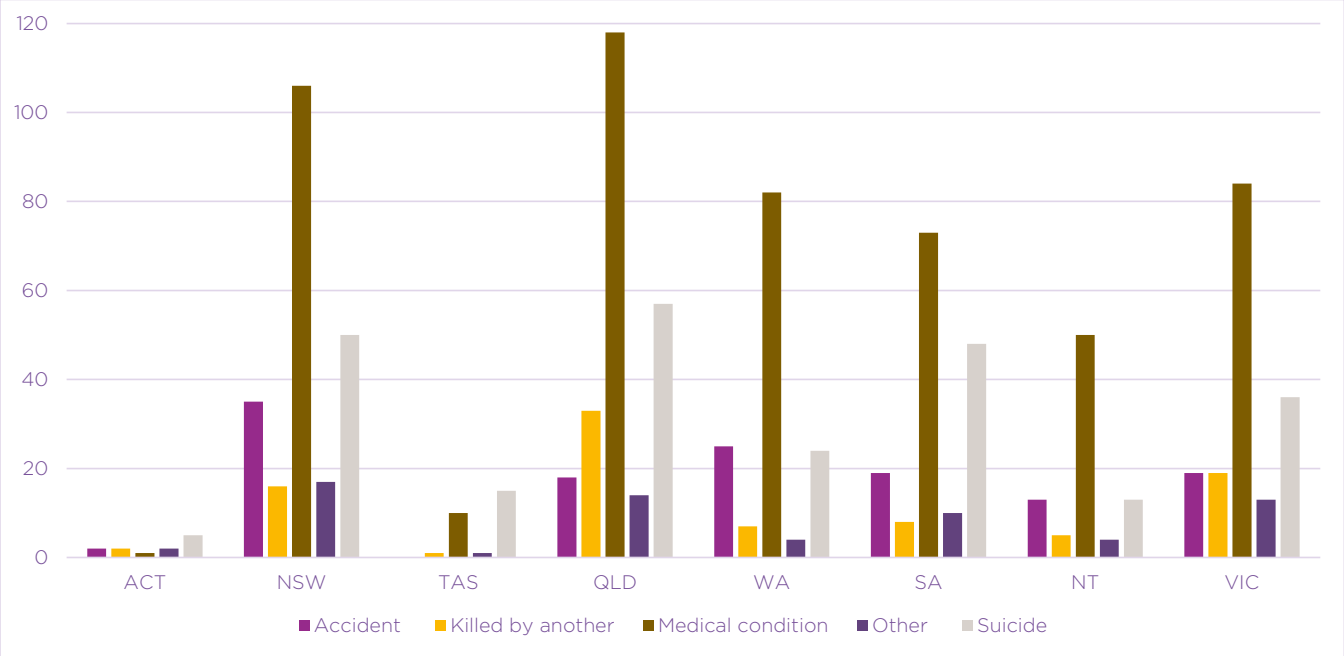


Figure 2: Percentage of cause of death across total data set

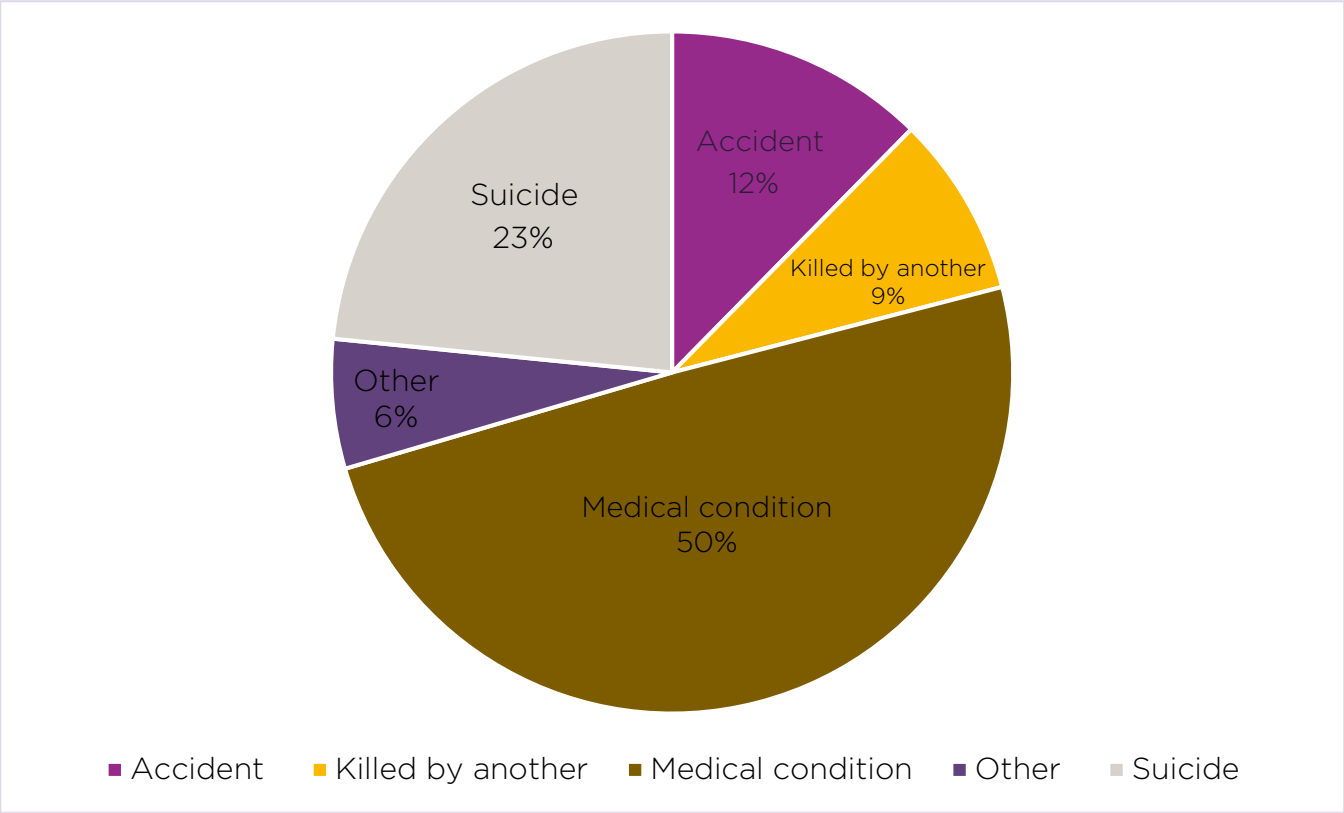
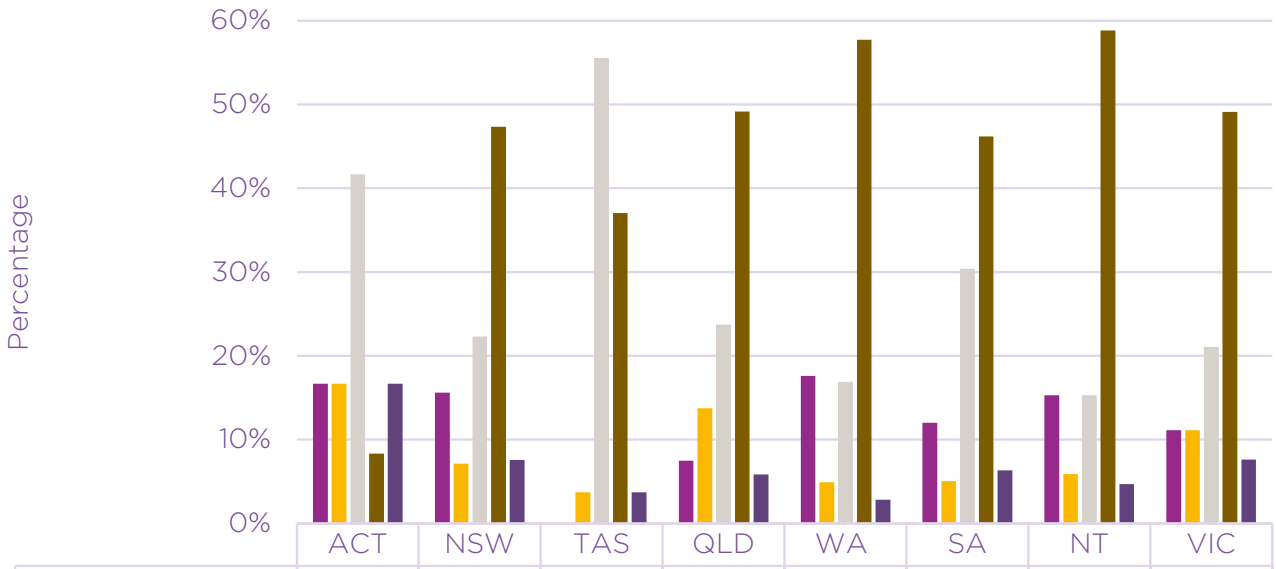
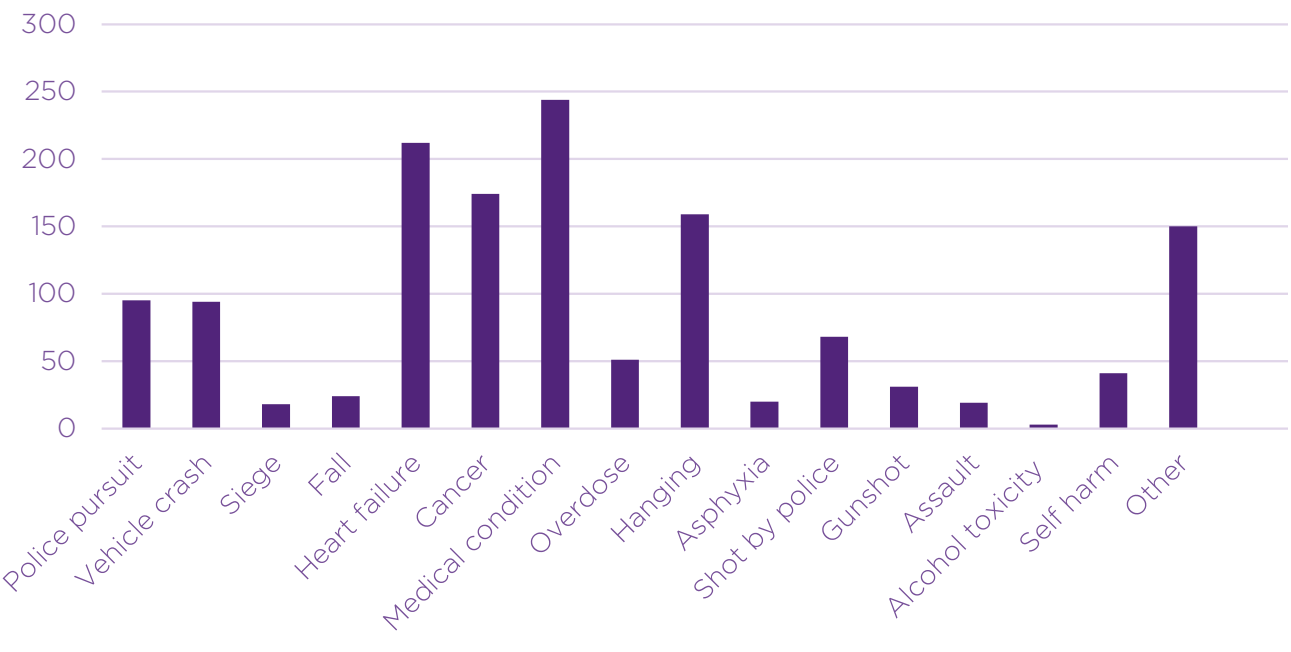


Figure 3: Percentage of cause of death by State/Territory



	ACT	NSW	TAS	QLD	WA	SA	NT	VIC
Accident	17%	16%	0%	8%	18%	12%	15%	11%
Killed by another	17%	7%	4%	14%	5%	5%	6%	11%
Suicide	42%	22%	56%	24%	17%	30%	15%	21%
Medical condition	8%	47%	37%	49%	58%	46%	59%	49%
Other	17%	8%	4%	6%	3%	6%	5%	8%

Figure 4: Frequency of specific cause of death across total data set



Coroners' Recommendations

The coroner made recommendations in just over one-third of all cases (37%, *n* = 395). No recommendations were made in 63% of cases (*n* = 664).

Overwhelmingly, coroners did not specify whether there had been reasonable medical care provided to the deceased (85%, *n* = 898). In cases where the coroner made recommendations and specified whether a reasonable standard of medical care was or was not attained (*n* = 69), there was a conclusion of unreasonable medical care reached in 74% of cases (*n* = 51) and reasonable medical care in 26% (*n* = 18).

Conversely, where no recommendations were made by the coroner, and standard of medical care was addressed (*n* = 92), medical care was considered reasonable 90% of the time (*n* = 83) and unreasonable in just 10% of cases (*n* = 9).

Table 6: Reasonable standard of medical care and whether recommendations were made

	Unreasonable	Reasonable	Not Specified	TOTAL
Recommendations	51	18	326	**395**
No recommendations	9	83	572	**664**
TOTAL	**60**	**101**	**898**	1059

Recent Research on Deaths in Custody in Australia

Of all the papers focusing on the issue of deaths in custody in Australia, a majority detail the issue of *Indigenous* deaths in custody. Several papers deal with women's death in custody (specifically, Indigenous women's death in custody), and one article reports on coronial attitudes and opinions on deaths in custody in general, touching on the topic of coroners' perspectives on Indigenous deaths in custody.

Gannoni and Bricknell, 'Indigenous deaths in custody: 30 years since the Royal Commission into Aboriginal Deaths in Custody'

A report published in 2021 by Alexandra Gannoni and Samantha Bricknell,[6] examines the trends and characteristics of Indigenous deaths in custody since 1991-92, using data obtained

6 Alexandra Gannoni and Samantha Bricknell, 'Indigenous deaths in custody: 30 years since the royal commission into Aboriginal deaths in custody' (2021) 13(2) *Australasian Policing* 12.

through the National Deaths in Custody Program database ('NDICP'). Its purpose is to provide a picture of trends and characteristics of Indigenous deaths in prison and police custody in the 30 years since the RCIADIC. It describes the circumstances of Indigenous deaths in custody now and how these compare to those reported on by the RCIADIC.

NDICP data is based on two sources: data provided by the state and territory police services and corrections departments, and the coronial records accessed through the National Coronial Information System ('NCIS'). The report draws data from deaths occurring in prison and police custody between the financial years of 1991-92 and 2015-16.

Gannoni and Bricknell's findings indicate that, between the years of 1991-92 and 2015-16, the death of Indigenous prisoners has been lower than that of non-Indigenous prisoners. The authors also found that, for each year from 1991-92 to 2002-03, the leading cause of death among Indigenous prisoners was either from natural causes or hanging. For each year from 2003-04 to 2015-16, deaths due to natural causes surpassed hanging deaths; this pattern was similar for non-Indigenous prison deaths. Furthermore, the number of Indigenous deaths in police custody each year was relatively small, and the authors found no clear trend over the reference period.

The authors noted that the absence of reliable data on the number of people placed in police custody/people who come into contact with police operations each year makes it difficult to calculate the precise rate of deaths in police custody.

Walsh, Alagappan and Cornwell, 'Coroners' Perspectives on Deaths in Custody in Australia'

A paper by Walsh, Alagappan and Cornwell reports on coroners' perspectives on deaths in custody, specifically (a) Indigenous deaths in custody (the role of racism in criminalisation and Indigenous identification); (b) repeated recommendations by coroners (and gaps in mental health care, unimplemented recommendations, and coroners' reluctance to repeat them); and (c) the coronial process itself.[7]

The authors found that most coroners did not think that race played a role in how Indigenous prisoners were treated, despite academic findings to the contrary. It was also found that Indigenous status is not always mentioned in natural cause deaths despite, once again, the finding that Indigenous status is relevant to these deaths.

Klippmark and Crawley, 'Justice for Ms Dhu: Accounting for Indigenous Deaths in Custody in Australia'

Another paper with a focus on Indigenous deaths in custody is 'Justice for Ms Dhu'.[8] This paper focuses on the death of Indigenous woman Ms Dhu and the coroner's inquest report that was released after her death. It examines themes such as: rates of imprisonment and

7 Tamara Walsh et al, 'Coroners' Perspectives on Deaths in Custody in Australia' (2022) 71 *International Journal of Law, Crime and Justice* 100558.

8 Pauline Klippmark and Karen Crawley, 'Justice for Ms Dhu' (2018) 27(6) *Social & Legal Studies* 695.

death for Indigenous women specifically (who suffer discrimination at the intersections of 'oppressive regimes of poverty, race, and gender'); the failure of both the police and healthcare professionals to properly look after Ms Dhu and discharge their duty of care (and the systematic issues in both fields that this is a symptom of); and the social justice movement that followed her death, including community activism (eg. projecting images of her and her grieving family onto prominent buildings in Perth).

The authors found that ongoing colonial-settler attitudes against Indigenous women contributed towards the death of Ms Dhu.

Walsh, 'Women Who Die in Custody: What Australian Coroners' Reports Tell Us'

The subject of women's deaths in custody (and Indigenous women's deaths in custody) was also explored by Professor Tamara Walsh in 'Women Who Die in Custody: What Australian Coroners' Reports Tell Us'.[9] This paper focused on the 34 coroners' reports that concerned people who identified as women dated between 1991 and 2020.

The paper found that there were various systemic and institutional issues within the prison system that contributed to these women's deaths, even in cases of 'natural causes' deaths or suicide, and that although individual risk factors contributed to the women's deaths, they were also subject to myriad systemic failures as a result of unconscious bias and prejudice. For example, women's medical and mental health complaints were often not taken seriously, and proper care was not taken of women who were incarcerated/in custody because they were considered 'drunks'. This was particularly true of Indigenous women, whom other studies have found are over-policed as perpetrators, and under-policed as victims.

Doherty and Bricknell, Deaths in Custody in Australia 2018-19

This quantitative analysis conducted by Laura Doherty and Samantha Bricknell examines the extent and nature of deaths occurring in prison and police custody (using the NDICP definition) and compares these findings to long-term trends.[10]

The report found that deaths in prison custody were the most common type of death in custody since the NDICP data collection began. The authors note the increase in prisoner population contributed to this. The authors report that there were 16 Indigenous deaths in prison custody, accounting for 18% of all deaths in prison custody in 2018-19. It was reported that the death rate of Indigenous prisoners was lower than the death rate of non-Indigenous prisoners nationally. The authors also found that in 2018-19 there were 24 deaths in police custody and in the course of police operations in Australia – four of the deceased were Indigenous.

9 Tamara Walsh, 'Women Who Die in Custody: What Australian Coroners' Reports Tell Us' (2022) 61(4) *Howard Journal of Crime and Justice* 540.

10 Laura Doherty and Samantha Bricknell, 'Deaths in Custody in Australia 2018-19 (extract)' (2021) 13(2) *Australasian Policing: A Journal of Professional Practice and Research* 33.

Deaths in Custody by Hanging

Suicide by hanging accounted for 15% of all recorded deaths in our dataset. This was the fourth highest specific cause of death, following medical condition (*n* = 244), heart failure (*n* = 212) and cancer (*n* = 174).

The Australian Institute of Criminology has reported that over 64% of the deaths in custody between 1980-2019 that were not related to natural causes were caused by a hanging.[11]

In 2018/19, of the 17 self-inflicted deaths in custody, 15 were by hanging and related complications.[12] Walsh reported that of the 34 coroners reports that concerned women, seven died by hanging.[13] Prison suicide has reached epidemic levels in the Western world and, globally, hanging is the preferred method of suicide for those who are incarcerated.[14] Yet, there is a gap in the literature regarding deaths by hanging.

Over many years, coroners have recommended the removal of hanging points from all cells.[15] Yet, this remains an ongoing concern. Often, claims are made that there is limited funding for this. In 2015, it was reported that 85% of secure cells in Queensland had been modified to implement safer cell measures.[16] However, there were still 340 cells across the state that remained in operation but were yet to have safer cell modifications in place; 268 of these unsafe cells were located at the Arthur Gorrie Correctional Centre.[17] In one 2021 case, the coroner recommended that the Queensland Government publish annual updates providing information around their strategy for the implementation of safer cell measures and updates as to their progress towards the completion of these upgrades.[18] As far as we can ascertain, this has not occurred.

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11 Deaths in Custody Australia, 2018-19, Table D13: Deaths in prison custody by cause of death, 1979–80 to 2018–19. The total number of deaths was 1880. Note that these numbers may vary to those provided in the UQDIC database due to differing definitions, potential resource availability and additional years considered by the AIC.

12 Doherty and Bricknell (n 9).

13 Walsh (n 8).

14 Rachael Sabrinskas et al, 'Suicide by Hanging: A Scoping Review' (2022) 31(2) *International Journal of Mental Health Nursing* 278.

15 Inquest into the death of David Morris (QLD000100), Inquest into the death of Adam Cartledge (QLD000101), Inquest into the death of Charles Hurst (QLD000129), Inquest into the death of Farrin Vetters (QLD000139), Inquest into the death of Scott O'Connor (QLD000145), Inquest into the death of Dane Sloan (QLD000167), Inquest into the death of Franky Houdini (QLD000174), Inquest into the death of Zachary Holstein (QLD000178), Inquest into the death of Colin Blair (QLD000191), Inquest into the death of Dylon Ahquee (QLD000212), Inquest into the death of SVE (QLD000213), Inquest into the death of Luke Cunningham (QLD000216), Inquest into John Harris (QLD000219), Inquest into the death of Frederick Row Row (QLD000221). This excludes three hangings that have occurred since Inquest into the death of Colin Blair (QLD000091) during police operations: Inquest into the death of Peter Sutcliffe (QLD000124), Inquest into the death of Matthew Richardson (QLD000134), Inquest into the death of Robert Turpin (QLD000164).

16 Department of Justice and Attorney-General, '*Inquests into the deaths of Christopher Steven Bell, Robert Gary Mitchell and Adam Cartledge*', (Web Page, n.d.) <https://www.justice.qld.gov.au/__data/assets/pdf_file/0010/452845/qgr-cartledge-a-20160114.pdf>.

17 Ibid.

18 Inquest into the Death of SVE (QLD000213). <https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/684729/cif-SVE-20210524.pdf p.21>

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