Contemporary Comment

Mandatory Sentencing: A Death Sentence in the Northern Territory?

The Royal Commission into Aboriginal Deaths in Custody was held from 1989-1991. The Commission resulted in the making of 339 recommendations. The intention of the Commission was two-fold: to reduce Aboriginal over-imprisonment, and to put an end to Aboriginal deaths in custody. Sadly, neither aim has been achieved. In the ten years following the publication of the Commissioner's Report, research data prepared by the Australian Institute of Criminology has demonstrated that Aboriginal incarceration rates are on the increase as are the numbers of Aboriginal deaths in custody (Carcach, Grant & Conroy 1999:6). However, such dry statistics hide the real story. There is no analysis of how many deaths have given rise to complaints about police or prison officer treatment; how many prisoners have died in unsafe cells; nor what Royal Commission recommendations may not have been followed.

I have been following the case of a particular death in custody in the Northern Territory, where one young boy was failed by the system from the outset.

'Benjamin'[1] died by his own hand at the Don Dale Correctional Centre, Darwin on 9 February 2000. He was a 15-year old Aboriginal boy from Groote Eylandt. The boy's parents were both dead; he had been passed around his extended family, spending a lot of his time with his grandmother. As a teenager, he began to smoke cannabis and sniff petrol. He received his first mandatory sentence of 28 days on October 18, 1999 when he was convicted of minor thefts committed shortly after his 15th birthday. The sentencing magistrate, Mr. Cavanagh, (according to the court transcript) said that he had 'no discretion' but to sentence the boy to 28 days under the Territory's mandatory sentencing laws (Seccombe 2001:10). Yet, under these laws, the boy should not have received a mandatory sentence of imprisonment for this first offence. His prior record prior to his 15th birthday should not have counted. The magistrate was wrong.

A few months later Benjamin was convicted of entering a council building on Groote Eylandt on November 27 and stealing pens, pencils, felt-tipped pens and correction fluid estimated at approximately $50. He was also convicted of entering the local primary school in early December and taking oil and paint worth $40 and breaking 5 glass louvers worth $50.

At this point the court could have sentenced him to attend a victim-offender conferencing program instead of sending him to Don Dale again. But his lawyer, Selwyn Hausman, was unaware that this new option (passed into law the previous August) was available on Groote. It appears that neither the prosecutor nor the sentencing magistrate Mr. Cavanagh were aware of the changes. As Hausman explained at the Coroner's inquest in September, 'You don't consume the time of the court ... when you know what the outcome's going to be'.

1 Due to cultural reasons it is inappropriate to use the boy's real name. This is the name that his family asked to be used for publication.

All the staff that came into contact with the boy gave evidence that during his second stint at the Centre he was a different boy from his first incarceration at Don Dale. He was 'volatile' and seemed 'tortured'. They attributed his behavior to his being a sniffer, but didn't ask. His grandmother was seriously ill in Darwin Hospital. There were no other children from Groote in Don Dale and English was not his first language.

He soon began exhibiting worrying behavior. Staff recounted individual incidents at the inquest that included his threatening to kill himself and his report of hearing voices in his head telling him to attack another detainee. He thought that people were watching him. One day he lay on the ground wailing uncontrollably; he put his fingers in his ears and chanted during a lesson; he hid under his bed with a blanket over his head. He complained about severe headaches.

The one common factor amongst these incidents was that they were never recorded in his case notes. He had daily contact with his senior case-worker and neither the doctor (called because of his headaches) nor the case-worker considered him to be at risk. But the fact remains that although some of the incidents were discussed amongst staff, none had been recorded and therefore the full picture of what could have been a mental illness was not available to the visiting doctor. The youth workers had no relevant training in mental health. One had owned a gun and fishing shop; another had been hairdresser; another a meat works boner. None had been issued with their own copy of the Northern Territory Correctional Service Procedures Manual. On the day he died, Benjamin had just three days left to serve.

Custody Issues in the NT

In the Northern Territory, Indigenous people comprised 67% of the prison population during 1999 (ABS 1999). Recent research conducted in the Territory has found that mandatory sentencing has increased the incarceration of Aboriginal people including women and young people. Between June 1996 and March 1999 adult imprisonment had increased by 40%. The number of women in prison in the NT has increased by 485% (Sheldon & Gowans 1999). Nearly 80% are under the age of 24; more than three quarters came from remote communities (76%), and 68% convicted under the laws did not speak English as a first language. In some cases it is not even their second language. Almost two in three had not completed more than the first two years of junior high school. Almost two in three people have substance abuse problems (alcohol and petrol).

From 1980-99 the overall incidence of deaths in custody seems to have been largely unaffected by the outcomes of the Royal Commission. The Commission required governments be responsible for their own monitoring and implementation. Each State published annual implementation reports that could be assessed by community-based watchdogs. However, this ceased to be a requisite in 1997. There are now no current mechanisms in place for the ongoing monitoring of the implementation process (ATSIC 2000:6). In Benjamin's case alone, there have been some twenty-four possible breaches of Royal Commission's recommended guidelines, as follows.

Circumstances of the Deceased's Incarceration.

Recommendation 92: Imprisonment 'as a last resort'.
Comment: Has been clearly breached.

Recommendation 96: Requires cross cultural awareness training for any staff coming in contact with Aboriginal people, and encourages informal contacts.
Comment: Not implemented in this case.

Recommendation 99: Court must be satisfied that the defendant is able to fully understand proceedings.
Comment: English was a second language yet there was no interpreter at court or in later contact with his lawyer.

Recommendation 108: Adequacy of legal aid funding[2].
Comment: On the day that Benjamin was sentenced there were 40 or 50 matters before the magistrate on 18 January. There is only one lawyer on Groote. Miwatj is only able to provide a visiting service to Groote and there doesn't seem to be sufficient funds to employ a field officer/client liaison officer/interpreter.

Recommendation 109: Ensuring appropriate range of non-custodial sentencing options is available.
Comment: Options are inevitably restricted by Mandatory Sentencing. There is only one available option for second-strike convictions on Groote, namely Victim-Offender Counselling.

Recommendation 168: Placement of Aboriginal detainees as close to place of residence as possible.
Comment: However, options for juvenile detention is limited only to DDC.

Recommendations 239 & 240: Review legislation and standing orders to minimise use of arrest powers in relation to Aboriginal juveniles.
Comment: The NT government reports this has been implemented through standing orders. However, while the cautioning system is established through General Orders, this is significantly undermined by the mandatory sentencing scheme.

Systems at Don Dale Centre

Recommendation 96: Cross cultural awareness training for any staff in contact with Aboriginal people.
Comment: Throughout the coroner's inquest, staff consistently gave evidence stating that they had received no formal cross-cultural awareness training.

Recommendation 122: Ensure police, corrections and juvenile facility staff recognise the duty of care owed and have appropriate training.
Comment: The Superintendent could not supply the court with evidence that any of his staff received any training in either cross-cultural awareness or about their duty of care. The Superintendent had not been on any training courses either, but was generally responsible for staff training.

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2 This is the responsibility of the Commonwealth.

Recommendation 123: Deals with breaches of departmental instructions. Instructions re care of detainees should be mandatory, enforced and enforceable and understood by all officers.
Comment: The Superintendent informed the court that although the Policy and Procedures Manual was available, he considered certain parts of the departmental instructions to be 'flexible'.

Recommendation 124: Post-incident debriefing to discuss and assess the operation of procedures, actions and application of instructions, to reduce future risks.
Comment: As yet, no formal review of the incident has taken place within Don Dale to reduce future risks although six separate hanging points have been identified in detainee's rooms.

Recommendation 125 & 126: Requirement to have screening form utilised at reception of prisoners, such form to include risk management, and to be completed with 'care and thoroughness'.
Comment: Although this appears to have been complied with on a basic level, the implementation requires the detainee disclosing medical information to the youth worker and/or medical examiner. Here the youth worker was an Aboriginal man, but the medical examiner was a non-Aboriginal woman.

Recommendation 151: Referral procedures in place to ensure assessment by qualified mental health expert when required.
Comment: No formal mental health assessment of Benjamin was ever undertaken despite the various staff members indicating that they were concerned about his mood swings and apparent sadness/loneliness. Also breach of NTCS Directors Rule 12/94.

Recommendation 154: Training for all staff to have awareness of specific Aboriginal health issues, consultation between prison medical services and Aboriginal health services, and employment of Aboriginal staff in health service delivery in prisons.
Comment: Although some training had been given to some staff members, there was no record on who had received what training. No Aboriginal health service staff employed.

Recommendation 155: Recruit in-service training for corrections staff and cover Aboriginal health issues, indicators of risk and procedures for responding to 'at risk' detainees.
Comment: Youth Workers at Don Dale appear to have little or no recruit training nor any minimum selection qualifications.

Recommendation 156: Intake assessment for all new detainees, including psychiatric assessment when identified as necessary.
Comment: In this case it appears to have been complied with, but cultural issues arise as the medical examiner was a non-Aboriginal woman and her assessment relied heavily upon self-reporting.

Recommendation 159: Resuscitation equipment in all prisons and watch-house and staff trained in use.
Comment: Don Dale did not have any specialised resuscitation equipment. Only one staff member was listed as having Advanced Resuscitation Training. One other is a qualified nurse. However, neither was on duty at the time. One of the four staff on shift did not possess a current First Aid Certificate at the time of the incident.

Recommendation 165: Removal of all self-harm equipment, hanging points etc.
Comment: The NT government reports implementation. Yet the Superintendent gave evidence that there remained six hanging points in each room, and at the time of Benjamin's death, the fan in his room had a three-foot long cable.

Recommendation 181: Highly undesirable to place Aboriginal prisoners in segregated or isolated detention.
Comment: Segregation is supposed to be used as a last resort for prisoner management. Statements were made by the staff that 'room placement' or 'time-out' is a common form of behaviour management after the token economy system. However, in this instance it was the first resort, not the last.

The Deceased's Background and his State of Mind.

Recommendation 169: Consideration to providing financial assistance to families to facilitate visits.
Comment: While not specifically relevant, the absence of any family visits may have been a contributory factor in his deteriorating emotional state. The NT government, due to financial constriants, has not supported this recommendation.

Recommendation 171: Recognition to be given to the needs of detainees to attend funerals, burials and other significant events.
Comment: This recommendation has been reported as implemented but it is dependent on the detainee having access to funds to pay for travel costs for self and escort as well as the salary for the escort. Benjamin was unable to attend the funeral of his uncle on Groote because the Groote Eylandt Aboriginal trust did not have sufficient funds.

Recommendation 174: Employment of Aboriginal Welfare Officers in correctional service settings.
Comment: Only one staff member at the time of death was identified as being of Aboriginal descent. He did not speak any Aboriginal languages and did not appear to have any special relationship with the deceased. This recommendation is reported as being implemented.

Conclusion

The inquest focused primarily on the actions of staff at Don Dale: how they failed to record details of the deceased's aberrant behavior; how he was never referred for specialist medical attention despite obvious indicators. It was inadequate. The tragic and ultimately preventable death of Benjamin in Don Dale highlights the Northern Territory's insufficient implementation of recommendations from the Royal Commission into Aboriginal Deaths in Custody.

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