Australian coronial inquest reveals Aboriginal death in custody due to horrific neglect and cruelty

Sue Phillips
7 February 2023

A 366-page coronial inquest finding, issued last week, outlined in horrifying detail the chain of neglectful and cruel events that led to the death in custody of 37-year-old Aboriginal woman Veronica Nelson on January 2, 2020.

Coroner Simon McGregor described the last days and hours of Nelson's life as a "harrowing" experience in which she endured "inhumane" conditions including medical "neglect" and "degrading cruelty" that contributed to her preventable death, alone on the floor of her maximum-security prison cell. These comments in fact represent a significant understatement—what happened amounted to a state murder.

Not much information was provided in the coroner's report, nor in related media coverage, on Veronica Nelson's personal background. The report did note that she lost her father unexpectedly and, while grieving, became addicted to heroin. She divided her time between Collingwood, an inner Melbourne suburb where she lived with her partner, and Shepparton, a regional working class city in northern Victoria where many of her extended family live.

Shepparton, a city that has disproportionately high poverty and unemployment rates, is where Nelson was charged with shoplifting from a chemist in October 2019. She was also subsequently charged with the summary offence of failing to appear before a magistrate's court, as had been required by her bail conditions.

On December 30, 2019, police in central Melbourne arrested Nelson for outstanding warrants. The coroner deemed the arrest lawful, but criticised police for handcuffing her, noting that policy states this should only be done when "reasonably necessary in the circumstances."

Police took Nelson to Melbourne Custody Centre where she was interviewed and held overnight. On December 31, the Melbourne Magistrates court refused bail. This followed Nelson privately speaking with a publicly appointed legal counsel for just six minutes. The barrister excused himself at the hearing, leaving Nelson to speak for herself with no legal support.

Her democratic right to bail, given the presumption of innocence and the lack of any record of violent crime, was denied—primarily because of the state Labor government's draconian restrictions.

In 2018, Victorian bail laws were massively tightened after a terrible incident in central Melbourne when an individual in a drug-induced psychosis, who had been released on bail days earlier, drove over and killed six people. This led to an aggressive Murdoch media campaign that ignored the social background and causes of that tragedy, and instead demanded tighter bail. The state Labor government of Premier Daniel Andrews immediately responded and its legislation has resulted in an enormous increase in bail refusals and incarcerations.

This has impacted on the poorest sections of the working class, the most vulnerable, the unemployed, homeless, those suffering mental illness and drug and alcohol dependency and in particular, Aboriginal people. By mid-2019, more than a third of adults in Victoria's prison were unsentenced, while nearly half (47.7 percent) of Aboriginal prisoners were unsentenced.

On December 31, 2020, Veronica Nelson was transferred from the Melbourne Magistrates court to a maximum security prison in Melbourne's outer western suburbs, the Dame Phyllis Frost Centre.

During transportation, Nelson began suffering from opiate withdrawal and vomited multiple times. When she arrived at the prison she was met by a doctor and a nurse, both employed by the private company Correct Care Australasia, to which the state Labor government contracts all medical care within prisons. Correct Care Australasia is owned by the US billion dollar corporation Wellpath, which dominates privatised healthcare within the American prison system.

The coronial inquest finding outlined a series of damning conclusions about the role played by the Correct Care Australasia doctor in Nelson's death. The doctor dismissed the nurse's suggestion that Nelson be sent to hospital for emergency treatment. The coroner's report concluded that it was clear that Nelson should have been transferred to a hospital and the "ongoing failure [to do this] causally contributed to her death."

The coroner concluded that a "physical examination of Veronica was not conducted," contrary to the doctor's report of the assessment. She had also not been weighed, despite the doctor's recorded entry of her being 40 kilograms. After Nelson's death, she was weighed at just 33 kilograms, with this emaciated state itself warranting hospitalisation.

The coroner found that the doctor's failure to physically examine Nelson, plan ongoing care and maintain accurate records are "significant departures from reasonable standards of care and diligence expected in medical practice." The coroner has raised the episode with the Australian Health Practitioner Regulation Agency, which investigates malpractice.

The report also noted that the "insufficient treatment" for Nelson's addiction "constituted cruel and inhumane treatment." This was partly due to stigmatisation of prisoners who had drug addiction and are of Aboriginal descent.

In the assessment, Nelson reported that she had a heroin addiction.

A mental health check was then carried out by a psychiatric nurse who suggested Nelson remain overnight in the prison medical centre, as she struggled to sit up and was shaking and vomiting. Following the assessment, Nelson received opiate-related medications, however the doses proved inadequate to address her heroin withdrawals.

During the night of December 31 and throughout the morning of January 1, Nelson continued to vomit. She requested assistance by using the cell intercom 20 times. Just before 9 a.m. she was moved to a clean cell after lying in a vomit-ridden cell for over 15 hours.

Throughout the morning she requested to see a doctor. When Nelson asked when the doctor would see her, she was told, "It's not an emergency, stop asking." At 10 a.m. Nelson was given additional medication through the cell door and moved to another cell where she vomited again. At 12.37 p.m. she was examined by a doctor and nurse and given electrolytes, but she continued to vomit.

At 5.20 p.m., Nelson was transferred from the medical ward to the general prison population. At 7 p.m., a sign was placed on her cell door: "LATE RECEPTION – DO NOT UNLOCK."

Nelson's final hours leading to her agonising death represent a shocking and inhumane crime. At 9 p.m. she requested blankets twice, due to muscle cramping. An inmate reported that Nelson was repeatedly screaming for help. At 1.30 a.m. on January 2, Nelson used the intercom to plead for assistance, explaining she was in severe pain. Another inmate also called, alerting staff that "someone needs help."

At 1.37 a.m., a nurse and prison officer provided Nelson with paracetamol and a nausea medication through her cell flap. The nurse was forced to pry open Nelson's fingers to place pills in her hand, "because they [had] cramped into a claw." Between 2 a.m. and 4 a.m., Nelson, wailing in pain, called for assistance another 11 times. She was told by the prison officer to stop screaming, because "you are keeping other prisoners awake."

During most of the night, the duty nurse was seen on CCTV watching a movie on a computer.

At 3.56 a.m. Nelson was in extreme pain and heard wailing over the intercom. Her breath was heavy and she was sobbing, calling out for her deceased father, "Daddy, Daddy, Daddy…"

During a subsequent intercom communication, Nelson stopped responding and a thud was heard from the cell. No-one in the prison investigated, including during mandatory unit patrols by the prison officer. Only several hours later, amid a prisoner count carried at 7.50 a.m., was Nelson found dead, lying naked on the floor in a foetal position.

This marked the first time that an officer or nurse had attended Nelson's cell in six hours and the first time the cell door had been opened in more than 12 hours. An autopsy later found that Nelson had been suffering from Wilkie's Syndrome, a rare gastrointestinal condition, in the context of opiate withdrawal and malnutrition.

Part of the coronial inquest provided details of the official reviews following Nelson's death in custody. This included a debrief by authorities at the Dame Phyllis Frost Centre, a report by the Justice Assurance and Review Office, Justice Health and Correct Care Australasia. In all, they amounted to yet another death in custody whitewash.

Rather than providing a detailed account of the complete and utter failure and exposure of the indifference to Nelson's life and care, in most official reviews the actions of staff were exonerated and even praised. Typical was the formal debrief carried out by Dame Phyllis Frost Centre. The prison governor stated that she was "proud" of the prison officer on duty the night that Nelson died, "for the way she sensitively managed the intercom calls and how Nelson was treated in the last few hours." Another senior prison official praised the response as "textbook."

The coroner noted that employees of Correct Care Australasia had omitted key details of what had happened in their initial accounts, while Dame Phyllis Frost Centre authorities appeared not to probe for the necessary information. The inquest report characterised this as a "don't ask/don't tell" arrangement, representing "a matter of grave public interest and goes part of the way to explaining how so many continual and repeated systemic failings were permitted to occur in this case."

The coroner concluded that Correct Care Australasia "lacked a number of clear policies or processes for the safe medical management of their patients." He has notified the Director of Public Prosecutions that "an indictable offence may have been committed."

It remains to be seen whether anyone will face charges for the killing of Veronica Nelson. No confidence whatsoever ought to be lent to state institutions to "reform" the brutal and repressive prison system. The capitalist state creates these brutal and violent environments—controlled by the police, courts and prison officials—to discipline and punish the most vulnerable, marginalised and poor sections of society.

The continuation of state brutality and the killing of Aboriginal people proves that various promises on the issue made by the ruling elite—including the Hawke Labor government's 1987–91 "Royal Commission into Aboriginal Deaths in Custody," Labor Prime Minister Kevin Rudd's apology to the Stolen Generation and the Closing the Gap program—have resolved nothing for Aboriginal people.

Aboriginal people are disproportionately impacted by the violent incarceration system, but regardless of racial and national background, all of the most oppressed sections of the working class are affected. The coronial report noted that in the twelve months since Nelson's death, four more women died at Dame Phyllis Frost Centre—one indigenous, three non-indigenous.

While racism certainly exists within the police and prison system, in the final analysis the reason for the level of Aboriginal incarceration rates lies in the fact that most indigenous people are poor and working class, as are the vast majority of non-Aboriginal prisoners, who are also dying in custody at a frightening rate.