Australian police not charged over death of Aboriginal woman

Karen Maxwell 30 September 2020

Last month, the Victorian state Labor government's Department of Public Prosecutions (DPP) announced that no charges would be laid against the police officers involved in the death of Aboriginal woman Tanya Day, nearly three years ago. She died from a brain haemorrhage while being held by the police for four hours.

Neither the DPP nor the government gave any reasons for this decision. The DPP did not even directly inform Day's family and their lawyers.

In a statement issued through the Human Rights Law Centre, Day's family said prosecutors seemed to have based their conclusion on "a police investigation that we have said all along was flawed and lacked independence." They added: "We are devastated and angry. The two police officers who failed to properly check on our mum, have been let off. It is not good enough that such an important decision was made behind closed doors, without any input from our family or the broader Aboriginal community."

The circumstances of Day's death, and the failure to hold any police officer to account, shows the increasing impunity with which the forces of the state treat the poorest and most oppressed sections of the working class, especially Aboriginal workers and young people.

On December 5, 2017, Day, a 55-year-old grandmother, travelled on a train in country Victoria to visit her youngest daughter in Melbourne. After she fell asleep, the conductor deemed her to be "unruly" and called police to remove her when the train pulled in at Castlemaine station. Police took her off the train at 3.14 p.m., arresting her for "public drunkenness," and drove her to the Castlemaine police station in a divvy van. She was placed in a cell at 4 p.m., to "sober up."

Day received no medical or welfare assistance, even though, in her intoxicated state, she was unbalanced and presented a high risk of falling. CCTV footage captured her stumbling, falling and knocking her head against cement on four occasions.

Sergeant Edwina Neale was asked during the inquest why she conducted no falls risk assessment before placing Day in the cell. Neale said she did not know the arrested woman had the potential to fall. When it was suggested that she could have taken Day to hospital for observation, rather than a prison cell, Neale replied that she had never taken anyone to hospital because they were "merely drunk."

While Day was in the cell alone, "physical checks" on her welfare consisted of Leading Senior Constable Danny Wolters taking a glance through venetian blinds on the cell window, and engaging in a quick verbal exchange, all in the space of 6 or 7 seconds. At 4.50 p.m., Day fell forward and hit her forehead hard against the wall. This impact caused a brain haemorrhage that remained undetected until police entered the cell at 8.03 p.m. to prepare her for release.

From 6.38 p.m. onward, Day lay on the floor of the cell. This was observed by Wolters during a check at 6.42 p.m. Neale said she did not check on Day because, "she's an intoxicated human being who was sleeping on the floor, which is not unusual for intoxicated people."

At 8.03 p.m., Neale and Wolters entered the cell but could not rouse Day to full consciousness. They observed an oval-shaped bruise on her forehead and called for an ambulance. Day was taken to a regional hospital in Bendigo, and then transferred to a hospital in Melbourne, where she died from her injuries 17 days later.

For all deaths in custody, the standard process is an initial investigation by the police themselves, via the Professional Standards Command. The actual purpose of this procedure is to ensure that officers escape any accountability. A coroner's investigator (also a police officer) then carries out an "investigation," and the results

are handed to a coroner, who conducts an inquest.

On average, these inquests occur two years after the victim's death. The inquest is designed to create the illusion of a transparent and independent process, while the role of the coroner is only to "determine causal factors and identify systemic failures with a view to preventing similar deaths from occurring in the future" (as explained in the coroner's report into Day's death).

Typically, inquests end with toothless recommendations, similar to those of previous inquests, and nothing changes.

Day's coronial inquest began in August 2019. Coroner Caitlin English announced her findings seven months later, in April 2020. She found that Neale and Wolters had taken "a minimised approach to the medical needs" of Day. She said the "quality of the checks, indicated by their speed, did not meet the standards of the official guidelines," resulting in their failure "to take proper care of Ms Day's safety, health and welfare."

English also found that Wolters was not a credible witness due to apparent "contradictions" in his evidence. These related to the officer's evidence, in which he asserted: "I didn't ever actually see her hit her head at any stage."

Yet in the emergency call that Wolters made to Ambulance Victoria, he is recorded as saying: "She has fallen over in the cells. I seen her slip over an hour ago."

The paramedic who arrived first at the police station, Sarah Harrup, stated in her evidence that she clearly recalled Wolters describing the fall to her, and she inferred from this that he had witnessed it on CCTV. In her electronic patient record, Harrup had written: "Approx 7 p.m., police witnessed the patient, via cell camera, roll from a slouched/seated position on the bed (approx. 30 cm high), and strike her forehead on the ground. States that patient immediately got up (denies loss of consciousness)."

The coroner noted that during the inquest, Wolters had rejected the accuracy of the paramedics' accounts. She added that due to Wolters' lack of credibility, her ability to accept other aspects of his testimony was "impaired."

English directed that the case be referred to the DPP for a criminal investigation, as an indictable offence may have occurred. But the DPP declared on August 27 that no such offence had occurred.

Among her recommendations, English called for the abolition of the criminal offence of public drunkenness. Day's arrest had been made solely on the basis of that law.

Such a recommendation was made nearly 30 years ago, in 1991, by the Royal Commission into Aboriginal Deaths in Custody, but the Victorian and Queensland state governments have refused to implement it.

The Hawke federal Labor government launched the Royal Commission in 1987, to head off growing public indignation with the mounting numbers of unexplained deaths of Aboriginal people in custody. Tanya Day's uncle, Harrison Day, was one of the deaths investigated by the Royal Commission.

No police officer was charged with homicide as a result of the Royal Commission, giving a green light for killings to continue. Since 1991, 434 Aboriginal people have died in custody, and not a single police officer has been charged.

In December 2019, the indigenous incarceration rate was 2,536 per 100,000, compared to 218 per 100,000 for non-indigenous people. Aboriginal and Torres Strait Islanders make up 2 percent of the Australian population, but 27 percent of prisoners.

While systemic racism is clearly involved, indigenous people, along with immigrants, refugees and working class youth, are victimised because they are the among the most impoverished and vulnerable layers of the working class.

The purpose of the Royal Commission, and the hundreds of coronial inquests that have followed, has been to promote the illusion that the capitalist state can be pressured into reducing its violence against the working class, Aboriginal and non-Aboriginal alike. The DPP's decision to lay no charges over Tanya Day's death is a signal that both Labor and Liberal-National governments will continue to provide police with a free hand to commit such crimes with impunity, as the economic and social crisis pervading the lives of ordinary working people escalates throughout the country.



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