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Ms Dhu's inquest shines spotlight on failures but will it prompt change?

Coroner catalogues 'unprofessional and inhumane' treatment but stops short of apportioning blame for individual or systemic disregard

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On page 88 of the findings on the death in custody of Indigenous woman Ms Dhu, coroner Ros Fogliani explains that it is not possible to "gently" drag a prisoner across the floor.

"The act of dragging a person across a floor has no gentle aspect whatsoever," she wrote. "Detainees who are incapacitated, or who appear to be incapacitated, such as Ms Dhu, are not to be dragged along the floor. It is particularly inappropriate to do so where medical assistance is being sought."

It's an extraordinary statement – not for its message, which is surely uncontroversial, but because it needed saying at all.

Yet at 12.33pm on 4 August 2014, having slipped into septic shock some hours earlier and being unable to stand, 22-year-old Dhu was dragged and then carried from her cell to the police van for what would transpire to be her last visit to hospital. One of the police officers responsible, who had also handcuffed her under the "inexplicable" belief that the incapacitated, dying woman was a flight risk, had offered in his defence that he had tried to drag her "gently".

Dhu's heart stopped some 10 minutes later, before she had even reached the emergency room window.

It was one of many examples of police showing "unprofessional and inhumane" conduct toward the Yamatji woman, Fogliani wrote.

But while her lengthy findings handed down on Friday chastise the actions and attitudes of several police officers, and the failures of key medical staff, they stop short of apportioning blame for the individual or systemic disregard shown to Dhu in her final 45 hours of life.

They also dismiss systemic racism as a factor in her death, despite finding that she was dismissed as a "junkie" who was "faking it" by most police officers, and despite finding that doctors succumbed to premature diagnostic closure and assumed her complaints to be "behavioural issues" caused by an unwillingness to be in custody.

It was a devastating outcome for Dhu's family, mitigated only by Fogliani's decision to release "profoundly disturbing" CCTV footage of her treatment in custody.

"I came here hoping hoping for justice," Dhu's mother, Della Roe, said outside the Perth court where the findings were handed down. "And I still haven't got it."

"Missed opportunities"

Dhu was arrested in Port Hedland, 1,500km north of Perth on a warrant of commitment for $3,622 in unpaid fines on 2 August, 2014.

She was ordered to serve four days in custody to "cut out" the debt and taken to hospital twice, on the 2 August and 3 August, before her final collapse on 4 August.

At the time of her arrest, pathologist Dr Jodi White said the infection that had begun as osteomyelitis in a rib broken in a domestic violence incident by her partner three months earlier, had already spread to the surrounding soft tissue, causing septicaemia and pneumonia. The autopsy revealed an abscess that was between five and seven centimetres in diameter nested beneath her broken 10th rib.

Had it been discovered and antibiotics administered on 2 August, White said they would have had a reasonable prospect of saving her life. Antibiotics administered on 3 August would have a reduced success rate, because the infection had advanced by then, but they still could potentially be lifesaving.

Both White and emergency medicine specialist Dr Stephen Dunjey said there were "no clues to her life-threatening illness" on the first hospital visit. Despite being in significant pain, the outward signs of infection were not recorded, and emergency department doctor Annie Lang – influenced, Fogliani said, by the word of police that Dhu had only become distressed after being told she would have to stay in custody overnight – declared her "agitated" and noted the diagnosis "behavioural gain".

Lang, Fogliani wrote, was dismissive of Dhu's pain in a way that fell short of the standards expected of public hospital doctors, and in her conclusion of "behavioural gain" contributed to the premature diagnostic closure of Dr Vafa Naderi, who treated Dhu on 3 August.

Dhu waited almost two hours to see Naderi, as a result of being under-triaged by nurse Alyce Heatherington. Heatherington recorded Dhu's pulse rate of 126 and noted her skin temperature as "warm," but did not take her temperature. At the inquest, she argued that "warm" meant "normal," despite "unremarkable" being an option on the triage form immediately above "warm".

Gitte Hall, the ward nurse, also didn't take Dhu's temperature because she didn't feel "hot".

"I know that it's an antiquated practice but generally, if you feel somebody, you can actually tell whether they feel like they're febrile or not and the thermometer will just confirm, basically, the numbers that you need to make it accurate," Hall told the inquest.

Naderi also didn't take Dhu's temperature and did not note that no temperature had been recorded. That was "unsatisfactory" and a "significant failure," Fogliani said: it is likely that Dhu would have had an elevated temperature at that stage, and that may have prompted Naderi to abandon the diagnosis of "behavioural issues" and discover the infection.

Fogliani described the steps taken by Naderi, including deciding not to order a chest x-ray and performing an ultrasound instead, as a series of "missed opportunities."

Medical staff didn't contribute to Dhu's death, she said, but nor did they do anything to prevent it.

The only police officer to show any empathy or urgency towards the health concerns of Dhu was constable Carrie Sharples, the most junior officer at the station.

In CCTV footage of Dhu being dragged out of her cell on 4 August, Sharples is the only one running.

The police officers carrying Dhu, constable Christopher Matier and senior constable Shelly Burgess, are unhurried. Matier goes back into the station after lifting Dhu into the back of the police van to dispose of the gloves he wore to carry her. Burgess, who can be seen on the CCTV folding up Dhu's legs so they can close the door of the van, is equally unhurried.

Fogliani found both Matier and Burgess, and sergeant Rick Bond, who was shift supervisor that day, were "unprofessional and inhumane".

Matier, she said, adopted Bond's suggestion that Dhu was "faking" her illness in spite of all evidence to the contrary, and "inexplicably" believed she was feigning her injuries up to the point that hospital staff told him she was in cardiac arrest.

"His behaviour toward Ms Dhu was of one who appeared not to be consciously aware that he was dealing with another human being," Fogliani wrote.

Burgess, who is seen on footage yanking Dhu into a sitting position and then dropping her hand, causing her to fall and smack her head on the concrete, was senior to Matier and should have known not to carry her from her cell, Fogliani wrote.

Fogliani said Burgess's failure in that regard, and her failure to show any concern for having dropped Dhu, was "incomprehensible."

Bond, who has retired from the police force, accepted that he influenced his staff and was responsible for the running of the south Headland police station. His final entry into the custody log book, made just 15 minutes before she had a heart attack, was: "Detainee appears to be suffering withdrawals from drug use and is not coping well with being in custody."

Police commissioner Karl O'Callaghan conceded police had failed Dhu.

“We are the guardians of their safety, their welfare and of course, their dignity, and I accept that we failed Ms Dhu in this regard,” he told reporters on Friday, according to PerthNow.

“She was not treated with the right level of human compassion or dignity.”

Asked if police should face criminal charges over their treatment of Dhu, O’Callaghan said: “Police breached procedures but there’s been no criminality identified.”

The penalty for the 11 officers found to have breached police procedures was a letter, of varying sternness. At the inquest, several police who received the disciplinary letter said they did not understand what it meant.

Dhu’s family has instructed the Aboriginal Legal Service of WA to write to the director of public prosecutions to seek criminal charges.

Addressing a crowd of reporters outside court on Friday, Aboriginal Legal Service’s chief executive, Dennis Eggington, said the 11 recommendations made by Fogliani were “fine”.

They were no more than changes that had been recommended by the royal commission into Aboriginal deaths in custody 25 years ago, and never enacted. ALSWA and the Dhu family supported them, he said, but Fogliani could hardly do anything less.

The most significant recommendation was that the WA government should legislate to end the practice of jailing people for fines, a practice that disproportionately affects Aboriginal women.

Fogliani said that if the government would not accept an outright ban it should require the decision to send someone to jail for unpaid fines be made by a magistrate, rather than by police.

She also recommended the Aboriginal Visitors Scheme, a government-run phone service intended to provide support to Indigenous detainees, be made mandatory, but importantly found it did not fulfil the role played by an independent mandatory custody notification service.

Western Australia should investigate implementing such a system, following the New South Wales model, alongside the expanded Aboriginal visitors scheme, she said.

Other recommendations included improved training on the duties of police charged with the care of detainees; improved cultural competency training; and localised, on-country training for officers in regional stations to be carried out by local Aboriginal people.