Comment

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The tragic death in custody of Cleveland Dodd: 'Abandon all hope, ye who enter here' (Dante Alighieri, *Inferno*)

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Abstract
The 2023 death in custody of 16-year-old Cleveland Dodd, an Aboriginal youth in solitary confinement on remand in the now notorious Unit 18 in Perth Western Australia, has renewed concerns about staggering rates of Indigenous incarceration, the extent of non-compliance with the recommendations of the Royal Commission into Aboriginal Deaths in Custody (1988–91), and 'unlawful' solitary confinement practices (as determined by the WA Supreme Court).

Keywords
Indigenous incarceration, solitary confinement, youth incarceration

There were 225 submissions made to the Commonwealth government's 2024–5 inquiry into youth justice and incarceration.[1]

Sydney solicitors Levitt Robinson's submission to that inquiry was fairly representative:

> The deprivation of liberty which results from a period of detention is itself the punishment. Children are not meant to be sent to detention to be additionally punished but rather, to be rehabilitated to the extent that they can be reintegrated into the community. The Court punishes offenders. It is not up to Custodial Officers to devise separate punishment.[2]

Matters of insistent concern across the whole country included the use (and abuse) of isolation and solitary confinement to further punish children; the physical conditions in cells (often farcically described as 'sleeping quarters') and custodial settings, including the recourse to adult custodial facilities; and the persistent (some thought cynical) failure to adopt recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991).[3]

The significant overrepresentation of Indigenous children in custody was a persistent refrain.

Sadly, none of these concerns are new and none of them will necessarily abate as a function of the Inquest into Cleveland Dodd's death in custody.[4]

The death in custody, by hanging,[5] of Cleveland Dodd a 16-year-old Aboriginal youth confined in solitary in Unit 18 in Western Australia (WA), brings all these issues into very sharp focus. He hanged himself on 12 October 2023 and was pronounced dead in hospital, surrounded by family, on 19 October.

The Coroner inspected the scene of Cleveland's death. The Inquest was given 'priority' the next day and the call-over

[1]Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Inquiry into Australia's Youth Justice and Incarceration System* (2024–25) https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Incarceration47/Submissions.
[2]Levitt Robinson, Submission 191 to Senate Legal and Constitutional Affairs References Committee, *Inquiry into Australia's Youth Justice and Incarceration System*.
[3]*Royal Commission into Aboriginal Deaths in Custody: Recommendations* (National Report Volume 5, 1991) https://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html#Heading5 (RCIADIC Report, vol 5).
[4]*Inquest into the Death of Cleveland Keith Dodd* (CORC 3139 of 2023) [2025] WACOR 49 Coroner Urquhart (28 November 2025) https://www.coronerscourt.wa.gov.au/_files/inquest_2025/DODD_Cleveland_Keith.pdf.
[5]Resuscitation efforts were not successful and for that reason I will be referring to Cleveland's death as 'by hanging'.

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was conducted on 23 February 2024. The hearing began on 3 April 2024 and ran until 24 July that same year.[6] The final day of evidence was 11 December 2024 after which parties about whom potential adverse findings were being considered were given an opportunity to file additional material (some of which was filed in May 2025).

After many days of hearings, a late submission that the Coroner should disqualify himself on the basis of 'apprehended bias' was rejected. Other submissions that sought to 'fetter' the Coroner and limit his examination of systemic failings, which ran contra to the 'national consensus' about coronial procedure, were also rejected.[7] These submissions are an echo of those made in a number of Royal Commission into Aboriginal Deaths in Custody hearings (1988–91), specifically in WA and Queensland.

The investigation conducted by Coroner Urquhart and his office was extensive, scrupulous and, to the extent it could be, inclusive.

The Inquest was preceded by a Corruption and Crime Commission inquiry[8] where no action was recommended as no 'serious misconduct' warranting two or more years imprisonment was found. Further an investigation was undertaken by the Department of Justice (the Department) Professional Standards Division (interim and final reports November and December 2023),[9] and a Departmental Performance Assurance and Risk Directorate inquiry was held and made suggestions as to how to improve Unit 18 operations.[10]

Urquhart 'carefully considered' these reports and remarked he was not bound by their findings.[11]

Urquhart listed multiple failures as factors that contributed to Cleveland's death in Unit 18 in Perth.[12] The custodial management failures which he found included:

- Failure to recognise that 'confinement orders' of children and young people were inappropriate custody management mechanisms and their use at Unit 18 was generally excessive, specifically for Cleveland
- Failure to staff Unit 18 – the staffing of Unit 18 was 'dire' and led to other failings including as follows:
- Failure to properly supervise by leaving cell CCTV cameras covered with toilet paper
- Failure to fix an obvious hanging point even though staff were alert to the problem as another youth had tried to hang himself that same day, in the same way, in the cell next to Cleveland's
- Failure to remove Cleveland from his cell where he had devised a hanging point by damaging the cell's ceiling vent
- Failure to provide drinking water to Cleveland in spite of numerous requests, noting his cell had been without running water for days
- Failure of staff to wear supervisory alert radios on the day Cleveland hanged himself (this being an ongoing issue)
- Failure of relevant officers to prepare an Individual Engagement Plan for Cleveland
- Failure of relevant officers to put Cleveland on a Departmental 'At Risk Management System' plan notwithstanding many assertions of his intention to kill himself or self-harm both on the day he hanged himself and previously
- Failure of relevant officers to provide mental health supports
- Failure of relevant officers to implement a Model of Care
- Failure of the Department to provide staff training given the 'very high volume of threats of self-harm and suicide in Unit 18'
- Failure of the Department to provide a trauma informed environment in Unit 18.

The Coroner concluded his report questioning whether society was prepared to bear the 'cost' of more young people detained in the 'care' of the State taking their own lives 'because they have given up all hope'?[13]

This question emerges insistently from the description of Cleveland's and other young people's time in detention. The Inquest transcript is hard to read but should be on every Law School's reading list.

In considering all the evidence and listing the failures that led to Cleveland's death (above) the Coroner came to the conclusion that the conditions to which young people were subjected in Unit 18 were 'reminiscent of 19th century jails'[14] and that the place was 'dysfunctional' and 'disturbing'.[15]

The Coroner's investigation exposed, through concessions made during the cross examination of Dr Tomison, then Director General of the Department, that a Briefing

[6]Some witnesses were excused from giving evidence on the basis that they had filed affidavit material.

[7]See Inquest Cleveland Dodd paras 57 and 58 where the Coroner refers to proposed interventions in the conduct of his inquiry as 'fettering' the exercise of his judgment as to the matters that should be investigated. Also see para 65 where he observes the submission of the Senior Counsel for the ALSWA is 'worth repeating'. Counsel argued that government submissions failed to accept the present 'national consensus' about how inquests should be conducted: that is exploring more than narrow concerns about the death under investigation.

[8]Corruption and Crime Commission, *An Investigation into Allegations of Serious Misconduct following the Death of a Young Detainee in Unit 18 Casuarina Prison* (Report, 11 June 2024) https://www.ccc.wa.gov.au/investigations/reports/2024.

[9]See Inquest Cleveland Dodd paras 40 and 42.

[10]See Inquest Cleveland Dodd para 43.

[11]See Inquest Cleveland Dodd para 44.

[12]Inquest into the death of Cleveland Keith Dodd (n 4). All references to 'paras' in the Inquest hearing relate to this transcript and findings. There were 22 barristers and associated solicitors who appeared. The Department of Justice briefed four members of counsel. Six departmental officers were individually represented. The Inquest was preceded by a Corruption and Crime Commission (n 8) which found no 'serious misconduct' (Inquest Cleveland Dodd para 37).

[13]Inquest Cleveland Dodd para 1657.

[14]See Inquest Cleveland Dodd para 77.

[15]See Inquest Cleveland Dodd para 83.

Note to the Minister contained 'blatant lies' about the benefits and appropriateness of Unit 18 as a place for youth detention.[16]

Everyone who worked in or who supervised Unit 18 knew that, contrary to the communication spin in a departmental video and letters to parents, it did not provide a full suite of programs or 'intensive support'; it was not 'light and airy'; there would be no 'study rooms' or access to 'therapeutic programs'. It was not possible to determine who was responsible for these misrepresentations, they were certainly 'not accurate'.[17]

This raft of communication was devised in the lead up to the 'move' on 20 July 2022 of young people from Banksia Hill to Unit 18.[18] It may have been crafted to respond to the WA Corrections Inspectorate which issued an unprecedented 'Show Cause Notice' to the Director General of the Department about its youth detention inadequacies in December 2021.[19]

The Inspectorate was not alone in concerning itself with Unit 18 and the oppressive conditions being imposed on young people in custody in the lead up to Cleveland's death on 19 October 2023.

Two Supreme Court of Western Australia (Supreme Court) cases launched by the Aboriginal Legal Service of Western Australia (ALSWA) on behalf of young people held in solitary confinement in Perth are also highly instructive as to what should have been known, what should have been done, and who was responsible for the conditions in which Cleveland found himself before he took his life. While it depersonalises the young people who bravely provided evidence in these cases about conditions in youth detention, their names and identifying details have been redacted. The first case involved one young man given the identifying title VYZ; the second case involved three young people, two young men and a young woman. They are identified as CRU, HBS and OPS.

The first case was launched on 14 July 2022, when the Supreme Court was invited by the ALSWA to consider Declaratory Relief for the unlawful solitary confinement of a 14-year-old child, VYZ, who was detained at Banksia Hill (the dedicated youth detention facility and precursor to Unit 18).[20] Justice Tottle's decision was delivered on 25 August 2022.

Within three months (on 6 December 2022) the second, three youth-plaintiff case was launched by the ALSWA, again in the Supreme Court. The ALSWA was again seeking declaratory relief, an injunction and increasing the pressure on the Department to remedy unlawful conduct. The ALSWA was asking that the Court exercise its 'coercive powers' against the Department's criminally responsible contempt of the earlier orders in VYZ's case.[21]

In VYZ's case, Tottle J had granted a Declaration on 25 August 2022 on the basis that this child was held unlawfully in solitary confinement, often over many consecutive days. In both this and the subsequent cases, confinement was not imposed for any disciplinary offence, but rather for the convenience of a short-staffed custody centre, and without any school, engagement, or rehabilitation opportunities being provided.[22] Tottle concluded that unless he granted the relief sought, the Department's unlawful conduct would continue as its answer to the ALSWA proceedings had been to argue that 'locking detainees in their *sleeping quarters* is a regular occurrence'.[23]

Tottle found that '*very significant harm* can be done to children by confinement'.[24] He accepted the material (which is legion) that young people who find themselves in custody are, more often than not, already vulnerable, exposed, and dealing with homelessness and untreated mental health issues. In this instance the systematic 'rolling lockdowns' impacted all young people and the overwhelming majority of them had not committed any disciplinary offence in custody and they had not been convicted of any criminal offence: 79 of the 106 boys and 8 of the 10 girls were on remand.[25]

Turning to the second case dealing with unlawful confinement of children, that of CRU, OPS and HBS, Tottle was again the judge.

Although this second litigation was first launched in early December 2022 for hearing on 23 December, Tottle gave the Department the opportunity to demonstrate its bona fides by putting them on court oversight from the period 19 December 2022 to 2 January 2023, extended from 3 January 2023 to 17 January 2023. The Department was required to report back to him by affidavit if/as the matter progressed. The Department returned to court asserting that it had complied with the supervised regime. The ALSWA youth-plaintiffs disputed that claim and, on the basis of amended paperwork, the cases for the three young people were relaunched for a hearing on 9 March 2023.

After CRU, OPS and HBS's case ran, Tottle found (again) in favour of the ALSWA clients and against the Department. He held that the requirement that a formal Order be made to confine young people in their 'sleeping quarters' for extensive periods of time was not a safeguard that could be ignored. After argument about what constituted 'exercise' he also found that the requirement was not an aspiration but an 'absolute entitlement'.[26] In the opening paragraphs of his judgment Tottle talked of 'systemic failures'; chronic

[16]See Inquest Cleveland Dodd paras 93, and 1227, 1228, 1235, 1456 as to Dr Tomison's evidence.
[17]See Inquest Cleveland Dodd para 1235.
[18]See Inquest Cleveland Dodd para 1253, the evidence of Peter Collins ALSWA and the transcript surrounding this comment.
[19]Pursuant to Section 33A of the *Inspector of Custodial Services Act 2003* (WA).
[20]*VYZ v CEO Department of Justice* [2022] WASC 274 before Justice Tottle ('*VYZ v CEO DOJ*').
[21]*CRU and others v CEO DOJ* [2023] WASC 257 para 77.
[22]The dates on which VYZ had been held in isolation for more than 20 hours a day were – 21, 23, 28, 29, 30 and 31 January 2022; 1, 4, 5, 6, 10, 11, 12, 13, 16, 18, 19, 20, 21, 25, 26 and 27 February 2022; 15 May 2022; and 12 and 13 June 2022.
[23]*VYZ v CEO DOJ* [2022] WASC 274 at para 87 (emphasis added).
[24]*VYZ v CEO DOJ* [2022] WASC 274 at para 71 (emphasis added).
[25]I do not propose going into the harm this practice imposes on those detained; the material is available and the conclusion is obvious.
[26]*CRU and others v CEO DOJ* [2023] WASC 257 paras 46(d), 190.

staff shortages; and inadequate infrastructure. Chillingly, however, all parties recognised that *provided* Confinement Orders were made in respect of each child on every specific occasion (daily), and they were permitted to exercise as per the entitlements set out in the legislation, solitary confinement would be 'lawful'.

Taking this strictly legal view of the relevant provisions, Tottle nevertheless noted with concern that one child, OPS, had been confined for more than 20 hours on 23 of 31 days, mostly for periods of 22 hours, and that 19 of his days in isolation fell on successive days in Unit 18. Having regard to that level of isolation, he added this rider in his judgment:

> I very much doubt that Parliament envisaged that a superintendent's power to order [confinement] would be exercised as frequently, or in circumstances in which it has, and is likely to continue to be, exercised.[27]

The evidence heard in the Supreme Court about the conditions experienced by these young people was part of a continuum, and echoed when custodial staff gave evidence at Cleveland Dodd's inquest. A worker who started work at Unit 18 in August 2022 said the place operated in a 'very distressful way'.[28] In February 2023 another worker in a personal journal described Unit 18 as a 'chaotic' 'war zone' where workers were 'on the front line'.[29]

In May 2023 the Inspector of Custodial Services found that young people, staff, and the physical environment at Unit 18 and Banksia Hill, was in acute crisis. In the lead up to his inspection that year, the rates of self-harm and attempted suicide were unprecedently high.[30] Staffing was in terminal decline.[31]

Turning now to what this all meant for Cleveland.

In late September 2023, the ALSWA had asked for the urgent consideration of Cleveland's transfer out of Unit 18 where he had been held on remand since 17 July.[32] While that correspondence had been referred for comment within the Department, the ALSWA received no response. Cleveland was deeply distressed about the conditions in which he was being held.[33] In evidence it was suggested Cleveland was transferred to Unit 18 because he was a spitter who damaged property. He was described as oppositional, defiant, and angry, with a communications disability and no capacity for consequential thinking.[34]

On 11 October 2023, Cleveland Dodd had recently turned 16. The 11th was his mother's birthday. He ate his breakfast, lunch and dinner in his cell.[35] He was taken from his cell in handcuffs for the video link where his case was adjourned.[36] He was given a little over an hour for recreation out of his cell, being escorted in handcuffs. During his recreation at A-Wing he used the landline and tried three times, unsuccessfully, to make a phone call to his mother.[37]

On 11 October he had been in Unit 18 for 87 days, and his circumstances would have been no different than others detained there. He told his lawyers that he tried to sleep all day. Much of his time was spent in rolling lockdowns and isolation with very limited time outside his cell. In Cleveland's case on this day he was not 'locked down' for a discipline matter.

On 11 October Cleveland covered the surveillance CCTV with wet toilet paper. No one remedied that on the second occasion he did it that day.

Over the day, Cleveland asked six times for drinking water. His cell had had no running water for 20 of the previous 22 days. He had damaged the taps. To shower he had to be removed from his cell.

More significantly, over the day and evening Cleveland made eight separate threats to correctional staff that he intended to kill himself. On many other occasions Cleveland had made similar threats to kill himself or self-harm. In April 2022 the police had been concerned enough to take him to the Kalgoorlie Regional Hospital. On 11 October, and early in the morning on 12 October, Cleveland also asked staff at least twice to help him calculate how long he had been in Unit 18. The Coroner heard he had been transferred there on 17 July 2023.

While one might expect the humiliation of two Supreme Court youth-plaintiff cases to improve departmental procedures, that was not the case.

CRU, OPS and HBS's case was heard six days before Cleveland Dodd's final period of detention began and the Coroner

> had found no reduction in the number of confinement orders that were imposed on every detainee in Unit 18 during the period.[38]

As to the whether there was any real commitment to complying broadly with Supreme Court orders about exercise and confinement, the 'unchallenged evidence' before the Coroner from Unit 18 custodial officers

> was that there was a *particular emphasis* on one or two detainees having two hours of exercise every day when a confinement order was imposed.[39]

[27] *CRU and others v CEO DOJ* [2023] WASC 257 para 9.
[28] Inquest Cleveland Dodd para 283.
[29] Inquest Cleveland Dodd para 272.
[30] Inquest Cleveland Dodd para 1022.
[31] Inquest Cleveland Dodd para 1020.
[32] Inquest Cleveland Dodd para 145.
[33] Inquest Cleveland Dodd paras 158–160.
[34] Inquest Cleveland Dodd para 148.
[35] Inquest Cleveland Dodd paras 172, 173, 180.
[36] Inquest Cleveland Dodd para 175.
[37] Inquest Cleveland Dodd para 179.
[38] Inquest Cleveland Dodd para 591.
[39] Inquest Cleveland Dodd para 598.

As to who those detainees were, Urquhart was

> satisfied that [they] were *very likely the applicants* in the Supreme Court [youth-plaintiff] proceedings. As to the balance of detainees, the direction … was that they must have the opportunity to exercise for at least one hour every day. However, as can be seen from Cleveland's prolonged periods of detention in his cell, that did not always eventuate for him.[40]

Relaxation of the intolerable and isolating conditions imposed on youths like Cleveland appears to have been cynically selective, strictly compliant with Supreme Court orders about very specific young people, and rare.

Cleveland, like others, had also damaged the air vent in the ceiling of his cell, creating a hanging point. Although the correction workers were aware of this, nothing effective was done to fix it or move him, a repairer was organised but other matters took priority, even though another young person – in the neighbouring cell – had tried unsuccessfully to hang himself from just such a hanging point on that same afternoon.[41]

The Coroner himself observed with 'considerable unease'[42] that on the day after Cleveland hanged himself in Unit 18, seven of the 16 cells had continuing damage their ceiling vents.[43] Instructively, the youth in the cell next to Cleveland survived on 11 October 2023 but he continued to be housed in that same cell with the ceiling vent still capable of providing a hanging point, with the CCTV blocked, and with the cell intercom not working.[44]

The Department's submission to the Coroner disingenuously asserted that 'prior to Cleveland's death […] there had been no known deaths in custody using a ceiling vent as a ligature anchor point'.[45] That claim was strictly true but in its partiality it was misleading, intentionally or otherwise.

As to his mental health issues and the responsibility of those charged with his care, during this last remand Cleveland asked for but was not provided with access to psychologists. This failure was compounded by the Department's neglect of the requirement that it develop a Plan for his welfare.

The treatment of Cleveland Dodd and the other young people who prosecuted the Department is deeply concerning and there is no doubt that treatment failed to meet international standards.[46]

This short case note is just another element of the truth-telling we need to do in our country. I would urge everyone to access the full Inquest finding into this young man's death and to also read the Supreme Court cases of youth-plaintiffs VYZ and CRU, OPS and HBS.

The worry is that such treatment will continue (and potentially even worsen, noting the 'law and order' agendas being prosecuted in various jurisdictions) and that efforts to remedy the situation are regarded with cynical contempt, addressed only when necessary and when subjected to judicial scrutiny, either in courts of review or, more tragically, in Coronial Courts.

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[40]Ibid (emphasis added).
[41]Inquest Cleveland Dodd para 210.
[42]Inquest Cleveland Dodd para 406.
[43]Inquest Cleveland Dodd para 327.
[44]Inquest Cleveland Dodd para 414.
[45]Inquest Cleveland Dodd para 408.
[46]Internationally the provision of a single hour of exercise and fresh air for those in solitary confinement flies in the face of the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules) and the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules). The United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) prohibit cruel, inhuman or degrading disciplinary treatments and this includes closed or solitary confinement.