Aboriginal Deaths in Custody Royal Commission

THE HEALTH CONTEXT OF THE DEATHS IN CUSTODY

It is apparent that health was a key vulnerability facing those Aboriginal people who died in custody and, indeed, is a key vulnerability of all people taken into custody. The poor health of many individual Aboriginal people reflects the nature of many Aboriginal communities in which feelings of individual despair and hopelessness are often found. These feelings are reflected by violence, drunkenness, vandalism and other forms of crime, as well as illness and self-destructive behaviour.

Aboriginal people are the least healthy identifiable sub-population in Australia. The health problems of Aboriginal people vary across the country, reflecting different circumstances, but the overall standard of health is low throughout Australia.

By virtually every health status measure, and for almost all disease categories, the health of Aboriginal people is much worse than that of other Australians. The extent of Aboriginal health disadvantages can be gauged from their overall mortality: [Aboriginal people have rates of death] roughly two to four times that of the total Australian population. As a result, Aborigines can expect to live many years less than other Australians: for males, between 12 and 20 years less, and, for females, between 14 and 21 years less.

In summarising a variety of health data from different sources, this report, and five others (an overview for each State) prepared for the regional Commissioners drew attention not only to the poor level of health experienced by Aboriginal people, but also to the relative paucity of Aboriginal health statistics. I find it unfortunate that data for any key health indicator for Aboriginal people are not available at a national level, and many are not even available at State and Territory level. Data on Aboriginal deaths, for example, only started to become separately identifiable in the 1980s. Even today, reliable statistics are not available for Aboriginal people living in New South Wales, Victoria, Queensland, Tasmania and the Australian Capital Territory--although there are some statistics collected for Aboriginal people living in a number of communities. That is, reliable death statistics are available for less than two-fifths of the country's Aboriginal population.

In the absence of comprehensive statistics, to present a picture of Aboriginal health it is necessary to piece together data from different places and for different time periods.

To illustrate the very poor health status of Aboriginal people, I will summarise a few of the statistics from the various reports prepared by Dr Thomson and his colleagues at the Australian Institute of Health, and from a recent paper comparing the risks of death of Aboriginal and non-Aboriginal people in custody with the risks in the total populations, Aboriginal and non-Aboriginal.

Specific Health Risks Encountered by Aboriginal People in Custody

I will now summarise briefly the specific risks encountered by Aboriginal people in custody. From the deaths examined by the Commission, the greatest specific risk for Aboriginal people in custody was self-harmful behaviour. Of the 99 deaths examined by the Commission were as a result of such behaviour, most commonly by hanging. However, the details of the cases suggest that this risk of death could be greatly reduced.

First, a number of those dying in custody from self-harmful behaviour had been incarcerated for minor offences, frequently alcohol related, and the cases may well have been able to be handled without recourse to incarceration. Also, Dr Reser, in considering the self-inflicted deaths occurring in Queensland, draws attention to a variety of situational factors, including age, intoxication, and social environment. To some degree, a number of situation factors apply to many of the cases of people dying in police custody, for instance intoxication, isolation and incarceration in poor facilities. As well, other situational factors (such as domestic or economic difficulties), could also act as triggers for self-harmful behaviour. While many of these
situational triggers may not be avoidable, custodial authorities need to recognise the greater risks involved. The improved physical safety of cells needs to be accompanied by the much better surveillance of at-risk prisoners by custodial officers.

In summary, there are a complexity of factors which may be precipitative of suicidal behaviour. The cases investigated have highlighted a number of factors which appear to be significant but which have not been reflected in the past in either custodial officers training or in police and prison practices and procedures. These are:

- Intoxication, including alcohol withdrawal
- Anger, aggression and emotional distress
- Mental disorder
- Previous attempts or threats to commit self-harm
- Age and gender (younger adult males appear to be the most vulnerable).
- Time. The Research Unit found that the majority of suicides occurred within the first three hours of admission to custody.
- Method of self-harm. The most common method is hanging.
- Other situational factors, for instance loss of job, family disagreements and isolation in custody.
- There may not necessarily be any outward signs of depression.

While not discussed in this chapter, the literature identifies first-time prisoners, those prisoners whose offences involve violent crime, for example domestic murders and prisoners who face long sentences. Sexual offenders may possibly also be included in this category.

Another area of great risk for Aboriginal people in custody relates to the failure, by health care workers and custodial authorities, to recognise or anticipate treatable life-threatening conditions. I have mentioned already the way that alcohol can mask a number of conditions, such as subdural haematoma, delirium tremens, severe infection, hypoglycaemia and co-existing drug overdose. As well as these, health care workers, in particular, need to be aware that Aboriginal people may present with unusual health conditions or with unusual presentations of common conditions.

The cases of Jimmy Njanji and of the man who died in Perth's Sir Charles Gairdner Hospital provide examples. The exaggerated impact of an infectious agent in a poorly nourished person contributed to the failure by the doctors caring for Jimmy Njanji to recognise that an apparently minor wound could have such a dramatic presentation, eventually leading to his death. In the case of the man who died in Sir Charles Gairdner Hospital, the delayed diagnosis of miliary tuberculosis, an unusual condition in Australia today, led to his death from tuberculous meningitis.

In general, the vulnerability, of Aboriginal people, in and out of custody, to severe infections is particularly related to the higher levels of malnutrition in the Aboriginal population than in the general Australian population. It is likely that those Aboriginal people coming into contact with custodial authorities are worse off than most other Aboriginal people, to the point that some are, in fact, quite debilitated. This is an area of risk which demands special attention.

Of the ninety-nine cases examined by the Commission, nineteen people had a history of epileptiform seizures, with a seizure being directly implicated in the death of six people. The prevalence, and apparently poor management, of such long-term health conditions needs to be recognised by those responsible for the care of Aboriginal people in custody. Without such recognition, including recognition of the need for medication, needless deaths in custody will continue to occur. Much the same can be said for other long-term health conditions known to be more prevalent among Aboriginal people. Of major importance is diabetes mellitus, and hypertension is also a problem for some Aboriginal people. It is important that custodial authorities do all they can to ensure that people with the need for regular medications continue to receive them while they are in custody.
The deaths, and morbidity, from ischaemic heart disease are really of a different nature. The extent of ischaemic heart disease, particularly among young adults, is absolutely remarkable. Although descriptive studies have documented high death rates from ischaemic heart disease among young and middle-aged Aboriginal people, some doubts have existed about the total accuracy of the certification of these deaths. On the other hand, there can be little doubt about the impact of ischaemic heart disease for many of the Aboriginal people who died in custody; the autopsy evidence is undeniable. In addition to the twenty people whose deaths were caused directly by disease of the circulatory system, autopsies revealed significant heart disease in a number of other young Aboriginal people. In some cases (for example, Stanley Brown and Donald Harris), the disease was so severe that an experienced forensic pathologist noted that, in other circumstances, it could well have been the cause of death.

It is likely that the emergence of significant ischaemic heart disease among Aboriginal people is a relatively recent phenomenon, but it appears that its impact is particularly lethal. Even though the changes found at autopsy of ischaemic heart disease result from long term health factors, the intensity is so severe that the fatal outcome is being seen in very young men.

For the general population, death rates from ischaemic heart disease, particularly for young and middle-aged adults, have declined since the late 1960s. Although a significant number of deaths still occur among middle-aged adults, acute myocardial infarction, the main fatal manifestation of ischaemic heart disease, is increasingly becoming a cause of death found mainly among older Australians. In recent years, 91% of male deaths from acute myocardial infarction occurred to men aged 55 years or more, and 98% to those aged 45 years or more. For men aged 34 years or less, deaths from acute myocardial infarction are now very uncommon.

It is against this background that the deaths occurring in custody from disease of the circulatory system must be viewed. The numbers of deaths occurring in custody were well above the numbers expected from total Australian rates (for Aboriginal males, 7.3 times for those in police custody and 3.1 times for those in prison; for Aboriginal females, there were only 2 deaths).

But the differences are much more than these figures suggest, as can be seen from the ages of those dying from disease of the circulatory system. For the 7 Aboriginal males dying in police custody, the mean age at death was 46 years and the median age 50 years. For the 13 Aboriginal males dying in prison, the mean age at death was 37 years and the median age 34 years. The 2 Aboriginal females (both in police custody) who died from disease of the circulatory system were aged 30 years.

The cases examined by the Commission provide undeniable evidence of the alarming impact among young Aboriginal people of disease of the circulatory system, particularly ischaemic heart disease. For Aboriginal people, the extent of premature mortality caused by these diseases warrants urgent attention from all responsible authorities.