They just let her die,” Dawn Delaney says as she walks to the dining table in her suburban home, carrying two files on the death of her daughter-in-law, Janet Beetsen. The room is busy with books, sunlight and family photographs, of large groups of children, family weddings and one of a smiling mother holding her child — Janet and her young son, Shawn. Outside, highway noises recede behind those of hammers and drills. Billy Delaney, Dawn’s husband of 44 years, is preparing for house renovations with Shawn’s help.

“The prison staff have a lot to answer for when they face their maker,” Dawn Delaney continues. “We couldn’t even touch her in the morgue in case we bruised her, you see, so we couldn’t even say goodbye properly. Some of the staff were good, but others needed to learn about human beings. People don’t go to jail to die, that’s not their punishment. She was only in there for nine months, it wasn’t a death sentence.”

As it turned out, for Janet Beetsen it was precisely that.

The 30-year-old was found dead in Cell 4 of the medical annexe at Mulawa women’s prison in Sydney on June 3, 1994. Beetsen became the year’s ninth Aboriginal death in custody and the 61st since May 1989, the cut-off date for investigations by the Royal Commission into Aboriginal Deaths in Custody.

Her story, little noticed at the time, tells of the fatal combination of forces — bureaucratic bungling, neglect and prejudice among them — that are still turning some prisoners’ sentences into horrifying one-way journeys.

Like many other deaths in custody, Janet Beetsen’s could probably have been avoided. And like many of them, hers was due to illness. She died of the treatable disease endocarditis, an inflammation and infection of the heart. The warning signs were there. Sadly, it seems that not enough people took notice of them. In the days before she died, Beetsen, who had a known history of infective heart disease, was pale and thin, weak, ate little and complained of pain. Often, she couldn’t walk, so she’d crawl or drag herself along the walls. She reportedly had a convulsion. But despite attempts by other prisoners and some prison officers to get medical staff to take some action, Janet Beetsen, no stranger to the prison system, was largely ignored.

On the afternoon of May 27, 1994, Janet Beetsen appeared in court on several charges. Among other things, she was accused of social security offences and having stolen $4000 from a client while working as a prostitute. Found guilty on five charges, she was remanded for sentencing three days later. As part of standard procedure for admitting inmates, an officer had filled out a form listing personal and medical
details. On it she'd written the word “endocaitos”, and then “(sick)” after it, highlighting both in fluoro-yellow. On another form it was noted that Beetsone had a heart condition and a 20-centimetre chest scar from a “by-pass op”. (In fact, she had had her mitral valve replaced with an artificial valve during open-heart surgery in 1991.)

Both forms accompanied Beetsone to Mulawa, where the fact that she had “endocaitos” was noted in the reception area log book.

It was after that that the lines of communication seem to have begun to fray.

From reception, Mulawa inmates are taken to the medical annexe for assessment. Two nurses on duty that night, Dipankar Dattaray and Ronald Hullo, would later say at the inquest into her death that they didn’t know about her heart condition then. Hullo claimed he didn’t see the forms until three days later — a claim that Derrick Hand, the coroner at Beetsone’s inquest in August 1995, did not accept “on the balance of probabilities”.

Dattaray told the inquest that he could not recall seeing Beetsone or the forms that night, although he acknowledged that he had signed for them. He told HQ: “I had the least involvement in Janet Beetsone’s death. I didn’t see her on reception and didn’t see the forms... It was a very busy night.”

However, prison officer Scott Gapes told the inquest that he remembered making a point of handing the forms to a nurse called Ray (Dattaray’s nickname), who signed the log book for them, because he was specifically asked by the reception officer to make sure medical staff were aware of Beetsone’s illness and because it was highlighted on her form, which was unusual. “We don’t have many of these highlighted areas... usually it’s all pretty straight-cut. When it’s highlighted, you do it,” he said.

The information on her health, taken so seriously in one part of the prison, was overlooked by another: the medical annexe, where it counted most.

The medical service log sheet records that, at her initial brief medical assessment that night, Janet Beetsone appeared to be in drug withdrawal and couldn’t stay awake. Her pulse rate and blood pressure were recorded. There is no mention of endocarditis. Following that assessment, she was placed in the therapeutic (psychiatric) unit because of fears that she might try to harm herself.

The next day, according to the records, there were no signs of withdrawal symptoms and she no longer appeared to be a suicide risk. She was moved out of the therapeutic wing and taken to Conlon, a more general, non-medical prison wing.

Despite Royal Commission recommendation 156 — that all new prisoners have a thorough medical examination by a doctor on admission, or, if that’s not possible, by a doctor within 72 hours, provided there are no signs that ➤
anything is wrong — Beeton didn’t undergo a complete examination. In fact, she received no further medical examination until a doctor saw her four days later, even though during this time she was clearly weak, thin and pale, and had vomited at least twice in her cell. The only treatment she did receive was for narcotic withdrawal.

At the inquest it was pointed out that Beeton, given her history of endocarditis and the immediate state of her health, should have been sent straight to hospital, even if staff thought she was under the influence of drugs. Thomas Oettle, the doctor attending the inquest and a former director of the Institute of Forensic Medicine, was also critical of the initial medical assessment: “To take blood pressure and a pulse rate is hardly a medical examination,” he said.

After three days on remand, Janet Beeton went back to court and was sentenced to nine months’ prison. Back at the jail that evening, May 30, she was put into a cell with two other women, one of whom gave evidence at the inquest. “The cell we were in was extremely cold and one of the heaters wasn’t working,” she said. “Between the three of us, we dragged a filing cabinet over and placed it on its side so that we could sit on it to be nearer to the heater ... While we were there, Janet ... asked if she could put her head in my lap. I think she did this for comfort and warmth ...”

“Janet appeared to me not to be in good health. She was shaking and she told me that all she did at Conlon was stay in the shower all day as it was warm. I massaged her a little and when I was massaging the area of her kidneys, she told me that it was hurting her ...

“Janet had spoken to me about seeing if I could be placed in her room. I think this was because she thought I was a compassionate person who could be a friend to her.”

The next day, Beeton was at last taken to the medical annexe for the initial routine examination by a doctor. She was seen by Dr Karen Oswald, a GP who visits the prison.

As well as noting her drug intake, Oswald recorded that Beeton couldn’t sleep, appeared unwell, had a sallow complexion and found it hard to keep her eyes open. Oswald also questioned whether she was under the influence of drugs and wrote: “No mention of SBE [sub-acute bacterial endocarditis].”

At the inquest, Oswald said that she didn’t know Beeton had a history of endocarditis. She hadn’t seen her forms, and normally wouldn’t. She made the file note “No mention of SBE (meaning the patient hadn’t mentioned it) because a member of the nursing staff had told her Beeton may have endocarditis. Oswald didn’t specifically ask her if she had. Instead she asked what she routinely asks new inmates: “Do you have any other health problems that I should be aware of?” She said Beeton didn’t tell her she had a heart problem, or any other health problems, so she didn’t pursue it with her.

To be sure, Karen Oswald ordered blood tests and liver function tests to get further information and to see if Beeton had endocarditis, but these were never carried out. A note in the medical records says the nurse hadn’t in-law needed more treatment, and possibly surgery, for an aneurysm in her brain, and for her spleen, so she was worried about her being in prison and not getting proper medical attention: “Everyone knew about her medical condition because I kicked up such a fuss. I made sure everybody knew.”

It was one of the many times Dawn Delaney had gone in to bat for Janet Beeton. Beeton had been befriended by the Delaneys as a teenager, when one of their sons had brought her home and she’d promised to straighten herself out.

She’d grown up in Sydney’s west and had started getting into trouble at a young age, falling into typical juvenile crimes like shoplifting and other theft. Unwelcome in her own family (she found out only by accident that her mother had died of cancer), she found an accepting and loving home with the Delaneys whose house was like a local drop-in centre. “We had nine kids here at one stage,” Dawn says. The couple

“You just had to look at her, she had no colour, no energy at all. She would crawl from her cell out to the wing, lie on the floor”

became like a mother and father to Beeton, whose birth family, says Dawn, are from the Torres Strait Islands. She lived with the Delaneys on and off for almost 15 years.

Her son Shawn was born when she was 17. Beeton was in a juvenile detention centre towards the end of the pregnancy, on more serious charges than she’d faced before, and was released into the Delaneys’ care. But there were more charges to come. Shawn lived with his grandparents as his mother struggled to keep off drugs and out of jail. She saw him when she could.

Now 15, Shawn remembers playing basketball and other sports with his mother, and having sporadic conversations with her. They’d talk about what had been happening in their lives and when they could next meet. “It was sort of like a broken romance,” he says.

In a letter he wrote in the months following her death, he said:

Went to see [a friend]. I ... had a chat to her and got very emotional like a wildfire. I
Dawn Delaney, with her grandson Shawn, now 15. "Through lack of care and consideration that girl died," Delaney says of her daughter-in-law, Janet Beets. "I suddenly felt like throwing the table. You see I saw a girl that looked exactly like my mum. It’s like your head and all other insides are just burning up and you get a head like no other. It just eats you up; your stomach shudders, you just sort of freeze up. You can hardly talk."

Dawn Delaney might have kicked up a fuss about Beets’s need for medical attention, but it didn’t help. Here was a young woman who had symptoms of endocarditis, plus a 20-centimetre scar on her chest, and who was well-known within the prison system to have had serious health problems. Also well-known was the fact that there is a higher incidence of sub-acute endocarditis among intravenous drug users. Despite all that, she was not thoroughly examined, her files were not looked at, and no action was taken.

It’s more than likely that if any of the medical staff had listened to her heart through a stethoscope they would have heard the murmur made by the failing valve and been immediately alerted to the fact that something was wrong.

An increased pulse rate can also indicate endocarditis. The medical notes, made by a nurse on May 31, show that her pulse rate had jumped to 120, up from 78 recorded upon admission. Alarm bells that should have been ringing by now remained silent.

The explanation is that it was assumed she was withdrawing from drugs, that the symptoms of drug withdrawal and endocarditis can be similar.

Which is precisely why, Dr Thomas Oettle said at Beets’s inquest, a full medical examination and the availability of the patient’s file are even more essential in such cases.

Janet Beets was kept in the annexe for observation after seeing the doctor but later that day was sent back to the general prison wing where she was put into a cell on her own.

Leisa Morrissey was in the same prison wing. She remembers how Beets was at that time. “You just had to look at her, she had no colour, I mean no colour, no energy at all. She would crawl from her cell out to the wing, lie on the floor. She wouldn’t move, you’d try to feed her, she wouldn’t eat, she couldn’t eat, she was just sick, too sick,” she said.

Some of the prison officers were also concerned about her. “I observed inmate Beets in the recreation area of the wing and she appeared to me to be very ill,” a prison officer on duty said in his statement to the police. “At this time she couldn’t walk properly and she appeared to be very weak.”

Several inmates recall Beets having to be helped to the “pill parade”, the barred window of the medical annexe where medication, mostly methadone, is collected. When Morrissey asked her if she was coming, Beets said that she didn’t have the energy. “She was standing outside the wing door and hanging onto the fence. One of the prison officers asked me if I would help her walk over there ... I walked back and virtually had to carry Janet over to the medical annexe,” Morrissey said.

According to a report by the then governor of Mulawa, John Kelly, Janet Beets collapsed at 2pm, Wednesday, June 1. This was her fifth day in Mulawa. Clearly she was deteriorating. Nurse Ronald Hellier’s statement says that he and another nurse were summoned by prison officers who reported that she had been convulsing. When they went into her cell, he said, she seemed to be
very pale and there was a suggestion that she might be anaemic.

The nurses didn’t see her convulsing but they did contact a doctor at another prison who prescribed an anti-convulsant drug over the phone. There is no record that Beetson’s vital signs were checked. She was then left alone.

At 5pm, three hours after her collapse, Beetson was transferred to the medical annex. At 8.15, she was admitted for observation. Where did she spend the missing three and a quarter hours? She may have been inside the annex without being formally admitted or she may have been in the waiting area, an open-air cage. It was winter and, chances are, she had a temperature.

When she was finally admitted to the annex she was given medication for drug withdrawal and locked in a cell. Again, there was no physical examination, nor was her pulse rate or blood pressure taken until the next morning, at which time her pulse rate was still racing at 120. There is no record of her temperature being taken at any time.

About noon of June 2, six days after arriving at the prison, Beetson was allowed to have a bath. But when prison officer Catherine Harrison checked on her, she found her standing beside the tub complaining that she couldn’t turn the taps on, although Harrison found them easy enough. When she returned 10 minutes later, Beetson was lying sideways in the bath, her legs hanging over the side. “The bath was overflowing onto the floor and Janet was sitting with her eyes closed. I said, ‘Janet, are you all right?’ I had to lift her out of the bath. I dried and dressed her, helped her back to her cell and put her into her

bed.” Harrison told the sister she was worried about Beetson. But when she finished her shift early in the afternoon, no doctor or nurse had visited the cell.

That same afternoon a one-litre bottle of methadone went missing from the medical annex. Several inmates were suspected of having used some; one had overdosed and was in the annex. The

Despite the Royal Commission, Aboriginal deaths in custody remain high. Janet Beetson’s was the 61st death since the commission’s cut-off date.

big concern was overdose deaths. So the inmate who had overdosed was given priority attention, while in a nearby cell, Janet Beetson was slowly dying.

When asked at the inquest if he had any concerns for Beetson at that time, a prison officer on duty answered: “That day was a difficult day. Any other day

may be I would have taken more notice of Janet but because of the circumstances I was preoccupied with other things … Being in the annex, there’s medical staff up the hallway who are responsible for her and I assume that they would do everything that’s needed to look after the lady.”

The methadone theft was a major breach of prison security and “managing” this crisis was paramount. According to evidence at the inquest, a male nurse by the name of Ray had told

an inmate: “Yes, we were going to take Janet to an outside hospital but we had orders from the Super, Mr Kelly, that the girl who stole the methadone was top priority and under no circumstances was this to leak out to the public, and he did not want her going to an outside hospital. [We were told]: “Every time

Prison, has reduced the numbers at Mulawa from 300 to 175.

But will history merely continue to repeat itself, despite such changes?

The 1976 Nagle Royal Commission into NSW prisons found that the medical services for women at Mulawa were inadequate and that, on many occasions, the medical examination on reception was perfunctory and inadequate. Nine years later, the NSW Women in Prison Task Force commented that little had been done to improve health-care services to women in prison since the Nagle Royal Commission.

Nine years after that, the system was still fatally flawed.

Trouble at Mulawa

Janet Beetson’s death at Mulawa was the second of three in the prison in less than a year. During this period, there was a dramatic increase in self-mutilations, and prisoners had been writing to both the media and authorities with allegations of widespread sexual exploitation of inmates by prison staff. They also described the inadequacies of medical treatment within the prison. As a result, an Ombudsman’s investigation was begun into the conditions there.

The report on this investigation was due in July last year, two years after it was set up. It has not yet been released.

Since Janet Beetson’s death, changes have been made to medical procedures at Mulawa. According to the coroner, there is now a doctor on call 24 hours a day. The NSW Corrections Health Service reports the appointment of a part-time medical director at Mulawa, codification of annex admission procedures, and the setting-up of a crisis intervention team. The opening of a new women’s prison at Emu Plains in Sydney’s west, converted from a men’s prison, has reduced the numbers at Mulawa from 300 to 175.

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Nine years after that, the system was still fatally flawed.
that girl [who had overdosed] closes her eyes, hit her up with Narcan [a narcotic antidote]." Then Ray the nurse said that the following afternoon we were going to have [Janet] taken out to hospital, but she died before we did.

Through a spokesperson for the NSW minister for corrective services, Bob Debus, Kelly denied giving those orders and said he was not aware of anybody under his authority giving them.

Inmate Catherine Bell, also suspected of taking some of the stolen methadone, had been brought to the annexe for observation and was put into the cell next to Beeton's. She said she heard a lot of moaning. When two prison officers and a nurse came to take her blood pressure around midnight, Bell said, she asked who was in pain and was told it was Beeton. She said she then asked, "Why isn't she out at hospital?" and prison officer Vicki Finn allegedly replied, "She's all right, she's in there having multiple orgasms."

Said Bell: "I told the officers that Janet had open-heart surgery and they replied that she was a hypochondriac. The sister and officers left my cell and, in between me reading the paper to [the inmate who had overdosed] to keep her awake, I was yelling out to Janet, but she was only mumbling. I didn't see any officers walk past my cell to check on Janet. The only time that they did go into Janet's cell was when she was dead. One of them said, 'Oh shit, she's dead.'"

Prison officer Sharon Young, who found Beeton's body, said in her statement that she'd heard her moaning on both nights she was in the annexe. She said that on the first night, "These noises were fairly regular and she was not in any obvious distress. On one occasion I called out to her, 'Janet, are you all right?' I saw her nod her head in the affirmative. On the second night she was still making groaning noises and on one occasion Cathy Bell said to me, 'What's that?' or words to that effect. I told her that it was Janet and she must be having a good dream or was enjoying herself."

Young told the inquest that at the time she had no idea Beeton was seriously ill, and that if she had she would have taken more notice of these groans.

At the inquest, prison officer Vicki Finn said she could remember going into Bell's cell but not having a conversation with her about Beeton's condition. She said she didn't recall saying she was having multiple orgasms, and definitely didn't say she was a hypochondriac. She did remember her groaning, and said these groans would have been audible to medical staff in the annexe.

Finn also did not know Beeton was seriously ill. She said the only advice she had from medical staff that night was that the inmate who had overdosed had to be checked every 10 minutes.

Of medical staff denials that she was moaning, the coroner said he accepted inmate and prison officer evidence that she was, "I just find it hard to accept, or hard to believe that the nurses still persist in saying there was no moaning and groaning," he said.

Janet Beeton didn't need to die. The overwhelming evidence is that if the recommendations of the Royal Commission had been implemented, especially those dealing with prison health services and the duty of care, she would still be alive. Even without Royal Commission recommendations, no prisoner should have to die in this way.

At the inquest, Dr Thomas Oettle said that although acute endocarditis kills quickly, it also responds quickly to intravenous antibiotics and adequate general medical care.

For his part, the coroner made it clear that Beeton's medical care was anything but adequate, and said he was extremely disappointed with the nurses' attitude towards her.

"The nursing of Janet Beeton was very lax to say the least," he said in his findings. "If they had notified the proper people of this endocarditis there is a strong possibility that this death would never have occurred, because at least then some appropriate treatment may have been started."

The coroner accepted the evidence of inmates that they, and some prison officers, had made attempts over several days to get medical staff to take some action. "But still nothing was done, other than just a pulse rate [taken] on occasions and blood pressure, etcetera, and generally having a look at her without any full examination. She should have been immediately taken to a doctor, or the doctor called when this illness persisted."

Dawn Delaney is still grieving over her daughter-in-law's death. People who die in custody take a long time to be "buried", as the resulting legal processes can drag on for years. "I don't want Janet's death to be in vain because I don't want it to happen to anybody else," Delaney says. "Through lack of care and consideration, that girl died. We can go to the moon but we can't be compassionate enough to take a girl who needs help to hospital."

Once more into the breach

The Royal Commission into Aboriginal Deaths in Custody investigated the circumstances of the lives of the 99 Aboriginal people who died in custody between January 1, 1980, and May 31, 1989. It also looked at the economic, social, cultural, legal and institutional factors surrounding their deaths. The Royal Commission presented its findings in May 1991, and made 339 recommendations. Some $400 million has been spent to implement them. And according to the 1994/95 NSW Department of Corrective Services annual report, the recommendations "continue to be implemented in all correctional centres". Yet in 1994, the year Janet Beeton died, 14 Aboriginal people died in either prison or police custody (mostly as a result of illness), a figure an Australian Institute of Criminology report found to be substantially higher than at any time over the previous 15 years. And the worst wasn't over. In 1995 there were 22 such deaths in custody, 17 of them in prison, and by October 1996 a total of 96 Aboriginal people had died in custody since the cut-off date for the Royal Commission.

Ray Jackson, of the NSW Aboriginal Deaths in Custody Watch Committee, believes the problem lies at ground level rather than the administrative level. "The majority of individuals working in the judicial system don't know how to use or understand the commission recommendations," he told HQ.

Mick Dodson, the Aboriginal and Torres Strait Islander Social Justice Commissioner, recently launched a report that examined indigenous deaths in custody between 1989 and 1996. "Governments claim they have implemented the recommendations but the stories of the indigenous people who died tell otherwise," he said. The report, which Dodson's office compiled for ATSIC, found that an average of 8.5 recommendations were breached for each of the deaths examined. In Janet Beeton's case, the number was 16.