IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6424

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of:	TANYA LOUISE DAY
Delivered On:	9 April 2020
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	26, 27, 28, 29, 30 August 2019 2, 3, 4, 5, 6, 10, 11, 12, 13 September 2019 11 November 2019
Findings of:	Caitlin English, Deputy State Coroner
Counsel Assisting:	Catherine Fitzgerald
In House Legal Solicitor:	Jo Wilson & Nicholas Ngai
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Counsel for V/Line:	Ben Ihles Instructed by Kristy Brockwell, Minter Ellison
Counsel for Victoria Police:	Rachel Ellyard Instructed by Katherine Goldberg, Norton Rose Fulbright
Counsel for Ambulance Victoria:	Robyn Kaye Instructed by Fiona Karmouche & Jane Fiske, Lander & Rogers Lawyers
Counsel for Lisa Harrup:	Anna Robertson Instructed by Sophie Pennington & Genevieve Bolton, HWL Ebsworth Lawyers
Counsel for Scott Riley:	Marion Isobel Krystyna Grinberg Instructed by Laura D'Amico & Jacinta Gibbs, Victorian Government Solicitor's Office
Counsel for Sarah Holland and Emma Matheson:	Megan Fitzgerald Instructed by Hannah Jankiewicz & Claire Bassili, K&L Gates
Counsel for the Victoria Equal Opportunity and Human Rights Commission:	Kylie Evans Instructed by Tal Schmerling, Victorian Equal Opportunity and Human Rights Commission

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INTRODUCTION

1. I acknowledge the traditional owners of the land where the Coroners Court sits, the Wiradjuri people of the Kulin nation, and I pay my respects to their elders, past and present.

2. Tanya Day was a Yorta Yorta woman who died at St Vincent's Hospital on 22 December 2017, following a fall in custody at the Castlemaine police station. She was 55 years old.

3. On 5 December 2017 Ms Day was travelling from her home in Echuca to Melbourne. Whilst on the train from Bendigo, she was arrested by police for being drunk in a public place, removed by police from the train at Castlemaine train station and taken into custody in a cell at the Castlemaine police station. Following a fall whilst in the cell, she was transported by Ambulance to the Bendigo Hospital, then airlifted to St Vincent's Hospital in Melbourne.

4. Ms Day commenced her journey that day at the Echuca railway station where she purchased a ticket to travel to Melbourne. She boarded a bus to Bendigo which arrived at 2.15pm at Bendigo railway station. She then boarded the 2.40pm train to Melbourne.

5. Shortly after departure from the station, the train conductor started checking passengers for tickets. He found Ms Day lying on the seat with her feet across the aisle way. He asked for her ticket and destination and she responded with unrelated statements. The conductor contacted the train driver to request Centrol to contact Victoria Police.

   The basis upon which the conductor made this decision and action taken were subject to examination at inquest.

6. At 3.05pm the train stopped at Castlemaine Railway Station and the conductor left the train to wait for the police. At 3.10pm the two police officers arrived and were directed by the conductor to where Ms Day was in the train.

7. The two police officers entered the train carriage and saw Ms Day who appeared to be asleep. She was awoken, and she sat up and they could smell alcohol. Her replies made no sense. Ms Day was arrested and removed from the train.

   The basis upon which the two police officers made this decision to arrest and remove Ms Day from the train and subsequent actions were subject to examination at inquest.

8. On the train platform police sought information from Ms Day, such as her name and family contacts. She was able to tell police her name and handed over her bank card.

9. Whilst the police officers were attempting to establish Ms Day's identity, two further police officers arrived in a divisional van. Further inquiries were made with police communications using the police radio. At the same time the police officers looked in Ms Day's bag and saw what appeared to be a bottle of spirits in a brown paper bag and a bottle of wine under some clothing. One of the police officers obtained the mobile number for a Tanya Day residing in Echuca and after calling that number they established her identity.

   The inquiries made and decision to take Ms Day to the Castlemaine police station by the police officers at the Castlemaine train station were subject to examination at Inquest.

10. At 3.30pm Ms Day walked unaided to the rear of the police divisional van. Around the same time she unlocked her phone and one of the police officers accessed two numbers which he passed on to another officer.

11. A police officer telephoned Ms Day's daughter, Kimberly Watson, advising her Ms Day had been found asleep on the train and asking if she could collect her. Ms Watson indicated she would call another person to see if they could collect her.

    When this telephone call was made was the subject of examination at inquest.

12. Ms Day was taken to Castlemaine police station in the divisional van. From the Castlemaine police station sally port Ms Day walked unaided along a corridor to the custody counter.

13. Ms Day's attendance was entered manually into the attendance module by the watch housekeeper. The sergeant conducted a welfare check and a detainee risk assessment.

    The decision to place Ms Day in a cell was subject to examination at inquest.

14. At the same time a police officer called the Aboriginal Community Justice Panel (ACJP) and asked the ACJP contact if someone could collect Ms Day. The ACJP was not able to send someone to collect Ms Day. The police officer asked whether further efforts could be made to contact someone who knew Ms Day, and he would do the same. He called ACJP back 20 minutes later but there was no answer.

The contents of this telephone call and the decisions made by ACJP staff was subject to examination at inquest.

15. At 3.56pm Ms Day was taken to holding room one (the cell) by the Sergeant. She lay on the concrete bed whilst police officers organised some bedding. She stood up and a pat down search was conducted whilst the bedding was put in place. Ms Day then lay back down and covered herself with a blanket. Police left the cell at 3.59pm.

16. The police officer who was the nominated informant completed a penalty notice for Ms Day for the offence of drunk in a public place and, together with the form indicating contact with the ACJP, placed them in the Sergeant's tray.

17. At 4pm the watch housekeeper entered Ms Day on the custody module and the Sergeant requested that Ms Day be observed every 20 minutes. At some point the Sergeant and the watch housekeeper agreed to vary the observations from 20 to 40 minutes, requiring a verbal response every second check. Castlemaine police station was short staffed and the watch housekeeper did not have an assistant.

18. Level 3 observations[1] is the minimum level for detainees who are affected by drugs or alcohol or have been assessed by a medical practitioner as presenting with physical or mental health risks. Detainees are to be physically checked and roused at least every 30 minutes, and CCTV can be used in addition to physical checks and the detainee is to be actively engaged during every physical check.

    The decision to place Ms Day in the cell and the decisions made about the level/frequency of observations were subject to examination at inquest.

19. At 4.19pm the watch housekeeper received a call from Ms Day's daughter, Belinda Stevens, who informed him the family would not be able to attend to collect Ms Day.

20. At 4.20pm[2] Ms Day stood up and walked to the cell door. She tried to open the door but stumbled back to bed. She went to sit on the end of the bed but fell off as the mattress had moved. She hit the back of her head when she fell. The fall was minor, and she lay back on the bed. This was not seen by the watch housekeeper as around the same time he was on the phone to Belinda Stevens.

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[1] Coronial Brief (CB) 231 Victorian Police Manual Guidelines Safe Management of Persons in Police Care or Custody. Level 3 is defined at section 8.3.

[2] The times referred to and descriptions of Ms Day's movements in the cell in paragraphs [20-36] are taken from the summary prepared by the Coroner's Investigator in the CB 1-18.

21. At 4.44pm Ms Day stood up, she stumbled back and hit the back of her right shoulder on the wall. The impact was low. She then lay back down on the bed.

22. At 4.49pm the watch housekeeper and another police officer went to the cell. The watch housekeeper looked through the window. The CCTV footage shows Ms Day lying on the bed on her left side facing the cell door. She moved her head and rubbed the side of her face with her left hand.

23. At 4.50pm Ms Day stood up and walked away from the bed. She then stumbled back, fell forward and hit her forehead hard on the wall. She tried to sit up, but her right arm would not support her. She sat up briefly then fell to her right side and appeared to hit the right side of her head. She sat, then lay down and rubbed her head. This fall was not seen by the watch housekeeper. He was walking to the custody counter to enter the details of the check he had just conducted. At 4.51pm the watch housekeeper recorded in the custody observation record that he assessed Ms Day as Level 3 Observations, and that he had received a verbal response from her.

24. At 5.03pm Ms Day sat up. She lost her balance from sitting position but righted herself. She hit the back of her head on the wall as she lowered herself. This does not appear to have been observed by the watch housekeeper.

25. At 5.07pm she sat up and again fell in the same manner, she did not hit her head, this too was unwitnessed.

26. At 5.12pm the watch housekeeper viewed Ms Day on the monitor and noted in the custody observation record that she was moving on the bench in the cell.

27. At 5.23pm the watch housekeeper received a call from Shane Day, Ms Day's brother, stating he was not coming to collect Ms Day. At this point the CCTV shows Ms Day attempting to sit up with difficulty.

28. At 5.33pm the watch housekeeper attended the cell and looked through the window. At 5.35pm he made an entry on the custody observation record that he had checked Ms Day and that she had provided a verbal response.

29. Between 5.40pm and 5.48pm the CCTV footage shows Ms Day trying to sit up several times. Her right arm appears limp and is behind her back. It appears she is unable to move it from this position and she is having difficulty sitting up without the use of the arm.

30. At 5.56pm the watch housekeeper viewed Ms Day on the monitor. On the custody observation record he noted he checked Ms Day on the monitor and that she was moving around freely. Between 5.54pm and 5.55pm the CCTV shows Ms Day on her back on the bed with her legs hanging off the side and the blanket on the floor. She moves her left leg and arm.

31. At 6.15pm the watch housekeeper viewed Ms Day on the monitor. He noted on the custody observation record that he had checked her on the monitor, and she was moving on the cell bench. The CCTV footage between 6.12pm and 6.15pm shows Ms Day on the bench with her legs hanging off the side. She is moving on the bench and the blanket is on her.

32. At 6.38pm Ms Day rolled off the bench and landed on her back on the floor. She remained there, lifting her head trying to pull the blanket over herself.

33. At 6.42pm the watch housekeeper went to the cell and looked through the window. Ms Day was lying on her back on the floor with the blanket covering her body and face. At 6.43pm he noted in the custody observation record he assessed her as Level 3 and recorded that he had received a verbal response from her.

34. Ms Day remained on the floor of the cell. The CCTV footage shows her moving trying to sit up. She does not seem to have control over her left arm.

35. At 7.28pm the watch housekeeper viewed Ms Day on the monitor. He noted on the custody module record she was sleeping on the floor and moving about freely.

    The CCTV footage and the custody observation records were subject to examination at inquest.

36. At 8.03 pm the Sergeant and watch housekeeper went to the cell to assess Ms Day with a view to discharging her following the elapse of four hours.

37. They entered the cell and found her on the floor. They placed the mattresses back in position on the bench and lifted Ms Day onto the bed.

38. Ms Day was able to answer some questions coherently but to others she simply groaned. They noticed a small oval shaped bruise on her forehead that was not present when she arrived at the police station.

    The quality of observations made by the watch housekeeper, the entries about the observations in the custody module and compliance with the Victoria Police Manual

Rules and Guidelines and Castlemaine police station Standard Operating Procedures regarding observations and monitoring were subject to examination at inquest.

39. At 8.04pm the police officers left the cell and at 8.05pm the watch housekeeper called emergency services and requested the attendance of Ambulance Victoria.

40. At 8.12pm the Sergeant recorded in the custody observation record that she assessed Ms Day at observation Level 3 and that she had told Ms Day that Joe Day was on his way from Echuca to collect her. She also noted she observed the bruise on her forehead, that she was verbally responsive but wanting the sleep and that an ambulance had been requested.

41. At 8.17pm the Sergeant and watch housekeeper returned to the cell. The watch housekeeper pulled the blanket back and Ms Day pulled the blanket with her left hand. They took a closer look at her forehead and both left the cell at 8.19pm.

    The observations made of Ms Day by the two police officers in the cell and the information given by the watch housekeeper to the sergeant and to emergency services were subject to examination at inquest.

42. At 8.17pm an Ambulance Victoria paramedic officer arrived at the police station and she was shown to cell at 8.21pm where she assessed Ms Day. She determined Ms Day needed to be taken to hospital.

    The information given by the watch housekeeper to the ambulance paramedic and the assessment of Ms Day made by the ambulance paramedic was subject to examination at inquest.

43. At 8.47pm two other ambulance paramedics attended. Ms Day was placed on the stretcher and taken from the cell at 8.54pm. She was transported to Bendigo Hospital and arrived at 9.48pm.

    The information given to them by the watch housekeeper and first paramedic and observations made by the two paramedics was subject to examination at inquest.

44. The initial imaging of Ms Day at Bendigo Hospital showed a large 7.7 x 5.2 cm cerebral bleed involving the temporal, frontal and parietal lobes.

45. At 3.25am on 6 December 2017 Ms Day was transferred to St Vincent's Hospital in a critical condition. She underwent a craniotomy and surgical evacuation of the haematoma. She had ongoing supportive measures in the Intensive Care Unit but had a

very poor neurological recovery with a poor prognosis. She was subsequently extubated on 17 December 2017 and died at 12.40am on 22 December 2017.

Expert evidence from the forensic pathologist and expert neurosurgeon regarding the timeliness and appropriateness of medical treatment, Ms Day's prospects for survival and the cause of her death were subject to examination at the inquest.

THE CORONIAL INVESTIGATION

46. Ms Day's death was reported to the Coroners Court as it fell within the definition of a reportable death in section 4 of the *Coroners Act* 2008 (the Act) both because she was in a person in police custody and her death appeared to be the result of accident or injury.

Explanation of coronial investigation

47. The role of the coroner is to independently investigate reportable deaths to find, if possible, identity, cause of death and the circumstances in which the death occurred. Circumstances are limited to events which are sufficiently proximate and causally related to the death.

48. Another important function of the coroner is to reduce the number of preventable deaths, and the coroner can make comments and recommendations connected with the death, including matters relating to public health and safety or the administration of justice.

49. In examining the circumstances, the coroner makes factual findings about what happened. It is not the role of the coroner to lay legal or moral blame. The coroner's role is to determine causal factors and identify any systemic failures with a view to preventing deaths from occurring in similar circumstances in the future.

50. In considering whether Ms Day's death was preventable, I refer to the *Preamble* of the Act which couples the role of the coroner in the independent investigation of deaths '*... for the purpose of finding the causes of those deaths...and to contribute to the reduction of the number of preventable deaths ...*'

51. The Act specifically prohibits a coroner from including in a finding or comment any statement that a person is, or may be, guilty of an offence. The coroner does not make a determination of guilt or negligence. However, if a coroner believes that an indictable

offence may have been committed in connection with the death, the court is obliged to notify the Director of Public Prosecutions of this.[3]

52. This inquest has examined the conduct of V line staff, police members and ambulance officers to determine whether their actions were within or short of reasonable or expected standards. In assessing those actions, I have had regard to the existing standards of the profession or the organisation as indicated through procedures and policies as well as an expert opinion regarding Ms Day's medical management.

The position of persons in custody or care

53. As Ms Day was, *immediately before death, a person placed in custody or care*, pursuant to section 52(2)(b) of the Act an inquest into her death is mandatory.

54. Section 3 *person placed in custody or care* (k) of the Act defines a person in custody to include a person in Victoria who is dying from an injury incurred while in the custody of the State.

55. The deaths of people in custody or care are reportable to the coroner regardless of their cause. Further, where the coroner usually has discretion as to whether to hold an inquest, a coroner is required to hold an inquest into the death of a person in custody or care, unless the death was due to natural causes.

56. This requirement ensures the independent scrutiny of the circumstances surrounding the deaths of persons for whom the State has assumed responsibility, whether by reason of an inability to care for themselves, or such as in this case, where the State has deprived them of their liberty, or some other reason.

57. It was noted in the Royal Commission into Aboriginal Deaths in Custody:

'[The] criterion acknowledges the fact that a person held in care by a State agency is owed a special obligation. A duty of care arises where public authority has been exercised to assume control over a person's life. Not only are persons in custody deprived of their liberty, they are deprived of the ability and resources to care for themselves. Where a death ensues, it is a matter of great public importance that the circumstances of death should be thoroughly reviewed to ensure this duty of care has been adequately discharged.

[3] See sections 49 and 69(2) *Coroners Act* 2008.

Moreover, this rationale is not ultimately dependent on the place where death occurs: nor is it limited to circumstances where a person is actually confined or held in custody. In the ultimate analysis the proper performance of the duty of care turns on the exercise of powers held by custodial officers.

The essential quality which attracts the public interest in reviewing the circumstances of death is the exercise of powers conferred on officers entrusted with a public duty. Such powers may or may not be used to ensure that prompt medical attention is provided to a sick prisoner. The exercise of such powers may also manifest as the use of fatal force to effect an arrest. In both cases it is imperative to review the use of powers conferred by the State to ensure that they have been exercised in a reasonable, justifiable way and have not been abused.'[4]

58. Prisoners deaths are also reviewed by the Justice Assurance and Review Office (JARO), which is part of the Department of Justice and Community Safety (DJCS) and reports to the Secretary of the Department as the person with responsibility for the monitoring of all correctional services to achieve the safe custody and welfare of prisoners and offenders. In preparing a report, the JARO usually also has regard to a separate report prepared by another business unit of the DJCS, namely Justice Health. Justice Health has responsibility for the delivery of health services (including drug and alcohol services) to Victoria's prisoners.

59. In Ms Day's case, as she was detained for being drunk in a public place and was detained in a police cell, not in a prison, and not on remand or a sentenced prisoner, neither a JARO nor a Justice Health review were conducted.

60. In custodial deaths the importance of an independent investigation is reflected by the fact that what goes on inside a jail or police cell is hidden public view, and after a death, very frequently, the only witnesses are custodial officers:

'*The issues go far beyond questions of homicide or deliberate infliction of physical harm; they extend to the care taken of a prisoner, often one who is intoxicated or under the influence of drugs, and to the psychological treatment of the prisoner.*'[5]

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[4] The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) at 4.5.41, 4.5.42 & 4.5.43.
[5] JH Wootten QC, 'Deaths in custody' Current issues in criminal law. Vol 2, no 3. P60.

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC)

61. The RCIADIC investigated 99 cases involving Aboriginal deaths in custody between 1980 and 1989. The RCIADIC produced an interim report and a five-volume final report with 339 recommendations.

62. Ms Day was the second member of her family to have died in police custody. The death of her uncle, Harrison Day in police custody, in Echuca on 23 June 1982 was the subject of investigation by Commissioner Wootton during the RCIADIC.

63. A number of the recommendations made by the RCIADIC are relevant to this inquest. They provide a framework for relevant standards and a template of best practice in areas such as custodial health and safety and provide a *useful comprehensive accountability structure*[6] against which to assess aspects of the evidence. A number of witnesses were cross examined about their knowledge of the RCIADIC and its recommendations.

64. The recommendations which are relevant to this inquest include the de-criminalisation of the offence of drunk in a public place, the standard of coronial investigations of deaths in custody, the recommendations relating to conditions and procedures at police lockups and those relating to policing practices and custody being a last resort.

65. I have noted in my examination of the evidence the responses by witnesses at to their knowledge or awareness of the RCIADIC and its recommendations.

Public drunkenness

66. The RCIADIC made recommendations in 1989 regarding the de-criminalisation of public drunkenness.

67. Of the three indigenous people whose deaths in custody in Victoria were examined, all three incarcerations related to public drunkenness.

68. Commissioner Wooten stated:

> '*James Archibald Moore, like Harrison Day and Arthur Moffat, the other two Aboriginals into whose deaths in Victoria I have inquired, owed his custody to the archaic and ludicrous laws relating to drunkenness that still apply in this state.*'[7]

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[6] Halstead, B Coroners Recommendations and the prevention of deaths in custody, November 1995 Australian Institute of Criminology p 17.
[7] RCIADIC Volume 3

69. The RCIADIC's National Police Custody Survey (Preliminary Findings) found disproportionate numbers of arrests for drunkenness involved Aboriginal people and found that in Victoria Aboriginal people were overrepresented in police custody by a factor of 13:2. Aboriginal people in this period were also three times more likely to be in police custody in Victoria for drunkenness than were non-Aboriginal people.[8]

70. The RCIADIC made a number of recommendations to divert offenders charged with public drunkenness away from the criminal justice system including:

Recommendation 79

That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness.[9]

71. At the Directions Hearing on 5 December 2018 I foreshadowed my intention to make a recommendation in my findings, to decriminalise the offence of public drunkenness in section 13 of the *Summary Offences Act 1966* (Vic). I invited the Attorney General to make submissions.

72. This was an unusual step given I was yet to hear any evidence but having read the coronial brief of evidence I formed the view that there was no justification for the offence of public drunkenness to remain in the *Summary Offences Act 1966* some 30 years after the RCIADIC had recommended its abolition.[10] Victoria and Queensland remained the two states that had not followed that recommendation. That offence was the reason police were able to arrest Ms Day on 5 December 2017 and take her into police custody and detain her. She was in custody, neither on remand nor as a sentenced prisoner, but on the basis of the power to arrest for being drunk in a public place. The RCIADIC recommended its abolition on the basis it unfairly impacted on Aboriginal people and contributed to the high rate of Aboriginal people in custody.

73. In June 1989 the Victorian Law Reform Commission report on Public Drunkenness also recommended decriminalisation through the repeal of sections 13, 14 and 15 of the *Summary Offences Act 1966* (Vic).

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[8] Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness – Final Report June 2001, p 279.
[9] Recommendation 3 of the Interim Report.
[10] RCIADIC Recommendation 79.

74. In June 2001 the Victorian Parliament's Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness also recommended decriminalisation of the offence of public drunkenness.[11]

75. The RCIADIC recommendations 79 to 81, 84, 85 and 135 highlight the need for the decriminalisation of public drunkenness, and the need for the provision of alternative non-custodial facilities for the care and treatment of intoxicated persons.

76. In considering approaches in different states taken to decriminalise public drunkenness, the RCIADIC Report noted:

'*Legislation decriminalising public drunkenness is, at the time of writing, before the Victorian Parliament.*'[12]

77. Further, in 2005, the Victorian Implementation Review of the Recommendations from the RCIADIC in Recommendation 54 urged the Victoria Government:

'(a) Proceed, as a matter of urgency, to abolish the offence of public drunkenness (Recommendations 79-80)'[13]

78. The Attorney General advised by letter dated 23 August 2019 the Victorian Government's commitment in principle to repeal the offences relating to public drunkenness in the Summary Offences Act 1966 and the thereby decriminalise public drunkenness.

79. By letter dated 17 December 2019 the Attorney General provided an update on the progress towards the decriminalisation of public drunkenness and the steps the government is taking to ensure the circumstances surrounding the death of Ms Day are not repeated. This included advice an Expert Reference Group had been convened to provide advice to the Victorian Government on the design and delivery of a public health response and an expectation legislation would be introduced '*as soon as possible within the term of government.*'

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[11] Having said that, although the offence has been removed in the Northern Territory, as the Finding into the Inquest into the death of Terrence Briscoe demonstrates, the alternative 'protective custody' has not prevented Aboriginal people from dying as a result of being placed in protective custody for being drunk. In that case, Kwementyaye was detained in the Alice Springs Watch House pursuant to s 128 of the *Police Administration Act* '*because he was thought to be so intoxicated that he fulfilled the criteria for what is colloquially known as 'protective custody.' He had committed no crime.*' 2012 [NTMC] 032.

[12] RCIADIC Final Report Vol 3, Part D at [21.1.29] 1991.

[13] Dr Joy Murphy & Dr Mark Rose, Victorian Implementation Review of Recommendations from the RCIADIC, Review Report volume 1, October 2005, p 49.

Standards of coronial investigations

80. The RCIADIC also made recommendations in response to shortcomings identified with the independent investigation of Aboriginal deaths in custody. The recommendations that relate to the coronial system number six through to forty. It is useful to consider these recommendations having regard to the wider public interest of public confidence in the coronial system.

81. Commissioner Wootton was scathing of the coronial investigation into Harrison Day's death:

'*There was the minimum of investigation of any kind of Harrison Day's death and no independent investigation at all.*'

82. His formal findings included that '*The police investigation, autopsy and coronial inquest were inadequate*' and in Part 3, he stated:

'*The coronial Inquiry was worse than useless, in that it simply ran uncritically over and gave legitimacy to the inadequate police investigation.*' [14]

83. Recommendation 12 provides:

'*That a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.*'[15]

84. I understand the West Australian and Queensland coronial legislation have adopted recommendation 12 however the Victorian *Coroners Act* 2008 does not include this provision. The care, treatment and supervision of Ms Day whilst in custody is highly relevant to this inquest.

85. Recommendation 35 is also relevant:

(b) All investigations should extend beyond an inquiry into whether death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;

[14] RCIADIC Volume 3
[15] *Coroners Act* (1996) WA, section 25(3).

(c) The investigations into deaths in police watch houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;

(d) In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased.

86. I am of the view that consideration of the factors described in recommendations 12 and 35 are relevant and within the scope of this Inquest. They fall within my consideration of '*the circumstances in which the death occurred*' as envisaged by section 67 of the Act.

87. I note the value of Recommendation 36:

'Investigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner on inquest into the cause and circumstances of the death and the quality of the care and treatment and supervision of the deceased prior to death.'

Submissions from Ms Day's family and consideration of the scope

88. Ms Day's family submitted the role of systemic racism be included as a consideration in the scope of the inquest.

89. Significant consideration was given to the scope of the inquest and witnesses to be called at inquest. Subsequent directions hearings on 19 March and 30 April 2019 considered this. The Victorian Equal Opportunity and Human Rights Commission supported the family's submission and the interested parties made submissions as to whether systemic racism should be included as part of the scope of the inquest.

90. On 25 June 2019 I handed down my ruling on the scope of the Inquest confirming the scope of the inquest was to consider:

(a) The mechanism of Ms Day's death;

(b) Whether the death was preventable if earlier medical intervention had been provided;

(c) The decision by V/Line employees to remove Ms Day from the train and contact police, relevant policy and procedure and whether it was complied with;

(d) The decision made by Victoria Police members to take Ms Day into custody at the Castlemaine train station and then keep her in custody at Castlemaine police station including any relevant policy and procedure and whether it was complied with;

(e) The appropriateness of the response by the Aboriginal Community Justice Panel to the notification regarding Ms Day's incarceration, the reasons for their non-attendance, including any relevant policy or procedure and whether it was complied with;

(f) Whether the custody management of Ms Day was in accordance with relevant Victoria Police Manual policies, procedures and guidelines;

(g) Whether the processes for the required automatic notification regarding an indigenous person in custody was sent to the Victorian Aboriginal Legal Service, and the response to it;

(h) The appropriateness of the treatment by Ms Day by attending ambulance officers, whether it was in accordance with relevant policy and procedure and whether it was otherwise appropriate; and

(i) Whether any type of racism, systemic or otherwise, was a factor in the cause or circumstances of Ms Day's death.

91. Although the scope specified consideration of the role of medical intervention and whether Ms Day's death was preventable had that been more timely, I am not of the view that limits or constrains my consideration of preventability merely to Ms Day's medical management. I have considered the preventability of Ms Day's death in the context of the whole of the circumstances on 5 December 2017. This is in accordance with the Preamble of the Act and particularly relevant for a death that has occurred in police custody.

92. In their final submission Ms Day's family sought that the coronial process be a thorough and independent investigation, extend to determining whether the police conduct was lawful and whether it was affected by systemic racism.[16]

93. They submitted that I should form the view that an indictable offence may have been committed by Sergeant Neale and Leading Senior Constable Wolters and thus refer the case to the Director of Public Prosecutions pursuant to section 49 of the Act.

[16] Family's submissions, p 5 paragraph 42.

94. The submission also criticised the Coroner's Investigator, Detective Senior Constable Riley's investigation as neither independent nor effective as it did not consider possible criminal responsibility.[17]

95. Further the family's submission summarised that Ms Day:

'...died because police put her in a cell and neglected her... the evidence shows that police failed to properly care for her and that as a result they failed to prevent her fatal fall and contributed to her death.'[18]

Consideration of how the inclusion of systemic racism in the scope relates to the evidence

96. Section 67 of the Act requires the coroner to determine, if possible, the identity, cause of death and circumstances in which the death occurred.

97. The *circumstances in which the death occurred* were relatively straight forward: Ms Day's journey on 5 December 2017 from Echuca bus station to the cell at Castlemaine police station was captured on CCTV footage. Most of this was played and tendered in evidence at the inquest.[19]

98. The questions considered at the inquest were not so much *what* happened, but rather *why* did events unfold the way they did. Why was Ms Day taken off the train? Why was Ms Day taken from the Castlemaine train station to the Castlemaine police station? Why was she lodged in the cell? Why was that not a safe environment for her?

99. The evidence examined the behaviour and actions of the witnesses from V/Line, Victoria Police and Ambulance Victoria and whether their decision making complied with their relevant organisations' policies and procedures.

100. The scope of the Inquest allowed witnesses' evidence to be tested as to whether systemic racism played a part in Ms Day's death. Witnesses were cross examined about the motivations for the decisions they made and the potential role of unconscious bias in their decision making.

101. The Day family's submission about the scope of the inquest included the following definition of systemic racism:

'...systemic racism' refers to a process that produces statistically discriminatory outcomes for particular racial or cultural groups. It may involve unconscious bias, or

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[17] Family's submission p 5 [43-44].

[18] Family's submissions p 7 [56].

[19] There is no gap in the evidence as there was in the Inquest into the death of Mulrunji (COR 2857/04(9) where the central issue for determination was what happened in a period of tens of seconds to cause the injuries and subsequent death of Mulrunji at the Palm Island Police Station.

laws, policies and practices, that operate to produce such outcomes. That outcome may occur without conscious racist intent, and despite individuals believing they are simply 'doing their job'. Critically, systemic racism can operate without any individual displaying expressly racist or discriminatory behaviour, and without institutional policies or practices that are expressly or openly racist.'[20]

102. The RCIADIC referred to systemic racism as '*... rules, practices, habits which systematically discriminate against or in some way disadvantage Aboriginal people ...*' and '*the differential application of discretions,*' such as turning a blind eye to particular behaviour or in the exercise of the power to arrest.'[21]
103. I note Principle 10 of the current Victorian Aboriginal Justice Agreement is to '*address unconscious bias: Identify and respond to systemic racism and discrimination that persists in the justice system.*'

Two aspects of the definition of systemic racism

Rules and practices

104. The consideration of systemic racism in the course of the inquest had two aspects. The first related to '*rules and practices*' such as the offence of public drunkenness, and the second, the role of '*unconscious bias*' in individual decision making by the *agents of institutions* such as in the exercise of discretion.
105. Section 13 of the *Summary Offences Act 1966* is an example of a law which operates to the disadvantage of Aboriginal people hence the RCIADIC recommendation.
106. The cross examination of witnesses considered the potential operation of unconscious bias against Aboriginal people in decision making, or the exercise of discretion.
107. Witnesses were examined and cross examined about their decisions and the relevant applicable rules, policies and procedures. They were also questioned about the exercise of their discretion, for example, decisions to stop the train and organise for police attendance, or to arrest Ms Day, remove her from the train and take her to the police station. The cross examination attempted to reveal whether an unconscious bias against Aboriginal people was a factor in the decision-making processes by witnesses in the course of their duties, whether as train conductor, police officer or ambulance officer.
108. Unsurprisingly, no witness admitted to holding racist beliefs and the witnesses denied Ms Day's Aboriginality played a role in their actions or decision making on 5 December

[20] Day Family submissions dated 29 March 2019 p 1.
[21] Day Family submissions dated 29 March 2019 pp 7-8.

2017. Cross examination endeavoured to elicit points of difference in the treatment of Ms Day by comparing how the witness would act in the hypothetical scenario involving a middle-aged white woman in a similar situation to Ms Day. I do not intend to detail the responses of all witnesses to this line of questioning. It yielded denials. I give one example as representative of the responses:

109. Senior Constable Hurford was asked, if, when he had arrived at Castlemaine train station, he had '*found that the other members had detained a sweet natured confused blonde grandma who was on her way down to see the grandkids in Melbourne, ...[he] might've just held off a bit longer before she was put in the divvy van.*'[22] He disagreed. He was then asked once it was determined Ms Day was indigenous and alcohol affected, it was the default position '*she was just going to be swept into that cell down at Castlemaine.*' Senior Constable Hurford stated, *'Not at all, if we could've got someone to come get her or if she lived obviously locally or we could come to some arrangement, she wouldn't have been in the cell.*'[23]

110. I rejected the use of inductive reasoning in consideration of the evidence in my ruling on the scope, on the basis that statistical evidence about the over representation of Aboriginal women in custody does not establish a causal link to Ms Day's outcome.

111. I can only make my findings of fact based on the evidence before the court if I am satisfied to the relevant standard on the balance of probabilities.

112. Further, any non-compliance with organisational policies or procedures does not necessarily make the causal act or decision the result of unconscious bias and thus illustrative of systemic racism.

Unconscious bias and the differential application of discretions

113. The aspect of systemic racism which relates to unconscious bias and the differential application of discretions has significant relevance to police who have considerable discretion or choice whether or not to charge a person. *'Like other powers and functions (and especially so where they affect liberty or involve coercion) they must be exercised reasonably, rationally and fairly.*'[24]

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[22] Transcript (T) 625.
[23] T 625.
[24] *Wotton v State of Queensland* [2016] FCA 1457 at [83].

114. Police discretion as it applies to an offence such as public drunkenness is very broad. The Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness in 2001 noted:

'*Although it is expected that police must exert a certain level of latitude in their dealings with members in a community, their job is not made easy when it is considered that, unlike many other areas within policing that are defined precisely by judicial or statute interpretation, such precise limits are almost non-existent when it comes to exercising discretion in areas such as public drunkenness.*'[25]

115. Recognising the importance of police discretion, Justice Mortimer referred to the Supreme Court of Canada's consideration in *Beaudry v The Queen* [2007] 1 SCR 190:

'*...Applying the letter of the law to the practical, real life situations faced by police officers in performing their everyday duties requires that certain adjustments be made. Although these adjustments may sometimes appear to deviate from the letter of the law, they are crucial and are part of the very essence of the proper administration of the criminal justice system, or to use the words of s 139(2) are perfectly consistent with the course of justice. The ability – indeed the duty- to use one's judgement to adapt the process of law enforcement to individual circumstances and to the real- life demands of justice is in fact the basis of police discretion.*'[26]

116. In their article *Understanding discretion in modern policing,* Bronitt and Stenning consider the meaning of discretion. Distinguishing it from interpretative judgment, which is the decision that an offence *has* been committed, discretion comes into play when making a discretionary decision as to whether to take certain enforcement actions. '*In exercising such discretion, the officer will typically be expected to be guided by police service policies or guidelines on such matters.*'[27] I have not been directed to any Victoria Police policies or guidelines regarding the exercise of police discretion for the offence of public drunkenness.

117. As well as considering limited resources and harsh and intolerable results, a further reason was cited for why discretion is a legitimate aspect of police work:

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[25] Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness – Final Report June 2001, p 139. Police view public drunkenness as a complex policing area because of the varying manifestations of the person who is drunk in a public place; from the homeless, itinerant drunk, the youth 'binge' drinking, sports and large event crowds, licensed premises, poly drug users to the harmless or 'quiet' drunk. Different approaches can and are applied to the different categories of intoxicated persons (at p 137).

[26] *Wotton v State of Queensland* [2016] FCA 1457 at [83].

[27] Bronitt, S & Stenning P, Understanding discretion in modern policing, (2011) 35 Crim LJ 319 at 321.

'failure to eliminate poorly drafted and obsolete legislation renders the continued existence of discretion necessary for fairness.'[28]

118. Pointing out the historical mandate from a time when police distinguished between the 'respectable' and 'rough' classes and taking action against intoxicated persons and Aboriginals amongst others, *'formed the focus of uniformed policing from its very inception in Australia,'* Bronitt and Stenning advocate the importance of guidelines to moderate the risk of the misuse of discretion.[29]

119. In a prescient voice from the past, In the Report of the Inquiry into the death of Harrison Day, Commissioner Wootten considered '*Discretions*' stating:

'It is unavoidable that a workable system of justice will leave some discretions with police and courts. The difficulty is ensuring that discretions are exercised fairly and impartially, and not influenced by racist practices or conscious or unconscious prejudice. It is common experience that the powerful and 'respectable' are the ones who benefit most from police discretions. Aboriginals, who are not usually seen in that light, frequently complain that they do not get equal treatment where discretions are involved... Officers sometimes exercised a discretion to drive drunks home, but not Harrison Day...

Apparently in many towns' magistrates exercised a discretion to discharge without penalty persons charged with drunk, or drunk and disorderly, in a public place. In Echuca, where most of the charges were against Aboriginals, and Harrison Day was the most arrested of all, this did not happen; fines were imposed and enforced...Harrison Day's situation is a reminder of how discretions can easily end up operating adversely against those who lack power and influence.'[30]

120. To divine the existence of unconscious bias in decision making in this case has required me to consider the evidence of related facts to determine whether I can infer the existence of unconscious bias. In criminal trials, where juries are asked to draw the ultimate inference, the accused's guilt, that inference must be the only rational or reasonable inference that can be drawn from the evidence and there must be no reasonable inference consistent with innocence.

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[28] Bronitt & Stenning, at 323.
[29] Bronitt & Stenning, at 324-5.
[30] Royal Commission into Aboriginal Deaths in Custody, Report of the Inquiry into the Death of Harrison Day, 9 August 1990, Commissioner JH Wootton.

Evidence at inquest

121. There were three forms of evidence at the inquest. Firstly, written statements and oral evidence was heard from those witnesses who had direct dealings with Ms Day and their memory and perception of events and their decision making. The witness's evidence was not so critical regarding the sequence of events, as much of what occurred was not disputed. The oral evidence provided a picture of the perspective the witnesses brought to the way they discharged their role and responsibilities as either train conductor, police officer or ambulance officer, particularly regarding their dealings with individuals who were intoxicated.

122. Secondly there was real time evidence, namely the CCTV footage of Ms Day at the railway station, at the police station and in the police cell which meant there was little factual dispute regarding the chronology of events. There was also the organisational policies procedures and training materials from V/Line, Ambulance Victoria and Victoria Police, which were tendered and subject to examination.

123. Thirdly, there was circumstantial evidence, which refers to inferences used to reconstruct an event that is not actually witnessed. To be of evidential value, circumstantial evidence must be drawn from inferences that are reasonable and definite. Hypothesis, speculation or conjecture are not inferences. An inference that something or an event might have happened, is insufficient proof.

124. In considering a representative proceeding alleging unlawful discrimination based on race, Justice Mortimer stated:

'*An inference drawn to make a finding of fact must be one that is reasonably available on the evidence and capable of being expressed with clarity...*

Most findings of unlawful discrimination, including those arising from a provision such as s 9 with its formula 'based on race,' will be based on inferences drawn from the evidence. Seldom is it the case that there is either an admission of the racial basis for the conduct, or direct evidence of that basis...In most cases dealing with a course of human conduct, the picture will be more complex, and the drawing of inferences will be required. All the more so when there are, as here, multiple actors. Where I have drawn inferences in reaching my conclusions in this proceeding, I am satisfied they are reasonably available on the evidence and I have sought to express clearly the inference I have drawn.'[31]

[31] FCA [2016] 1457 at [47-48].

125. I find this analysis relevant and helpful. In considering the evidence in this case regarding whether systemic racism was a factor in Ms Day's death, I have adopted the reasoning process in considering the evidence as articulated by Justice Mortimer.
126. Justice Mortimer's commentary regarding inferences is also helpful: '*An inference drawn to make a finding of fact must be one that is reasonably available on the evidence and capable of being expressed with clarity.*'[32]
127. In this hearing which is the civil standard of proof, I adopt Justice Mortimer's test, that any inferences I have drawn are properly or reasonably available or deduced from the evidence.
128. The Supreme Court in *Transport Industries Co Ltd v Longmuir* has stated that in evaluating circumstantial evidence in civil cases, evidence is required only of circumstances raising a reasonable, definite and more probable inference of what is alleged. It is not necessary to exclude reasonable hypotheses consistent with the contrary of what is alleged. The Supreme Court also held that each item of circumstantial evidence is not considered in isolation from the others, the proper approach when considering circumstantial evidence is to consider the weight of the combination of proven facts and determine whether the combined weight of those facts supported the inference, as a matter of probability.[33]
129. In considering the evidence, I am also conscious of the dangers of hindsight bias. The submission on behalf of Victoria Police cautioned me against this when assessing the CCTV footage in retrospect, for the signs of Ms Day's head injury, or her level of intoxication.

Standard of proof

130. Unlike civil or criminal cases, no party bears the burden of proof in coronial cases.
131. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities with the *Briginshaw* qualification, that:

    '*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable*

[32] FCA [2016] 1457 at [116].
[33] Transport Industries Insurance Co. Ltd v Longmuir [1997] 1 VR 125.

satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences ...'[34]

132. This was accepted by the Supreme Court in *Anderson v Blashki*, where Gobbo J stated: '*... because of the gravity of the allegation, proof of the criminal act must be 'clear cogent and exact and when considering such proof, weight must be given to the presumption of innocence.*'[35]

133. This was followed in *The Secretary to the Department of Health and Community Services v Gurvich* (also adopting Briginshaw) which held before a coroner made a finding under section 19 of the *Coroners Act 1985* that a professional person '*contributed to the cause of death*' of another within the course of his or her professional duties, there must exist a comfortable satisfaction that negligence had been established which contributed to the death.

134. The family's submissions[36] contend the Briginshaw standard should not apply. The family argues to apply Briginshaw prefers police officers' reputations over the truth.

135. The submission distinguished the court's role as defined in section 67 of the current Act and its earlier iterations which required a finding of contribution, if possible.[37] Section 67 requires the coroner to inquisitorially make findings if possible and no question of balance of probability reasoning applies as it would be inconsistent or contrary to that approach to privilege the interests of one or other party.

136. The submission referred me to *Karakatsanis v Racing Victoria Limited*[38] in which the Victorian Court of Appeal held, that whilst it doubted the Victorian Civil and Administrative Tribunal was 'bound' by the principles stated in Briginshaw in the same way as a court would be, '*...it was entirely proper for the Tribunal to take the approach that it did and require that it be 'comfortably satisfied' of the facts in issue.*'[39]

137. Like VCAT, the Coroners Court is not bound by the rules of evidence. The family's submission argues that as the Coroners Court is not bound by the rules of evidence, Briginshaw considerations, now reflected in section 140 of the *Evidence Act 2008* do not apply. In *Karakatsanis*, Justice Osbourne went on to state:

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[34] *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362-363.
[35] *Anderson v Blashki* [1993] 2 VR 89 at 95-6.
[36] Paragraphs 57 -68.
[37] *Coroners Act 1985* s 19(1)(e).
[38] [2013] VSCA 305.
[39] [2013] VSCA 305 at [37].

'In the present case as I have said the Tribunal expressly directed itself to the need to be 'comfortably satisfied' of its conclusions concerning the matters in issue. The primary question before Kaye J was whether it was open to the Tribunal to be so satisfied. I shall approach the matters in issue on the same basis, although for like reasons to those explained by Phillips JA in S v Crimes Compensation Tribunal it must always be borne in mind that ultimately on an appeal on questions of law the correct test is simply whether the Tribunal's findings were 'open.'[40]

138. The family's submission also referred me to Mortimer J in *Wotton v State of Queensland*. When considering the seriousness of allegations that police officers performing public functions and exercising public powers did so on the basis of race, her Honour stated: '*That said, the seriousness of the circumstances in this case is not one-sided. A young man died in custody, having entered that custody apparently active and well just under an hour earlier. A community lost that young man and a family lost a loved one.*'[41] The family argue likewise, weighing the evidence is not just a consideration of the reputation of professional persons but also the family that has lost their mum has '*an equal interest in those findings.*'[42]

139. I note Justice Mortimer accepted that neither section 140 of the *Evidence Act* nor the common law in *Briginshaw* created a third standard of proof between the civil and the criminal, and the standard remains proof on the balance of probabilities. She also took the view that as the allegations against the police were serious: '*To allege that individuals performing public functions and exercising public powers did so on the basis of race is to make an allegation that reflects poorly upon those individuals.*'[43] She accepted the features of the applicant's case required the Court to be mindful of the three factors set out in section 140(2) of the *Evidence Act* which reflects the common law in *Briginshaw*.

140. The Queensland Court of Appeal in *Hurley v Clements & Ors* [2009] QCA 167 in considering the applicable standard made two points.

141. First, as Lord Lane CJ said in *R v South London Coroner; ex parte Thompson*[44] in a passage referred to with evident approval by Toohey J in *Annetts v Mc Cann*:[45]

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[40] [2013] VSCA 305 at [40].
[41] [2016] FCA 1457 at [114-115].
[42] Family's submissions, p 8.
[43] [2016] FCA 1457 at [114].
[44] Unreported, Lord Lane CJ, Watkins L, and Robert Goff J, Queen's Bench Division, 9 July 1982.
[45] (1990) 170 CLR 596 at 616.

'...an inquest is a fact finding exercise and not a method of apportioning guilt...In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance in the ring, which ever metaphor one chooses to use.'

142. Secondly, the application of the sliding scale of satisfaction test explained in *Briginshaw v Briginshaw* does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not...'

143. The Court of Appeal reiterated that a '*state of satisfaction on the balance of probabilities appropriate to the gravity of the consequences of a finding does not involve the need to exclude competing possibilities.*'[46]

144. In my view the applicable test for findings in the coronial jurisdiction is the balance of probabilities and I reject the inquisitorial nature of the role negates the application of a standard of proof to my findings.

145. I do not accept that because the Coroners Court is not bound by the rules of evidence, the factors in *Briginshaw* should not apply to the civil standard of proof. Just as Justice Mortimer noted, I am aware of the gravitas of my findings for all parties, whether reputationally, or as a factor in the death of a loved one. I am of the view the standard of proof in this case is the balance of probabilities having regard to the factors in *Briginshaw*.

Relevant coronial cases

146. The existence of implicit or unconscious bias against Aboriginal people in healthcare settings was considered by the NSW Deputy State Coroner Grahame in the *Inquest into the death of Naomi Williams*.[47] Expert evidence was accepted from Professor Yin Paradies who referenced data in Australia that Aboriginal patients in hospitals across the country compared to non-Indigenous patients received 30% fewer procedures and that there is a correlation between less treatment and Aboriginality at an epidemiological level.

[46] [2009] QCA 167 at paragraph [31].
[47] Coroner's Court of New South Wales 2016/ 2569.

147. Coroner Grahame did not find it established on the evidence '*that any individual decision with regard to treatment offered to Naomi or denied was directly referable to her Aboriginality. What can be said...is that it is 'consistent with a pattern.' I accept that there is difficulty in extrapolating from the general to the individual ...*'[48]

148. Other Victorian coronial cases that have considered deaths in police custody, and the *Inquest into the death of Stephen Niit* is relevant. Mr Nit was lodged for drunk in a public place in a cell at the Echuca police station. The coroner noted:

'*In my view the standard operating procedures governing custody of intoxicated persons are adequate, provided they are followed to the letter. There is no room for discretion. They have been formulated relying on histories of often fatal and near misses occurring over the years in prison cells. If to the exclusion of these rules, reliance is had on hands-on experience over, in many cases, many years experience of dealing with intoxicated persons, there is a real risk that this can lead to complacency and 'bending the rules.' It only needs the relaxation of one of those rules to potentially have fatal consequences.*'[49]

149. The coroner went on to make comments and recommendations including recognising vulnerability, and training, and that Victoria Police '*institute an 'alert' process 'to be widely broadcast and disseminated amongst members providing information about deaths and 'near-misses' in respect of persons in custody in police cells. Such information should list the specific failures to observe the rules, thereby re-enforcing the importance of compliance, leaving nothing to discretion. The exact mechanism for this to be achieved, I leave to Victoria Police to work out.*'[50]

150. There are many other Victorian cases where coroners have made recommendations and or comments to improve the safety of detainees held in the custody of either Police or Corrections, in an attempt to reduce the number of preventable deaths.[51]

Human Rights

151. The application of *The Charter of Human Rights and Responsibilities Act 2006* (the Charter) is relevant to this investigation.

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[48] Finding in the Inquest into the death of Naomi Williams, NSW 2016/2569 at 46-47.
[49] Finding into death with Inquest Stephen Arthur Niit (2009/ 5931) at p 12.
[50] Finding into death with Inquest Stephen Arthur Niit (2009/ 5931) at p 16.
[51] I requested data from the Coroners Prevention Unit regarding deaths in custody in Victoria from non natural causes over the past ten years. The data identified 31 findings which included 163 comments or recommendations. For example, the Inquest into the death of Michael John Darmody (2014/ 2445) who died after being found unconscious in the Moorabbin Police Station cell, the coroner made recommendations including those relevant to the training of custody staff and the contents of the medical checklist.

152. Section 9 of the Charter provides: *'Every person has the right to life and the right not to be arbitrarily deprived of life.'*

153. This encompasses a positive measure to protect life through a comprehensive, thorough and independent death investigation process. This positive duty to protect life and prevent death has particular application to protect people who are detained by the state. This duty extends to ensuring appropriate monitoring and supervision of people in detention and providing appropriate medical care.[52]

154. The scope of the inquest had included consideration of both the immediate cause and potential systemic causes of Ms Day's death to meet the Charter's human rights obligations applicable to this court's interpretation of its duties in section 67 of the Coroners Act 2008. I have also taken into account the recommendation 12 of the RCIADIC to consider *the quality of the care, treatment and supervision of the deceased prior to death.*

155. The application of other Charter rights, such as section 12, Freedom of movement and section 22 the right to humane treatment, by public authorities are also considered.

INQUEST

156. The inquest commenced on 26 August 2019 and ran for 14 days and 26 witnesses were called. A final submissions hearing was held on 11 November 2019.

157. This finding is based on the totality of the contents of the coronial investigation into Ms Day's death. This includes the coronial brief, the evidence adduced at inquest and the submissions of Counsel. It is unnecessary to summarise of all this material. It will remain on the court file. I will refer only to so much as is relevant or necessary for narrative clarity.

158. In so far as the scope of the inquest includes the consideration of whether any type of racism, systemic or otherwise, was a factor in the cause or circumstances of Ms Day's death, I have considered this aspect as part of my consideration of each aspect of the scope.

159. I have structured this finding in accordance with my statutory obligations in section 67 of the Act and my examination of the circumstances of Ms Day's death is a

[52] Hunyor, J, Human Rights in coronial inquests, (2008) 12 (SE 2) AILR p 66.

chronological consideration of events on 5 December 2017 in accordance with the scope.

IDENTITY

160. Identity is not in dispute. Ms Day was identified by her daughter Belinda Stevens on 22 December 2017.

I make the following finding of identity pursuant to section 67(1)(a) of the Act:

I find the deceased was Tanya Louise Day born on 8 September 1962.

CAUSE OF DEATH

161. On 22 December 2017, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Pathology conducted an autopsy on Ms Day's body.
162. Whilst noting the evidence of prior surgery, his report referred to the neuropathology report prepared by Dr Linda Iles that had no findings to indicate an underlying brain pathology that could have caused the brain haemorrhage. Dr Burke opined that taking into account Dr Iles' report, together with the imaging, the cause of the brain haemorrhage appeared to be traumatic in origin.
163. Dr Burke had reviewed the CCTV footage of Ms Day in the cell and noted a number of falls, the most severe recorded at 4.51pm when Ms Day fell forward against the wall onto her forehead.
164. Dr Burke noted that individuals, such as Ms Day, with liver cirrhosis may bleed easier than those without liver disease and that Ms Day had a platelet level of 40 with the normal range being 150 - 400. Platelets are needed in the process to stop bleeding.
165. Dr Burke formulated the cause of death as 1(a) *Left cerebral haemorrhage in a woman with liver cirrhosis.*
166. Dr Linda Iles, forensic pathologist with the Victorian Institute of Forensic Pathologist examined Ms Day's brain on 3 January 2018 confirmed there was no underlying pathology and that the haemorrhage is most likely of traumatic origin.
167. In view of the traumatic origin of the haemorrhage I intend to include this in the formulation of the cause of death.

I make the following finding pursuant to section 67(1)(b) of the Act regarding the cause of death:

1(a) Left cerebral haemorrhage of traumatic origin in a woman with liver cirrhosis.

I will make a direction that the Registrar of Births, Deaths and Marriages amend the currently registered cause of death to reflect my findings into the cause of death of Tanya Louise Day.

Whether the death was preventable if earlier medical intervention had been provided

168. Associate Professor John Laidlaw, a specialist neuro-surgeon, prepared a report dated 14 March 2019 and gave expert evidence at inquest.[53] His evidence was largely uncontested.

169. Associate Professor Laidlaw, was asked to advise, amongst other things, whether the haemorrhage was instantly catastrophic or would it have evolved over a period of time, and whether earlier recognition of Ms Day's condition could have altered her outcome, and whether there was there a realistic opportunity for earlier recognition and intervention.

170. Associate Professor Laidlaw advised that the probable clinical course from the time of injury is that:

'*...the patient would have sustained a relatively small intracerebral haematoma within minutes of the impact and that it would have expanded to form a significant haematoma over the relatively short period of time (this varies, but my guess in this case would have been 15 – 90 minutes, depending on the size and type of vessels injured.)*'

171. With respect to whether earlier recognition of her intracranial haemorrhage could have altered her outcome, Associate Professor Laidlaw stated:

'*I do think that earlier recognition of Ms Day's intracranial haemorrhage, assuming that it did lead to earlier treatment particularly with clotting factors and platelets and surgical decompression, could have altered the outcome and would have improved the chances of Ms Day's survival. However, considering that Ms Day's haematoma in her dominant temporal lobe had already progressed to the size causing a dense hemiparesis in the holding room prior to paramedic assessment, the large size of the haematoma with subfalcine and uncal herniation on formal diagnosis, and the comorbidities, it is likely that if Ms Day survived she would have had a significant neurological deficit that included, at a minimum, a right hemiparesis and dysphasia.*'

172. Following his attendance at court, Associate Professor Laidlaw was asked to provide his further opinion as to whether Ms Day would have survived, if hypothetically, following her fall at 4.51pm, she had presented to Bendigo Hospital by 6.00pm and thereafter at half hourly intervals until 9.00pm.

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[53] Exhibit 68.

173. In a second written report dated 11 September 2019,[54] (which was tendered, without objection, at inquest) Associate Professor Laidlaw referenced three main prognostic tools, and used two, CRASH and IMPACT with the following qualifications. Firstly he indicated these tools are useful in auditing large groups of head injured patients, therefore their predictive value in the individual head injury case is not reliable. Secondly, given the cohort was from young head injured patients, the outcome assessments would be expected to would underestimate the risk of poor outcome or mortality in a patient like Ms Day who had significant chronic liver disease and portal hypotension causing secondary low platelets and coagulopathy. Using the most optimistic scenario, if Ms Day had arrived at Bendigo Hospital at 6.00pm hours, and then in surgery at St Vincent's hospital at 9.00pm:

'The use of the models indicates to me that even under ideal circumstances it is probable that Tanya Day would not have survived...Therefore considering these very significant factors that deviate from the ideal optimistic scenario tested with the IMPACT and CRASH calculators, I think it is very unlikely that Ms Day would have survived (my estimate is less that 20% chance of survival) even if she had been given an early preliminary diagnosis and presented to Bendigo Hospital at 6pm and had ideal management. Also, in the unlikely event of survival, the almost total destruction of her left temporal lobe and mass effect would have left Ms Day with a severe disability (dysphasia, and probably hemiparesis and cognitive deficit.)

174. In summary therefore, in his first report Associate Professor Laidlaw states earlier recognition and treatment could have improved Ms Day's chances of survival, albeit with a significant neurological deficit. In his second report he specifically referred to times frames and at the best scenario gave Ms Day a 20% chance of survival albeit with a severe disability.
175. Regardless of the time frame, Associate Professor Laidlaw's evidence was Ms Day would have had a severe disability had she had an opportunity to survive.
176. Taken at its highest, or the best case scenario considered by Associate Professor Laidlaw, there was an opportunity lost by the time frame to prevent Ms Day's death, subject to the qualification that she would not have been able to fully recover from her injury and had she survived she would have been severely disabled.

[54] Exhibit 91.

177. Whilst Counsel Assisting submits Ms Day's death was not preventable on the basis of Associate Professor Laidlaw's reports, in my view his evidence is more nuanced and less categoric, given his estimate of a 20% chance of survival for Ms Day, although severely impaired. In paragraph 15 of submissions, Counsel Assisting notes that: '*Even if police members had sought medical attention immediately after the fall at 4.51pm or at a sooner point than they did, and even if ideal treatment and management was then provided within 3 hours, it would not have prevented her death.*'

178. The second report from Associate Professor Laidlaw was sought for his expert opinion on exactly this scenario: the hypothetical scenario of Ms Day being presented to Bendigo Hospital at 6.00pm (on the basis that an Ambulance was called immediately after the fall, and took 30 minutes to travel to Bendigo) and he gave a 20% chance of survival with significant impairment.

179. I accept the expert opinion of Associate Professor Laidlaw on this point and whilst I cannot make a finding that Ms Day's was preventable in that she could have survived and made a full recovery, there was an opportunity lost (for her survival). I note had the physical checks been in accordance with the requirements of every 30 minutes, she would have been checked at approximately 4.30pm and then 5.00pm, ten minutes after her fall.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

180. I make the following findings regarding the circumstances in which Ms Day's death occurred for the purposes of section 67(c) of the Act and in accordance with the scope of the inquest:

The decision by the V/ Line employee to remove Ms Day from the train and contact police, the relevant policy and procedure and whether it was complied with

Ms Day's removal from the train

181. On 5 December 2017, Shaun Irvine was the V/ Line train conductor checking tickets on the train travelling from Bendigo to Southern Cross station. At 2.50 pm he approached Ms Day who was asleep, lying on a seat with her feet across the aisle way. He asked her for her ticket and her response made him believe she was under the influence of drugs or alcohol. '*She appeared to be delirious.*'[55] He formed the view she was *unruly* and contacted the train driver to organise the police.

[55] CB 63.

182. The train made an unscheduled stop at Castlemaine train station. Police attended and removed Ms Day from the train.

183. The relevant V/Line Emergency procedures for conductors provides:[56]

Customers not in control on a train

A person not in control is a customer who is incapable of taking care of themselves, whether by virtue of drugs, alcohol or illness.

Should such a customer be detected on V Line premises they should be placed in an area where they can be monitored by staff.

Depending on the situation the Police, Ambulance, or relative are to be called so that they can assess that person's state and decide what to do.

On the train

Before a customer is removed from a train, the conductor will assess the situation. Depending on the situation contact:

- *a relative/ carer for assistance in the assessment using your mobile phone*
- *the driver and arrange for an Ambulance or*
- *the driver and arrange for Police.*

Unruly customers on a train

If a customer who is not in control presents a danger to staff, other customers, themselves or property, and the conductor is unable to gain their co-operation, it may be necessary for the person to be removed. This person is now defined as unruly.

On the train

When dealing with an unruly customer(s), foremost in your mind should be your personal safety. Do not enter into an argument with the unruly customer(s). Do not try to intervene or insert yourself into a situation between customers.

If safe to do so, move other customers away from the unruly customer(s) or preferable (sic) to another part of the train.

If, at any time you fear for your safety, are threatened, or assaulted, the safest option for you is to leave the immediate area. Retreat to the nearest work area and lock yourself

[56] CB 409 *V Line Customer Emergency Procedures, Conductor training April 2016.*

in. Contact the driver and arrange for the Police to meet the train. Remain in the secure area until the Police arrive.

As your safety is paramount, do not attempt to physically remove a customer from the train for any reason. Where it is necessary for the unruly customer(s) to be removed, either Police or Authorised Officers will perform the task. Again, contact the driver and arrange for the Police to meet the train.

In the event the disruption delays the train...[57]

***Decision Ms Day was* unruly**

184. Mr Irvine took the view Ms Day was an *unruly* customer as she presented a danger to herself[58] and that she was unable to cooperate because '*she was unable to provide meaningful responses when asked questions.*'[59] He explained that he required police attendance because Ms Day's '*safety was threatened by allowing her to continue to travel in the state that she was in.*'[60] He was concerned because the train was approaching Castlemaine train station and beyond that, unmanned stations were a potential risk to Ms Day's safety, in that she could potentially hurt herself: '*there are risks of falls and trips and express trains.*'[61]

185. Mr Irvine agreed Ms Day also fell within the definition of the V/ Line Procedures as being a customer *not in control* as she appeared incapable of taking care of herself by virtue of drugs, alcohol or illness. He did not contact a relative or carer, or an Ambulance but decided to contact the train driver to call police. He agreed it was *possible* he could have spent longer assessing the situation.[62]

186. Passenger, Ms Cheryl McInerny stated Mr Irvine spoke to Ms Day for a '*matter of seconds...it certainly couldn't have been any more than a minute.*'[63] Within three to four minutes of first encountering Ms Day he had made contact with the train driver.[64]

187. Following his call to the train driver, Mr Irvine did not have any further contact with Ms Day.

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[57] CB 448.
[58] T 82-83.
[59] T 83.
[60] T 70.
[61] T 70.
[62] T 119.
[63] T 163-4.
[64] T 88-89.

Sleeping passengers

188. Mr Irvine evidence was Ms Day appeared to be *asleep or unconscious*.[65] He explained that it was not unusual for people to be asleep on the train, particularly in the mornings and evenings, but he was still required to check tickets, and this was the reason he was not able to leave Ms Day without saying anything to her.[66]
189. Mr Irvine did not believe Ms Day required medical attention or an ambulance,[67] and she was not disturbing the other passengers in any other way.[68]
190. Mr Irvine agreed this was the first time he had had someone removed '*when they were simply lying asleep on the seat*' and had not heard of any other case where a person was removed in that setting, despite encountering '*plenty of people asleep in their seat.*'[69]
191. On the three previous occasions when Mr Irvine had been involved with customers being removed from the train, on all occasions they had been '*abusive, aggressive or annoying*' or '*interfering with other people.*'[70]
192. Evidence from other staff and passengers on the train, namely Mr Bodie and Mr Ellerton, is that Mr Irvine stated to them that he had *trouble*[71] with Ms Day, and Ms McInerney stated that Mr Irvine told her he had had *behavioural issues*[72] with Ms Day and that she was *disturbing other passengers*.[73]
193. Mr Irvine agreed in evidence Ms Day had been asleep and was not disturbing other passengers.[74] Her behaviour was not of itself '*unruly*' in that sense of the word meaning aggressive or disruptive. Although Mr Irvine did not know at the time, it was also the case that Ms Day *did* have a ticket, which she had purchased at Echuca train station.[75]

Conclusion

194. I find Mr Irvine made the decision Ms Day was an unruly *customer* but could equally have decided she was a *customer not in control.*

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[65] T 67.
[66] T 68.
[67] T 71.
[68] T 74.
[69] T 118.
[70] T 118.
[71] CB 70 & 75-76.
[72] CB 72.
[73] CB 72.
[74] T 74.
[75] Coroners Investigator's summary CB 4-5.

195. I find Ms Day was the first sleeping passenger that Mr Irvine had removed from the train.

Power of conductor to remove passenger

196. Mr Irvine stated that as a conductor he did not have the power to make an assessment about whether or not Ms Day needed to be removed from the train, so he called for the police, stating he '*... didn't really have a preference either way.*'[76]

197. This is contrary to the evidence of V/ Line Acting General Manager Mr Brady who said it the V/Line conductor's decision whether or not a passenger is removed from a train.[77] He also stated it was up to the conductor's discretion, the conductor could have made the call to do nothing, '*it's their assessment of the situation.*'[78]

198. Further, Mr Irvine requested the train driver to contact Centrol to contact police. The audio tape of the train driver's call to Centrol states: '*... she's got no idea where she is, who she is, she hasn't got a ticket, can't make any sense out of her and he doesn't want her on the train.*'[79] (emphasis added)

199. Other V/Line staff and passengers were of the view that stopping the train meant a passenger was going to be removed. Ms McInerny stated by calling the police, '*we're only doing it because you're going to arrange for her to be removed.*'[80] Mr Bodie, V/Line service officer, heard over the V Line radio that the 3.01pm train was stopping '*so that a passenger could be removed by police.*'[81] Evidence from police members who attended Castlemaine train station was to the effect the train was stopping because there was a female they wanted '*kicked off*' the train.[82] Sergeant Neale stated: '*... what I was advised was that the conductor from the train had put her off the train.*'[83]

Conclusion

200. The evidence supports the view that by asking the train driver to call the police and stop the train Mr Irvine made a decision he wanted Ms Day to be removed from the train. I reject his evidence he did not have a *preference either way.*

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[76] T 71-72 (or '*an opinion either way*' T 99 or *'... for her own safety, I think it was appropriate.*' T 84).
[77] T 213-214.
[78] T 212.
[79] Exhibit 10.
[80] T 166.
[81] CB 70.
[82] Exhibit 32, CB 101.
[83] CB 124.

201. When Mr Irvine decided to call the train driver to call the police, there was a strong prospect that Ms Day was going to be removed from the train.

Concerns for Ms Day's safety

202. Mr Irvine stated his main consideration for Ms Day '*... was just her safety moving about on the rail network and where she was going to, whether she knew where she was going to and whether she was going to the right place.*'[84]

203. Mr Irvine agreed he had no objective information that there was any present existing danger to Ms Day on the train, and that his concern for her safety was not in the present moment on the train, but in future possibilities.[85] It appeared Ms Day had been able to negotiate herself onto the train.

204. When it was put him that he was *very quick* to reach the decision to call for the police, he explained that the train was getting close to Castlemaine and beyond that, Kyneton station was a further half an hour away and there was a station after that, Malmsbury, that was not a manned station.[86] Mr Irvine clarified his concern for Ms Day's safety was not on, but off the train,[87] and it was the imminent approach of Castlemaine train station that made him contact the police so quickly.

205. Acting General Manager Mr Brady supported Mr Irvine's course of action in contacting the train driver to call the police as in accordance with V/ Line training and instructions. In his opinion, Mr Irvine's principal concern was for Ms Day's safety.[88]

Did Mr Irvine know Ms Day was Aboriginal and did it impact his decision making?

206. In his statement Mr Irvine described Ms Day as '*...indigenous, with dark hair, about 40 years old.*'[89] In his evidence he could not recall how or when he knew Ms Day was indigenous. He could not recall whether he told police officers at the train station that Ms Day was Aboriginal, but agreed it was possible he told Senior Constable Thomas that Ms Day was '*... intoxicated ... she didn't have a ticket ... unruly ... Aboriginal.*'[90]

207. Mr Irvine agreed in his evidence he noticed Ms Day's dark hair but was equivocal in his evidence whether he noticed Ms Day's dark skin at the time he approached her on

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[84] T 202.
[85] T 184.
[86] T 105.
[87] T 106.
[88] T 217.
[89] CB 63.
[90] T 197.

the train.[91] He did not notice the shape of her facial features and was not certain whether she was '*white Anglo-Saxon.*'[92] Mr Irvine could not recall whether he noticed Ms Day was indigenous when he first saw her.[93] He could not recall whether he told the police officers on the train station that Ms Day was Aboriginal.[94]

208. Mr Irvine agreed that he took in details about Ms Day for a minute, namely his impressions about her behaviour, and her answers, which he thought were odd. His visual impression and her unrelated responses were the information on which he formed the view that she was *unruly* and required police attendance.[95]

209. Mr Irvine was asked '*Was she Aboriginal*?' and he replied, '*I don't believe so, no.*' and when asked whether Ms Day was '*of any identifiable cultural background*' Mr Irvine replied, '*... Not that I recalled noticing.*'[96] Mr Irvine was asked '*would her cultural background have made a difference to what you did?*', he answered '*No.*'[97]

210. Mr Irvine denied his decision to require police attendance '*was based on unconscious shortcuts ... partly based on a perception that Ms Day was Aboriginal.*'[98]

211. He was equivocal in his evidence as to whether he knew or noticed whether Ms Day was Aboriginal and even expressed uncertainty as to whether she was Anglo-Saxon. The direct evidence is that he referred to her Aboriginality in his statement and he mentioned it to police at Castlemaine train station. It was unclear why he was vague in his evidence about this. I find his equivocation as to when and whether he noticed the colour of her skin and her features as Aboriginal unconvincing.

212. In his statement he indicated '*I didn't smell alcohol, but my sense of smell is not very good.*'[99]

Conclusion

213. In her expert report on unconscious bias, Professor Jill Klein states:

'*Unconscious bias affects how we observe and interpret the behaviour of a person in a stereotyped group. Our unconscious biases can direct:...how we interpret a person's behaviour, with interpretation consistent with our stereotypes most likely to be*

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[91] T 180-181.
[92] T 181.
[93] T 181.
[94] T 181.
[95] T 183-184.
[96] T 201.
[97] T 201.
[98] T 190.
[99] CB 63.

adopted...we might see the behaviour of someone in a negatively stereotyped group as disruptive or disturbing to others, while we would give a more generous interpretation to the same behaviour by a person in a positively stereotyped group (such as our own group).'[100]

214. The report by Dr Thalia Anthony on systemic racism[101] notes, '*Unfair and discriminatory outcomes from laws that have universal application arise because agents of institutions adhere to dominant values and assumptions...Among these dominant assumptions include that Aboriginal people are drunks, drug addicts and unruly.*'
215. I find Mr Irvine made rapid decisions in less than a minute: he made a snap decision that Ms Day was an *unruly customer*, a *danger to herself* and required police attendance for her removal from the train.
216. He could also have made a decision she was a *passenger not in control*, which, the V/ Line procedures calls for consideration of other options.
217. Ms Day was sleeping and although she was no danger to herself or to anyone else, he told other passengers and staff she was *trouble* and disturbing others.
218. She was the only sleeping passenger he has ever called the train driver to call police for removal from a train (although he comes across three sleeping passengers a week).
219. He has called the train driver for police to attend to other *unruly* passengers, the three he recalled had been aggressive and abusive.
220. He was reluctant to own that his intent or preference was for Ms Day to be removed from the train.
221. This suggests Ms Day may have been treated differently to other passengers.
222. Whilst it was ultimately the police who arrested Ms Day and removed her from the train, Mr Irvine's decision to contact the driver to stop the train (for an unscheduled stop) and organise for police attendance did have a significant bearing on her being removed from the train.
223. He was equivocal in his evidence whether he knew she was Aboriginal.
224. Although describing her as *asleep or unconscious* and *delirious,* as well as *under the influence of drugs or alcohol* he did not consider calling for medical assistance such as

[100] CB 488.
[101] CB 927.

an Ambulance. He did not know at the time Ms Day was drunk (he did not smell alcohol on her) but thought she was affected was either drugs or alcohol.

225. The combination of this evidence suggests it is open to me to draw the inference that Mr Irvine's decision-making process was influenced by an unconscious bias in immediately deciding Ms Day was unruly, putting her in a higher category of response without considering other options. I find the decision to define her *unruly* and to call for police rather than pursue other options has been influenced by her Aboriginality.

V/Line training materials

226. The V/Line training materials which formed part of the coronial brief contained important information on emotional intelligence training for V/Line conductors in dealing with customer service and conflict management.

227. The V/Line training materials also included information about cultural and ethnic sensitivities, as well as a specific section titled 'Indigenous Australians.'[102]

228. Mr Brady agreed that safety was paramount, regardless of cultural and ethnic sensitivities: safety was the primary consideration and that training for staff is developed with that objective.

229. Mr Brady accepted the definition of unconscious bias in Professor Klein's report[103] and he understood the concept of unconscious bias, he was not able to say whether that concept informed '*any of the training that a conductor gets in relation to their roles and duties*' or that it was referred to in any V Line training documents.[104] Likewise, he was not aware of any measures employed by V Line or references to the concept of systemic racism in V Line policy documents.

230. Mr Brady was not aware whether the training materials had been prepared in consultation with the Aboriginal community, however, was of the view the training materials were appropriate.[105]

231. Mr Brady was not aware whether V/Line employed an Aboriginal liaison officer. Mr Brady was not aware of any review of the extent of racism or unconscious bias in its staff, but agreed this was a *good idea*, as was undertaking training about Aboriginal cultural competency with input from Aboriginal people.[106]

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[102] T 220.
[103] CB 849, T 238.
[104] T 221.
[105] T 243.
[106] T 247 – 248.

232. I sincerely hope that an organisation the size of V/Line, which provides such an important public transport service to the whole community, does have an indigenous liaison officer. I also hope the organisation takes steps to ensure an Aboriginal voice, perspective and input into its staff training materials.

Human rights engaged

233. In this investigation, Ms Day's right to freedom of movement under section 12 of the Charter appears to have been engaged.[107] V/Line is a Public Authority for the purposes of the Charter. The right was engaged by the conduct or decision to contact the train driver to contact police. The question then becomes whether any limitation of that right was demonstrably justified or potentially unreasonable.

234. I intend to recommend to V/Line to request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 4(c) review of the compatibility of its training materials with the human rights set out in the Charter.

The decision made by Victoria Police members to take Ms Day into custody at the Castlemaine Train Station and then keep her in custody at Castlemaine Police Station including any relevant policy and procedure and whether it was complied with

Police job to attend Castlemaine train station

235. At approximately 3.00pm on 5 December 2017, a job came over the police radio to attend Castlemaine train station about an '*unruly female passenger on board. She's either intoxicated or drug affected.*'[108]

236. Senior Constable (SC) Stephen Thomas and Senior Constable (SC) Aaron Towns were conducting 'tasking duties' in a marked station wagon, Goldfield 720. They were the first unit to arrive at the train station. They spoke to the train conductor who detailed '*that there was an Aboriginal in that carriage who was unruly/ intoxicated and didn't have a ticket.*'[109]

237. Senior Constable (SC) Kristian Hurford and Leading Senior Constable (LSC) Matthew Fitzgibbon (Kyneton police officers) were working the Castlemaine divisional van and heard the same job come over the police radio, '*The details we had were that there was a female they wanted kicked off the train as she was causing trouble on the train.*'[110]

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[107] Section 12, *Charter of Human Rights and Responsibilities Act 2006.*
[108] T 255.
[109] T 262.
[110] CB 101.

238. SC Hurford agreed with the proposition an independent assessment predicated Ms Day's removal for the train, his statement indicated he and SC Fitzgibbon's view that: '*We were of the belief they were holding the train until she could be taken off.*'[111]

239. The fact of Ms Day being removed from the train was not unusual to Sergeant Neale, the sergeant at Castlemaine Police station, because, '*If someone's drunk on a train, they generally get put off or police remove them.*'[112]

Police on the train

240. SC Thomas decided to '*go and have a chat with her ... and see what's going on*'[113] and when he alighted the train, he could see a pair of legs from the knees down blocking the carriage aisle. He got the feeling other people on the train '*had a look of disgust*' and '*it was obvious to me that she made other people on the train feel uncomfortable.*'[114]

241. SC Towns entered the train carriage following SC Thomas and his first impressions were, '*I thought she was drunk ... she was curled up in the seat, she was asleep ... she wasn't really responsive ... to people trying to talk to her ... the observation was ... she wasn't causing any trouble. She was just asleep.*'[115]

242. SC Thomas spoke to Ms Day and was unable to get a response. When he tapped her shoes, she *sprang up* and appeared *disoriented.*[116] She sat up and he could immediately smell alcohol and formed the view Ms Day was drunk.[117]

243. SC Thomas, who had been a police officer for nine years, was of the view he could see the signs of intoxication. He described her words as '*random*' and '*slurred*, '*her replies made no sense*' and '*Her words were almost unintelligible.*' He could make out some of the words she was saying, like '*jacks*' 'and *'it was more like moans and groans that a drunk person would make.*'[118]

Decision to remove Ms Day from the train

244. SC Thomas decided Ms Day could not remain on the train. He stated he did consider letting her continue to sleep on the train however '*I was worried that I'd be liable for something that happens if I left her there.*'[119] Although it crossed his mind to leave her

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[111] CB 101.
[112] T 758.
[113] T 264.
[114] T 265, CB 79.
[115] T 354.
[116] T 266-7.
[117] T 271.
[118] CB 79-80.
[119] T 273.

on the train, he could not assess her wellbeing as he did not know where she was going or her identity.

245. He described effecting the '*most low key arrest I've ever done*'[120] by asking her to come with him. He led the way off the train with her blue bag, '*for her own wellbeing.*'[121]

246. SC Towns stated they took Ms Day off the train because *'she was intoxicated and she never had a ticket.'*[122]

247. He stated the conversation with her was along the lines of, we needed to take her off the train and '*kind of look after her.*'[123] He explained as she did not know where she was going and had no ticket, '*We can't just leave her to travel the trainline without any place to go.*'[124]

248. SC Thomas stated it was not his intention to take Ms Day back to the police station, but he was hoping that there was *someone close by who would have come and picked her up.*[125] He agreed that when she was taken off the train she was arrested and effectively in police custody.[126]

Conclusion

249. The evidence suggests an expectation or anticipation by the police officers that if a train has been stopped requiring police attendance, then a person will be removed from the train: '*female they wanted kicked off,*' *holding the train until she could be taken off,*' '*generally get put off or police remove them.*' This expectation was a pressure on the attending police officers, as was the time pressure of the unscheduled stopping of the train. It was not however a predetermined decision: SC Thomas' evidence was he considered leaving Ms Day to sleep, then decided to arrest Ms Day for being drunk in a public place and removed her from the train.

250. The inclusion of whether systemic racism was a factor in Ms Day's death required me to consider whether this was a factor in the decision to arrest Ms Day, which gave police the power to remove her from the train.

251. Effecting his '*most low key arrest'* for Ms Day's '*own well being'* and other police officers referred to her '*protection*' and '*safety.*' SC Thomas refers in his statement to

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[120] T 274 & 280.
[121] T 312.
[122] T 355.
[123] T 355.
[124] T 355.
[125] T 275.
[126] T 275.

other passenger's '*looks of disgust*' and being '*uncomfortable*' about Ms Day when he entered the train. I am not satisfied those observations are sufficient evidence for me to draw an inference.

252. The general policing approach to section13 of the *Summary Offences Act 1966* has been to either use their discretion not to charge, or to charge[127] and arrest the person and transport them to the police cells to '*sleep it off.*' '*The rationale often given for such a process is that it is usually for the person's own protection.*'[128]

253. Victoria Police has previously stated '*that arrest (for drunk in a public place) is the option of last resort not first.* '[129]

254. I note the RCIADIC Interim Report stated:

'*Ignoring for a moment the question of whether the high arrest and detention rate demonstrates or reflects a bias against Aborigines in police practice, the question still arises as to whether Aboriginal people, having apparently committed an offence of a minor nature are being arrested and detained in custody when an appropriate exercise of discretion should have led to proceedings by summons rather than arrest ...*

Police officers should not arrest for a minor offence unless there are reasonable grounds for believing that the option of proceeding by summons is inappropriate. Unless there is demonstrable evidence that an offender will, if not arrested, either commit further offences or be a catalyst for the commission of offences by others, then the process of arrest should not be adopted.'

The two relevant recommendations are:

Recommendation 8:

Police officers should receive emphasis in training that arrest for minor offences must be avoided when alternative steps are available.

Recommendation 9

It should be the duty of officers in charge of police stations to evaluate (with a view to providing guidance for future situations) the decisions made by officers engaged on police patrols to arrest, rather than proceed by summons or caution.[130]

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[127] This Inquiry into Public Drunkenness predates section 13 of the Summary Offences Act becoming 'infringeable' in 2009 so that now, rather than a charge being laid, an infringement notice is issued.
[128] Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness – Final Report June 2001, p 109.
[129] Drugs and Crime Prevention Committee, Inquiry into Public Drunkenness – Final Report June 2001, p 117.
[130] RCIADIC Interim Report, p 68.

255. It is a rare situation when police get called to a job, only to attend and take no action. I accept the decision to arrest was made in the operational context and the pressure of time. SC Thomas arrested Ms Day for her own safety. He did not want to leave her sleeping on the train for both his own liability and her safety. Whilst an arrest for this offence is supposed to be the *last resort,* I am satisfied once he decided it was unsafe to leave her sleeping, it was his only viable option. I am not satisfied there is any evidence to support a finding Ms Day's Aboriginality played a role in this decision making.

On the platform

256. Ms Day was described as unsteady on her feet. The police officers tried to ascertain her name. SC Towns described the plan as '*trying to find her a place to go.*'[131] They were trying to get numbers from her phone because the best solution would be if they could get someone to come and get her.[132]

257. In terms of being concerned for her safety and being vulnerable, SC Towns identified potential risks such as Ms Day running or falling onto train tracks or being stolen from or mugged.[133] SC Thomas' concerns for Ms Day's wellbeing related to her being vulnerable to inappropriate conduct from someone else.[134]

258. SC Towns' rated Ms Day's level of intoxication, in retrospect, to be 7.5/10, but did not consider when he was dealing with her to call for an ambulance. He described her as '*improving*' and '*she'd become quite responsive as ... it went on.*'[135] Although it did not seem that she was deteriorating, '*... it's just too unsafe for her to be left on the train ... you've got an elderly lady that's in a vulnerable state...it wouldn't be the right thing to leave her on a train by herself.*'[136]

259. Whilst they were on the platform LSC Fitzgibbon and SC Hurford arrived in the divisional van as the train was pulling out.

260. LSC Fitzgibbon's first assessment of Ms Day's level of intoxication at the train station was '*She was seated, so it was only at that stage I only had her slurred, and riddled ...*

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[131] T 359.
[132] T 359.
[133] T 360.
[134] T 344.
[135] T 361.
[136] T 362.

response to her answer s... I couldn't smell alcohol.'[137] In his statement he was satisfied Ms Day was intoxicated and it was for her safety the best option was to arrest her.[138]

Ms Day's condition in relation to the Medical Checklist

261. The *Victoria Police Manual (VPM) - Guidelines for the Safe management of persons in police care or custody* at 2.1 has a Medical Checklist. The VPM requires members to assess persons that come into police care or custody using the Medical Checklist.

262. The Medical Checklist[139] states it '*Applies to ALL persons in the care and custody of police at ALL TIMES.*' It contains a coma scale and is structured under related three headings with five levels: Best verbal response, coma scale and medical action, as follows:

5 ORIENTED Knows and clearly states name, date and place = coma scale 5 – no action required.

4 CONFUSED unable to state name, date, place, etc = coma scale 4 – Consider obtaining medical advice. Monitor regularly for signs of deterioration.

3 MEANINGLESS UNINTELLIGIBLE = coma scale 3 – Send to hospital or seek urgent medical advice.

2 MOANS/GROANS no sensible words = coma scale 2 – Send by ambulance to hospital.

1 NIL RESPONSE No response at all = coma scale 1 – URGENT action required Send by ambulance to hospital

263. The police officers were questioned about their assessment of Ms Day's condition against the Medical Checklist.

264. SC Thomas stated was that whilst Ms Day was '*meaningless and unintelligible'* on the train, once on the platform, her responses were getting *a lot better a lot quicker.*[140]

265. He agreed according to the Medical Checklist '*meaningless and unintelligible'* required hospital or urgent medical advice. He could have driven her to hospital in two minutes. He described her as improving to a state of being '*confused*' once she was on the train platform.

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[137] T 411.
[138] T 413.
[139] CB 236.
[140] T 293.

266. He considered calling an ambulance for Ms Day given her level of intoxication, but in the short time she was with police, '*she had improved ...and had got to the point where I didn't think an ambulance was required.*'[141]

267. SC Towns explained the decision-making process as having a three-minute conversation with Ms Day on the train when she may have fallen into the category of *meaningless, unintelligible* and *confused*, but following a further fifteen minute conversation with her, she fell into the category of *confused.*[142]

268. As the minutes ticked over her responses were improving so he did not consider it necessary to seek medical attention, to the point that when she climbed into the divisional van her state was between '*confused and oriented.*'[143] By the time she was put in the divisional van, she was having difficulties communicating, '*it wasn't to the point where it made no sense.*'[144]

269. H was asked why she was not taken straight to hospital once Ms Day was taken off the train, or whether that would have been a sensible and available option to take her two minutes down the road to the hospital and have her checked out. He stated: '*Well at that point, the decision was made that it wasn't necessary, so we didn't take her to hospital.*'[145]

270. SC Thomas stated he always tries to find an alternative arrangement when someone is not physically aggressive, '*back to the cells is the last resort.*'[146]

271. When Ms Day was placed in the van, SC Towns described her condition as '*confused*' and agreed the course suggested on the Medical Checklist is to: '*Consider obtaining medical advice and monitor regularly for signs of deterioration.*' He stated there was no discussion between himself and SC Thomas about this and he did not hear the other members discuss this as a course for Ms Day.

272. SC Fitzgibbon described Ms Day as '*confused*' when he arrived at the train station and '*oriented*' by the time she was in the back of the divvy van.[147] He did not give consideration to calling for medical assistance or an ambulance as he '*didn't believe it was required.*[148]

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[141] Tb289.
[142] T 374.
[143] T 294.
[144] T 372.
[145] T 375.
[146] T 282.
[147] T 414.
[148] T 413.

273. SC Hurford described police interaction with Ms Day at the train station as '*struggling to communicate...as she was making no sense ... looked puzzled as to what was going on ... talking to each of us and not focussed on any of us.*'[149]

274. When asked if her presentation fell within coma scale 3, '*meaningless, unintelligible, not able to be understood,*' he responded '*Perhaps. Or confused ... she was obviously talking. We could make some words out ... so she's just a bit disoriented at the scene,*' however the appropriate medical action '*send to hospital or seek urgent medical advice*' was not discussed and at no point did he suggest calling an ambulance or seeking any medical attention for Ms Day.

275. In his statement, SC Hurford described Ms Day looking at her mobile phone '*like it was some sort of foreign object*' and '*swiping at the screen but [she] couldn't answer it.*' '*We kept asking her, but I couldn't make out what she was saying. I could only understand every third word as she was slurring her speech really badly. She was saying things like 'yes, numbers.' She kept looking at us like she couldn't understand what was going on.*'[150]

276. When asked whether that was something he thought was appropriate at that point in time he stated: '*Well, at that time because obviously I could smell the alcohol, I'd just made an observation and a generalisation that perhaps intoxicated because we could smell it. I could smell it.*'[151]

277. Although Ms Day was saying some things that were meaningless and unintelligible, and that she appeared to be confused about certain matters, she did improve.[152] SC Hurford disagreed about taking her to hospital: '*No, we don't, we don't just take them to hospital – look, after ringing her daughter and with her daughter saying that she had no medical or was on no medication, and to us she was identifying as intoxicated.*'[153]

278. LSC Fitzgibbon stated Ms Day was not treated like any drunk. '*... we spent more time with Ms Day. We were gentle with Ms Day, ... we showed her compassion as she wasn't your regular, everyday drunk as such ... we actually tried to treat her, in fairness, better*

[149] CB 102.
[150] CB 102.
[151] T 507.
[152] T 626.
[153] T 627.

than equal ... Because she was vulnerable. She wasn't hurtin' anyone. We just showed her the respect that she deserved.'[154]

Conclusion

279. Ms Day's presentation on the train appeared to meet the requirements of coma scale 3[155] requiring that she be sent to hospital or seek urgent medical advice.

280. Although on the platform there was reference to '*her responses were improving*' and to her becoming '*quite responsive,*' it was unclear how that manifested. I presume the improving aspects of Ms Day's presentation were of a non-verbal nature, in that she could walk and somewhat follow police instruction.

When asked whether she required medical attention or whether it was considered by the police officers they were of the view that because Ms Day was affected by alcohol, her presentation was not 'medical' in nature and did not require a medical response. That Ms Day's daughter had told SC Hurford she had no existing medical conditions contributed to their belief she was *identifying as intoxicated.*

281. Despite her lack of orientation, incoherence and being so unintelligible SC Hurford can only understand *every third word*, only one police officer gave consideration to getting her medical attention. If she had improved so that she was at coma scale 4, I find there was minimal evidence of compliance with the Medical Checklist: 4 Confused - *Consider obtaining medical advice. Monitor regularly for signs of deterioration.*

Other options to custody

282. SC Thomas agreed Ms Day was in custody, but he could not leave her on the train station platform and did not want to take her back to the police station so was searching for an alternative arrangement.

283. SC Fitzgibbon agreed that once the discretion to arrest was exercised, it was starting a process that a person was very likely to end up in the cells.[156]

284. SC Hurford explained: '... *she was under arrest for drunk in a public place, and as part of that is to obviously try and protect them as well, as they could be a danger to themselves or someone else.*'[157]

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[154] T 493-4.
[155] T 273 SC Thomas' evidence also references on the train Ms Day made '60% moans and groans.' (T 273).
[156] T 458.
[157] T 605.

285. SC Hurford agreed that once the decision is made to arrest someone for drunk, '*that stream is going to sweep her into custody and doing four hours down in the cells? Ultimately, yes.*'[158]

286. S/C Hurford agreed he was acting to protect Ms Day and keep her safe.[159]

287. SC Towns conducted a name check and established her identity.

288. The police officers tried to get some phone numbers out of Ms Day's phone. After seeing the CCTV footage from the train station SC Thomas noted Ms Day's phone screen was badly smashed and was difficult to make out the numbers in the sun.

289. In his statement he stated, '*We got to the point where we had to take Tanya back to the police station.*'[160] He confirmed that was the point at which there appeared to be no other viable options. In re-examination he could not recall any other discussions for options there might have been for Ms Day.[161]

290. SC Thomas could not recall SC Towns taking numbers out of Ms Day's phone for the other police members to type into their phone but became aware this had happened after they left the train station.

291. SC Towns stated there was no family contact made prior to Ms Day being put in the back of the divvy van. He explained we '*only actually got the numbers out of the phone as we were walking back towards the van.*'[162] SC Towns retained Ms Day's phone and attended to other tasks whilst Ms Day was taken to the police station in the divvy van.

292. SC Hurford's statement indicates he called Kimberley, Ms Day's daughter, whilst he was at the train station and spoke to her: '*She asked what was going to happen to her mum and I advised that as she was intoxicated and she would be taken to the Police Station as per our procedure with any drunk.*'[163]

293. The CCTV footage does not show SC Hurford making the call to Kimberly on the train platform.

294. SC Hurford's recollection was the phone call to Kimberley was made by him prior to Ms Day being placed in the back of the divisional van[164] however after reviewing the

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[158] T 625.
[159] T 623.
[160] T 324.
[161] T 347.
[162] T 363.
[163] CB 103.
[164] T 630-31.

CCTV footage he conceded he was on the phone to Kimberley at the time Ms Day was being put in the divisional van.[165]

295. SC Fitzgibbon believed the call was made whilst on the train station and before a decision was made to put Ms Day in the divisional van. The CCTV footage shows SC Thomas take Ms Day's bag at 3.27pm, so at that point it appears that Ms Day is going to be put in the divisional van.[166]

296. SC Fitzgibbon denied it was a '*done deal*' that Ms Day was going to be taken back to the police station and stated: '*Not at all. Even on the phone, he still tried to get someone to come and collect her.*'[167]

297. I am satisfied SC Hurford made the call to Kimberley when Ms Day was being placed in the divisional van.

298. This call appears to be the only call made by police officers from the train station to find alternatives to Ms Day going into custody.

299. When asked what other options were considered for Ms Day, SC Thomas stated he could not leave her on the platform, because she was in 'police care' at that stage. He had given evidence he was part of the 'tasking unit' which was a 'floating unit' and had been travelling to places such as Pyramid Hill which is about an hour and a half from Castlemaine. He would have liked to leave her in the care of someone who knew her. It did not occur to him to think of taking her to the Bendigo District Aboriginal Corporation (BDAC).[168]

300. SC Towns stated did not think of driving her somewhere, such as Echuca as '*that's just not normal practice.*'[169] He agreed he had done community policing as far as Pyramid Hill. He did not consider taking her to Bendigo to the BDAC as it '*just didn't occur to me at the time.*'[170]

301. SC Fitzgibbon stated he was aware of the local aboriginal community organisation in Bendigo, BDAC. His evidence was that it was not an available option to take Ms Day there. He stated: '*We tried to find alternate- get someone to come and collect her or whatever the case is and we couldn't. We all discussed the situation and we felt at the time our best option was to lodge her in the cells.*'[171]

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[165] T 637.
[166] T 452.
[167] T 454.
[168] T 334.
[169] T 333.
[170] T 334.
[171] T 444.

302. S/C Fitzgibbon denied if she had been a white woman from Bendigo they would have not put her in the cells and would have found an '*ad hoc solution.*'[172]

303. SC Thomas stated police spent about 20 minutes with Ms Day at the train station, which he described as '*probably fifteen minutes more than a lot of other people get.*'[173] He stated that all four police officers '*had a try at ... getting the information ... to have someone come and pick her up or to not to bring her back to the station.*'[174]

304. SC Towns stated Ms Day had to go back to the police station. '*There's nothing else we could do.*' '*... we had no other contact details of anybody else in the area, ... that was related to her or family members.*' '*...we didn't have an address in the local area,*' '*... there were no other real options. We were standing on the side of the train platform, ... it's not the safest area to be ... so it was decided the best option was to proceed back to the police station, where we could utilise other information and ring other services ... to obviously assist us in finding somewhere for her to go.*'[175]

305. SC Towns indicated that had he ascertained whilst on the train station that Ms Day had an address nearby, he would have taken her to that address, or alternatively, if someone could have come to collect her within 20 minutes or half an hour, he would have waited for that person to come and collect her.

306. In SC Fitzgibbon's view, it was not an option to leave Ms Day to wait for the next train, because she'd been '*passed out,*' '*she was still slurred, a little bit confused*' '*It just didn't seem the right thing to do – leave her sitting there.*' He did not believe it would have been safe as she was still intoxicated.[176]

Conclusion

307. The majority of time at the train station appears to have been spent establishing Ms Day's identity and trying to unlock her phone for contact numbers. The evidence from the officers suggests talk of proactive attempts to find an alternative to taking Ms Day to the police station but there is no *evidence* of any calls to, for example the Victoria Police Aboriginal Liaison Officer, or elsewhere. Clearly the police officers were concerned about Ms Day and they said they were trying to find alternatives, but there was no evidence of how that translated to action.

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[172] T 447.
[173] T 344.
[174] T 345.
[175] T 386.
[176] T 416.

308. The police officers did action appropriate welfare requirements at the police station, by contacting Ms Day's family, the ACJP and send the notification to VALS via the custody notification system.

309. The lack of alternative options to custody for Ms Day is hardly surprising. She had travelled from Echuca[177] and was removed from the train on her way to Melbourne in Castlemaine. It was not difficult to foresee that removing her from the train part way through a journey through country Victoria would present difficulties with finding her an alternative to custody. Many people so removed from a V/Line train would find themselves in a similar position. Her family resided hours away and she was alone on the train.

310. Although police officers spent 20 minutes with her at the train station it was to little result. There was no list of alternatives canvassed although the officers regarded custody as the last resort. There was evidence of attempts to access Ms Day's phone but no evidence of what she said or communicated to officers. There was one call to her daughter made when Ms Day was being put in the divisional van.

311. I note the observation made in the Inquest Finding into the death of Ling Gong Tang: '*...whilst incarcerating citizens may become routine for police officers, there is no such thing as a minor deprivation of liberty- particularly for the offence of drunk in a public place.*'[178]

Decision not to hand cuff

312. There is a general police rule that everyone should be hand cuffed. On her journey in the divisional van Ms Day was not hand-cuffed.

313. SC Towns stated he did not feel it was warranted: '*I think she's someone who would have been upset by being handcuffed and – and I felt like she didn't pose a threat to us.*'[179]

314. LSC Fitzgibbon stated, '*Just about all arrested people are, but Ms Day wasn't a threat to any of us so it was discussed and she wasn't handcuffed.*'[180]

315. I am of the view this was a small but sensitive act by police officers having regard to Ms Day's age and status.

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[177] The coroner's investigators summary and the statement of identification completed by Belinda Stevens refer to Ms Day living in Moama, NSW. On 5 December 2017 she commenced her journey from Echuca.
[178] COR 2010 1790 p 26 [119].
[179] T 349.
[180] T 401.

Penalty notice

316. When he returned to the police station, SC Towns made enquiries about a penalty notice and was advised the Kyneton police officers had already written it.[181]

317. SC Thomas confirmed that for the hundreds of arrests he had made for someone being drunk, a penalty notice is always issued, and usually posted out.

318. SC Fitzgibbon explained that before the offence of being drunk in a public place became infringeable, a person would be charged on bail. Now that an infringement notice is issued, it was his evidence that he would be criticised if he did not issue an infringement notice.[182] In his view, he had no choice but to issue an infringement notice. The process is that Ms Day would receive the infringement notice when she was '*discharged ... let out.*'[183]

319. There was some exploration at inquest as to why, if an infringement notice is issued, it was still necessary to keep Ms Day in the cells. The four-hour rule was cited so she could sober up.[184] SC Thomas was of the view the source of police power to take Ms Day into custody and hold her until she is sober was section 13 *Summary Offences Act 1966* and she was under arrest until she left the police station.[185]

320. Section 13 of the *Summary Offences Act* was made an infringeable offence by the *Summary Offences and Control of Weapons Amendment Act 2009*, which came into effect on 16 December 2009. The Explanatory Memorandum notes:

'*Victoria Police statistics clearly demonstrate that there has been a marked increase in the number of people detained for being drunk in a public place over the last five years. Increasing the maximum penalty for the offence (from one to four penalty units) and allowing for it to be enforced by infringement notice is intended to significantly deter people from engaging in public drunkenness.*'[186]

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[181] T 285 'obviously I've ... enquired about the penalty notice because that's just...that's what we do...when someone goes in the cells, that's generally what happens.'
[182] T 421-22.
[183] T 423.
[184] T 423.
[185] T 424.
[186] Summary offences and Control of Weapons Acts Amendment Bill 2009 Explanatory Memorandum, clause 4, page 3.

321. Rather than keeping people out of custody, the effect of making the offence of drunk in a public place an infringeable offence appears to have doubled the penalty by the operation of the four hour rule *and* an infringement notice for $634.[187]

Heavily intoxicated female at the Cumberland Hotel

322. After leaving the train station (Ms Day was in the divisional van being taken to the police station), the running notes indicate that SC Thomas and SC Towns then dealt with a '*heavily intoxicated female at the Cumberland Hotel.*'[188]

323. SC Towns had written the running sheet and wrote this entry an hour before he went off duty. It was his evidence the entry and description of the woman being '*heavily intoxicated*' was correct.[189]

324. SC Thomas did not recall the woman as being '*heavily intoxicated*' although she '*might've been drinking.*'[190] He agreed that he had read and signed the running sheet at the end of his shift which described the woman as '*heavily intoxicated.*'[191]

325. SC Thomas recalled the woman was not indigenous but may have been '*middle eastern or European.*'[192]

326. As SC Towns recalled, the job came over the radio, '*she was in the Cumberland Hotel and she was ... she had no money and was annoying patrons in the hotel to try and get some money. So we've gone into the hotel and I believe she was intoxicated and she needed to get home but she had no money to get home so we had contact details for a partner, ... she gave ... to us.*'[193]

327. SC Towns described Ms Day as more intoxicated '*than this female.*'[194] SC Towns said that as he knew the given address, they dropped her there. She was not issued with an infringement notice as '*I don't believe she was drunk to the point where you'd issue an infringement notice for a person that was drunk in a public place. The circumstances were completely different in relation to Ms Day ... and the ability she had to communicate with us, compared to this female having the ability to communicate with*

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[187] The original rationale for making offences infringeable was to offer a 'deal' for minor offending and reduce the strain on the court system: people could choose to pay a fine (calculated at approximately 25% of the maximum penalty) and avoid having to attend court. No conviction was recorded and the offence expiated upon payment.
[188] CB 203 T 295.
[189] T 369.
[190] T 296.
[191] T 297.
[192] T 298.
[193] T 366.
[194] T 367.

us as well.'[195] He did not consider arresting this woman as '*the circumstances were completely different.*'[196]

328. SC Thomas confirmed they drove her to her friend's place and did not arrest her or issue her with a penalty notice, as there was no reason, as he did not recall her being '*heavily intoxicated.*'

329. SC Thomas agreed that he took a '*community type of response'* policing approach to looking after this woman and driving her home. He confirmed police had discretion on a case by case basis as to whether to arrest, charge or issue an infringement notice, and he had previously dealt with people who were drunk in that way.

330. In her consideration of section 9 of the *Racial Discrimination Act* Justice Mortimer considered whether a *comparator* was required by the words '*on an equal footing*' in both section 9 and Article 1(1) of the ICERD. She referenced Gleeson CJ who in *Griffiths v Minister for Lands, Planning and Environment* [2008] HCA 20: 235 CLR 232 at [7] stated: '*Discrimination is judged by making comparisons.*' In her view, the presence of the words '*on an equal footing'* required some comparative analysis of the circumstances.

331. I am not seeking to apply the legal test from the *Racial Discrimination Act* but using the jurisprudence to assist in my assessment of the evidence having regard to the scope of the inquest including the role, if any, of racism, systemic or otherwise in the decision making on 5 December 2017.

332. Justice Mortimer referred to the *Minister for Immigration and Multicultural Affairs v Khawar* [2002] HCA 14; 210 CLR 1 at [78] which cited Justice Gaudron in *Street v Queensland Bar Association* when dealing with '*disability or discrimination'* in section 117 of the Constitution she said:

''*Although in its primary sense 'discrimination' refers to the process of differentiating between persons or things possessing different properties, in legal usage it signifies the process by which different treatment is accorded to persons or things by reference to considerations which are irrelevant to the object to be attained. The primary sense of the word is 'discrimination between'; the legal sense is 'discrimination against'.*'

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[195] T 367.
[196] T 368.

333. Justice Mortimer concluded that both the *Racial Discrimination Act* and *ICERD,*[197] '*are at base concerned with eliminating the unjustified differential treatment of people on the basis of race. It is the assessment of the difference in treatment and its basis in race which is the gravamen of the prohibitions.*'[198]

Conclusion

334. The comparison of the differential treatment between Ms Day and the *heavily intoxicated woman at the Cumberland Hotel* can be explained by the fact that woman had an address in Castlemaine where she could be easily driven by the police officers. The police officers' evidence was that '*her circumstances were completely different to that of Ms Day*' although the address appears to be the significant point of difference. Police officers referred to communication differences and she was annoying hotel patrons for money.
335. However, she was not arrested, not taken to the police station, not put the cell and not issued with an infringement notice for either drunk in a public place or for begging. She was given a lift home.
336. The comparison is notable for both its similarity and timing. Having discounted the need to get medical attention for Ms Day, but for being able to provide an address, the circumstances do not appear to be *completely different* to Ms Day.
337. I have referred above to police evidence that custody was the *last resort*, and the *plan* for Ms Day was to '*find a place for her to go*' and '*alternative arrangements*.' There was little in the way of community or medical options explored for Ms Day at the train station platform. One phone call was made to her daughter at the same time Ms Day was being placed in the back of the divisional van.
338. It is hard not to compare Ms Day's treatment with that of the *heavily intoxicated woman at the Cumberland Hotel*. The lack of options *actually canvassed* for Ms Day (such as considering driving her to Bendigo BDAC or ringing the Aboriginal Liaison officer for advice) as an alternative to custody, in comparison to the treatment of *the heavily intoxicated woman at the Cumberland Hotel* immediately after Ms Day's arrest suggests to me a clear inference there was a differential treatment of Ms Day.
339. Ms Day was not the beneficiary of '*community policing,*' a friendly alternative of being driven somewhere so she could avoid being placed in custody. Ms Day, whose voice

[197] International Convention on the Elimination of All Forms of Racial Discrimination.
[198] Wotton p 183 [544].

has not been heard during the course of the evidence as to what she said to police, did not provide an address of a friend or family member in Castlemaine. It was more challenging but there were potential alternatives for her which the police officers did not think of.

340. As Commissioner Wootten pointed out in his Finding into the death of Harrison Day, *'Officers sometimes exercised a discretion to drive drunks home, but not Harrison Day ...'*[199]

341. Through the comparison of differential treatment, in the exercise of their discretion between Ms Day and that of the *heavily intoxicated woman at the Cumberland Hotel,* the police officers' actions reflected an absence of problem solving and the genuine treatment of custody as a place of last resort, particularly for a minor offence. However I am not of the view there is evidence to make a finding the differential treatment was based on Ms Day's Aboriginality.

The appropriateness of the response by the Aboriginal Community Justice Panel to the notification regarding Ms Day's incarceration, the reasons for their non-attendance, including any relevant policy or procedure and whether it was complied with

342. Aboriginal Community Justice Panels (ACJP) were established in Victoria prior to the final report of the RCIADIC.

343. They arose in response to the recommendation for a means of either diverting indigenous people from police custody or at least reducing the amount of time they spent in police custody.

344. The CCTV footage shows Ms Day arriving at Castlemaine Police Station in the divvy van and being processed at the police station.

345. At the Castlemaine police station SC Fitzgibbon called the ACJP as required by the VPM Guidelines Safe management of persons in police care or custody.[200] He spoke to Sandra Owen, '*Just to inform them that we have got an aboriginal in custody.*'[201] He estimated that he had dealt with the ACJP approximately a dozen times, and in relation to someone being drunk, '*I've dealt with them probably half a dozen times.*' Of those, he estimated perhaps 10 per cent had actually attended and seen someone in a cell.[202]

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[199] Royal Commission into Aboriginal Deaths in Custody, Report of the Inquiry into the Death of Harrison Day, 9 August 1990, Commissioner JH Wootton.
[200] CB 249.
[201] T 417.
[202] T 418.

346. It was SC Fitzgibbon's evidence Ms Owen said that Ms Day was not known to her and she was not prepared to send staff to collect her. SC Fitzgibbon said she told him '*she may be able to get someone or make some enquiries if she knew someone.*' He said, '*We'll touch base in about 20 minutes.*' He called back and there was no answer. SC Fitzgibbon was not surprised the ACJP were not able to come or send staff to collect Ms Day.[203]

347. SC Fitzgibbon hand wrote on the ACJP Call Out Register[204] that Ms Owen was '*not attending at this stage – not known to CJP.*' He wrote this down because that is what he understood Ms Owen said to him.[205]

348. SC Fitzgibbon agreed that, although he did not consider it at the time, potentially, he could have asked Ms Owen if he could take Ms Day up to her.[206]

349. LSC Rowe estimated he had called the ACJP approximately 40 times when he had Aboriginal people in custody, but could not recall a time when someone from ACJP had collected someone who was intoxicated before the four hours had expired.[207]

350. Sergeant Edwina Neale, the custody supervisor, also understood that ACJP volunteers could come to the station to collect intoxicated persons, but in her experience not seen that happen.[208]

351. Ms Owen gave evidence she was a volunteer and Chair of the ACJP which was established to assist members of the Aboriginal community in police custody. As at 5 December 2017, Ms Owen and two other volunteers comprised the ACJP in Bendigo, which provided a 24-hour seven day a week service.[209] At the time, they would each be on-call for two weeks at a time, with Ms Owen being the backup, in case the volunteer did not answer a call to the ACJP phone.[210]

352. Ms Owen agreed she spoke to SC Fitzgibbons but did not accept his recall of their conversation.[211] Although she was asked if she knew Ms Day and stated that she was not known to her, '*that didn't mean that we weren't going to support her.*'[212]

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[203] T 419.
[204] CB 211.
[205] T 489.
[206] T 485.
[207] T 689.
[208] T 765.
[209] T 533.
[210] T 534.
[211] T 590.
[212] T 590.

353. Ms Owen stated her rational for not attending was not that she did not know Ms Day but that '*I asked them to call me back once she had sobered up.*'

354. Ms Owen's evidence was that the majority of callouts when ACJP volunteers attend the police station is for people under the age of 18, sitting with the young person and '*waiting for DHS to come.*'

355. Ms Owen estimated that in 50% of cases involving adults, a volunteer would attend the police station,[213] however ACJP volunteers do not attend police stations to collect intoxicated people because it puts the volunteer at risk.[214] Ms Owen indicated she would not be willing to collect someone from the police station who was still intoxicated because of the potential risk, particularly if she did not know the person or their level of intoxication.[215]

356. Ms Owen was taken to a document of ACJP policies and procedures whish states: '*One of the major roles fulfilled by the ACJP program is provide a callout service to Aboriginal people who have been involved in an incident and are held in custody in a police station.*'[216] Ms Owen agreed this was a major role of the ACJP, but stated '*... if they don't want us there then ... we can't really offer that support and we have to respect that.*'[217]

357. Ms Owen was taken to the ACJP Attendance Policy which states:
'*Each local ACJP must attempt to attend the majority of callouts within its local area. A reason should be specified for any non-attendance...Where a member of the local ACJP cannot attend a call-out for a particular reason, alternate measures need to be put in place.*'[218] Ms Owen cited an '*alternative measure'* as '*The police officer to call me back once the person had sobered up.*'[219] Ms Owen noted that ACJP volunteers do not get training in dealing with intoxicated people or medical emergencies.[220]

358. Ms Owen was asked whether Ms Day could have been taken to BDAC, but her response was that it would have put the community at risk.[221]

359. It was put to Ms Owen that there is nothing in the ACJP policy that anticipates an intoxicated person will not be picked up by the ACJP, and that in some Victoria Police

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[213] T 538.
[214] T 540.
[215] T 548.
[216] CB 351, T 544.
[217] T 544.
[218] CB 351, T 549.
[219] T 549.
[220] T 548.
[221] T 550.

policy documents there is an expectation that ACJP could collect someone who is intoxicated. Ms Owen stated: '*I don't think they have any regards for a volunteer or the safety or well-being of a volunteer. There has been expectations that we drive someone home, intoxicated, and we're just not going to put ourselves at risk, especially if we don't know the person. If you don't know the person, you don't know their background, you don't know what ...they are like when they're...affected by alcohol or drugs.*'[222]

360. Ms Owen noted that since Ms Day's death there has been a change to procedure at police stations whereby people in custody are now put on the phone, '... *we have to hear it from them that they don't want the support or they do want the support. Where, in the past, in custody officers would not put offenders on the phone.*'[223]

361. Ms Owen was in favour of being able to use an iPhone to have visual contact by way of a video call with detainees,[224] and agreed there was a need for 'sobering up safe places' with a health based focus.[225]

362. LSC Fitzgibbon did not believe he could have taken additional steps with Ms Day.[226] He stated that police officers tried to contact a friend or relative of Ms Day for 20 minutes. There was the automatic notification of VALS. He contacted the ACJP. He was not aware of a sobering up centre near Castlemaine. Ms Owen did not ask him to take Ms Day up to her. Never in his prior dealings with ACJP had he been asked to take someone to them. In terms of a 'work around solution' although noting he had to follow police guidelines, LSC Fitzgibbon stated: '*If we could have found an alternate place to take Ms Day, we would have been able to.*'[227]

Conclusion

363. The ACJP was contacted by LSC Fitzgibbon as required by the VPM Guidelines.

364. Whilst there is a conflict in the evidence as to how and why ACJP staff non-attendance was articulated, the reality described by Ms Owen was that ACJP volunteers never attend to collect intoxicated detainees from custody.

365. There is a lack of consistency between the ACJP policy and procedures and the implementation by staff.

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[222] T 550-1.
[223] T 575.
[224] T 577.
[225] T 578.
[226] T 494.
[227] T 497.

366. I accept that despite the intent of the RCIADIC recommendations to establish ACJP's, in practice the ACJP does not provide a protective measure for intoxicated Aboriginal persons in custody.

367. The VPM Guidelines present the ACJP as a realistic alternative to lodgement in custody, when that is not the case. No police officer who gave evidence could recall an occasion when someone from the ACJP took custody of an intoxicated person.

368. Whilst Ms Owen's response may have been usual practice, it was not in accordance with ACJP policy and procedure.

369. The intent behind the establishment of the ACJP model was laudable. The reality is it has been established using a volunteer model (with incumbent difficulties attracting and maintaining volunteers as described by Ms Owen) which struggles to fulfil the demanding time and physical requirements of the role.

370. I intend to make a recommendation that the appropriateness of the current model of the ACJP to perform the protective measures originally envisaged be reviewed, particularly given the differences revealed between policy and practice. The disconnect between the VPM Guidelines and the ACJP policy and procedure will be reviewed in the context of this proposed recommendation.

Sobering up centres

371. Ms Owen's evidence was that there had been no 'sobering up' centres since she has been an ACJP volunteer.[228]

372. There was no evidence of any 'sobering up' centres being in existence.

At the Castlemaine police station - Alternatives to being placed in a cell

373. Sergeant Neale stated that once a person is arrested for being drunk in a public place, it is inevitable they will be placed in a cell at the police station if someone cannot come an collect them.[229] There were no alternatives. such as sitting in the waiting room.[230]

374. When asked whether there was a 'workaround solution' or a least punitive, least restrictive option available, the alternatives were a call to family (SC Hurford called Kimberley, Ms Day's daughter) and SC Fitzgibbon called the ACJP.

375. LSC Cairnes stated he would have been available, with LSC Rowe, to take Ms Day to Bendigo had he been asked to.[231] He agreed it was a possibility, but he never thought of

[228] T 549.
[229] T 754.
[230] T 439.
[231] T 728.

raising it, as he thought other members were negotiating '*with Tanya ... in relation to other ... methods of transportation or releasing her into other people's or person's custody.*'[232]

Whether the custody management of Ms Day was in accordance with relevant Victoria Police Manual policies, procedures and guidelines

Relevant obligations of custodial authorities in Victoria to protect the safety and welfare of persons who are drunk in custody

376. In 2014, the Victorian Ombudsman prepared a report: Investigation into deaths and harm in custody (March 2014) which made the following overarching statements:

- *The State owes a duty of care to every person detained in custody to ensure their safety and wellbeing. For example, in the Victorian prison system the Secretary of the Department of Justice has a statutory duty to ensure the safe custody and welfare of prisoners and offenders in the Secretary's custody.*
- *There are a number of rights that are engaged under the Victorian Charter of Human Rights and Responsibilities Act 2006 when a person is detained in custody, including a person's right to humane treatment and the right not to be arbitrarily deprived of life.*
- *The Victorian community should have confidence in what happens behind the closed doors of custodial facilities – that detainees are managed in a fair and consistent manner; that they are treated with dignity and respect for their human rights; and that those responsible for caring for detainees are held accountable for their actions.*
- *Many people in custody are vulnerable, often with complex social, legal and medical histories. Each year a number of people die in custody, while many more experience some form of harm, injury or illness.*

295. The applicable policy, procedure and legislation at the time of Ms Day's death included:

- *The Victoria Police Manual – Policy Rules, Persons in police care or custody* (dated 31/07/2017) – referred to as 'VPM Rules';

[232] T 728.

- *The Victoria Police Manual – Procedures and Guidelines, Safe management o persons in police care or custody* (dated 09/10/2017) – referred to as 'VPM Guidelines';
- *Castlemaine Police Station, Standard Operating Procedures Including Watch House Keeper and Care of Prisoners Instructions Updated 09/06/ 2016* – referred to as CPS SOPS (9/6/2016);[233] and
- *The Charter of Human Rights and Responsibilities Act 2006*. There are a number of relevant sections including 22(1) which provides that: *All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.*

377. The VPM Rules state:

Persons in care or custody – principles

The following principles underpin the management of persons in police care or custody. Members who have the responsibilities in relation to persons in care or custody, as outlined in this policy must apply these principles:

- *The overarching consideration is the safety, security, health and welfare of the person in care or custody.*
- *Each person in police care or custody must be treated as an individual, having regard to their specific risks and needs. It must not be assumed that all persons need to be managed as high risk.*
- *Decisions about how a person is managed and what amenities they are given access to must balance the person's welfare, dignity and human rights against any risk to their safety and security, or the safety and security of others, including police members.*
- *Persons must be continually monitored and assessed, particularly in respect of their medical condition, risk of self harm, risk of harming others and security risk. When medical or safety risks are identified, they must be responded to promptly and the appropriate assistance or advice must be obtained.*

Taking a person into care or custody

[233] CB 600. Further, the Castlemaine Police Station, *updated Standard Operating Procedures,* reviewed 08/10/2018 were also tendered, Exhibit 59.

Responsibility

When a police member takes a person into their care or custody, they are responsible for ensuring the safety, security and welfare of that person. Where the care or custody of the person is transferred to another member, that member assumes the responsibility for the person's safety, security and wellbeing.

Medical assessment and treatment

Members who take a person into care or custody must:

- *Assess the person against the Medical Checklist and obtain medical assistance if required. If responsibility for the person is transferred to another member, they must re-assess the medical state of the person and take any action required.*

378. VPM Rules are mandatory and provide the minimum standards that employees must apply. It makes it clear that non-compliance with or a departure from a VPM Rules may be subject to management or disciplinary action. The VPM Rules apply to operational supervisors and watch housekeepers (amongst others). When reading the VPM Rules police officers must have regard to the VPM Guidelines *Safe management of persons in police care or custody* to ensure best practice is applied and minimum standards are met.

379. VPM Rules provide that a risk assessment must be conducted for each person in custody to *ensure that an assessment has been made against the Medical Checklist.* The police assessment is dependent on a detainee's best verbal response to questions. The VPM Rules provide that the watch housekeeper must ensure that the assessment and monitoring is conducted on a *continuous* basis.

380. The VPM Guidelines contain a sliding scale with respect to a Medical Checklist which must be applied for *all* persons in the care or control of police *at all times.*

It further notes that:

2.1 Medical checklist[234]

The Coma Scale provides the police response required dependent on a person's best verbal response to questions. If their best verbal response deteriorates over time

[234] The Medical Checklist is referred to in full at paragraph [253].

respond as indicated by the next lower score. If the person appears to be intoxicated, the best verbal response should be assessed at least half hourly.

When assessing and dealing with persons believed to be intoxicated, members should be mindful that:

- *The health of intoxicated persons may deteriorate more quickly than non-intoxicated persons*
- *Intoxicated persons may have other pre-existing health conditions that may need medical attention*
- *Head injury victims and persons with diabetes may appear to be drunk...*

381. The Detainee management requirements state:[235]

Determining requirements for observation and ongoing welfare checks

After conducting the detainee risk assessment, the Custody Supervisor is to determine the observation level and checking that the detainee should be subject to, as follows:

Level 3 – Intermittent Observations

*This is the **minimum** acceptable level for detainees affected by alcohol or drugs or has been assessed by a medical practitioner as presenting with physical or mental health risk:*

- *Detainees to be physically checked and roused at least every 30 minutes.*
- *CCTV can be used in addition to physical checks*
- *The detainee is actively engaged during each physical check.*

Guidelines for conducting checks (includes):

- *Detainees are to be physically checked. This means that custody staff are to go to the detention facility and observe the detainee. Whilst CCTV enhances the monitoring of detainees, physical checks are still required. CCTV is not to be used as the sole means of monitoring a detainee's condition.*
- *When the observation level requires custody staff to actively engage with the detainee, this should include speaking with them, asking questions about their health or welfare needs and obtaining responses.* [236]

[235] CB p 246.
[236] CB 254.

382. The VPM Guidelines are not mandatory requirements on their own. They state '*This document outlines what Victoria Police considers to be good practice on managing persons in care or custody.*'[237] However the VPM Guidelines must be used to inform decisions in support of the VPM Rules.

383. The CPS SOPS provide further detail regarding the obligations of police members. The SOPS provisions at [52] *Reception of Intoxicated Persons* use mandatory language. The obligations are detailed, in particular:

- *All persons brought to the Castlemaine Watch House arrested for drunk must be given special attention. The member receiving the person must ensure that the charge is justified.*
- *If the person is so incapacitated by intoxicating liquor as to be unconscious or unable to respond, they are not to be accepted; or where the slightest doubt exists about their condition, medical attention must be sought without delay.*
- *The Coma scale as outlined on the prisoner medical checklist is to be used to determine action and a full risk assessment conducted.*
- *In all cases particular care must be taken to establish that the person is intoxicated and not suffering from an illness having similar symptoms to intoxication or drugs and that the person has no injuries requiring medical attention.*
- *The drunken person is ... monitored each half hour and noted on the appropriate entry on the custody module. If the person is asleep they are to be woken and a verbal response obtained. If a prisoner cannot give a verbal response, medical attention must be sought immediately...*
- *All prisoners lodged for drunk are to be checked every 30 minutes*
- *Where a prisoner is found insensible or cannot state his/her name and address or there is the slightest doubt about his/her condition, medical attention must be sought without delay.*
- *Prisoner who are insensible or who cannot communicate due to consumption of alcohol or drugs or other medical condition are to be referred to the Supervising*

[237] CB 234 at [1.1].

Shift Sergeant to arrange examination by the on-call doctor or transport to the Casualty Section for treatment.

384. The obligations of police members with respect to intoxicated detainees is readily discernible from this documentation.

385. Based on these documents the following was required in relation to Ms Day at the very minimum:

- For lodgement into police cells, an assessment of Ms Day against the applicable Medical Checklist on the basis of the best verbal response;
- Checks of Ms Day to be conducted at least every half hour against the applicable Medical Checklist on the basis of the *best verbal response* (and those checks to be recorded) and there was to be continuous monitoring and assessment.
- Level 3 – Intermittent observations guidelines require the detainee to be *roused* and *actively engaged*, this should include a best verbal response .
- The use of CCTV can *enhance* monitoring but cannot be a substitute for physical checks.

386. The RCIADIC Reports also noted the importance of initial risk assessment at the watch house to identify and assess persons at risk of death through suicide or illness. The recommendations proscribe a greater scrutiny for detainees than that in the VPM Rules, VPM Guidelines and CPS SOPS.

387. The RCIADIC Interim report noted:

'*Numerous studies, both in Australia and overseas, have emphasised that it is within the first hours of police detention that the risk of cell death is at its highest, especially if the person is under the influence of alcohol or drugs. This is the period where watch-house keepers and guards must be vigilant.*'[238]

388. The Interim Report made a number of relevant Recommendations including Recommendation 15:

Persons detained in custody must be closely monitored for the first six hours of detention and the appearance of the person should be recorded. Where persons detained are

[238] RCIADIC, Interim Report p 35.

apparently intoxicated or appear angry or disturbed, very close surveillance must be maintained.

389. The Final Report made extensive recommendations 125 – 149 that relate to the safety of persons held in police custody.

390. I particularly note Recommendation 127(f) *that Police Services develop protocols for the care and management of Aboriginal prisoners at risk, including (i) intoxicated persons*, and Recommendation 129 *that the use of breath analysis equipment to test the blood alcohol levels at the time of reception of persons taken into custody be thoroughly evaluated by Police Services in consultation with Aboriginal Legal Services, Aboriginal Health Services, health departments and relevant agencies.*

391. Further, Recommendation 137 (b) states:

During the first two hours of detention, a detainee should be checked at intervals of not greater than fifteen minutes and that thereafter checks should be conducted at intervals of no greater than one hour.

392. Recommendation 139 refers to TV monitoring devices and states: '*a monitoring aid and not as a substitution for human interaction between the detainee and his/her custodians.*' This is reflected in the terms of the VPM Guidelines.

393. So far as the VPM Policy Rules and Guidelines, as they relate to the care of persons in custody are not mandatory, means they are not in accordance with recommendation 123 of the RCIADIC which states:

'*...Instructions relating to the care of persons in custody should be in mandatory terms and be both enforceable and enforced. Procedures should be put in place to ensure that such instructions are brought to the attention of and are understood by all officers and that those officers are made aware that the instructions will be enforced. Such instructions should be available to the public.*'

394. Whilst it is the VPM Rules, VPM Guidelines and SOPS that are the standard against which to assess police compliance, the RCIADIC recommendations suggest the current standards could be both revised and strengthened. Compliance may improve if the requirements were at one reference point.

Staffing

395. As 5 December 2017 was the night of the Castlemaine police station Christmas function some of the staff were rostered from other stations. Illness resulted in the station being short staffed.

396. Sergeant Edwina Neale from Kyneton Police Station was thus performing two roles at Castlemaine Police Station: patrol sergeant and section sergeant. From 5.00pm there was one watch housekeeper, Leading Senior Constable (LSC) Danny Wolters, when normally there would be an additional custody staff member.

397. Both were responsible for detainees in custody, with Sergeant Neale having overall responsibility[239] and LSC Wolters conducting the observations and checks.

398. LSC Wolters had previous experience as a watch housekeeper. In the course of his police career he estimated he had dealt with between 100 and 150 people arrested for being either drunk or drunk and disorderly and had dealt with intoxicated people in custody at both Bendigo and Sunshine police stations.

Welfare check and detainee risk assessment

399. As Custody Supervisor, Sergeant Neale was responsible for conducting the welfare check when people arrive at the police station in custody. At the charge counter, Sergeant Neale conducted a welfare check *'to see that the person ... has been lawfully arrested, and see if the person's injured or not, and basically the state the person's in.'* She established that Ms Day was drunk and that she had been lawfully arrested.[240]

400. Following the welfare check, Sergeant Neale also conducted a detainee risk assessment in accordance with provisions of the VPM Guidelines. She was responsible for determining '*the observation and checking levels the detainee should be subject to.*'[241]

401. To conduct the risk assessment, she asked Ms Day if she had any illnesses or injuries, and also relied on information on LEAP, as well as what she had been told members who had spoken with Ms Day's daughter about whether she had any specific illnesses.[242]

402. The risk assessment did not include a falls risk assessment for Ms Day.[243]

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[239] CB 227 VPM Policy Rules at [4.2].
[240] T 750.
[241] CB 246: VPM Guidelines, Safe management of persons in police care or custody, Detainee management requirements - determining requirements for observation and ongoing welfare checks at [5.3].
[242] T 766.
[243] T 766.

403. Sergeant Neale had seen other intoxicated people in the cells in a similar state to Ms Day. Although she was unsteady, she was not worried about her ability to stand upright and she did not turn her mind to Ms Day's risk of falling over in the cell.[244]

404. When conducting the welfare check, Sergeant Neale made an overall observation and assessment that Ms Day was fit to go in the cells and that she did not need medical assistance or an ambulance to be called: she did not directly reference the Medical Checklist.[245]

Ms Day goes into the cell

405. Ms Day was accompanied to the cell by SC Fitzgibbon, SC Hurford, LSC Anthony Rowe, (the assistant watch housekeeper until 5pm), and Sergeant Neale. LSC Rowe attended the stores and obtained some bedding materials for her.

406. LSC Rowe did not regard Ms Day's behaviour, from his experience of dealing with intoxicated people, as in any way unusual.[246] He did not believe her level of intoxication had changed from her time at the counter. '*I was assessing her the whole time and it hadn't changed.*'[247]

407. Upon entering the cell, Ms Day lay down on the cell bench before the bedding was laid out. He disagreed that Ms Day seemed more intoxicated at that point, than at the charge counter, and disagreed that she appeared to be very unbalanced.[248] When asked about the efforts to get Ms Day up off the bench when the bedding arrived, he disagreed '*that there seems to be an awful lot of effort going into something that should have been a very simple task?*'[249]

408. LSC Rowe confirmed he treated Ms Day '*as we treat intoxicated people that are going into the cells.*'[250]

409. LSC Rowe was of the view placing Ms Day in custody was the last resort: '*...we've tried the [A]CJP, we've tried the family, there's no other option to us at that stage. But they're being held in the cell until someone come and pick her up or until she was sober.*'[251]

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[244] T 759-60.
[245] T 759.
[246] T 679-680.
[247] T 680.
[248] T 679.
[249] T 680.
[250] T 692.
[251] T 693.

410. The fact that Ms Day was Aboriginal did not trigger for LSC Rowe any concerns about her being at increased risk,[252] '*... it was my opinion that we were putting an intoxicated person in the cell. I didn't say just because she was Aboriginal.*'

411. Sergeant Neale's impression of Ms Day in the cell was that she wanted to go to sleep, and her presentation did not raise any concerns that she may have had difficulty standing up.[253] She believed Ms Day's intoxication level had remained the same.[254]

412. Police witnesses were questioned about their observations both at the time and from the CCTV footage whether Ms Day's level of intoxication seemed to worsen after she was taken from the custody counter to the cell. No witness noticed any deterioration at the time, although upon review of the CCTV footage of Ms Day in the cell at around 4.07pm, Sergeant Neale conceded her way of walking was worse than it was at the charge counter.[255]

413. The evidence of Dr Angela Sungaila was that it was *conceivable* that at the time of her arrest Ms Day's blood alcohol concentration was rising, however this could not be determined without knowing the time when she had her last alcoholic drink.[256]

Observation levels

414. As indicated from the VPM Guidelines and CPS SOPS, the minimum observation levels applicable to Ms Day were 30 -minute physical checks with active engagement.

415. At approximately 4pm Sergeant Neale directed LSC Wolters that Ms Day be physically checked every 20 minutes. This was more frequently than the required 30-minute observations, as she '*was an Aboriginal woman, around the same age as myself...more vulnerable in custody.*'[257] [258]

416. However, '*early on in the piece*'[259] the observation times were changed to alternating each physical check with a CCTV monitor check which meant that physical checks were to be conducted every 40 minutes.

417. There was conflicting evidence as to who instigated this change and why.

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[252] T 699.
[253] T 671.
[254] T 762.
[255] T 822.
[256] CB 558.
[257] T 762.
[258] Sergeant Neale gave evidence she had undertaken the standard police training regarding Aboriginal people. She worked as a Sergeant at the Northcote police station, which she stated has the highest urban Aboriginal population in Australia, and had also worked as a Police Aboriginal Liaison Officer for 12 months.
[259] T 830.

418. In her statement and her evidence Sergeant Neale indicated LSC Wolters suggested the change because '*it was stirring her [Ms Day] up each time we woke her to check on her*'[260] and that Ms Day was becoming, '*... a bit distressed and asking to go home so he felt she would be better if she was left to sleep a little bit longer in between checks...So he- we agreed that... every single 20-minute check would be done on a CCTV cameras and the other 40 minute would be the usual physical check.*'[261]

419. However LSC Wolters' recollection was that Sergeant Neale asked him to alternate the 20 minute physical observations with the CCTV monitor because, '*we wanted Tanya to be comfortable and sleep*' and '*I was under the impression it was because of staffing issues.*'[262]

420. LSC Wolters agreed that the change to the observation regime meant non-compliance with the VPM Guidelines[263] and noted, '*My experience when going and dealing with an intoxicated person is that the longer you engage with them in conversations, the more likelihood they are going to get upset and get up and walk around and complain ...*'[264]

421. Sergeant Neale, when questioned about non-compliance with the VPM Guidelines[265] noted that the Guidelines were not mandatory, '*These are a guidelines, not a set rule, if the person was detrimentally affected by the checks – particularly with a drunk we want them to sleep, basically we want them to sleep it off.*'[266]

422. LSC Wolters agreed that the CPS SOPS were not complied with, and responded:
'*... it is just to keep her on the mattress ... because of that incident where I'd seen that she'd done the drunken stumble and we wanted her to rest on the bench and we wanted ... her to sober up and knew there was going to be a fair bit of time involved in that.*'[267]

Conclusion

423. I prefer Sergeant Neale's evidence that it was LSC Wolters who made the suggestion to change the observations times. He described being short staffed in the watch house and without support and he wanted Ms Day to *sleep it off*. The CCTV footage did not bear

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[260] CB 126.
[261] T 768-9.
[262] T 935.
[263] T 937.
[264] T 94.
[265] CB 232.
[266] T 769.
[267] T 948-9.

out Ms Day being *stirred up* when he checked the cell or asking when she could go home.

424. Regardless of who suggested the change, Sergeant Neale was the responsible officer in charge.

425. The change meant the observations did not comply with the VPM Guidelines or the SOPS of at least every 30-minute physical observations.

426. Both Sergeant Neale and LSC Wolters were steadfast that, regardless of the VPM Guidelines and CPS SOPS noncompliance, allowing Ms Day to '*sleep it off*' was the preferred state of an intoxicated detainee.

On the floor

427. Much of the CCTV footage from Ms Day's cell showed her lying on the floor. The police witnesses were asked about this.

428. Sergeant Neale stated, *'... a lot of people like to sleep on the ... cell floor it's not uncommon, particularly if people are drunk. She had a blanket at the time.'*[268]

429. Sergeant Neale indicated, '*I did not check how she got onto the floor.*' When pressed why not, Sergeant Neale stated, *'Because she's an intoxicated human being who was sleeping on the floor which is not unusual for intoxicated people to sleep on the floor in police cells. Very common.'*[269]

430. SC Fitzgibbon checked the monitor after returning to the station on a break when he was told Ms Day had fallen and hit her head He did not consider it unusual for her to be on the floor and stated '*... drunks will lay and intoxicated people will lay against a wall, on the floor, sit on the toilets ... all over the cell. Not unusual at all.*'[270]

431. LSC Wolters was also asked about Ms Day being on the floor: '*It's indicative of 75% or 80% of intoxicated people, a lot of them have preferences for lying on the floor. Some people who are not even intoxicated lie on the floor.*'[271] When he was asked about Ms Day's *preference* for the floor, recorded in the custody module, he stated: '*Lots of people, lots of people had a preference to sleep on the floor. We've had people in custody who aren't drunk who prefer to sleep on the floor.*'[272]

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[268] T 772.
[269] T 862-3.
[270] T 425.
[271] T 1086.
[272] T 953.

How were the observations conducted?

432. Sergeant Neale stated a '*physical check*' does not necessarily require entry into the cell.[273]

433. She described a physical check as meaning Ms Day must be, '*physically sighted, roused sufficiently that she gives a verbal response,*'[274] and that a verbal response means, '*... that she answers some sort of question and generally, to see some sort of movement something to ensure she's understood the question and responded.*'[275]

If a response was not intelligible, Sergeant Neale stated: '*we'd probably go in ... to the cell, and rouse her fully, and see whether she was just sleeping unintelligible ... particularly with drunks, once they're asleep, they're often a little bit harder to rouse and have an intelligent conversation with, particularly every, ... 20 to 30 minutes.*'[276]

434. LSC Cairnes described a '*physical check*' as: '*A physical check is when police members attend the actual cell. So, Ms Day was in cell number 1. Physically, police members go down there and will have a conversation or view Ms Day or the person in custody. So, the physical component is the police actually going down there and being interactive with Ms Day.*'[277]

435. LSC Cairnes would go into a cell, '*It could be if we're providing blankets or other comforts like pillows or giving food or water. That would be the reasons that we would enter a cell, or in extreme medical emergency.*'[278]

436. His understanding was a '*physical check*' did not require entry into a cell.

437. LSC Wolters made the first physical check at 4.50pm as shown on the CCTV footage. He attended outside the cell and stated, as the venetian blinds were slightly open, he could see through them.[279] He did not go into the cell to speak to Ms Day because: '*I've attended at the cells, I've asked her a question, she's provided an appropriate answer which satisfies a verbal response for the coma scale.*'[280]

438. LSC Cairnes accompanied LSC Wolters and described, '*he looked inside and then he spoke to her,*' words to the effect '*Tanya, are you okay*?'[281] LSC Cairnes stated '*I also stepped forward and looked through the ... roller shutters.' 'I didn't hear what Ms Day*

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[273] T 763.
[274] T 762.
[275] T 762-3.
[276] T 763.
[277] T 712.
[278] T 713.
[279] T 1036.
[280] T 1037.
[281] T 719-720.

said ... in reply ... but I did hear a verbal response, and Danny seemed very happy with that.'[282]

439. LSC Wolters did not open the trap door on the cell door when he checked on Ms Day, and although the visit to the cell took only 6-7 seconds,[283]LSC Cairnes was of the view it was sufficient time for a physical check and a verbal response from Ms Day: '*there was nothing other that we could see or that would alert to us being any issue at all.*'[284]

440. Sergeant Neale was asked to comment on the CCTV footage of the physical checks conducted by LSC Wolters. Sergeant Neale agreed they accorded with her view of a physical check and she had no '*great concern*' about the fact they seemed to be '*very quick.*'[285]

441. Later in her evidence when asked to view the CCTV footage of the check by LSC Wolters at 4.50pm she agreed the physical check was '*completely inadequate.*'[286]

442. When asked about LSC Wolters' physical check at 5.35pm, and that Ms Day had not stood up since 5.00pm, Sergeant Neale stated, '*I don't know, I don't know what he said or what she said at that time.*'[287] then conceded '*I would suggest that perhaps the flap was opened.*'[288]

443. Both Sergeant Neale and LSC Wolters were of the view that a 'physical check' did not require the officer to enter the cell.

Conclusion

444. The CCTV footage of the physical checks reveal them to be quick and cursory, however police witnesses were generally of the view they were adequate. Sergeant Neale did agree the check at 4.50pm was *completely inadequate* and was of the view that at 5.35pm check the door flap could have been opened.

445. Dr Sungalia's evidence was that at 0.3%BAC[289] '... *it's inconceivable that she would have been able to communicate rationally ... she wouldn't have been able to have had a meaningful conversation, certainly reply yes or no or I don't know but to have any other sort of conversation ... if someone was to ask her about what she did during the*

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[282] T 720.
[283] T 735.
[284] T 735.
[285] T 778.
[286] T 827.
[287] T 842.
[288] T 843.
[289] Dr Sungaila's assessment of Ms Day's blood alcohol concentration at about 16.50 on 5 December 2017 Exhibit 77.

day or what her occupation was or ... have any other sort of social interaction, it is highly unlikely or inconceivable that it would be a ... rational response.'[290]

446. The VPM Guidelines state, at *Guidelines for conducting checks:*

'Detainees are to be physically checked. This means that custody staff are to go to the detention facility and observe the detainee...'

447. In my view the physical check does not necessarily require the custody staff to enter the cell although LSC Cairnes described instances when that might be required.

448. In my view the quality of the physical checks, indicated by their speed and the question/answer exchange, did not meet the specification in the VPM Guidelines stipulating the detainee is to be roused, actively engaged. The VPM Guidelines provide an example about what that means: '*this should include speaking with them, asking questions about their health or welfare needs and obtaining responses.*'

449. Dr Sungaila described 'rousable' as requiring an appreciation of an audible response and a physical observation. She was not of the view that a '*yes*' response to '*Are you okay*' was sufficient.[291]

450. I find the standard of the physical checks was contrary to the specifications in the VPM Guidelines requiring the *best verbal response*. This is required so any deterioration can be identified and the Coma Score adjusted accordingly, to manage risk.

Use of intercom

451. In evidence LSC Wolters stated he spoke to Ms Day in the cell '*through the intercom.*'[292] and that he said, '*Are you comfortable Tanya?*' or something similar and she said '*yes.*'[293] This was at about 6.39pm, when he noticed her on the floor.[294]

452. There is an implied reference in LSC Wolter's statement that after seeing her on the bed and then seeing on the floor: '*I spoke to her about it a short time later she indicated that she had a preference to sleeping on the floor.*' That is when LSC Wolters stated he used the Intercom and then recorded her preference in the custody module.[295]

453. If he did use the intercom, it suggests more verbal contact with Ms Day that apparent from the CCTV footage.

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[290] T 1451-2.
[291] T 1470-1.
[292] T 952.
[293] T 953.
[294] T 1080.
[295] T 1160.

454. Sergeant Neale was not aware LSC Wolters used the intercom to communicate with Ms Day, but in evidence indicated '*I've been informed since that she was spoken to through the intercom.*'[296]

455. LSC Wolters conceded it was incorrect and I am of the view he embellished his statement regarding Ms Day's response to his physical check by stating, '*whenever I conducted a welfare check ...discussions with her and conveyed any conversation I had with her family'*.[297]

456. This level of interaction or conversation is not demonstrated by the CCTV footage.

Conclusion

457. I am not convinced from the evidence that LSC Wolters did not use the intercom to communicate with Ms Day.

Falls risk

458. Sergeant Neale did not consider conducting a falls risk assessment for Ms Day as part of her risk assessment. In evidence she stated she did not know Ms Day had the potential to fall in the cell.[298]

459. LSC Cairnes was asked whether an assessment of falls risk was made during the custody intake process, and he did not believe so, but was of the view members were '*... very aware of it*' as a risk.[299] He stated, '*I remember members discussing conversation in relation to trying to settle Tanya ... when someone's first in custody, we need to try and settle them quickly.*'[300]

460. Although LSC Wolters saw what he described as a '*drunken stumble*'[301] on the monitor, he did not note it in the custody module and it was not behaviour he was concerned with,[302] '*I've seen people in the cells do a lot, a lot worse than that.*'

461. When it was put there was a risk of her falling over and not being able to stand up he responded, *'... like I said, it's behaviour that's normal.*'[303]

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[296] T 770.
[297] T 941.
[298] T 809.
[299] T 729.
[300] T 730.
[301] CB 119, Exhibit 76.
[302] T 951.
[303] T 952.

462. LSC Wolters agreed Ms Day was in danger of falling over, and he stated that part of the conversation he had with Sergeant Neale was to encourage Ms Day to '*utilise the bedding and the blankets and rest.*'[304]

463. When asked about CCTV footage at 4.21-22pm. Sergeant Neale had not seen Ms Day fall over at the time, when asked, if she had seen it, would she have gone in, responded: '*Not necessarily, she looks very drunk there but that's -she's not a lot different to many other drunks that we deal with.*'[305] She agreed Ms Day looked very unsteady and very drunk and agreed, possibly, she was more of a falls risk than she had been at the charge counter.[306] Sergeant Neale could not say whether she would have gone into the cells if she had seen Ms Day: *'I've seen many drunks in cells doing exactly that.*'[307]

464. Sergeant Neale did not agree if she had seen the CCTV footage she would have thought Ms Day was deteriorating, '*... she's behaving as a conscious breathing drunk ... she's behaving in a manner that many drunks behave in the cells.*'[308]

465. Sergeant Neale was asked about Ms Day being in danger of falling over and cracking her head, she stated: '*I would say all drunks are at risk of falling and cracking their head in a police cell, yes. She was no more a risk than any other intoxicated drunk, and with her behaviour, at that point, doesn't alert me particularly.*'[309]

Conclusion

466. Evidence of Ms Day's lack of balance, being unsteady or her drunken stumbles did not appear to alert either Sergeant Neale or LSC Wolters to consider that Ms Day was a falls risk.

467. In her report, Dr Sungaila was asked her opinion as to the impact of intoxication on Ms Day's ability to function throughout her incarceration. In addition to noting a number of impacts, she stated: '*It is highly likely that she would have been at high risk of falling.*'[310] Ms Day's coordination was affected to a large extent and she was less able to protect herself in a fall.

468. Aside from what the police witnessed, the medical evidence is that Ms Day was at a high risk of falling, and that risk was realised.

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[304] T 1030.
[305] T 823.
[306] T 824.
[307] T 824.
[308] T 824.
[309] T 825.
[310] CB 558.

469. Deaths which are the direct or indirect result of accident or injury are reportable to the coroner and many deaths reported each year arise from elderly people who have had a fall and then are hospitalised and subsequently die. If they had been living in an Aged Care Facility as a matter of course the ACF will provide its policy regarding falls, the assessment of the deceased persons' falls risk, and the strategies taken to address the falls risk to the coroner.

470. A falls risk standard recognises that in Aged Care facilities, elderly people are more prone to losing their balance and falling, which could lead to an injury which results in death. This model could be useful for people who are intoxicated in custody as falls amongst intoxicated detainees are regarded as common place from the evidence heard from those responsible for the care and management of those in custody.

471. I intend to make a recommendation that the custody risk assessment include falls risk assessment for detainees whose balance may be affected by alcohol, drugs or illness.

Alcohol and risk

472. Sergeant Neale stated she did not consider breathalysing Ms Day using a lion Alcolmeter to establish Ms Day's level of intoxication because, '*... she was clearly intoxicated ... no reason to use it to prove that she was intoxicated.*'[311]

473. LSC Wolters stated he had never seen a breathalyser test used to determine alcohol level in this context in 12 years of policing.[312]

474. When it was put that Dr Sungaila's report indicated Ms Day's alcohol level may have been as high as 0.3% BAC Sergeant Neale replied '*No, there's no need for me to know that.*'[313]

475. She disagreed that if she had known Ms Day had such a high reading the best thing would be to take her to hospital and have her checked there, '*I could see no reason to take her to hospital. She was intoxicated.*'[314]

476. Sergeant Neale advised she has never taken someone to hospital because they are '*merely drunk.*'[315]

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[311] T 807.
[312] T 1023.
[313] T 807.
[314] T 808.
[315] T 906.

477. Sergeant Neale was not of the view it was an option to take Ms Day to hospital – '*It's not common police practice to do that ... If the person needs urgent medical attention, police practice is to call an ambulance.*'[316]

478. LSC Wolters stated that even if he had known Ms Day's BAC was .313 he would not have taken her to hospital because of her behaviour, '*she didn't present like someone with that high level of intoxication.*'[317] He agreed if knew she was .313 he would have given very strong thought to taking her to hospital.[318]

479. I note RCIADIC recommendation 129 states:

'that the use of breath analysis equipment to test the blood alcohol levels at the time of reception of persons taken into custody be thoroughly evaluated by Police Services in consultation with Aboriginal Legal Services, Aboriginal Health Services, health departments and relevant agencies.

480. Commissioner Johnstone stated that a situation where the use of a breathalyser could be useful, '*... is where the person has a dangerously high blood-alcohol level but owing to the development of a high tolerance to alcohol often observed in alcohol dependent persons, has the appearance of being only mildly intoxicated.*'[319]

481. The report regarding implementation of RCIADIC recommendations noted:

'*The Victorian Government stated in their 1994 implementation report that they have not implemented this recommendation as they believed that breath alcohol analysis of prisoners at their time of entry to the watch-house rarely resolved medical management issues. Instead, police training and policy was aimed at identifying and resolving these issues.*'[320]

482. Dr Sungaila's evidence was she had seen cases at police stations where police had used a breathalyser to assess a person's fitness for interview.[321]

483. In evidence Dr Sungalia's opinion was a person with a blood alcohol concentration over 0.3% should immediately seek medical attention.[322]

484. In Dr Sungaila's view a police cell is not adequate observation for anyone who is drug affected or alcohol affected. In the absence of facilities in a hospital emergency

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[316] T 809.
[317] T 1022.
[318] T 1023.
[319] RCIADIC at 24.3.38.
[320] Deloitte Access Economics, Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody, Department of Prime Minister and Cabinet, August 2018, p 252.
[321] T 1464.
[322] T 1456.

department to observe people '*if they need to be observed in a police cell, then there has to be policies and there has to be rules, so it's the best that can be done.*'

485. Counsel for Victoria Police in her written submissions stated at [6]:

'*Police members monitoring Ms Day had substantial experience of dealing with intoxicated persons in custody and substantial familiarity with how such persons tended to move and behave. They were entitled to rely on that experience and familiarity and their evidence about how Ms Day presented to them should be accepted.*'

I note Counsel for the Day family responded to this submission: '… *the effect of that stereotyping is to fail to see clearly the human being in front of it and their needs …*'[323]

Conclusion

486. The clear medical evidence is that with a blood alcohol concentration of at least 0.3%, Ms Day should have been in hospital.

487. The evidence establishes both Sergeant Neale and LSC Wolters held definite opinions about how intoxicated persons were likely to behave. They had definite opinions that intoxication alone would not be a factor calling for medical intervention. This formed the lens through which they both perceived events in this case. Every instant of Ms Day's behaviour in the cell was simply the stereotypical conduct of an intoxicated person.

488. This approach is a consistent attitude of the police witnesses and appears to be a systemic attitude and failure in both recognising the medical dangers of intoxication and complying with the mandatory terms of the governing policy and procedures regarding the management of persons in care or custody.

Checks and observations in custody and the CCTV footage

489. The chronology of checking and observations of Ms Day in the cell can be summarised as follows:

4.01pm lodged in cells

4.17pm checked on monitor

4.51pm checked in cells

5.12pm checked on monitor

5.35pm checked in cells

5.56pm checked on monitor

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[323] T 1779.

6.15pm checked on monitor

6.43pm checked in cells

7.28pm checked on monitor

8.12pm checked in cell

I note between 5.35pm and 6.43pm there is a 68-minute gap between the second and third physical checks and an 81-minute gap between 6.43pm and the 8.04pm which is the third physical check and entry into the cell at the expiration of four hours. From 6.39pm Ms Day remained on the floor.

490. A custody module on the computer is created for every person who goes into the cells, with a section to record observations and welfare checks.[324] LSC Wolters made the entries in the custody module.

491. Sergeant Neale and LSC Wolters were cross examined about many parts and aspects of the CCTV footage of Ms Day in the cell and the recordings in the custody module.

492. I will not traverse all the examples, two suffice.

The monitor check at 5.56pm

493. The custody module at 5.56pm Ms Day was noted to be '*moving around freely.*'[325]

494. The CCTV footage[326] shows Ms Day lying diagonally on the bed in the cell with her feet on the floor. Between 5.54 and 5.55pm she moves her left leg and arm. At 5.56.24pm her left hand, which was on her chest, moves to her face and it remains there until 5.56.54pm when she moves it back to her chest.

495. Sergeant Neale did not agree it is was an inaccurate entry: '*She appears to be sleeping and still moving so we know she's conscious and breathing and still ... moving around. That's really how we want our intoxicated people to be. Sleeping it off.*'[327]

496. The VPM Guidelines at 'Recording checks' on the custody module state '*... observations should include meaningful information ...*'[328]

497. Sergeant Neale stated: '*The fact she hadn't stood up doesn't bother me at all if we've had a verbal response in between. Hopefully she's starting to sleep it off.*'[329]

498. LSC Wolters also disagreed it was a '*false entry*,' stating:

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[324] CB186-7.
[325] T 846.
[326] Exhibit 51.
[327] T 841.
[328] CB 255, T 1125.
[329] T 848.

'It's indicative of about 75%-80% of intoxicated people we have in our custody would behave in that manner when they're trying to get comfortable and sleep.'[330]

The physical check at 6.43pm

499. The CCTV footage at 6.43pm[331] was played and showed the final physical check by LSC Wolters lasting five to seven seconds. In the footage, Ms Day is unmoving on the ground, with her head covered by a blanket. It was put to Sergeant Neale this was a *completely inadequate physical check.* She responded: *'I don't know what the verbal response was ... she was lying under a blanket in the cells and moving, which indicates to me that she's conscious and breathing...many, many of our drunks and prisoners and detainees always sleep with a blanket over their head. The lights are very bright in the cells and it's not an unusual situation.'* Sergeant Neale agreed she did not see any signs of a verbal response from Ms Day during the check.[332]

500. LSC Wolters was asked if she made a verbal response and stated: *'My recollection was at the time, yes.'*

501. When asked if his physical check was inadequate, he stated:
'I was satisfied that she was resting. Ah that was what we'd hoping to achieve for the majority of the evening. She looked comfortable and I was satisfied.'[333]

502. It was put to LSC Wolters that Ms Day remained on the floor for 81 minutes without a single visit, and she could not stand or move around. He agreed and stated: *'That's the normal observations from a person drunk in custody.'*[334]

503. When asked if an hour of not moving is unusual, he replied, *'It's not unusual.'*[335]

504. With respect to quality and frequency of the checks, Sergeant Neale stated: *'Proper checks were done and face to face contact isn't necessary or generally done for people that are drunk. Generally, we like them to sleep. Quite often, because of the bright lights, they're under a blanket, as Ms Day was at times.'*[336]

505. Examples of the CCTV footage were played in court to Sergeant Neale at 5.09pm, 5.36pm, 5.42pm, 5.47pm as footage capturing evidence of Ms Day's right-side weakness. Sergeant Neale indicated she did not see any of these examples of

[330] T 1070.
[331] Exhibit 45 split screen footage.
[332] T 853.
[333] T 1078.
[334] T 1078.
[335] T 1160.
[336] T 837.

deterioration in Ms Day's ability to use her right side from looking sporadically at the monitor. LSC Wolters did not notice this either.[337]

Conclusion

506. To summarise the CCTV footage evidence: the 40-minute physical checks were illusory as there was a 68-minute gap between the second and third physical checks and an 81-minute gap from the last physical check and police entering Ms Day's cell at the expiration of the four hours.
507. The frequency of observations did not meet the VPM Guidelines or the CPS SOPS.
508. The quality of the physical checks was quick and cursory. I do not accept that LSC Wolters did receive a verbal response from Ms Day for the two physical checks at 4.51pm and 5.35pm. It was not apparent from the CCTV footage whether there was any response, let alone a *best verbal response*.[338] The evidence of Dr Sungaila was that a question requiring a 'yes' or 'no' answer was not sufficient for 'active engagement.' LSC Wolters gave a very different account in his statement about his verbal interaction with Ms Day.
509. The accuracy of the custody module entries was concerning as there was not much correlation between the CCTV footage at 5.56pm and the entry '*moving around freely.*'
510. The information is not meaningful if the entry is not accurate.
511. The relevance of this goes at the adequacy of the checks conducted by monitor. The VPM Guidelines allow CCTV to be used *in addition* to physical checks and can *enhance* monitoring whilst not being used as the sole means of monitoring a detainee's condition.[339]
512. Neither Sergeant Neale nor LSC Wolters identified or noticed Ms Day's signs of right sided weakness at the time or from the CCTV footage. This was understandable and I note Associate Professor Laidlaw stated in his report whilst it was obvious to him as a neurosurgeon, '*... attuned to looking for such things, I think to a non-medical person observing the video it might not be often [sic] not be immediately apparent.*'[340]
513. I am of the view the evidence of Sergeant Neale and LSC Wolters demonstrated a cultural complacency regarding people who are drunk, and they took a minimised

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[337] T 971.

[338] For example, it was put that at the 5.35pm physical check LSC Wolters made no genuine attempt to verbally communicate with Ms Day. He responded she was in a '*very undignified position*' (T 1063) and he left her to her, '*privacy and dignity*' because, '*I didn't want to get caught leering at her.*' (T 1064).

[339] CB 254.

[340] CB 399.

approach to any medical needs. Even when the non-compliance with the VPM requirements was pointed out (which they accepted), they offered no insight and defended their positions. I find that as a result of their non-compliance neither Sergeant Neale nor LSC Wolters took proper care of Ms Day's safety, security, health and welfare as required by the VPM Rules, Guidelines and SOPS.

The evidence about Ms Day's fall

514. LSC Wolters was extensively cross examined about what he actually saw of Ms Day's fall and what he told others about what happened.

515. He was taken to seven instances in the evidence[341] such as his call to 000 and statements and records by witnesses such as Sergeant Neale, and the ambulance para medics, Ms Harrup, Ms Matheson and Ms Holland, noting what they had been told by either him or 'police'[342] about Ms Day's fall.

516. LSC Wolters refuted those accounts as either incorrect or by denying he had said what was recorded.

517. In his statement LSC Wolters stated: '*I didn't actually see her fall over nor did I see her hit her head at any stage*'[343] and he stated in evidence he never saw Ms Day fall in any other way while inside the cell.[344]

518. The 000 call is the most concerning aspect of his evidence. It records him stating: '*She's fallen over inside the cells*' and '*I seen her slip over an hour ago.*'

519. When asked what he meant by '*I seen her slip over an hour ago'* he stated: '*I'm saying I seen her on the bed and I've now seen her on the floor and as a result of that, I think she slipped off the bench.*'[345]

520. He clarified that at no point did he see Ms Day slip onto the floor and never saw her fall in any other way while she was inside the cell.[346]

521. LSC Wolters stated: '*I told ambulance paramedics that I made an observation of her on the bench. I made an observation of her on the floor. I made an observation of her bruise and I've made – I surmised that she'd rolled off face down onto the floor.*'[347]

522. I accept that LSC Wolters did not see Ms Day fall but was drawing a conclusion.

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[341] T 1113-1119.
[342] It was established in the evidence that LSC Wolters was the police officer the paramedics were referring to.
[343] CB 119.
[344] T 960.
[345] T 960.
[346] T 960.
[347] T 985.

'I'm describing to the operator that Tanya's been in an upright position on the bench, she's fallen face down on the floor and as a result of that struck her head. That's how I envisaged that it's happened ... from what I can make out of all those three observations.'[348]

523. LSC Wolters indicated he would not do anything differently, '*... we were looking after her ... respecting her right to privacy and dignity ... checks were conducted ... in a least intrusive manner and when we noticed that she had a medical need, we called an ambulance.*'[349]

Conclusion

524. I did not find LSC Wolters to be a credible witness. He was unable to acknowledge the inherent contradiction in saying in the 000 call, '*I seen her slip over about an hour ago*' when in fact he had not. His response when questioned was to say: '*It's not a lie at all,*'[350] and when pressed, '*I think there's been a fall.*'[351]
525. I do not accept he was '*trying to be helpful.*'[352]
526. This impacts my ability to accept his evidence about using the intercom and whether he obtained a verbal response from Ms Day at the physical checks at both 5.35pm and 6.43pm and what he told the ambulance paramedics about Ms Day's fall.
527. I do not accept the deficiencies of nature and number of the physical checks identified through the evidence are cured, explained or ameliorated by LSC Wolters reliance on respecting Ms Day's human rights, particularly privacy, dignity and gender.
528. I find both the physical checks and the monitor checks were inadequate for the reasons characterised above.
529. Both Sergeant Neale and LSC Wolters thought at all times they were looking at Ms Day as a '*conscious, breathing drunk*' doing what all drunks do.
530. This illustrates the power of stereotype and its resistance to correction.[353] If the required physical checks had been conducted every 20 minutes or every 30 minutes, and met the requirements in the VPM Guidelines, it may well be that Ms Day's deterioration would have been identified and actioned earlier. That tone of the VPM Guidelines exhorts

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[348] T 958-9.
[349] T 972.
[350] T 996.
[351] T 997.
[352] Submission by Counsel for Victoria Police.
[353] *R v Doering,* 2019 ONSC 6360 at [36].

caution and vigilance, noting for example: *the health of intoxicated persons may deteriorate more quickly than non-intoxicated persons.*[354]

Human rights engaged

531. Ms Day was deprived of her liberty. In this investigation section 22(1) of the Charter appears to be engaged. Victoria Police is a Public Authority for the purposes of the Charter. Section 22(1) states:

'*All persons deprived of liberty must be treated with humanity and with respect for the dignity of the human person.*'

532. Central to this right is that a person in detention is vulnerable. The right requires that public authorities to take positive measures to ensure a detainee is treated with dignity and humanity, which includes adequate conditions such as access to medical services.

533. Ms Day had multiple vulnerabilities, including her extreme intoxication and her lack of balance. Ms Day's deprivation of liberty meant she was completely dependent on police officers for her health needs with no capacity to help or look after herself. The minimum conditions of monitoring were not complied with. There was a culture of complacency regarding intoxicated detainees. As a person deprived of her liberty, I find that Ms Day was not treated with humanity and respect for the inherent dignity of a human person as required by the Charter.

534. I intend to recommend to Victoria Police to request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 4(c) review of the compatibility of its training materials with the human rights set out in the Charter.

Learnings from Ms Day's death

535. Sergeant Neale was unaware of the circumstances of Ms Day's death until she was asked to provide a statement. She did not see Ms Day's fall on the monitor and only learnt, 12 months later, that it was the fall that led to Ms Day's death.[355] She had originally been told that Ms Day came into the police station with a brain bleed.[356]

536. Sergeant Neale was not aware of any review or learnings by Victoria Police following Ms Day's death in custody.

537. No police officers gave evidence of any changes or reviews that had taken place following Ms Day's death.

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[354] CB 235.
[355] T 829.
[356] T 877.

538. The evidence of Sergeant Neale and other police officers on this point indicates it does not appear the coroner's recommendation in the Findings in the Inquest into the death of Stephen Arthur Niit of an: '*'alert' process 'to be widely broadcast and disseminated amongst members providing information about deaths and 'near-misses' in respect of persons in custody in police cells'* noted above at has been implemented by Victoria Police.

539. I note recommendation 124 of the RCIADIC states:

'*The Police and Correctional Services should each establish procedures for the conduct of de-briefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides so that the operation of procedures, the actions of those involved and the application of instructions to specific situations can be discussed and assessed with a view to reducing risks in the future.*'

540. Victoria Police quickly responded in the aftermath of Ms Day's hospitalisation prior to her death by instigating steps for the police officers involved with her arrest and placement in custody to be interviewed in accordance with a police contact death.

541. It is clear however there has been no review of her time in custody or any learnings from that by Victoria Police.

542. I contrast this case to the Northern Territory coroner's comment in his Finding into the death of Kwementyaye Briscoe:

'*The tragic death of Kwementyaye Briscoe prompted NT Police Command to undertake an immediate and comprehensive review of what went wrong, and to institute a suite of reforms aimed at cementing best practice for the care of detainees in custody. It is clear that Kwementyaye's death was a catalyst for deep reflection and change. The level of commitment of NT Police to transparent internal and external review, as well as to every aspect of this coronial process is, in my experience, unprecedented and deserving of recognition.*

The Assistant Commissioner has been in court every day of the proceedings and has been joined on many days by the Commissioner himself, and the Deputy Commissioner. That reflects a very genuine commitment to implementing best practice and shows great respect to the coronial process and to the grieving family they sat alongside in court.'[357]

[357] Finding into the death of Terrence Briscoe p 62.

Police knowledge of the RCIADIC

543. SC Thomas stated he was aware, through his training, of the '*special sensitivities*'[358] of placing Indigenous people in custody, he did not think that Ms Day was someone who would be particularly vulnerable in custody because she was indigenous.[359]

544. SC Towns stated: '*I just know that they are vulnerable in custody and that's something that you take on consideration when you're arresting someone or lodging them into a cell.*'[360] He had completed courses in relation to dealing with the Aboriginal community. '*We were trying to take care of her and do the right thing by her, the last resort we wanted to do was to take her back to the police station and place her in the cells. If there was anything else that was available to us, then that option would have been the preferred option and that's what we would have done.*'[361]

545. LSC Fitzgibbon had recently volunteered to be the PALO, or Police Aboriginal Liaison Officer, though he was yet to complete the training. He had completed some relevant cultural training whilst at the Police Academy.

546. SC Fitzgibbon stated that '*Since the incident ... We actually got Darcy*[362]*to come to our station,*[363] *introduced himself and spent probably half an hour at a training day.*'[364] SC Fitzgibbon found the training day to be relevant because he was not aware that that the Aboriginal Liaison Officer position existed. He later confirmed the training day had nothing to do with Ms Day's death.[365]

547. SC Hurford had also completed cultural training at the Police Academy and was aware from his general knowledge that indigenous people are more vulnerable in custody.[366] He stated that in he the course of his work as a police officer, he did not deal with many Aboriginal people.

548. For the Assistant watch housekeeper at Castlemaine Police station, SC Rowe, the fact that Ms Day was Aboriginal did not trigger for him any alarm about increased risk.[367]

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[358] T 317.
[359] T 318.
[360] T 385.
[361] T 384-5.
[362] Darcy Bartlett, Victoria Police, Aboriginal Liaison Officer.
[363] Kyneton police station, not Castlemaine police station.
[364] T 462.
[365] T 488.
[366] T 607-8.
[367] T 699.

549. With respect to Ms Day being Aboriginal and whether that should have set off a warning for him, he stated: '… *it was my opinion that we were putting an intoxicated person in the cell. I didn't say just because she was Aboriginal.*'

550. Custody supervisor Sergeant Neale showed awareness of Ms Day's vulnerable status in custody, requesting that Ms Day be checked every 20 minutes as she: '… *was an Aboriginal woman, around the same age as myself ... more vulnerable in custody.*'[368]

551. Coroner's Investigator DSC Scott Riley was aware of the RCIADIC but had had no training about it.[369] He believed the investigation conducted was in accordance the findings and recommendations of the RCIADIC, that investigations into Aboriginal deaths in custody extend beyond whether there was intentional causing or contributing to the death in custody to consider the duty of care owed and whether reasonable steps were taken to prevent the harm to a person within police care.[370]

552. Justice Mortimer in *Wotton v State of Queensland*[371] stated:

'*Police officers who gave evidence disclosed little interest in RCIADIC recommendations and little awareness of how the matters discussed by the Royal Commission should affect their day to day policing where any Aboriginal person dies in custody or where there is a risk of that occurring, especially in communities consisting overwhelmingly of Aboriginal people. This attitude is one of the circumstantial matters contributing to the view I have formed that the conduct of the QPS officers I their investigation into Mulrunji's death involved distinctions that were based on race.*'

Conclusion

553. Whilst the witnesses did not demonstrate any great knowledge or awareness of the RCIADIC recommendations most witnesses had a sense that Ms Day was vulnerable in custody owing to her Aboriginal heritage.

554. There is clearly a significant amount of work to do within Victoria Police regarding education of police officers about the RCIADIC and training regarding its recommendations.

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[368] T 762.
[369] T 1545.
[370] T 1545-6.
[371] (No 5) [2016] FCA 1457 (38 at [86]).

Victoria Police training

555. Sussan Thomas, Superintendent responsible for the Aboriginal and Youth portfolios in the Priority Communities Division, made a statement and gave evidence at the inquest. The Priority Communities Division is a policy unit which is part of the Capability Department of Victoria Police.

556. Although not responsible for education and training, Superintendent Thomas noted in her statement a current review of the existing Victoria Police Aboriginal Cultural Awareness package which will be rolled out to every serving police officer and has a particular emphasis on Aboriginal people in custody.

557. Superintendent Thomas noted the emphasis on Aboriginal people in custody was '*a prior commitment on the part of Victoria Police and did not arise from the death of Ms Day.*'[372]

558. She further noted there had been no policy changes to the VPM or any other policies or procedures as a result of Ms Day's death, and that Victoria Police had not undertaken any review of its interactions with Ms Day on 5 December 2017except for the coroner's investigation and the disciplinary action taken against police members.[373]

559. Whilst she was not necessarily aware of training at a regional level, which will not necessarily be captured on Victoria Police HR systems, she did refer to the fact that the Human Rights Portfolio Manager had presented human rights training at the annual custody conference in August 2019, which was a gathering of police custody officers from across Victoria.[374]

560. When asked whether the Priority Communities Division acknowledged unconscious and implicit bias within the practice of Victoria Police Superintendent Thomas stated that her division does not educate, that is a 'professional development command piece' however they have produced fact sheets and 'a whole framework on how we can actually translate good policy and practice out into our service delivery.'[375]

561. In cross examination it was clarified there was no 'one' Aboriginal cultural training package in place for Victoria Police at the time of Ms Day's death, and Victoria Police was not able to monitor effectiveness as they were localised packages. She was unable

[372] Exhibit 92, paragraph 33.
[373] Exhibit 92, paragraphs 57 & 69.
[374] Exhibit 92, paragraph 67 (c).
[375] T 1645.

to say where it would be found or even written down and could not confirm whether there was one for the Castlemaine area in 2017.

562. This may explain why none of the police officers who were at Castlemaine train station with Ms Day were able to come up with any ideas, such as contacting the Aboriginal Liaison Officer for assistance, as an alternative to taking Ms Day to the police station.

Whether the processes for the required automatic notification regarding an indigenous person in custody was sent to the Victorian Aboriginal Legal Service, and the response to it

563. Gary Bamblett is an employee of the Victorian Aboriginal Legal Service (VALS) who worked in the custody notification service. He was working on 5 December 2017 when the notification was made to VALS that Ms Day was in custody in the police cells at Castlemaine police station.

564. The Custody Notification Service (CNS) is described in the Client Service Officer Manual (CSOM) and requires police to email notification to VALS and details the requirements from the Victorian Police Manual.

565. Mr Bamblett was training a new employee, Lucy Arnold when the email notification came through at 3.50pm. Ms Arnold called the Castlemaine police station and Mr Bamblett heard the contents of the call.

566. Mr Bamblett made a follow up call to Castlemaine police station at 7.45pm and recalls being told that Ms Day was still intoxicated, and would be for another few hours, that she was sleeping on the floor and did not want to sleep on the bed.

567. The CSOM 'Handovers and follow ups' section has been amended to require, where a client is drunk or drug affected, to check with police every two hours. This amendment has been introduced subsequent to Ms Day's death.

568. It was Mr Bamblett's evidence that although one of the purposes of the CNS is to provide a welfare check, CSO's do not usually speak with a client when they are first picked up, when they are drunk. The reason for this is to protect the CSO from either getting abused or from the expectation that they will pick up the person in custody.[376]

569. Mr Bamblett explained that although VALS takes the calls, they do not do physical visits, but rely on the ACJP to do what they can at their end. It was Mr Bamblett's belief that ACJP's role was to attend the police cells and potentially assist a person in custody.

[376] T 1422 -3.

570. He agreed they rely on information from the police as to when the person in custody is ready to speak to a CSO.[377]

Conclusion

571. The purpose of the CNS is to ensure people's welfare and rights while they are in custody and ensure they have an opportunity to obtain legal advice prior to being interviewed by police.

572. In the case of Ms Day the CNS was unable to provide additional protection and the evidence was that CSO's do not usually speak to intoxicated detainees, as that is the role of the ACJP.

573. This evidence illustrated another disconnect between the expectations of VALS and the role of the ACJP.

The appropriateness of the treatment by Ms Day by attending ambulance officers, whether it was in accordance with relevant policy and procedure and whether it was otherwise appropriate

574. On 5 December 2017 Ms Harrup was rostered as a spare reserve paramedic, known as a single responder and attended Castlemaine Police Station to attend to Ms Day.

575. She was the first witness to apologise to Ms Day's family when giving her evidence at the inquest.

576. Upon arrival at the police station she was met by LSC Wolters. She entered a description of her conversation with him in the electronic patient care record: '... *Approx 7pm Police witnessed the patient (via cell camera) roll from a slouched/seated position on the bed (approx. 30 cm high) and strike her forehead on the ground. States patient immediately got back up and was moving normally (denies LOC).*'[378]

577. Ms Harrup stated she had a clear recollection of him describing the fall and inferred '*From the entire conversation ...*'[379] that he had been watching Ms Day on the CCTV monitor. Ms Harrup stated he told her that Ms Day had not been knocked unconscious and that she had a strong memory of him saying after the fall Ms Day was '*moving around the cell normally.*' Ms Harrup's evidence was that she was under the impression that LSC Wolters '... *witnessed the fall via the CCTV monitor and explained it that way.*'[380]

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[377] T 1428.
[378] CB 281.
[379] T 1196.
[380] T 1197.

578. Ms Harrup assessed Ms Day and took her Glasgow Coma Score. She formed the view Ms Day was intoxicated when she assessed her '*from the smell of alcohol and her movements and slurred speech and the history that she had been intoxicated on the train.*'[381]

579. Ms Harrup decided Ms Day required transport to hospital because she could not rule out that a head strike had not contributed to intoxication, to explain her presentation, and stated in her evidence that with a head strike it was always the case she was going to hospital.[382]

580. Because of the way the fall had been described, Ms Harrup decided spinal precautions were not necessary. She explained if she had taken spinal precautions, it would have taken longer to get Ms Day out of the police station.[383]

581. Ms Harrup did not identify that Ms Day had right sided hemiplegia. In her evidence she indicated she was '*quite mortified*'[384] that she missed this. In her second statement she saw that it was possible to detect when she examined the CCTV footage. She explained she may have missed it because she spent most of her time on Ms Day's left hand side, and that its harder to assess intoxicated patients because their movements are uncoordinated.[385]

582. In hindsight, Ms Harrup indicated she would have moved Ms Day differently as the movement of Ms Day on the CCTV footage appeared to be rough and hasty. She indicated that in future she will always check for hemiplegia and since 5 December 2017 she had learnt a new technique for moving patients in Ms Day's condition using a '*double fold slide sheet around a pat slide.*'[386]

583. Ms Harrup denied Ms Day's Aboriginality and alcohol use affected the way she treated Ms Day.[387] She relied on what she had been told about the fall by LCS Wolters and as she knew there was a CCTV monitor believed he had witnessed the mechanism of Ms Day's fall.

584. When the two other paramedics arrived, Sara Holland and Emma Matheson, they were given the same description of Ms Day's fall, as detailed in their electronic patient care record, by Ms Harrup and LSC Wolters.

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[381] T 1198-9.
[382] T 1199.
[383] T 1267.
[384] T 1209.
[385] T1209.
[386] T 1230.
[387] T 1271.

585. In her statement Ms Holland states she was told by a police officer who had reviewed the CCTV footage and that there had been no other falls.[388] LSC Wolters and Sergeant Neale both denied this was said to Ms Holland. In her evidence Ms Holland stated she was told this when she was looking for a reason for Ms Day's haematoma, given the minor mechanism fall that had been described. She did not believe the bruise to Ms Day's forehead, '*a moderate to significant haematoma …*' which *'took my breath away'*[389] equated to or matched the mechanism description of the fall. She later clarified it was only Ms Harrup who told her about the minor mechanism fall, and she sought clarification whether or not there were other falls from the police officers.[390]

586. Ms Holland advised if she had been told there was no explanation for Ms Day's bruise, different measures, such as spine immobilisation, would have occurred, but the process would not necessarily have been quicker.

587. Ms Holland stated she had no prior knowledge that Ms Harrup was going to move Ms Day by pulling her by the arm.[391] She was of the view there was a proper way to move Ms Day, *'which could have easily happened when she was appropriately rolled, the boards under and across.'*[392]

588. Ms Holland described Ms Day's presentation as unusual, as with a cerebral haemorrhage she would have expected to see uneven pupils and a GCS around 3, '*an extremely reduced conscious state.*'[393]

589. Although she was not sure of the cause of Ms Day's level of consciousness, she was sufficiently concerned with her presentation to load her Code 1 for Bendigo.

590. Ms Holland was of the view, given Ms Day's level of consciousness, it was not appropriate for her to be in a police cell.[394]

591. Whether or not Ms Holland was told it was from reviewing the CCTV footage, she was clear in her evidence she was told by police there had been no other falls.[395]

592. Ms Mathieson's entry in the electronic patient care record recorded the version of the fall given by Ms Harrup,[396] and clarified that LSC Wolters, '*interjected and confirmed*

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[388] T 1280.
[389] T 1307.
[390] T 1282.
[391] T 1284.
[392] T 1286.
[393] T 1288.
[394] T 1294.
[395] T 1306.
[396] T 1319.

those details.'[397] She understood LSC Wolters was describing a fall he had actually seen.[398]

593. Ms Mathieson noted that as time progressed Ms Day had less movement and she was starting the get concerned by the time she was moved and heading to the ambulance so the decision was made to proceed as Code 1, lights and sirens.[399]

594. Associate Professor Laidlaw was asked to comment on whether the paramedics management was reasonable. In respect of Ms Harrup's attendance he noted a number of deficiencies.

595. Firstly, he was concerned about Ms Day's airway protection, but noted ultimately there was no adverse consequence or effect on Ms Day's outcome.

596. Secondly, Associate Professor Laidlaw was '*surprised that the paramedic did not recognise a dense right hemiparesis when she attempted to sit the subject up.*'[400] He noted that recognition of this would have indicated to Ms Harrup the need for urgent transfer to hospital.

597. The evidence supports a finding that recognition of this would not have necessarily saved any time as both Ms Harrup and Ms Holland agreed that taking spinal precautions would have added to the time taken to convey Ms Day from the cell to the ambulance.

598. Associate Professor Laidlaw ultimately concluded he did not believe any specific action taken by the paramedics impacted on Ms Day's outcome, and the '*surprising*' failure to recognise the right hemiparesis was '*probably of minimal significance.*'[401]

599. Michael Stephenson, Executive Director of Clinical Operations for Ambulance Victoria provided a statement and gave evidence at the inquest. He also apologised to the Day family on behalf of Ambulance Victoria.

600. When questioned about changes to practices, procedures and changes since Ms Day's death he stated:

'*...it's caused an enormous amount of interest in the organisation from the board level...right through the organisation in terms of trying to improve cultural safety for the Aboriginal people...*'[402]

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[397] T 1319.
[398] T 1320.
[399] T 1322.
[400] CB p 396.
[401] CB p 397.
[402] T 1358.

Conclusion

601. I prefer the evidence of the ambulance officers to LSC Wolters.
602. I am of the view Ms Harrup was entitled to believe what she was told by LSC Wolters when she arrived, and I accept her evidence he told her he had witnessed a fall.
603. I accept Ms Harrup conducted a GCS assessment of Ms Day and I accept Associate Professor Laidlaw's evidence that whilst she failed to recognise Ms Day's semi paresis, this did not represent a lost opportunity as Associate Professor Laidlaw considered it of '*minimal significance.*'
604. I am of the view that Ms Harrup quickly formed a view Ms Day was intoxicated and it anchored her decision making regarding Ms Day's management. Despite this, she made the correct decision to transfer Ms Day to hospital based on her assessment of Ms Day's head strike.
605. I accept Associate Professor Laidlaw's assessment of the appropriateness of the ambulance officer's care for Ms Day.
606. I note Ms Harrup was apologetic to Ms Day's family in court and her evidence confirmed she admitted her mistakes and had learnt from them for the future.

Referral to the Director of Public Prosecutions

607. The family's submissions urge me to refer Ms Day's death to the Director of Public Prosecutions pursuant to section 49 of the Act if I believe that an indictable offence may have been committed in connection with the death.
608. The family submit the offence of negligent manslaughter may have been committed by Sergeant Neal and LSC Wolters, as detailed in paragraphs 139 – 144 of their submissions.
609. Counsel Assisting's submission, at paragraph 65 states: '*Despite the inadequacies in care by Sergeant Neale and LSC Wolters, the evidence earlier outlined in the submissions suggests that the death of Ms Day was not preventable. To that extent, any adequacies in their care of Ms Day have not ultimately been causative of her death.*'
610. As indicated earlier, I am not of the view the examination of whether Ms Day's death was preventable is limited in this way. The inquest broadly examined whether Ms Day's death was preventable by considering each stage of her journey and the decisions on 5 December 2017. The consideration of whether her death was preventable was not limited to events after she had sustained the fall.

611. My forming a belief an indictable offence may have occurred is a separate to the issue to whether Ms Day's death was preventable.

612. In the submissions hearing on 11 November 2019, Counsel for Victoria Police, in respect to section 49 of the Act, stated:

'Your Honour has had that power throughout the proceeding, but before and since the inquest brief was prepared and circulated. And Your Honour plainly didn't, prior to the inquest opening, form such a view. Because if you had, you would've exercised the power and made a referral. In my submission, nothing in the evidence that has been called before you in the inquest, more detailed though it is, changes the position that existed prior to the inquest starting. There isn't in the evidence a proper basis for Your Honour to form the view that an indictable offence of the kind raised by the family has been committed by anybody, or that offences might have been committed by Victoria Police under Occupational Health and Safety legislation. The evidence isn't there.

If it were, Your Honour would long since have made the referral, in my submission, because consistent with your obligations of natural justice, Your Honour wouldn't have continued with the inquest and permitted people to give evidence if Your Honour had formed a view that they might've engaged in criminal conduct.

And on the evidence before you, Your Honour couldn't form that view. Detective Senior Constable Riley gave evidence about the elements of negligent manslaughter. Your Honour has not only the evidence of Professor Laidlaw as to causation matters, but a whole weight of other evidence that demonstrates, in my submission, that even if Your Honour is minded to find some deficiencies in the conduct of police, those deficiencies fall well, well short of the standard of criminal negligence.'

613. All the evidence at inquest examined how it was Ms Day was taken into police custody for her safety and ended up dying from an injury which occurred in custody. Ms Day's death was clearly preventable had she not been arrested and taken into custody.

614. The question is whether I can form the belief an indictable offence may have been committed based on the entirety of the evidence. Section 49 requires the coroner to draw a conclusion about the state of the evidence. The forming of such a belief does not occur as a flash of enlightenment, but more from reflection on the possibilities enlivened by the evidence.[403]

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[403] *Maksimovich v Walsh* (1985) 4 NSWLR 318 at 330 per Kirby P at 330.

615. Police officers gave evidence at the inquest represented by the Counsel for Victoria Police. Counsel should have referred them to separate representation if their interests conflicted with that of Victoria Police for advice about giving evidence. Some were asked in the course of their evidence whether their conduct amounted to criminal negligence and they chose to answer questions without objection and without seeking a certificate. Counsel made submissions on their behalf about section 49. I do not accept the matters raised by Counsel for Victoria Police on this point.

616. A coroner is not required to immediately notify the DPP upon forming a belief that a person may have committed an indictable offence in connection with a death. The referral can be made at the end of the proceeding as reflected in section 69(2) of the Act.

617. It is not the coroner's role to gather evidence in preparation for a criminal prosecution.[404]

618. Section 69(1) states '*A coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence.*'

619. The Court of Appeal in *Priest v West*[405] explained that the coronial investigation must include an investigation into whether any person contributed to the death. Failing to do so will mean the coroner has not discharged properly the obligation to find the cause of death and the circumstances in which it occurred.

620. It is not my role to determine what criminal charge may be laid, or to analysis whether there is a reasonable chance of prosecution. I note, however, that evidence which would not be admissible in a criminal trial does not provide a suitable basis for forming a belief that an indictable offence was committed.[406]

621. My role is to record my factual findings as to the sequence of events which culminated in Ms Day's death and not to express any judgment or evaluation of the legal effect of those findings.

622. In considering facts sufficient to induce a state of mind for a suspicion and a belief, the High Court stated;

'*The objective circumstances sufficient to show a reason to believe something need to point more clearly to the subject matter of the belief, but that is not to say that the objective circumstances must establish on the balance of probabilities that the subject matter in fact occurred or exists: the assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than*

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[404] *Maksimovich v Walsh* (1985) 4 NSWLR 318 at 330 per Kirby P at 330.
[405] [2012] VSCA 327.
[406] *Leahy v Barnes* [2013] QSC 226 at [59]-[61].

rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.'[407]

623. Ms Day was in a highly vulnerable state when she was detained in a cell, without medical assessment, and although it was clear she was a falls risk from her stumbling and lack of balance, a falls risk assessment was not considered. She was not observed and monitored in compliance with the VPM Guidelines or the Castlemaine Police Station's Standard Operating Procedures either in terms of frequency or quality and the observations that were made were of a cursory nature. This mitigated against the opportunity to detect deterioration. The clear and unambiguous wording of those key documents leaves no doubt about the duty of custodial officers to take all reasonable steps to avoid acts or omissions which they could reasonably foresee would be likely to harm a detainee and to be vigilant in observations and monitoring. The quality of the observations proscribed requiring 'active engagement' is specifically to detect any deterioration. Ms Day sustained a traumatic head injury within the first hour of her detention and all aspects of her behaviour following were attributed by police officers to her being drunk and behaving as drunks do. She had two physical checks which each lasted six seconds between the time of her fall at 4.51pm and 8.04pm and I was not satisfied she was verbally actively engaged as required on those occasions. Her injury was not identified, thus there was potentially an omission to obtain timely, appropriate medical care which impacted on her death.

624. With respect to the elements of the offence of negligent manslaughter, I do not intend to enumerate the evidence in support of each element as to do so would render me evaluating the legal effect of the facts I have found, which is not my role. I only note that as to causation, Associate Professor Laidlaw's expert opinion was that Ms Day, in the most optimal circumstances of receiving medical treatment, had a 20% chance of survival albeit with significant impairment. I am conscious that simply because there was a duty of care, and a serious injury resulting in death occurred, does not mean that there must have been criminal negligence. It may well be the Director may form the view there is insufficient evidence to lay a charge.

625. However that is not test here for the purposes of section 49(1). Whilst there may be room for some 'surmise or conjecture', the totality of the evidence inclines me to

[407] *George v Rockett* [1990] HCA 26 at [14].

assenting to a belief that an indictable offence *may* have been committed, and on this basis, I intend to direct that the principal registrar must notify the Director of Public Prosecutions.

Criticisms of the coronial investigation

626. Whilst the coroner is assisted in their investigation by a member of Victoria Police who becomes the coroner's investigator, the role of that police officer and the nature of their reporting relationship to the coroner is not defined in the Act.

627. The legislative basis for police assistance or involvement with coronial investigations derives from the Coronial legislation and section 59 of the *Victoria Police Act 2013* which provides: '*A police officer may assist a coroner in the investigation of a death or fire under Part 4 of the Coroners Act 2008.*'

628. The arrangements for Victoria Police members to provide assistance to a coroner as a coronial investigator are not formalised, but proceed as a convention.

629. The Day family made a number of criticisms of the about the investigation from the outset. These included concerns about the collection of CCTV footage from Castlemaine police station, the lack of analysis of a blood stain in Ms Day's cell and the failure to treat police officers as suspects.

630. I am conscious of the historical basis for the distrust by the Aboriginal community towards Victoria Police, which has been described as:

'*Many Aboriginals see police in a historic continuity where they started off as armed agents of invaders who in many areas sought to exterminate them, and everywhere to deprive them of their land and means of livelihood ... Police have always been called on to do the dirty work associated with government policies in relation to Aboriginals, including the dispersal of camps which offended local residents and even today the suppression of Aboriginal lifestyles that offend middle class propriety, such as drinking in the streets or in the parks ... The significance for this for coronial inquiries which have been the subject of inquiry by the Royal Commission is the very high degree of suspicion of foul play that surrounds the deaths.*'[408]

[408] The Hon JH Wootten QC, Commissioner, *Deaths in custody*, Paper delivered at a public seminar entitled 'Coronial Inquiries', convened by the Institute of Criminology at Sydney University Law School, 10 October 1990, p 59.

631. The mistrust and suspicion by Ms Day's family towards the coroner's investigator was palpable during the investigation and concerned a perceived conflict of interest arising from police investigating the actions of other police.

632. Where the only witnesses to a death are those whose conduct is under scrutiny, it is very important to collect as much 'hard' evidence as possible after the death. Police members, as the coroner's investigator, should ensure the most thorough investigation of facts and circumstances is conducted, which includes retaining all hard independent evidence, such as CCTV footage, from a scene.

633. I accept the family's concerns about the collection of the CCTV footage. However I do not find their concerns have been borne out or that the quality of the coronial investigation was detrimentally affected.

634. The investigation by DSC Riley was overseen by Professional Standards. The oversight by Professional Standards was subject to review by the Independent Broad-based Anti-Corruption Commission.[409]

635. In respect to the relationship between the coroner and investigator, the RCIADIC made the following recommendation 29:

'*That a coroner in charge of a coronial inquiry into a death in custody have legal power to require the officer in charge of the police investigation to report to the coroner.*'

636. The Victorian Parliamentary Law Reform Committee which considered the Coroners Act 1985, although noting the positive relationship between the Coroner's office and Victoria Police stated:

'*... the Committee has a number of concerns with the current arrangements and considers that on occasion there may well be a need for coroners to have the legal authority to direct police officers in their inquiries ... The Committee considers that the power is particularly necessary in relation to coronial deaths in police custody and deaths resulting from police actions in order to avoid the perception that there is a conflict of interest in police directing investigations into police-related deaths.*'

637. The report went on to state:

[409] At the time of finalising this finding I have been advised that IBAC has completed an interim review but as that was not available for distribution to all parties I have not read it.

'However, the committee is of the view that, without the power to direct, a coroner's ability to effectively investigate a death from a community safety and prevention viewpoint may be compromised.'[410]

638. Recommendation 42 stated:

'That the Coroners Act 1985 be amended to provide that a coroner may give a police officer direction concerning investigations to be carried out for the purpose of an inquest or inquiry into a death or suspected death, whether or not the inquest of inquiry has commenced.'[411]

639. The perception of conflict of interest was also identified in an Office of Police Integrity Report from June 2011.

640. Neither the recommendation from the RCIADIC nor the recommendation from the Victorian Parliamentary Law Reform Committee have been implemented into the Victorian coronial legislation.

641. As I indicated earlier, I do not accept there were deficiencies in the standard of the coronial investigation. I am not of the view that any matter of significance has been missed as a result of DSC Riley's conduct of the investigation.

642. There were however difficulties in the perception and lack of clarity in the relationship between coroner and police officer as coroner's investigator which led to the coroner's investigator being separately represented and unable to assist me during the inquest.

643. I take into account the RCIADIC recommendation 29 (detailed above), and the Victorian Parliamentary Law Reform Committee report recommendation 42 making a similar recommendation to clarify the role of the coroner's investigator and relationship with the coroner. I also have regard to the lack of clarity both real and perceived regarding the independence of the coroner's investigator from Victoria Police.

644. I intend to make recommendation repeating Recommendation 29 of the RCIADIC and Recommendation 42 of the Victorian Parliamentary Law Reform Committee Report seeking the legislative recognition that the coroner is directing the investigation by the coroner's investigator rather than relying on the current arrangements of convention.

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[410] Law Reform Committee, Coroners At 1985, p 204.
[411] Law Reform Committee, Coroners At 1985, p 204.

FINDING

645. Having considered all the evidence I find that Tanya Louise Day born on 8 September 1962 died on 22 December 2017 from Left cerebral haemorrhage of traumatic origin in a woman with liver cirrhosis in the circumstances described above.

I direct, pursuant to section 49(2) of the Act, that the Principal Registrar notify the Registrar of Births Deaths and Marriages of the prescribed particulars in this finding and accordingly amend the currently registered cause of death to reflect my findings into the cause of death of Tanya Louise Day.

I direct, pursuant to section 49(1) that the Principal Registrar must notify the Director of Public Prosecutions that I believe an indictable offence may have been committed in connection with Ms Day's death.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008,* I make the following comment:

1. During the course of this inquest it became apparent to me that the Coroners Court of Victoria should review the relevant recommendations from the Royal Commission into Aboriginal Deaths in Custody as they relate to coronial investigations. This review is currently underway.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

To: The Attorney General, The Honourable Jill Hennessey

1. I recommend that the offence of public drunkenness be decriminalised and that section 13 of the *Summary Offences Act 1966* be repealed.

2. I recommend legislative amendment to the *Coroners Act 2008* that the coroner in charge of a coronial investigation may give a police officer direction concerning investigations to be carried out for the purpose of an inquest or investigation into a death being investigated by the coroner, thus legislatively recognising the role of the Coronial Investigator.

I refer to both the Royal Commission into Aboriginal Deaths in Custody, Recommendation 29 and the Victorian Parliamentary Law Reform Committee Report regarding the *Coroners Act* (1985) Recommendation 42.

To: The Chief Commissioner, Victoria Police

3. I recommend that the Victoria Police Manual Rules and Guidelines be amended to include a falls risk assessment as part of the detainee risk assessment for each person in custody who appears to be affected by alcohol or drugs or illness.

4. I recommend that there be a review of training and education within Victoria Police regarding the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody to ensure knowledge and appropriate compliance.

5. I recommend training be implemented for all Victoria Police custody staff regarding the Victoria Police Manual Rules, Guidelines and local police station Standard Operating Procedures regarding the mandatory requirements applicable for the safe management of persons in police care or custody.

6. I recommend training be implemented within Victoria Police regarding the medical risks of individuals affected by alcohol.

7. I recommend Victoria Police request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 4(c) review of the compatibility of its training materials with the human rights set out in the Charter.

To: The Chief Executive Officer, V/Line

8. I recommend V/ Line review training materials to include input from the Aboriginal and Torres Strait community about unconscious bias and to provide training to staff as to how to reduce the impact of unconscious bias in decision making.

9. I recommend V/Line request the Victorian Equal Opportunity and Human Rights Commission to conduct a section 4(c) review of the compatibility of its training materials with the human rights set out in the Charter.

To the Secretary, Department of Justice and Community Safety

10. I recommend that the current volunteer model for the Aboriginal Community Justice Panel be reviewed as to its effectiveness in providing protection for Aboriginal people

in custody and that this review include a clarification of the services offered by the Aboriginal Community Justice Panel with both Victoria Police and the Victorian Aboriginal Legal Service.

Pursuant to section 73(1) of the *Coroners Act 2008*, I order that this finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Human Rights Law Centre on behalf of the Day family
The Attorney General, The Honourable Jill Hennessey
Minter Ellison on behalf of V/Line
Norton Rose Fulbright on behalf of Victoria Police
Lander & Rogers Lawyers on behalf of Ambulance Victoria
HWL Ebsworth Lawyers on behalf of Lisa Harrup
K&L Gates on behalf of Sarah Holland and Emma Matheson
Victoria Equal Opportunity and Human Rights Commission
Victorian Government Solicitor's Office on behalf of Sergeant Scott Riley, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 9 April 2020