IN THE CORONER'S COURT OF VICTORIA **No: COR 2020 0021**

INQUEST INTO THE DEATH OF VERONICA NELSON

SUBMISSIONS ON BEHALF OF UNCLE PERCY LOVETT

A. INTRODUCTION

1. This submission is made on behalf of Veronica's partner, Uncle Percy Lovett. Percy is grateful to the Court for its time and diligence in its investigation of Veronica's passing and in the hearing of the Inquest. He is also grateful to the Court for the respect it has shown to Veronica, her family, her loved ones, and her Aboriginal culture throughout the hearing of the Inquest.

2. Percy is hopeful that any findings and recommendations the Coroner makes will bring about real change. Too many Aboriginal people have died and continue to die in custody. These repeated deaths are preventable. They must stop.

3. This year marked the 31st anniversary of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), which made 339 recommendations aimed at the prevention of Aboriginal deaths in custody. More than three decades on, over 512 Aboriginal and/or Torres Strait Islander people have died in custody.[1] Many of the recommendations of RCIADIC sit gathering dust while the unnecessary loss of life accumulates.[2]

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[1] Australian Institute of Criminology, 'Deaths in custody in Australia', 7 June 2022, available at <https://www.aic.gov.au/statistics/deaths-custody-australia>.
[2] Thalia Anthony et al, '30 years on: Royal Commission into Aboriginal Deaths in Custody recommendations remain unimplemented', 2021, accessed at <https://caepr.cass.anu.edu.au/sites/default/files/docs/2021/4/WP_140_Anthony_et_al_2021_0.pdf>.

4. As stated by Dr Amanda Porter, and supported by a consensus of the Administration of Justice Conclave, hollow words and hollow promises, including a "culture of denial, of not hearing and of impunity" are part of the problem.[3]

5. Had the Victorian Government listened to the advocacy of Aboriginal and Torres Strait Islander peoples and organisations, and enacted the genuine systemic reforms demanded by RCIADIC and by Aboriginal organisations since RCIADIC, Veronica would be alive. She would not have died alone, in pain, calling for her father and screaming out for help. More than mere words are required. Percy seeks real action and long-term change. He wants to make sure this does not happen again.

6. In these submissions, the factual evidence is recounted in brief terms, pausing at relevant stages to submit what findings should be made. Respectfully, Percy agrees with the Coroner's "Draft Findings and Recommendations" circulated by solicitors assisting on 30 May 2022. He does, however, submit that certain additions and amendments to the findings are open on the evidence and should be made.

7. Percy also respectfully submits that strong and direct criticism of individuals, organisations and Government agencies is both justified and required. Individuals who hold responsibility should be named. The total neglect of Veronica and the denial of her basic humanity and dignity by numerous individuals and by the private and Victorian government organisations with responsibility for her treatment and care, was more than merely 'inadequate' or 'deficient'. It was deliberate. It was grossly negligent. It was inhumane. It was brutal. It was tortuous. It killed her. As stated by Gomeroi writer Alison Whittaker, "[w]hile coroners can't impose any legal liability for the cases before them, they can and do use condemnatory language to express a sense of culpability –

[3] Collated Transcript of Inquest (**T**) 2718.

just like you and I might."[4] It is respectfully submitted that this approach is important for accountability and for prevention.

8. To achieve true accountability and justice for Veronica, and to ensure that this does not happen again, Percy submits that the Coroner should go further than making the findings proposed. Percy submits that the Coroner should refer Correct Care Australasia (**CCA**), and the individual doctors, nurses and prison officers who were responsible for Veronica's neglect and/or eventual passing through their neglect and inhumane treatment, to the Director of Public Prosecutions (**DPP**) for consideration of pursuing criminal charges. He also seeks referrals to regulatory bodies, as described below. In Percy's words, "we're held accountable when we do something wrong, so why shouldn't they be accountable when they killed Veronica".

9. In 1991, RCIADIC stated that "[n]on-Aboriginal Australia has developed on the racist assumption of an ingrained sense of superiority that it knows best what is good for Aboriginal people."[5] Percy submits that racist values and assumptions which exclude and inferiorise Aboriginal people impacted on Veronica's care and treatment by both individuals and agencies within systems. He submits that the Coroner can and should make findings regarding racial bias and systemic racism when considering the relevance of Veronica's Aboriginality to her treatment and care.[6] Systemic racism describes how laws, policies and practices across agencies work together to produce a discriminatory *outcome* for racial or cultural groups. It can be measured in the uneven or unfair manner in which certain apparently 'neutral' laws impact Aboriginal and/or Torres Strait Islander

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[4] Alison Whittaker, '"Dragged like a dead kangaroo": why language matters for deaths in custody', 8 September 2018, *The Guardian,* available at <https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody>.
[5] RCIADIC vol. 1, 1.4.10, available at <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/>.
[6] Item 4, Amended Scope of Inquest.

people.[7] Systemic racism operates because agents of institutions hold racial bias, including values or assumptions that exclude and inferiorise Aboriginal people.[8] Veronica received the grossly deficient treatment and care that she did because of intersecting discrimination she faced as an Aboriginal woman and a drug user. In the body of this submission, certain aspects of racial bias and systemic racism are discussed. Further, in Part D below, racism is addressed in further detail.

10. In order to address these matters, at the relevant points in this submission, the Coroner's draft findings are identified. Where Percy submits there should be amendments made to the Coroner's draft findings, the Coroner's draft finding number is indicated in square brackets, for example, "[4]". Where further findings are sought, they are indicated with "[#]". Percy's submitted amendments and additions to the Coroner's draft findings are marked in blue underlined font.

11. At Annexure 1, a marked-up version of the Coroner's draft recommendations is provided. As with the findings, the blue underlined text indicates the amendments and additions Percy seeks.

12. The submitted additions and amendments to the recommendations at Attachment 1 draw on the near 50 years of experience of the Victorian Aboriginal Legal Service (**VALS**) in delivering a dedicated, culturally safe legal service for Aboriginal and/or Torres Strait Islander people in Victoria. They are also drawn from the expertise of leading academics and Aboriginal advocacy and health organisations, as well as from the esteemed experts in the Medical and Administration of Justice Conclaves. Percy

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[7] See Harry Blagg, Neil Morgan, Chris Cunneen and Anna Ferrante, 'Systemic Racism as a Factor in the Over-representation of Aboriginal People in the Criminal Justice System', Report to the Equal Opportunity Commission and Aboriginal Justice Forum, 2005, 12;

[8] Thalia Anthony (2013), Indigenous People Crime and Punishment, Oxon: Routledge, 68; T. Gray, S. Burgess, and M. Hinton, (2008) 'Indigenous Australians in Sentencing', in E. Johnston, M. Hinton and D. Rigney (eds) Indigenous Australians and the Law, 2nd edn, New York: Routledge-Cavendish. Patricia Gray (2005) 'The Politics and Risk and Young Offenders' Experiences of Social Exclusion and Restorative Justice', British Journal of Criminology 45(6): 119.

acknowledges the leadership of Aboriginal and Torres Strait Islander people and organisations in pushing for the changes proposed in the recommendations.

B. VERONICA

13. In Percy's words:[9]

> Veronica was born on 3 March 1982, in Dandenong. She was a Gunditjmara, Dja Dja Wurrung, Wiradjuri and Yorta Yorta woman.
>
> She was the beloved daughter of Russell and Donna, and sister of Belinda, Russell, Dwayne, Tricia, Richard and Jodie.
>
> Veronica never used to let anyone, or anything get her down. She always tried to stay positive. A lot of times she was happy. It was her personality. A happy personality. She had a beautiful laugh. A happy laugh.
>
> Family was everything to her. Whenever the family got in trouble, she would be right there. No hesitations. She was mainly really proud of having the family together. Family came before everything. She was most proud of her family.

14. Veronica was a deeply spiritual woman, she was dignified, she was respectful, and she was dearly loved.

15. The evidence was clear that when Veronica needed to see a doctor, she would see a doctor.[10] When she needed to go to hospital, she would go to hospital.[11] Had she presented with similar symptoms to those she experienced at Dame Phyllis Frost Centre (**DPFC**) at home, Percy would have taken her to hospital.[12]

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[9] Final Inquest Brief (**IB**) 203.
[10] T48:14.
[11] T57:17-19.
[12] T57:15.

16. Veronica, suffering from obvious malnutrition, and severely withdrawing, continually vomited, causing electrolyte deficiencies and ultimately, her death. It is immaterial whether her vomiting was caused by severe withdrawal or Wilkie's Syndrome. Her vomiting and inability to hold down fluids could have been easily addressed with proper medical intervention. Her severe pain, terrible suffering and ultimate death were preventable.[13] No one should die while suffering the cruelty of "physical pain and psychological pain",[14] powerless, denied medical treatment, uncared for and ignored by those who held her life and welfare in their hands.

Findings:

[1] Veronica Marie Nelson (**Veronica**) died on 2 January 2020 at the Dame Phyllis Frost Centre (**DPFC**) of complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition.

[2] At the time of her passing, Veronica was a person in the custody of the Secretary of the Department of Justice and Community Safety (**DJCS**).

[3] Veronica's death was preventable.

[#] If Veronica had not been in custody, and was with her loved ones, she would not have died.

C. THE EVENTS

17. In the weeks and days leading up to her arrest, Veronica appeared to be happy, alert, her usual self and in good health.[15]

18. On 30 December 2020, Veronica left her home in Collingwood with Percy.

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[13] T2245-2247.
[14] T2236-2237.
[15] T48.

Veronica's arrest by Victoria Police

19. Veronica, an Aboriginal woman was walking in the city with her brother, minding her own business, when an off-duty police officer, Sgt Brendan Payne, a police officer of 23 years, (who had never arrested her before[16]) "recognised her".[17]

20. Prior to any enquiries or LEAP checks being undertaken, Sgt Payne "knew" that Veronica was wanted on outstanding warrants, he "knew she was Aboriginal",[18] and he decided to arrest Veronica. Veronica, who was always respectful to people in positions of authority, followed Sgt Payne's orders and walked with him to the police station without handcuffs.[19]

21. During her time in Police custody, Veronica did not speak to any other Aboriginal person or any legal representative.

22. Veronica was isolated and alone the entire time she was in Police custody.

23. That afternoon, one of Veronica's brothers told Percy that she had been arrested.[20]

24. In Victoria, numerous studies have found that Aboriginal and/or Torres Strait Islander women are more likely to be apprehended by Police than non-Aboriginal women.[21] This policing is most likely to focus on theft and breach of justice offences, which together

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[16] T68, T71.
[17] T67: 21.
[18] T68:4.
[19] T71.
[20] T44.
[21] The landmark report on systemic racism in Victoria's criminal justice system, commissioned by the Equal Opportunity Commission of Victoria, cited data that police are five times more likely to arrest Aboriginal women compared to non-Aboriginal women: Harry Blagg, Neil Morgan, Chris Cunneen, Anna Ferrante, 'Systemic Racism as a Factor in the Over-representation of Aboriginal people in the Victorian Criminal Justice System', Equal Opportunity Commission of Victoria, September 2005, available at <https://tr.uow.edu.au/uow/file/64419d5f-d183-49c2-90d9-d81c8dc44f17/1/2005-blagg-1-210.pdf>. See too Office of Police Integrity Victoria, 'Talking Together – relations between Police and Aboriginal and Torres Strait Islanders in Victoria: A Review of the Victoria Police Aboriginal Strategic Plan 2003-2008', available at <https://www.ibac.vic.gov.au/docs/default-source/reviews/opi/talking-together---relations-between-police-and-aboriginal-and-torres-strait-islanders-in-victoria-.pdf?sfvrsn=8>.

constitute almost 50% of all charges laid against Aboriginal women.[22] Systemic barriers contribute to Aboriginal people, and in particular Aboriginal women, finding it harder to attend Court and comply with onerous bail conditions. This issue was highlighted by RCIADIC, which emphasised the barriers faced by Aboriginal people in regard to complying with culturally inappropriate bail conditions and other court conditions.[23]

Findings:

[4] Veronica's arrest by Victoria Police (**Police**) on 30 December 2019 was lawful.

[#] Although lawful, Veronica's arrest was due to her visibility as an Aboriginal woman in public. Veronica would not have been arrested if she was not Aboriginal. Her arrest was the result of interpersonal racism.

[#] Veronica's arrest for shoplifting and breach of justice related offences was the result of systemic racism.

[5] The use of handcuffs by First Constable Eliza McMonigle and Senior Constable Rebecca Gauci (upon the Direction of Sgt Payne) was disproportionate in the circumstances and an unlawful use of force. It was also in breach of Veronica's rights under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**the *Charter***) to liberty (s 21), privacy (s 13) and humanity and dignity in detention (s 22).

[22] Peta MacGillivray and Eileen Baldry, 'Australian Indigenous Women's Offending Patterns', June 2015, available at <https://www.indigenousjustice.gov.au/wp-content/uploads/mp/files/publications/files/rb19-indigenous-womens-offending-patterns-macgillivray-baldry-2015-ijc-webv2.pdf>.

[23] RCIADIC vol. 3, 21.4.15, 21.4.18, 21.4.27, available at <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol3/>. See too Blagg et al, 'Systemic Racism as a Factor in the Overrepresentation of Aboriginal People in the Victorian Criminal Justice System', 2005.

Bail in Victoria

25. Veronica would not have died, and would have been at home with her family, if it were not for Victoria's punitive and discriminatory bail laws.

26. The punitive bail system in Victoria is the single largest factor contributing to the growth in prison and remand populations and has disproportionately impacted Aboriginal and/or Torres Strait Islander peoples. Relevantly, in June 2019, 57.5% of Aboriginal women in prison in Victoria were on remand, compared to 48% in June 2017 and 29.6% in June 2010. Between 2009-2010 and 2019-2020, the number of Aboriginal women entering prison on remand increased by 440%, compared to a 210% increase for the total prison population.[24]

27. The discriminatory, and sometimes deadly impact of bail laws on Aboriginal and/or Torres Strait Islander women is not new. Of the 99 deaths investigated by RCIADIC, 30% involved unconvicted Aboriginal people being held in prison. Of the 11 Aboriginal women investigated by RCIADIC, 10 (91%) died in custody without a conviction or sentence. Of the 26 Aboriginal women who have died in custody since 2001, 23 (88%) were in custody without a conviction/sentence. Studies in other States have found that Aboriginal people (and in particular, Aboriginal women) are more likely to be refused bail by police and Courts than non-Aboriginal people.[25]

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[24] Corrections Victoria, 'Annual prisoner statistical profile 2009-10 to 2019-20: Dataset', December 2020, available at: <https://www.corrections.vic.gov.au/annual-prisoner-statistical-profile-2009-10-to-2019-20>, cited in E. Russell, B. Carlton and D. Tyson, "It's a Gendered Issue, 100 Per Cent': How Tough Bail Laws Entrench Gender and Racial Inequality and Social Disadvantage" *International Journal for Crime, Justice and Social Democracy is the* (2021), 2, available at <https://www.crimejusticejournal.com/article/view/1882/1151>.

[25] NSW Bureau of Crime Statistics and Research, 'What factors influence police and court bail decisions?', 23 March 2021, available at <https://www.bocsar.nsw.gov.au/Pages/bocsar_media_releases/2021/mr-What-factors-influence-police-and-court-bail-decisions-CJB236.aspx>.

28. Deputy Commissioner of DJCS, Melissa Westin, gave evidence regarding more recent statistics during the Inquest.[26]

Veronica's bail refusal by Victoria Police

29. Veronica was interviewed by Police. Before she had even finished being interviewed, Senior Constable Gauci started compiling the remand brief. No one obtained any relevant information from Veronica for the purpose of considering whether to grant bail or oppose bail.[27]

30. Sgt Nick McDonald, who had the power to grant Veronica bail, does not even remember Veronica. To him, her custody was entirely "routine".[28] He would never have granted her bail because she fell under the "exceptional circumstances threshold".[29]

Findings:

[#] Sgt Nick MacDonald failed to comply with Victoria Police policies, and the provisions of the *Bail Act 1977* (Vic) (***Bail Act***), in regard to Veronica.

[6] The Police Bail Decision Maker (**BDM**), Sgt Nick MacDonald, was empowered to grant bail to Veronica, as an Aboriginal and/or Torres Strait Islander person who was subject to the exceptional circumstances threshold, but failed to give proper consideration to granting Veronica bail. This included failure to consider relevant factors under s 3A and s 3AAA of the *Bail Act*.

[7] Police failed to gather information already in their possession relevant to a proper consideration of the surrounding circumstances and failed to present such matters to Police and Court BDMs.

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[26] T2519.
[27] T76; T77; T80:13; T83:4; T100.
[28] Additional Materials (**AM**) 841.
[29] AM843.

[#] Police failed to obtain information from Veronica and/or her legal representatives in order to enable them to give proper consideration to granting Veronica bail.

[#] Senior Constable Gauci acted improperly by preparing Veronica's remand brief while Veronica was in an interview.

[#] Victoria Police acted in accordance with an informal policy to oppose all remand bail applications involving the exceptional circumstances test. This informal policy is contrary to the *Bail Act* and human rights under the *Charter* to liberty (s 21), equality and non-discrimination under law (s 8), and cultural rights (s 19).

[#] Sgt MacDonald and Victoria Police acted incompatibly with Veronica's rights under the *Charter* to liberty (s 21(1)), not to be subject to arbitrary arrest or detention (s 21(2)), not to be detained except in accordance with law (s 21(3)), not to be automatically detained pending trial (s 21(6)), equality and non-discrimination under law (s 8), and cultural rights (s 19). Sgt MacDonald and Victoria Police also failed to give proper consideration to these rights under s 38 of the *Charter*.

Veronica's application for Bail at Melbourne Magistrate's Court

31. Victoria Police would never have granted Veronica bail and its members opposed her bail application. Victoria Police and its members wanted her jailed for shopstealing – an outcome they well-knew they would not achieve in sentencing, should she be found guilty of any of the relevant offences.

32. Police transported Veronica to the Melbourne Magistrates' Court (**MMC**). From around 3pm, until she was transported to DPFC, no Koori welfare officer, Aboriginal and/or Torres Strait Islander person, community member or welfare officer saw or spoke to her.

Audrey Walker, the Koori Court Officer who was working at MMC, was not contacted. Veronica was completely culturally isolated during her time at MMC from 30 December to 31 December.[30]

33. Veronica was lodged in the cells underneath the MMC around 7:30pm on 30 December 2019. She was utterly alone in the MMC cells for the 20 hours she was there.

34. Despite being lodged prior to the 8pm "cut off", Veronica was not provided any legal assistance, and did not appear before the Court on 30 December 2019. Magistrate Lamble did not bring Veronica into Court to explain what was happening. Magistrate Lamble did not seek clarification as to how long a hearing might take, nor did she call the matter on for mention or bail application that evening. Veronica was the only new remand not called on/reached on 30 December.

35. Veronica spent the night alone, in lockup, away from the safety of her loving family and community.

36. Between 30 and 31 December, the only person in a position to truly advocate on her behalf, and to act as her lifeline, was her barrister Tass Antos. He had been privately briefed to appear for Veronica. On 31 December, Mr Antos spent, at most, 6 minutes with Veronica.[31] In that time he did not take Veronica through the remand summaries, her prior history, the corrections report, the *Bail Act* requirements or relevant s 3A and s 3AAA matters.[32] He did not promote or protect her, her rights or her interests. His treatment of Veronica was dismissive.[33]

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[30] T533.
[31] T398.
[32] T411:9-T413:4.
[33] IB2111.1-2 (email to Jill Prior); IB2422:14.

37. Mr Antos persuaded[34] Veronica to appear unrepresented despite her obvious desire for legal representation.[35] He claimed in his evidence that he does not remember anything about the interaction, despite learning of Veronica's passing only days later.[36] His evidence as to his lack of recollection was not credible.

38. Percy came to Court on 31 December 2019 for Veronica. He sat in the body of the courtroom alone. He was there waiting for a few hours. No lawyer, no police officer, no Court employee and no support worker bothered to speak to him. He was there to take Veronica home. When Veronica came into Court, she did not look like herself,[37] she was not acting normal. She looked unwell. At the end of the hearing, Percy yelled out to Veronica to get medical help.[38]

39. The Prosecutor and Magistrate Bolger, between themselves, discussed Veronica's presumed drug use and criminal history.

40. Neither the Prosecutor nor Magistrate Bolger asked Veronica about her health nor her Aboriginality.

41. No one, including Magistrate Bolger, referred to Veronica's Aboriginality, s 3A, or its importance, at any time during the proceeding.

42. Veronica brought up illness in her family, which should have alerted Magistrate Bolger and the Prosecutor to kinship obligations, relevant to s 3A. This should have prompted further questions.

43. It is clear that Percy is correct when he says that Magistrate Bolger "had already made up her mind before Veronica even started talking … some of the questions that the

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[34] IB2111.1-2 (email to Jill Prior); T402, T406.
[35] IB2422.
[36] T399, T437, T439.
[37] T53.
[38] T54.

Magistrate asked Veronica didn't – she didn't even know how to answer … She didn't want to go to Shepparton for medical reasons. The Magistrate didn't even give her a chance to explain what – what – what she meant."[39]

44. Veronica was isolated and alone in her attempts to advocate for herself. Percy was scared for Veronica. This was the last time Percy and Veronica saw each other.

Findings:

[#] On 30 December 2019, Veronica was not provided any legal assistance by the Victoria Legal Aid (**VLA**) Duty Lawyer Service or any other lawyer. No adverse comment is made or sought regarding Peter Schumpeter of counsel.

[#] Despite being lodged prior to the "8pm cut off" and being an Aboriginal Woman in custody, the Magistrates' Court of Victoria (**MCV**) did not provide Veronica with an opportunity to appear before the court for a bail hearing on 30 December 2019.

[#] The actions of Peter Schumpeter of Counsel in assisting Veronica, by emailing Jillian Prior, and sending Veronica's remand documentation, were reasonable and appropriate.

[10] Given that Veronica's legal representative of record had been notified by VLA of her remand in custody on 30 December 2019 and arranged for a barrister to appear on her behalf on 31 December 2019, Veronica should not have appeared in person on that date.

[11] The legal services provided to Veronica on 31 December 2019 by Tass Antos of counsel were grossly inadequate.

[39] T44.

[#] Mr Antos did not take Veronica through the remand summaries, her prior history, the corrections report, the *Bail Act* requirements and relevant s 3A and s 3AAA matters.[40]

[#] Mr Antos persuaded[41] Veronica to appear unrepresented.[42]

[#] Veronica was not aggressive, hostile or paranoid when she met with Mr Antos.[43]

[12] Section 4AA(2)(c), section 4A and clauses 1 and 30 of Schedule 2 of the *Bail Act 1977* (Vic) (***Bail Act***) are incompatible with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (***Charter***).

[#] Veronica was not provided any culturally safe or competent support when she appeared at the Bail and Remand Court (**BaRC**).

[#] Veronica's bail hearing before Magistrate Bolger was not culturally competent. Magistrate Bolger did not properly consider the health and kinship issues raised by Veronica, and that Veronica's partner, Percy Lovett, was in the courtroom.

[#] The Prosecutor, a model litigant, did not furnish the Court with accurate and fulsome matters for the Court to properly consider during the bail hearing.

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[40] T411:9-T413:4
[41] IB2111.1-2 (email to Jill Prior); T402, T406.
[42] IB2422.
[43] Mr Antos claims he has no recollection of his interaction with Veronica and relies on his notes. Against this, it is so unlikely to the point of being fanciful that Mr Antos was the only person Veronica treated that way given the many audio and video recordings of Veronica which the Court has considered over the relevant period – even as she became more and more desperate for help. Moreover, it is not supported by the evidence of the people who dealt with Veronica over the relevant period, nor those who knew Veronica generally.

[#] The Prosecutor, a model litigant, did not properly discharge his duties as an officer of the Court.

[#] Magistrate Bolger did not properly consider Veronica's Aboriginality in accordance with s 3A or 3AAA(1)(h) of the *Bail Act* in Veronica's bail application on 31 December 2019.

[#] Veronica's treatment by Police, lawyers and Court staff at BaRC was culturally unsafe and incompetent.

[#] Veronica had no access to dedicated or culturally safe access to bail support services that may have increased her chances of being granted bail and would have been considered under s 5AAA of the *Bail Act*.

[#] From the time of her arrest, until her transfer to DPFC, Veronica was culturally isolated in custody.[44]

[#] Veronica's treatment by Victoria Police and its members, Court staff and MCV was in breach of her rights under the *Charter* to liberty (s 21), dignity and humane treatment in detention (s 22), equality and non-discrimination (s 8), and cultural rights (s 19). Victoria Police, its members, Court staff and MCV did not act compatibly with these rights or give adequate consideration to these rights when making decisions under s 38 of the *Charter*.

Veronica's treatment and care at DPFC

45. Veronica was transferred from MMC to DPFC in the afternoon of 31 December. During the trip, Veronica was very unwell, vomiting in the truck on the way. When Veronica

[44] T533.

arrived at DPFC reception, she was obviously unwell, climbing off the truck carrying a bag full of her vomit, and having to lean to support herself.

46. When Veronica arrived at DPFC, her weight was about 33kg.[45]

47. Veronica weighed the same as an average 10 year old girl. Prison officers, nurses and doctors all observed this, and many stated she was the most unwell person they had ever seen. But they did nothing.

48. The unanimous view of the medical conclave was clear: Veronica needed to be transferred to hospital immediately upon entry to DPFC.[46] Her medical care was grossly deficient in all respects. If she had been transferred to hospital, even on the night she died, her death could have been prevented. The conclave struggled to find strong enough words to describe the "utterly, appallingly undignified"[47] and "inhumane"[48] treatment of Veronica by medical staff and prison officers at DPFC.

49. Dr Sean Runacres conducted a reception medical assessment that could only have lasted 13 minutes at most. During the assessment, Veronica could barely sit up and was unresponsive to questions. She could not muster the strength to even fill out the relevant paperwork.[49] Despite stating in Court that he did weigh her, the evidence is clear that Dr Runacres did not weigh Veronica.[50] He did not conduct any physical examination of her. His JCARE record contained fabricated and deliberately misleading

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[45] This was Veronica's weight only two days later, when she died: Dr Yeleina Baber, T2054-2055.
[46] While the medical conclave initially stated a majority view that Veronica needed to be transferred to hospital, the minority position was based on Dr Runacres recorded weight being accurate. The consensus of the conclave was that if Veronica weighed approximately 33kg, she needed to go to hospital immediately upon entry to DPFC: T2205: 27-29.
[47] T2239: 18-19.
[48] T2227:20-22; T2228:11.
[49] RN Hills' observations regarding Veronica's clinical state was supported by the evidence of Bester Chisvo, who assessed Veronica only minutes after Dr Runacres, as well as PO Christine Fenech, PO Watts, Lee-Anne Reid, and PO Hermans.
[50] Dr Runacres recorded a weight of 40.7kg. Veronica's weight two days later, when she died, was 33kg. It was impossible for Veronica to have weighed anywhere close to 40.7kg on 31.12.19. See Dr Yeleina Baber, T2054-2055.

information, including Veronica's weight, which Dr Runacres simply invented. His JCARE record also included details erroneously copied from a pro forma supplied by CCA. When Nurse Stephanie Hills suggested that Veronica be immediately transferred to hospital, Dr Runacres condescendingly dismissed her. Despite finding out about her death only days later, Dr Runacres claimed he had no memory of Veronica or his assessment of her. His evidence to the Inquest lacked all credibility and his responses were disrespectful and offensive to Veronica's family. His evidence as to his lack of recollection was not credible.

50. Percy wishes to specifically note that although RN Hills failed to send Veronica to hospital, she was in a difficult position to escalate Veronica's care given her role as a nurse and the dismissal of her concerns by Dr Runacres, who was more senior in the medical heirarchy. Mr Lovett also appreciates the concessions made by RN Hills, the difficult position she faced in providing evidence in the Inquest, and her sincere apology to Veronica's family.

51. The next day, Dr Alison Brown missed crucial and clear signs that Veronica had clinically deteriorated and continued to require urgent treatment at a hospital. Dr Brown conceded in her evidence that she should have followed up on Veronica's condition or checked in with a nurse, and she did not properly document her examinations of Veronica on 1 January 2020.[51] Opportunities to assess Veronica and monitor her symptoms were continuously missed throughout her time in custody.

52. During Veronica's time in DPFC, she was treated in a cruel and inhumane way which amounted to torture and degrading treatment. She was distressed. She shouted for help. She pressed the intercom button seeking help approximately 49 times.[52] Prison officers answered her calls, but only rarely actually assisted her. She was lied to,

[51] AM1418.
[52] Multimedia Extract List.

provided incorrect medical advice, dismissed and was not referred for medical assistance.

53. She was in pain, had severe cramping and was suffering from hot and cold flushes. She vomited at least 15 times and had diarrhea.

54. This was while she was already considerably malnourished and considerably unwell and was extremely vulnerable from a mental health, cultural and social wellbeing perspective. All while she was locked behind a door.[53]

55. During this time, those who should have cared for and helped Veronica persistently ignored her cries for help.

56. Nurses, doctors, and Corrections staff dismissed Veronica's safety and welfare callously. They showed Veronica no basic respect or dignity, as though she was not human. They knew, and did not care, that she was suffering or that there was a possibility that she would become so unwell that she would pass away. Despite this treatment, Veronica remained courteous and polite throughout. She treated all who she interacted with with respect and dignity, even though she was provided none.

57. Prison officers lied to Veronica. They chastised her. They degraded her – for simply using the cell buzzer as her only lifeline. Despite PO Tracey Brown telling Veronica that her cries for help were keeping other prisoners awake, the evidence demonstrates that others who were imprisoned were the only ones actually trying to assist Veronica, despite their own difficulties of being locked down. Both Kylie Bastin and Bonnie McSweeney could hear Veronica screaming for help, and tried calling for assistance for her. The other women inside DPFC were the only people who treated Veronica with humanity and dignity on the night she died.

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[53] T2227.

58. Nurse Athaena George spent almost her entire shift watching movies at her nursing station[54] whilst Veronica repeatedly screamed and pleaded for help. When she was taken to see Veronica, RN George did not bother to examine her; instead she simply looked through the small trap,[55] laughed at Veronica's nudity, and conceded she had to pry Veronica's fingers open to give her medication.[56]

59. RN George conceded she should have, but did not, ask for the cell door to be unlocked.[57]

60. Astonishingly, PO Brown, Veronica's only real lifeline on the night of 1 January 2020, did not know of, and said she had received no training from her employer, the Victorian Government, on the increased risks to Aboriginal and/or Torres Strait Islander people of passing away in prison for medical reasons compared to non-Aboriginal people.[58]

61. Between the last call from Veronica to PO Brown at 3:58am,[59] and her body being discovered at 7:30am on 2 January, PO Brown, who conducted inadequate patrols at 4:00am and 5:00am, failed to notice the shower consistently running in Veronica's cell.[60] The shower running behind the closed door of cell 40 was perfectly audible from the end of the hall during the day.[61] It must be that it was even more audible in the silence of the night.

62. Contrary to its own policies, Corrections Victoria (**CV**) staff did not ensure that Veronica was seen by the Aboriginal Liaison Officer upon entry to DPFC. Veronica was culturally and spiritually isolated throughout the entirety of her time at DPFC.

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[54] T1768:9-14.
[55] T1746:8.
[56] T1739:30-T1740:26, T1743:19.
[57] T1745:1.
[58] T1928:17.
[59] T1876:9.
[60] See T1616 where Heath noted that the shower was running as early as 1:30am. T1409, T1616, T1645, T1879, T1885-1886.
[61] This was clear duing the legal representatives' attendance at DPFC on 30 April 2022, when the shower was left running, the cell door was closed, and the attendees stood along the hallway listening to the shower running.

63. RCIADIC recommended prison health care be culturally safe and "be of an equivalent standard to that available to the general public".[62] This recommendation still has not been implemented.

Findings:

[#] Veronica would not have died if she had been provided with competent and culturally safe medical treatment and care in custody.

Correct Care Australasia

[14] The medical records maintained by Correct Care Australasia (**CCA**) staff were grossly incomplete and contained inaccurate and misleading information about Veronica's medical history and clinical presentation while at DPFC between 31 December 2019 and 2 January 2020.

[15] The CCA staff involved in Veronica's care between 31 December 2019 and 2 January 2020 all failed to keep proper documentary records of their observations and treatment of Veronica, and failed to complete proper handovers, including:

a. Dr Sean Runacres;

b. RN Stephanie Hills;

c. Dr Alison Brown;

d. RN Mark Minett; and

e. RN Atheana George.

[62] RCIADIC Rec 150, RCIADIC Report Findings and Recommendations, Vol 5, available at <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html#Heading5>.

[16] The medical assessments, treatment and care provided to Veronica by CCA and its staff, in particular Dr Sean Runacres, Dr Alison Brown and RN Athaena George, were grossly deficient and causally contributed to her death.

[17] Dr Sean Runacres' treatment of Veronica was grossly deficient and neglectful and directly contributed to her death. Dr Sean Runacres failed to conduct an adequate comprehensive assessment of Veronica on 31 December 2019, and failed to identify Veronica's urgent need to be sent to hospital, by failing to:

a. conduct any physical assessment of Veronica;

b. identify Veronica's state of severe malnutrition;

c. identify Veronica's need for urgent medical treatment;

d. order ongoing observations of Veronica;

e. take any action to prevent Veronica's transfer to a mainstream prison cell;

f. send Veronica to hospital when concern was raised by RN Stephanie Hills; and

g. treat Veronica with dignity, respect and in a humane manner, as required under s 22 of the *Charter*.

[#] Dr Sean Runacres did not weigh Veronica or conduct any physical assessment of Veronica. He invented Veronica's weight on the relevant JCARE entry. He copied and pasted from pro forma notes and did not amend them as required. In relation to these matters, Dr Runacres's evidence and entries in JCARE was deliberately untruthful.

[18] RN Stephanie Hills failed to send Veronica to hospital on 31 December 2019, once she had formed the view that hospital treatment was required.

[19] Dr Alison Brown's healthcare to Veronica was grossly inadequate and directly contributed to her death. She failed to identify Veronica's urgent need for medical treatment on 1 January 2020 by failing to:

a. appreciate the significance of Veronica's tachycardia and send Veronica immediately to hospital;

b. weigh and assess Veronica for malnutrition;

c. follow up on Veronica's condition;

d. follow up on her request for afternoon nursing observations;

e. properly document her examination of Veronica on JCARE; and

f. take any action to prevent Veronica's transfer to a mainstream prison cell.

[20] RN Mark Minett's care of Veronica was inadequate. He failed to conduct a review of Veronica's condition on 1 January 2020 and failed to identify Veronica's need for urgent medical attention.

[#] RN Mark Minett failed to convey relevant information regarding Veronica's vomiting to Dr Brown.

[21] RN Atheana George's treatment of Veronica was grossly deficient, neglectful, inhumane, and directly contributed to her death. She failed to provide Veronica with adequate treatment and care by failing to:

a. inform herself of Veronica's health status or treatment needs on the nights of 31 December 2019 and 1 January 2020;

b. conduct any welfare checks;

c. direct CV staff to unlock Veronica's cell door;

d. conduct a proper assessment of Veronica when she attended her cell on 2 January 2020; and

e. treat Veronica with dignity, respect, and in a humane manner, as required under s 22 of the *Charter*.

[22] CCA clinicians, Dr Sean Runacres, RN Stephanie Hills, Dr Alison Brown, RN Mark Minett and RN Athaena George, failed to appropriately escalate Veronica's care on 31 December 2019, 1 January 2020 and 2 January 2020.

[#] Veronica was provided with grossly neglectful and inhumane medical treatment by CCA throughout the entirety of her time at DPFC.

[23] At the latest, Veronica should have been transferred to hospital immediately upon entry to DPFC, on the afternoon of 31 December 2019.

[24] There were many missed opportunities for the better capture and handover of significant clinical information about Veronica among CCA clinicians.

[25] There were many missed opportunities for the provision of further or better medical and nursing treatment, and escalation of Veronica's clinical care.

[26] The medical assessment, treatment and care provided to Veronica by CCA fell significantly short of equivalent care she would have received from the public health system in the community.

[#] CCA clinicians failed to follow CCA policies and guidelines in regard to Veronica's treatment and care.

[#] CCA clinicians, Dr Sean Runacres and Dr Alison Brown, failed to provide Veronica with adequate treatment and care for opiod dependence.

[#] CCA failed to conduct adequate cell-health checks on Veronica during the entirety of her time in custody.

[#] The deficiencies in Veronica's care by CCA clinicians, in particular Dr Sean Runacres and RN Athaena George, were due to both direct racism and systemic racism. This was in breach of Veronica's right to equality and non-discrimination under s 8 of the *Charter*.

[#] CCA clinicians failed to provide Veronica with culturally competent or culturally safe healthcare at DPFC. This was in breach of Veronica's cultural rights under s 19 of the *Charter* and right to humanity and dignity in detention under s 22 of the *Charter*.

[#] Veronica's treatment by CCA clinicians amounted to cruel, inhuman and degrading treatment and torture, contrary to s10 of the *Charter* and was incompatible with Veronica's right to dignity and humane treatment in detention under s22 of the *Charter*. CCA clinicians failed to give proper consideration to her human rights under s 38 of the *Charter*.

Corrections Victoria

[28] Whilst in custody at DPFC, Veronica was never well enough to be cleared for placement in a mainstream cell.

[29] Notification to the Aboriginal Wellbeing Officer of Veronica's reception at DPFC should have been undertaken shortly after her arrival on 31 December 2019. DPFC staff failed to comply with CV policies in this regard.

[#] Veronica was culturally and spiritually isolated at DPFC.

[30] There were many missed opportunities for better capture and handover of significant information about Veronica's health presentation among Corrections Victoria (**CV**) Prison Officers, including to Senior Prison Officers.

[31] There were many missed opportunities for the better capture and handover of information about Veronica that was of potential clinical significance from Prison Officers to CCA clinicians on 31 December 2019, 1 January 2020 and 2 January 2020.

[#] Prison Officers on duty in the medical centre from 31 December 2019 to 1 January 2020:

a. Treated Veronica in a way that was inhumane and breached her rights to dignity and humanity under s 22 of the *Charter*;

b. Lied to Veronica;

c. Provided Veronica with medical information that they were not qualified to give, such as directing her to consume salt;[63]

d. Failed to properly record information relevant to Veronica's medical condition, such as her repeated distressed calls and numerous vomits;

e. Failed to appropriately refer medical information, such as distressed calls and vomits, to medical staff;

f. Failed to call a Code Black when Veronica was repeatedly vomiting;

g. Failed to properly conduct cell-checks on Veronica.

[33] The Second Watch Prison Officer, PO Tracey Brown, failed to escalate or adequately escalate Veronica's care on at least three occasions on the morning of 2 January 2020, between 1:30 am and 4 am.

[63] T2216:9-17, T2298:7, T2788.

[#] Between the last call from Veronica at least 3:58am[64] and her body being discovered at 7:30am on 2 January Prison Officers failed to notice the shower consistently running in Veronica's cell.[65]

[#] PO Tracey Brown should have called a Code Black on the morning of 2 January 2020 at 1.30am and should have called an ambulance at that time.

[34] The Second Watch Prison Officer, PO Tracey Brown's, failure to physically check on Veronica at any point overnight, but particularly after Veronica became unresponsive during the final intercom call around 3:58 am on 2 January 2020, was grossly inappropriate and contrary to DPFC policy.

[35] Communication with Veronica by PO Tracey Brown failed to treat Veronica with dignity and respect.

[36] Veronica was lied to by PO Tracey Brown multiple times on 2 January 2020 before she died.

[#] The treatment of Veronica by PO Tracey Brown between 1-2 January 2020 was grossly inadequate, neglectful, inhumane and in breach of her right to dignity and humanity under s 22 of the *Charter*.

[#] Veronica's treatment by CV staff at DPFC amounted to cruel, inhuman and degrading treatment and torture, in breach of s 10 of the *Charter* and was incompatible with her *Charter* rights to dignity and humane treatment in detention (s 22) and right to life (s 9). CV staff failed to give proper consideration to Veronica's human rights under s 38 of the *Charter*.

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[64] T1876:9.
[65] See T1616 where Heath noted that the shower was running as early as 1:30am. T1409, T1616, T1645, T1886.

[#] CV staff failed to provide Veronica with culturally competent or culturally safe care at DPFC. This was in breach of Veronica's cultural rights under s 19 of the *Charter* and right to humanity and dignity in detention under s 22 of the *Charter*,

[#] The treatment of Veronica's body on 2 January 2020, relevant to the circumstances of her death, was culturally unsafe and incompetent and in breach of her cultural rights under s 19 of the *Charter*.

[#] Male prison officers viewed Veronica's naked body after she was found on 2 January 2020. They should not have been able to do so.

[#] Staff members moved items, placed new items into the room, mopped up the floor of Veronica's cell, and moved Veronica's body,[66] after she was found deceased on 2 January 2020. This was in breach of DPFC policies and procedures in relation to the preservation of crime scenes and the *Charter*.

The 'review' of Veronica's death by CCA and Justice Health

64. As emphasised at the first directions hearing, as Veronica was deemed to have died from 'natural causes',[67] a Coronial Inquest was not mandatory.[68] If there had been no Inquest, the only official review of Veronica's death would have been the grossly deficient and misleading JARO review, the Justice Health Death in Custody Report, and

[66] T1409.
[67] We note that the term 'natural causes' was not used in the Coroner's draft findings. Percy urges the Coroner not to describe Veronica's death as due to 'natural causes'. Although this term has a particular legal meaning, it is apt to mislead as it suggests that Veronica was destined to die, and obscures culpability and preventability. See Alison Whittaker, 'Dragged like a dead kangaroo': why language matters for deaths in custody', 8 September 2018, *The Guardian,* available at <https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody>.
[68] See Transcript Directions Hearing 16 July 2020, T4-5. See too *Coroners Act 2008* (Vic) s52(3A).

the 'root cause analysis' by CCA. Put simply, if there was no Inquest, CCA, Justice Health and DJCS would have successfully swept the shocking circumstances of Veronica's death under the carpet. CCA would have gotten away with its central role in Veronica's death. Veronica's family and community, and the broader public, would never have known the truth.

65. Even once the Court confirmed it would hold an Inquest, at every stage, CCA acted to withhold information from the Court, despite consistent pleas for information from Veronica's family.

66. Whilst it is understood that the Coroner will provide a process for submissions regarding CCA's conduct concerning RN Hills's draft statement and what it knew about her likely evidence, the following paragraphs are provided as they also speak to CCA's conduct and approach more broadly.

67. CCA was aware of the central relevance of RN Stephanie Hills's evidence shortly following Veronica's death, and at least from the time that CCA's regional manager, Jeremy Limpens, was directed to interview all staff involved in Veronica's care (including RN Hills).[69] After interviewing RN Hills, who relayed relevant information, Mr Limpens was told by CCA executive management not to take a formal statement from her.[70] Information from RN Hills, or others interviewed by Mr Limpens, was not conveyed to Justice Health and was not included in any official review of Veronica's death.[71] CCA's Deputy CEO, Christine Fuller told the Court that at the time, CCA was not aware of the relevance of RN Hills evidence.[72] Given the statement of Mr Limpens, evidence of RN Hills, and RN Hill's signature on relevant paperwork, this is simply not credible. It is

[69] Statement of Jeremy Limpens, AM1173.
[70] Statement of Jeremy Limpens, AM1173.
[71] T2908-2911.
[72] T2968.

submitted that the withholding of this information from Justice Health and JARO was misleading.

68. Deficiencies and gaps in Veronica's care, of which CCA must have been aware from the documents in its possession, were not disclosed to Justice Health, JARO, CV or DJCS.

69. Despite the Court apparently having issued requests for crucial information, such as contemporaneous notes and relevant CCTV, these were only provided during the Inquest itself, and many times after the conclusion of a witness' evidence.[73]

70. For two and a half years, CCA acted evasively. Four women and one baby have died at DPFC since January 2020. It will never be known whether those deaths would have occurred if CCA had immediately conducted a proper review into Veronica's death.

71. Percy submits that the same obligations stated by the Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) to apply to the Coroner's Court in conducting investigations into a person's death should also apply to investigations into deaths conducted by CCA, Justice Health, JARO or any subsequent body established in its place.[74] This is particularly the case where an Inquest is not mandatory and may only take place years after a person has died in custody.

72. As public authorities under the *Charter*, which are tasked with conducting reviews following a person's death in custody, CCA, Justice Health, and JARO have functions under the right to life to conduct an effective investigation into deaths.[75] As submitted by VEOHRC, "an effective investigation is one that considers and properly investigates apparent breaches of human rights that might have caused or contributed to the death.[76]"

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[73] See for example, AM35, 37, 58, 62, 66, 67.
[74] See VHREOC "preliminary submissions on the Charter" dated 22 April 2022.
[75] See VHREOC "preliminary submissions on the Charter" dated 22 April 2022.
[76] See VHREOC "preliminary submissions on the Charter" dated 22 April 2022 at 8.1.1.

73. Percy submits that CCA's actions of apparently covering-up and/or failing to investigate Veronica's death, and the deficiencies in the JARO and Justice Health reviews, were in breach of Veronica's right to life under s 9 of the *Charter*.

Findings:

[27] CCA's failure to undertake a root cause analysis, or any similar internal review process, within a reasonable time of Veronica's passing was neglectful, misleading, grossly inappropriate and contrary to requirements of the Justice Health Quality Framework (**JHQF**). This failure was also in breach of its obligations to Veronica as a Public Authority under the *Charter* and Veronica's right to life under s 9 of the *Charter*.

[#] CCA's conduct, in failing to correct information in JCARE records it knew to be incorrect or misleading, was misleading.

[#] CCA was aware of the likely contents of a statement of RN Hills and instructed its regional manager, Jeremy Limpens, not to take a statement from RN Hills. This was deliberately misleading.

[#] CCA failed to provide all relevant information regarding Veronica's death and its investigation into Veronica's death, to Justice Health, JARO, CV or DCJS, within a reasonable timeframe after Veronica's death, for the purpose of a review into Veronica's death. This was deliberately misleading and in breach of its obligations to Veronica as a Public Authority under the *Charter* and Veronica's right to life under s 9 of the *Charter*.

[#] CCA's conduct, in failing to provide all relevant information regarding investigations into Veronica's death, including contemporaneous notes, to the Coroner's Court was misleading.

[#] CCA's conduct, in failing to provide a statement from RN Hills in a timely manner and failing to notify the Court that RN Hills was separately represented, was misleading.

Department of Justice and Community Safety

[37] Justice Health's failure to ensure CCA undertook a root cause analysis, or any similar internal review process, within a reasonable time of Veronica's passing, was grossly inappropriate and contrary requirements of the JHQF. This was also in breach of its obligations to Veronica as a Public Authority under the *Charter* and Veronica's right to life under s 9 of the *Charter.*

[38] The Justice Assurance and Review Office (**JARO**) review of Veronica's passing was grossly inadequate. This was also in breach of JARO's obligations to Veronica as a Public Authority under the *Charter* and Veronica's right to life under s 9 of the *Charter.*

[39] The Justice Health Death in Custody Report (**JHDIC**) of Veronica's passing was grossly inadequate. This was also in breach of Justice Health's obligations to Veronica as a Public Authority under the *Charter* and Veronica's right to life under s 9 of the *Charter.*

D. RACISM AND THE RELEVANCE OF VERONICA'S ABORIGINALITY

74. The MCV, Victoria Police, Magistrates Lamble and Bolger, Mr Antos, medical and prison staff who were involved with Veronica, did not treat her with humanity, dignity or respect.[77]

75. Many witnesses gave evidence about their training and policies, however, their attitudes and actions demonstrate they know *how to say* the right thing, but not *how to do* the right thing.

[77] T2421; T2422:12-18.

76. None of these people actually recognised or understood the impact of their (own personal or institutional) culture and values on Aboriginal people.[78]

77. Expert and lay witnesses gave evidence highlighting that, unfairly, the onus was shifted to Veronica to advocate for herself throughout her time in custody.[79] Despite being so sick, vulnerable, and isolated; she attempted to do so time and time again. She was disregarded and dismissed each time.

78. The Amended Scope of Inquest includes at item 4:

> *4. The relevance of …a. Ms Nelson's Aboriginality…to the decisions made in relation to her from her arrest on 30 December 2019 to her death on 2 January 2020.*

79. Systemic racism is 'the most insidious form of racism because it is difficult to quantify' and is performed by people 'who see themselves as "just doing their job".[80]

80. Given that blatant and overt forms of discrimination and subjective intentions tend to be relatively rare, an inquiry into systemic racism requires consideration of *circumstances* that infer unconscious beliefs and biases and the prejudicial *effect* of policies, procedures and practices.[81]

81. Among these dominant *assumptions* include that Aboriginal people are drunks, drug addicts, rude, uneducated, unruly or aggressive and of little utility. Among these dominant *values* is that a non-Aboriginal person's life is worth more than an Aboriginal person's life.

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[78] T2422.
[79] T2639; T2713.
[80] Harry Blagg, Neil Morgan, Chris Cunneen and Anna Ferrante (2005) Systemic Racism as a Factor in the Over-representation of Aboriginal People in the Criminal Justice System, Report to the Equal Opportunity Commission and Aboriginal Justice Forum, Melbourne, 7.
[81] Gerry McNeilly, *Broken Trust: Indigenous People and the Thunder Bay Police Service*, Office of the Independent Police Review Director, December 2018, 181.

82. A key finding of RCIADIC is that the over-representation of Aboriginal people in the criminal justice system and in custody is a direct contributor to the over-representation of Aboriginal deaths in custody.[82]

83. Racism in the health system is compounded when a person is in custody. This can be due to the intersectional bias that medical and paramedical personnel bring to bear on Aboriginal people in custody, or where they uncritically accept prejudicial judgments on the part of the police, including that the Aboriginal person is fabricating their illness or that the Aboriginal person's pain or incapacity is attributed to alcohol and drugs.[83]

84. Any reasonable, open-minded view of the evidence of Veronica's treatment between 30 December 2019 and 2 January 2020 readily reveals that there was something more sinister at play than simple neglect. Clearly Veronica's drug use and criminal antecedents also played a role in the way she was treated; however, those factors are common to a larger number of the prison population than Aboriginality, which is the focus of this section of the submissions.

85. Clearly Veronica was denied simple humanity and dignity by each of the members of Victoria Police, the barrister briefed to represent her on 31 December 2021, MCV, the representatives of CCA and CV officers. The question is whether the Coroner can or should make a finding that the reason that Veronica was denied humanity and dignity was, in part, due to bias against her because she was an Aboriginal woman.

86. As to whether the Coroner can make such a finding, it is certainly supported by both lay and expert evidence. Percy, who has also spent time in prison, gave evidence that:

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[82] RCIADIC, National Report, Volume 1, 1.3.3, available at <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/>.
[83] See Thalia Anthony Report into Systemic Racism for the Tanya Day Inquest, at [38] citing the Inquest into the death of Robert Taylor Daly [2008] NTMC 055, [34] and Inquest into the Death of Ms Dhu, Coroner's Court of Western Australia, No. 11020-14, 16 December 2016, [857].

> *"It's bad, the way they look at us and treat us. They think they didn't care about her. They just thought she was a heroin addict and another blackfella, just wanting a quick fix. There's another black girl crying out for drugs, she wants a quick fix. I don't think she would've been treated that way if she wasn't a blackfella. I know how they treat us."*[84]

87. Kylie Bastin's evidence was that:

> *"Are you able to say as an Aboriginal woman, do you experience in your view that you're treated any differently because you're Aboriginal?---They, they kind of - yeah, like they don't um - like they just assume that we're all, like, the same like just ruby (as said by witness). Like we don't - they don't care about us. Like they don't really, like - (indistinct) especially when it comes to our medications. Like, you know - like we - like they don't - they make us wait, like they don't - they say that we get this and that, like we don't - but we don't. It's, like, takes forever."*[85]

88. Later in her evidence:

> *And Counsel Assisting asked you a few questions about Aboriginality. Given your evidence that you say, 'They treat us all like shit,' have you experienced or have you observed a worse treatment for Aboriginal - - - ?---No. - - - women than other women in the prison?---Oh, yeah, like, I believe that they've treated, like, especially with this situation, she was treated like, I've never seen a situation like that. That was pretty bad. Like, anyone else would be, you know, they'd rush, like, like, they would make sure, like, there'd be help for them,*

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[84] T46:8-15.
[85] T1404-1405.

> *yeah? Where, like, see how you said the way they spoke to her? Like, that, yeah, I've never heard that, that happening to anyone else, yeah.*
>
> *So understand that but are you talking about that in the context of Veronica being an Aboriginal woman?---Yeah.*
>
> *All right?---Yeah.*
>
> *So your answers are that you haven't seen them treat a white woman that same way?---No, no, no – that's right.*[86]

89. Neither Percy nor Ms Bastin were challenged on their evidence in this regard.

90. Moreover, the expert evidence before the Coroner, provided by internationally recognised experts, strongly supports the making of such a finding. In the interests of brevity, only some of the relevant evidence is identified in short form in the following paragraphs.

91. Dr Amanda Porter's opinion on this point was clear, emphatic and uncontested.[87] So was Professor Megan Williams's opinion.[88] Based on this evidence, the Coroner should accept that at each of the stages at which Victoria Police, the legal system (with the exception of Ms Prior and Mr Schumpeter, but specifically including the MCV), CCA (with the exception of RN Hills) and CV dealt with Veronica, their conduct was affected by systemic racism, interpersonal racism, unconscious bias and structural racism.

92. The above lay and expert evidence supports the further submitted findings relevant to Veronica's Aboriginality indicated in the body of this submission.

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[86] T1415.
[87] See in particular the passages of Dr Amanda Porter's opinion in the Coroner's Brief, IB2311 onwards.
[88] See in particular the passages of Professor Megan Williams's opinion in the Coroner's Brief, IB4141 onwards.

Findings:

Systemic issues

[#] Veronica's healthcare was deficient due to systemic racism, racial bias and stereotyping.

[#] Veronica's treatment in custody was deficient due to systemic racism, racial bias and stereotyping.[89]

[#] The MCV, Victoria Police, Magistrates Lamble and Bolger, Mr Antos, medical (with the exception of RN Hills) and prison staff who were involved with Veronica, did not treat her with humanity, dignity or respect.

[40] Various entities failed to adequately take into account Veronica's greatly increased likelihood of dying in custody from inadequate medical care as an Aboriginal woman including:

a. Police;

b. the Magistrates' Court of Victoria (**MCV**);

c. CCA at DPFC; and

d. CV.

[41] Various entities failed to adequately take into account or make reasonable enquiries as to Veronica's vulnerability in custody as a person with opioid dependencies including:

a. Police;

b. the MCV;

[89] T2424.

c. CCA at DPFC; and

d. CV.

[42] Various entities failed to adequately take into account the minor and non-violent nature of Veronica's criminal antecedents in determining her treatment including:

a. Police;

b. the MCV;

c. CCA at DPFC; and

d. CV.

[43] Various entities failed to treat Veronica in a culturally competent and culturally safe manner including:

a. Victoria Police;

b. the MCV;

c. CCA at DPFC; and

d. CV.

[44] There existed no adequate procedure at DPFC for the medical clearance of a prisoner from the Health Centre to another accommodation unit, and this systemic failure causally contributed to Veronica's death.

[45] Cell placement decisions at DPFC were made on the basis of incomplete information.

[46] Clinical decisions at DPFC were made on the basis of incomplete information.

> [47] The medical assessments, treatment and care Veronica received while at DPFC between 31 December 2019 and 2 January 2020 were not equivalent to the care she would have received in the community.

93. Veronica was loved and adored.

94. Percy felt safe with her. He felt loved by her. She felt loved by him. She knew he loved her. They were always happy. Only the two of them knew the relationship they had. Veronica was a young woman. She and Percy had plans for the future.[90]

95. Veronica loved her family. Veronica is missed every minute of every day.

96. Veronica deserved a life of dignity and respect, a life worthy of her.

E. REFERRALS TO THE DPP

97. Percy submits that the Coroner can (on the whole of the evidence) safely form a belief[91] that an indictable offence may have been committed and refer the matter to the DPP per s 49(1) of the Act. There is no requirement the Coroner be satisfied or hold a belief that an indictable offence has been committed.

98. The Coroner must, in discharging his duties, include whether any person contributed to Veronica's death,[92] however the Coroner must not record within his findings any belief of guilt for an offence,[93] consideration of sufficiency or admissibility[94] of evidence for a prosecution, nor prospects of a prosecution.

99. Percy submits that in relation to referrals to be made to the DPP, specific possible offences should be identified. Whilst those possible offences would not bind the DPP in

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[90] IB215.
[91] *Maksimovich v Walsh* (1985) 4 NSWLR 318 at 330, see also *George v Rockett* [1990] HCA 26 at [14].
[92] *Priest v West* [2012] VSCA 327.
[93] *Coroners Act* 2008 s69(1).
[94] *Leahy v Barnes* [2013] QSC 226 at [59]-[61].

considering the merits of prosecution, they would serve as guidance based on the significant evidence the Coroner has heard and considered.

100. Percy submits that on the evidence, the Coroner should form the belief that:

a. Dr Sean Runacres

b. Dr Alison Brown

c. RN Atheana George

d. PO Tracy Brown

e. CCA

f. CV

may have committed an indictable offence in connection with the death of Veronica, namely negligent manslaughter.

101. For the offence of manslaughter by criminal negligence, four elements need to be proven:

a. *First*, a duty of care was owed to Veronica. Given Veronica was in the custody of CV and in receipt of medical care by CCA staff, this element is not in doubt.

b. *Second*, the duty was breached, in that the acts of the accused fell so far short of the standard of care a reasonable person would have exercised, and involved such a high risk of death or really serious injury, that it deserves criminal punishment. Percy refers to his submissions above in respect of the conduct of the named individuals.

c. *Third*, the acts breaching the duty were voluntary and deliberate. This should not be controversial. There is no suggestion that the acts or omissions were accidental or unintended.

d. *Fourth*, that the breach caused Veronica's death. The breach need only be a substantial or significant cause, rather than the only, direct or immediate cause. Taking the evidence together, including the pathological evidence, the acts or omissions of the named parties were the substantial or significant cause of Veronica's death. The unanimous expert evidence was that Veronica would have survived had she been taken to hospital when she was first admitted into the prison system and for a significant time thereafter.

102. In addition, the Coroner should further form the belief that CV and CCA may have committed an indictable offence, being a breach of s 23 of the *Occupational Health and Safety Act 2004* which provides:

> *An employer must ensure, so far as is reasonably practicable, that persons other than employees of the employer are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer.*

103. Whilst their employees had the benefit of a certificate against self-incrimination, neither CCA and CV has such a benefit, and further, their employees can be compelled to give evidence, consistent with their Inquest evidence, as against their employers. If the matter is referred to the DPP against these bodies, there is no prejudice to them in having all the transcripts provided to the investigating bodies.

F. OTHER REFERRALS

104. Dr Runacres, Dr Brown, RN Minett and RN George are registered health practitioners subject to regulation by the Australian Health Practitioner Regulation Agency (**AHPRA**).

105. The Coroner should formally provide a copy of his findings to AHPRA, and make a notification of serious concerns regarding the medical care provided to Veronica by Dr Runacres, Dr Brown, RN Minett and RN George between 31 December 2019 and 2 January 2020.

106. It is understood that WorkSafe is currently investigating the circumstances of Veronica's passing, and in doing so is looking into systemic failures at DPFC. Percy supports that investigation occurring and supports the Coroner's Court providing all relevant information to WorkSafe, including the unredacted Coronial Brief and all transcripts, for the purpose of its investigation.

107. The Coroner should also formally provide a copy of his findings to:

    a. The DPP, to consider the conduct of any other person or witness in this proceeding not identified above;

    b. WorkSafe, to consider the conduct of CCA and CV;

    c. The Legal Services Board, to consider the conduct of Tass Antos.

G. RECOMMENDATIONS

108. Percy thanks the Coroner for listening to the expert voices presented throughout this Coronial Inquest in drafting the proposed recommendations. He seeks additions and amendments to the Coroner's recommendations below based on the experience of VALS and of experts.

109. Percy wishes to provide a short explanation as to two aspects of the proposed amendments to the recommendations.

Culturally appropriate bail proceedings

110. First, in its submissions dated 18 May 2022, VEOHRC made reference to 'Gladue Reports' and factors to be considered under s 3A of the *Bail Act*.

111. The Coroner is referred to the pre-existing project in Victoria, led by VALS, in collaboration with the University of Technology Sydney, and developed in consultation with Elders, the Courts and Judiciary, to implement Gladue-style reports, known as 'Aboriginal Community Justice Reports' (**ACJR**) in Victorian Courts.[95] VALS's work on ACJR reports dates back to 2015. This project exclusively relates to sentencing decisions and not bail. VALS has had initial conversations with its colleagues at Aboriginal Legal Services in Toronto to consider how this project might be extended to bail. VALS's preliminary view from these conversations is that Gladue-style reports are not appropriate for use in bail proceedings due to the potential for delay, the inappropriateness of commenting on offending prior to any offending being proven, and the imposition of burdens on an accused person. However, there have been positive results in Canada where specialised Indigenous courts have jurisdiction to hear bail proceedings. This includes in Ontario, where bail applications can be made in Gladue Courts, and Indigenous persons applying for bail have access to specialised Indigenous bail support programs.[96] Recommendations in regard to this are included below.

112. VALS has also commenced a scoping exercise with regard to producing a training guide and materials on consideration of Aboriginality under s 3A of the *Bail Act*, similar to the

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[95] For further information on Aboriginal Community Justice Reports see 'Aboriginal Community Justice Reports Project', available at <https://www.vals.org.au/aboriginal-community-justice-reports/>; 'CPD Session: Aboriginal Community Justice Reports Pilot Project', 2020, available at <https://www.cpdinsession.com.au/wp-content/uploads/2020/10/Paper-and-Presentation.pdf>; Thalia Anthony, Andreea Lachsz and Nerita Waight, 'The role of re-storying' in addressing over-incarceration of Aboriginal and Torres Strait Islander peoples', 17 August 2021, *The Conversation,* available at <https://theconversation.com/amp/the-role-of-re-storying-in-addressing-over-incarceration-of-aboriginal-and-torres-strait-islander-peoples-163577>.

[96] For further information, see 'Indigenous Bail Verification Supervision Program', available at <https://tbifc.ca/program/indigenous-bail-verification-supervision-program/>; Jonathan Rudin, *Indigenous People and the Criminal Justice System* (Emond Montgomery Publications, 2nd ed, 2022) (forthcoming).

Bugmy Bar Book in NSW which applies to sentencing decisions.[97] It is noted that the principle of self-determination and the need for cultural oversight of the development of this resource.[98] Recommendations are added below on this topic.

Culturally safe medical care in prison

113. The first Aboriginal Community Controlled Health Organisation (**ACCHO**) was founded in Redfern in 1971, "in response to experiences of racism in mainstream health services and an unmet need for culturally safe and accessible primary health care." Aboriginal-led health organisations are essential to ensuring culturally safe health services are provided to Aboriginal people, and are a manifestation of Aboriginal self-determination.[99]

114. In the Northern Territory[100] and the Australian Capital Territory,[101] ACCHO's have begun delivering primary health services in adult and youth prisons. This is an important first-step to the provision of equivalent and culturally safe healthcare in prisons. Recommendations on this topic are included below.

115. Last year, a Guardian analysis of 474 Aboriginal and/or Torres Strait Islander Deaths in Custody since 1991, found that for both Aboriginal and Torres Strait Islander people and

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[97] 'The *Bugmy* Bar Book', available at <https://www.publicdefenders.nsw.gov.au/barbook>.
[98] The *Bugmy* Bar Book was developed by the Aboriginal Legal Service (NSW) and all chapters are reviewed by an Aboriginal and/or Torres Strait Islander member of an independent advisory panel. Chapters which relate specifically to the experiences of Aboriginal and Torres Strait Islander peoples are also researched and/or supervised, and subject to expert review, by appropriate Aboriginal and/or Torres Strait Islander researchers, supervisors, Committee members and experts.
[99] National Aboriginal Community Controlled Health Organisation, 'Aboriginal Community Controlled Health Organisations', available at <https://www.naccho.org.au/acchos>.
[100] In 2019, Danila Dilba Health Service took over the provision of primary healthcare services at Don Dale Detention Centre: Territory Families, Northern Territory Government, 'Statement of Commitments', April 2019, available at <https://nt.gov.au/?a=1048286%3Anewsroom%2F28947_11435__statement-of-commitments-1.pdf>. However, Danila Dilba has faced difficulties due to the lack of access to medicare for people in prison, see: Jesse Thompson, 'Greg Hunt rejects Danila Dilba's request for Medicare-funded health services in Don Dale', *ABC News,* 19 October 2020, available at <https://www.abc.net.au/news/2020-10-19/don-dale-medicare-health-services-rejected-by-greg-hunt/12776808>.
[101] Heidi Shukralla, Julie Tongs, Nadeem Siddiqui, Ana Herceg, 'Australian first in Aboriginal and Torres Strait Islander prisoner health care in the Australian Capital Territory' (2020) 44(4) *Australian and New Zealand Journal of Public Health,* available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.13007>.

non-Indigenous people, the most common cause of death was medical problems, followed by self-harm. However, Indigenous people who died in custody were *three times more likely not to receive all necessary medical care*, compared to non-Indigenous people. For Indigenous women, the result was even worse – *less than half received all required medical care* prior to death.[102]

116. This statistic is particularly egregious given that Aboriginal and/or Torres Strait Islander people have higher rates of underlying health conditions than the general population.[103] It demonstrates the systemic racism within prison healthcare and the need for culturally safe care within prisons.

117. The State of Victoria is unique in outsourcing its prison health care to private for-profit providers. This leads to a fragmented system of healthcare and the exact sort of gaps and failings which led to Veronica's death.

118. The conduct of CCA in relation to Veronica's death, and the gross lack of healthcare provided by all of its employees to Veronica, readily demonstrate the urgent need for Victoria to transfer back the provision of healthcare in prison to the Department of Health. Recommendations to this effect are also set out below.

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[102] Lorena Allam, Calla Wahlquist, Nick Evershed, 'The facts about Australia's rising toll of Indigenous deaths in custody', *The Guardian*, 9 April 2021, available at <https://www.theguardian.com/australia-news/2021/apr/09/the-facts-about-australias-rising-toll-of-indigenous-deaths-in-custody>.
[103] Australian Institute of Health and Welfare, 'The health of Australia's prisoners 2018', 2019, available at <https://www.aihw.gov.au/getmedia/2e92f007-453d-48a1-9c6b-4c9531cf0371/aihw-phe-246.pdf.aspx?inline=true>.

ANNEXURE A
PROPOSED AMENDMENTS AND ADDITIONS TO CORONER'S DRAFT RECCOMENDATIONS

Bail Act 1977 (Vic)

[1] That the Attorney General of Victoria urgently review the *Bail Act* and amend its terms such that:

a. section 4AA is repealed;[104]

b. section 4A is repealed;

c. section 4C is repealed;

d. section 4D is repealed;

e. Schedules 1 and 2 are repealed;

f. section 4E is amended so that –

i. subsection (1)(a)(ii) refers to the commission of a 'violent offence' while on bail;

ii. subsection (1)(a)(iv) refers to a risk that a person will "flee the jurisdiction" and not a risk that a person will fail to attend Court for other reasons;[105]

iii. subsection (1A) is added to state "A bail decision maker must not refuse bail for a person accused of any offence if the alleged offence is unlikely to result in a sentence of imprisonment";

g. section 18(4) is repealed;

h. section 18AA is amended so that --

[104] The Administration of Justice Conclave reached a consensus view that the reverse onus provisions of the Bail Act 1977 (Vic) be repealed in their entirety: T2537:1-8.
[105] See Coronial Inquest into the death of Mr Ward, which recommended that breach of bail conditions by non-attendance at court should not be grounds for bail refusal and should be avoided due to the adverse impact on Aboriginal and/or Torres Strait Islander people: *Inquest into the death of Ian Ward*, State Coroner of Western Australia, 12 June 2009, available at: <http://www.abc.net.au/4corners/special_eds/20090615/ward/ward_finding.pdf>.

i. an applicant for bail need not establish 'new facts and circumstances' before making a second application for bail; and

ii. an applicant for bail who is vulnerable (for instance, by virtue of being an Aboriginal and/or Torres Strait Islander person, a child, or a vulnerable adult as these terms are defined in sections 3 and 3AAAA, respectively, of the *Bail Act*) need not establish 'new facts and circumstances' before making any subsequent application for bail.

i. section 30 is repealed;

j. section 30A is repealed;

k. section 30B is repealed;

l. Aboriginal and/or Torres Strait Islander people should always have the opportunity to be represented in all criminal legal proceedings, but particularly in bail proceedings, by a lawyer who provides culturally safe legal representation;

m. where an applicant for bail is not legally represented, BDMs are required --

i. to make inquiries as to whether the person is Aboriginal and/or Torres Strait Islander;

ii. to ensure, as far as possible, that an Aboriginal and/or Torres Strait Islander person has legal representation;

iii. to enquire about each of the matters specified in section 3A and 3AAA of the *Bail Act*, to enable them to comply with section 3A and the legislative obligation to take into account the surrounding circumstances and any issues arising due to a person's Aboriginality;

iv. keep a record of their enquiries; and

v. may direct an Informant (or nominal Informant) to interrogate any relevant database or other information in its possession to identify information relevant to a proper consideration of sections 3A and 3AAA of the *Bail Act*, particularly that which would favour a grant of bail, and present it to the BDM within a reasonable time;

n. BDMs who are Judicial Officers must articulate at the time of the decision, and with reference to sections 1B, 3A and 3AAA, the matters taken into account and reasons for any refusal to grant an application for bail made by a person to whom section 3A of the *Bail Act* applies; and

o. BDMs intending to refuse an application for bail are required to make all necessary enquiries about, and where necessary note on any remand warrant or order, any potential custody management issues.

Training on section 3A of the *Bail Act*

[#] VALS should be funded to work with Aboriginal communities to develop a formal guide and training for BDMs, legal practitioners, prosecutors and Magistrates, so that they understand the relevance of Aboriginality for bail decisions. These resources should include information on the unique systemic and background factors affecting Aboriginal people in the justice system, including the way that colonisation has impacted on their lives, families and communities. They should also identify the strengths of Aboriginal communities, including connection to culture, language and Country, and non-custodial, culturally-appropriate and culturally safe alternatives to remand.

[#] All BDMs, legal practitioners who may represent Aboriginal and/or Torres Strait Islander people, prosecutors, and Magistrates must be required to undertake mandatory training on s 3A and cultural awareness that is developed by VALS in conjunction with Aboriginal and/or Torres Strait Islander communities. Training must be delivered on a regular basis, not just as a "one off".

Crimes Act 1958

[#] That the *Crimes Act 1958* (Vic) be amended so as to include a principle that arrest is a last resort and requiring police to initiate charges by summons rather than bail or remand where this is the most appropriate enforcement action.

[2] That section 464FA of the *Crimes Act 1958* (Vic) (***Crimes Act***) be amended so as to require an investigating official to actively facilitate an Aboriginal and/or Torres Strait Islander person taken into custody to speak to the Victorian Aboriginal Legal Service (**VALS**) and to inform the person not only that VALS has been notified that they are in custody but also that:

a. the purpose of the notification is for VALS to perform a welfare and wellbeing assessment on the person including –

i. identification of any medical, physical and mental health concerns, disability or impairment (including due to substance use); and

ii. communication of any identified risks to the person's safety while in custody to Police so that appropriate management and care is provided.

b. the person may communicate with a VALS Client Notification Officer (CNO);

c. with the person's consent, CNOs may advise their family members, partner or other people of their wellbeing and whereabouts; and

d. with the person's consent, CNOs will contact a VALS on-call solicitor to provide pre-interview legal advice.

e. Inform the person that this service and support is available at any time, including during an interview.

[3] That section 464FA of the *Crimes Act* be further amended to require that compliance with this section, and any response provided by the Aboriginal and/or Torres Strait Islander person taken into custody, be documented.

[4] That in accordance with the principles known as the *Anunga Rules*,[106] sections 464A(3) and 464C of the *Crimes Act* be amended, respectively, to require an investigating official to explain to an Aboriginal and/or Torres Strait Islander person in custody in simple terms:

a. the meaning of the caution and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the caution to ensure that both the right to remain silent and that anything they do or say may be used in evidence is understood; and

b. the meaning of each communication right and ask the person to tell the investigating official in their own words, phrase by phrase, what is meant by the rights to ensure they are understood.

[106] *R v Anunga and ors* and *R v Wheeler and another* (1976) 11 ALR 412.

[#] Aboriginal Community Justice Panels (**ACJP**) should be adequately funded to provide culturally safe support to Aboriginal and/or Torres Strait Islander people in police custody, including during police bail or bail justice hearings.[107]

Victoria Police

[5] That Police amend any Victoria Police Manual (**VPM**) policies in order to:

a. require all police BDMs to enquire about each of the matters in section 3AAA and section 3A of the *Bail Act*.

b. ensure an Aboriginal and/or Torres Strait Islander person under arrest has a meaningful opportunity to make an informed decision about whether to accept an offer to communicate with a VALS CNO, including providing the person with information about the purpose of that contact and what assistance the CNO may be able to provide;

c. ensure an Aboriginal and/or Torres Strait Islander person under caution has a meaningful opportunity to both:

i. consider whether to exercise their rights to communicate with a friend or relative and a legal practitioner; and

ii. to exercise those rights;

d. require Police members to initiate charges by summons rather than bail or remand where charging is considered the most appropriate enforcement action;

e. ensure that the Appendix 2: Police Bail Process flow chart, and other Bail and Remand VPMs, prominently identify the circumstances in which Police BDMs are permitted under the *Bail Act* to grant bail to an Aboriginal and/or Torres

[107] The ACJP Program is currently a volunteer-based community initiative supporting communities and individuals needing assistance in justice or legal related matters. The Panels take a diversionary approach in supporting preventative initiatives for community and individual participation as well as providing direct support through a 'Call-Out' service to individuals held in Police custody. ACJP should be adequately funded to provide culturally safe support to Aboriginal people in police custody, including in relation to bail. For further information on the ACJP Program, see: Victorian Aboriginal Legal Service, 'Aboriginal Community Justice Panels (ACJP) Program', available at <https://www.vals.org.au/aboriginal-community-justice-panels-acjp-program/#:~:text=Aboriginal%20Community%20Justice%20Panels%20%28ACJP%29%20Program.%20The%20ACJP,and%20individual%20participation%20as%20well%20as%20providing%20>.

Strait Islander person required to demonstrate the existence of exceptional circumstances;

f. require a record of all bail decisions made by Police BDMs which reflects who made the decision, the relevant charge(s), the reasons for the decision and the sources of the information that informed the decision as well as those party to the decision making process;

g. minimise and eliminate where possible the use of nominal Informants at remand/bail hearings before Judicial Officers; and

h. ensure Informants (or any other delegated member) preparing a remand brief makes appropriate enquiries to enable an accurate estimate of the length of time required to prepare the brief of evidence (including the likely time to obtain any forensic analyses).

i. State that handcuffs, a use of force, should only be used as a last resort, when other control methods (including de-escalation techniques) have been exhausted and failed; certainly not as a matter of course. Handcuffs should only be used where necessary (to prevent escape, or an individual harming themselves or another person), should be for as short a time as possible, should be applied in a manner that respects the privacy and dignity of the person, especially in public (acknowledging that being handcuffed is a humiliating experience), should not be applied in a manner that causes pain. Any use of handcuffs should be recorded by police officers, and police officers who do not comply with policies should be subject to disciplinary processes.

[6] That Police urgently, within three months, correct any misunderstanding and commence re-training members in respect of any informal policy which requires Police to oppose all remand bail applications involving the exceptional circumstances test, as such an informal policy is contrary to:

a. the requirement that Police exercise genuine discretion as a Public Authority under the *Charter*;

b. the requirement that Police Prosecutors (whether legal practitioner or not) behave as model litigants in the conduct of litigation.

c. The obligations of model litigants and their positive duties to the Court.

[7] That Police require training to be provided to members, which is developed in consultation with VEOHRC, which highlights:

a. the requirement that Police as a Public Authority under the *Charter* are required to act in accordance with the *Charter* when making decisions in the course of their duties;

b. the requirement that Police Prosecutors behave as model litigants in the conduct of litigation.

c. The obligations of model litigants and their positive duties to the Court.

[8] That Police collect and retain statistics that identify:

a. the number of people charged with an offence to which the 'exceptional circumstances test' applies and, of those, how many are:

i. bailed by Police;

ii. remanded into custody;

iii. Aboriginal and/or Torres Strait Islander people;

iv. Aboriginal and/or Torres Strait Islander women; and

v. women.

b. the number of people charged with an offence to which the 'compelling reasons test' applies and, of those, how many are:

i. bailed by Police;

ii. remanded into custody;

iii. Aboriginal and/or Torres Strait Islander people;

iv. Aboriginal and/or Torres Strait Islander women; and

v. women.

To ensure transparency and accountability, and in accordance with Aboriginal data sovereignty,[108] this data must be published and made publicly available on a regular basis and disaggregated by region and police station.

[108] The concept of Aboriginal data sovereignty mandates that Aboriginal communities and ACCOs have a right to access and interpret information concerning Aboriginal individuals and communities, as well as the right to determine how the data is used and disseminated within mainstream society. The authority and control over such data not only ensures that the information is understood in its

Magistrates' Court of Victoria

[#] That the MCV implement a practice note requiring the prioritisation of Aboriginal and/or Torres Strait Islander applicants, and other vulnerable applicants, at the Bail and Remand Court.

[9] That the MCV collect and retain statistics that identify:

a. The number of people charged with an offence to which the 'exceptional circumstances test' applies and, of those, how many are:

i. bailed;

ii. remanded into custody;

iii. Aboriginal and/or Torres Strait Islander people;

iv. Aboriginal and/or Torres Strait Islander women;

v. Women; and

vi. Unrepresented persons (disaggregating this data).

b. The number of people charged with an offence to which the 'compelling reasons test' applies and, of those, how many are:

i. bailed;

ii. remanded into custody;

iii. Aboriginal and/or Torres Strait Islander people;

iv. Aboriginal and/or Torres Strait Islander women;

v. Women; and

vi. Unrepresented (disaggregating this data).

c. The percentage of Aboriginal and/or Torres Strait Islander people appearing before the BaRC who are able to access a Koori CISP worker.

To ensure transparency and accountability, and in accordance with Aboriginal data sovereignty, this data be made publicly available and published on a regular basis and disaggregated by region.

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appropriate context, but is also beneficial to ACCOs to ensure that the services and programs provided meet the demand and needs of Aboriginal communities. For further information, see AIATSIS, 'Delivering Indigenous Data Sovereignty', 2 July 2019, available at <https://aiatsis.gov.au/publication/116530>.

[10] That the MCV employ sufficient Aboriginal and/or Torres Strait Islander staff in roles (however described) within the court to provide assistance and, where necessary, advocacy, to Aboriginal and/or Torres Strait Islander court users including people remanded in custody, and develop and implement:

a. a process by which the Position Description for these roles is led by Aboriginal and/or Torres Strait Islander people with relevant expertise, in consultation with stakeholders including the end users of the service provided; and

b. robust processes to ensure timely notification of Aboriginal and/or Torres Strait Islander staff about the presence of any Aboriginal and/or Torres Strait Islander people at court or in the cells at the Melbourne Custody Centre.

[11] The MCV develop and implement a process to ensure that judicial officers determining applications for bail are informed of any custody management issues so that these are noted on remand warrants.

[12] The MCV ensure that the Court Integrated Services Program is available whenever the court is open, including throughout BaRC sessions, and is available at all Court locations in Victoria.

[#] The MCV ensure that leave of a Magistrate is not required for assessment for the Court Integrated Services Program at any location.

[#] The MCV review the Court Integrated Services Program assessment process, including any expiry periods for reports.

[#] The MCV ensure that a Koori Liaison support worker, as well as a Koori CISP worker, is available in person at all times when the Court is open, including throughout BaRC sessions.

[#] The MCV ensure that all Aboriginal and/or Torres Strait Islander people in court have access to a Koori Liaison support worker, as well as a Koori CISP worker.

[#] The Victorian Government should work with the MCV and with Koori Courts and Aboriginal communities to consider how Koori Courts can be expanded to hear bail applications in a culturally appropriate setting.[109]

[109] A consensus of the Administration of Justice conclave recommended an expansion of the Koori Court to hear bail hearings: T2647:5-31;T2648:1-25. Koori Courts were established in Victoria in 2002 in response to the RCIADIC. Currently, an Aboriginal person who has a matter at the Magistrates' Court, County Court or Children's Court, can choose to go to Koori Court rather than the generalist court. However, Koori Courts are sentencing courts; they do not hear contested matters and do not deal with bail applications.

[#] The Victorian Government provide sufficient funding for VALS to provide a culturally safe duty lawyer service at the BaRC.[110]

Drug and Alcohol Services

[13] The Victorian Department of Health (**DOH**), in collaboration with VACCHO and member organisations, and other stakeholders, design, establish and adequately resource multiple culturally safe, gender-specific, dually residential and out-patient rehabilitation facilities for Aboriginal and/or Torres Strait Islander women with drug and/or alcohol dependence. These facilities must be in locations which enable Aboriginal and/or Torres Strait Islander women to be able to choose to remain on country, close to their family and community, including their children.[111]

Victoria Legal Aid

[#] That Victoria Legal Aid implement mandatory minimum requirements for its summary criminal law panel, including

a. A requirement for a legal practitioner to have a minimum of two years practice experience in criminal law;

b. A requirement for mandatory training on s 3A and cultural awareness, developed in consultation with VALS;

c. A requirement for mandatory training on the prioritisation of Aboriginal and/or Torres Strait Islander people's bail applications.

In some parts of Canada, there are specialised bail courts for Aboriginal people. Similar to Koori Courts in Victoria, these specialised bail courts have judges/magistrates who are more familiar with the issues experienced by Aboriginal people, resulting in more culturally appropriate hearings and bail decisions than in generalist courts.

To reduce the number of Aboriginal people on remand and ensure that bail decision makers properly consider someone's Aboriginality, it is essential to provide access to culturally appropriate bail proceedings. The Government should work with Koori Courts and Aboriginal communities to look at how Koori Courts can be expanded to hear bail applications.

[110] Currently only Victoria Legal Aid is funded to provide a duty lawyer service at BaRC.

[111] The current Aboriginal Justice Agreement includes a commitment to "Develop and implement cultural and gender-specific supports for Aboriginal women involved in the corrections system to obtain bail and avoid remand", see Victorian Aboriginal Justice Agreement, 'Assist Aboriginal women with bail', available at <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-23-fewer-aboriginal-people-progress-3>.

Custodial Health Services

[14] Oversight and management of custodial health services be undertaken by the Victorian Department of Health (DoH) not the DJCS.[112]

[#] Custodial health care should not be contracted to private, profit-driven corporations and should be delivered through the DoH.[113]

[#] Justice Health should immediately review the breach and termination mechanisms in its its contract with CCA with a view to considering termination based on its conduct concerning Veronica Nelson. Given its conduct in relation to Veronica's death, and the lack of confidence in its provision of healthcare in prisons, the Victorian Government should require CCA to immediately show cause as to why it should be permitted to deliver health services to people in prison in Victoria.

[#] The Federal Government must ensure that incarcerated people have access to the Pharmaceutical Benefits Scheme and the Medicare Benefits Schedule. The Victorian Government should advocate with the Commonwealth to enable this access, in order to provide equivalence of care to Aboriginal and/or Torres Strait Islander people and other vulnerable people held in prison.[114]

[#] The Victorian Government should provide funding for a model of delivery of primary health services by Aboriginal Community Controlled Health Organisations (ACCHOs) in all places of detention, in consultation with VACCHO and member organisations.[115]

[#] The Victorian Government, in partnership with ACCHOs, must prioritise the development, finalisation and implementation of standards for culturally safe, trauma informed health services in the criminal legal system, as required in the current Aboriginal Justice Agreement.[116]

[#] The Victorian Government should employ an adequate number of Aboriginal Health Workers and Aboriginal Wellbeing Officers at all levels of the justice health system (Victoria Police, Courts, Forensicare/MHARS, Community Corrections, Correctional Health Services) to ensure that Aboriginal people in the criminal legal

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[112] T2280:25-28.
[113] T2281-T2282.
[114] T2280-T2282; T368; T2390-T2393.
[115] RCIADIC Recs 63, 127, 150, 152, 258, RCIADIC Report Findings and Recommendations, Vol 5, available at <http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html#Heading5>.
[116] T2375-T2380. The current Aboriginal Justice Agreement also contains a requirement for the government to develop culturally safe standards for health services in the adult and youth justice systems. See Victorian Aboriginal Justice Agreement, 'Cultural safety standards', available at <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-13>.

system have 24 hour in-person access to trained Aboriginal Health Workers and Aboriginal Wellbeing Officers.

[#] Aboriginal Health Workers and Wellbeing Officers must see a person within 2 hours of their entry into police or prison custody.

[15] A reception medical assessment in respect of an Aboriginal and/or Torres Strait Islander person entering prison must always be undertaken by an Aboriginal Health Practitioner in person.

[16] Any relevant Local Operating Procedure and any policy applicable to staff of the Health Service Provider at DPFC be urgently amended to include a procedure for the medical clearance of a prisoner as a component of her reception assessment.

[17] The procedure for clearance of a prisoner from the Health Centre to a Unit at DPFC should involve written certification from a Medical Practitioner, who is qualified as a General Practitioner, which indicates:

a. An assessment has taken place, and include details of the assessment;

b. the prisoner is certified by the Medical Practitioner as medically fit to leave the Health Centre;

c. whether the Medical Practitioner recommends any medical or management observations in relation to the prisoner;

d. specific clinical deterioration risk indicators the Medical Practitioner recommends custodial and health staff monitor; and

e. instructions to guide the response, including escalation of the prisoner's care, if clinical deterioration risk indicators are observed.

and this certification should be maintained in both the prisoner's health and custodial files.

[18] Prisoners who are not medically fit to be transferred from the Health Centre to a Unit at DPFC should be placed on a medical hold and remain in the Health Centre with the Medical Practitioner documenting:

a. the recommended medical observations in relation to the prisoner; and

b. the specific clinical deterioration risk-indicators the Medical Practitioner recommends custodial and health staff monitor; and

c. instructions to guide the response if clinical deterioration risk indicators are observed, including under what circumstances the prisoner ought be transferred to hospital.

and this documentation should be maintained in both the prisoner's health and custodial files.

[#] CCA, should it continue delivering services in prison in Victoria, in collaboration with CV and Justice Health, should develop clear guidelines that emphasise the ability to call an ambulance by any custodial staff. All health providers, existing and future, must similarly develop guidelines.

[19] CCA, should it continue delivering services in prison in Victoria, in collaboration with CV and Justice Health, should develop clear guidelines to assist custodial and health care staff to identify a prisoner's clinical deterioration, and implement policies and procedures applicable to custodial and health care staff which identify the key indicators that must result in an escalation of a prisoner's care to the Medical Practitioner or transfer to hospital. All health providers, existing and future, must similarly develop guidelines.

[20] The Health Centre at DPFC should provide Point-of-Care testing in accordance with the Royal Australian College of General Practitioners Standards for Point-of-Care testing.

[21] To achieve equivalence of health services in the Health Centre at DPFC, it should be continuously accredited as a General Practice in accordance with the National General Practice Accreditation Scheme.

[22] Medical Practitioners employed by the Health Service Provider at DPFC should be General Practitioners who have completed the General Practice Training Program and gained Fellowship.

[23] Medical Practitioners employed by the Health Service Provider at DPFC should be required to have completed the Royal Australian College of General Practitioners' Alcohol and Other Drugs GP Education Program, including at minimum:

a. the Essential Skills training program; and

b. the Treatment Skills training program

in the current Continuing Professional Development triennium.

[24] Registered Nurses employed by the Health Service Provider at DPFC should be required to have completed the Australian College of Nursing's Continuing Professional Development modules in:

a. Addressing AOD Use in Diverse Communities; and

b. Opioid Withdrawal Nursing Care and Management

in the current Continuing Professional Development year.

[25] Medical Practitioners and Nurse Practitioners employed by the Health Service Provider at DPFC should be qualified to practise opioid pharmacotherapy, having completed the Royal Australian College of General Practitioners Medication Assisted Treatment for Opioid Dependence training.

[26] The Health Centre at DPFC should employ a full-time specialist who has completed Advanced Training in Addiction Medicine.

[27] The Health Centre at DPFC should include a subacute unit operated by the DoH, to provide for medically managed inpatient withdrawal and stabilisation, overseen by a specialist who has completed Advanced Training in Addiction Medicine.

[#] The Health Centre at DPFC should include onsite pathology,

[28] As an interim measure, until a subacute unit on site at DPFC is operational, an agreement or Memorandum of Understanding should be entered into as a matter of urgency between CV, Justice Health, the Health Service Provider and the most proximate public hospital, Sunshine Hospital, for the provision of equivalent community health services not provided at the Health Centre.

[29] CV, in consultation with the DPFC Health Service Provider, amend its policy that only two officers have access to cell keys during the Second Watch.

[#] CV, in consultation with the DPFC Health Service Provider, end its practice of placing "do not open" signage on cell doors.

[#] DJCS review JCARE usability, and cease any ability to "cut and paste" data.

[30] The Justice Health Opioid Substitution Therapy Guidelines should be revised to allow all prisoners the option of suitable maintenance or substitution pharmacotherapy at the point of reception, including the option of methadone or suboxone and their long-acting injectable buprenorphine formulations, irrespective of the length of incarceration

[31] An independent body, such as Safer Care Victoria, should review and, if necessary, update the JHQF.

[32] Given CCA's extensive portfolio of custodial health care services within Victoria, the jurisdiction of Safer Care ought to be expanded as a matter of urgency to allow it to conduct investigations into subcontracted private providers of health services where they are Public Authorities under the *Charter*, and thereupon for it to conduct an audit of CCA to advise on any gaps between policy and practice in the provision of those services.

[33] In the interim, or if this is not possible in the next 12 months, Australian Health Practitioner Regulation Agency should consider conducting an audit as proposed in paragraph 31.

[34] CV should contract Safer Care Victoria and fund the Victorian Aboriginal Health Service to conduct a review of the policies and procedures of CCA relevant to the delivery of health services in Victorian prisons. These reviews must be made publicly available and be completed prior to any further tendering process.

[35] CCA report the deficiencies in care identified in these Findings to its current accreditation providers before it participates in any further tendering for the provision of custodial health services in Victoria.

[#] That DJCS require that all persons who work in any prison in Victoria have regular, in-person cultural awareness, cultural safety, unconscious and conscious bias training that is led and developed by Aboriginal and/or Torres Strait Islander people.

[#] That DJCS require that all persons who work in any prison in Victoria have training, which is developed in consultation with VEOHRC, which highlights a person's rights to dignity and humanity in detention and their requirements as Public Authorities under the *Charter* to act in accordance with the *Charter* when making decisions in the course of their duties.

Custodial deaths – Response and Review

[#] The Victorian Government must create an independent body, separate to Victoria Police, JARO and Justice Health, with appropriate investigatory powers and functions, to investigate all Aboriginal and/or Torres Strait Islander deaths in custody.[117]

[117] In the Parliamentary review into Aboriginal and/or Torres Strait Islander deaths in custody in NSW, the Jumbunna Institute recommended: 'a new, indigenous-informed and led investigative and

Development of this body must be self-determined by Aboriginal and/or Torres Strait Islander communities, their representatives, the AJC and ACCOs such as VALS. The body and its practices must be culturally appropriate.

[36] That DJCS oversee the development and implementation of a policy, and deliver training to CV staff about the operation of that policy, to ensure that cultural considerations are incorporated into management of a deceased Aboriginal or Torres Strait Islander person and, to the extent possible, the scene of that person's passing. This policy must be developed by Aboriginal and/or Torres Strait Islander people, and in consultation with VALS and ACCOs.

[#] Where an Aboriginal and / or Torres Strait Islander person dies in custody, notification of relatives of their death should occur, as a matter of urgency, through an ACCO, and not Victoria Police.[118]

[#] That DJCS develop and implement a policy for taking formal statements from all relevant witnesses within two weeks after a death in custody. These statements must be taken by an independent body, separate to Victoria Police, CV, JARO and Justice Health.

[37] CCA, if it continues to provide healthcare in prisons, CV and Justice Health each review, and if necessary, amend, any policy or practice relating to staff 'debriefs' following a death in custody or other sentinel events. The review should consider and clarify:

a. the purpose of debriefs, including whether they are intended to serve a staff welfare function, evaluate practice and/or policy to identify systems or other deficits, or a combination of these matters; and

b. a process to optimise the participation of relevant staff in any debrief.

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prosecutorial institution in relation to First Nation Deaths in Custody that is tasked with the investigation, on behalf of the NSW Coroner, of First Nation Deaths in Custody'. The Aboriginal Legal Service (NSW/ACT) also preferred this proposal in comparison to others put forward during the inquiry. The ALSNSW stated that it is 'critical that the independent body/agency has a holistic understanding of the factors that lie behind deaths in custody, and has the scope to investigate the factors behind why a person is in custody in the first place, as well as the specific circumstances of their death'. It suggested, however, that the Coroner be provided with additional resources and powers until this body is established. See NSW Legislative Council: Select Committee on the High Level of First Nations people in custody and oversight and review of deaths in custody, 'The high level of First Nations people in custody and oversight and review of deaths in custody', April 2021, available at <https://www.parliament.nsw.gov.au/lcdocs/inquiries/2602/Report%20No%201%20-%20First%20Nations%20People%20in%20Custody%20and%20Oversight%20and%20Review%20of%20Deaths%20in%20Custody.pdf>, at p 174-6.

[118] See Aunty Vicki Roach, T2026-T2027; Percy Lovett. T56:12-15.

c. A process to ensure transparency of information within these debriefs.

[38] That an independent body be established to take over JARO and JHDIC reviews to ensure they:

a. are independent;

b. receive input from relevant staff who interacted with or were responsible for decisions affecting the prisoner proximate to their death;

c. receive input from relevant experts they deem appropriate;

d. are comprehensive;

e. identify opportunities for improved practice and to enhance the wellbeing and safety of prisoners, rather than merely assess compliance with relevant policies;

f. if the deceased is an Aboriginal or Torres Strait Islander person, that adequacy of their cultural care (including post-death treatment) is assessed by an Aboriginal and/or Torres Strait Islander person appointed by an ACCO; and

g. are timely.

[#] The Victorian Government must urgently undertake robust, transparent and inclusive consultations with the Victorian Aboriginal community, its representative bodies and ACCOs on the implementation of the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment* (**OPCAT**) in a culturally appropriate way.

[#] The Victorian Government must ensure the mandate of the National Preventive Mechanisms which will be established/designated under OPCAT includes police custody, places of detention in which people may be detained for less than 24 hours, such as police vehicles and cells. These systems should examine the role of racial bias and systemic racism when exercising their mandates.

Addressing Systemic Issues

[39] That the Victorian Government in cooperation with Victoria Police, the Department of Justice and Community Safety, the Department of Health, Aboriginal communities,

VALS, the Victorian Aboriginal Health Service, Aboriginal Community Controlled Organisations, and all relevant government departments, urgently implement the 339 recommendations of the 1991 *Final Report of the Royal Commission into Aboriginal Deaths in Custody.*

[#] That the Victorian Government, including all relevant government departments, meaningfully resource and support the work of VALS and the Aboriginal Justice Caucus, which are about to commence a review of the State's implementation of the 339 recommendations of the RCIADIC, including by providing access to data and information.

[40] That the Department of Justice and Community Safety partners with appropriate Aboriginal Community Controlled Organisations to develop and implement a strategy for ongoing cultural awareness training, monitoring and performance review, which is applicable to:

a. Police;

b. CV; and

c. the Health Care Provider at DPFC.

[42] That Practical Legal Training course providers require students to complete Aboriginal and Torres Strait Islander cultural awareness training, as well as training on systemic racism and unconscious bias, as part of the curriculum. This training must be developed and led by Aboriginal and/or Torres Strait Islander people with cultural oversight.

[#] That the Legal Services Board and Commissioner and the Victorian Bar require students to complete Aboriginal and Torres Strait Islander cultural awareness training, as well as training on systemic racism and unconscious bias, as part of the Bar Reader's Course. This training must be developed and led by Aboriginal and/or Torres Strait Islander people, with cultural oversight.

[43] That the Legal Services Board and Commissioner and the Victorian Bar require periodic mandatory completion of Aboriginal and Torres Strait Islander cultural awareness training, and training on systemic racism and unconscious bias, as part of the Continuing Professional Development of legal practitioners. This training must be developed and led by Aboriginal and/or Torres Strait Islander people with cultural oversight.

Charter

[44] That no later than 12 months from the date of these findings, CV, JARO, Justice Health and CCA, as Public Authorities under the *Charter* request the VEOHRC conduct a review under Section 41(c) of the *Charter* of any improvements to programmes, practises, and facilities made in response to the recommendations above, and that the results of that review will be published on the Coroner's Court website along with the responses to the Recommendations made in this Finding.

Dated: 17 June 2022

ANDREW WOODS
STEPHANIE WALLACE
Counsel for Uncle Percy Lovett

Signed by Sarah Schwartz, Victorian Aboriginal Legal Service
Solicitor for Uncle Percy Lovett