CORONERS COURT
OF QUEENSLAND
AT TOWNSVILLE

INQUEST INTO THE DEATH OF MULRUNJI ON PALM ISLAND ON 19 NOVEMBER 2004

Final submissions on behalf of the Palm Island Aboriginal Council

Attachment A – Précis of findings and comments

Section 45 findings

(1) A death has occurred: s 45(1).

(2) The person who died was Cameron Francis Doomadgee, referred to in these proceedings as Mulrunji: s 45(2)(a).

(3) The time of death was between 10.26am and 12.00pm on 19 November 2004: s 45(2)(c).

(4) Mulrunji died whilst in police custody, on the cement floor of Cell 2 of the former Palm Island watch house which was contained within the Palm Island police station: s 45(2)(d).

s 45(2)(e) "what caused" Mulrunji to die

(5) The death was the result of an intra-abdominal haemorrhage, which was a secondary consequence of a ruptured liver and hole in the portal vein.

(6) The fatal injuries were caused by a severe compressive and localised force applied to Mulrunji's abdomen whilst he was immobilised against a hard surface. They could not have been caused simply by a fall onto a flat surface.

s 45(2)(b) "how" Mulrunji died

(7) At approximately 10.20am the police vehicle reached the police station. Hurley moved Mulrunji from the paddy wagon into the station. Mulrunji resisted being taken into custody and continued to protest his arrest. Each struck at the other violently.

(8) Once Hurley got Mulrunji into the station there were further assaults inflicted upon Mulrunji by Hurley. During this interaction Mulrunji received the fatal injury in his abdominal region. The most likely explanation for such an injury is that a knee, elbow or a closed fist was used with considerable deliberate force by Hurley whilst Mulrunji was on the ground.

(9) Following this altercation, Mulrunji appeared lifeless and was unconscious.

(10) Hurley was the only person who had been involved in any physical interaction with Mulrunji from the point of arrest to when he was rendered unconscious.

Findings/comments pursuant to both ss 45(2)(e) and 46

The alleged offence

(11) Mulrunji's conduct leading up to his arrest did not constitute a public nuisance offence.

The arrest

(12) Mulrunji's arrest was not lawful (i.e. does not fall within s 198 of the *Police Powers and Responsibilities Act 2000* ('PPRA')).

(13) Mulrunji's arrest was also inappropriate, in all of the circumstances. He should not have been taken into police custody. Senior Sergeant Hurley should have pursued one of the several available alternatives to arrest, even if he did hold the view that a public nuisance offence had been committed.

(14) Hurley forcibly placed Mulrunji into a caged section in the rear of a police vehicle and transported him to the police station.

(15) Mulrunji protested against and resisted being arrested.

Section 46 comments

The alleged offence and arrest

(16) Senior Sergeant Hurley and other police officers on Palm Island were clearly not aware of the elements of a public nuisance offence nor did they have any proper regard for prosecutorial discretion or the statutory requirements for an arrest to be lawful.

(17) It is recommended that the Queensland legislature and the QPS look at legislative, guideline, or educational-based ways to address this.

(18) The relevant PPRA provisions (ss 198, 210, 214) are not sufficient. Section 198 in particular, does not sufficiently direct the arrest discretion. To prevent deaths from happening in similar circumstances in the future (particularly to prevent future deaths in custody in indigenous communities where alternatives to arrest are available) the Queensland legislature ought to review and amend the PPRA:

- To require police officers to first consider alternatives to arrest. HREOC's suggested amendment to s 198 to require the officer to reasonably believe that no action other than arrest would be appropriate in the circumstances, is one measure to be taken.

- To enshrine the principle of arrest as a last resort. The Council again supports HREOC's suggestion that the PPRA Act be amended to include a specific statutory duty to consider and utilise alternatives to arrest and detention. The Council would submit that legislative provisions similar to those contained within the *Juvenile Justice Act* might be considered.

- Such amendments should have regard to relevant RCIADIC findings.

(19) The amendments should be coupled with relevant additions to the QPS OPMs.

(20) The QPS Commissioner should consider how to ensure that police officers are fully informed about the availability and intent of legislated diversionary strategies, and should encourage the appropriate exercise of that discretion through further training, particularly for officers working in indigenous communities.

(21) The comments urged by HREOC numbered from C11 to C14 regarding the consideration and consultation with the Palm Island community regarding an appropriate and community-based diversionary centre, and funding and training for the establishment and maintenance of such a centre are respectfully adopted by the Council.

Care in custody

(22) Mulrunji's body was dragged by Hurley and another police officer Sergeant Leafe into Cell 2 and left lying on the cement floor. Another unconscious person was placed into the cell and the cell door was locked.

(23) Mulrunji was not medically examined or assessed or physically searched prior to being placed in the cell, contrary to the OPMs. There was no reasonable excuse for this.

(24) Once lodged in the cell, Mulrunji's health and well-being were effectively ignored. The monitoring that did take place was grossly inadequate. Again, there was no valid explanation for this.

(25) Mulrunji called out for 'help' whilst in the cell but this was either unheard or unheeded by the police in the station.

(26) Mulrunji died, enduring considerable pain, within an hour or so of being placed in the cell.

(27) It is recommended that the QPS Commissioner/Police Minister consider allocation of resources, amendments to the OPMs and policy (including in line with those recommended by Dr Wells), and improved medical training for police officers with watch house duties, with a view to improving the care and assessment of the health needs of intoxicated or apparently unconscious persons in police custody. In particular, for example:

- To require mandatory minimum standards of medical training and as to the use of monitoring technologies for officers with watch house duties.
- To provide education as to the particular issues pertaining to indigenous incarceration.
- To strengthen the direction that health must be properly assessed, and if not possible, mandatory requirements to seek and obtain medical assistance immediately.
- To provide practical assistance as to the features required to be assessed in order to distinguish between intoxication and the effects of more serious medical conditions.
- To require that checks be made at least at half-hourly intervals, but with a preference for continuous monitoring capacity.
- To ensure that no person is left unattended in the watch house for any period of time.

(28) The conditions under which Mulrunji was detained and died were appalling. The design of cells in all future watch houses ought to include beds and basic facilities. The QPS should audit all existing watch houses and retrofit beds and basic facilities across the State.

(29) It is recommended that the QPS Commissioner ensure that the design, structure and technology used in the new Palm Island watch house (and indeed all new watch houses in indigenous communities) be such as to increase monitoring capabilities. In particular:

- Audio and video surveillance which cannot be interfered with by operators such as to be rendered useless.
- To permit communication between persons inside the cells and community and family members outside.

The investigation into Mulrunji's death

Notification of the family

(30) The protection of police interests determined the decisions made regarding notification of the family of the death over and above the dictates of RCIADIC recommendations, the OPMs or even the obligation to show basic decency to the family.

(31) Hurley's actions in misleading the family were unethical and capable of amounting to misconduct. Webber's responsibility for ensuring that notification to the family occurred in a timely way was not discharged.

(32) A formal apology ought to be made to the family by the QPS.

(33) It is recommended that the QPS Commissioner investigate how this issue might be addressed in the future, via reinforcement of the OPMs and education of officers.

Appointment of investigators

(34) The involvement of officers from Townsville and Palm Island in this investigation was wrong. It was not logistically necessary. The involvement of close friends and colleagues of Hurley in this investigation was completely unacceptable. In the result, important principles of independence and transparency required to meet community expectations of investigations into police conduct and deaths in custody, were not met.

(35) To the extent that it might be argued that the appointment of these investigators was made in compliance with the OPMs; those requirements are insufficient. The OPMs ought to be amended as follows:

- To implement the RCIADIC recommendation that officers of a Commissioner or Assistant Commissioner level appoint the investigators for deaths in custody investigations.

- To require that investigators be from a separate "region" from that of the officers who are involved in any death in custody, rather than the current requirement that they be from another "police establishment".

- To explicitly require that when considering appointments of investigators into deaths in custody, impartiality and the appearance of impartiality of the investigation must be given priority.

- To require disclosure of any relationship between investigators and police officers involved in, or a witness to, the death.

(36) The Minister for Justice and Attorney General, as minister responsible for the CMC should consider legislative changes requiring the QPS to inform the CMC, and for the CMC to be actively involved and directing all investigations into deaths in custody from the outset.

The investigation

(37) The Police Minister and QPS Commissioner ought to consider amending the OPMs to include the RCIADIC recommendation that all deaths in custody be considered and investigated as homicides. The 'sliding scale' currently set out in the OPMs – including that officers ought "not presume suicide or natural death regardless of whether it may appear likely" – is clearly not sufficient and easily worked around. QPS investigators did not in fact treat this matter as a serious investigation at all.

(38) The steps taken in the QPS investigation into Mulrunji's death up until the point of CMC involvement did not meet the standards required of them. There were a number of decisions made in the course of the investigation which were unacceptable and favoured and sought to protect the interests of Hurley over the integrity of the investigation.

(39) Not only was the investigation therefore objectively unable to be perceived by the community as impartial, but the evidence discovered and the flaws in the investigation undertaken permit a finding that it in fact was a biased and inadequate investigation by any standard.

(40) The OPMs should be amended to explicitly require, in the conduct of investigations, that impartiality and the appearance of impartiality must be given paramount regard.

(41) The QPS Commissioner should review what further training or education is necessary to ensure compliance with the OPMs in the investigation of deaths in custody and consider what effective sanctions are necessary to ensure compliance.

(42) Police witnesses to the death of Mulrunji impermissibly spoke with each other about their accounts before their interviews with investigators. This was contrary to the OPMs. However this was not investigated or of any real concern to the investigators or their superiors.

(43) The OPM should be amended to ensure the integrity of accounts given by directing that no witness in respect of a death in custody discuss the matter with any other witness before providing an account to investigators.

(44) Police witnesses, including Hurley, unacceptably communicated and socialised with the investigators whilst: at the airport, driving around the community and on the evening of the death, which included the consumption of food and alcohol together. This was clearly unacceptable and capable of leading to reasonable perceptions of bias.

(45) It is open to find that Hurley was informed by one of the investigators of the content of Roy Bramwell's account, before he participated in his second interview. This is clearly unacceptable and ought to be further investigated by the CMC.

(46) Detective Kitching's conduct in not informing the pathologist conducting the autopsy of the allegation of an intentional assault was unreasonable and probably intentional. It is capable of amounting to professional misconduct.

(47) The Minister for Police and the QPS Commissioner should consider amendments to the current Form 1 procedure and OPMs, perhaps in line with the suggested forms being developed by Dr Ranson's institution, to ensure that *all* relevant information is provided to pathologists in the investigation of a death, particularly, a death in custody.

(48) There is a widespread lack of appreciation within the QPS surrounding the need for independent and effective investigations into indigenous deaths in custody.

(49) It is recommended that the CMC should undertake research, pursuant to its functions in section 52 of the *Crime and Misconduct Act 2001* (and particularly in the interests of achieving continuous improvement of the police service), into the culture of self protection, protection of other police and police interests, which has been demonstrated in this investigation, to establish whether it is an indication of a return to the pre-Fitzgerald culture within the police service and if so, what should be done to halt this trend.

Policing on Palm Island

(50) The Council would respectfully join in with HREOC's suggested comment C9, that particular attention ought to be given by the Police Commissioner to the training requirements of officers working in remote indigenous communities, and its reference to the type of experiential/recreational training utilised in the Kowanyama trial considered by the *Cape York Justice Study*.

(51) The Council also supports a comment that community policing models most suitable for the Palm Island community ought to be explored and funded.

(52) However, such initiatives need to be coupled with a broader practical review of policing on Palm Island. It is recommended that a task force be established, for 'negotiation' to occur between the QPS and the Palm Island community in this regard, involving the CMC, senior police, serving police officers on the Island, community and State and Federal Government representatives. Such an initiative must provide for the effective participation and involvement of Palm Island community leaders. Specific matters for this taskforce to negotiate include:

- The recruitment and induction processes for police
- The content of required training initiatives
- The prosecution of street and language offences
- Alternatives to arrest and watch house detention
- The establishment and operation of drug and alcohol diversion and rehabilitation programs
- Conditions in and monitoring of people in watch house detention
- The role if any of police liaison officers from the community
- The role if any of a Community Justice Group
- The training and appointment of indigenous police officers from the Palm Island community

- Increasing civilian community involvement in diversion from criminal prosecution via community-policing or patrol models
- Community relations programs to seek to improve police/community relations
- Complaint and investigation procedures in respect of alleged police misconduct on the Island.
- Access to legal advice by community residents

These negotiations and consultations may require the investment of significant financial resources by government agencies.

(53) Any initiatives put into place should only be done after effective community consultation and with commitment, through the provision of information, funding, training and resources by government for the establishment and maintenance of agreed programs.

(54) It is recommended that the QPS Commissioner and Police Minister put into place a transparent, independent process of investigation in respect of any serious allegation of police misconduct on Palm Island. The CMC should be asked to assist in the formulation of this system and in the education of police and the community as to how the system will operate.

(55) It is further recommended that the QPS Commissioner should review measures of supervision and accountability for police officers serving on Palm Island.

(56) There is a significant hiatus between published QPS policy objectives and what in fact is implemented on Palm Island. These matters bear further examination.

(57) It is recommended that the Minister for Justice and Attorney-General commission a broader-scale and independent Commission of Inquiry to be held into policing on Palm Island.