

# Disability and the Royal Commission into Aboriginal Deaths in Custody

## Cultural and Content Advisory: A Note Before You Read

This document contains the names and stories of Aboriginal and Torres Strait Islander people who have died, including deaths in custody. It also contains descriptions of restraint, self-harm, suicide, and the ongoing impacts of the Stolen Generations. Some readers may find this content distressing.

This document is shared in the spirit of truth-telling, accountability, and justice, to honour those who have died, those who have spoken the truth, and to strengthen the call for change.

We acknowledge the ongoing grief of families and communities, and the strength of First Nations people who continue to advocate in the face of profound loss.

If you or someone you know needs support, please contact 13YARN on 13 92 76 — a free, confidential crisis support line for Aboriginal and Torres Strait Islander peoples, available 24 hours a day, 7 days a week.

*The evidence base for this paper draws on the work of the National Disability Footprint, including the Data and Research Footprint (Element 2) delivered in partnership with Dr Scott Avery and Girra Maa Indigenous Health, University of Technology Sydney.*



First Peoples  
Disability Network

## The Unfinished Business of 1991

### Disability and the Royal Commission into Aboriginal Deaths in Custody: Inaction since 1991

This fact sheet examines what the 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC) found about disability, why most of its 339 recommendations remain effectively unimplemented, and why First Nations people with disability are dying in custody at record rates today. It is produced by First Peoples Disability Network Australia (FPDN), Australia's national peak body for First Nations people with disability.

### What the RCIADIC found, and what it could not yet name

The RCIADIC (1987–1991) investigated 99 deaths of Aboriginal and Torres Strait Islander people in custody. Commissioner Elliott Johnston QC found health among the 99 ranged from poor to very bad. Of the 99 deaths, 50 were self-inflicted; 30 involved hanging. Critically, 43 of the 99 had been removed from their families as children as part of the Stolen Generations.

The Commission documented pervasive failures in custodial health and mental health care: insufficient psychiatric support,

poor record-keeping, and health services that fell below community standards. Its central finding was that First Nations people were not dying at higher rates than non-Indigenous people in custody; they were dying because of **gross over-representation in a system that failed to care for them.**

This is, fundamentally, a finding about disability, even where the word does not appear. The Commission used the language of its time: “mental illness,” “psychiatric disturbance,” “intellectual handicap.” Modern terms such as cognitive disability, acquired brain injury, and foetal alcohol spectrum disorder (FASD) were not part of Australian policy language in 1991. This linguistic gap meant disability was present in the findings but largely invisible in the recommendations and in all subsequent tracking.

Key recommendation clusters relevant to disability include Recommendations 79–91 (diversion from police custody), 92–121 (imprisonment as a last resort), 122–167 (custodial health and safety, including mental health care and hanging point removal), and 246–271 (Aboriginal health, including mental health integration).

# 617

**First Nations deaths in custody since the RCIADIC reported in 1991**

Zero criminal convictions. Not one officer, nurse, or corrections staff member has been found criminally liable.

# 33

**First Nations deaths in custody in 2024–25 alone**

The highest annual figure in 45 years of national monitoring. Nearly double the long-term average.

# 89%

**Of young people at Banksia Hill with severe neurodevelopmental impairment**

74% were Aboriginal. Only 2 of 36 diagnosed with FASD had been previously identified.

Sources: AIC Statistical Report No. 57 (2025); NATSILS (2025); Bower et al., BMJ Open (2018).

## What was promised, what was delivered

The Australian Government commissioned Deloitte Access Economics to review implementation in 2018. Deloitte found 64% of the 339 recommendations had been “fully implemented.”

This figure has been forcefully contested. A landmark 2021 analysis from ANU’s Centre for Aboriginal Economic Policy Research, endorsed by 33 academic and professional experts, found the Deloitte review assessed **outputs (actions taken) rather than outcomes (actual improvements)** and therefore misrepresents governments’ responses to the RCIADIC. The assessment counted policies written, not lives saved.

The case of Recommendation 165 (removal of hanging points from cells) is emblematic. Deloitte rated it “fully implemented.” Yet coroners investigating deaths in Tamworth (Tane Chatfield, 2017) and Silverwater (Timothy Garner, 2018) both found hanging points remained in cells. NATSILS reported in December 2025 that at least 75% of unsentenced First Nations people who died in custody in 2024–25 died by hanging and related complications.

FPDN CEO Damian Griffis described the Deloitte review as a “whitewash” that “doesn’t show a meaningful picture of the whole response to the Royal Commission because it excludes the voices of Aboriginal and Torres Strait Islander communities.”

### Implementation Gap

#### RCIADIC Recommendations: What Was Claimed vs What Happened

The 2018 Deloitte review found 64% of 339 recommendations “fully implemented.” Academics and First Nations organisations have forcefully contested this, arguing the review measured actions taken, not lives changed.

Recommendation	Deloitte Assessment	What the Evidence Shows
<b>Rec 165: Remove hanging points from cells</b>	Rated “fully implemented”	75% of unsentenced First Nations deaths in 2024–25 were by hanging. Coroners continue finding hanging points in cells.
<b>Recs 79–91: Diversion from custody</b>	Rated substantially implemented	First Nations imprisonment rate up 30% since 2019. Youth detention over-representation at 21:1. No national diversion framework for cognitive disability.
<b>Recs 122–167: Custodial health and safety</b>	Rated mostly complete	Only 51% of those with mental health conditions received needed care. Agencies failed own procedures in 41% of deaths.
<b>Recs 246–271: Aboriginal health including mental health</b>	Rated partially to mostly complete	No routine disability screening in any Australian prison. FASD not systematically assessed. 79% of those with intellectual disability only accessed services after prison.

### Core Metric

The Deloitte review assessed whether governments had taken actions. It did not assess whether those actions changed outcomes. Since the RCIADIC reported, at least 617 First Nations people have died in custody. Incarceration has more than doubled. The system the Commission described has deepened, not receded.

**Sources:** Deloitte Access Economics (2018); Anthony, Jordan et al., ANU CAEPR (2021); AIC (2025); NATSILS (2025); Baldry et al., UNSW (2015); Guardian Australia Deaths Inside database.

## Disability at the centre of the crisis

The most comprehensive evidence on disability among First Nations people in the criminal justice system comes from the UNSW Mental Health Disorders and Cognitive Disability (MHDCD) dataset, led by Professor Eileen Baldry, Professor Leanne Dowse, and Associate Professor Ruth McCausland. Their 2015 report, *A Predictable and Preventable Path*, analysed linked data for 2,731 people imprisoned in NSW.

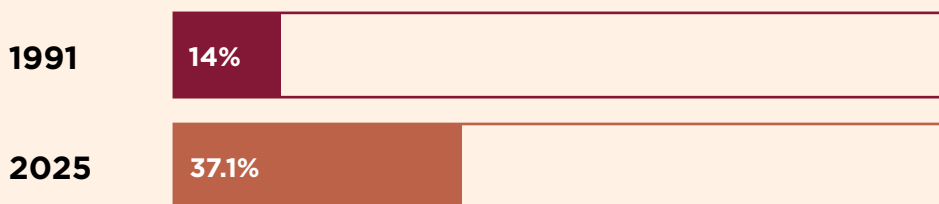
One quarter of the cohort (676 people) were Aboriginal and/or Torres Strait Islander. Indigenous people in the cohort had the highest rates of complex needs. Of those with intellectual disability, 68% also had co-occurring mental health or substance use diagnoses. Only one quarter of those with intellectual disability were clients of disability services, and 79% of those who eventually became clients did so only after going to prison.

The Banksia Hill Detention Centre study (Bower et al., 2018) found 36% of sentenced young people had FASD. Eighty-nine per cent had at least one domain of severe neurodevelopmental impairment. Seventy-four per cent were Aboriginal. Only 2 of 36 diagnosed with FASD had been previously identified. This was the highest FASD prevalence ever recorded in a justice setting globally.

Human Rights Watch found that between 2010 and 2020, approximately 60% of adults who died in WA prisons had a disability.

### Then and Now

## First Nations Share of Australia's Prison Population



**+165%**  
increase  
over 34 years

First Nations peoples make up **3.8% of the total Australian population**, but **37.1% of all prisoners: 17,432 people** as at 30 June 2025.

**Closing the Gap Target 10** required a 15% reduction in the adult incarceration rate by 2031. Instead, the rate has **increased 30%** since the 2019 baseline. The imprisonment rate reached 2,630 per 100,000 First Nations adults by December 2025.

Sources: ABS, *Prisoners in Australia 2025*; ABS, *Corrective Services December 2025*; Productivity Commission, *Closing the Gap Data 2025*.

## What the Disability Royal Commission confirmed

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC, 2023) described the over-representation of First Nations people with cognitive disability in custody as a **“largely hidden national crisis”** driven by the **“criminalisation of disability.”**

Volume 8 (*Criminal Justice and People with Disability*) found disability-related behaviours are routinely mistaken for wilful defiance, delinquency, or substance use. Volume 9 (*First Nations People with Disability*) explicitly recognised the double disadvantage of racism and ableism.

The DRC recommended nationally consistent screening for disability in custody, court-based diversion programs for people with cognitive disability, culturally safe support from First Nations organisations, and data collection on people found unfit to stand trial. The Australian Government’s response accepted only one of the 57 recommendations FPDN identified as most relevant to First Nations communities outright.



## The voices that the data cannot carry

**First Nations people with disability and their families have consistently articulated what the statistics confirm. Their testimony forms an unbroken thread from 1991 to today.**

“That morning when he went to court, he sang out ‘Mum, put the chicken out, I’ll come back and cook you supper.’ But he never came back.”

### **Georgette Jackamarra**

First Nations mother, Broome, Western Australia. Her son, an Aboriginal man with psychosocial disability, died in Broome Regional Prison after being denied his mental health medication for hours following his arrest on a bailable offence.

**Why This Matters** The RCIADIC recommended adequate mental health care in custody. Thirty years later, a man died because a prison withheld his medication.

“No ... I am not free. I am out of prison, but I am not free yet.”

### **Marlon Noble**

Yamatji man with intellectual disability, Geraldton, Western Australia. Found “unfit to plead,” he was imprisoned for over 10 years without trial or conviction. The UN Committee on the Rights of Persons with Disabilities found Australia breached his rights. After release, he remained subject to restrictive conditions of unlimited duration.

**Why This Matters** People found unfit to stand trial can be detained longer than if convicted. In some jurisdictions, indefinitely. The DRC called for urgent national reform.



“This young man was living away from his community, in town, in supported accommodation because of his disabilities, and he was very vulnerable. He needed support and not to be criminalised because of his disability.”

#### **Ned Jampijinpa Hargraves**

Senior Warlpiri Elder, Yuendumu, Northern Territory. Grandfather of Kumanyjayi White, a 24-year-old Warlpiri man with cognitive disability who died in May 2025 after being restrained by police in Alice Springs supermarket. He had been taking food. Elder Hargraves also lost his grandson Kumanyjayi Walker, shot by NT Police in 2019.

**Why This Matters** Kumanyjayi White was under a state guardianship order and on an NDIS plan.

“I’m seeing my brother with physical signs all over his chest and all over his arms. That he was cutting himself. These were weeks old! Never in a million years did I ever think that the jail would neglect him so badly.”

#### **Jacinta Miller**

Noongar woman, Western Australia. Sister of Stanley, a 19-year-old Noongar man with depression and anxiety who died in Acacia Prison, Wooroloo, in July 2020. Stanley was a talented artist planning an exhibition upon release. He had been sentenced to two years for burglary and could have been released in six months with parole.

**Why This Matters** Weeks of visible self-harm went unaddressed. The RCIADIC recommended custodial staff be trained to identify people at risk. Stanley was 19.

#### **Sources:**

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Noble Australian Museum, **Noble Cause (Unfinished Business)**; AHRC, **Presumed Guilty**, 2013

Hargraves **National Indigenous Times**, 29 May 2025

Miller **Human Rights Watch**, 16 September 2020; **SBS News**, September 2020

## Recent deaths that echo 1991

Coronial inquests in recent years have produced findings that read as if the RCIADIC never reported. In each case, disability or mental health was central.

**Veronica Nelson (2020, Victoria)** was detained on shoplifting-related charges under bail laws the Coroner called a “complete, unmitigated disaster.” Weighing 33 kilograms at death, suffering undiagnosed illness and opioid withdrawal, no staff member opened her cell door in the 12 hours before she died. The Coroner found her treatment was “cruel” and “degrading.”

**David Dungay Jr (2015, NSW)** was in the mental health wing of Long Bay Jail, diagnosed with psychiatric conditions including psychosis. Restrained face-down by five officers over a packet of biscuits, he repeated “I can’t breathe” 12 times. The Australian Government conceded to the UN Human Rights Committee in 2021 that it had violated his right to life.

**Kumanjaji White (May 2025, Northern Territory)** was a 24-year-old Warlpiri man with cognitive disability, under a guardianship order and on an NDIS plan. He died after being restrained by police inside a Coles supermarket in Mparntwe/Alice Springs. He had reportedly been taking food.



## What needs to change

### **Implement the RCIADIC, in full, through a disability lens.**

The 339 recommendations must be reassessed against contemporary disability evidence and implemented with accountability mechanisms that measure outcomes, not outputs. First Nations people with disability must be central to this process.

### **End the criminalisation of disability.**

Establish nationally funded, community-controlled First Nations Disability Justice programs as alternatives to police-led crisis intervention. Mandate culturally safe de-escalation training for all police. Ban prone restraints and restrictive practices. This aligns with Closing the Gap Priority Reform 2 (building the community-controlled sector) and Priority Reform 3 (transforming government organisations).

### **Screen, diagnose, and support, not punish.**

Fund nationally consistent screening for cognitive disability, FASD, and psychosocial disability at every point of justice contact, from first police encounter to exit from custody. Redirect resources from incarceration to early diagnosis and community-based support through Aboriginal Community Controlled Organisations.

### **Fix the NDIS for First Nations people involved in the justice process.**

Implement the NDIS Review's recommendation for alternative commissioning in remote and First Nations communities. Ensure NDIS transitional supports do not rely on a release date. Publish data linking NDIS participation and justice involvement for First Nations people.

### **Close the data gaps that make disability invisible.**

Mandate disability status recording in the AIC's National Deaths in Custody Program. Disaggregate all Closing the Gap justice data by disability status. Fund FASD prevalence studies in adult prisons. These gaps are not incidental; they function to render First Nations people with disability invisible within systems that harm them.

### **Implement the DRC recommendations in full.**

Accept and action the DRC's Volume 8 and Volume 9 recommendations, co-designed with First Nations people with disability, with binding timelines and independent monitoring.

## Further information

If you or someone you know is in distress, please contact **13YARN (13 92 76)**, a national crisis line for Aboriginal and Torres Strait Islander peoples, available 24 hours.

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