NOTICE OF FILING

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Details of Filing

Document Lodged:	Statement of Claim - Form 17 - Rule 8.06(1)(a)
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Registry:	QUEENSLAND REGISTRY - FEDERAL COURT OF AUSTRALIA

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Important Information

As required by the Court's Rules, this Notice has been inserted as the first page of the document which has been accepted for electronic filing. It is now taken to be part of that document for the purposes of the proceeding in the Court and contains important information for all parties to that proceeding. It must be included in the document served on each of those parties.

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Federal Court Rules
Rule 8.05(1)(a)

Third Further Amended Statement of Claim

(Filed pursuant to the Court's Orders dated 21 August 2015)

No. **QUD 535 of 2013**

Federal Court of Australia
District Registry: Queensland
Division: General Division

Lex Wotton and Others
Applicants

State of Queensland and Another
Respondents

Filed on behalf of	The Applicants	
Prepared by	Stewart A Levitt and Daniel Meyerowitz-Katz	
Law firm	Levitt Robinson Solicitors	Ref: SAL:100547:3012
Tel	(02) 9286 3133	Fax (02) 9283 0005
Email	slevitt@levittrobinson.com	
Address for service	Level 6, 162 Goulburn Street, Sydney (East) NSW 2010	

[Form approved 01/08/2011]

A DEFINITIONS

Term	Paragraph	Definition
1994 Review	31	Report dated 25 August 1994 of the QPS *Review of Policing on Remote Aboriginal and Torres Strait Islander Communities*
Action Plan	279	
AHRC	O	Australian Human Rights Commission
CAU	186	Cultural Advisory Unit, Office of the Commissioner of Police
CCLO	189	QPS Cross Cultural Liaison Officer
CMC	106.i.A	Queensland Crime and Misconduct Commission
CIB		Criminal Investigation Branch
COB	207	Crime Operations Branch of the SCOC
Code of Conduct	72	Version 29 of the QPS Code of Conduct (August 2003)
Constable Steadman		Constable Kristopher Steadman
Coroner Duty	100.a	Duty on the QPS to abide by the Coroner's Guidelines
Coroner's Guidelines	99.e	Version 0 December 2003 of the Queensland State Coroner's Guidelines
Coroners Act	99.a.i	*Coroners Act* 2003 (Qld)
DCDCEO	206	Deputy Commissioner, Deputy Chief Executive (Operations)
DI Strofeldt		District Inspector Gregory Strohfeldt
DI Webber		Detective Inspector Warren Thomas George Webber
Document [X]		Where [X] is a number, refers to a document discovered by the Respondents pursuant to the Or-

		ders made by the Honourable Mortimer J on 28 April 2015 and 28 May 2015, adopting the numbering in the various Lists of Documents filed by the Respondents.
DS Robinson		Detective Sergeant Darren Allen Robinson
DSS Kitching	121	Detective Senior Sergeant Raymond Kitching
ESC	57	QPS Ethical Standards Command
FCAA	1	*Federal Court of Australia Act* 1976 (Cth)
Form 1	150	Form 1, "Police Notification of Death to Coroner"
Functions	6.d	
Further Failures	309	
HRM	70	QPS Human Resource Management Manual
Impartiality Duty	108	
Inspector Richardson		Inspector Brian Richardson
Inspector Williams		Inspector Mark Williams of the QPS Ethical Standards Command
Integrity Duty	115.a	
Investigation Team	125	DI Webber, DSS Kitching, and DS Robinson
Mulrunji		Aboriginal man who died in police custody on Palm Island on 19 November 2004
Notification Duty	118	
OPM		Queensland Police Service Operational Procedures Manual Issue 24 - July 2004
Palm Island Council	232	Palm Island Aboriginal Shire Council
PGFPC	70.b	HRM s 17.2 'Procedural Guidelines for Professional Conduct'
PPRA		*Police Powers and Responsibilities Act* 2000 (Qld)
Preliminary Autopsy Report	162	Report by Dr Guy Lampe dated 24 November 2004.
Presumption Duty	117	
PSAA		*Police Service Administration Act* 1990 (Qld)
PSPA	275	*Public Safety Preservation Act* 1986 (Qld)

QPS	6.a	Queensland Police Service
QPS Failures	244	
Palm Island Council	232.c.i	Palm Island Aboriginal Shire Council
PLO Bengaroo		Police Liaison Officer Lloyd Bengaroo
Prescribed Responsibility	6.a	
PSRT	279.b	Public Safety Response Team
Raids	283	
Reasonable Diligence Duty	115.b	
Regional Reports	27	
RCADIC	27	Royal Commission into Aboriginal Deaths in Custody
RDA	244	*Racial Discrimination Act* 1975 (Cth)
SCOC	205	State Crime Operations Command
Sergeant Leafe		Sergeant Michael Patrick Leafe
SERT	279.b	Special Emergency Response Team
SS Hurley		Senior Sergeant Christopher Hurley
Sub-Group	4	

B INTRODUCTORY

1. The Applicants commence these proceedings as a representative party pursuant to Part IVA of the *Federal Court of Australia Act* (1976) Cth (**FCAA**).

1A. The Applicants and the persons they represent in these proceedings pursuant to Part IVA of the FCAA were Indigenous people resident on Palm Island on 19 November 2004 who remained ordinarily resident on Palm Island until 25 March 2010. The persons whom the Applicants represent in these proceedings will be referred to independently of the Applicants as the "Group Members".

1B. At all relevant times, the Indigenous population of Palm Island was greater than 95% of its total population and from 19 November 2004 until the present day numbered approximately 2000 people.

Particulars

Queensland Labour Market Research Unit, *Queensland's Labour Market Progress: A 2006 Census of Population and Housing Profile* (Issue No 11.11, Northern Statistical Division, August 2008).

1C. The Group Members number more than seven people.

2. At all relevant times, the Applicants, and the Group Members, were Aboriginal persons or Torres Strait Islanders.

3. The Applicants and Group Members were ordinarily resident on Palm Island between 19 November 2004 and 25 March 2010.

4. The Applicants also represent a sub-group of Group Members, (**Sub-Group**) being persons who either:

   a. were apprehended or arrested by, or in the presence of SERT or PSRT officers in connection with the events on Palm Island on 26 November 2004;

   b. were present at the arrests referred to in the preceding sub-paragraph;

   c. otherwise witnessed or were present during the Raids (as defined in paragraph 283 below); and/or

   d. had their homes entered into, or their property otherwise interfered with, by officers of the QPS during the Raids without their consent.

5. The members of the Sub-Group number more than seven people.

C Police Service Administration Act 1990 (Qld)

~~4.~~6. At all relevant times:

a. the Second Respondent was responsible for the efficient and proper administration, management and functioning of the Queensland Police Service (**QPS**) in accordance with law (**Prescribed Responsibility**).

Particulars

b. Police Service Administration Act 1990, s 4.8(1), s.4.8(2) the Prescribed Responsibility, further included the following responsibilities:

i. determination of priorities of the QPS;

ii. control of the human, financial and other resources of the QPS;

iii. determination of the number and deployment of QPS officers and staff members;

iv. training and development of members of the QPS;

v. discipline of members of the QPS;

vi. internal redeployment and retraining of QPS officers and staff members;

Particulars

PSAA s4.8(2)(a), (d), (f), (k), (l), (p)

c. in discharging the Prescribed Responsibility, the Second Respondent, subject to the PSAA, was to ensure compliance with the requirements of all Acts and laws binding members of the QPS, and directions of the Second Respondent.

Particulars

PSAA s4.8(4)(b))

d. the functions of the QPS were prescribed in s.2.3 PSAA (**The Functions**), and included:

i. the preservation of peace and good order in all areas of the State.

Particulars

PSAA s2.3(a)(i)

ii. the protection of all communities in the State, and all members thereof –

A. from unlawful disruption of peace and good order that results, or is likely to result from actions of criminal offenders, or, actions or omissions of other persons;

B. from commission of offences against the law generally.

Particulars

PSAA, s. 2.3(b)

iii. the prevention of crime;

Particulars

PSAA, s. 2.3(c)

iv. the detection of offenders and bringing of offenders to justice;

Particulars

PSAA, s. 2.3(d)

v. the upholding of the law generally;

Particulars

PSAA, s. 2.3(e)

vi. the administration, in a responsible, fair and efficient manner and subject to due process of law and directions of the Second Respondent, of –

A. the provisions of the Criminal Code;

B. the provisions of all other Acts or laws for the time being committed to the responsibility of the QPS;

C. the powers, duties and discretions prescribed for officers by any Act.

Particulars

PSAA, s. 2.3(f)

vii. the provision of the QPS services, and the rendering of help reasonably sought, in an emergency or otherwise, as are –

A. required of officers under any Act or law or the reasonable expectations of the community; or

B. reasonably sought of officers by members of the community.

Particulars

PSAA, s 2.3(g)

e. in performance of The Functions, members of the QPS were to act in partnership with the community at large to the extent compatible with efficient and proper performance of those functions.

Particulars

PSAA, s2.4(2)

f. in discharging the Prescribed Responsibility, the Second Respondent may give, and cause to be issued, to officers, staff members or police recruits, such directions, written or oral, general or particular as the Second Respondent considers necessary or convenient for the efficient and proper functioning of the police service.

Particulars

PSAA, s4.9(1)

g. the Second Respondent gave directions, or caused directions to be issued in accordance with s.4.9(1) PSAA, as contained in the Queensland Police Service Operational Procedures Manual and Human Resource Management Manual as amended from time to time.

Particulars

Operational Procedures Manual – Introduction

h. at any incident that calls for action by police and at which officers are present, the officer who is responsible for taking such action, and for action taken is –

i. the officer designated for the purpose in accordance with established administrative arrangements;

ii. if there is no officer such as is referred to in the preceding subparagraph, the officer present who is most senior by rank;

iii. if there is no officer such as is referred to in the preceding two subparagraphs, the officer present who is most senior by length of continuous service as an officer.

Particulars

PSAA, s. 7.1(1)

D ARREST OF MULRUNJI AND DEATH IN CUSTODY ON 19 NOVEMBER 2004

D.1 Arrest and subsequent treatment of Mulrunji to the time of his death

(a) *Arrest*

~~5.~~7. At or about 10.20am on 19 November 2004, Senior Sergeant Christopher Hurley (**SS Hurley**) arrested Cameron Francis Doomadgee, posthumously known as "**Mulrunji**", as he was walking down Dee Street, Palm Island, and placed him in the locked area of a police van. Mulrunji was an Aboriginal person.

~~6.~~8. Police Liaison Officer Llyoyd Bengaroo (**PLO Bengaroo**), an ~~Indigenous officer~~Aboriginal person employed in the QPS, was ~~in the van~~ present with SS Hurley at the time of the events described in paragraph 7.

~~7.~~9. Upon arrival at the police station, SS Hurley removed Mulrunji from the police van and a struggle ensued.

10. At the time SS Hurley removed Mulrunji from the police van:

a. Roy Bramwell, was inside the Palm Island Police Station;

b. Penny Sibley was outside the Police Station in the vicinity of the police van;

c. Constable Steadman was standing at the front passenger's side of the police van in a position where he was able to see, and did see, some of the events that occurred after SS Hurley removed Mulrunji from the police van to the time when they entered through the door of the police station.

(b) *The Fall*

~~8.~~11. On the way into the police station, Mulrunji and SS Hurley fell through the rear door of the police station as they were entering it (**The Fall**).

12. At or about the time of The Fall, Mulrunji became limp and unresponsive.

~~9.~~13. Mulrunji was dragged, limp, to a watchhouse cell in the police station by Sergeant Michael Patrick Leafe and SS Hurley at about 10.26 am.

14. [Deleted]

(c) *Death*

~~10.~~15. At or about 11 am on 19 November 2004, Mulrunji died in police custody on Palm Island.

~~11.~~16. The cause of death was intra-abdominal haemorrhage due to ruptured liver and portal vein. Mulrunji had also sustained four broken ribs.

17. [Deleted]

18. [Deleted]

19. [Deleted]

D.2 Discovery of death and notification of QPS officers

20. [Deleted]

21. At about 11.19 am SS Hurley telephoned for the Queensland Ambulance Service (QAS) to attend an emergency at the watchhouse.

22. At about 11.30 am, SS Hurley called the Townsville District Police Communications Centre and advised Senior Sergeant Frank Jenkins of the death in custody.

23. At about 11.30 am, SS Hurley telephoned DI Strohfeldt and advised him of the death in custody.

24. At about 11.33 am Senior Sergeant Frank Jenkins telephoned DI Strohfeldt and advised him of the death in custody.

25. At about 11.45am:

a. SS Hurley telephoned DS Robinson, the Officer in Charge of the Criminal Investigation Branch (**CIB**) on Palm Island;

b. SS Hurley advised DS Robinson of the death in custody;

c. DS Robinson was in Townsville;

d. DS Robinson was the second most senior police officer stationed on Palm Island;

e. SS Hurley was the most senior police officer then stationed on Palm Island.

D.3 Officers in charge of Watchhouse and Responsible for Watchhouse

26. As at 19 November 2004:

a. SS Hurley was the officer in charge of the watchhouse and cells at the Palm Island Police Station;

b. DI Strohfeldt:

i. was the QPS Officer, to whom SS Hurley was directly responsible;

ii. was the commissioned officer responsible for the watchhouse and cell at the Palm Island Police Station;

iii. had held the positions referred to in sub-paragraphs i. and ii. directly above since 29 March 2004;

iv. was stationed in Townsville, and had been stationed there since at least 29 March 2004;

v. had not visited Palm Island since 29 March 2004.

E Aboriginal Deaths in Custody – Interest of the Community and Reasonable Expectations of the Community

27. In 1991, the report of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), making recommendations concerning such deaths and the investigation thereof was publicly released. In addition to the report of the RCIADIC, individual reports were also prepared in respect of each State and Territory of Australia, including Queensland (**Regional Reports**).

28. The RCIADIC:

    a. inquired into deaths in Australia, of Aboriginals and Torres Straight Islanders, whilst in police custody, prison or any other place of detention, between 1 January 1980 and 31 May 1989, and also into any subsequent action taken in respect of each of those deaths including the conduct of coronial, police and other inquiries and any other things that were not done but ought to have been done;

    b. was authorised, for the purpose of reporting on any underlying issues associated with those deaths, to take account of social and cultural and legal factors which, in the opinion of the Royal Commission, appear to have bearing on those deaths.

29. On 15 April 1991, the report of the RCIADIC was presented to all Australian Commonwealth, State and Territory Governments, including the First Respondent.

30. The passages set out in Annexure 'A' hereto are contained with the report of the RCIADIC within the body of the report, and passages set out in Annexure 'B' hereto are contained in the report as recommendations of the RCIADIC.

31. In November 2004, the following QPS officers were aware of, and/or alternatively ought reasonably have been aware of the content of the report of the RCIADIC and the recommendations made therein:

    a. Senior officers of the QPS stationed in communities with a significant population of Aboriginal persons, such as Palm Island;

    b. SS Hurley and DS Robinson;

    c. Inspector Richardson and Senior Sergeant Whyte;

    d. Senior officers who had achieved the rank of inspector or higher;

e. Officers who were higher in the chain of command to those officers referred to in sub-paragraphs a. to c. hereof.

Particulars

The Applicants rely on the following:

(i) The general notoriety of the RCIADIC.

(ii) Report dated 25 August 1994 of the QPS *Review of Policing on Remote Aboriginal and Torres Strait Islander Communities* ("**1994 Review**"), which was "conducted pursuant to recommendations made by the Royal Commission into Aboriginal Deaths in Custody" (at [1.6]) and the recommendations at 6.17 to 6.23.

(iii) The Functions of the QPS included the preservation of peace and good order in all areas of the State, and the provision of QPS Services required by the reasonable expectations of the community, which included Palm Island.

32. The community of Palm Island, including the Applicants, Group Members and Sub-Group, at all relevant times in November 2004:

a. were aware of the existence of the report of the RCIADIC, and the general nature of the matters discussed therein and the recommendations made therein;

b. were, by reason of the circumstances in which Mulrunji was arrested and died, and by reason of their being a predominantly Aboriginal community and the history of the community upon Palm Island, prone to forming a suspicion that the death in custody of Mulrunji was caused by or contributed to by SS Hurley, and that a fair and impartial investigation of the death would not occur;

c. had cultural needs peculiar to the community, by reason of the community being predominantly Aboriginal, and against the background of the circumstances in which the Aboriginal community came to inhabit Palm Island, and the treatment of the community by Public Officials since that time;

d. were concerned to ensure that the First Respondent, all Public Officials, the Second Respondent and QPS officers and members paid appropriate regard to the report of the RCIADIC and the recommendations contained therein in relation to the investigation of deaths in custody of Aboriginal persons and the care of Aboriginal persons whilst in Police custody;

e. by reason of their identities as Aboriginal persons who were resident in a predominantly Aboriginal community situated in the State of Queensland, who relied upon the QPS services on Palm Island, as a social service, a service for use by the general public, as an organ administering justice, and as an arm of the State providing protection and security of person to the community, and responsible for the matters pleaded in paragraph 6 here-

of, had a special interest in the conduct of the Second Respondent, QPS officers, and other QPS members, in relation to:

i. the provision of policing services on Palm Island;

ii. the general care and/or treatment of persons coming into contact with, or being detained by the Second Respondent, QPS officers, or other QPS members on Palm Island;

iii. the investigation of deaths occurring in the custody of the Second Respondent, QPS officers, or other members on Palm Island; and

iv. the holding of the Second Respondent, QPS officers, or other QPS members to account under the due process of law in relation to all matters connected with QPS services being provided on Palm Island.

f. reasonably expected that in the provision of policing services upon Palm Island, the Second Respondent and all QPS Officers and members would:

i. have proper regard to the report of the RCIADIC in the context of policing the Aboriginal community of Palm Island;

ii. implement all recommendations of the RCIADIC in so far as they affected the custody and care of Aboriginal persons on Palm Island, the community's desire to prevent Aboriginal deaths in custody on Palm Island, and their expectation that investigations into such deaths in custody would be thoroughly, rigorously and impartially investigated;

iii. provide policing services on Palm Island that appropriately took into account and addressed the cultural needs peculiar to the community, including the fact that the community is predominantly Aboriginal, and against the background of the circumstances in which the Aboriginal community came to inhabit Palm Island, and the treatment of the community by Public Officials since that time;

iv. Conduct themselves and discharge their responsibilities with professionalism and integrity;

v. Observe fairness and equity in their official dealings with the public and other public sector staff;

vi. Comply with, and be seen to act within the spirit and letter of the law;

vii. Act in the public interest and give priority to official duties and obligations;

viii. Comply with the directions of the Second Respondent, and all Policies, Orders and Procedures of the Second Respondent as required;

ix. Achieve desirable outcomes which reflect the needs and expectations of the community of Palm Island;

x. In fulfilling their obligations under the Code of Conduct, not only meet the minimum standards of conduct required, but strive to and encourage others under their supervision to achieve the highest standards of conduct possible;

xi. Act properly, in good faith, in accordance with both the spirit and the letter of the law and in the best interests of the community of Queensland;

xii. Properly exercise their powers as public officials, both lawfully, ethically and fairly;

xiii. Respect the dignity rights and views of all persons, including the members of the community of Palm Island;

xiv. Perform QPS duties in such a manner that public confidence and trust in the integrity and impartiality of the QPS and its members is preserved;

xv. Comply with the PSAA and all other Acts and laws;

xvi. Preserve the peace and good order in all areas of the State, including Palm Island;

xvii. Provide the QPS services, and the rendering of help reasonably sought in an emergency or otherwise as are required of officers under any Act or law or the reasonable expectations of the community, or reasonably sought of officers by members of the community;

xviii. Act in partnership with the community at large, including the community of Palm Island, to the extent compatible with the efficient and proper performance of the functions of the QPS;

xix. Provide responsive policing to the community of Palm Island, that meets the particular needs and expectations of the community from time to time.

F Provisions applying to QPS officers/members in November 2004

F.1 Operational Procedures Manual

33. In November 2004, Issue 24 - July 2004 of the Operational Procedures Manual (**OPM**) was in force, and contained Orders, Policies and Procedures.

(a) *Use of Manual – Definition of Order, Policy and Procedure*

34. Under the heading '*Use of Manual*' in the OPM it states:

> "Policy and instructions in this Manual are in the form of Order, Policy and Procedure. These terms are defined in the 'Definitions' section of this Manual.
>
> The OPM has been designed as a Service wide document and as such does not generally prescribe instructions unless applicable in all areas of the Service. In order to recognise the needs of local communities and policing requirements, it will be necessary for officers in charge of regions, districts and stations/establishments to develop Standing Operating Procedures (SOPs) and Standing Orders (SOs) to give effect to the OPM at a local level. These SOPs and SOs should then be held at local level with a reference to the relevant chapter of the OPM.
>
> SOPs and SOs are to be ancillary to and not conflict with the OPM. The OPM will have precedence over any SOPs and SOs developed at the local level."

35. In the OPM, the terms Order, Policy and Procedure are defined as follows:

a. "**ORDER** an order requires compliance with the course of action specified. Orders are not to be departed from."

b. "**POLICY** a policy outlines the Service attitude regarding a specific subject and must be complied with under ordinary circumstances. Policy may only be departed from if there are good and sufficient reason(s) for doing so. Members may be required to justify their decision to depart from policy."

c. "**PROCEDURE** A procedure outlines generally how an objective is achieved or a task performed, consistent with policies and orders. A procedure may outline actions which are generally undertaken by persons and organisations external to the Service."

(b) *Rules and Laws governing conduct in relation to persons in custody and Watchhouses*

36. Section 16.1 of the OPM provided:

d. "That the purpose of this chapter is to:

(i) reinforce the legal obligations of officers to care for the health and safety of persons in their custody;

(ii) set uniform minimum standards of custodial care throughout the State;

(iii) consolidate policies, orders and procedures for the performance of duties; and

(iv) allow additional specific standing orders where necessary."

e. an Order that "[o]fficers who have custody of persons are to ensure that persons are treated with dignity and that they are provided with the necessaries of life."

37. Section 16.1.1 *'Duty of care'* provided:

a. "Officers have a duty of care to those persons in their custody, which is recognised in both criminal and civil law. Each is derived from notions of common humanity."

b. "Chapter 27 of the Criminal Code provides for duties relating to the preservation of human life."

c. "Section 285 of the Code imposes duties to provide the necessaries of life. Section 285 imposes the same duty on one having charge of another who is unable by reason of that person's detention to provide themselves with the necessaries of life, as it does on a parent in relation to that parent's child. Therefore, the people to whom necessaries are being provided would be the persons who are being detained."

d. "Additionally, various provisions of the Police Powers and Responsibilities Act place an onus on officers regarding the responsibility to those persons in their custody. In particular, Division 1 and Division 2 of Part 3 of Chapter 10 contain specific responsibilities regarding searches of persons in custody."

e. "A failure to discharge a duty that is imposed by these provisions of the Code or the Police Powers and Responsibilities Act and which results in some detriment to another person may make the person upon whom that duty is imposed liable for the result."

38. Section 16.13 *'Health of prisoners'* provided:

> "Officers have a duty to exercise reasonable care to protect all prisoners from illness or injury during their detention and to exercise reasonable care in the provision of food, medical care, shelter, etc. for those prisoners. Safeguards including monitoring prisoners, should be put in place to observe the behaviour of prisoners."

39. Section 16.22 *'Administration of a watchhouse'* provided Orders that:

a. "The officer in charge of the watchhouse is responsible for the efficient and effective management of a watchhouse. This includes the development of appropriate systems for the:

(i) safety of people in the watchhouse;

(ii) health care of prisoners and members;

(iii) security of prisoner and their property; and

(iv) performance of staff."

b. "The commissioned officer responsible for a watchhouse is to ensure that the systems mentioned in the previous order are in place."

40. Section 16.22.3 *'Watchhouse training'* provided an Order that *"[t]he officer in charge of a watchhouse is to ensure that staff are trained in the use of first aid and resuscitation equipment provided at the watchhouse."*

F.2 Rules and Legislation governing conduct of the QPS following death in custody

(a) *Operational Procedures*

41. The death of Mulrunji was a "*death in custody*" as that term is defined in section 16.24 of the OPM.

(i) s. 16.24.1 'Investigation of death in custody' OPM

42. Section 16.24.1 '*Investigation of death in custody*' of the OPM provided relevantly that:

a. "A death in custody should be treated as a significant event, and the provisions of s. 1.4.6: 'Regional Duty Officer' and s. 1.4.7: 'Shift Supervisor' of this Manual apply. The first response or investigating officer as the case may be should notify the:

(i) shift supervisor;

(ii) regional duty officer;

(iii) ...; and

(iv) Officer in Charge, Cultural Advisory Unit, Office of the Commissioner.

b. "Where the Officer in Charge, Cultural Advisory Unit, Office of the Commissioner, is to be notified, such notification should include the information outlined in parts (i) to (xiii) of s.16.24.3: 'Additional responsibilities of officers investigating deaths in custody' of this chapter where available."

c. "All deaths which occur while a person is 'in custody' or while any person is in the company of police, should be fully investigated in accordance with s. 1.17: 'Fatalities or serious injuries resulting from incidents involving members (Police related incidents)' of this Manual";

d. "Where responsibility for the investigation of a death in custody reverts to a commissioned officer pursuant to s. 1.17: 'Fatalities or serious injuries resulting from incidents involving members (Police related incidents)' of this Manual, the investigation should be carried out in line with the provisions of s. 2.4: 'Crime scene', s. 2.5: 'Investigation' and Chapter 8: 'Coronial Matters' of this Manual.

(ii) s. 13.30, 6.4 OPM - Cultural Advisory Unit, Office of the Commissioner/Cross-Cultural Issues

43. Section 13.30 of the OPM provided that:

> "[t]he Cultural Advisory Unit (CAU), Office of the Commissioner, provides advice and support to members of the Service in relation to cultural issues and monitors racial incidents including offences against the Act. Also see s. 6.4: 'Cross-cultural issues' of this Manual."

44. Section 6.4 '*Cross cultural issues*' and the sub-sections thereof concerned cross-cultural issues relevant to policing in Aboriginal communities and will be referred to for its full terms meaning and effect. It further provided:

a. Policy in s. 6.4 that:

"To achieve the goals of the Service, strategies emphasizing joint community and police activities have been adopted.

Officers should always consider cultural needs which exist within the community."

b. Policy in s. 6.4.7 '*Community involvement – responsibilities of officer in charge*'

"Officers in charge of stations or establishments should, in managing the provision of services, take into account the specific cultural and ethnic demographic characteristics of their area of responsibility and the needs thereby created."

45. Section 6.4.8 '*Cross Cultural Liaison Officers*' provided:

"Cross cultural liaison officers are available in all regions. The role of a cross cultural liaison officer is to establish and maintain effective liaison between police, Aboriginal, Torres Strait Islander and ethnic communities to identify the needs of communities and enable appropriate policies and strategies to be developed to ensure the delivery of an equitable service within the district or region.

The principal responsibilities of cross cultural liaison officers include:

(i) managing and coordinating cultural support activities in line with Service policy;

(ii) developing and maintaining effective communication with Aboriginal/Torres Strait Islander and ethnic community representatives, colleagues and representatives of government departments and external agencies;

(iii) developing and presenting community based policing programs in line with service policy; and

(iv) providing operational support particularly in the investigation of crime in ethnic, Aboriginal and Torres Strait Islander communities.

PROCEDURE

Officers requiring assistance or advice can obtain the contact numbers for cross cultural liaison officers from the Bulletin Board on the QPS computer system."

(iii) s. 1.4.6, s.1.4.7 OPM - Significant Events – allocation of resources, ensuring that information or intelligence is effectively evaluated and disseminated

46. Section 1.4.6 of the OPM, under the heading '*Significant events*' provided Policies that:

a. "Regional duty officers are to include in their activity log details of significant events occurring during their shift."

b. "A significant event includes any:

(iii) police related incidents resulting in death or serious injury as defined in s. 1.17 …;

(xii) Case of a death in custody as outlined in s. 16.24 …"

c. "In each of these cases, the regional duty officer is to ensure a computer message is sent to the Deputy Commissioner, Deputy Chief Executive (Operations) …".

47. Section 1.4.7 of the OPM under the heading '*Shift Supervisor'* provided Policies that the shift supervisor is responsible for:

"(i) the security and allocation of station or establishment resources;"

"(vi) ensuring that information or intelligence is effectively evaluated and disseminated;"

"(xi) in the case of significant events, as outlined in the above order, cause a computer message to be sent to the Deputy Commissioner, Deputy Chief Executive (Operations), … The information in the message should include (a) a summary of the event; (b) action taken or pending; (c) details of any complaints, suspects or offenders; and (d) the name, station and telephone number of the officer responsible for investigation of the event."

(iv) s.16.24.2 - OPM Additional First Response procedures for deaths in custody

48. Section 16.24.2 *'Additional first response procedures for deaths in custody'* provided a Procedure that:

"An officer who finds a person in custody or in police company in circumstances that lead the officer to believe that the person may be deceased, whether by apparent suicide, foul play, accident or natural causes, in addition to s. 2.4: 'Crime scene' and s. 1.17: 'Fatalities or serious injuries resulting from incidents involving members (Police related incidents)' of this Manual, should:

(i) immediately render any assistance necessary;

(ii) …

(iii) attempt resuscitation when finding an apparently dead prisoner, if appropriate; and

(iv) notify the responsible officer."

(v) s.16.24.3 OPM - Additional responsibilities of officers investigating deaths in custody, including responsibilities for the Commissioned Officer (DI Webber)

49. Section *16.24.3 'Additional responsibilities of officers investigating deaths in custody'* provided Procedures that:

a. "Where responsibility for the investigation of a death in custody or in police company reverts to a commissioned officer pursuant to s.1.17 …, that commissioned officer should, as part of the investigation:

(i) Advise the Coroner and government pathologist;

(ii) Not presume suicide or natural death regardless of whether it may appear likely;

(iii) Obtain statements from all witnesses, including police officers, as soon as practicable after the incident and prior to any debriefing session where practicable;

(iv) Include investigations into the general care, treatment and supervision of the deceased immediately before the death in line with Service policy, orders and procedures;

(v) Inquire fully into the circumstances of the arrest or apprehension including any relevant activities of the deceased beforehand;

(vi) Immediately arrange for the next of kin or person previously nominated by the deceased to be notified. Cultural interests of the person being notified should be respected by using the cross cultural liaison officer, if practicable. Where the deceased is an Aborigine or Torres Strait Islander and there is a delay or inability to notify the next of kin, efforts to notify the next of kin should be recorded;

(vii) In circumstances where the deceased is an Aborigine or Torres Strait Islander, notification should preferably be assisted by an Aboriginal or Torres Strait Islander person known to those being notified;

(viii) If the deceased is an Aborigine or Torres Strait Islander, advise the Aboriginal and Torres Strait Islander Legal Service or other Aboriginal and Torres Strait Island community organisation with responsibility for the area, as soon as possible, whether or not the relatives have been located;

(ix) …

(x) Ensure that the Government Forensic Pathologist performs the autopsy;

(xi) Provide such information as sought by the family of the deceased and/or lawyers representing the family, unless the Coroner directs otherwise, about the progress of the investigation and the preparation of the brief for the inquest (where the deceased is an aborigine or Torres Strait Islander, the local cross cultural liaison officer should be consulted);

(xii) …

(xiii) …"

b. "See also Chapter 8: 'Coronial Matters; and Appendix 16.4: 'Suggested format for reports on death in custody or in police company' of this Manual."

(vi) s.1.17 OPM - 'Police related incidents' – Integrity of Investigation, Responsibilities of Investigators, including First Response Officer, Regional Duty Officer, Regional Crime Coordinator, Ethical Standards Command

50. Section 1.17 '*Fatalities or serious injuries resulting from incidents involving members (Police related incidents)*' provided Orders and Policies in relation to the investigation of '*Police related incidents*' and conduct of QPS members following '*Police related incidents*', under the headings:

a. '*Definition*';

b. '*Coordination*';

c. *'Duties and responsibilities';*

d. *'First response officer';*

e. *'Regional duty officer';*

f. *'Regional crime coordinator';*

g. *'Role of the Internal Investigation Branch, Ethical Standards Command';*

h. *'Integrity of Investigation';*

i. *'Welfare'.*

51. The death of Mulrunji fell within the defined term "*Police related incidents*" in section 1.17 of the OPM.

- *Expeditious and Impartial Investigations under Section 1.17 OPM*

52. Under the heading '*Coordination*' s. 1.17 of the OPM provided an Order that "*[i]nvestigations of police related incidents are to be conducted expeditiously and impartially and the psychological welfare of individuals considered*", which applied to all QPS members in relation to the investigation into the death in custody.

53. Under the heading 'Integrity of investigation' s. 1.17 of the OPM provided a Policy that:

> "First response officers, regional duty officers and regional crime coordinators should ensure that the integrity of the independent versions of members directly involved and members who are witnesses to a police related incident is preserved as far as practicable.
>
> In this regard, members directly involved in the incident or who are witnesses to the incident should be interviewed separately and as soon as practicable following the incident. It is highly desirable that interviews occur prior to any critical incident stress debriefing, including any defusing. Members directly involved in the incident or who are witnesses to the incident should not discuss the incident amongst themselves prior to being interviewed."

- *First Response Officer's Responsibilities under Section 1.17 OPM*

54. The first response officer's responsibilities under section 1.17 of the OPM included Orders that the first response officer was to:

"(i) assume command and control at the incident scene;"

"(ii) make an immediate assessment of the situation and inquire as to the circumstances surrounding the incident;"

"(iii) immediately notify the shift supervisor and the relevant regional duty officer in the region where the incident occurred, and the appropriate police communications centre;"

(iv) contain and preserve the scene;

"(v) take possession of or safeguard exhibits;"

"(vi) detain offenders;"

"(vii) wherever practicable, ensure that members involved in the incident do not leave the scene; and"

"(viii) wherever practicable, ensure that members who are involved in the incident, or who are witnesses to the incident, do not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene."

- *Regional Duty Officer's responsibilities under Section 1.17 OPM*

55. The regional duty officer's responsibilities under section 1.17 of the OPM included Orders that the regional duty officer who is notified of a police related incident is to:

> "(i) attend the scene, make an immediate assessment of the situation and make brief inquiries with persons at the scene, including members directly involved in the incident or who may be witnesses to the incident, as to the circumstances surrounding the incident"
>
> "(ii) assume command and control of the situation pending the arrival or involvement of the regional crime coordinator";
>
> "(iv) cause the following officers or units to be immediately notified: … (h) the Deputy Commissioner, Deputy Chief Executive (Operations);
>
> "(v) wherever practicable, ensure that members who are involved in the incident, or who are witnesses to the incident, do not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene";
>
> "(vi) wherever practicable ensure that members involved in the incident or who are witnesses to the incident are available for interview by the regional crime coordinator, officers from the Crime and Misconduct Commission or the Internal Investigation Branch, Ethical Standards Command, as the circumstances require."

- *Regional Crime Coordinator's responsibilities under Section 1.17 OPM*

56. The regional crime coordinator's responsibilities under section 1.17 of the OPM included:

a. Under the heading '*Coordination*':

i. an Order that, "*All police related incidents are to be investigated by or under the direction of the regional crime coordinator unless otherwise directed by the Internal Investigation Branch, Ethical Standards Command or the Crime and Misconduct Commission.*";

ii. Policies that:

A. "When investigating police related incidents, a regional crime coordinator should conduct the investigation or appoint an independent senior investigator with sufficient criminal investigation background to carry out investigations. Considerations by regional crime coordinators in making any such appointments should include the gravity of the incident, the rank of the officers or the level of seniority of the members who are directly involved in the incident (as opposed to witnesses), and the establishment at which those officers or members directly involved in the incident are stationed."

B. "In cases involving custody police related incidents, a regional crime coordinator should appoint an investigator from a police establishment

other than from where the incident occurred, or where the officers or members directly involved in the incident are stationed."

C. "Where the Crime and Misconduct Commission or Internal Investigation Branch, Ethical Standards Command, overviews an investigation of a police related incident, the regional crime coordinator retains responsibility for that investigation."

b. Under the heading '*Regional crime coordinator*' Orders that the regional crime coordinator is to:

"(i) be directly responsible for the investigation of a police related incident, unless otherwise directed by the Deputy Commissioner, Deputy Chief Executive (Operations), or unless responsibility for the investigation is assumed by the Internal Investigation Branch, Ethical Standards Command or the Crime and Misconduct Commission"

"(iii) ensure that the members directly involved in the incident or who are witnesses to the incident are interviewed as soon as practicable and it is highly desirable that interviews occur prior to any critical incident stress debriefing, including any defusing"

"(v) in cases of deaths in custody as defined in s. 16.24.1 … , ensure that where necessary the provisions of ss. 16.24 to 16.24.5 … are complied with."

- *Ethical Standards Command – Responsibilities of Officer representing, under Section 1.17 OPM*

57. The role of the officer representing the Internal Investigation Branch, Ethical Standards Command (**ESC**) under section 1.17 of the OPM included:

a. Orders that the officer is to:

"(i) on being advised of a police related incident, liaise with the regional crime coordinator and officers from the Crime and Misconduct Commission;

(ii) make an immediate assessment of the incident in conjunction with the regional crime coordinator and Crime and Misconduct Commission officers; and

(iii) in conjunction with the Crime and Misconduct Commission officers, overview the investigation and provide appropriate advice and assistance to the regional crime coordinator."

b. Policies that:

(i) "If, in the opinion of the officer representing the Internal Investigation Branch, Ethical Standards Command, proper investigational or procedural matters are not being adhered to, or there are matters which may adversely effect an impartial investigation, that member should confer with the regional crime coordinator and officers from the Crime and Misconduct Commission in an endeavour to resolve the issue."

(ii) "If an issue can not be resolved, the officer of the Internal Investigation Branch, Ethical Standards Command is to advise the Superintendent, Internal Investigation Branch, Ethical Standards Command, who should if necessary discuss the issues with the Deputy Commissioner, Deputy Chief Executive (Operations). …"

(iii) "The Deputy Commissioner, Deputy Chief Executive (Operations) may direct that the Superintendent, Internal Investigation Branch, Ethical Standards Command assume responsibility for the investigation of a police related incident. Following any such direction or as a result of the Internal Investigation Branch Ethical Standards Command assuming responsibility for an investigation, the regional crime coordinator and the appropriate assistant commissioner are to provide all reasonable assistance."

(vii) s. 8.4.2, 17.1 – Requirement to treat Death as a Major Incident

58. Section 8.4.2 '*First response actions – deaths*' of the OPM provided Orders that:

(i) "Where initial enquiries indicate beyond doubt that no suspicious circumstances surround the death, officers may treat the matter as a routine investigation. Officers are to treat all other cases as major incidents until such time as investigations indicate that no suspicious circumstances surround the death. The provisions of Chapter 2: 'Investigative Process' of this Manual apply."

(ii) "Where the death of a person occurs whilst that person is in custody, officers are to comply with the provisions of Chapter 16: 'Custody' of this Manual. … For homicides generally refer to s. 2.6.2: 'Homicide' of this Manual."

59. As outlined in s. 17.1 of the OPM, Chapter 17 '*Major Incidents':*

"deals with the processes and procedures for the police response to major incidents. For the purposes of this chapter, major incidents include situations related to … incident management. … Incident management involves situations where the … social routines of the community continue to operate with limited disruption. The Service and other emergency services manage the situation within the limits of the normal operating environment."

(viii) s. 17.3, 1.13, 1.13.1 - Management of Major Incidents

60. Section 17.3 '*Incident management*' of the OPM provides a Policy that:

a. "The Service response to and management of an incident varies and is dependent upon whether it is the lead agency or it coordinates a multi-agency response. As a lead agency, the Service response should be undertaken in accordance with the provisions of Chapter 2: 'Investigative Process' of this Manual."

b. "Irrespective of the identity of the lead agency, the incident command structure contained in s. 1.13 'Incident Command Structure' of this Manual is to be implemented and adapted as required."

61. Section 1.13 '*Incident command structure*' of the OPM provides:

"The roles and functions of the incident command structure are designed to facilitate the effective deployment and coordination of resources at an incident. The incident command structure is capable of being adapted to suit a variety of policing activities including major investigations, … and incident management …".

62. Section 1.13.1 of the OPM provides:

"The role of the police commander (PC) …, is to be responsible to the Commissioner for the overall management of an incident, the provision of strategic direction and guidance to the police forward commander (PFC), making decisions requiring a higher level of authority and the allocation of resources for the management and resolution of the incident.

The PC may perform this function from a police operations centre (POC). The PC may command one or more PFCs, depending on the circumstances.

The duties and responsibilities of the PC include:

(i) where applicable, activating a POC;

(ii) establishing the strategy and formulating the plan for managing the operational response to the incident;

…

(v) ensuring that information and intelligence is collected in relation to the incident;"

(ix) s. 2.5.1, 2.5.3 OPM – Investigation of Major Incidents

63. Section 2.5.1 of the OPM provided as follows:

a. Policy:

(iv) "The investigation of offences and the management of incidents requiring police action are dependent on timely, accurate information being passed to investigating officers. Officers collecting such information should investigate the facts and circumstances as completely as possible in order to obtain relevant, usable information."

(v) "To ensure investigations are conducted in a professional manner, members should co-operate to allow the effective use of resources and to achieve desirable outcomes which reflect the needs and expectations of the community."

(vi) "In all investigations, officers should strictly adhere to first response procedures. The incident scene should be preserved and contained until the arrival of any specialists. Even so, primary investigation techniques should be followed in order to ensure that potential witnesses are identified and that complete information is obtained."

(vii) "The State Crime Operations Command is responsible for the control of certain investigative activities and should provide support and assistance to regions in appropriate cases (refer to s.2.7 of this chapter for responsibilities assigned to State Crime Operations Command)."

b. Procedure:

a. "It is critical that primary investigations be carried out as completely as possible. Wherever possible, primary investigations should be undertaken by the first response officer."

b. "Activities undertaken during primary investigations may include:

(i) identification of witnesses;

(ii) identification of potential witnesses;

(iii) interview of available witnesses;

(iv) taking of statements from witnesses (suitable for court production);

…

(xiii) identifying and notifying appropriate support groups;

(xiv) notifying appropriate specialist groups;

…

(xvi) arranging for necessary inquiries to be conducted by other members; and

(xvii) recording of all activities undertaken and their outcomes."

c. "Information obtained during the primary investigation will assist in the decision regarding the priority to be given to the investigation. Primary investigators should make recommendations in criminal offence reports for the information of supervisors."

64. Section 2.5.3 '*Investigation and the community*' provided a Policy that:

"Police investigations often include contact with members of the public who have been adversely effected by criminal activity or other major personal trauma. The attitude of officers carrying out investigations is critical to how the Service is perceived by the community. Officers should therefore demonstrate professional behaviour at all times. Officers should refer to s.2.12: 'Victims of crime' of this chapter."

(x) s. 2.7, 2.7.1, 2.7.2, 2.7.11, 2.6.2 OPM – State Crime Operations Command, Crime Operations Branch, Homicide Investigation Group

65. Section 2.7 '*State Crime Operations Command*' provides a Policy that:

a. "The State Crime Operations Command and the regions or commands should work together to provide high quality, professional investigative services to the community."

b. "Officers in charge of regions or commands should ensure that information is distributed to the State Crime Operations Command in appropriate cases, in a timely fashion."

c. "The Assistant Commissioner, State Crime Operations Command, should ensure that assistance is given to regions or commands in appropriate cases and that effective communication and feedback systems are maintained."

66. Section 2.7.1 defines the term "*Major Crime*" to include "*serious crime, especially offences involving violence against the person…*" and provides a Policy that "*The major roles and responsibilities of the Crime Operations Branch, are those required for the investigation and suppression of organised and major crime.*"

67. Section 2.7.2 '*Functions of the Crime Operations Branch*' provides a Policy that:

a. "Responsibilities include:

…

(ii) major or organised crime which is not within the capabilities of regions; and

(iii) serial or notable crimes at the discretion of the Assistant Commissioner, State Crime Operations Command; and

(iv) other matters as directed by the Deputy Commissioner, Deputy Chief Executive (Operations)."

b. "Within Crime Operations Branch, specialist personnel will be maintained to investigate, assist, provide information, advise and train others in the following: … • homicide …"

68. Section 2.7.11 of the OPM provided a Policy that "*The Homicide Investigation Group, Crime Operations Branch will upon determination, be involved in the investigation of homicides, deaths in custody …*".

69. Section 2.6.2 '*Homicide*' provided a Policy that:

> "Regional duty officers, notified of homicides and serious assaults likely to cause death … are to notify the Duty Officer, Crime Operations Branch, State Crime Operations Command, as soon as possible."

F.3 Human Resource Management Manual: Code of Conduct and Procedural Guidelines for Professional Conduct

70. The Human Resource Management (**HRM**) Manual, was issued by the Second Respondent pursuant to section 4.9 of the *Police Service Administration Act* 1990 (Qld) and includes:

a. Section 17.1 '*Code of Conduct*', established by the Second Respondent in satisfaction of section 15 of the *Public Sector Ethics Act* 1994 (Qld); and

b. Section 17.2 '*Procedural Guidelines for Professional Conduct*' (**PGFPC**), which provides Procedures in relation to the conduct of members of the QPS.

71. Section 18 of the *Public Sector Ethics Act* 1994 (Qld) provided that, "*A public official of a public sector entity must comply with the conduct obligations stated in the entity's code of conduct that apply to the official.*" Accordingly, all QPS officers had a statutory obligation to comply with the Code of Conduct.

72. In November 2004, Version 29 of the QPS Code of Conduct dated August 2003 (**Code of Conduct**) was in force.

73. The applicants refer to the Code of Conduct and the PGFPC for their full terms, meaning and effect, in addition to those provisions separately set out herein.

(a) *s. 2 Code of Conduct – Purpose and Scope*

74. Section 2 '*Purpose and Scope*' of the Code of Conduct provided:

a. "The purpose of this code of conduct is to provide all members of the Queensland Police Service with a set of guiding principles and standards to assist them determine acceptable standards of conduct."

b. "This code is intended to be used by members of the Service in determining what is right and proper in their actions."

c. "This code outlines the "Standards of Conduct" that apply to all members of the Service."

d. "All members of the Service are "Public Officials" as defined in the Public Sector Ethics Act and are employed at public expense for the benefit of the community. As such, in the delivery of policing services to the community, the Service and its members must strive to

achieve the highest standards of conduct and accountability. In the provision of these policing services, the public are entitled to expect that all members will:

- Conduct themselves and discharge their responsibilities with professionalism and integrity;
- Observe fairness and equity in their official dealings with the public and other public sector staff;
- Comply with, and be seen to act within the spirit and letter of the law; and
- Act in the public interest and give priority to official duties and obligations."

e. "At all times under the provisions of this code members are expected to conduct themselves in a manner that does not discredit:

- The individual member, having regard to their official position held within the Service; or
- The reputation of the Queensland Police Service."

(b) *s. 7 Code of Conduct – Determination of Conduct*

75. Section 7 *'Determination of Conduct'* of the Code of Conduct provided that:

"Determining whether a member's conduct, **whether on or off duty**, is right and proper in terms of this code requires an examination of:

- the nature of the conduct exhibited; and
- the context in which the conduct takes place.

Within this framework, appropriateness of conduct is then determined with reference to the expectations of the Service, the wider community and the provisions of this code.

Members assessing the appropriateness of their conduct, or of the conduct of other members, against the provisions of this code should apply the **SELF** test:

- Would your decision withstand **Scrutiny** by the community or the Service?
- Will your decision **Ensure** compliance with your Oath of Service, this Code of Conduct and Service policy?
- Is your decision **Lawful**? Does it comply with all laws, regulations and rules?
- Is your decision **Fair** to the community, your family and colleagues and others?

Where the conduct of a member, whether on or off duty, does not satisfy the provisions of the SELF test or it will otherwise adversely reflect on the Service, it will be deemed by the Service as inappropriate under the provisions of this code.

The Service expects that members, in fulfilling their obligations under this code, will not only meet the minimum standards of conduct required, but will strive to, and encourage others under their supervision to achieve the highest standards of conduct possible."

(c) *S. 9 Code of Conduct – Ethics Obligations*

76. Section 9 *'Ethics Obligations'* of the Code of Conduct states *"[t]his section outlines the ethics obligations as stated in the Public Sector Ethics Act."*

(i) Respect for Law and System of Government

77. Section 9.1 '*Obligation: Respect for the Law and System of Government*' of the Code of Conduct provided that *"[a] public official should uphold the laws of the State and the Commonwealth and carry out official public sector decisions and policies faithfully and impartially."*

78. Section 3.1 '*Respect the Law and System of Government*' of the PGFPC provided:

a. "The obligation under this principle, supports the system of responsible parliamentary government established in Queensland by convention and the rule of law. The role and responsibilities of the appointed public official in such a system are summarised in the following statements:

- public employment involves a position of trust (ie. Public officials are employed at public expense for the benefit of the community); and
- public officials must ensure that their powers and influence are used lawfully and fairly."

b. "As such, public officials are expected to act properly, in good faith, in accordance with both the spirit and the letter of the law and in the best interests of the community of Queensland."

c. "Members should refer to "The Role of the Public Official" in Appendix A of this section for further information."

79. Appendix A of the PGFPC provided:

"The Role of the Public Official

The following statement sets out the role of the appointed public official in a system of responsible Parliamentary Government. It has particular relevance to the regular public servant or public employee who works in a government department or authority which provides service delivery, regulatory or policy-advisory functions.

"Public employment involves a position of trust.

The standards of conduct which may be expected of public officials at all levels are therefore a matter for legitimate and continuing concern by the Government of the day, public sector organisations, and the community.

Public officials are employed at public expense for the benefit of the community, as identified by an elected Government and its agencies. In performing official duties, public officials are expected to act "in the public interest".

Public officials at all levels take action and make decisions which can have significant effects on the lives of ordinary citizens, who generally expect to be able to take on trust that the powers exercised by those officials were used properly.

The idea of "the public interest" lies at the centre of the concept of responsible public service, which has its roots in the conventions of the "Westminster" tradition of democratic government and public administration. In general, "to act in the public interest"

means to act in accordance with the law and the policy objectives of the elected Government, under the direction of the responsible Minister.

Public Officials are often called upon to make decisions or implement policy in circumstances in which their personal values and beliefs, or their individuals interests, may be in conflict with government policy. Or it may be necessary to recommend a course of action in a matter involving conflicting interests, or competing views about what "the public interest" requires.

Public officials also control, in various ways, the use of financial and other valuable resources provided by the community. The use, and misuse, of those resources raises important questions of professional ethics for administrators.

In our system of government and public administration, it is a long-established expectation that those public officials who make decisions or exercise powers on behalf of a minister, or who provide policy advice which may affect the welfare, rights or entitlements of the community and individuals, are subject to an ethical obligation to ensure that their powers and influence are used lawfully and fairly.

It is similarly expected that those public officials who control the financial and other resources provided by the community have an ethical obligation to ensure that those resources are used efficiently and appropriately.

Given those traditional expectations, concern will be likely to arise where public officials (especially those in positions of authority or sensitivity) become involved in, for example, questionable use of official information or inappropriate personal conduct in the workplace, conflicts between their personal interests and their duty as an official, or where their preparedness to implement the policies of the government of the day appears to be in question.

How public officials use their official positions, their powers and the resources available to them are therefore the central concerns of this Code of Conduct.

It is therefore essential that individuals and organisations have a clear understanding of the role of the public official, and of the "professional ethics" standards which may be expected in the public sector.""

(ii) Respect for Persons

80. Section 9.2 '*Obligation: Respect for Persons*' of the Code of Conduct provided that:

> "[a] public official should treat members off the public and other public officials honestly and fairly, with proper regard for their rights and obligations. A public official is to act responsively in performing official duties."

81. Section 3.2 '*Respect for Persons*' of the PGFPC provided that:

a. "This obligation covers the conduct of public officials in their dealings with members of the public, and other public officials. It requires that members be responsive to the rea-

sonable demands of members of the community, including other public officials (e.g. by being courteous and helpful). It also requires that public officials avoid patronage, favouritism and act fairly in their management and dealings with all persons."

b. "Public officials should not allow personal feelings to improperly influence their judgements (sic) or decisions on work related issues."

c. "Under this obligation public officials are expected to respect the dignity, rights and views of all persons. This principle is complementary to both Equal Opportunity in Public Employment and Anti-Discrimination legislation in that all public officials are responsible for providing an environment conducive to equity of employment opportunity for members of target groups and ensuring that the workplace is free of unlawful discrimination."

d. "The obligation encompasses and affirms the belief that the principle of natural justice is integral to sound administrative decision-making. This principle should be observed in the settlement of disputes or when making decisions that may result in adverse effects on a persons' rights, interests or legitimate expectations. Natural justice (or procedural fairness) is concerned with ensuring that a fair decision is reached by an objective decision maker."

(iii) Integrity

82. Section 9.3 '*Obligation: Integrity*' of the Code of Conduct provided that:

> "In recognition that public office involves a public trust, a public official should seek to maintain and enhance public confidence in the integrity of public administration and advance the common good of the community the official serves. Having regard to that obligation, a public official:
>
> - Should not improperly use his or her official powers or position, or allow them to be improperly used;
> - Should ensure that any conflict that may arise between the official's personal interests and official duties is resolved in favour of the public interest; and
> - Should disclose fraud, corruption, misconduct and maladministration of which the official becomes aware. …"

83. In Appendix A, Section 17.1 of the Code of Conduct and for the purposes of the PGFPC, the term '*Improper*' is defined as: "*Improper means anything that is not in accordance with propriety of behaviour or conduct suitable for a particular purpose, person or occasion.*"

84. Section 3.3 '*Integrity*' of the PGFPC provided:

a. "This obligation requires public officials to recognise that public service involves a position of trust. It recognises that confidence in public administration may be compromised when the conduct of an official appears to, or involves dishonesty, untruthfulness or a conflict of interests between their private dealings and their public duty."

b. "The obligation also requires that public officials ensure that their actions, conduct and relationships do not raise questions about their willingness and ability to:

- …
- use official powers, influence, resources and information properly; and
- avoid using, the powers or influence of public office, official resources or official information, for personal or other improper advantage."

(iv) Diligence

85. Section 9.4 '*Obligation: Diligence'* of the Code of Conduct provided that:

> "[i]n the performance of official duties, public officials should exercise proper diligence, care and attention. Officials should seek to achieve high standards of public administration."

86. Section 3.4 '*Diligence'* of the PGFPC provided:

> "In practice, this obligation requires that public officials should:
>
> - act with due diligence and provide "a fair day's work";
> - observe the principles of "natural justice";
> - ensure that "duty of care" requirements are observed;
> - act in good faith and avoid negligent behaviour;
> - provide expert and comprehensive advice commensurate to the position held; and
> - seek to maintain high standards of public administration."

(d) *s. 10 Code of Conduct – Standards of Conduct*

87. Section 10 'Standards of Conduct' of the Code of Conduct provided that:

> "The following standards are derived from the ethics principles and obligations as outlined in sections 8 and 9 of this code. They apply to all members of the Service and are the standards that will be used by the Service when determining appropriateness of a member's conduct against the provisions of this code."

(i) Responsibility to Community, Government and the Law

88. Section 10.1 '*Responsibility to Community, Government and the Law'* of the Code of Conduct provided that:

> "[m]embers are to act in good faith, in accordance with both the spirit and the letter of the law and in the best interests of the community of Queensland."

(ii) Lawful Directions

89. Section 10.5 *'Lawful Directions'* of the Code of Conduct provided that *"[m]embers are to obey any lawful direction instruction or order given by any member or person authorised by law to do so."* Accordingly, in all cases where a QPS officer failed to obey any lawful direction instruction or Order, such failure was a breach of s. 10.5 of the Code of Conduct.

90. Section 4.1 '*Questioning Lawful Directions, Instructions or Orders*' of the PGFPC provided:

"As outlined in s.10.5 of the Code of Conduct, all members have an obligation to obey any lawful direction instruction or order given by any member or other person authorised by law to do so. **This is a very clear statement by the Service to all members** in relation to their requirements when subject to lawful directions."

"Where members fail to comply with any lawful direction in the performance of their official duties they should expect to be subject to appropriate corrective or disciplinary action. The obligation to comply with lawful directions should not be taken lightly as it is paramount to the effective and efficient functioning of the Service."

"Policing agencies and their members provide specific and unique services to the community that are vital to the well being of persons and maintenance of a peaceful, ordered and lawful society. As members of a policing agency we all have responsibilities in the provision of these services to the community. The best way of achieving this is through respect, support and compliance with the chain of command and lawful directions of authorised persons."

"While the information contained in this section is supplied to assist members when dealing with unlawful, improper or inappropriate directions, instructions or orders, it is not prescriptive and could never cover every eventuality or situation that arises. **When dealing with matters of this nature, members are to at all times, conduct themselves in a professional manner.** Members are to make every effort to ensure that their actions in these situations are not observed or perceived by members of the community as undermining the authority of supervisors, the chain of command or public confidence in the Service."

(iii) Conflict of Interests

91. Section 10.6 '*Conflict of Interests*' of the Code of Conduct, provided:

a. "Members of the service are expected to perform their duties in such a manner that public confidence and trust in the integrity and impartiality of the Queensland Police Service and its members is preserved."

b. "Further, members are to ensure as far as practicable there is no conflict between their personal interests and the impartial fulfilment of their official duties and responsibilities."

c. "Members are to avoid both actual or apparent conflicts of interests in all matters relating to their employment with the Service."

d. "Where a conflict of interest does arise between the private interests of a member and the official duties or responsibilities of that member, the member is to disclose details of the conflict to their supervising Executive Officer."

e. "All conflicts of interests relating to a member's employment with the Service will be resolved in favour of the Service and the public interest."

92. In Appendix A, Section 17.1 of the Code of Conduct and for the purposes of the PGFPC:

a. "Apparent Conflict of Interests" is defined as: "An apparent conflict of interests exists when it appears that a member's private interests could interfere with the proper performance of their official duties."

b. "Actual Conflict of Interests" is defined as: "An actual conflict of interests exists when a reasonable person, in possession of the relevant facts, would conclude that the member's private interests are interfering with the proper performance of their official duties."

93. Section 4.4 'Conflict of Interests' of the PGFPC provided:

a. "As outlined under the provisions of the Code of Conduct, members are required to arrange their private affairs in a manner that will prevent any actual or apparent conflict of interests from arising wherever foreseeable. Further, members are to ensure there is no incompatibility between their personal interests and the impartial fulfilment of their official duties and responsibilities."

b. "Whilst the Service recognises that it is difficult to foresee or predict every possible conflict of interests that may arise, members should take all reasonable steps in both their private and working environments to prevent or minimise the occurrence or likelihood of such conflict of interests arising."

c. "Where members become aware of an actual or apparent conflict of interests between official duty and their private interests, they are required under the provisions of the Code of Conduct to disclose details of the conflict to their supervising Executive Officer.

d. "The Executive Officer is to:

   (i) consider information contained in the disclosure;

   (ii) determine the extent of the conflict of interests; and

   (iii) direct any remedial action to resolve the conflict."

e. "Members should be aware that any conflict of interests which arises between their private interests and official duties or responsibilities will be resolved in favour of the Service and the public interest."

(iv) Personal Conduct, Influence to Secure Advantage

94. Section 10.8 *'Personal Conduct'* of the Code of Conduct provided that:

> "[a]t all times, members are to act and be seen to act properly and in accordance with both the spirit and the letter of the law and the terms of this code of conduct. Members are not to act in a manner which will adversely reflect on the service generally or on themselves as members of the Service."

95. Section 10.11 *'Influence to Secure Advantage'* of the Code of Conduct provided that:

> "Members shall not use the influence of their official powers or position, or the influence of any other person to obtain improperly, any … advantage, either personally or on behalf of another."

(v) Performance of Official Duties

96. Section 10.14 *'Performance of Official Duties'* of the Code of Conduct provided:

> "In the performance of official duties members are to:
>
> (i) Demonstrate high standards of professional integrity and honesty;
>
> (ii) Apply themselves to the efficient and effective achievement of the functions of the Queensland Police Service;
>
> (iii) Perform any duties associated with their position diligently and to the best of their ability, in a manner that bears the closest public scrutiny and meets all legislative, Government and Service standards;
>
> (iv) Set and maintain standards of leadership that are consistent with corporate goals and policies, and be seen at all times to act in support of those corporate goals and policies;

(v) Promote and encourage members of the Service under their supervision to exercise high standards of personal and professional conduct;

(vi) Act with fairness and reasonable compassion;

(vii) Provide conscientious, effective, efficient and courteous service to all those with whom they have official dealings. In particular, members are to be sensitive to the special circumstances and needs surrounding victims of crime;

(viii) While members will put family responsibilities first, duty to the people of Queensland will always be given priority over the other private interests of members;

(ix) Perform their duties impartially and in the best interests of the community of Queensland, without fear or favour;

(x) Act in good faith; and

(xi) Actively contribute to the achievement of the Service's corporate goals."

(vi) Conduct towards Members and Other Persons

97. Section 10.15 *'Conduct Toward Members and Other Persons'* of the Code of Conduct relevantly provided:

"In the course of their duties, and in particular when exercising discretionary powers, members are to:

(i) Treat all persons with respect and dignity and in a reasonable, equitable and fair manner;

(ii) Not intimidate, engage in sexual or other forms of harassment, unlawfully discriminate or otherwise abuse any person;

(iii) …

(iv) …

(v) Adhere to the principles of natural justice;

(vi) …

(vii) …

(viii) …

(ix) Not allow personal relationships to adversely affect their work performance or that of other members; and

(x) Not induce other members to breach this code."

98. Appendix A of the Code of Conduct and for the purposes of the PGFPC the term 'Natural Justice' is defined as:

"Natural justice (or Procedural Fairness) is concerned with ensuring that a fair decision is reached by an objective decision maker. It requires that two rules be observed:

- The **hearing rule**, which states that a person or body deciding a particular matter must give the affected person the opportunity to present their case and have that material considered before any decision is made.
- The **rule against bias**, which states that a decision maker should have no personal interest in the matter to be decided, have no bias as to the outcome and act in good faith throughout the process."

F.4 Duty to assist Coroner

99. In November 2004:

a. The death of Mulrunji:

i. was a '*reportable death*' as defined in section 8 of the *Coroners Act* 2003 (Qld) (**Coroners Act**);

ii. was required to be investigated by a Coroner by reason of it being a reportable death, in accordance with section 11(2) of the Coroners Act;

b. The Coroner investigating the death of Mulrunji was required to hold an inquest, in accordance with section 27(1)(a)(i) of the Coroners Act.

c. The functions and powers of the State Coroner were set out in section 71 of the Coroners Act, which provided:

"(1) The State Coroner's functions are -

(a) to oversee and coordinate the coronial system; and

(b) to ensure the coronial system is administered and operated efficiently; and

(c) to ensure deaths reported to coroners that are reportable deaths are investigated to an appropriate extent; and

(d) to ensure an inquest is held if –

(i) the inquest is required to be held under this Act; or

(ii) it is desirable for the inquest to be held; and

(e) to be responsible, together with the Deputy State Coroner, for all investigations into deaths in custody; and

(f) to issue directions and guidelines about the investigation of deaths under this Act; and

(g) any other function given to the State Coroner or a coroner under this or another Act."

d. Section 14 of the Coroners Act provided:

"(1) To ensure best practice in the coronial system, the State Coroner … must issue guidelines to all coroners about the performance of their functions in relation to investigations generally …

(2) When preparing the guidelines, the State Coroner must have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCADIC) that relate to the investigation of deaths in custody.

(3) The guidelines must (a) deal with the investigations of deaths in custody. …

(4) When investigating a death, a coroner must comply with the guidelines and any directions issued to the coroner to the greatest practicable extent."

e. Version 0 December 2003, of the Queensland State Coroner's Guidelines (**Coroner's Guidelines**) had been issued by the State Coroner pursuant to section 14 of the Coroners Act.

f. Section 15(2) of the Coroners Act provided that, "*The duty of a police officer to help a coroner is stated in the Police Powers and Responsibilities Act 2000, section 447A.*"

g. Section 447A of the *Police Powers and Responsibilities Act* 2000 (Qld) (**PPRA**) established a duty in the following terms:

> "(1) It is the duty of police officers to assist coroners in the performance of a function, or exercise of a power, under the Coroners Act 2003, including--
>
> (a) the investigation of deaths; and
>
> (b) the conduct of inquests.
>
> (2) Without limiting subsection (1), it is the duty of police officers to comply with every reasonable and lawful request, or direction, of a coroner."

h. Section 8.4.1 of the OPM provided an Order that:

> "Officers are to assist coroners in the performance of a function, or exercise of a power, under the Coroners Act and are to comply with every reasonable and lawful request, or direction of a coroner."

100. By reason of the matters pleaded in paragraph 99 above:

a. all officers of the QPS had a duty to assist coroners in the performance of a function or exercise of a power under the Coroners Act in relation to the death of Mulrunji (**Coroner Duty**);

b. the Coroner Duty included a duty or obligation upon QPS to abide by the Coroner's Guidelines in relation to the investigation of the death of Mulrunji.

101. Clause 7.2 '*How should deaths in custody be investigated?*' of the Coroner's Guidelines, provided that:

> **In principle**
>
> Deaths in custody warrant particular attention because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained. Further, a thorough and impartial investigation is also in the best interests of the custodial officers.
>
> …
>
> **In practice**
>
> All deaths in police custody … will be undertaken by officers from the State Homicide Investigation Group and overviewed by officers from the Crime and Misconduct

> Commission or the Ethical Standards Command of the QPS. If the investigation is conducted in accordance with the policies of those agencies relating to such deaths it will be consistent with the recommendations of the RCADIC and these guidelines.
>
> In all cases investigations should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour. It should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention. The general care, treatment and supervision of the deceased should be scrutinised and a determination made as to whether custodial officers complied with their common law duty of care and all departmental policies and procedures and whether these were best suited to preserving the prisoner's welfare. Only by ensuring the investigation has such a broad focus as to identify systemic failures will a Coroner be given a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations.
>
> In most cases a full internal autopsy should be undertaken by a forensic pathologist. The pathologist should be provided with all information gathered from the scene and any witnesses that is available at the time the autopsy is undertaken. If, during the course of the investigation evidence is uncovered that contradicts or is inconsistent with the information available when the autopsy was undertaken that information should be conveyed to the pathologist and he/she should be asked to provide a further report indicating whether the new information provides any basis to vary the conclusion of the earlier report.

102. As a result of the operation of section 14 of the Coroners Act and clause 7.2 of the Coroner's Guidelines and the matters referred to in paragraphs 74 and 77 to 81 above, the Coroner Duty included an obligation on officers of the QPS to:

a. Appoint officers from the State Homicide Investigation Group to investigate the death of Mulrunji;

b. provide the pathologist conducting the autopsy upon Mulrunji with all:

   i. Information gathered from witnesses that is available the time the autopsy is undertaken;

   ii. Information about evidence that is uncovered that contradicts or is inconsistent with the information available when the autopsy was undertaken.

c. investigate the death of Mulrunji in accordance with the RCADIC recommendations in relation to investigations into deaths in custody and, or alternatively, to construct their operational procedures relating to all aspects of the investigation of a death in custody to be consistent with those recommendations.

(a) *Completion of Form 1*

103. Section 8.4.3 '*Responsibilities of investigating officers*' of the OPM provided:

> a. Procedure:

"Where initial enquiries indicate that a death is one that falls within the ambit of Part 3 of the Coroners Act, the Service is obliged to investigate and report on the cause of the death. The actions required to do so will vary from case to case, dependent on the circumstances of the death. In all cases however, certain actions must be taken and certain reports must be completed. The following points provide a list of those reports and actions, and the sections that follow discuss those requirements in greater detail."

b. Policy:

"In the case of any death which falls within the circumstances outlined in Part 3 of the Coroners Act the investigating officer is responsible for:

(v) completing a 'Police Report of a Death to a Coroner' (Form 1) then:

(a) forwarding or delivering the original and a copy of the Form 1 to the coroner and obtaining from that person an order for autopsy;

(b) delivering the order for autopsy and another copy of the Form 1 to the Government Pathologist who is to perform the autopsy;

(d) forwarding an electronic copy of the Form 1 to their respective Officer in Charge so that it is checked and forwarded via Email to the State Coroner's Police Support Unit …

(e) submitting a signed copy of the Form 1 to the respective Officer in Charge to be forwarded to the local Coroner.

(vi) completing, where applicable, a Supplementary Form 1 (QP528). The Supplementary Form 1 is used to provide additional information to a coroner or State Coroner.

(vii) attending and witnessing the autopsy, where applicable, or arranging for the attendance of another officer in line with local arrangements;

(ix) where an inquest is to be held, ensuring that the following forms have been completed as fully as possible and copies are available for submission to the coroner in compliance with s. 8.4.20 'Statutory forms' of this chapter:

Form 1".

c. Order:

"In cases where additional or relevant information comes to hand that may assist a government pathologist in determining a cause of death at a time prior to an autopsy being conducted, investigating officers are to contact the pathologist as a matter of urgency and provide that information on a Supplementary Form 1. The Supplementary Form 1 should also be completed and submitted in the same way as a Form 1. A copy of the Supplementary Form 1 should also be forwarded to the relevant pathologist."

104. Section 8.4.8 *'Completion of Form 1'* of the OPM provided Procedures that:

a. "The purpose of the Form 1 is to assist the Coroner in deciding whether an autopsy should be ordered, and to assist the pathologist performing the autopsy to establish the cause of death. Therefore the investigating officer should complete the relevant parts of the form as soon as possible. …"

b. "Where an officer has additional information that could not be included on the Form 1 at the time of submission, they should provide this information on a Supplementary Form 1 (QP528)."

F.5 Requirement for impartial investigation

105. By reason of the matters referred to in paragraph 52 above, all QPS Officers were subject to an Order that the investigation of the death of Mulrunji was "*to be conducted expeditiously and impartially and the psychological welfare of individuals considered*".

106. By reason of the matters referred to in paragraphs 57.a, 57.b and 165 hereof, upon being advised of the death of Mulrunji, Inspector Williams was subject to:

i. Orders that he:

A. liaise with DI Webber and officers from the Crime and Misconduct Commission (**CMC**);

B. make an immediate assessment of the incident in conjunction with those persons; and

C. in conjunction with the CMC officers, overview the investigation and provide appropriate advice and assistance to DI Webber.

ii. Policies that:

A. If in his opinion, proper investigational or procedural matters were not being adhered to, or there are matters which may adversely affect an impartial investigation, he should confer with DI Webber and officers from the CMC in an endeavour to resolve the issue;

B. If an issue cannot be resolved, he should advise the Superintendent of the ESC.

b. In the event that the Superintendent of the ESC was advised by DI Webber that an issue could not be resolved, the Superintendent should if necessary discuss the issues with the Deputy Commissioner, Deputy Chief Executive (Operations), who may direct that the Superintendent of the ESC assume responsibility for the investigation.

107. Clause 7.2 of the Coroner's Guidelines provided that "a thorough and impartial investigation is also in the best interests of the custodial officers".

108. As a result of the matters pleaded in paragraphs 70 to 97 and 105 to 107 above and in light of the Coroner Duty, QPS officers investigating a death in custody in November 2004, including Mulrunji's death in custody, were subject to an obligation (**Impartiality Duty**) to:

a. expeditiously conduct a thorough and impartial investigation;

b. strive to achieve the highest standards of conduct and accountability as Public Officials;

c. conduct themselves and discharge their responsibilities with professionalism and integrity;

d. observe fairness and equity in their official dealings with the public and other public sector staff (which included other QPS officers and members);

e. comply with, and be seen to act within the spirit and letter of the law;

f. act in the public interest and give priority to official duties and obligations;

g. conduct themselves in a manner that does not discredit themselves, having regard to their official position held within the QPS;

~~a.~~h. conduct themselves in a manner that does not discredit the reputation of the QPS;

i. comply with the Code of Conduct, including:

i. the ethics obligations in sections 9.1, 9.2, 9.3 and 9.4; and

ii. the standards of conduct in sections 10.1, 10.5, 10.6, 10.8, 10.11, 10.14 and 10.15.

F.6 Protections of the integrity of investigation

109. In November 2004, clause 2.3 of the *Police Service Administration Act* 1990 (Qld) provided as follows:

> The functions of the police service are--
>
> (a) the preservation of peace and good order--
>
> (i) in all areas of the State …
>
> (b) the protection of all communities in the State and all members thereof--
>
> (i) from unlawful disruption of peace and good order that results, or is likely to result, from--
>
> (A) actions of criminal offenders;
>
> (B) actions or omissions of other persons;
>
> (ii) from commission of offences against the law generally;
>
> (c) the prevention of crime;
>
> (d) the detection of offenders and bringing of offenders to justice;
>
> (e) the upholding of the law generally;

110. In November 2004, clause 7.2 of the Coroner's Guidelines provided that:

> Deaths in custody warrant particular attention because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained.

111. Section 16.24.3 of the OPM provided that a commissioned officer responsible for an investigation into a death in custody should:

> (iii) obtain statements from all witnesses, including police officers, as soon as practicable after the incident and prior to any debriefing session where practicable;
>
> (iv) include investigations into the general care, treatment and supervision of the deceased immediately before the death in line with Service policy, orders and procedures;
>
> (v) inquire fully into the circumstances of the arrest or apprehension including any relevant activities of the deceased beforehand.

112. Section 2.13.1 of the OPM provided a Policy that:

> "Statements form a written version of the oral testimony of a witness and therefore should be as comprehensive as possible.
>
> … Statements should be obtained at the earliest practicable opportunity … In appropriate situations statements should be obtained and should be accepted from suspects/offenders."

113. Section 2.13.8 of the OPM provided that:

> Members who may be required to give evidence of conversations, events or occurrences should compile relevant notes at a time during the conversation, event or occurrence, or as soon as practicable thereafter while details are still fresh in their mind.

114. Section 1.17 of the OPM provided:

a. a Policy that following a death in custody, police officers directly involved in the incident or who were witnesses to the incident should not discuss the incident amongst themselves prior to being interviewed;

b. an Order that the regional duty officer who was notified or who became aware of a police related incident was to assume command and control of the situation pending the arrival or involvement of the regional crime coordinator and, "wherever practicable, ensure that [QPS] members who were involved in the incident, or who were witnesses to the incident, [did] not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene"; and

c. a Policy that first response officers, regional duty officers and regional crime coordinators should ensure that the integrity of the independent

versions of events of members directly involved and members who are witnesses to a police related incident is preserved as far as practicable.

115. By reason of the matters pleaded in paragraphs 70 to 97 and 109 to 114 above and, or alternatively, at common law, QPS officers investigating a death in custody, including the death of Mulrunji, had an obligation:

a. to preserve the integrity of the investigation and evidence obtained, collected or produced in the course of the investigation (**Integrity Duty**); and, or alternatively

b. to conduct the investigation with reasonable diligence, and take all steps and make all decisions that would reasonably be expected of QPS officers in their position (**Reasonable Diligence Duty**).

F.7 Support to Aboriginal witnesses

116. Sections 6.3.2 and 6.3.6 of the OPM provided:

a. An Order (6.3.2):

> "When an officer wishes to interview a person, the officer is to first establish whether a special need exists. … the officer is to evaluate the ability of the person to be interviewed to look after or manage their own interests and is to establish whether the person meets the following conditions.
>
> (i) capable of understanding the questions posed;
>
> (ii) capable of effectively communicating answers;
>
> (iii) capable of understanding what is happening to him/her;
>
> (iv) fully aware of the reasons why the questions are being asked;
>
> (v) fully aware of the consequences which may result from questioning; and
>
> (vi) in the opinion of the investigating officer, capable of understanding his or her rights at law.
>
> In making an evaluation , the officer is to take into account the following factors:
>
> (i) the seriousness of the condition giving rise to the special need […]
>
> (ii) the reason for which the person is being questioned , whether as a witness or in relation to their complicity in an offence. Where the information to be obtained may later be used in a court, it will be necessary to show that any special need was overcome;
>
> (iii) the complexity of the information sought from the person; and
>
> (iv) the age, standard of education, knowledge of the English language, cultural background and work history of the person.
>
> When questioning anyone with a special need officers must comply with ss. 249 and 2 50 of the *Police Powers and Responsibilities Act*."

b. A Policy (6.3.6):

"Persons of Aboriginal and Torres Strait Islander descent are to be considered people with a special need because of certain cultural and sociological conditions. When an officer intends to question an Aborigine or Torres Strait Islander, whether as a witness or a suspect, the existence of a need should be assumed until the contrary is clearly established using the criteria set out in s. 6.3.1 . 'Circumstances which constitute a special need' of this chapter."

F.8 Other duties

117. Section 16.24.3 of the OPM provided a Procedure that a commissioned officer responsible for an investigation into a death in custody should *"not presume suicide or natural death regardless of whether it may appear likely"* (**Presumption Duty**).

118. Section 16.24.3(vi) –(viii) of the OPM provided a Procedure that a commissioned officer responsible for an investigation into a death in custody should (**Notification Duty**):

(vi) immediately arrange for the next of kin or person previously nominated by the deceased to be notified. Cultural interests of the person being notified should be respected by using the cross cultural liaison officer, if practicable. Where the deceased is an Aborigine or Torres Strait Islander and there is a delay or inability to notify the next of kin, efforts to notify the next of kin should be recorded;

(vii) in circumstances where the deceased is an Aborigine or Torres Strait Islander, notification should preferably be assisted by an Aboriginal or Torres Strait Islander person known to those being notified;

(viii) if the deceased is an Aborigine or Torres Strait Islander, advise the Aboriginal and Torres Strait Islander Legal Service or other Aboriginal and Torres Strait Islander community organisation with responsibility for the area, as soon as possible, whether or not the relatives have been located.

119. The Notification duty substantially conformed with recommendations of the RCIADIC.

Particulars

The Applicants rely on RCIADIC recommendations 19 and 20.

~~QPS Conduct following death of Mulrunji~~

G EVENTS OF 19 TO 24 NOVEMBER 2004 FOLLOWING DEATH IN CUSTODY

G.1 Notification of Death and Appointment of Investigative Team

(a) *Appointment of Investigation Team*

~~12.~~120. Between about 11.40am and 12 noon on 19 November 2004, District Inspector Gregory Strohfeldt, notified DI Webber, of Mulrunji's death.~~SS Hurley's supervisor, notified Detective Inspector Warren Thomas George Webber, Regional Crime Coordinator for the Townsville District (**DI Webber**), of Mulrunji's death.~~

~~13. As the Regional Crime Coordinator, DI Webber was directly responsible for the investigation of Mulrunji's death in custody under section 1.17 of the Queensland Police Operational Procedures Manual, issued pursuant to s 4.9 of the *Police Service Administration Act 1990* (Qld) (**OPM**).~~

~~14.~~121. Between about 11.40am and 12 noon on 19 November 2004, DI Webber appointed Detective Senior Sergeant Raymond Kitching (**DSS Kitching**), from the Townsville Criminal Investigation Branch, as the primary investigator in the investigation into Mulrunji's death and, therefore, the Investigating Officer under the OPM.

~~15.~~122. Some time shortly thereafter, DI Webber also appointed ~~Detective Sergeant Darren Allen Robinson (**DS Robinson**), who was in charge of the Criminal Investigation Branch on Palm Island,~~DS Robinson to ~~conduct or~~ assist with the investigation.

123. At or about 12.10 pm the Ethical Standards Command was notified of the death in custody.

~~16.~~124. At or about 12.30pm on 19 November 2004, DI Webber notified Detective Inspector Aspinall, the Officer in Charge of the Coronial Support Unit in Brisbane, of Mulrunji's death. The State Coroner was immediately notified.

~~17.~~125. At or about 2.20pm on 19 November 2004, the "**Investigation Team**" (DI Webber, DSS Kitching and DS Robinson) travelled to Palm Island by charter aircraft, accompanied by technical support staff (Senior Sergeant Arthy, Constable Tibbey, Sergeant Bartulovich, two Constables and a Human Services Officer).

126. Before the Investigation Team arrived on Palm Island, SS Hurley, Sergeant Leafe and PLO Bengaroo discussed Mulrunji's death.

(b) *Transit from Palm Island airport*

~~18.~~127. SS Hurley and Sergeant Leafe met the Investigation Team at the airport, bringing two vehicles to transport the Investigation team and support staff to the police station on Palm Island.

128. Constables Ben Tonges and Kristopher Steadman, who were present on Palm Island at the time, were not asked or directed by any officer to transport the Investigation Team from the airport despite both officers:

a. having attended the Palm Island Police Station after the death of Mulrunji;

b. being aware of the death in custody and having conversed with SS Hurley at the Palm Island Police Station; and

c. being readily available to commence their shifts prior to 4 pm at which time they were rostered to commence duty.

~~19.~~129. SS Hurley drove DI Webber and DSS Kitching from the airport to the police station. During that trip, there was a discussion about how the Investigation Team was going to conduct the investigation. At that time, SS Hurley, DI Webber and DSS Kitching:

a. had knowledge of the types of matters required to be investigated following a death in custody, which included those matters referred to in s. 16.24.3 of the OPM (as referred to in paragraph 49 above), sub-paragraphs (ii), (iii), (iv) and (v);

b. knew or reasonably apprehended that SS Hurley would be a 'person of interest' in the investigation; and

c. knew or reasonably apprehended that any persons present on Palm Island, including the Aboriginal residents of Palm Island may become aware of the fact that SS Hurley drove the investigators into the death of Mulrunji from the airport to the Police Station, as they were doing so openly and in broad daylight.

G.2 Conduct of investigation on 19 November 2004

(a) *Preliminary interviews*

~~20.~~130. Between about 4.04pm and 4.36pm on 19 November 2004, DSS Kitching and DS Robinson interviewed SS Hurley. During the interview, SS Hurley made remarks to following effect:

a. as SS Hurley removed Mulrunji from the police vehicle, Mulrunji had struck him in the face;

b. SS Hurley had then grabbed hold of Mulrunji and a "struggle" had ensued, resulting in the two men falling through the door to the police station;

c. after the "fall", Mulrunji had been dragged into the cell by SS Hurley and Sergeant Leafe; and

d. after placing Mulrunji in the cell, SS Hurley had noticed "a small amount of blood" coming from an injury above Mulrunji's right eye.

131. In the period between 19 November 2004 and 24 November 2004, inclusive, SS Hurley was not advised or directed by any QPS officer (other than as provided for in the OPM and the Code of Conduct), not to discuss the circumstances surrounding the death in custody with other QPS officers.

132. After his initial interview on 19 November 2004, and prior to the interview referred to in paragraph 146 hereof, SS Hurley discussed the death of Mulrunji and surrounding circumstances with other QPS members and officers, namely:

a. the QPS Human Services Officers who arrived at Palm Island with the investigation team and debriefed SS Hurley;

b. Sergeant Leafe.

133. Further, after his initial interview on 19 November 2004, and prior to the interview referred to in paragraph 146 hereof:

a. SS Hurley became aware of Roy Bramwell's allegations which were first made in the time between SS Hurley's first interview and subsequent interviews, in particular the enactment video;

b. The information referred to in the preceding sub-paragraph concerning Roy Bramwell's allegations became known to SS Hurley, either:

i. because it was divulged to him by DS Robinson; or alternatively

ii. because SS Hurley was in his office and had a capacity to hear conversations or interviews, concerning the investigation or in the course of the investigation, from his office in the Palm Island Police Station.

~~21.~~134. Between about 4.50pm and 7.10 pm on 19 November 2004, DSS Kitching and DS Robinson conducted recorded interviews with PLO Bengaroo, Gladys Nugent and Patrick Bramwell.

~~22.~~135. Between about 7.50pm and 8.12 pm on 19 November 2004, DSS Kitching conducted a recorded interview with Sergeant Leafe. During the interview, Sergeant Leafe made remarks to the effect that:

a. as SS Hurley was removing Mulrunji from the police vehicle, he had heard SS Hurley cry out that Mulrunji had hit him;

b. he had then seen SS Hurley "scuffling" with Mulrunji; and

c. a few seconds later, Mulrunji had been lying limp on the ground of the police station and had felt like a "dead weight" as Sergeant Leafe and SS Hurley dragged him into the cell.

~~23.~~136. Between about 8.22pm and 8.35 pm on 19 November 2004, DSS Kitching and DS Robinson conducted a recorded interview with Edna Coolburra.

(b) *Meal at SS Hurley's residence*

~~24.~~137. At or about 10.30pm on 19 November 2004, at SS Hurley's residence, DI Webber, DSS Kitching and DS Robinson ate a meal with SS Hurley, which had been prepared by DS Robinson, ~~and~~ drank beer with SS Hurley, and had discussions with SS Hurley concerning the investigation. Sergeant Leafe and his wife were also present for part of the dinner.~~ at SS Hurley's residence.~~

G.3 Conduct of investigation on 20 November 2004

(a) *Interview with Roy Bramwell*

~~25.~~138. On or about 20 November 2004, between about 8.15am and 8.27am, DSS Kitching and DS Robinson conducted an interview with Roy Bramwell, an Aboriginal Palm Island resident. During that interview, Mr Bramwell alleged that he saw SS Hurley assault Mulrunji.

139. DS Robinson subsequently prepared a type written statement of Roy Bramwell.

(b) *Arrival of Inspector Williams*

~~26.~~140. On or about 20 November 2004, at or before 10.30am, Inspector Mark Williams~~Inspector with~~ of the QPS Ethical Standards Command (**Inspector Williams**) arrived on Palm Island to overview the QPS investigation.

~~27.~~141. Shortly after arriving on Palm Island, Inspector Williams received a briefing from DI Webber, DSS Kitching and DS Robinson, then reviewed the interviews and statements which ~~had been conducted~~were then in existence.

(c) *Video re-enactments and trip to scene of arrest*

~~28.~~142. At or about 10.52 am on 20 November 2004, Inspector Williams and DI Webber conducted a video re-enactment with Roy Bramwell of the events surrounding Mulrunji's death, during which Mr Bramwell repeated his allegation that SS Hurley assaulted Mulrunji.

~~29.~~143. At or about 11.20 am on 20 November 2004, ~~DI Webber~~SS Hurley drove ~~the investigating officers (~~DI Webber, Inspector Williams, DSS Kitching, and Constable Tibbey~~)~~ to the site of Mulrunji's arrest.

~~30.~~144. The investigating officers asked SS Hurley to recount events at the arrest scene, but did not take PLO Bengaroo to the scene or ask PLO Bengaroo to accompany them, either at that time, or at any other time.

145. The investigating officers knew or ought reasonably have known:

a. that members of the community would be in a position to observe SS Hurley being taken to the arrest scene; and

b. that members of the community may become aware of the fact that PLO Bengaroo was not taken to the arrest scene.

~~31.~~146. Between about 11.53 am and 1.12 pm on 20 November 2004, Inspector Williams and DI Webber conducted video re-enactments with SS Hurley, PLO Bengaroo and Sergeant Leafe.

147. During the re-enactment interview with PLO Bengaroo referred to in paragraph 146 above:

a. PLO Bengaroo was asked by DI Webber whether he was watching what happened after the fall;

b. PLO Bengaroo replied, "*No I wasn't*";

c. DI Webber asked, "*What were you doing? What, how come you were standing there?*";

d. PLO Bengaroo replied, *"I can't remember. I just stood there because I was thinking , um, if I see something I might get into trouble myself or something … the family might harass me or something you know."*

e. DI Webber responded, "*Oh, OK*";

f. Neither DI Webber nor Inspector Williams asked PLO Bengaroo any questions seeking clarification of or elaboration upon the statement referred to in paragraph 147.d hereof.

(d) *Further interviews*

~~32.~~148. At or about 1.10pm on 20 November 2004, DSS Kitching and Inspector Williams commenced a recorded interview with SS Hurley.

~~33.~~149. At some time on 21 November 2004, DSS Kitching conducted an interview with Ms Penny Sibley, an ~~Indigenous~~Aboriginal woman. Ms Sibley alleged that she saw SS Hurley punch Mulrunji outside the police station on 19 November 2004.

G.4 Completion of Form 1 and conduct of inquest

~~(b)~~(a) *Form 1*

~~34.~~150. "**Form 1**", published in the Queensland *Gazette* on 21 November 2003 pursuant to the *Coroners Act 2003* (Qld), was entitled "*Police Notification of Death to Coroner*."

151. The OPM provided in Procedures in section 8.4.8 (as referred to in paragraph 104 hereof) that:

a. the purpose of the Form 1 was to assist the Coroner in deciding whether an autopsy should be ordered and to assist the pathologist performing the autopsy to establish the cause of death;

b. the investigating officer should complete the Form 1 as soon as possible;

c. where an officer has additional information that could not be included on the Form 1 at the time of submission, this information should be provided on a Supplementary Form 1.

152. Section 8.4.3 (as referred to in paragraph 103 hereof) of the OPM provided where the death was a reportable death, the investigating officer was responsible for:

a. an Order that where additional or relevant information comes to hand that may assist the government pathologist in determining a cause of death at a time prior to the autopsy, the pathologist is to be contacted as a matter of urgency and provided with that information on a Supplementary Form 1, which should be completed and submitted in the same was as a Form 1, and forwarded to the pathologist also;

b. Policies that:

i. where an inquest is to be held, ensuring that the Form 1 was completed as fully as possible, at subparagraph (ix);

ii. completing the Form 1 then forwarding it to the coroner and obtaining an order for autopsy, to the Government Pathologist who is to perform the autopsy, and the investigator's officer in charge so that it was checked and forwarded to the State Coroner's Police Support Unit and the local coroner, at subparagraphs (v)(a)-(e);

iii. completing a Supplementary Form 1 where applicable, which is used to provide additional information to a coroner/State Coroner, at subparagraph (vi);

iv. attending and witnessing the autopsy, or arranging for the attendance of another officer, at subparagraph (vii).

153. As regional crime coordinator, DI Webber was the officer in charge of DSS Kitching.

(b) *Preparation of Form 1*

~~35.~~154. DSS Kitching prepared a Form 1 on the night of 19 November 2004 at about 8:58pm, and forwarded it to DI Webber.~~but did not send it to the coroner on that day.~~

~~36.~~155. DSS Kitching stated in the Form 1:

a. under the heading "*Summary of Incident*":

> "The deceased was arrested by Senior Sergeant HURLEY of Palm Island Police at approximately 10.15am on the morning of the 19th November 2004 in Dee Street Palm Island for an offence of Breaching of the peace. At that time the decease [sic] was aggressive and was restrained and placed in the rear of a caged police vehicle. The deceased was then transported to the Palm Island Police Station where he again became aggressive when police attmepted [sic] to remove him from the rear of the police vehicle. At that time the deceased is alleged to have assaulted Senior Sergeant HURLEY. The deceased was then physically restrained and placed in Cell 2 of the Palm Island Police Watchhouse and charged at 10.26am. At that time the deceased laid on the floor of the cell and went to sleep immediately. A physical inspection was conducted of the deceased at 10.55am and he was asleep and breathing at that time. A further physical inspection of the deceased was conducted at 11.23 am. At that time police could not see the deceased breathing and could find no pulse. Queensland Ambulance Service was contacted immediately and attended the Palm Island Watchhouse and resusicitation [sic] was not possible."

b. under the heading "*Précis of Statements*":

> "Senior Sergeant Christopher James HURLEY has been interviewed by Detective Senior Sergeant KITCHING of the Townsville CIB. HURLEY stated that he arrested the deceased in Dee Street, Palm Island. At that time the deceased was ag-

gressive and abusive towards police and was physically placed in the rear of a caged police vehicle. HURLEY states that upon arrival at the police station he opened the door on the cage of the police vehicle and at that time the deceased became aggressive and punched HURLEY in the side of the face. HURLEY then physically restrained the deceased and struggled with him to the rear door of the police station where they both fell to the ground. Another police officer Sergeant Michael LEAFE then assisted Senior Sergeant HURLEY place [sic] the deceased into the watchhouse cell by dragging him with both arms. He was charged at 10.26am. HURLEY then conducted a physical inspection of the deceased at 10.55am and he was asleep and breathing. A further inspection was conducted by Sergeant LEAFE at 11.23am and the deceased was not breathing and had no pulse. HURLEY states that QAS attended the watchhouse and resusicitation was not possible. Dr IBE of the Palm Island Hospital later attended the watchhouse and pronounced life extinct. HURLEY noticed a small abrasion to the right eye of the deceasedafter [sic] he was found to be deceased. This injury was brought to the attention of HURLEY by the QAS. This was the only injury identified on the deceased."

~~Mulrunji "laid [sic] on the floor of the cell and went to sleep immediately".~~

~~37. DSS Kitching reported, in the Form 1, evidence, provided by a member of the Palm Island community to DS Robinson, which DS Robinson had reported to DSS Kitching, that Mulrunji had been drinking bleach.~~

~~38.~~156. ~~Inspector~~ DI Webber examined the Form 1 on the evening of 19 November 2004 and:

a. did not make any amendments to the Form 1;

b. did not instruct DSS Kitching to forward the Form 1 to any person.

157. DSS Kitching and DI Webber:

a. failed to forward the Form 1 to the State Coroner, the Government Pathologist, the State Coroner's Police Support Unit or the local coroner on 19 November 2004;

b. failed to cause the Form 1 to be sent to the State Coroner until about 10.40am on 22 November 2004, when Constable Paul Harvie of the Townsville QPS forwarded the Form 1 to the State Coroner, unamended, at DSS Kitching's request;

c. failed to cause the Form 1, as originally prepared by DSS Kitching to be amended to include the allegations that SS Hurley assaulted Mulrunji prior to his death, as made by Roy Bramwell and referred to in paragraphs 138 and 142 hereof and Penny Sibley, referred to paragraph 149 hereof.

158. Neither DI Webber nor DSS Kitching prepared a Supplementary Form 1 to notify the Coroner, State Coroner or Government Pathologist of the allegations of assault by SS Hurley made by Roy Bramwell and Penny Sibley.

(c) *Autopsy*

~~39.~~159. On ~~or about~~ 23 November 2004, an autopsy was conducted by Pathologist Dr Guy Lampe in Cairns.

~~40.~~160. On 23 November 2004, DSS Kitching attended the autopsy conducted by Dr Lampe in Cairns, and Dr Lampe made known to DSS Kitching:

a. That Mulrunji's death was not from natural causes;

b. That the cause of death was intra-abdominal haemorrhage due to ruptured liver and portal vein;

c. That the autopsy revealed that Mulrunji had four broken ribs.

161. On 23 November 2004, at or about the time of the autopsy but prior to the conclusion of the autopsy, DSS Kitching:

a. advised Dr Lampe that Mulrunji may have been sniffing petrol or drinking bleach; and

b. did not advise Dr Lampe of the allegations made by Patrick Bramwell or Penny Sibley that Mulrunji had been assaulted by SS Hurley.

~~(c)~~(d) *Preliminary Autopsy Report*

~~41.~~162. ~~The autopsy~~In his "**Preliminary Autopsy Report**" dated 24 November 2004, Dr Lampe found that Mulrunji's death was ~~not from natural causes.~~"*as a result of haemorrhage into his abdominal cavity*", which occurred "*secondary to a rupture of the liver (which [had] virtually cleaved the liver in two), as well as from a hole in the portal vein*". Dr Lampe further found that the degree of liver rupture and injury to soft tissues was "*indicative of a moderate to severe compressive force applied to the upper abdomen*" and that "*there was no evidence to suggest the ingestion of any caustic substance*".

(e) *CMC assumption of investigation*

~~42.~~163. On 24 November 2004, the Queensland Crime and Misconduct Commission (CMC) assumed responsibility for the investigation.

H QPS Failures of 19 to 24 November 2004

H.1 Responsible officers

164. Upon being notified of the death of Mulrunji as pleaded in paragraphs 23 and 24 hereof, DI Strohfeldt was the regional duty officer for the purposes of OPM s. 1.17 as pleaded in paragraph 55.

165. In the course of the investigation into the death of Mulrunji, pursuant to OPM s 1.17 as pleaded in paragraph 57 hereof, Inspector Williams was the officer representing the Internal Investigation Branch, ESC.

166. In November 2004, DI Webber was the Regional Crime Coordinator and, pursuant to OPM s 1.17 as pleaded in paragraph 56 hereof, was the commissioned officer responsible for the investigation of the death of Mulrunji.

H.2 Unlawful arrest of Mulrunji

167. [Deleted]

168. [Deleted]

169. [Deleted]

170. [Deleted]

H.3 Failure to attempt resuscitation

171. [Deleted]

172. [Deleted]

173. [Deleted]

174. [Deleted]

175. [Deleted]

176. [Deleted]

H.4 Failure to take adequate care of person in custody

177. [Deleted]

178. [Deleted]

179. [Deleted]

180. [Deleted]

181. [Deleted]

182. [Deleted]

183. [Deleted]

184. [Deleted]

185. [Deleted]

H.5 Failures in relation to Cultural Advisory Unit and Cross Cultural Liaison Officers and to Consider Cultural Needs which exist within the Palm Island Community

186. As a result of the matters referred to in paragraph 42.a and 42.b hereof, following the death of Mulrunji, the Officer in Charge, Cultural Advisory Unit, Office of the Commissioner ('**CAU**') was required to be notified in accordance with s.16.24.1 of the OPM.

187. The CAU was responsible for the matters referred to in paragraph 43 hereof.

188. All QPS Officers:

a. were subject to the Policy in s. 6.4 of the OPM as referred to in paragraph 44.a hereof, namely that officers should always consider cultural needs which exist within the community, which required officers to consider the matters referred to in paragraph 32 hereof;

b. who were officers in charge of stations or establishments, were subject to the Policy in s. 6.4.7 of the OPM as referred to in paragraph 44.b. hereof, namely that they should, in managing the provision of services, take into account the specific cultural and ethnic demographic characteristics of their area of responsibility and the needs thereby created, which required officers to consider the matters referred to in paragraph 32 hereof.

189. The QPS provided Cross Cultural Liaison officers ('**CCLO**') to all regions, whose role is set out in s.6.4.8 of the OPM as referred to in paragraph 45 hereof.

190. In the premises, the QPS had systems in place which provided for advice and support to be given to QPS officers in relation to cultural issues which existed on Palm Island following the death of Mulrunji, and to enable and assist QPS officers to comply with the Policy that they should always consider cultural needs which exist within the community.

191. The existence and appropriate utilisation of those systems would have accorded with recommendations 210, 214, 215, 225, and 228 of the RCIADIC, as set-out in Annexure B hereof and the reasonable expectations of the community referred to in paragraph 32 hereof.

192. Following the death of Mulrunji, the Officer in Charge, CAU was not notified in accordance with s.16.24.1.

193. Further and/or in the alternative to paragraph 192, following the death in custody of Mulrunji:

a. No officer of the CAU provided advice and support to members of the QPS stationed on Palm Island in relation to cultural issues; or alternatively

b. Any advice and support to members of the QPS stationed on Palm Island was not appropriate in all the circumstances or not followed by members of the QPS stationed on Palm Island.

194. Following the death of Mulrunji, no CCLO:

a. attended at Palm Island until 26 November 2004 until at or about the start of the riot;

b. provided any advice to QPS Officers on Palm Island, either in connection with the investigation into the death in custody or other operational policing on Palm Island.

195. As a result of the matters referred to in paragraphs 186 and 194 hereof, despite there being systems in place for advice and support to be given to QPS officers in relation to cultural issues which existed on Palm Island following the death of Mulrunji, these systems were not adequately utilised, or utilised at all.

196. Following the death of Mulrunji:

a. SS Hurley, Sergeant Leafe, Constable Steadman, Inspector Strohfeldt, DI Webber, Inspector Williams, DSS Kitching, DS Robinson, Inspector Richardson, and Senior Sergeant Whyte failed to follow the Policy referred to in s. 6.4 of the OPM as set out in paragraph 44.a hereof and referred to in paragraph 188.a hereof; and

Particulars

(i) None of the Officers referred to, at all times considered the cultural needs which existed within the Palm Island Community by:

a. Ensuring that their conduct as referred to in this Third Further Amended Statement of Claim did not breach or contravene any Acts and laws, or directions of the Second Respondent, including the

OPM and the Code of Conduct, as referred to or particularised throughout this pleading;

b. Considering the impact of their acts, or failures to act as otherwise particularised in this pleading, and the impact of such acts and failures upon the Palm Island community in so far as it affects the matters referred to in paragraph 32 hereof;

c. Acting in accordance with all Acts and laws and directions of the Second Respondent in the course of the arrest of Mulrunji, and/or the investigation of the death of Mulrunji, and/or providing QPS services upon Palm Island as pleaded in this Third Further Amended Statement of Claim, in light of the Palm Island community's susceptibility to the suspicions referred to in paragraph 32.b hereof.

b. SS Hurley, Inspector Strohfeldt, DI Webber, Inspector Richardson and Senior Sergeant Whyte, as officers in charge of the Palm Island Police Station, failed to follow the Policy referred to in s. 6.4.7 of the OPM as set out in paragraph 44.b hereof and referred to in paragraph 188.b hereof.

Particulars

(i) None of the Officers referred to, at all times considered the cultural needs which existed within the Palm Island Community by:

a. Ensuring that their conduct as referred to in this Third Further Amended Statement of Claim did not breach or contravene any Acts and laws, or directions of the Second Respondent, including the OPM and the Code of Conduct, as referred to or particularised throughout this pleading;

b. Considering the impact of their acts, or failures to act as otherwise particularised in this pleading, and the impact of such acts and failures upon the Palm Island community in so far as it affects the matters referred to in paragraph 32 hereof;

c. Acting in accordance with all Acts and laws and directions of the Second Respondent in the course of the arrest of Mulrunji, and/or the investigation of the death of Mulrunji, and/or providing QPS services upon Palm Island as pleaded in this Third Further Amended Statement of Claim, in light of the Palm Island community's susceptibility to the suspicions referred to in paragraph 32.b hereof.

H.6 Failure of Strohfeldt to comply with s. 1.17 OPM

197. As RDO, Inspector Strohfeldt was required to comply with Orders under s.1.17 of the OPM as referred to in paragraph 55.

198. Despite being advised of the death of Mulrunji, and of the obligations referred to immediately above, Inspector Strohfeldt failed to attend Palm Island on 19 November 2004 and comply with any of the Orders referred to in paragraph 55.

199. If Inspector Strohfeldt had attended at Palm Island and followed the Orders in s. 1.17 OPM:

a. he would have made inquiries and determined that Constable Steadman had relevant evidence to give in relation to the investigation, and he would

have provided for Constable Steadman to be interviewed by the Investigation Team as soon as practicable;

b. he would have been under a duty pursuant to OPM s 1.17 to ensure that SS Hurley was not rostered or permitted to continue performing duties at the scene.

200. As a result of the failure of Inspector Strohfeldt to attend at Palm Island and comply with the obligations referred to in paragraph 55:

a. Constable Steadman was not interviewed by the Investigation Team at all prior to the QPS involvement in the investigation being taken over by the CMC on 24 November 2004;

b. SS Hurley continued to perform duties at the Palm Island Police Station, and was permitted to remain in the Police Station whilst the investigation into the death in custody occurred, including the interview of witnesses, in the vicinity of his office within the Police Station.

H.7 Failure of DI Webber to ensure Constable Steadman was interviewed as soon as practicable

201. As RCC, DI Webber was required to comply with Policy under s.1.17 of the OPM as referred to in paragraph 53, and an Order under s. 1.17 of the OPM as referred to in paragraph 56.b in sub-paragraph (v), that he ensure that where necessary the provisions of ss. 16.24 to 16.24.5 were complied with.

202. Section 2.5.1 of the OPM as referred to in paragraph 63 hereof required QPS officers investigating Major Incidents to carry out primary investigations as completely as possible, including identification of witnesses and potential witnesses and interviewing and taking statements.

203. Neither DI Webber nor DSS Kitching interviewed Constable Steadman in the course of the investigation, despite Constable Steadman having seen SS Hurley remove Mulrunji from the police van, and fall through the door of the police station.

204. Accordingly, DI Webber and DSS Kitching failed to carry out their obligations under s. 2.5.1 of the OPM.

H.8 Failure to involve the SCOC, Homicide Investigation Group

205. The State Crime Operations Command ('**SCOC**') ought to have been involved in the investigation of the death of Mulrunji by reason of:

a. the Policy in s. 2.5.1 of the OPM referred to in paragraph 63.a at sub-paragraph (iv);

b. the Policy in s.2.7 of the OPM referred to in paragraph 65;

c. the Policy in s.2.7.2 of the OPM referred to in paragraph 67.a;

d. the Policy in s. 2.7.11 of the OPM referred to in paragraph 69; and

e. the Coroners Guidelines.

206. The SCOC was under the direct control of the Deputy Commissioner, Deputy Chief Executive (Operations) ('**DCDCEO**').

207. The SCOC had, as part of its operational structure, a division called the Crime Operations Branch ('**COB**').

208. Within the COB, specialist personnel were maintained as part of the Homicide Investigation Group.

209. As a result of the QPS internal notification requirements following a death in custody:

a. the DCDCEO was to be advised of all deaths in custody (paragraph 55);

b. the Officer in Charge of regions or commands should ensure that information is distributed to the SCOC in appropriate cases in a timely fashion (paragraph 65.b);

c. RDO's notified of homicides and serious assaults likely to cause death are to notify the Duty Officer, COB, SCOC as soon as possible (paragraph 69).

210. The death of Mulrunji was a major crime which was not within the capabilities of the region in which it occurred, and accordingly fell within the responsibilities of the COB and the Homicide Investigation Group.

211. Despite the matters pleaded in paragraphs 205 to 210 hereof, the QPS failed to involve the Homicide Investigation Group in the investigation of the death of Mulrunji.

~~Appointment of improper investigation team~~

~~43. Clause 7.2, on p 7.5 of the Queensland State Coroner's Guidelines Version 0 December 2003, applicable in 2004 (Coroner's Guidelines), required the State Homicide Investigation Group to conduct an investigation into the death in custody of Mulrunji and for the investigation to be overviewed by officers from the CMC or the Ethical Standards Command of the QPS.~~

~~44. Contrary to the Coroner's Guidelines, DI Webber appointed DSS Kitching and DS Robinson, and not the State Homicide Investigation Group, to conduct the investigation into Mulrunji's death.~~

H.9 Failure to assist the Coroner in relation to conducting the inquest, and Failures in relation to the Form 1 and Supplementary Form 1

212. By reason of the acts pleaded in paragraphs 153 to 160.c above, DSS Kitching and, or alternatively, DI Webber breached their duties under section 8.4.8 and 8.4.3 of the OPM and their Coroner Duty (referred to in paragraph 100 hereof) and, or alternatively, seriously compromised the conduct of the inquest and investigation by the Coroner, and breached the Impartiality duty, the Integrity Duty, the Reasonable Diligence Duty and created a reasonable apprehension of bias in that:

a. despite being completed in the evening of 19 November 2004, the Form 1 was not sent to the Coroner until about 10.40am on 22 November 2004;

b. when the Form 1 was provided to the Coroner and the Government Pathologist it failed to include any reference to the allegations of assault by SS Hurley upon Mulrunji which had been made by Roy Bramwell and Penny Sibley;

c. through their involvement in the investigation into Mulrunji's death as pleaded in paragraphs 130 to 136 and 138 to 149 above, when the Form 1 was sent to the Coroner and the Government Pathologist, each of DSS Kitching and DI Webber were aware of or ought reasonably have been aware that:

i. when removed from the police van Mulrunji had been active and aggressive;

ii. SS Hurley was alleged to have physically assaulted Mulrunji by two witnesses, independently of each other, during the period between when he was removed from the police van and when he was taken to the cell;

iii. after the alleged fall, Mulrunji:

A. had been a "dead weight";

B. had been dragged limp to his cell;

C. was not physically restrained or required to be physically restrained in any way whilst being taken to or placed in the cell;

D. was not observed by any QPS officer or witness to be active or aggressive prior to his death (other than as recorded on the cell watchhouse video recording);

E. may have been incapacitated, or suffering from an injury caused by the fall;

F. was observed on the watchhouse video to lay on the floor of the cell, intermittently rolling and moving round and apparently making loud noises as if in distress; and

iv. the Form 1 did not contain any of the information referred to in sub-paragraphs b. and c.i.-iii. above;

d. the Form 1 stated that Mulrunji "*laid [sic] on the floor of the cell and went to sleep immediately*" which was incorrect;

e. notwithstanding the Policy in section 8.4.3(vi) of the OPM (as referred to in paragraph 103 hereof), no Supplementary Form 1 was prepared to notify the Coroner of the allegations of assault made by Roy Bramwell and Penny Sibley, or of the fact of Mulrunji being dragged limp into his cell, in circumstances where there was no good and sufficient reason(s) for departing from the Policy;

f. notwithstanding the Order in section 8.4.3 of the OPM (as referred to in paragraph 103 hereof), the Government Pathologist was not contacted as a matter of urgency with additional or relevant information which had come to hand that may have assisted the Government Pathologist in determining a cause of death at a time prior to an autopsy being conducted, or provided with a Supplementary Form 1 containing the additional or relevant information which had come to hand.

g. as pleaded in paragraphs 159 to 160.c above, when present at the autopsy conducted by Dr Lampe, DSS Kitching:

i. advised Dr Lampe that Mulrunji may have been drinking bleach or sniffing petrol;

ii. failed to advise Dr Lampe of the allegations made by Patrick Bramwell or Penny Sibley that Mulrunji had been assaulted by SS Hurley.

Particulars

Preliminary Autopsy Report (Document 14).

H.10 Failure to immediately notify next of kin

~~45. Pursuant to section 1.17 of the OPM, DI Webber, as the Regional Crime Coordinator, was directly responsible for the investigation into Mulrunji's death.~~

~~46. Section 1.17 of the OPM required the commissioned officer responsible for the investigation into Mulrunji's death to immediately arrange for the deceased's next of kin to be notified.~~

~~47.~~213. In contravention of ~~section 1.17 of the OPM~~the Notification Duty in section 16.24.3(vi)-(viii) of the OPM, his obligation in section 1.17 to ensure compliance with section 16.24, and, or alternatively, the Reasonable Diligence Duty, DI Webber did not make immediate arrangements, or cause immediate arrangements to be made, for Mulrunji's next of kin to be notified of his death.

Particulars

(i) Mulrunji's partner, Ms Twaddle, was not notified of Mulrunji's death until at or about 3.40pm on 19 November 2004~~ at which time she was so notified~~ by DI Webber and Sergeant Leafe and Owen Marpoondin of the Aboriginal and Torres Strait Islander Legal Service;

(ii) Mulrunji's mother and other family members were not notified of Mulrunji's death until about 3.55 pm on 19 November 2004, ~~when they were so notified~~by DI Webber and Sergeant Leafe and Owen Marpoondin of the Aboriginal and Torres Strait Island Legal Service.

214. The Notification Duty conformed with recommendations 19 to 20 of the RCIADIC, as set out in Annexure B hereof.

~~Improper management of crime scene~~

~~48. Section 1.17 of the OPM provided that the regional duty officer who was notified or who became aware of a police related incident was to assume command and control of the situation pending the arrival or involvement of the regional crime coordinator and, "wherever practicable, ensure that [QPS] members who were involved in the incident, or who were witnesses to the incident, [did] not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene".~~

~~49. Inspector Strohfeldt was the Regional Duty Officer who was notified or who became aware of the incident involving Mulrunji's death.~~

~~50. SS Hurley, who was involved in the incidents leading to the death of Mulrunji, undertook and continued to perform duties associated with the investigative process, or other duties at the scene.~~

~~51. In breach of section 1.17 of the OPM, on becoming aware of the death of Mulrunji, each of:~~

~~DI Webber, as the Regional Crime Coordinator, and~~
~~District Inspector Gregory Strohfeldt~~
~~failed to provide any advice or instructions to SS Hurley, or to the investigation team, or to otherwise take any steps to ensure that SS Hurley did not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene.~~

~~***Failure of Ethical Standards Command***~~

~~52. Section 1.17 of the OPM provided that, if the officer representing the Ethical Standards Command considered that there were any matters which might adversely affect an impartial investigation, the officer should confer with the regional crime coordinator and the CMC to resolve the issue.~~

~~53. After receiving a briefing from DI Webber, DSS Kitching and DS Robinson on 20 November 2004, and reviewing the interviews and statements which had been conducted, Inspector Williams had actual or constructive knowledge that DS Robinson was from the same police establishment as SS Hurley and that DS Robinson had been involved in the investigation.~~

~~54. In contravention of section 1.17 of the OPM, Inspector Williams failed to confer with the regional crime coordinator (that is, DI Webber) and the CMC to resolve the issue.~~

~~*Visit to Scene of Mulrunji's Arrest in the absence of PLO Bengaroo*~~

~~55. Section 2.13.1 of the OPM provided that statements from witnesses should be as comprehensive as possible and should be obtained at the earliest practicable opportunity.~~

~~56. In breach of section 2.13.1 of the OPM, on 20 November 2004, DI Webber, Inspector Williams, DSS Kitching and Constable Tibbey asked SS Hurley to recount the events of Mulrunji's arrest at the site of the arrest, but did not take PLO Bengaroo to the scene or ask PLO Bengaroo to do so — thereby failing to obtain a statement from PLO Bengaroo which was as comprehensive as possible or obtained at the earliest practicable opportunity.~~

H.11 Failure to treat PLO Bengaroo appropriately

215. By about 10pm on 19 November 2004, each of the members of the Investigation Team knew or reasonably ought to have known that SS Hurley was the QPS officer most closely associated with Mulrunji's arrest and subsequent death in custody as:

a. SS Hurley was the most senior officer on Palm Island at the time of the arrest and death of Mulrunji and the officer in charge of the watchhouse at the time of death;

b. whilst both SS Hurley and PLO Bengaroo had been present at the arrest of Mulrunji, SS Hurley was the arresting officer;

c. SS Hurley had been the officer who took Mulrunji from the police van into the police station;

d. SS Hurley had been present at the Palm Island Police Station when Mulrunji is believed to have died, and reported Mulrunji's death;

e. SS Hurley was the only QPS officer or member who had been present both at the scene of the arrest and the scene of the death;

f. Mulrunji sustained the injuries referred to in paragraph 130.d hereof, during the period between being removed from the van by SS Hurley and prior to being placed in the cell;

g. prior to Mulrunji's death in custody, Mulrunji and SS Hurley had been involved in a struggle.

Particulars

The Applicants rely on the matters pleaded in paragraphs 130 to 136 above.

216. By reason of the matters pleaded in paragraphs 138, 141, 142, and 143 above, on or about 20 November 2004 and prior to being driven to the site of the arrest (as pleaded in paragraph 143 above), each of the members of the Investigation team and Inspector Williams knew or reasonably ought to have known of:

a. the matters pleaded in sub-paragraph 215 above; and

b. the allegations made by Roy Bramwell that SS Hurley had assaulted Mulrunji in the police station, as pleaded in paragraphs 142, 143, and 146 above.

217. In the circumstances pleaded in paragraphs 143 to 144, 147, and 215 to 216 above, each of the members of the Investigation Team and Inspector Williams:

a. contrary to sections 2.13.1 and 16.24.3 of the OPM, failed to obtain a statement from PLO Bengaroo which was as comprehensive as possible or obtained at the earliest practicable opportunity;

b. contrary to the reasonable expectation of the community, treated PLO Bengaroo as a person who was inferior to themselves and did not afford him the level of respect afforded to police officers who were not Aboriginal, such as SS Hurley;

Particulars

The Applicants refer to and rely on paragraph 6.157 of the QPS 1994 Review.

c. failed to perform their duties in such a manner that public confidence and trust in the integrity and impartiality of the QPS and its members was preserved in accordance with s. 10.6 of the Code of Conduct;

d. contrary to s. 10.14 of the Code of Conduct:

i. failed to demonstrate high standards of professional integrity;

ii. failed to perform duties associated with their position diligently and to the best of their ability, in a manner that bears the closest public scrutiny and meets all legislative, Government and Service standards;

iii. failed to provide courteous service to all those with whom they have official dealings;

iv. failed to perform their duties impartially and in the best interests of the community of Queensland, without fear or favour.

e. Contrary to s. 10.15 of the Code of Conduct, failed to treat PLO Bengaroo with respect and dignity and in a reasonable, equitable and fair manner.

f. breached the Impartiality Duty, Integrity Duty and Reasonable Diligence Duty.

~~57. The PLO's role included liaising between police officers and Indigenous people on Palm Island, establishing and maintaining a positive rapport between Indigenous people and the QPS, promoting trust and understanding between Indigenous people and the QPS, including by advising and educating police officers on culture and cultural issues and establishing and maintaining communication between the community and police.~~

~~58. Both (the non-Indigenous) SS Hurley and (the Indigenous) PLO Bengaroo were at the scene of the arrest. The differential treatment by the investigation team of SS Hurley and PLO Bengaroo involved a distinction based upon PLO Bengaroo's race.~~

~~59. This differential treatment also involved a distinction based upon the race of the Applicants and Group Members, given PLO Bengaroo's role and the impact that failure to interview him comprehensively had on the investigation into Mulrunji's death.~~

H.12 Failure to treat SS Hurley as a suspect

~~60. Section 16.24.3 of the OPM, provided that the commissioned officer responsible for an investigation into a death in custody should not presume suicide or natural death, regardless of whether it may appear likely.~~

~~61. As the officers responsible for the investigation into the death of Mulrunji in custody, and in the knowledge that SS Hurley was the person most closely associated with Mulrunji's death, DI Webber, DSS Kitching and DS Robinson were obliged to treat SS Hurley as a homicide suspect.~~

218. By reason of:

a. the matters pleaded in paragraphs 215 and 216 above;

b. the matters pleaded in paragraph 130.d;

c. recommendation 35(a) of the RCIADIC; and

d. the Presumption Duty,

on about 19 November 2004 or, alternatively, 20 November 2004, each of the officers in the Investigation Team and Inspector Williams had reasonable grounds to suspect that Mulrunji had died as a result of an act of homicide in which SS Hurley was involved, or alternatively, that Mulrunji had been assaulted by SS Hurley prior to his death. Accordingly, those QPS officers suspected or, alternatively, ought reasonably to have suspected, that SS Hurley had been involved in the commission of an indictable offence.

~~62.~~219. Section 246 of the *PPRA* defined "*relevant person*" as a person "*in the company of a police officer for the purpose of being questioned as a suspect about his or her involvement in the commission of an indictable offence*."

~~63.~~220. ~~Accordingly~~In the premises, where ~~DSS Kitching and DS Robinson~~QPS officers were in the course of conducting the investigation into Mulrunji's death and were in the company of SS Hurley, SS Hurley was, and ought reasonably have been considered, to be a "relevant person" within the meaning of section 246 of the PPRA.

~~64.~~221. Section 263 of the *PPRA* provided that the questioning of a relevant person must, if practicable, be electronically recorded.

~~65.~~222. Section 2.14.2 of the OPM required that interviews with suspects for indictable offences be electronically recorded where practicable.

~~66.~~223. In contravention of ~~section 16.24.3 of the OPM~~the Presumption Duty and, or alternatively, the Reasonable Investigation Duty, DI Webber, DSS Kitching and DS

Robinson failed to treat SS Hurley as a suspect in a homicide or assault investigation.~~through~~

Particulars

The Applicants rely on the matters pleaded in paragraphs 127 to 128.c, 137, and 143 to 144.

224. In contravention of the Presumption Duty and, as a result, section 2.14.2 of the OPM and, or in the alternative, section 263 of the PPRA, the QPS officers other than SS Hurley involved in the discussions pleaded in paragraphs 129, 137, and 144 above failed to electronically record those discussions in circumstances where:

a. it was practicable to electronically record those discussions; or, in the alternative

b. it was practicable to have those discussions in a location in which they could have been and were electronically recorded.

~~a. being picked up by him from the airport and DI Webber and DSS Kitching being driven by him to the police station; and~~

~~b. dining and consuming alcohol with him at his home.~~

~~67. In contravention of section 16.24.3 of the OPM and, as a result, section 2.14.2 of the OPM and, or in the alternative, section 263 of the PPRA:~~

~~a. DI Webber and DSS Kitching discussed the investigation with SS Hurley in the car on the way from the airport to the police station;~~

~~b. Di Webber, DSS Kitching, and DS Robinson discussed the investigation with SS Hurley over dinner at his home; and~~

~~c. DI Webber, Inspector Williams, DSS Kitching and Constable Tibbey discussed the investigation with SS Hurley in the vehicle on the way to and from the arrest site and at the arrest site~~

~~and failed electronically to record the said discussions in circumstances where it was not impracticable to electronically record those discussions or, in the alternative, if this was impracticable, it was not impracticable to have those discussions in another location where they could be electronically recorded.~~

~~68. SS Hurley was not treated as a homicide suspect because he was a non-Indigenous police officer who had likely killed an Indigenous man. These contraventions of section 16.24.3 of the OPM section 2.14.2 of the OPM and, or in the alternative, section 436 of the PPRA therefore involved a distinction based upon the race of the Applicants and Group Members.~~

~~B.2~~H.13 ~~Lack of~~Failure to provide support to ~~Indigenous~~Aboriginal witnesses

~~69. Section 6.3.6 of the OPM provided that persons of Aboriginal and Torres Strait Islander descent are to be considered people with special needs.~~

~~70. Section 6.3.6 of the OPM further provided that, when questioning people of Aboriginal and Torres Strait Islander descent, whether as witnesses or suspects, the existence of a special need should be assumed until the contrary is clearly established using specified criteria.~~

~~71.~~225. In contravention of section 6.3.6 of the OPM, members of the Investigation Team and/or Inspector Williams interviewed seven ~~Indigenous~~Aboriginal witnesses, being PLO Bengaroo, Roy Bramwell, Patrick Bramwell, Penny Sibley, Gladys Nugent, Edna Coolburra and Gerald Kidner (see paragraphs 134, 136, 137, 142, 146, and 149 above), and:

a. failed to adequately consider, or ~~to~~ address, the ~~Indigenous~~Aboriginal witnesses' special needs; ~~and~~

b. failed to ask any of the ~~Indigenous~~Aboriginal witnesses whether they would like to have a support person present at the interview; and

c. specifically, in relation to the interview of PLO Bengaroo at the time of the interview:

i. DSS Kitching formed the opinion that he found PLO Bengaroo difficult to understand, quiet and not very articulate;

ii. DI Webber formed the opinion that PLO Bengaroo was at times extremely difficult to understand and comprehend; and

iii. Inspector Williams formed the opinion that PLO Bengaroo was a very difficult person to interview, was quietly spoken and was "for want of a better word terrified".

Particulars

(i) Officers of the Aboriginal and Torres Strait Islander Legal Service were asked to assist with the notification of Mulrunji's family of his death, but were not asked to assist with the interviews in the investigation.

(ii) DSS Kitching later remarked that he found PLO Bengaroo difficult to understand, quiet, and "not very articulate" (Document 17, pages 818-819), but did not offer him the benefit of a support person.

(iii) DI Webber later remarked that PLO Bengaroo was "at times … extremely difficult to understand and … comprehend" (Document 17, page 482), but did not offer him the benefit of a support person.

(iv) Inspector Williams later remarked that PLO Bengaroo was a "very difficult person to ah interview. He was very quietly spoken, he was ah for want of a better word terrified" (Document 17, page 625) but did not offer him the benefit of a support person.

~~72.~~ Failure ~~This contravention of s 6.3.6 of the OPM involved a distinction based upon the race of the Applicants and Group Members.~~

~~*Failure to assist the coroner in conducting the inquest*~~

~~73. All police officers had a duty, pursuant to s 447A of the PPRA, to assist coroners in the performance of functions under the Coroners Act 2003, including the investigation of deaths and the conduct of inquests.~~

~~74. The Coroner's Guidelines recommended that a "thorough and impartial investigation" be made into any death in custody.~~

~~Particulars~~
~~Coroner's Guidelines, cl 7.2, p 7.5~~

~~75. Form 1, published in the Queensland Gazette on 21 November 2003 pursuant to the Coroners Act 2003 (Qld), was entitled "Police Notification of Death to Coroner."~~

~~76. The OPM provided in section 8.4.8 that the purpose of the Form 1 was to assist the Coroner in deciding whether an autopsy should be ordered and to assist the pathologist performing the autopsy to establish the cause of death.~~

~~77. Section 8.4.3(ix) of the OPM provided that, where an inquest was to be held, the investigating officer was responsible for ensuring that the Form 1 was completed as fully as possible.~~

~~78. Section 8.4.3(v)(a), (b) and (d) of the OPM provided that the investigating officer was responsible for completing the Form 1 and forwarding a copy for review to each of: the coroner, the Government Pathologist performing the autopsy, and the investigator's officer in charge so that it was checked.~~

~~79. Section 8.4.3(vi) of the OPM provided that the investigating officer was responsible for completing a Supplementary Form 1 where additional information became available that might assist in determining the cause of death at a time prior to the autopsy.~~

~~80. As regional crime coordinator, Inspector Webber was directly responsible for the investigation under section 1.17 of the OPM.~~

81. In his preparation of a Form 1 on the night of 19 November 2004 at about 8:58pm, and in his subsequent conduct, DSS Kitching breached his duties under section 447A of the PPRA and section 8.43 of the OPM in that:

a. the Form 1 was not sent to the coroner until about 10.40am on 22 November 2004, when Constable Paul Harvie of the Townsville QPS forwarded the Form to the State Coroner at DSS Kitching's request;

b. despite knowing that Mulrunji had been dragged limp to his cell following a struggle with SS Hurley, DSS Kitching stated in the Form 1 that Mulrunji "laid [sic] on the floor of the cell and went to sleep immediately";

c. DSS Kitching failed to include on the Form 1 any reference to the allegations of assault by SS Hurley upon Mulrunji which had been made by Roy Bramwell and Penny Sibley;

d. DSS Kitching included on the Form 1 information which was adverse to Mulrunji, such as the allegations of him drinking bleach, and excluded allegations which were adverse to SS Hurley;

e. DSS Kitching did not prepare a Supplementary Form 1 to notify the coroner of the allegations of assault made by Roy Bramwell and Penny Sibley; and

f. when present at the inquest by Dr Lampe and in breach of his obligations under the OPM, DSS Kitching failed to inform Dr Lampe of the allegations that SS Hurley had assaulted Mulrunji.

82. Inspector Webber breached his duties under s 447A of the PPRA and, or in the alternative, s 8.43 of the OPM in that he failed to check that the Form 1 was sent on the night of 19 November 2004, and failed to ensure that the coroner was notified of the allegations made by Mr Bramwell, despite knowing about those allegations prior to the autopsy.

Conduct of investigation notwithstanding actual and apparent conflicts of interest

83. Section 10.6 of Version 29 of the QPS Code of Conduct dated August 2003, in force in November 2004 (Code of Conduct) required officers to avoid both actual and apparent conflicts of interests and disclose details of any conflict to their supervising executive officer.

84. Section 1.17 of the OPM provided that an investigation of a death in custody is to be conducted expeditiously and impartially.

85. All police officers had a duty, pursuant to s 447A of the PPRA, to assist coroners in the performance of functions under the Coroners Act 2003, including the investi-

~~gation of deaths and the conduct of inquests – and the Coroner's Guidelines recommended that a "thorough and impartial investigation" be made into any death in custody.~~

~~86. SS Hurley was the officer most likely to be under investigation for causing the death of Mulrunji.~~

H.14 to avoid actual and apparent conflicts of interest

~~87.~~226. DS Robinson had an actual and or, alternatively, an apparent ~~A~~conflict of interest in investigating the death of Mulrunji, in that DS Robinson:

a. was a personal friend of SS Hurley;

b. was from the same police station or establishment as SS Hurley;

c. had worked closely with SS Hurley for about two years on Palm Island;

d. had lived in close proximity to SS Hurley for about two years on Palm Island;

e. was stationed with SS Hurley on Palm Island in circumstances where SS Hurley was his superior officer. ~~;~~

~~88.~~227. By reason of the matters pleaded in paragraph 226 above, DS Robinson's involvement in the investigation of the death of Mulrunji created a reasonable apprehension of bias.

228. In contravention of the Impartiality Duty, the Integrity Duty and/or the Reasonable Diligence Duty, DS Robinson failed to:

a. perform his duties in such a manner that public confidence and trust in the integrity and impartiality of the Queensland Police Service and its members was preserved;

b. ensure as far as practicable there was no conflict between his personal interests and the impartial fulfilment of his official duties and responsibilities;

c. avoid both actual or apparent conflicts of interest in all matters relating to his employment with the QPS; or

d. advise his supervising Executive Officer, or any other more senior QPS officer, of his conflict of interest when it arose.

~~89. .DSS Kitching and DI Webber knew of the friendship between DS Robinson and SS Hurley and knew that DS Robinson was from the same police establishment as SS Hurley.~~

~~90.~~229. The decision of DI Webber, DSS Kitching, and DS Robinson to eat a meal with and consume alcohol at SS Hurley's residence on 19 November 2014 gave rise to an actual and, or alternatively, an apparent conflict of interest in the conduct of the investigation and was a breach of the Impartiality Duty, the Integrity Duty and the Reasonable Diligence Duty. ~~, and constituted a failure to avoid such conflict.~~

230. The decisions of DI Webber to:

a. allow SS Hurley to collect the Investigation Team from the airport (as pleaded in paragraphs 127 and 129 above); and

b. allow SS Hurley to drive members of the Investigation Team to the site of the arrest, to recount the arrest of Mulrunji (as pleaded in paragraphs 143 and 144 above); and

c. not require that the Investigation Team also accompany PLO Bengaroo to the site of arrest to recount the arrest of Mulrunji;

each gave rise to an actual and, or alternatively, an apparent conflict of interest in the conduct of the investigation, created a reasonable apprehension of bias and was a breach of the Impartiality Duty, the Integrity Duty and/or the Reasonable Diligence Duty.

231. Between 19 November 2004 and 24 November 2004:

a. DSS Kitching and DI Webber knew or, alternatively, ought reasonably to have known of the matters pleaded in paragraph 226 above, but nevertheless allowed DS Robinson to be a part of the Investigation Team;

b. the matters in sub-paragraph 231.a gave rise to an actual and, or alternatively, an apparent conflict of interest in the conduct of the investigation and was a breach of the Impartiality Duty, the Integrity Duty and the Reasonable Diligence Duty, and created a reasonable apprehension of bias.

Particulars of knowledge

(i) As the officer in charge of the CIB on Townsville, DSS Kitching had regular contact with both SS Hurley, the officer in charge of the Palm Island police station, and DS Robinson, the officer in charge of the Palm Island CIB.

(ii) DI Webber selected DS Robinson for the Investigation Team because of his position as head of the Palm Island CIB, in which he worked closely with and directly under SS Hurley.

(iii) DS Robinson was not the only senior QPS officer available with local knowledge of Palm Island—Sergeant Melrose also had local knowledge (Document 60, Item 260), and other senior QPS officers had, in the past, been stationed on Palm Island and thereby acquired local knowledge.

232. The perceived partiality of the investigation was further compromised as it was conducted in circumstances where:

a. SS Hurley was not suspended from duty immediately after Mulrunji's death and, remained a stationed officer on Palm Island until he was removed from Palm Island by the QPS in the afternoon of 22 November 2004;

Particulars

The Applicants rely on the matters pleaded under sub-heading J.1(a) hereof.

b. SS Hurley was permitted to continue performing an operational role on Palm Island whilst the investigation was ongoing, until the afternoon of 22 November 2004, after allegations had been made by Roy Bramwell and Penny Sibley that SS Hurley had assaulted Mulrunji;

c. the Investigation Team did not take any reasonable steps in good faith to:

i. keep the community on Palm Island informed of the progress of the investigation as it unfolded, such as advising the Palm Island Aboriginal Shire Council (**Palm Island Council**) of the nature of the investigation and providing them with appropriate updates as the investigation developed; or

ii. appropriately address and respond to the Palm Island community's characteristics, and cultural needs which exist within the community as required by Policy in s. 6.4 of the OPM (as referred to in paragraph 44.a hereof), including the matters alleged in paragraph 32 hereof.

233. By reason of the matters pleaded in paragraphs 229 to 232 above, DI Webber, DSS Kitching, and DS Robinson:

a. in breach of the Impartiality Duty, failed to:

i. perform their duties in such a manner that public confidence and trust in the integrity and impartiality of the Queensland Police Service and its members was preserved;

ii. ensure as far as practicable there was no conflict between their personal interests and the impartial fulfilment of their official duties and responsibilities;

iii. avoid both actual or apparent conflicts of interest in all matters relating to their employment with the QPS; or

iv. advise their supervising Executive Officers, or anyone, of actual or apparent conflicts of interest as and when they arose;

b. in breach of section 1.17 of the OPM and, or alternatively, their Coroner Duty, failed to conduct the investigation into Mulrunji's death in custody impartially.

~~91. In the premises, QPS breached section 10.6 of the Code of Conduct, section 1.17 of the OPM, and, or in the alternative, section 447A of the PPRA through:~~

~~DS Robinson participating in the investigation into the death of Mulrunji without declaring a conflict of interest or disclosing it to a supervising officer;~~
~~DSS Kitching and DI Webber including DS Robinson in the investigation team and allowing him to continue to be part of, or to assist, the investigation team despite having knowledge of the friendship between DS Robinson and SS Hurley and knowing that DS Robinson was from the same police establishment as SS Hurley;~~
~~DI Webber allowing SS Hurley to transport investigators to the police station on 19 November 2014; and~~
~~DI Webber, DSS Kitching and DS Robinson eating a meal and consuming alcohol at SS Hurley's residence on 19 November 2014.~~

~~92. In the premises, in contravention of section 447A of the PPRA, the investigation was neither thorough nor impartial.~~

~~Compromising of integrity of investigation~~

~~93. Section 1.17 of the OPM provided that the regional crime coordinator should ensure that the integrity of the independent versions of events of officers is preserved as far as practicable. It further provided that, following a death in custody, police officers directly involved in the incident or who were witnesses to the incident should not discuss the incident amongst themselves prior to being interviewed.~~

~~94. Section 2.13.8 of the OPM provided that officers who may be required to give evidence of conversations, events or occurrences should compile relevant notes at the time of the conversation, event or occurrence or as soon as practicable thereafter.~~

~~95. All police officers had a duty, pursuant to s 447A of the PPRA, to assist coroners in the performance of functions under the Coroners Act 2003, including the investigation of deaths and the conduct of inquests – and the Coroner's Guidelines recommended that a "thorough and impartial investigation" be made into any death in custody.~~

~~96. The Code of Conduct required police officers to maintain and foster public trust and confidence in the operations of the QPS.~~

~~97. In contravention of section 1.17 of the OPM and the Code of Conduct:~~

~~DI Webber, as the regional crime coordinator, failed to instruct officers not to talk to each other about Mulrunji's death and the surrounding events;~~
~~before the investigating team arrived on Palm Island, SS Hurley, Sergeant Leafe and PLO Bengaroo discussed Mulrunji's death;~~
~~DSS Kitching and DS Robinson failed to instruct SS Hurley not to discuss the matter with other witnesses after conducting an interview with him between about 4.04pm and 4.36pm on 19 November 2004, notwithstanding that it was likely that the investigating team would need to interview SS Hurley again; and~~
~~SS Hurley discussed the death of Mulrunji and surrounding circumstances with others, including Sergeant Leafe, after his initial interview on 19 November 2004.~~

H.15 Compromise of integrity of investigation

234. Contrary to clause 7.2 of the Coroner's Guidelines (and therefore to his Coroner Duty) and section 2.7.11 of the OPM, DI Webber appointed DSS Kitching and DS Robinson, and not the State Homicide Investigation Group, to conduct the investigation into Mulrunji's death.

235. The appointment of DSS Kitching and DS Robinson to the Investigation Team was not appropriate in the circumstances as they were from the same police establishment and/or region as the officers in whose custody the death had occurred.

236. SS Hurley, who was involved in the incidents leading to the death of Mulrunji, undertook and continued to perform duties associated with the investigative process, or other duties at the scene, and was present in the police station whilst the Investigation Team conducted interviews with other witnesses on 19 and 20 November 2004, in circumstances where there was an unacceptable risk that he may see or hear the interviews conducted at the police station.

Particulars

SS Hurley:

(i) was present at the police station on Palm Island on 19 and 20 November 2004;

(ii) maintained command of the scene until the arrival of the Investigation Team and took on the role of First Response Officer in between the time when Mulrunji was found to be deceased and the Investigation Team arrived on Palm Island; and

(iii) collected the Investigation Team from the airport.

237. In breach of the provisions of section 1.17 of the OPM detailed in paragraphs 53 and 55 above, on becoming aware of the death of Mulrunji, each of:

a. DI Webber, as the Regional Crime Coordinator; and/or alternatively

b. District Inspector Strohfeldt as Regional Duty Officer;

failed to provide any advice or instructions to SS Hurley or the Investigation Team, or otherwise take any steps to ensure that SS Hurley did not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene.

238. On 19 November 2004, Inspector Williams was advised of the death of Mulrunji, and was thereafter required by reason of the matters referred to in paragraph 106 to liaise with DI Webber and overview the investigation and provide appropriate advice and assistance to DI Webber, which Inspector Williams failed to comply with in that he:

a. failed to liaise closely with Inspector Webber such that he was able to overview the investigation properly; and

b. as a result, was not able to and did not confer with DI Webber about those matters which may have adversely affected an impartial investigation as they arose.

239. After and as a result of:

a. receiving a briefing from DI Webber, DSS Kitching and DS Robinson on 20 November 2004; and

b. reviewing the interviews and statements which had been conducted,

Inspector Williams had actual or constructive knowledge of the matters pleaded in paragraphs 229 to 232 above.

240. As a result of the matters pleaded in paragraphs 106 and 238 to 239 above, Inspector Williams:

a. ought to have provided appropriate advice to DI Webber, including advice that proper investigational or procedural matters were not being adhered to and that there were matters which may adversely affect an impartial investigation; but

b. failed to do so.

241. In contravention of their obligations under section 1.17 of the OPM, DI Webber, as the regional crime coordinator, and Inspector Strohfeldt as regional duty officer, failed to instruct officers not to talk to each other about Mulrunji's death and the surrounding events, and thereby failed to ensure the integrity of the independent versions of events of officers was preserved as far as practicable.

Particulars

The Applicants rely on the matters pleaded in paragraphs 126 and 131 above.

~~98.~~242. ~~In contravention of section 1.17 of the OPM, s 447A of the *PPRA*, and the Code of Conduct, i~~In the course of conducting the ~~following~~ interviews referred to in paragraphs 130, 134, 135, and 136 above, DSS Kitching took no steps to ascertain what had been discussed by witnesses prior to their interviews.

243. The conduct of the QPS pleaded in each of paragraphs 234 to 242 above, constituted a breach of the Integrity Duty and, or alternatively, the Impartiality Duty and, or alternatively the Reasonable Investigation Duty.

~~a. the interview of SS Hurley by DSS Kitching and DS Robinson which took place between about 4.04pm and 4.36pm on 19 November 2004;~~

~~b. the interviews of PLO Bengaroo, Gladys Nugent and Patrick Bramwell by DSS Kitching and DS Robinson which took place between about 4.50pm and 7.10 pm on 19 November 2004;~~

~~c. the interview of Sergeant Leafe by DSS Kitching which took place between about 7.50pm and 8.12 pm on 19 November 2004; and~~

~~d. the interview with Edna Coolburra by DSS Kitching and DS Robinson which took palce between about 8.22pm and 8.35pm on 19 November 2004.~~

~~99. In contravention of section 2.13.8 of the OPM:~~

~~a. SS Hurley, Sergeant Leafe and PLO Bengaroo failed to compile relevant notes of the discussions they had about Mulrunji's death before the investigation team arrived on Palm Island;~~

~~b. SS Hurley, DI Webber and DSS Kitching failed to compile relevant notes of the conversation they had about what the investigation team was going to do, which occurred whist SS Hurley was driving DI Webber and DSS Kitching from the airport to the police station;~~

~~c. DSS Kitching and SS Hurley failed to compile relevant notes of their conversation, which occurred on 19 November 2004, about discrepancies between times recorded on the surveillance video recorder in the Palm Island watch house and actual times;~~

~~d. DI Webber, Inspector Williams, DS Robinson and SS Hurley failed to compile relevant notes of the discussion they had on 20 November 2004 about discrepancies between times recorded on the surveillance video recorder in the Palm Island watch house and actual times; and~~

~~DI Webber, Inspector Williams, DSS Kitching and Constable Tibbey failed to compile relevant notes of the discussions they had on 20 November 2004 as they drove with SS Hurley to and from the site of the arrest of Mulrunji.~~

~~100. Owing to the various breaches of the OPA – in particular the failure to avoid actual or apparent conflicts of interest – in contravention of section 447A of the *PPRA*, the investigation was neither thorough nor impartial.~~

~~101. In the premises, members of the QPS involved in the investigation, including DI Webber, Inspector Williams, DSS Kitching, DS Robinson and PLO Bengaroo, failed to maintain and foster public trust and confidence in the operations of the QPS, thereby breaching the Code of Conduct.~~

~~Effect of QPS Failures~~

~~102. The failures of the QPS referred to in paragraphs 43 to 100 above (**QPS failures**), constituted an overt and wilful disregard of the law, of governmental policy, and of police procedures.~~

~~103. As a direct consequence of this disregard of the law, of governmental policy, and of police procedures, the QPS failed to:~~

~~a. conduct a thorough and impartial investigation into the violent death of Mulrunji in police custody; or~~

~~b. ensure the integrity and impartiality of the QPS investigation into the violent death of Mulrunji in police custody.~~

~~**Unlawful Racial Discrimination in QPS failures**~~

I Unlawful Racial Discrimination in QPS Failures

I.1 QPS Failures

244. Each of the following acts, or failures to act, or so many as are established at trial (collectively, "**QPS Failures**") was constituted by "acts", or was itself an "act", as defined in section 3 of the *Racial Discrimination Act* 1975 (Cth) (**RDA**):

a. [Deleted]

b. [Deleted]

c. [Deleted]

d. the failures pleaded under sub-heading H.5 hereof with respect to:

i. advising the CAU and utilising the systems in place for advice and support from the CAU and CCLO's in relation to cultural issues in Aboriginal communities as pleaded in paragraphs 186 to 195 hereof;

ii. SS Hurley, Sergeant Leafe, Constable Steadman, Inspector Strohfeldt, DI Webber, Inspector Williams, DSS Kitching, DS Robinson, Inspector Richardson and Senior Sergeant Whyte, not considering the cultural needs which existed within the Palm Island community as pleaded in paragraph 196 hereof;

e. the failures of Inspector Strohfeldt to attend Palm Island and comply with s. 1.17 of the OPM as referred to under sub-heading H.6 hereof;

f. the failure of DI Webber to ensure Constable Steadman was interviewed as soon as practicable as referred to under sub-heading H.7 hereof;

g. the failure to involve the SCOC, Homicide Investigation Group as referred to under sub-heading H.8 hereof;

h. the failures of DS Kitching and/or DI Webber in relation to the preparation of the Form 1 and failure to prepare a Supplementary Form 1, and failure to advise Dr Lampe of the allegations of Patrick Bramwell and Penny Sibley as referred to under sub-heading H.9 hereof;

i. the failure to immediately notify Mulrunji's next of kin of the death, as referred to under sub-heading H.10 hereof;

j. the treatment of PLO Bengaroo, as referred to under sub-heading H.11 hereof;

k. the failures to treat SS Hurley as a suspect and to electronically record conversations with him, as referred to under sub-heading H.12 hereof;

l. the failure to provide adequate support to Aboriginal witnesses, as pleaded under sub-heading H.13 hereof;

m. the failures and acts referred to under sub-headings H.14 and H.15 hereof, including:

    i. DS Robinson's involvement in the investigation in circumstances where he had an actual or apparent conflict of interest and his failure to advise senior officers of same;

    ii. The decision of DI Webber, DS Kitching and DS Robinson to eat a meal with and consume alcohol with SS Hurley;

    iii. The decision of DI Webber to allow SS Hurley to collect the Investigation Team from the airport and drive them to the site of arrest and not require that PLO Bengaroo be accompanied to the site of arrest;

    iv. The decision of DSS Kitching and DI Webber to allow DS Robinson to be part of the Investigation Team when they knew or ought to have known of DS Robinson's actual or apparent conflict of interest;

    v. The failure to suspend Hurley from duty, and permitting him to continue performing an operational role whilst the investigation was ongoing until the afternoon of 22 November 2004,

    vi. The failure of the Investigation Team to take reasonable steps to keep the community of Palm Island informed of the progress of the investigation, and appropriately address and respond to the Palm Island community's characteristics, including the matters referred to in paragraph 32;

    vii. The breach of the Impartiality Duty, the Coroner Duty and s. 1.17 of the OPM by DI Webber, DSS Kitching and DS Robinson by reason of the conduct referred to above in paragraph 233 above;

n. the compromise of the integrity of the investigation, breach of the Integrity Duty, and or the Impartiality Duty and or the Reasonable Investigation Duty as referred to in paragraphs 234 to 243 hereof, including;

i. the failure to appoint the State Homicide Investigation Group to conduct the investigation contrary to the Coroner's Guidelines and the Coroner Duty;

ii. the appointment of DSS Kitching and DS Robinson to the Investigation Team being inappropriate;

iii. SS Hurley continuing to undertake and perform duties associated with the investigative process or other duties at the scene, and being present in the police station when the investigation was taking place;

iv. The breach by DI Webber and/or DI Strohfeldt of s. 1.17 of the OPM by failing to provide advice or instructions or take steps to ensure SS Hurley did not continue to perform duties at the scene;

v. The failure by Inspector Williams to overview, advise on, and confer with DI Webber and the CMC to resolve issues regarding the integrity of the investigation;

vi. the failure of DI Webber and Inspector Strohfeldt to instruct officers not to talk to each other about Mulrunji's death and the surrounding events, as pleaded in paragraph 241 above, and that the officers did in fact talk to each other about Mulrunji's death;

Particulars

The Applicants rely on the matters pleaded in paragraphs 126, 132.b and 133.b.i. above.

vii. DSS Kitching's failure to ascertain what had been discussed by witnesses, as pleaded in paragraph 242 above. ;

I.2 Distinction, exclusion, restriction, or preference

245. The QPS Failures occurred during the arrest and death in custody of an Aboriginal member of the Palm Island community, and an investigation by the QPS into the death, in circumstances where:

a. the residents of Palm Island were overwhelmingly Aboriginal;

Particulars

The Applicants rely on the matters pleaded in paragraph 1A above.

b. most of the Aboriginal residents of Palm Island, including the Applicants and Group Members, had either been forcibly relocated to Palm Island from elsewhere in Queensland by Public Officials, or were descended from persons who had been forcibly relocated there;

c. the Aboriginal community on Palm Island had historically been subjected to discriminatory treatment by the State of Queensland and its organs;

d. the community had a special interest in implementation and carrying into effect of the recommendations of the RCADIC; and

Particulars

The Applicants rely on the matters pleaded in Part E hereof.

e. the Second Respondent and QPS officers involved in the investigation knew of the report of the RCIADIC, or ought reasonably to have been aware of the recommendations of the RCADIC referred to in Annexure 'B' as:

i. they were widely discussed in public;

ii. they were a matter of public knowledge in the public domain;

iii. they were relevant to policing in an Aboriginal community such as Palm Island;

iv. they were explicitly referred to into the Coroners Act and the Coroner's Guidelines; and

v. a number of OPM procedures had been drafted with a view to implementing the recommendations;

f. the matters alleged in paragraph 32 existed.

~~104.~~246. In November 2004, ordinarily in Queensland, the Second Respondent and QPS Officers:

a. complied with QPS Policy, Orders and Procedures and all Acts and laws required to be complied with, in the provision of QPS services to residents of Queensland;

b. conducted investigations into deaths in police custody ~~are investigated~~according to QPS Policy, Orders and Procedures;

c. complied with the PSAA, including ss. 2.3 and 2.4(2) of the PSAA;

d. acted in partnership with the community at large, and provided QPS services as were required under any Act or law or the reasonable expectations of the community or as reasonably sought of officers by members of the community;

e. provided to communities in Queensland which were predominantly made up of members of the racial majority in Queensland:

i. QPS Services and the rendering of help reasonably sought, as are required of officers under any Act or law or the reasonable expectations of those communities;

ii. QPS Services which considered the cultural needs of those communities;

iii. QPS Services which met the cultural needs of those communities;

iv. QPS Services which met the specific cultural and ethnic demographic characteristics of those communities and the needs thereby created.

~~105.~~247. In 2004, residents of Queensland ~~are~~ were entitled to expect that the QPS ~~will~~ would uphold the law.

248. In committing each of the acts comprising the QPS Failures, or so many of them as are established at trial, the Second Respondent and relevant QPS officers:

a. f~~F~~ailed to provide QPS services to the Applicants and Group Members, as residents of Palm Island, and members of the community of Palm Island, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community;

b. failed to provide QPS services to the Applicants and Group Members, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, that was geographically located in a remote location;

c. did not demonstrate high standards of professional integrity in the provision of QPS services to the Applicants and Group Members according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that community was geographically located in a remote location;

d. did not perform the duties associated with their position diligently or in a manner that bears the closest public scrutiny and meets all legislative, Government, and QPS standards in the provision of QPS services to the Applicants and Group Members, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that community was geographically located in a remote location;

e. in the provision of the QPS services to the Applicants and Group Members, did not perform their duties in the best interests of the community of Queensland, without fear or favour, and according to the same standard as those QPS services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that community was geographically located in a remote location;

f. failed to conduct a thorough and impartial investigation into the violent death of Mulrunji in police custody, and according to the same standards as an investigation would have been conducted if:

    i. the deceased was not an Aboriginal person or a member of the racial minority; and

    ii. who resided in and was being detained in a predominantly Aboriginal community or a community predominantly made up of a racial minority; and

    iii. whether or not that community was geographically located in a remote location;

g. failed to ensure the integrity and impartiality of the QPS investigation into the violent death of Mulrunji in police custody, and that the investigation was conducted according to the same standards as an investigation would have been conducted not on Palm Island and elsewhere within the State of Queensland if:

    i. the deceased was not an Aboriginal person or a member of a racial minority; and

    ii. the death did not occur in a location or community which was predominantly inhabited by or made up of Aboriginal persons or members of a racial minority; and

    iii. whether or not that location or community was geographically located in a remote location.

and thereby breached the Prescribed Responsibility, breached section 10.14 of the Code of Conduct and, or alternatively, acted so as to create the appearance of a poorly conducted investigation and thereby brought the QPS into disrepute.

~~106.~~249. As a result of the circumstances pleaded in paragraphs 245 to 248 above ~~The nature and extent of the QPS failures:~~:

a. the rights and protections which applied generally to residents of Queensland who did not reside in a community that predominantly consisted of Aboriginal persons, did not apply to the Applicants and Group Members; and

b. the QPS services provided to the Applicants and Group Members were not provided according to the same standard that they were provided in other areas of Queensland and to members of other communities in Queensland;

c. the QPS services provided on Palm Island were not provided according to the same standard that they were provided in other areas of Queensland;

d. the QPS services provided to the Applicants and Group Members, were provided to a lower standard than that those QPS services were provided to other communities in Queensland;

e. the QPS services provided on Palm Island were not provided according to the same standard that they were provided in other areas of Queensland;

and the QPS Failures, or so many of them as proven at trial, thereby constituted a "distinction, exclusion, restriction or preference", within the meaning of section 9(1) of the RDA. The distinction, exclusion, restriction or preference was based on the race, colour, descent, or national or ethnic origin of the Applicants and Group Members, Mulrunji, and PLO Bengaroo as:

f. Aboriginal persons; or

g. Aboriginal persons who reside in a community that is predominantly made up of Aboriginal persons; or

h. Aboriginal persons who reside in a community that is predominantly made up of Aboriginal persons who reside in a remote location.

250. In the premises of paragraphs 245 to 249 above, the acts comprising the QPS Failures were based on the race of the Applicant and the Group Members and, or alternatively, of Mulrunji and/or PLO Bengaroo.

~~B.3~~I.3 Systemic and institutional discrimination

251. Alternatively, if the QPS officers and the Second Respondent are found to have acted in accordance with all Acts and laws and with QPS Policies, Orders and Procedures, then the Second Respondent established QPS Policies, Orders and Procedures which allowed for the QPS to provide services to the Applicants and Group Members in circumstances where the acts, or failures to act that comprise the QPS Failures occurred, despite notice of:

a. the report and recommendations of the RCIADIC;

b. the poor historical relationship between the residents of Palm Island and the police;

c. the likely sensitivity to the community of a death in custody; and

d. the matters referred to in paragraph 32 existing. ~~;~~

252. By reason of the matters referred to in paragraph 251, the establishment and/or application of the QPS Policies, Orders and Procedures was:

a. an act involving a distinction, exclusion, restriction or preference based on the race, colour, descent or national or ethnic origin of the Applicants and the Group Members; and

b. systemic and institutional discrimination, by reason of the fact that acts or failures to act comprising the QPS Failures, were acts based upon the race, colour, descent or national or ethnic origin of the Applicants and Group Members, because they affected the Applicants and Group Members disproportionately to other residents of Queensland or members of communities that were not made up predominantly of Aboriginal persons with the characteristics of the Applicants and Group Members.

~~a. the rights and protections which apply generally to residents of Queensland did not apply to the Applicants and Group Members; and~~

~~b. QPS members could breach the rights of the Applicants and Group Members, generally with impunity~~

~~thereby excluding the Applicants and Group Members, on the basis of race, from the policing services to which residents of Queensland are entitled.~~

I.4 Breaches of rights

~~107.~~253. In all the circumstances, ~~Taken as a whole,~~ the distinctions, exclusions, restrictions or preferences based on race, colour, descent or national or ethnic origin

pleaded in paragraphs 249 to 250 or, alternatively, 252 hereof had the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, by the Applicants and the Group Members, of their human rights or fundamental freedoms in the political, economic, social, cultural or any other field of public life, namely:

a. equality before the law and equal protection of the law without any discrimination, under Article 26 of the International Covenant on Civil and Political Rights (ICCPR);

~~a.~~b. to enjoy their own culture in community with other members of their group, as persons belonging to an ethnic minority, under Article 27 of the ICCPR;

~~b.~~c. equality before the law and equal treatment before all organs administering justice, under Article 5(a) of the International Convention on the Elimination of all Forms of Racial Discrimination (ICERD);

d. security of person and protection by the State against violence or bodily harm, under Article 5(b) of the ICERD;

e. equality before the law and in the enjoyment of the social right to social services under Article 5(e)(iv) of the ICERD;

f. equality before the law and in the enjoyment of the cultural right to equal participation in cultural activities under Article 5(e)(vi) of the ICERD; and

g. equality before the law and in the enjoyment of the right of access~~s~~ to any service intended for use by the general public under Article 5(f) of the ICERD;

~~c.~~h. equality before the law; and, or alternatively

~~d.~~i. go about their affairs in peace under the protection of the police services, under the common law.

254. The QPS thereby breached section 9 of the RDA.

~~108.~~255. As a result of the~~is unlawful racial discrimination~~ breach of section 9 of the RDA, the Applicants and some or all of the Group Members:

a. experienced emotional distress and psychological harm;

b. felt humiliated and degraded;

c. were fearful for their safety and for the safety of their families; and

d. were caused to feel as though they were not entitled to the same legal protections as other Australians

and thereby suffered loss and damage.

Particulars

(i) Report by Stephen Ralph filed by the Applicants on 9 June 2015.

(ii) Particulars of the Group Members will be provided after the determination of the common issues in this proceeding.

J EVENTS ~~OF~~FROM 22 NOVEMBER 2004~~6 AND THE AFTERMATH~~

J.1 Week after Mulrunji's death

(a) *Hurley not suspended from duty*

256. After Mulrunji's death SS Hurley remained on Palm Island and was not removed from his operational duties on Palm Island until the afternoon of 22 November 2004, following his being confronted by a crowd of Palm Island residents who were angry at the death of Mulrunji.

(b) *Arrival of Inspector Richardson and SS Whyte*

257. On 22 November 2004:

a. QPS Regional Duty Officer, Inspector Brian Richardson, was instructed by Acting Assistant Commissioner Roy Wall to travel to Palm Island to take charge of overall policing on Palm Island after the removal of SS Hurley following a confrontation with members of the Palm Island community in relation to the death in custody of Mulrunji, which he did until 26 November 2004;

b. Senior Sergeant Roger Whyte ('SS Whyte') was also flown to Palm Island and that day, and was appointed to act as the Officer in Charge of Palm Island Police Station, and acted in that role until 26 November 2004, under the command of Inspector Richardson.

258. Inspector Richardson was accompanied by nine other police officers who were not ordinarily stationed on Palm Island.

259. Following upon the death of Mulrunji:

a. the numbers of QPS members rostered to perform duties on Palm Island was increased from 7 QPS officers on 19 November 2004;

b. to approximately 20 QPS members by 26 November 2004.

(c) *Public gatherings*

260. In the week after Mulrunji's death, a number of public gatherings took place in the "Mall" on Palm Island, adjacent to the police station, in which residents publicly expressed:

a. their dissatisfaction about the death in custody;

b. a desire to be informed of the circumstances surrounding the death and the cause of death;

c. a perceived lack of inaction by the Government and the QPS in holding SS Hurley to account for the death of Mulrunji whilst in his care;

d. a perception that the QPS had failed to follow the recommendations of the RCIADIC.

Particulars

(i) Meeting on 22 November 2004 attended by DS Robinson, Inspector Richardson, and SS Whyte.

(ii) Meeting on 23 November 2004 at about 10.30am attended by Senior Sergeant Bennett.

(iii) Meeting on 24 November 2004 at about 3.30pm.

(iv) Meeting on 25 November 2004 at about 10am.

261. Each of the gatherings were attended by officers of the QPS then working on Palm Island, or otherwise watched and/or monitored by QPS officers from the police station, from which it was possible to view the "Mall".

(d) *Other community unrest*

262. In the period between 19 November 2004 and 25 November 2004, QPS officers stationed on Palm Island:

a. received numerous reports of there being discontent amongst members of the community of Palm Island as a result of the death in custody of Mulrunji and the manner in which the investigation into the death was being conducted;

b. observed an escalation in the number of anti-social acts of members of the community directed at the QPS and/or QPS property;

c. observed a deterioration in the preservation of peace and good order upon Palm Island;

d. observed an increase in civil unrest upon Palm Island;

e. received reports from members of the community that other members of the Palm Island Community intended to cause damage to and/or fire bomb the police station and barracks.

Particulars

(i) Rocks thrown at police vehicle on 22 November 2004 at about 10:30pm; on 24 November 2004 at about 12:40am;

(ii) Report to DS Robinson by confidential informant at about 2:30pm on 23 November 2015 that certain persons were going to fire bomb the police station and barracks.

(iii) Discussion between DS Robinson, Dwayne Blanket, and Frank Conway at about 5:20pm on 23 November 2004.

(iv) Bricks thrown at police station on 24 November 2004 at about 11:00pm.

263. On about 23 November 2004, at about 3:20pm, Acting Assistant Commissioner Wall directed that police officers on Palm Island take their weapons to their sleeping quarters with them.

264. On about 23 November 2004, at about 5:40pm, in response to intelligence that there was a threat that the police station may be firebombed, Sergeant Leafe arranged for additional firefighting personnel to be on standby.

(e) *Release of Preliminary Autopsy Report*

265. At about 5.55 pm on 25 November 2004, SS Whyte was advised by Denise Geia, an employee of the Palm Island Council, that Mayor Erykah Kyle was at that time speaking to the family of Mulrunji about the Preliminary Autopsy Report which was then being released to the family. SS Whyte advised Inspector Richardson of the above information.

266. On the evening of 25 November 2004, at or about 6.40 pm, Inspector Richardson was advised by Acting Assistant Commissioner Wall in a telephone conversation, that the results of the post-mortem examination upon Mulrunji had either been delivered to the family of Mulrunji or was about to be delivered to the family.

267. Inspector Richardson and SS Whyte were not advised or otherwise made aware of:

a. the injuries Mulrunji had sustained prior to his death whilst in police custody;

b. the cause of death, including the fact that Mulrunji's liver had been ruptured;

c. the fact that Mulrunji had sustained 4 broken ribs whilst in QPS custody.

268. In response to receiving the advice referred to in paragraphs 265 and or 266 hereof:

a. Inspector Richardson, warned the QPS members under his direction on Palm Island to "be on your toes and be on the look out, you know things could turn a bit hostile";

b. Inspector Richardson knew or ought to have known that the release of the results of the post-mortem examination to members of the community was imminent;

c. Inspector Richardson formed the opinion that there was an increased risk that civil unrest upon Palm Island would escalate.

~~B.4~~J.2 ~~Declaration of e~~Emergency situation

(a) *Public meeting*

~~109.~~269. On or about 26 November 2004, a community meeting was held on Palm Island, convened by the ~~local aboriginal~~ Palm Island Council ~~and the QPS~~. ~~The~~ Members of the Palm Island community gathered to hear the findings of the ~~report of the investigating officers~~Preliminary Autopsy Report being announced by Mayor Erykah Kyle of the Palm Island Council.

270. Inspector Richardson and SS Whyte~~,~~ knew or ought to have known:

a. That the meeting was to be held;

b. That there was a risk that the results of the post-mortem examination would be released to members of the community who attended the meeting;

c. That there was an increased risk that the preservation of peace and good order on Palm Island would not be maintained.

Particulars

The Applicants rely on the matters pleaded in paragraphs 266 to 294 hereof.

~~110.~~271. ~~Ms Erikah Kyle, the Council chairperson, disclosed some details from the autopsy report, including that~~ At that meeting, Mayor Kyle represented:

a. that the report had found that Mulrunji's death was caused by an accidental fall;

b. that SS Hurley was not responsible for any criminal wrongdoing in relation to the death. ~~;~~

272. No police officer or government representative addressed the crowd before, during, or after the meeting.

~~111.~~273. Following the meeting, the community protested against the death in custody of Mulrunji and the perceived failure of the QPS to hold SS Hurley to account for

that death. During this time the police station, the courthouse and the police officer-in-charge residence were set on fire.~~by protesters~~

274. ~~No person was physically harmedduring the protest.~~At about 1.30pm, the crowd of Palm Island residents dispersed.

(b) *Declaration of emergency situation*

~~112.~~275. At all material times, DI Webber was a commissioned officer, within the meaning of the *Public Safety Preservation Act 1986* (Qld) (***PSPA***) and was employed under the *Police Service Administration Act 1990* (Qld).

~~113.~~276. At or about 1.45pm on 26 November 2004, DI Webber orally declared that an emergency situation existed on Palm Island~~, (Declaration),~~ purportedly pursuant to s 5 of the *Public Safety Preservation Act 1986* (Qld).

277. DI Webber did not, and neither did any other QPS officer, on 26 November 2004:

a. issue or caused to be issued a "Certificate relating to the Declaration of an Emergency Situation" as required by section 5(2) of the PSPA;

b. make, or caused to be made, any public announcement to the people of Palm Island or to the Palm Island Council that an emergency situation had been declared;

c. explain, or cause to be explained, to the people of Palm Island or to the Palm Island Council why an emergency situation had been declared, what that entailed, and for how long it was expected to remain in place.

~~114. Sometime after this, DI Webber issued a "Certificate relating to the Declaration of an Emergency Situation" purportedly pursuant to s 5 of the *Public Safety Preservation Act 1986* (Qld).~~

~~115.~~278. The basis on which the emergency situation was declared, according to the certificate later issued by DI Webber, was that the unrest on Palm Island was "any other accident … that causes or may cause a danger of death, injury or distress to any person, a loss of or damage to any property" within the definition of "emergency situation" in the Dictionary to the *Public Safety Preservation Act 1986* (Qld).

~~116.~~279. On or about 26 November 2004, senior police officers on Palm Island, including DI Webber, formulated the following action plan (**Action Plan**):

a. DS Robinson to identify addresses of interest;

b. Special Emergency Response Team (**SERT**) and Public Safety Response Team (**PSRT**) officers to acquire addresses of interest;

c. DS Robinson to enter residence and identify persons of interest;

d. DS Robinson accompanied by SERT and PSRT officers who would apprehend the person or persons of interest with minimum force necessary, secure that person and that person would then be taken from the residence;

e. If doors were locked and secured, SERT would use force to gain entry;

f. Other occupants within the dwellings would not be disturbed, if possible;

g. Team would then move on.

~~117.~~280. Chief Superintendent Wall approved the Action Plan on or about 26 November 2004.

~~118.~~281. SERT and PSRT were heavily armed police units with specialist training for dealing with particularly dangerous suspects and situations.

~~119.~~282. On or about 26 November 2004, around 60 SERT and PSRT personnel were flown on to Palm Island by helicopter.

(c) *The Raids*

~~120.~~283. ~~On the evening of 26 November 2004, and~~In the early morning of 27 November 2004 and throughout that day and the next day, ~~elite police officers from special response teams~~SERT and PSRT officers, heavily armed and with their faces covered by balaclavas, entered and searched dwellings of ~~Indigenous~~Aboriginal Palm Island residents, purportedly pursuant to s 8 of the *Public Safety Preservation Act 1986* (Qld) ~~and/or s 19 of the PPRA~~ (the "**Raids**").

~~121.~~284. Pursuant to the Action Plan, the persons to be arrested, and who were arrested, ~~had been~~were identified by DS Robinson.

285. The list of persons to be arrested had been prepared on the night of 26 November 2004 in Townsville by Detective Senior Sergeant David John Miles, by reference to advice from DS Robinson, the police running sheet of the previous week on Palm Island, and footage of the events of 26 November 2004.

286. Neither DSS Miles nor any other QPS officer obtained a warrant for the arrest of any person arrested in the presence of SERT and PSRT officers in connection with the events on Palm Island of 26 November 2004.

~~122.~~287. During ~~these arrests~~the Raids, ~~police~~ the SERT and PSRT officers, and DS Robinson:

a. entered the homes of ~~Group Members, including~~ all three Applicants, and members of the Sub-Group, without permission, without obtaining a warrant to enter the premises, and with no reasonable cause to enter the premises;

b. ransacked the~~ose~~ home~~s~~ of the First and Third Applicants and the homes of Sub-Group Members;

c. entered the homes of ~~many of~~ the Second Applicant and of Sub-Group Members whilst they or their relatives were naked or not fully clothed

Particulars

(i) Richard Poyner, the Second Applicant's son-in-law, was arrested in the Second Applicant's home whilst in the shower.

(ii) ~~and, in the case of~~ Sub-Group member David Bu~~a~~lsey was dragged ~~him~~ outside his home whilst he was naked from the waist down.

d. subjected Sub-Group Members, and the First Applicant, who were not resisting arrest, to ~~beatings and other~~ violence—including through the use of tasers—in front of their families and loved ones.

Particulars

(i) The First Applicant, who was not resisting arrest, was shot with a taser.

(ii) The home of the First and Third Applicants was entered without their consent and was ransacked.

(iii) The Second Applicant's home was entered without consent and her bathroom door was damaged as QPS officers forcibly entered the bathroom whilst her son-in-law, Richard Poynter, was in the shower.

(iv) Sub-Group member David Bulsey was dragged from his home whilst naked from the waist down.

(v) Further particulars of the Sub-Group will be provided after the determination of the common issues in this proceeding.

~~123.~~288. Notwithstanding that the Applicants and Sub-Group Members ~~had been~~were compliant with police instructions and had made no threatening actions whatsoever, the ~~QPS members~~SERT and PSRT officers, in the presence of DS Robinson:

a. held a number of unarmed Sub-Group Members, and the First and Third Applicants, at gunpoint;

b. forced the First and Third Applicants~~,~~ to lie face down with guns pointed at them; and

c. ~~as the Group Members, and the First and Third Applicants, lay face down with guns pointed at them,~~ pointed guns at their children, including the First and Third Applicants' daughter Schanara Bulsey, and forced the children to lie face down with guns continuing to point at them.

~~(a)~~(d) *Revocation of emergency situation*

~~124.~~289. On or about 28 November 2004, at approximately 8.10am, DI Webber declared the emergency situation to be revoked. After revoking the emergency situation, DI Webber issued a "Certificate relating to the Declaration of an Emergency Situation" purportedly pursuant to s 5 of the *Public Safety Preservation Act 1986* (Qld), and faxed the certificate to the QPS in Townsville at about 9:15am on 28 November 2004.

Particulars

Document 60, Item 294.

~~(b)~~(e) *QPS conduct during and after emergency situation*

~~125.~~290. During the ~~entire~~ period that the emergency situation was in effect, and the days immediately after it was revoked, the QPS members:

a. commandeered the local school bus, thereby forcing children of the Applicants and Group Members to walk home at that time, and subsequently walk each school day to and from school in the summer heat;

b. damaged property from the homes of the Applicants and Sub-Group Members;

Particulars

(i) The First and Third Applicants' home was ransacked.

(i) The Second Applicant's bathroom door was damaged.

(ii) Particulars of the Sub-Group will be provided after the determination of the common issues in this proceeding.

~~b.~~c. established a visible presence throughout the island and patrolled the island in a manner which resembled a military occupation force; and

Particulars

SERT officers armed with assault rifles and dressed in black uniforms, including body armour, patrolled up and down the streets in unison and with no apparent purpose other than making their presence felt.

~~c.~~d. otherwise behaved in a disrespectful and intimidatory manner towards the Applicants and Group Members,

thereby creating an atmosphere of hostility and intimidation, causing the Applicants and Group Members to feel fearful, humiliated and degraded.

(f) *Evacuation of ~~non-Indigenous~~ residents*

~~126.~~291. On or about 26 November 2004, the QPS evacuated the majority of the teachers, and other public sector employees from Palm Island, thereby creating the perception amongst community members, including the Applicants, that employees of service providers on the Island who were predominantly non-Aboriginal and not long-term residents of Palm Island were being removed from the island whilst the remainder of the Aboriginal Palm Island community were being left there under quasi-martial law. ~~non-Indigenous residents from Palm Island.~~

Particulars

At about 4:15pm and 4:51pm on 26 November 2004, DSS Scanlon advised the staff of the schools to board a ferry from Palm Island (Document 20, Items 38 and 58).

~~127. Indigenous residents were not given the option of leaving Palm Island.~~

~~128.~~292. Over the course of the purported "emergency situation", none of the Applicants or Group Members were permitted to travel to Palm Island or to leave Palm Island, otherwise than in police custody, as all flights and ferry services were suspended.

~~Subsequent treatment of arrested persons~~

~~129. Group Members, and the First Applicant, who were also arrested during the emergency situation (**arrested persons**), were After being arrested on 27 November 2004, the First Applicant was taken to Townsville, then charged with various offences and imprisoned. In about late November 2004 and after 27 November 2004, Tthe Second Applicant was wrongfully arrested and charged., who was present in Townsville, was also charged.~~

~~130. Bail was granted to most or all of the arrested persons after between one and two weeks, and to the First Applicant after about four months.~~

~~131. The arrested persons were not tried for between one and two years after the events occurred.~~

~~132. Whilst on remand, upon the application of the Respondents and pursuant to information provided and endorsed by the QPS, the arrested persons, including the First and Second Applicants, were not permitted:~~

~~a. to return their homes on Palm Island; or~~

~~b. to assemble in groups larger than two other arrested persons.~~

~~133. Over the objections of the Respondents, the venue for the trial of the arrested persons was moved from Townsville to Brisbane by his Honour Skoien ACJ in the District Court of Townsville, on the basis that the arrested persons could not re-~~

~~ceive a fair trial in Townsville due to the underlying racial prejudice against Indigenous persons amongst Townsville jurors, and the consequent apprehended bias of any potential proceedings.~~

K Unlawfulness of events ~~of~~ from 22 November 200~~46~~ ~~and the aftermath~~

K.1 Failure to immediately suspend SS Hurley

293. In the circumstances pleaded in paragraphs 7 to 16, 215 and 216 above, the failure to immediately suspend SS Hurley from duty following the death in custody, as pleaded under sub-heading J.1(a) above, was contrary to the reasonable expectations of the community and was an act which was reasonably likely to, and which did in fact, bring the QPS into disrepute.

K.2 Failure to communicate with local community and diffuse tensions

294. The Applicants and Group Members repeat and rely upon the matters pleaded in Part E hereof, and paragraphs 43 to 45 hereof. By reason of those matters, each of SS Hurley, DI Webber, ~~a~~and Inspector Richardson and SS Whyte knew or reasonably ought to have known that:

a. t~~T~~he community of Palm Island, or a reasonable proportion thereof:

i. would be or were reasonably likely to be suspicious of the circumstances in which Mulrunji died in QPS custody;

ii. may perceive that the QPS would not be held to account for any wrongdoing in relation to the death of Mulrunji;

iii. were likely to react differently to other communities that were not predominantly Aboriginal, as Palm Island was;

iv. were likely to react differently to other communities in Queensland that did not share the same or similar history as Palm Island;

v. would require culturally sensitive policing services to be provided to meet the reasonable expectations of the community as referred to above in paragraph 32, and the other matters referred to therein.

b. s~~S~~pecial considerations, efforts and strategic planning would have to be provided as part of the QPS services on Palm Island following the death in custody of Mulrunji, which adequately addressed the particular attributes of the Aboriginal community, cross-cultural issues, the reasonable expectations of the community, and the obligation to preserve peace and good order in all areas of the State of Queensland, including Palm Island;

c. tThe QPS had CCLO's and the CAU to assist in providing culturally sensitive policing, and which ought to be utilised upon Palm Island as part of an effective strategic plan to preserve peace and good order in all areas of the State, including Palm Island.

295. Despite the matters pleaded in paragraph 294 hereof and the Prescribed Responsibility of the Second Respondent, particularly with respect to section 2.3(a)(i) of the PSAA, no special measures were put in place or undertaken by the Second Respondent or QPS officers to preserve peace and good order on Palm Island in the period following the death of Mulrunji.

296. In the circumstances pleaded under sub-heading J hereof:

a. in the circumstances pleaded under sub-headings J.1(c), J.1(d), and J.1(e) hereof, the QPS officers stationed on Palm Island, including in particular Acting Commissioner Wall, DS Robinson, and Inspector Richardson and SS Whyte:

i. had actual knowledge that there was a feeling of grief and anger amongst the residents of Palm Island over Mulrunji's death in custody and a widespread perception that SS Hurley was not being held to account for that death; and

ii. anticipated that the grief and anger was such that it might lead to riotous and/or socially disorderly behaviour; but

iii. did not attempt to liaise with those members of the community who attended the public meetings and were apparently dissatisfied with the death of Mulrunji in police custody, and the subsequent police investigation;

iv. did not issue or caused to be issued any public statement to the residents on Palm Island or otherwise, containing an apology for Mulrunji's death or an expression of regret or remorse for the death having occurred in police custody and/or an explanation of the investigation into Mulrunji's death and the procedure that would then be followed;

v. instead of taking any steps to diffuse the community's grief and anger, and provide responsive and culturally sensitive policing in the community, increased the police presence upon the Island with Officers who were not appropriately trained in culturally sensitive policing in a community such as Palm Island;

b. no QPS officers or officials of the First Respondent took any steps to cause either:

   i. the position of the QPS in relation to the death in custody, or the investigation; or

   ii. an apology for Mulrunji's death or an expression of regret or remorse for the death having occurred in police custody;

   to be communicated to the community on Palm Island;

c. no CCLO was sent to Palm Island to assist the QPS to manage obvious tensions within the community, which had arisen since the death of Mulrunji, until at or about the time of the commencement of the riot on 26 November 2004;

d. no other visible attempts were made by police to engage with the Aboriginal community upon Palm Island to adequately address the concerns amongst the community of Palm Island which had arisen since the death in custody of Mulrunji;

e. Inspector Richardson, as the most senior QPS officer on Palm Island at the time:

   i. was not adequately briefed on the contents of the Preliminary Autopsy Report;

   ii. failed to appropriately engage with the Palm Island Council, or the community in a culturally appropriate and sensitive way;

f. the QPS increased the police presence on Palm Island with QPS officers from other establishments or stations, without ensuring that those officers were provided with appropriate training in relation to cross-cultural issues that existed by reason of the predominantly Aboriginal community and the history of the community;

g. the strategic planning of the QPS in response to the intelligence that the autopsy report was to be released to the members of the public, failed to take into account important and relevant information known to members of the QPS, such as DSS Kitching, DI Webber and Inspector Williams, namely the fact that Mulrunji had sustained four broken ribs and his liver had been ruptured at or about the time of his death;

Particulars of knowledge

The Applicants rely on the matters pleaded in paragraph 160 and under subheadings G.4(d) and J.1(e) hereof.

h. no special or other arrangements were made by the QPS Officers on Palm Island in response to the information that the autopsy report upon the post-mortem examination of Mulrunji was to be released to the community, other than advising officers of the matters referred to in paragraph 268.a hereof;

i. in the premises:

i. the QPS failed to provide appropriate responsive policing services upon Palm Island in accordance with the Second Respondent's Prescribed Responsibility; and

ii. the QPS failed to act in partnership with the community, in a way that met or considered the cultural needs which existed within the community, as required by s 2.4(2) of the PSAA.

~~B.5~~K.3 Unlawful Declaration of Emergency Situation

~~134. By entering the Palm Island residents' dwellings unlawfully, pointing guns at residents, assaulting residents, and otherwise behaving in an intrusive and aggressive manner, members of the QPS subjected the Applicants and Group Members to unlawful racial discrimination.~~

~~135.~~297. The Dictionary to the *Public Safety Preservation Act 1986* (Qld) defined "emergency situation" as:

> (a) any explosion or fire; or
>
> (b) any oil or chemical spill; or
>
> (c) any escape of gas, radioactive material or flammable or combustible liquids; or
>
> (d) any accident involving an aircraft, or a train, vessel or vehicle; or
>
> (e) any incident involving a bomb or other explosive device or a firearm or other weapon; or
>
> (f) any other accident;
>
> that causes or may cause a danger of death, injury or distress to any person, a loss of or damage to any property or pollution of the environment, includes a situation arising from any report in respect of any of the matters referred to in paragraphs (a) to (f) which if proved to be correct would cause or may cause a danger of death, injury or distress to any person, a loss of or damage to any property or pollution of the environment.

298. Section 5 of the PSPA provided:

> (1) Subject to section 6, if at any time a commissioned officer (the "incident coordinator") is satisfied on reasonable grounds that an emergency situation has arisen or is likely to arise the commissioned officer may declare that an emergency situation exists in respect of an area specified by the commissioned officer.

(2) The incident coordinator, as soon as practicable after he or she declares that an emergency situation exists, shall issue a certificate to this effect signed by the incident coordinator which certificate shall set out the nature of the emergency situation, the time and date it was declared to exist and the area in respect of which it exists.

~~136.~~299. In the circumstances pleaded in paragraphs 276 to 278 above, the declaration of an emergency situation was unlawful and, or alternatively, invalid as:

a. t~~T~~here had been no event meeting the definition of "emergency situation" in the Dictionary to the Public Safety Preservation Act 1986 (Qld)~~;~~

b. t~~T~~he "Certificate relating to the Declaration of an Emergency Situation" issued by DI Webber, purportedly pursuant to s 5 of the Public Safety Preservation Act 1986 (Qld), did not provide for adequate particulars of the alleged emergency, as required by s 5(2) of the Public Safety Preservation Act 1986 (Qld)~~;~~

Particulars

Document 16.

~~b.~~c. i~~I~~n particular, the emergency situation was declared on the basis that the unrest on Palm Island was "any other accident … that causes or may cause a danger of death, injury or distress to any person, a loss of or damage to any property" within the definition of "emergency situation" in the Dictionary to the Public Safety Preservation Act 1986 (Qld). No "accident" had occurred by any definition, legal or otherwise~~;~~

d. f~~F~~urther, or in the alternative, if there was an emergency situation during the protests on 26 November 2004, it ended when the crowd of protesters dispersed and returned to their homes as pleaded in paragraph 274 above. When the emergency situation ended, DI Webber failed to declare the emergency situation to be revoked, and the QPS officers on Palm Island proceeded to act as though an emergency situation was lawfully in place when it in fact was not~~;~~

~~c.~~e. i~~I~~n breach of section 5(2) of the PSPA, the Certificate was not issued as soon as practicable after the emergency situation was declared, but was issued almost 48 hours later, after the emergency situation had been revoked.

~~Failure to avoid conflict of interest~~

~~137. Section 10.6 of the Code of Conduct required officers to avoid both actual and apparent conflicts of interests and disclose details of any conflict to their supervising executive officer.~~

~~138. The Code of Conduct required police officers to maintain and foster public trust and confidence in the operations of the QPS.~~

~~139. In breach of the Code of Conduct, DS Robinson was assigned to identify all persons to be arrested for their conduct during the protests, despite his being intimately involved in the events which those persons had been protesting against.~~

~~B.6~~K.4 Unlawful arrests

~~140.~~300. In the circumstances pleaded in paragraphs 283 to 288 above, the arrests conducted in the course of the Raids were not conducted in accordance with the Action Plan, as they were not conducted with the minimum force necessary, and neither were they conducted lawfully.

Particulars

QPS officers were reminded in section 14.3 of the OPM that "it is lawful to use such force as may be reasonably necessary to overcome any force used in resisting the execution of any lawful process or arrest. However, it is unlawful to use more force than is justified by law to effect a lawful purpose."

~~141.~~301. Section 198 of the *PPRA* provided for circumstances in which arrests could be made without first obtaining a warrant. Relevantly it provided:

> (1) It is lawful for a police officer, without warrant, to arrest an adult the police officer reasonably suspects has committed or is committing an offence if it is reasonably necessary for 1 or more of the following reasons—
>
> (a) to prevent the continuation or repetition of an offence or the commission of another offence;
>
> (b) to make inquiries to establish the person's identity;
>
> (c) to ensure the person's appearance before a court;
>
> (d) to obtain or preserve evidence relating to the offence;
>
> (e) to prevent the harassment of, or interference with, a person who may be required to give evidence relating to the offence;
>
> (f) to prevent the fabrication of evidence;
>
> (g) to preserve the safety or welfare of any person, including the person arrested;
>
> (h) to prevent a person fleeing from a police officer or the location of an offence;
>
> (i) because the offence is an offence against section 444 or 445;
>
> (j) because the offence is an offence against the Domestic and Family Violence Protection Act 1989, section 80;
>
> (k) because of the nature and seriousness of the offence;
>
> (l) because the offence is--
>
> (i) an offence against the Corrective Services Act 2000, section 103(3); or
>
> (ii) an offence to which the Corrective Services Act 2000, section 104 applies.

(2) Also, it is lawful for a police officer, without warrant, to arrest a person the police officer reasonably suspects has committed or is committing an indictable offence, for questioning the person about the offence, or investigating the offence, under chapter 7."

~~142.~~302. At the time of the arrests, any actual or potentially unlawful activity being committed by any of the Applicants or Group Members had ended. None of the arrests of Applicants or Group Members were made pursuant to the requirements of section 198 of the *PPRA*. The arrests without warrant were unlawful.

~~B.7~~K.5 Unlawful entry into dwellings by police

~~143.~~303. In the circumstances pleaded in paragraphs 283 to 288 above the entry into dwellings by QPS members during the Raids was not conducted in accordance with the Action Plan, as the occupants were unnecessarily disturbed, and neither was it conducted lawfully.

~~144. On the evening of 26 November 2004, and the early morning of 27 November 2004, the police officers forcibly entered, searched, and ransacked dwellings of Group Members, and all three Applicants, purportedly pursuant to s 8 of the *Public Safety Preservation Act 1986* (Qld) or s 19 of the *PPRA*, without the consent of the occupants.~~

~~145.~~304. During the Raids, the police officers did not enter dwellings pursuant to s 8 of the *Public Safety Preservation Act 1986* (Qld) as, in the circumstances pleaded in paragraph 298 above:

a. when police officers entered the dwellings there was no emergency situation; and

b. at the times police officers entered dwellings, DI Webber could not have been satisfied on reasonable grounds that it was necessary to effectively deal with the emergency situation, as declared, to enter or cause to be entered any premises or to search or cause to be searched any premises, within the meaning of s 8(1) of the *Public Safety Preservation Act 1986* (Qld).

~~146.~~305. During the Raids, the police officers did not enter dwellings pursuant to s 19 of the *PPRA* as, in the circumstances pleaded in paragraph 298 above:

a. the police officers who entered those dwellings did not reasonably suspect that the person to be arrested or detained was at the dwelling, within the meaning of s 19(2) of the PPRA, when they entered the dwellings; and

b. in particular, when the police officers forcibly entered the dwelling of the First and Third Applicants, the police officers had already arrested the First Applicant outside the dwelling.

~~147.~~306. In the premises, the dwellings were entered by the police officers unlawfully and without the consent of the occupants.

Particulars

Aboriginal and Torres Strait Islanders (Queensland Discriminatory Laws) Act 1975 (Qld), section 8.

K.6 Failure to comply with the Code of Conduct

307. In each of:

a. the commandeering of the school bus, the damage to property, and the other conduct pleaded under sub-heading J.2(e) hereof; and

b. the evacuation pleaded under sub-heading J.2(f) hereof;

in contravention of s 10.14 of the Code of Conduct, the QPS officers responsible for those events failed to:

c. d~~D~~emonstrate high standards of professional integrity and honesty;

d. p~~P~~erform any duties associated with their position diligently and to the best of their ability, in a manner that bears the closest public scrutiny and meets all legislative, Government and Service standards;

e. a~~A~~ct with fairness and reasonable compassion;

f. p~~P~~rovide conscientious, effective, efficient and courteous service to all those with whom they have official dealings. In particular, members are to be sensitive to the special circumstances and needs surrounding victims of crime;

g. p~~P~~erform their duties impartially and in the best interests of the community of Queensland, without fear or favour; and, or alternatively

h. a~~A~~ct in good faith.

L ~~Particulars of~~ Unlawful Racial Discrimination

~~148. The unlawful declaration of a state of emergency, the conduct of the Respondents in the course of the state of emergency – such as evacuating non-Indigenous residents from the Island whilst restricting the ability of Indigenous residents to travel to and from the island – and the failure of the QPS to call an end to the state of emergency after any emergency had subsided, nullified or impaired the recognition, enjoyment or exercise, on an equal footing, by the Applicants and Group Members, of their rights to:~~

~~a. liberty of movement and freedom to choose one's residence under Art 12 of the ICCPR;~~

~~b. equality before the law and equal protection of the law, under article 26 of the ICCPR;~~

~~c. equality before the law and equal treatment before all organs administering justice under Art 5(c) of the ICERD;~~

~~d. security of person and protection by the State against violence or bodily harm within the meaning of Art 5(b) of the ICERD; and~~

~~e. go about their affairs in peace under the protection of the police services, under the common law.~~

L.1 Distinction, Exclusion, Restriction or Preference

308. The Applicants and Group Members repeat and rely upon the matters alleged in paragraph 32 hereof.

309. Each of the following acts, or failures to act, or so many as are established at trial, (collectively, "**Further Failures**") was constituted by "acts", or was itself an "act", as defined in section 3 of the RDA:

a. the failure to suspend SS Hurley from duty, as pleaded under sub-heading K.1 hereof;

b. the acts and omissions to act with respect to communication with the Palm Island community and putting into place special measures to address community concerns, as pleaded under sub-heading K.2 hereof;

c. the unlawful declaration of an emergency situation by DI Webber and, or alternatively, the failure to revoke the declaration of an emergency situation, as pleaded under sub-heading K.3 hereof;

d. the unlawful arrests pleaded under sub-heading K.4 hereof;

e. the unlawful entry into dwellings pleaded under sub-heading K.5 hereof; and

f. the commandeering of the school bus, the damage to property, the evacuation, and the other conduct pleaded under sub-heading K.6 hereof.

310. The Further Failures occurred during the aftermath of community discontent and suspicion over the involvement of SS Hurley in the arrest and death in custody of an Aboriginal member of the Palm Island community, and a widespread perception in the community of Palm Island, that the investigation by the QPS into the death was not being, or had not been conducted fairly and impartially, as well as in the circumstances pleaded in paragraph 245 hereof.

311. The Applicants and Group Members repeat and rely upon the matters alleged in paragraphs 246 and 247 hereof.

312. In committing each of the acts comprising the Further Failures, the Second Respondent and relevant QPS officers:

a. ~~f~~Failed to provide policing services to the Applicants and Group Members, as residents of Palm Island, and members of the community of Palm Island, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community;

b. failed to provide policing services to the Applicants and Group Members, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, that was geographically located in a remote location;

c. did not demonstrate high standards of professional integrity in the provision of policing services to the Applicants and Group Members according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that community was geographically located in a remote location;

d. did not perform the duties associated with their position diligently or in a manner that bears the closest public scrutiny and meets all legislative, Government, and QPS standards in the provision of policing services to the Applicants and Group Members, according to the same standard as those services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that

community was geographically located in a remote location; and, or alternatively

e. in the provision of policing services to the Applicants and Group Members, did not perform their duties in the best interests of the community of Queensland, without fear or favour, and according to the same standard as those QPS services were supplied to other residents of Queensland who did not reside in a predominantly Aboriginal community, whether or not that community was geographically located in a remote location;

and thereby breached the Prescribed Responsibility, breached section 10.14 of the Code of Conduct and, or alternatively, acted so as to create the appearance of an excessive and unwarranted response to the events on Palm Island of 26 November 2004, and thereby brought the QPS into disrepute.

313. By reason of the matters pleaded in paragraphs 310 to 312 hereof:

a. the Further Failures, taken individually or as a whole, constituted a "distinction, exclusion, restriction or preference", within the meaning of section 9(1) of the RDA; and

b. those distinctions, exclusions, restrictions or preferences were based on the race, colour, descent, or national or ethnic origin of the Applicants and Group Members as:

i. Aboriginal persons; or alternatively

ii. Aboriginal persons who reside in a community that is predominantly made up of Aboriginal persons; or alternatively

iii. Aboriginal persons who reside in a community that is predominantly made up of Aboriginal persons who reside in a remote location.

L.2 Systemic and institutional discrimination

314. Alternatively, if the QPS officers and the Second Respondent are found to have acted in accordance with all Acts and laws and with QPS Policies, Orders and Procedures, then the Second Respondent established QPS Policies, Orders and Procedures which allowed for the QPS to provide services to the Applicants and Group Members in circumstances where the acts, or failures to act that comprise the Further Failures occurred, despite notice of:

a. the report and recommendations of the RCIADIC;

b. the poor historical relationship between the residents of Palm Island and the police;

c. the likely sensitivity to the community of a death in custody; and

d. the matters referred to in paragraph 32 existing.

315. By reason of the matters referred to in the preceding paragraph, the establishment and/or application of the QPS Policies, Orders and Procedures was:

a. an act involving a distinction, exclusion, restriction or preference based on the race, colour, descent or national or ethnic origin of the Applicants and the Group Members; and

b. systemic and institutional discrimination, by reason of the fact that acts or failures to act comprising the Further Failures, were acts based upon the race, colour, descent or national or ethnic origin of the Applicants and Group Members, because they affected the Applicants and Group Members disproportionately to other residents of Queensland or members of communities that were not made up predominantly of Aboriginal persons with the characteristics of the Applicants and Group Members.

L.3 Breach of rights: Group Members

316. In all the circumstances, the distinctions, exclusions, restrictions or preferences based on race, colour, descent or national or ethnic origin of the Applicants pleaded in paragraph 313 or, alternatively, 315 hereof had the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, by the Applicants and the Group Members, of their human rights or fundamental freedoms in the political, economic, social, cultural or any other field of public life, namely:

a. equality before the law and equal protection of the law without any discrimination, under Article 26 of the International Covenant on Civil and Political Rights (ICCPR);

b. to enjoy their own culture in community with other members of their group, as persons belonging to an ethnic minority, under Article 27 of the ICCPR;

c. equality before the law and equal treatment before all organs administering justice, under Article 5(a) of the International Convention on the Elimination of all Forms of Racial Discrimination (ICERD);

d. security of person and protection by the State against violence or bodily harm, under Article 5(b) of the ICERD;

e. equality before the law and in the enjoyment of the social right to social services under Article 5(e)(iv) of the ICERD;

f. equality before the law and in the enjoyment of the cultural right to equal participation in cultural activities under Article 5(e)(vi) of the ICERD; and

g. equality before the law and in the enjoyment of the right of access~~s~~ to any service intended for use by the general public under Article 5(f) of the ICERD;

h. equality before the law; and, or alternatively

i. go about their affairs in peace under the protection of the police services, under the common law.

317. The QPS thereby breached section 9 of the RDA.

318. As a result of the breach of section 9 of the RDA, the Applicants and some or all of the Group Members:

a. experienced emotional distress and psychological harm;

b. felt humiliated and degraded;

c. were fearful for their safety and for the safety of their families; and

~~f.~~d. were caused to feel as though they were not entitled to the same legal protections as other Australians

L.4 Breach of rights: Sub-Group

~~149.~~319. In the circumstances pleaded in paragraphs 276 to 278, 298, and 303 to 306 above, the use by the QPS of the unlawful declaration of a state of emergency to bypass the due process of law and enter the properties of the Applicants and members of the Sub-Group ~~Members~~ with neither the permission of the owners nor a warrant from a judge, nullified or impaired the recognition, enjoyment or exercise, on an equal footing, by the Applicants and ~~Group Members~~the Sub-Group, of their rights to not be subjected to arbitrary and unlawful interference with their privacy, family and home within the meaning of Article 17 of the ICCPR.

~~150. The manner of the arrest of the arrested persons, to those persons and to other persons present during the arrests:~~

~~a. caused intense physical and/or mental suffering;~~

~~b. aroused feelings of fear, anguish and inferiority; and, or alternatively~~

~~c. otherwise caused them to be humiliated and debased.~~

~~151.~~320. ~~Accordingly, the manner of the arrest of the arrested persons~~ By reason of the matters pleaded under sub-headings K.4 and K.5 above, and in paragraph 322 below, the manner in which the Raids were conducted by the QPS nullified or impaired the recognition, enjoyment or exercise, on an equal footing, by the Applicants and the Sub-Group~~Members~~, of their rights to:

a. not be subjected to inhuman and degrading treatment or punishment within the meaning of Article 7 of the ICCPR;

b. security of person and protection by the State against violence or bodily harm within the meaning of Article 5(b) of the ICERD;

c. liberty and security of person under ICCPR Article 9;~~ and~~

d. go about their affairs in peace under the protection of the police services under the common law;

~~152. The unlawful entry into dwellings deprived the Applicants and Group Members of their rights to:~~

~~a.~~e. not be subjected to arbitrary or unlawful interference with their privacy, family, or home under ICCPR Art 17; and, or alternatively

~~b. go about their affairs in peace under the protection of the police services under the common law; and~~

f. enjoy their property under the common law.

321. By reason of the matters pleaded in paragraphs 313 and 319 to 320 above, the QPS officers who conducted the Raids breached section 9(1) of the RDA.

322. As a result of the breach of section 9(1) of the RDA pleaded in paragraph 321 above, the Applicants and the Sub-Group:

a. experienced intense physical and/or mental suffering;

b. experienced feelings of fear, anguish and inferiority; and, or alternatively

c. experienced emotional distress and psychological harm;

d. were made to feel humiliated and degraded;

e. were fearful for their safety and for the safety of their family; and, or alternatively

f. had their rights to enjoy their property interfered with.

Particulars

(i) Report by Stephen Ralph filed by the Applicants on 9 June 2015.

(ii) Particulars of the Sub-Group will be provided after the determination of the common issues in this proceeding.

~~153. The conduct of the QPS in Palm Island on 26 and 27 November 2004 and in the aftermath of those events was wholly unprecedented and would have been inconceivable almost anywhere else in the State of Queensland. The nature and extent of the unlawful declaration of a state of emergency indicated institutional and systemic issues which caused or contributed to the QPS's failure to comply with its own policies and its own action plan.~~

~~154. The Applicants and Group Members are distinguished from other communities predominantly because of their racial and ethnic origin as Indigenous Australians.~~

~~155. The conduct of the QPS, as pleaded in paragraphs 109 to 148 above, was based on the race of the Applicants and Group Members.~~

~~156. Based on the race of the Applicants and Group Members, the QPS members acted as though the Applicants and Group Members:~~

~~a. were not entitled to the same standards of treatment as other residents of Queensland; and~~

~~b. posed a stronger and more immediate threat to others than they in fact posed and therefore stronger action was warranted against them than was actually warranted,~~

~~thereby excluding the Applicants and Group Members, on the basis of race, from the standards of policing to which residents of Queensland are entitled.~~

L.5 Loss and damage: Group Members

~~157.~~323. In the circumstances pleaded under sub-headings L.1 and L.3 or, alternatively, L.2 and L.3 hereof, the Respondents ~~therefore~~ committed unlawful racial discrimination within the meaning of section 9 of the RDA.

~~158.~~324. As a result of this unlawful racial discrimination, the Applicants and Group Members~~, or sub-classes thereof:~~

a. experienced emotional distress and psychological harm;

b. were made to feel humiliated and degraded;

c. were fearful for their safety and for the safety of their family; and

d. were made to feel as though they were not entitled to the same legal protections as other Australians. ~~; and~~

~~were unable to enjoy property in which they had rights or title.~~

Particulars

(i) Report by Stephen Ralph filed by the Applicants on 9 June 2015.

(ii) Particulars of the Group Members will be provided after the determination of the common issues in this proceeding.

M ~~EVENTS DURING AND SUBSEQUENT TO 2006~~AGGRAVATED OR EXEMPLARY DAMAGES

~~i. Palm Island Review~~

M.1 Exemplary Damages

325. The breaches of section 9 of the RDA pleaded in paragraphs 254, 321, and 323 above, viewed individually or on aggregate, were so egregious as to entitle the Applicants to exemplary damages.

M.2 Aggravated Damages

326. Subsequent to November 2004, the Respondents engaged the following conduct which aggravated the loss and damaged suffered by the Applicants and the Group Members, and thereby entitles the Applicants to aggravated damages.

(a) *Inquest*

~~159.~~327. In September 2006, Acting State Coroner Christine Clements delivered the results of an inquest into the death of Mulrunji, finding that SS Hurley had caused the death of Mulrunji, and calling SS Hurley's treatment of Mulrunji "callous and deficient" and his arrest "completely unjustified".

~~160. On 14 December 2006, notwithstanding the Acting State Coroner's findings, the Director of Public Prosecutions for the First Respondent determined not to bring any charges against SS Hurley.~~

~~161.~~328. On 19 December 2006, in response to the Acting State Coroner's comments, the Commissioner of Police formed an Investigation Review Team (**IRT**) to examine in detail any criticisms of the QPS and its members arising from the Inquest and the Acting State Coroner's findings. The Commissioner also requested the CMC to review the internal investigation.

~~162.~~329. The IRT conducted a disciplinary investigation into the conduct of members of the QPS, pursuant to section 18 of the HRMM.

~~163. On 4 January 2007, in response to public outrage at the decision not to bring charges against SS Hurley and with reluctance, the First Respondent appointed former NSW Supreme Court Chief Justice Sir Laurence Street to review the decision.~~

~~164. On 25 January 2007, Sir Street overturned the decision not to prosecute SS Hurley, and SS Hurley was finally charged on 5 February 2007.~~

~~165. Following the overturning of the decision not to prosecute SS Hurley, rallies in support of SS Hurley were then organized by the representative body of the QPS – the Queensland Police Union of Employees, including (but not limited to):~~

~~c. a rally in Brisbane on 1 February 2007 attended (and endorsed) by Police Minister Judy Spence;~~

~~d. a rally at Namour on the Sunshine Coast on 5 February 2007; and~~

~~e. a rally in Gladstone on 9 February 2007.~~

~~166. These rallies were organised by QPS members with the support of the First Respondent.~~

~~167.~~330. In November 2008 the ~~QPS~~ IRT delivered the three-volume report of its internal investigation, entitled ***Palm Island Review***, to the CMC.

~~***Improper conduct of Palm Island Review***~~

~~168. In conducting its investigation, the IRT was obliged to comply with the provisions of the QPS Code of Conduct, Version 6, October 2006 (**2006 Code of Conduct**) and section 18 of the QPS Human Resource Management Manual.~~

~~169. The 2006 Code of Conduct required the IRT to maintain and foster public trust and confidence in the operations of the QPS.~~

~~170. Section 18 of the QPS Human Resource Management Manual provided that, the more serious the alleged conduct and its consequences, the greater the degree of thoroughness, care, attention to detail and accuracy required.~~

~~171. In the Palm Island Review, the IRT failed to comply with the 2006 Code of Conduct and s18 of the QPS Human Resource Management Manual through failing to hold the QPS members to account for their activities during the course of the events of November 2004, and instead attempting to justify their wrongdoing. Examples of these breaches included the that IRT:~~

~~justified the inclusion of DS Robinson in the investigation team in terms of logistics and the lack of other easily available options, even though the IRT recognised that it would have been a preferred course to exclude him from the investigation and acknowledged that DS Robinson had a conflict of interest;~~

~~sanctioned SS Hurley collecting, or being permitted to transport, the investigation team from the airport, and transporting the investigation team to the scene of the arrest — despite recognising that, in normal circumstances, investigators would have little or no contact with officers involved in incidents such as those leading to the death of Mulrunji until such time as they were ready to interview or record conversations, and that SS Hurley was clearly a person of interest at the time he collected the investigation team from the airport;~~

~~failed to hold the investigating officers accountable for having a meal and consuming alcohol at SS Hurley's residence on 19 November 2004, notwithstanding that he was a suspect in their investigation, and despite the IRT finding that the meal at SS Hurley's residence affected the perceived impartiality of the investigation;~~

~~was not duly critical of senior officers, despite observing that they could have given, but did not give, a direction to SS Hurley regarding preservation of the crime scene, separation of witnesses, and the intent of the relevant section of the OPM — and that doing so might have prevented SS Hurley, Sergeant Leafe and PLO Bengaroo having discussions about Mulrunji's death before the investigation team arrived on Palm Island;~~

~~noted that recording the "off the record" discussions which occurred between SS Hurley and the investigators about discrepancies in time would have lessened criticism about the lack of independence of the investigation, but failed to find that the discussions should have been recorded and failed to adequately consider OPM requirements to that effect;~~

~~found that, in his Form 1, DSS Kitching should have made mention of Roy Bramwell's allegation that he saw SS Hurley assault Mulrunji, but proceeded to inappropriately dismiss Mr Bramwell's evidence and to find that it was understandable that neither DI Webber nor Inspector Williams thought to check the Form 1 before it was submitted;~~

~~further failed to consider the omission of Ms Sibley's allegations from the Form 1, or to consider or comment upon DSS Kitching's failure to complete a Supplementary Form 1, or to refer to parts of the OPM that are inconsistent with DSS Kitching's actions and explanations, such as the obligation to complete a Supplementary Form 1 and the obligation to contact the pathologist as a matter of urgency with new information, before the autopsy is performed;~~

~~unduly excused the investigation team for failing to provide the appropriate support to Indigenous witnesses and, in so doing, failed to identify or refer to the obligations under the OPM in relation to interviewing Indigenous witnesses; and~~

~~failed to give appropriate weight to the requirements of the OPM that DI Webber immediately arrange for Mulrunji's next of kin to be notified, and supported DI Webber's decision to personally notify Mulrunji's family, even though this meant they could not be immediately notified.~~

(b) *Failure to discipline QPS officers*

~~172.~~331. Between 19 November 2004 and the time these proceedings were commenced:

a. no member of the QPS faced any disciplinary action over the events the subject of this claim;

b. no member of the QPS was charged with criminal proceedings in relation to ~~the events on Palm Island~~Mulrunji's death or the subsequent investigation, except for ~~in the case of~~ SS Hurley; and

c. DS Robinson was ~~promoted to Sergeant, and, in 2008, was~~ awarded the top police bravery medal, the Queensland Police Valour Award, for his actions ~~during the~~ on Palm Island ~~uprising~~on 26 to 29 2004; and

d. SS Hurley was promoted to Acting ~~Sergeant~~Inspector.

~~173.~~332. The First and Second Applicants and eighteen Group Members were charged with various offences almost immediately after 26 November 2004.

~~174.~~333. SS Hurley was not charged with an offence until 5 February 2007. ~~, and this occurred as a result of public pressure and despite reluctance on the part of the Respondents to charge him.~~ The Second Applicant had had the charges against her abandoned at that time, and all Group Members who faced charges had already either faced trial or had the charges against them abandoned by that time.

334. In about June 2010, the CMC handed down a report entitled "CMC Review of the Queensland Police Service's *Palm Island Review*", which recommended that the QPS commence disciplinary proceedings for misconduct, in relation to their conduct on Palm Island in November 2004, against each of:

a. DI Webber;

b. DSS Kitching;

c. DS Robinson; and

d. Inspector Williams.

335. The QPS did not commence disciplinary proceedings against any of those officers.

336. The QPS has not, at any time, commenced an investigation into, or implemented disciplinary proceedings in respect of, the actions of any of the QPS officers involved in the Further Failures. Rather, DS Robinson was awarded the top police bravery medal, the Queensland Police Valour Award, for his actions during that period, and a number of other QPS officers were recommended for commendation for their actions during that period.

Particulars

Document 351.

337. In about August 2011, pursuant to the IRT's recommendations, the QPS issued 'Managerial Guidance' to each of Inspector Williams, DI Webber, and DSS Kitching. The fact of those officers receiving managerial guidance was not made known to the public or to persons who had complained about the conduct of those officers in the course of the investigation of Mulrunji's death, because Senior Sergeant Michael Bond of the Legal and Policy Unit of the QPS Ethical Standards Command was of the view that such advice may be viewed as "somewhat antagonistic" given the notoriety of the relevant events.

Particulars

Documents 370 and 372.

~~Particulars of unlawful racial discrimination~~

175. Owing to the deficiencies in the investigation of 19 and 20 November 2004, the deficiency in the *Palm Island Review*, and the delay in bringing charges against SS Hurley, the effectiveness of SS Hurley's prosecution was compromised.

176. The deficiencies in the *Palm Island* Review, the failure to take any disciplinary action against QPS members, the reluctance to prosecute and the delay in prosecuting SS Hurley, the strong support for SS Hurley after the decision to prosecute had been made, the promotion of SS Hurley and DS Robinson, and the awarding of the Queensland Police Valour Award to DS Robinson – when compared with the speedy arresting and charging of the Applicants and Group Members – were acts based on the race of the Applicants and Group Members which indicated that, insofar as the Respondents were concerned:

a. the rights and protections which apply generally to residents of Queensland did not apply to the Applicants and Group Members;

b. QPS members could breach the rights of the Applicants and Group Members, generally with impunity; and

c. unlawful conduct towards the Applicants and Group Members did not prejudice an officer's entitlement to awards and promotion and may contribute to such an entitlement,

thereby excluding the Applicants and Group Members, on the basis of race, from the policing services to which residents of Queensland are entitled.

177. The Respondents accordingly, through acts involving a distinction, exclusion, restriction or preference based on the race of the Applicants and Group Members, nullified or impaired the recognition, enjoyment or exercise, on an equal footing, by the Applicants and Group Members, or sub-classes thereof, of their rights to:

d. equality before the law and equal treatment before all organs administering justice under Article 5(c) of the ICERD;

e. equality before the law and equal protection of the law, under Article 26 of the ICCPR; and

f. not be subjected to inhuman and degrading treatment or punishment within the meaning of Article 7 of the ICCPR;

g. security of person and protection by the State against violence or bodily harm within the meaning of Article 5(b) of the ICERD; and

h. go about their affairs in peace under the protection of the police services, under the common law.

178. The Applicants and Group Members were distinguished from the majority of residents of Queensland because of their race.

179. The Respondents committed unlawful racial discrimination within the meaning of s 9 of the RDA.

180. As a result of this unlawful racial discrimination, the Applicants and Group Members:

i. experienced emotional distress and psychological harm;

j. were made to feel humiliated and degraded;

k. were fearful for their safety and for the safety of their family; and

l. were made to feel as though they were not entitled to the same legal protections as other Australians.

N VICARIOUS LIABILITY OF RESPONDENTS

~~181.~~338. Under section 18A of the RDA, a person is liable for acts which are unlawful under section 9 if those acts are performed by an employee or agent of a person in connection with his or her duties as an employee or agent; and the person did not take all reasonable steps to prevent the employee or agent from performing the acts.

~~182.~~339. Conduct performed in connection with employment duties can include criminal wrongdoing, conduct which is prohibited by rules regulating the conduct of employees, and conduct in the "private time" of employees.

~~183.~~340. Police officers, police recruits and special constables were employed pursuant to s 2.5A of the *Police Service Administration Act 1990* (Qld).

~~184.~~341. The employment of QPS members was taken to be by the Crown as employer.

Particulars

Police Service Administration Act 1990, ss 5.4(2)(b), 5.7(3)(b), 5.11(1)(b), 5.15(1)(b)

~~185.~~342. All ~~relevant~~ conduct by QPS members pleaded herein ~~from 19 November 2004 to 25 March 2010~~ was connected to employment duties. Further, those acts were performed by QPS members as employees or agents of the First Respondent and, or in the alternative, of the Second Respondent.

~~186.~~343. Neither the First Respondent nor the Second Respondent did ~~took~~ not take any steps to prevent its employees from performing any ~~the unlawful~~acts outlined above.

~~187.~~344. Further, or in the alternative, if any of the unlawful acts were initially committed outside of the scope of the relevant QPS member's employment duties, the Respondents subsequently affirmed those acts through:

a. conducting the Palm Island Review in a problematic and deficient fashion;

b. failing to take any disciplinary action against the QPS members;

c. promoting DS Robinson and SS Hurley; and

d. awarding DS Robinson a medal for his "bravery" during the course of the events on Palm Island in November 2004.

~~188.~~345. The Respondents are therefore vicariously liable for the acts the subject of this claim.

O AHRC Complaint

~~189.~~346. By letter dated 25 March 2010, the Applicants lodged a written complaint with the Australian Human Rights Commission (**AHRC**), pursuant to s 46P of the *Australian Human Rights Commission Act 1986* (Cth), on behalf of themselves and the Group Members. In the complaint, the Applicants alleged that the State of Queensland had unlawfully discriminated against them in contravention of s 9 of the *Racial Discrimination Act 1975* (Cth), and identified four heads of discrimination.

~~190.~~347. On 16 February 2012, the AHRC held a conciliation conference attended by representatives of the Applicants and the State of Queensland in Townsville. The complaint was not resolved at that conference or afterwards.

~~191.~~348. On 20 April 2012, the Applicants advised the AHRC by letter that they were no longer relying on the third head of discrimination.

349. On 13 June 2013, a delegate of the President of the AHRC, by letter to the Applicants' legal representatives, granted leave for the complaint to be amended to remove the third head of discrimination. The delegate also notified the Applicants in that letter of her decision to terminate the complaint under s 46PH(1)(i) of the *Australian Human Rights Commission Act 1986* (Cth) on the ground that she was satisfied that there was no reasonable prospect of the matter being settled by conciliation.

Date: 24/8/15

Signed by Stewart Alan Levitt
Solicitor for the Applicants

P Certificate of lawyer

I, Stewart Alan Levitt, certify to the Court that, in relation to the third further amended statement of claim filed on behalf of the Applicants, the factual and legal material available to me at present provides a proper basis for each allegation in the pleading.

Date: 24.8.15

Signed by Stewart Alan Levitt
Solicitor for the Applicants

The Second Further Amended Statement of Claim was prepared by Daniel Meyerowitz-Katz of Levitt Robinson and settled by Stewart Alan Levitt of Levitt Robinson and Dr Juliet Lucy of Counsel.

This Third Further Amended Statement of Claim was prepared by Daniel Meyerowitz-Katz of Levitt Robinson and settled by Stewart Alan Levitt of Levitt Robinson, Shaneen Pointing of Counsel, and the Honourable Ronald Merkel of Queen's Counsel.

Q ANNEXURE 'A'

1.1.2 This Royal Commission was established in October 1987 in response to a growing public concern that deaths in custody of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them.

1.1.3 Public agitation for a Royal Commission was led by members of the Aboriginal community. It is a revealing commentary on the life experience of Aboriginal people in 1987 and of their history that it would have been assumed by so many Aboriginal people that many, if not most, of the deaths would have been murder committed if not on behalf of the State at least by officers of the State. But disquiet and disbelief in official explanations was not only expressed by Aboriginal people; many non-Aboriginal people Shared the assumption that police and prison officer misconduct would be disclosed by a Royal Commission. Thus many non-Aboriginal people, whilst not sharing the life of Aboriginal people, had seen and heard sufficient evidence of the mistreatment of Aboriginal people to share their expectation that Aboriginal people would suffer and die from the same discrimination and brutality as they experienced during life.

1.2.4 Deaths in custody are particularly distressing for families and friends, and engender suspicion and doubt in their minds and also in the minds of members of the public. The deceased person has been in the custody and care of the State, not accessible in the general sense, his or her life controlled and ordered by functionaries of the State, out of sight and of normal contact. Deaths in such circumstances breeds anguish and suspicion equally. Time may heal some of the anguish, but the suspicion can be allayed only by the most open and thorough going laying of the facts on the table.

1.2.5 It is not surprising that there was much cynicism about official explanations for the deaths. It is quite clear that this Royal Commission would not have been necessary or at least its Terms of Reference would have been very different--had there been adequate, objective and independent investigations conducted into each of the deaths after they occurred and had those investigations examined not only the cause of death--in the medical sense--and whether there had been foul play but also questions of custodial care and the issue of responsibility in the wider sense.

1.2.7 I deal with these questions in Chapter 4 but it is plain that much harm was done to relations between Aboriginal people and the broader community, and great hardship was imposed on the relatives of the deceased persons as a result of the inadequacies of most post-death investigations. It must never again be the case that a death in custody, of Aboriginal or non-Aboriginal persons, will not lead to rigourous and accountable investigations and a comprehensive coronial inquiry.

1.4.15 But there was one aspect of the relations between Aboriginal people and non-Aboriginal people which was very important for all the others and where the relationship was at its worst; that is, the relations between Aboriginal people and the police forces of the dominant society.

1.4.16 Police officers naturally shared all the characteristics of the society from which they were recruited, including the idea of racial superiority in relation to Aboriginal people and the idea of white superiority in general; and being members of a highly disciplined centralist organisation their ideas may have been more fixed than most; but above and

beyond that was the fact that police executed on the ground the policies of government and this brought them into continuous and hostile conflict with Aboriginal people. The policeman was the right hand man of the authorities, the enforcer of the policies of control and supervision, often the taker of the children, the rounder up of those accused of violating the rights of the settlers. Much police work was done on the fringes of non-Aboriginal settlement where the traditions of violence and rough practices were strongest.

1.4.17 I do not add to this here since the matter is discussed in the history chapter (Chapter 10) of the Report. It is sufficient to say that a deep animosity and often hatred developed between Aboriginal people and police.

1.5.1 I mention three matters which seem important in a practical way and which arise from that history.

1.5.2 Firstly, Aboriginal people remember this history and it is burned into their consciousness.

3.1.2 As has been said earlier, there was a widely held suspicion amongst Aboriginal people, and others, that at the very least a number of the deaths were caused by foul play in the sense of the deliberate infliction of harm by custodians. This has turned out not to be the case. But it needs to be understood that this perception was not at all unreasonable for at least three quite separate reasons: firstly, custody by its nature being away from the public gaze and out of the range of family and friends, the circumstances are such as to easily lead to suspicion and doubt; secondly, the deep distrust grounded in history that Aboriginal people have for police and prison systems; and thirdly, the post-death investigations and the treatment of families were in not a few cases such as to raise suspicion rather than allay it. I refer later to some cases where it can be said that what happened after the death, so far from allaying the concerns of grieving relatives, was likely to increase them.

3.1.9 In virtually every case the family was legally represented at the hearing. In the final analysis, as a result of rigourous inquiry and the free flow of information, there were very few cases where foul play was alleged at the conclusion of the inquiry. I hasten to add that in many cases a lack of care on the part of custodians was alleged (and in many such cases found to have occurred), but the pre-existing suspicion of a large number of deaths brought about by deliberate violence on the part of custodians was largely dispelled. I cannot sufficiently stress the need when a death occurs in custody for full, open and searching inquiry in which the families feel that they are given all the available facts and given the power to participate in a meaningful way.

3.3.1 It has to be said immediately that the inquiries into the deaths disclosed glaring deficiencies in the standard of care afforded many of the deceased during at least portions of their period of incarceration. This applies, broadly speaking, to all types of custody, but more so in relation to custody in police cells where, generally, the standard of accommodation is much lower and the officers are less experienced and trained in the task of acting as custodians. This is, of course, not unnatural since in the case of police officers watch-house duties are a small part of their duties and not highly regarded, whilst in the case of prison officers custodial duties are their whole occupation. But, of course, it cannot be excused. I will deal with prison care (and juvenile detention care) separately from police custody care.

3.4.1 I said at the very beginning of this chapter that in some cases actions taken immediately following the death were such as to increase rather than allay suspicions which Aboriginal families would almost instinctively have following a death in custody.

3.4.7 A feature which occurred in many cases and which can only cause concern and worry to families is that in many cases the inquiry into the death was conducted by local police officers, some of whom had some association with the particular custodial incident and all of whom worked closely with the officers involved with the detention and officers who had brought the deceased to the station and were on duty in the station at the relevant time. Additionally, it will be seen from the next chapter that the coronial inquiries in many cases were quite perfunctory. All these matters, and many others particular to individual cases, were calculated to inspire concern rather than allay suspicion in the minds of the families of those who died.

CHAPTER 4 THE ADEQUACY OF PREVIOUS INVESTIGATIONS

The tragedy of a death in custody is experienced most deeply by the family of the deceased. it occurs out of sight within a structure of confinement under the control of police or prison officers. Death occurs in circumstances where the deceased is totally dependent on his or her custodians for proper care and adequate medical attention. The anguish and anger of the relatives, their fear and suspicion as to what may have happened inside a police or prison cell, demands an assurance that the circumstances of death will be thoroughly and fairly investigated.

This need for assurance is not limited to the family of the deceased. A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of their duties. Justice requires that both the individual interests of the deceased's family and general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody. Where such deaths involve a distinct group, such as Aboriginal people, who may be the target of racial discrimination these requirements become imperative.

In this chapter, I examine various aspects of the investigative process following a death in custody, including police investigations, post-mortem examinations and the formal coronial inquiry. I conclude that the police should retain the authority to investigate all deaths in custody, subject to significant recommendations concerning the framework in which such investigations are conducted.

4.1.1 I respectfully endorse without qualification the words of Commissioner Muirhead in the Interim Report of the Royal Commission issued in December 1988 regarding the investigation of a death in custody:

> The situation demands the most thorough investigation of facts and circumstances by skilled investigators who hopefully may be regarded as impartial, autopsies performed by expert forensic pathologists followed by thorough coronial enquiries conducted by legally trained Coroners under modern legislation which enables such Coroners to make remedial recommendations. In all of these processes there must be sensitivity to the situation of the families of the deceased.
>
> If this degree of thoroughness, the implementation of such expertise, had been current in Australia over past years, it is arguable that the necessity

for establishment of this Royal Commission would not have arisen. It is for this reason, which appears to be widely misunderstood, that the Terms of Reference require investigation into enquiries made subsequent to death.

4.2 POLICE INVESTIGATIONS

4.2.8 An inquiry into the immediate cause of death does not constitute a thorough investigation of the circumstances of death. Investigations should extend beyond consideration of whether death occurred as a result of criminal behaviour. The general care, treatment and supervision of the deceased prior to death should be inquired into with particular attention to whether custodial officers observed all relevant departmental policies and instructions relating to the duty of care owed to the deceased while in custody. Any comprehensive investigation of the events leading to death should also consider the circumstances under which the deceased was taken into custody and the legality of his/her detention.

4.2.9 Foul play or the intentional causing of, or contributing to, a death in custody is the first matter which should be considered by investigators. However, there are lesser ways-which do not give rise to criminal responsibility--in which police or prison officers may be responsible for a death in custody. They may fail to take reasonable steps to prevent harm to a person in their care. If the harm, whether from self-injury, injury inflicted by others, or illness, is reasonably foreseeable then custodial authorities and/or individual officers may be in breach of the duty of care owed to all persons in custody. Such a breach may provide grounds for civil action by the family of the deceased--it is not a matter for the criminal law but it is certainly a matter which should be investigated in any inquiry into the circumstances of death.

4.2.10 Police investigations which are confined to the search for criminal misconduct are, by their nature, inadequate to detect those factors which were frequently found to contribute to the deaths inquired into by Commissioners. As a matter of frequency, the deliberate infliction of harm was a negligible factor when compared with the many cases in which a lack of care by custodians was found to have contributed to death. Chapter 3 reviews the Commissioners' findings as to the deaths.

4.2.11 The broadening of the focus of investigations to encompass the care, treatment and supervision of the deceased not only increases the likelihood of accurately identifying the operative factors contributing to a death in custody, it also offers the further prospect of these factors being addressed and rectified. The lack of adequate care for the deceased frequently reflected a failure in police or prison systems and procedures rather than personal failures by individual officers. Few of the police investigations directly addressed these issues or pursued them in a manner designed to present adequate material on which a coroner could make findings or recommendations to remedy such systemic failures. If the subsequent recommendations in this chapter which concern the powers of coroners to propose remedial action are to be effective, then police investigations must be broad enough to present the coroner with a proper evidentiary basis on which to make such findings and recommendations.

4.2.15 The expansion of the scope of police investigations must go hand in hand with an increased attention to the detail and the quality of investigative technique. There has, in fact, been a marked improvement in the standard of more recent police inquiries. In order to rectify the desultory approach demonstrated in many earlier investigations, some defined procedures have been introduced. In particular, police services now approach

investigations into deaths in custody on the basis that the death is a potential homicide. This reflects a recognition of certain general requirements: the approach of investigators must not be shaped by a presumption of suicide, police officers assigned to such inquiries must be highly qualified and experienced investigators, they should apply a rigorous standard of investigative procedure throughout the conduct of their inquiries.

4.2.16 The inadequacies and omissions of police investigations have led to situations where the coroner has had insufficient evidence upon which to base sound conclusions. Investigations into all deaths in custody should be structured to provide a thorough evidentiary base for consideration by the coroner on inquest into the circumstances of death. In particular it is necessary that:

- the scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography;
- all records, including medical records, relevant to the detention, care, treatment or supervision of the deceased should be obtained (or copied) by investigating officers;
- all witnesses should be separately and formally interviewed. It is desirable that interviews with custodians who were on duty during the time of last detention of the person who died should be tape recorded and that transcripts of all interviews be made;
- relevant witnesses should be interviewed, not only in relation to the immediate circumstances of death, but also in relation to the circumstances of detention and the general care, treatment and supervision of the deceased prior to death. Where suicide is a possible cause of death, the inquiry should be extended to the deceased's family and other witnesses in an endeavour to ascertain suicidal tendencies, suggestions of suicide and/or motive for suicide;
- where death occurs in a police cell, prison or juvenile institution, statements should be taken as soon as possible from all prisoners or persons who were detained or located at or near the scene of death, and all records which might assist in determining the identification and location of prisoners and/or detainees held in the institution should be seized and/or copied; and
- running sheets and full records of police investigations should be made and retained.

4.2.17 The acknowledgement of the serious nature of a death in custody and the recognition of the need to assign highly experienced officers to conduct such inquiries will, no doubt, result in an enhanced quality of police investigations. Nonetheless, it is appropriate that Police Standing Orders or Instructions should give explicit directions for the conduct of all investigations into deaths in custody. Recommendations in relation to the appropriate structure and conduct of such investigations appear at the end of this chapter.

4.2.20 Even if appropriate investigative procedures are followed by police officers who are personally involved in the arrest, detention or custody of a person who subsequently dies in custody, the credibility and quality of such an investigation is substantially eroded by their intimate involvement with the matters which are the subject of inquiry.

4.2.21 The mandatory appointment of police officers from an Internal Affairs Unit or from a police command area other than that in which the death occurred, would go some way to ensuring that investigating officers are as independent as possible. Further, selection of the officer in charge of the investigation should be made at the highest level. The practice in the Northern Territory is for either the commissioner of police or his deputy to personally determine the appointment of the senior officer in charge of an investigation into a death in custody. In my opinion, this critical decision should not be made by an officer below the rank of Assistant Commissioner.

4.2.22 Nonetheless, the broad decision still remains as to whether Police Services are, in fact, the most appropriate agencies to conduct investigations following a death in custody, particularly police custody. Given the deep distrust, grounded in history, which Aboriginal people feel towards the police (as discussed in Chapter 13) this question is particularly acute in the context of Aboriginal deaths in custody. It is a question of establishing and maintaining a system which will evoke trust. It is not only a question of justice but of justice being seen to be done.

4.2.30 If the expertise and resources available through the use of police investigators are to be utilised, then they must be harnessed to some external direction and supervision. In my opinion, immediately upon notification of a death in custody, a coroner should be appointed with overall responsibility for the conduct of all inquiries into the death. …

4.5.55 As Commissioner Wootten has expressed it, an inquest must be held when a death in custody occurs 'so there can be no opportunity for suspicion to arise about its circumstances. An investigation of a death in custody by police and other government officers does not preclude suspicion'.

4.6.1 Major problems observed in police investigations and inquests into deaths in custody concern the lack of sensitivity with which relatives of the deceased and Aboriginal communities were treated. The historical background of Aboriginal-police relations has resulted in custodial deaths being regarded with a high degree of suspicion by Aboriginal people, even in cases which are ultimately found to be straightforward deaths by natural causes. This is indicative of the suspicion with which Aboriginal people often regard police and prison officers. It demonstrates the need for openness and frankness when dealing with the family of the deceased at all stages of the coronial inquiry.

4.6.2 The experience of the Commission has shown that the anguish of relatives and their fears and suspicions have not been appreciated by persons involved in post-death investigations, and the family of the deceased have often been dealt with in a way which heightens their worst suspicions. It is natural for friends, relatives and community members to be apprehensive as to the circumstances of death when a person enters custody apparently alive and well and leaves dead. In many instances, custodial authorities have been secretive and defensive about a death in custody, rather than recognising the fact that relatives and the public have a right to know what happened. The family of the deceased are often regarded as trouble makers who do not deserve to be dealt with frankly. In many instances there has been little recognition that the family and the public have the right to expect a full, open and impartial inquiry with the greatest possible access to all relevant information.

4.6.4 There is a need for openness, frankness and sensitivity to the feelings of the relatives and friends of the deceased from the point of notification of death throughout the vari-

ous stages of investigation. It should include the family of the deceased's full involvement in the inquest, if this is what the family wishes.

4.7.1 The expressed direction in the Letters Patent to inquire into 'subsequent action taken in respect of each death in custody' and the particular identification of 'coronial police and other inquiries' as a proper subject for investigation by the Commission draws attention to the extremely significant role of post-death investigations. It must be acknowledged as a blunt reality that, despite all endeavours to lessen the risks, there will be future Aboriginal deaths in custody. The adequacy of coronial investigations is critical if the tragic aftermath of such deaths is not to perpetuate the feeling of anxiety and suspicion in the minds of the deceased's family and the Aboriginal community, which to a substantial degree gave rise to the need for this Commission's work. The inadequacies of post-death investigations throughout Australia must be addressed as a matter of urgency.

4.7.2 As I have observed, the very inclusion of this field of inquiry in the Commission's Terms of Reference reflects an understanding of its importance. The principles which underly its importance are by no means novel. As Commissioner Wyvill noted in his report into the death of John Pilot, the justification for a thorough and impartial inquiry was stated, well before the inception of this Commission, in a standard text book 'Coronial Law and Practice in New South Wales

> It is very desirable that no suspicion should arise in the public mind that deaths in Government Institutions such as gaols are made the subject merely of investigations by Government Officers, and that therefore, when deaths occur, it is not likely that everything which reflects on the management of the institution will be allowed to come into the public view. The public should be satisfied that the prisoner or confinee came to his death by the common course of nature, and not by some unlawful violence or unreasonable hardship put on him by those under whose power he was while confined. There should not be given an opportunity for asserting that matters with regards to deaths in public institutions are 'hushed up' .

NOTIFICATION OF DEATH

4.6.5 The initial notification of a death to the family of the deceased requires skill and sensitivity. It is a crucial time for the relatives who will naturally feel shock and great anguish. They will also be intensely concerned to know the circumstances of death. All too often, the task of notification of death is carried out by police officers who have little knowledge about the circumstances of death and, understandably, regard such notifications as one of their most unpleasant duties. The inability to communicate openly with the family of the deceased may be misunderstood for an attempt to conceal the truth.

4.6.14 In consideration of the above, I recommend that immediate notification of a death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of an emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known. The appropriate Aboriginal Legal Service should also be notified immediately of any Aboriginal death in custody.

Autopsies

4.4.1 In all deaths inquired into by Commissioners an autopsy was conducted on the body of the deceased. Professor Stephen Cordner, Director of the Victorian Institute of Forensic Pathology, is an eminent practitioner in his field and one of the specialist forensic pathologists who reviewed the findings of many of the post-mortem examinations for Commissioners. In his view, the fundamental purpose of an autopsy is to discover and describe all the pathological processes, including injuries, found on examination of the deceased. The object of the examination is to enable the pathologist to accurately determine the cause of death, the identification of pathology contributing to death, and to correlate these to clinical observations made in life. An additional and significant purpose is to contribute to the reconstruction of the events leading to death consistent with findings made on autopsy.

4.4.3 The findings on post-mortem examination and the conclusions drawn from those findings are critically important in every death in custody. The examination of the deceased's body by a pathologist provides important information as to the immediate cause of death. It may also yield some objective basis to test the evidence of witnesses concerning the broader circumstances leading to death.

13.4THE LEGACY: FEATURES OF THE RELATIONSHIP

13.4.1 Aboriginal people in their many submissions and in consultations conducted during this inquiry have most frequently identified their relations with police officers as the most serious and constant indicator of the injustice and prejudice which they experience in society. The circumstances which gave rise to this Commission illustrate starkly the extent to which Aboriginal people regard police as enemies. When a series of Aboriginal hangings occurred in police cells, there were large numbers of Aboriginal people who could and did readily draw the conclusion that police were simply killing Aboriginal people. Hostility to police is widely shared among Aboriginal people of all ages and in most communities throughout Australia, whether people are living on remote outstations, in rural towns and fringe camps, or in major cities.

13.5.20 Senior Sergeant Trevor Adcock of the Queensland Police, in a paper for the Royal Commission in Queensland, pointed out that Aboriginal communities or Trust Areas have been for many years 'a secondary consideration, approached generally in a reactionary fashion rather than in a needs-based fashion'. 37 Sergeant Adcock further pointed out that policing has been carried out with an apparent ignorance or lack of concern (or both) for the huge social problems 'created' on the communities. Many of these communities are artificially created and located in extremely harsh environments.

29.1THE IMPORTANCE OF IMPROVING RELATIONSHIPS

29.1.1 Generally speaking Aboriginal people accept the need for police, and do not want their communities to be without their services. What they typically complain of is that police are not 'accountable', and that they themselves are 'powerless' in the face of police. The power they. want over police is not physical power, but effective legal power--the power to make police themselves accountable for their actions in the community. A formal right of complaint to a senior police officer or a distant bureaucracy is seen as of little comfort. What they want is a real say at the local level in how their community is policed…

29.5.25 Senior police should seek frank discussions with Aboriginal communities to ascertain whether there are concerns about mistreatment, and should not refuse such discussions because no formal complaints are lodged or details given of particular incidents. While such complaints are necessary for disciplinary action, there are other ways in which an officer in charge may respond to general expressions of concern which appear sincere, for example by stressing to his officers the importance which he attaches to the matter, and ensuring appropriate supervision.

29.5.26 In my opinion it is essential that the investigative and hearing processes be seen to be both impartial and thorough….

29.8 CONCLUSION: THE BASIS FOR CHANGE

29.8.1 The basis for change must be the realisation that Aboriginal relations with police reflect general relations in the community. At the level of Aboriginal-police relations these relations have been unequal. However, the information available to the Commission indicates that there is beginning to be some improvement. The essential elements for building on these improvements are that there is a recognition of the common interest in improving relations between Aboriginal people and police. There must also be mutual respect, co-operation and the understanding that policing needs should not be dictated to the community. An environment of mutual trust will create the preconditions for solutions to wider problems.

Resuscitation

3.3.63 ... As with police custody, there were questions of the extent to which resuscitation was performed, and, in some cases, the actions of officers and the attitudes following death were criticised.

Resuscitation Training

24.5.3 In very few of the cases investigated was any attempt made by custodial staff to resuscitate the deceased person upon their discovery. Indeed, in only twenty-three cases was resuscitation actually attempted, and some of these involved attempts by fellow prisoners alone. I would record, however, that in at least three cases in which resuscitation was attempted (Jambajimba, Michael Gollan and John Highfold), Commissioners commended the valiant attempts made.

24.5.4 Expert evidence given during the Commission's hearings indicates that, in order for competence in resuscitation techniques to be maintained, regular training is required, with additional specialist training in the use of mechanical resuscitation aids. Indeed, one expert has recommended that, in order to ensure proficiency in Cardio Pulmonary Resuscitation (CPR), refresher training should be conducted at least annually, and where mechanical aids are to be used, at six monthly intervals.96 Currently, first aid and resuscitation training is provided to all police and corrections officers throughout Australia during their respective recruit-training programs. In many instances, the attainment of a Senior First Aid Certificate is required as a pre-requisite to the successful completion of the recruit-training course. The availability of refresher courses in such techniques varies, however, from one jurisdiction to another.

Resuscitation Aids

24.5.8 Access to appropriate resuscitation aids is equally important. In the Craig Karpany report, I commented that no officer should be expected 'to perform mouth to mouth resuscitation without access to resuscitation aids which would substantially minimise or remove the risk of infection. In addition, officers must be trained properly in the use of such aids. In recent years, police lockups and prisons across Australia have been supplied with prophylactic aids such as masks and air viva resuscitators. There is some disagreement between experts as to the efficiency of the various resuscitation aids which are currently available. In my view, it would be inappropriate for the Commission to make any recommendations as to the type of equipment which should be made available. This is an area which could be easily resolved through discussions with the relevant authorities. I mention, however, that in South Australia and Western Australia, police departments have distributed the 'Laerdal' pocket mask. These masks are made of disposable plastic and are reasonably small in size. The mask fits over the patient's nose and mouth and has a hole in the top, into which the rescuer blows air. The benefits of the mask are that it is relatively inexpensive (approximately $15-$20 per unit), is easy to use and can be adapted to more complex equipment such as breathing bag or flow of oxygen.

EMERGENCY RESPONSE TRAINING, INCLUDING RESUSCITATION

3.3.81 An important matter raised in the cases of both prison and police deaths was the deficiencies in the training of police and corrections officers to respond in medical emergencies. In many cases, officers had no, or inadequate, skills in resuscitation techniques (both expired air and cardio pulmonary resuscitation) or had no access to, or training in the use of, resuscitation aids such as prophylactic masks or automatic resuscitation equipment. Thus, it was revealed that in only 16% of cases in police custody was resuscitation actually attempted, whilst the figure for attempts in prison custody was 33%. 4 Additionally, deficiencies were noted in emergency response procedures generally resulting in delays in the provision of medical assistance once it was determined that such was necessary.

INSTITUTIONAL RACISM

12.1.30 I put it more generally. An institution, having significant dealings with Aboriginal people, which has rules, practices, habits which systematically discriminate against or in some way disadvantage Aboriginal people, is clearly engaging in institutional discrimination or racism. Generally speaking, if an institution which has significant dealings with Aboriginal people does not train its officers in such a way as to permit them to give the same level of service to Aboriginal people as it does to others, it is discriminatory against its Aboriginal clients. Medical and pain medical staff are good examples. Aboriginal patients have certain health problems which are not widely shared in the community; they present with some conditions in unusual numbers; many of them live in conditions in which non-Aboriginal people do not live. A doctor who has grown up in the broad society, been trained in Western medicine in a university influenced by Western culture is less able, without some special training, to provide a service to an Aboriginal person than to a non-Aboriginal person; this represents a discrimination. A health service that sends doctors to areas with an Aboriginal population without appropriate training is discriminating in an institutional way. The Australian Medical As-

sociation's submission to the Commission (see Chapter 31) makes the point that 'appropriate orientation courses should be considered for medical practitioners ... who are to serve in' Aboriginal communities.

12.1.31 But what is true of doctors is true of other service providers. It is essential that service providers in areas of Aboriginal population should receive training that generally informs them of the traditions and culture of contemporary Aboriginal society, particularly in the area of service, and the history of relations between Aboriginal and non-Aboriginal people in that area.

15. That within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person. (1:172)

19. That immediate notification of death of an Aboriginal person be given to the family of the deceased and, if others were nominated by the deceased as persons to be contacted in the event of emergency, to such persons so nominated. Notification should be the responsibility of the custodial institution in which the death occurred; notification, wherever possible, should be made in person, preferably by an Aboriginal person known to those being so notified. At all times notification should be given in a sensitive manner respecting the culture and interests of the persons being notified and the entitlement of such persons to full and frank reporting of such circumstances of the death as are known. (1:174)

20. That the appropriate Aboriginal Legal Service be notified immediately of any Aboriginal death in custody. (1:174)

32. That the selection of the officer in charge of the police investigation into a death in custody be made by an officer of Chief Commissioner, Deputy Commissioner or Assistant Commissioner rank. (1:177)

33. That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death. (1: 177)

34. That police investigations be conducted by officers who are highly qualified as investigators, for instance, by experience in the Criminal Investigation Branch. Such officers should be responsible to one, identified, senior officer. (1:178)

35. That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, *inter alia,* that:

    a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;

    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;

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; and

e. The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography. (1:178)

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, treatment and supervision of the deceased prior to death. (1: 179)

60. That Police Services take all possible steps to eliminate:

a. Violent or rough treatment or verbal abuse of Aboriginal persons including women and young people, by police officers; and

b. The use of racist or offensive language, or the use of racist or derogatory comments in log books and other documents, by police officers. When such conduct is found to have occurred, it should be treated as a serious breach of discipline. (2:223)

61. That all Police Services review their use of para-military forces such as the New South Wales SWOS and TRG units to ensure that there is no avoidable use of such units in circumstances affecting Aboriginal communities. (2:223)

86. That:

a. The use of offensive language in circumstances of interventions initiated by police should not normally be occasion for arrest or charge; and

b. Police Services should examine and monitor the use of offensive language charges. (3:29)

87. That:

a. All Police Services should adopt and apply the principle of arrest being the sanction of last resort in dealing with offenders;

b. Police administrators should train and instruct police officers accordingly and should closely check that this principle is carried out in practice;

c. Administrators of Police Services should take a more active role in ensuring police compliance with directives, guidelines and rules aimed at reducing unnecessary custodies and should review practices and procedures relevant to the use of arrest or process by summons and in particular should take account of the following matters:

i. all possible steps should be taken to ensure that allowances paid to police officers do not operate as an incentive to increase the number of arrests;

ii. a statistical data base should be established for monitoring the use of summons and arrest procedures on a Statewide basis noting the utilisation of such procedures, in particular divisions and stations;

iii. the role of supervisors should be examined and, where necessary, strengthened to provide for the overseeing of the appropriateness of arrest practices by police officers;

iv. efficiency and promotion criteria should be reviewed to ensure that advantage does not accrue to individuals or to police stations as a result of the frequency of making charges or arrests; and

v. procedures should be reviewed to ensure that work processes (particularly relating to paper work) are not encouraging arrest rather than the adoption of other options such as proceeding by summons or caution; and

d. Governments, in conjunction with Police Services, should consider the question of whether procedures for formal caution should be established in respect of certain types of offences rather than proceeding by way of prosecution. (3:42)

88. That Police Services in their ongoing review of the allocation of resources should closely examine, in collaboration with Aboriginal organisations, whether there is a sufficient emphasis on community policing. In the course of that process of review, they should, in negotiation with appropriate Aboriginal organisations and people, consider whether:

a. There is over-policing or inappropriate policing of Aboriginal people in any city or regional centre or country town;

b. The policing provided to more remote communities is adequate and appropriate to meet the needs of those communities and, in particular, to meet the needs of women in those communities; and

c. There is sufficient emphasis on crime prevention and liaison work and training directed to such work. (3:43)

92. That governments which have not already done so should legislate to enforce the principle that imprisonment should be utilised only as a sanction of last resort. (3:64)

123. That Police and Corrective Services establish clear policies in relation to breaches of departmental instructions. 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. (3:193)

124. That Police and Corrective 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. (3: 194)

125. That in all jurisdictions a screening form be introduced as a routine element in the reception of persons into police custody. The effectiveness of such forms and of procedures adopted with respect to the completion of such should be evaluated in the light of the experience of the use of such forms in other jurisdictions. (3:241)

126. That in every case of a person being taken into custody, and immediately before that person is placed in a cell, a screening form should be completed and a risk assessment made by a police officer or such other person, not being a police officer, who is trained and designated as the person responsible for the completion of such forms and the assessment of prisoners. The assessment of a detainee and other procedures relating to the completion of the screening form should be completed with care and thoroughness. (3:241)

127. That Police Services should move immediately in negotiation with Aboriginal Health Services and government health and medical agencies to examine the delivery of medical services to persons in police custody. Such examination should include, but not be limited to, the following:

a. The introduction of a regular medical or nursing presence in all principal watch-houses in capital cities and in such other major centres as have substantial numbers detained;

b. In other locations, the establishment of arrangements to have medical practitioners or trained nurses readily available to attend police watch-houses for the purpose of identifying those prisoners who are at risk through illness, injury or serf-harm at the time of reception;

c. The involvement of Aboriginal Health Services in the provision of health and medical advice, assistance and care with respect to Aboriginal detainees and the funding arrangements necessary for them to facilitate their greater involvement;

d. The establishment of locally based protocols between police, medical and paramedical agencies to facilitate the provision of medical assistance to all persons in police custody where the need arises;

e. The establishment of proper systems of liaison between Aboriginal Health Services and police so as to ensure the transfer of information relevant to the health, medical needs and risk status of Aboriginal persons taken into police custody; and

f. The development of protocols for the care and management of Aboriginal prisoners at risk, with attention to be given to the specific action to be taken by officers with respect to the management of:

i. intoxicated persons;

ii. persons who are known to suffer from illnesses such as epilepsy, diabetes or heart disease or other serious medical conditions;

iii. persons who make any attempt to harm themselves or who exhibit a tendency to violent, irrational or potentially self-injurious behaviour,

iv. persons with an impaired state of consciousness;

v. angry, aggressive or otherwise disturbed persons;

vi. persons suffering from mental illness;

vii. other serious medical conditions;

viii. persons in possession of, or requiring access to,medication; and

ix. such other persons or situations as agreed. (3:242)

131. That where police officers in charge of prisoners acquire information relating to the medical condition of a prisoner, either because they observe that condition or because the information is voluntarily disclosed to them, such information should be recorded where it may be accessed by any other police officer charged with the supervision of that prisoner. Such information should be added to the screening form referred to in Recommendation 126 or filed in association with it. (3:244)

133. That:

a. All police officers should receive training at both recruit and in-service levels to enable them to identify persons in distress or at risk of death or injury through illness, injury or serf-harm;

b. Such training should include information as to the general health status of the Aboriginal population, the dangers and misconceptions associated with intoxication, the dangers associated with detaining unconscious or semi-rousable persons and the specific action to be taken by officers in relation to those matters which are to be the subject of protocols referred to in Recommendation 127;

c. In designing and delivering such training programs, custodial authorities should seek the advice and assistance of Aboriginal Health Services and Aboriginal Legal Services; and

d. Where a police officer or other person is designated or recognised by a police service as being a person whose work is dedicated wholly or substantially to cell guard duties then such person should receive a more intensive and specialised training than would be appropriate for other officers. (3:245)

136. That a person found to be unconscious or not easily rousable whilst in a watch-house or cell must be immediately conveyed to a hospital, medical practitioner or a nurse. (Where quicker medical aid can be summoned to the watch-house or cell or there are reasons for believing that movement may be dangerous for the health of the detainee, such medical attendance should be sought). (3:246)

137. That:

a. Police instructions and training should require that regular, careful and thorough checks of all detainees in police custody be made;

b. 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;

c. Notwithstanding the provision of electronic surveillance equipment, the monitoring of such persons in the periods described above should at all times be made in person. Where a detainee is awake, the check should involve conversation with that person. Where the person is sleeping the officer checking should ensure that the person is breathing comfortably and is in a safe posture and otherwise appears not to be at risk. Where there is any reason for the inspecting officer to be concerned about the physical or mental condition of a detainee, that person should be woken and checked; and

d. Where any detainee has been identified as, or is suspected to be, a prisoner at risk then the prisoner or detainee should be subject to checking which is closer and more frequent than the standard. (3:246)

140. That as soon as practicable, all cells should be equipped with an alarm or intercom system which gives direct communication to custodians. This should be pursued as a matter of urgency at those police watch-houses where surveillance resources are limited. (3:247)

146. That police should take all reasonable steps to both encourage and facilitate the visits by family and friends of persons detained in police custody. (3:249)

147. That police instructions should be amended to make it mandatory for police to immediately notify the relatives of a detainee who is regarded as being 'at risk', or who has been transferred to hospital. (3:249)

158. That, while recognising the importance of preserving the scene of a death in custody for forensic examination, the first priority for officers finding a person, apparently dead, should be to attempt resuscitation and to seek medical assistance. (3:289)

159. That all prisons and police watch-houses should have resuscitation equipment of the safest and most effective type readily available in the event of emergency and staff who are trained in the use of such equipment (3:290)

160. That:

a. All police and prison officers should receive basic training at recruit level in resuscitative measures, including mouth to mouth and cardiac massage, and should be trained to know when it is appropriate to attempt resuscitation; and

b. Annual refresher courses in first aid be provided to all prison officers, and to those police officers who routinely have the care of persons in custody. (3:290)

161. That police and prison officers should be instructed to immediately seek medical attention if any doubt arises as to a detainee's condition. (3:290)

163. That police and prison officers should receive regular training in restraint techniques, including the application of restraint equipment. The Commission further recommends that the training of prison and police officers in the use of restraint techniques should be complemented with training which positively discourages the use of physical re-

straint methods except in circumstances where the use of force is unavoidable. Restraint aids should only be used as a last resort. (3:290)

2 10. That:

a. All employees of government departments and agencies who will live or work in areas with significant Aboriginal population and whose work involves the delivery of services to Aboriginal people be trained to understand and appreciate the traditions and culture of contemporary Aboriginal society;

b. Such training programs should be developed in negotiation with local Aboriginal communities and organisations; and

c. Such training should, wherever possible, be provided by Aboriginal adult education providers with appropriate input from local communities. (4:61)

214. The emphasis on the concept of community policing by Police Services in Australia is supported and greater emphasis should be placed on the involvement of Aboriginal communities, organisations and groups in devising appropriate procedures for the sensitive policing of public and private locations where it is known that substantial numbers of Aboriginal people gather or live. (4:85)

215. That Police Services introduce procedures, in consultation with appropriate Aboriginal organisations, whereby negotiation will take place at the local level between Aboriginal communities and police concerning police activities affecting such communities, including:

a. The methods of policing used, with particular reference to police conduct perceived by the Aboriginal community as harassment or discrimination;

b. Any problems perceived by Aboriginal people; and

c. Any problems perceived by police. Such negotiations must be with representative community organisations, not Aboriginal people selected by police, and must be frank and open, and with a willingness to discuss issues notwithstanding the absence of formal complaints. (4:85)

223. That Police Services, Aboriginal Legal Services and relevant Aboriginal organisations at a local level should consider agreeing upon a protocol setting out the procedures and rules which should govern areas of interaction between police and Aboriginal people. Protocols, among other matters, should address questions of:

a. Notification of the Aboriginal Legal Service when Aboriginal people are arrested or detained;

b. The circumstances in which Aboriginal people are taken into protective custody by virtue of intoxication;

c. Concerns of the local community about local policing and other matters; and

d. Processes which might be adopted to enable discrete Aboriginal communities to participate in decisions as to the placement and conduct of police officers on their communities. (4:111)

224. That pending the negotiation of protocols referred to in Recommendation 223, in jurisdictions where legislation, standing orders or instructions do not already so provide, appropriate steps be taken to make it mandatory for Aboriginal Legal Services to be notified upon the arrest or detention of any Aboriginal person other than such arrests or detentions for which it is agreed between the Aboriginal Legal Services and the Police Services that notification is not required. (4:111)

225. That Police Services should consider setting up policy and development units within their structures to deal with developing policies and programs that relate to Aboriginal people. Each such unit should be headed by a competent Aboriginal person, not necessarily a police officer, and should seek to encourage Aboriginal employment within the Unit. Each unit should have full access to senior management of the service and report directly to the Commissioner or his or her delegate. (4: 123)

228. That police training courses be reviewed to ensure that a substantial component of training both for recruits and as in-service training relates to interaction between police and Aboriginal people. It is important that police training provide practical advice as to the conduct which is appropriate for such interactions. Furthermore, such training should incorporate information as to:

a. The social and historical factors which have contributed to

   the disadvantaged position in society of many Aboriginal people;

b. The social and historical factors which explain the nature of contemporary Aboriginal and non-Aboriginal relations in society today; and

c. The history of Aboriginal police relations and the role of police as enforcement agents of previous policies of expropriation, protection, and assimilation. (4:150)