

The Case of Mr Ward

Summary Facts for the CERD Committee

Prepared by the Aboriginal Legal Service of Western Australia (Inc.) (ALSWA)

Introduction

Mr Ward was a respected Ngaanyatjarra Aboriginal Elder and leader who had represented his people at state, national and international levels. He was particularly acknowledged for his ability to walk between two worlds. He left behind a wife, four children, a large extended family and his community.

Mr Ward died on 27 January 2008 after suffering heat stroke in the rear pod of an unventilated prisoner transport vehicle during a 4.5 hour journey from Laverton to Kalgoorlie in remote Western Australia (WA), in circumstances where the air conditioning failed. The outside temperatures that day were over 40 degrees Celsius. On arrival at the Kalgoorlie hospital, Mr Ward had a large burn on his abdomen from contact with the pod's metal surface and a core temperature of over 41 degrees Celsius.

Mr Ward's death highlights structural discrimination against Aboriginal¹ peoples within the WA legal system demonstrated by over policing, denial of bail, inhumane prisoner transport conditions, inadequate training of Justices of the Peace (JPs), police and private contractor staff and lack of governmental supervision of contractual duties of the prisoner transport company GSL.² On 12 June 2009, the WA Coroner made 14 recommendations to prevent such a death from occurring again, many of which addressed the structural discrimination outlined above, that all contributed to his "wholly unnecessary and avoidable"³ death.

Arrest and interaction with police

On 26 January 2008, Mr Ward was arrested for driving under the influence of alcohol in Laverton. There is confusion as to whether Mr Ward was driving on a "road" for the purposes of *Road Traffic Act 1974* (WA), or a dirt track. Had he been on the latter, he may have had a defence. Even if he had committed an offence, the power to arrest for an offence that is not serious is discretionary⁴ and should be exercised as "the sanction of last resort".⁵

At the police station, Mr Ward was denied police bail, despite his strong community ties, co-operation with police and possibility of a defence. The police failed to properly comply with the *Bail Act 1982* (WA) by, amongst other things, taking into account inappropriate matters.⁶ The Coroner found that Mr Ward could have been bailed to appear in Laverton or Warburton instead of being transported to Kalgoorlie.⁷

The behaviour of Laverton police in their interactions with Mr Ward suggests that police obligations are routinely breached. They failed to supply Mr Ward with prescribed material⁸ and failed to call ALSWA despite Mr Ward advising that he wanted legal representation. Instead, they called GSL to arrange his transportation to Kalgoorlie within 35 minutes of his arrival at the police station, well before bail was considered by the JP the following day.

¹ 'Aboriginal peoples' refers to Aboriginal and Torres Strait Islander Peoples.

² In January 2008 the company that was contracted by the Department of Corrective Services (DCS) to provide prisoner transport services was GSL Custodial Services Pty Ltd (GSL). The same company continues to hold the contract but operates under the name G4S.

³ *Inquest into the death of Ian Ward*, State Coroner of Western Australia, 12 June 2009 ('Ward'), p5.

⁴ Factors to be considered in determining whether to arrest are set out in the *Criminal Investigation Act 2006* (WA) at section 128 (3) (a) and (b).

⁵ Recommendation 87 by the *Royal Commission into Aboriginal Deaths in Custody* (1991) ('RCIADIC').

⁶ Ward p42. In determining whether to grant bail, the police officer considered a previous alleged breach of bail in respect of which a charge had not been preferred.

⁷ Ward p141.

⁸ In accordance with section 8 of the *Bail Act 1982* (WA). This material includes a form that is designed to disclose to the authorised police officer or judicial officer who is making the bail decision all information that would be relevant to the decision.

Justice of the Peace

The next morning, the JP attended the police station, was briefed by police in Mr Ward's absence and then purported to hold a hearing at Mr Ward's cell door, after waking him. The JP described Mr Ward as "an Aboriginal in a very drunken state or very groggy state. That's all I knew him as."⁹ Mr Ward was remanded in custody despite a presumption for bail, and was not provided with reasons for the denial of bail.

The JP conceded he was unaware of his responsibilities as a JP, having never formally completed JP training. He was under the incorrect assumption¹⁰ that he did not need to consider granting bail unless expressly asked by the accused.¹¹ The inadequate training and limited interaction between the JP and Mr Ward reveals a lack of equality offered to Aboriginal peoples in remote areas who do not have the benefit of appearing before a Magistrate for early bail determinations.

Transport Conditions

Although prisoner transport in WA had been contracted to GSL, the State had a non-delegable duty of care, heightened in this instance by the State ownership of the fleet of vehicles. Both parties bore responsibility for the quality of care given to Mr Ward during his detention.

The Coroner found that the conditions of transport amounted to inhumane and degrading treatment and a breach of the ICCPR.¹² This included the quality and condition of the vehicle; the lack of air conditioning despite the extreme temperatures (and GSL knowledge that the vehicle's air conditioner had been experiencing ongoing problems); the failure of the GSL officers¹³ to advise Mr Ward about how he should get their attention if he had problems; the inadequacy of food and water provided to Mr Ward; and the absence of any rest stops or efforts by the GSL guards to perform welfare checks on Mr Ward.

Police investigation

The Coroner found that the State, GSL and the two drivers had contributed to the death and made a referral to the WA Director of Public Prosecutions (DPP) to consider whether criminal charges could be laid against anyone in relation to the death.

The police investigation into the death was unsatisfactory as it was not treated as a homicide investigation. Despite their close involvement, the drivers were not immediately separated by police upon arrival at the hospital. They remained together until they were individually interviewed and at one stage were placed alone in a room along with their supervisor, who was present during their police interviews. The similarities in the evidence of the drivers and their supervisor indicated that there had been collusion.

Other deficiencies in the investigation included that CCTV footage from the Laverton police station sally port that would have shown Mr Ward's entry into the transport vehicle was not obtained; statements were not obtained by police from relevant Aboriginal witnesses (in fact no police statements were taken from any Aboriginal people); and statements tendered as evidence from the police involved in Mr Ward's arrest and refusal of bail were almost identical.

The Coroner also found sinister aspects to the drivers' evidence. For example, according to their evidence, they only noticed Mr Ward's distress when they stopped a few kilometres from the hospital. Despite this, thirteen minutes elapsed where phone calls were made between the officers and their supervisor, before arrival at the hospital.

⁹ ABC Four Corners, 'Who killed Mr Ward?', 15 June 2009.

¹⁰ Section 7(1) of the *Bail Act* 1982 (WA) creates a duty for the judicial officer "to consider the accused's case for bail, whether or not an application for bail is made by the accused or on his behalf".

¹¹ Ward p46.

¹² Ward p129.

¹³ The two GSL officers who transported Mr Ward on 27 January 2010 were Nina Stokoe and Graham Powell.

Government Response

Following community outrage over the delayed implementation of some of the Coroner's recommendations, the WA Parliament announced an inquiry into the transportation of detained persons in WA on 31 March 2010, which is ongoing.

On 28 June 2010, the DPP¹⁴ stated that a *prima facie* case and reasonable prospects of conviction did not exist for criminal prosecution against anyone involved in the death of Mr Ward. Consequently, despite the Coroner's findings that the drivers, GSL and the State contributed to the death of Mr Ward, no criminal charges have been laid.

The State Government provided an ex-gratia payment to the widow of Mr Ward on 29 July 2010.¹⁵

Conclusion

The community remains outraged by the circumstances of the death and failure to hold anyone to account. There is ongoing concern about the lack of accountability surrounding Mr Ward's death and continued discrimination against Aboriginal peoples generally, particularly within the justice system. These tragic events demonstrate that little has changed since the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)¹⁶ almost 20 years ago.

The Australian Government must do more to protect Aboriginal peoples from discrimination and prevent deaths in custody. This raises issues with respect to Australia's compliance with Article 5(b) of CERD.

Recommendations

1. THAT the Australian Government, in consultation and partnership with Aboriginal peoples and communities, take immediate steps to review the recommendations of the RCIADIC, identify those which remain relevant and commence a program of implementation.
2. THAT the Australian Government establish an independent body for investigating deaths associated with police contact that is hierarchically, institutionally and practically independent of the police. The independent body must have features to ensure that investigations are effective, comprehensive, prompt, transparent, subject to public scrutiny and involve the family of the deceased. Particular care should be taken with regard to gathering evidence with integrity, high ethical standards and quality. The independent body should employ suitably qualified Aboriginal peoples to assist in the investigations of Aboriginal deaths associated with police contact.

¹⁴ Joseph McGrath is the WA DPP.

¹⁵ ALSWA Media Release, 29 July 2010, http://www.als.org.au/index.php?option=com_content&view=article&id=97:alswa-ward-ex-gratia-payment&catid=13:media-releases&Itemid=46

¹⁶ Commonwealth of Australia, Royal Commission on Aboriginal Deaths in Custody, *National Report* (1991) vols – 15.