THE AGE

'Inhumane and unprofessional': Shocking footage of Ms Dhu released as family fights on

By Heather Mcneill
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And her family will push for those involved in her "inhumane and unprofessional" treatment to be prosecuted after Coroner Ros Fogliani found her death could have been prevented if she had been treated with antibiotics.

Outside court, Ms Dhu's grandmother Carol Roe told *WAtoday* the family felt justice had still not been served after the Coroner failed to recommend anyone be charged for Ms Dhu's death.

She said the family would push for the police officers and medical staff who treated her to be prosecuted despite previous investigations by police and the Corruption and Crime Commission finding their actions involved no criminality.

"There's still no justice for the family," Ms Roe said.

"That's our next step, we want justice, we want to go to court and get everyone accounted for."

Ms Dhu, whose first name is not used for cultural reasons, died while spending three days locked up at South Hedland Police Station in August 2014 for $3622 of unpaid fines.

The woman's family initially opposed media requests to obtain the vision, which was repeatedly played during a coronial inquest into her death, but their lawyers later said they had reconsidered because it was in the public interest.

The damning footage, taken between August 2 and 4 at the police station's lock-up and Hedland Health Campus, showed Ms Dhu being dragged from her cell, handcuffed, while paralysed.

She was then hauled, dying, into the back of a police vehicle and either died in transit, or on arrival at hospital.

Handing down her inquest findings on Friday, the Coroner said she was releasing the footage publicly, however vision of Ms Dhu's final moments - when she was possibly already dead - would not be released, at her father's request.

"There's still no justice for the family."

Ms Fogliani called the treatment of Ms Dhu at the police station "inhumane and unprofessional".

"The circumstances around her death are tragic and disturbing," the Coroner said, before extending her condolences to Ms Dhu's family.

Ms Dhu's grandmother Carol Roe hugging a friend outside court.

She found the conduct of the medical staff and police officers involved was well below the standards expected.

Officers and medical staff were not motivated by conscious racism but it would be naive to deny existence of unfounded assumptions about Ms Dhu being formed, the Coroner found.

"Officers disregarded her welfare and right to treatment," she said.

Carol Roe outside court after the Coroner's findings were handed down.

"The majority of the persons responsible for Ms Dhu's care formed the view that she was exaggerating or feigning symptoms of being unwell.

"On the morning of 4 August 2014 the police assumed that she was feigning her collapse.

"That assumption persisted up until the time the doctors commenced their resuscitation attempts at Hedland Health Campus at 12.45 pm on 4 August 2014."

The Coroner made eleven recommendations at the inquest, including a review of incarceration as a penalty for unpaid fines.

Shortly after the findings were made public, Police Commissioner Karl O'Callaghan announced people on arrest warrants for unpaid fines would no longer be held in police lock-ups.

"A police lock up or watch house is not a place for any person to be held for a significant period of time.They are not designed for that purpose, especially those in regional Australia... it is simply not suitable," he said.

"[The warrants] will be served in prisons."

Mr O'Callaghan said people on arrest warrants would not be held more than eight hours in a lock-up, and that arrest warrants would not be executed unless a plan had already been made for the person to be transferred to a prison.

Despite family calls for the police officers involved in Ms Dhu's care before her death to be charged, Mr O'Callaghan said three investigations, including a CCC and internal police investigation, had revealed no criminality on the officers' part.

Four officers were sanctioned and another seven were found to have breached police procedure following the internal police investigation in 2014.

Mr O'Callaghan said he was not aware of how many of the officers were still serving with WA Police, or if any were still serving in South Hedland.

Meanwhile, all liquor outlets in Ms Dhu's home town of South Hedland have been closed by police due to concerns of "civil disorder".

South Hedland Police Senior Sergeant Dean Snashall said the booze ban was enforced following a series of serious alcohol-fueled assaults in recent days and the pending release of the footage showing Ms Dhu's final moments.

Infection could have been prevented: Coroner

Ms Dhu died from pneumonia and an infection from a broken rib that went untreated after police officers and medical staff tending to her assumed she was a "junkie" faking her illness.

But the Coroner found that, although Ms Dhu died from natural causes, she was not adequately assessed at Hedland Health Campus.

Her infection could likely have been treated with antibiotics on her first or second visit if she had been given an x-ray or her vitals had been checked.

Ms Dhu was on her third visit to hospital in as many days while in custody when she died.

Some of it shows police dragging and carrying her limp body to a police van, while another clip shows an officer pulling Ms Dhu by the wrist to sit her up before dropping her, causing Ms Dhu to hit her head.

Aboriginal Legal Service WA chief executive Dennis Eggington said the family and the Aboriginal community had suffered enough, describing Ms Dhu's death as a cruel injustice.

"I hope the coroner gives the utmost consideration to the family's wishes and their need for healing," he said.

Human Rights Law Centre spokesperson Ruth Barson said it had been two years since Ms Dhu's "cruel" death but the Barnett Government continued to lock up people who could not pay their fines - a policy that disproportionately affected Aboriginal women.

"Western Australia desperately needs to fix its over-imprisonment crisis and to change its fines laws to be fair and flexible," she said.

On Wednesday, Ms Roe said she wanted the world to know the truth.

"I hope the Coroner hands down the truth, then we will feel like there has been some justice, then we can put my girl to rest," she said.

"People need to see with their own eyes how my girl was treated.

"All Australians need to see this footage – we all need to stand together and say enough is enough, no more Aboriginal deaths in custody."

The Coroner's recommendations:

1: In every police station where detainees are held, there must be a dedicated lock-up keeper. Alternatively that a minimum of two officers are rostered for custodial care duties at any time.

2: Mandatory training course on the roles and responsibilities of lock-up keeper/supervisor be developed and introduced across Western Australia.

3: Mandatory initial and ongoing cultural competency training for its police officers to assist in their dealings with Aboriginal persons.

4: That it be a standard procedure for all police officers transferred to a location with a significant Aboriginal population to receive comprehensive cultural competency training, tailored to reflect the specific issues, challenges and health concerns relevant to the location.

5: Parliament consider whether legislative change is required in order to allow medical clinicians to provide the Western Australia Police Service with sufficient medical information to manage a detainee's care whilst in police custody.

6: Fines, Penalties and Infringement Notices Enforcement Act (WA) (Section 53) be amended so that a warrant of commitment authorising imprisonment is not an option for enforcing payment of fines. Alternatively, that the Fines, Penalties and Infringement Notices Enforcement Act (WA) (Section 53) be amended to provide that where imprisonment is an option, the imprisonment must be subject to a hearing in the Magistrates Court and determined by a Magistrate who should be authorised to make orders other than imprisonment if he or she deems it appropriate.

7: Pending reforms outlined by the Justice Ministers' Working Group be given a high priority for consideration by Parliament, with a view to providing alternatives to incarceration through legislative reform.

8: Fine defaulters, if incarcerated pursuant to a Warrant of Commitment, should be transported to the nearest prison within four to eight hours of their arrest, where the transport time does not exceed the detention period.

9: A policy be introduced by the Western Australian Police Service that requires the police to contact by telephone the Aboriginal Visitors Scheme once a decision has been made to detain an Aboriginal offender in a police lock-up.

10: The State Government gives consideration as to whether a state-wide 24 hours per day, seven days per week Custody Notification Service based upon the New South Wales model ought to be established in Western Australia, to operate alongside and complement the Aboriginal Visitors Scheme.

11: A greater degree of regular monitoring should be provided to any detainee complaining of severe symptoms that necessitate repeated hospital attendances within a short space of time.