CITATION:	*Inquest into the death of Robert Plasto-Lehner and David Gurralpa aka Moscow* [2009] NTMC 014
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0228/2007 and D0002/2008
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HEARING DATE(s):	25 February – 10 March 2009
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Death in Custody and care, restraint by police, positional asphyxia, police training in relation thereto, report of crime committed.

REPRESENTATION:

Counsel:

Assisting:	Philip Strickland
Police:	David Farquhar
Dept. of Health:	Kelvin Currie
Human Rights & Equal Opportunities Commission:	Ms O'Brien & Ms Redmond
Family of David Gurralpa:	Patrick McIntyre

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0228/2007 and D0002/2008

In the matter of an Inquest into the death of

ROBERT PLASTO-LEHNER ON 1 JANUARY 2008 and DAVID GURRALPA aka MOSCOW ON 28 DECEMBER 2007

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. These Inquests were held into the deaths of David Burumila Gurralpa aka Moscow and Robert Plasto-Lehner. Both deaths are "reportable deaths" under section 14(2) of the *Coroner's Act* ("the *Act*"). The Coroner was obliged to hold an inquest under section 15(1) of the *Act* into David Gurralpa because he was held in custody by the police immediately before his death. Similarly I held an inquest into the death of Robert Plasto Lehner pursuant to section 15(1a) of the *Act* because he was a person who was held in care at the time of his death, as he was detained in a hospital pursuant to the *Mental Health and Related Services Act.*

2. The circumstances of the deaths were investigated at the one inquest because of common factors and an overlap of issues. Both deaths were at least contributed to by injuries sustained after the police used force involving restraining the men in a prone position. Both men were large men who suffered from pre-existing heart conditions. An issue arises in both cases as to whether the deaths were caused by 'positional asphyxia'

3. The scope of the inquest is governed by the provisions of sections 26, 27, 34 and 35 of the *Act*:

26 Report on additional matters by coroner

(1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner -

(a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

27. Coroner to send report etc. to Attorney-General

(1) The coroner shall cause a copy of each report and recommendation made in pursuance of section 26 to be sent without delay to the Attorney-General.

34. Coroners' findings and comments

(1) A coroner investigating -

(a) a death shall, if possible, find -

(i) the identity of the Deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act ; and

(v) any relevant circumstances concerning the death; or

(b) a disaster shall, if possible, find -

(i) the cause and origin of the disaster; and

(ii) the circumstances in which the disaster occurred.

(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.

(3) A coroner shall not, in an investigation, include in a finding or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subsection (1)(a)(iv) are provided to the Registrar, within the meaning of the Births, Deaths and Marriages Registration Act .

35. Coroners' reports

(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

4. The public inquest into the deaths was heard in Darwin from 25 February 2009 to 10 March 2009. Mr Strickland SC appeared as counsel assisting the Coroner. Mr McIntyre appeared for the Gurralpa family, Mr Farquhar appeared for the Commissioner of Police, Mr Currie appeared for the Department of Health and Families and Ms O'Brien and Ms Redmond appeared for the Human Rights and Equal Opportunities Commission. I have read and considered the written final submissions filed by all parties.

5. I request the legal representatives of the Gurralpa family, that is the North Australian Aboriginal Justice Agency, advise the family of the content of these findings and, where necessary, translate them into their first language viz Djambarrpunya.

RELEVANT CIRUMSTANCES INVOLVING DEATH OF DAVID GURRALPA

6. I find the evidence establishes that David Gurralpa was 39 years old at the time he died. He spent most of his life at the Ramingining community but often left to go and work on various Outstations for employment. From 1994 to 2004 he worked at cleaning job at Wulkabirri Outstation. The Deceased was in a band called 'Black Iron' and travelled to various places playing with his band. He was well loved as a singer.

7. He married his wife Rhonda Malibirr at the Tanks Outstation and they later moved to Wulkabirri Outstation. They had 4 children; Evanthia (16), Arnold (14), Hilston (12) and Tiffany (6).

8. Shortly before his death, he and his wife arrived in Darwin to stay with his wife's sister, Anita Pascoe at Malak. They stayed there for about 2 weeks before moving to 18 Waterhouse Crescent, Driver, which was a property leased to Terry Moscoa, Peggy Rankine and Haggi Moscoa. They stayed there for 1 week before his death.

9. On 1 January 2008, a number of Aboriginal people gathered at 18 Waterhouse Crescent, Driver to celebrate the New Year. The celebration degenerated during the afternoon as people became progressively more intoxicated. Neighbours vividly describe hearing the sound of glass or bottles breaking, yelling and screaming from inside the premises and someone being thrown against a door or wall. An Aboriginal man was thrown out onto the road and cried out in distress and pain.

10. An argument took place between Peggy Rankine and the Deceased about whether he had stolen or taken any alcohol. The Deceased took umbrage at that suggestion and threw one or more items including a saucepan at Peggy Rankine in her front yard. It did not hit her. The Aboriginal witnesses describe the Deceased as being very angry or 'wild' at Peggy Rankine.

11. At 4.46pm on 1 January 2008, Jessica Wilson (one of those present at the house) called 000 from 18 Waterhouse Crescent. She told the service that lots of people were fighting over alcohol and were intoxicated. She said: "they are throwing saucepans at each other". She gave evidence at the inquest that she was frightened when she made the 000 call.

12. At 4.48 pm, Unit 418, a Police caged vehicle with Constables Melissa Kennedy and Ben Parfitt was dispatched to 18 Waterhouse Crescent Driver. However at 4.51pm, the first police vehicle to book off, that is to arrive, at 18 Waterhouse Crescent was Unit 36 with Constables Brendan Berlin and Marcus Lees. Unit 36 requested assistance for other units to attend the premises.

13. When Constables Berlin and Lees arrived, an ambulance was at the premises treating an Aboriginal man in the driveway. They approached the ambulance, which left shortly thereafter. They then spoke to a group of people at the front of the premises. Lees noticed one Aboriginal man yelling at another Aboriginal man outside the premises neither of whom were the Deceased. Berlin and Lees then saw a disturbance going on in the yard. Berlin closely followed by Lees walked inside the yard and spoke to Peggy Rankine.

14. Peggy Rankine told Berlin that she was the lawful occupier of the house and she didn't want these people to stay any longer in the house. Berlin says "Who do you want removed". She pointed to the Deceased. Rankine told the police that the Deceased had thrown a saucepan at her and showed them her slightly swelling hand. She pointed out the Deceased to the police, who was standing at the back of the house, and told Berlin and Lees that she wanted the Deceased and his wife, Rhonda Malabirr removed from her premises. In her statutory declaration, Peggy Rankine told police that she wanted the Deceased taken to a "sobering centre". Simeon Moscow, in his

statutory declaration told police that he heard Peggy Rankine tell police to take them to "spin dry"

15. At 4.57pm, as a result of hearing some chatter on radio channel 6 and the request from unit 36, Constables 1/Class Neil James and Kanyilmaz in unit 420 arrived and "booked off" at 18 Waterhouse Crescent. Once James went into the yard, he saw the Deceased in between Berlin and Lees and Berlin called out to James: "This one's going [referring to the Deceased]. There's another drunk out the front".

16. Constable Berlin walked up to the Deceased and asked what he was doing there and he said he had had an argument with Peggy and he threw a saucepan, which narrowly missed her. Berlin asked the Deceased if he had been drinking that day and he said 'yes'. Berlin told the Deceased he was not welcome to stay and he'd like him to leave the premises. The Deceased was bare-chested. Lees asked the Deceased to get his shirt and the Deceased agreed and asked his wife to get his shirt. The Deceased agreed to leave the premises and began to walk with Berlin and Lees towards the front gate. He was being co-operative.

17. Berlin and Lees walked out into the front yard with the Deceased. As they were moving towards the front gate of the house, Peggy Rankine said something to the Deceased in language. Janet Gunimirriwuay, sister of the Deceased, told the police in her statutory declaration that Peggy said to the Deceased: "You have to go to gaol, going to go to the paddy wagon". Rankine said she told the Deceased: "You've got to go to sobering centre. We'll pick you tomorrow morning." She said that the Deceased replied to her: "I'll come back tomorrow and hit you"

18. Whatever Rankine said to the Deceased, it triggered a tragic chain of events. The Deceased lunged towards Peggy Rankine with his right arm raised as if he was going to do something to her. In his interview with police on 15 January 2008, Simeon Moscoa made this observation:

> "He [the Deceased] tried to hit Peggy, two Policemen came in to stop him. They knew he was really getting wild. Peggy just told them to take him to the spin dryer. He was trying to hit [her] but the Police just rushed him, coming towards him".

19. Genevieve Smith told the police during her interview that Peggy said something to the Deceased "and she make him wild. He was going to hit her again".

20. Berlin stepped between the Deceased and Peggy Rankine and grabbed the Deceased by his right arm. Lees grabbed the Deceased's left arm. The Deceased began to struggle, and both police officers pushed the Deceased against the side of the Jackaroo vehicle, which was parked in the driveway. Lees said to the Deceased "Settle down. Settle down. You know we've got to leave." Lees told the investigating police that when the police grabbed the Deceased's arms, the Deceased's whole personality and demeanour changed. He became very aggressive.

21. Berlin and Lees were joined by Kanyilmaz, who tried to control the Deceased's left arm. The police did not at any point try to force the Deceased to the ground, or in police terminology; ground stabilise him. They tried to force his arms behind his back whilst the Deceased was standing up next to the Jackaroo car. However, the police were unable to do that because the Deceased was thrashing and swinging his arms about and kept breaking free from their grip. The Deceased's shirtless upper body was sweaty and slippery. The Deceased was a strong, muscular man, who weighed about 88 kilograms.

22. Berlin, Lees and the Deceased lost their balance in the struggle and fell on the bitumen driveway. There was no deliberate take down. The Deceased ended up face down on the ground. The majority of witnesses said that the struggle continued whilst the Deceased was face-down either on a grassy area just next to the side of the house or on the adjoining bitumen which was a drainage area. The struggle escalated. The police involved described the

intensity of the struggle as between a seven and nine out of ten or as "very high up the scale".

23. Acting in accordance with their training, Berlin and Lees applied a three point hold on the Deceased placing their knees on his right and left scapula. They attempted to get the Deceased's arms from under his body to behind his back so that they could apply handcuffs. Kanyilmaz attempted to control the Deceased's legs by applying a figure four lock. This did not work because the Deceased was kicking out and hitting Kanyilmaz with his legs. Kanyilmaz placed his knee on the Deceased's left leg and with great difficulty held the Deceased's right leg down with both his hands. The Deceased continued to struggle. Lees and Kanyilmaz were repeatedly yelling at the Deceased to stop resisting.

24. During the struggle, Constable James stood between the Deceased and the crowd and told the crowd to stay back. He had a Mach 9 canister of OC spray in his hand. James observed Lees appear to lose his grip and he thought the Deceased was turning over to try to get up. James lifted the Deceased's head, told the police: "I'm going to spray him" and then sprayed the Deceased to the face with the OC spray for 1-2 seconds from about ½ metres away. When James used the OC spray, he had twisted his wrist so that the OC canister was close to a horizontal position. Lees was the only member involved in the struggle who knew that the OC spray had been used because he could smell and taste it, but it did not affect him. None of the members were affected by the OC spray and some did not know it had been used. The Deceased did not appear to be affected by the use of the OC spray.

25. Forensic tests were conducted on the Mach 9 canister used by James, which revealed that only a small amount of the spray had been used. Sergeant Hansen conducted a test on the canister pressing the trigger at approximately the angle held by James on 1 January 2008. He discovered that all that

happened was the nitrogen gas in the canister was released, and nothing else.

26. In short, there is no evidence that the use of the OC spray in any way contributed to the death of the Deceased.

27. After using the OC spray, James returned to monitoring the crowd. Three more police officers arrived in two different units during the struggle. Constables Melissa Kennedy and Ben Parfitt arrived in Unit 418. Their arrival is not recorded until 5.05pm. The evidence is that they arrived before that time but Kennedy did not book off as soon as they arrived, so it is not clear exactly what time they arrived. The shift supervisor at Palmerston police station, Acting Sgt Wilson attended at the premises. He did not advise Communications of his arrival until 5.06pm because the radio operators were busy and upon arrival he immediately attended to maintaining crowd control.

28. Immediately after Kennedy entered the yard of 18 Waterhouse Crescent, she saw the Deceased on the ground with the police officers crouched around him attempting to restrain him. She heard one of the officers yelling at her to get her handcuffs out. She did so and one of the Deceased's arms was put behind his back and the handcuff was applied to it with some difficulty due to the size of the Deceased's wrist. The handcuffs were then applied to the Deceased's other wrist. Kennedy estimated that by the time she arrived (which was clearly after the struggle on the ground had commenced) the struggle continued for no more than one minute.

29. During the whole struggle on the ground, the crowd were calling out warnings to the police including: 'he is a sick man', 'he has asthma', 'leave him alone' and 'do not touch him, leave him because he's a sick person'. The warnings were yelled loud enough so that the neighbours heard them. Constables Lees, James and Kennedy heard those shouted warnings. A couple of Aboriginal witnesses heard the Deceased cry out in pain and heard

him say: ‘let me go. I need to breathe.’ No police officer said they heard the Deceased say he could not breathe.

30. After the police handcuffed the Deceased, he suddenly stopped struggling. A number of witnesses in close proximity to the Deceased described how all of a sudden, the Deceased stopped moving. Shawn Morris said that after the handcuffs were put on, all the police officers stood up and were standing. He said: “the Deceased. I couldn’t see him move again”. Simon Pascoe described the Deceased struggling violently, and then all of a sudden, he could not move anymore, he states “then suddenly he couldn’t breathe, he stopped breathing and I could see him.” Stella Smith said: “Last minute I could see him move and then suddenly he stopped it”. Agnes Warambala, who was the Deceased’s niece, described how, during the struggle, she had darted in and out trying to tell the police “leave him [the Deceased] alone. He’s too fat and short, something might happen to him.” She said that when the struggle had finished, she saw the Deceased on the ground. “I seen my uncle wasn’t moving and then I spoke up and I said ‘that’s it, he’s finished, you killed him.” Some witnesses observed the Deceased was bleeding through his nostrils.

31. These accounts are supported by evidence from the police. Constable Lees told the investigating police that after the Deceased was handcuffed, he noticed that the Deceased went ‘limp’ and appeared to be unconscious. At the inquest, he confirmed the truth of that statement. Lees said at the inquest that he saw the Deceased’s eyes were shut and he was not moving.

32. After the Deceased was handcuffed, he was lifted onto his knees, and then onto his feet. It appears that the Deceased could momentarily take some of his own weight and stood for a moment. However immediately after he stood up, the Deceased slumped unable to take the weight on his own legs. He had to be carried by three police to the police van – Parfitt and Berlin held the Deceased by his arms and Kanyilmaz took his legs. Kanyilmaz said

that the Deceased was still moving his feet whilst he was carrying him to the police vehicle. He had no concerns about the Deceased's health and assumed that the Deceased was simply being co-operative. He went round to the side of the police van to clean up. Berlin was talking to the Deceased continuously after he was handcuffed asking him if he was okay. Berlin said that he noticed something was wrong with the Deceased after the Deceased got to his feet and he slumped, unable to bear his own weight. Parfitt noticed as he was taking the Deceased to the van that his neck was strained as if it had gone rigid, his eyes were closed and his face "looked like he was holding his breath". Parfitt also observed that blood was smeared on the Deceased and that some of the blood had got on himself. Acting Sergeant David Wilson also noticed that the Deceased was not moving when they picked him up, apart from the fact that the Deceased appeared to throw his feet out. Wilson thought that the reason the Deceased needed to be dragged to the police van was because he was intoxicated.

33. Half way down the driveway, Kennedy was concerned how the Deceased looked. She noticed how the Deceased appeared rigid, his eyes were closed, his legs had not come down and he was saying and doing nothing. She said to the other police, "I don't think he's OK". She said the other officers 'took note' and then hurriedly took him to the back of the police van.

34. The Deceased was then placed in the police van with his handcuffs still on behind his back. Constable Parfitt then closed the police van's door because he was concerned that the Deceased was possibly going to struggle. He gave the following evidence (p.423):

> "MR STRICKLAND: So you've arrived then at the van?---That's right. And we sat him on the sill on the back of the van. Sit him in as much as we can and then we swung his legs into the van. At that point the door was closed. I can't remember who closed it, but it was closed for only a matter of seconds because he then sort of slid sideways and lay on the floor of the van. And it was obvious at that point that something was wrong.

When the doors – did someone shut the door?---Yes.

And what was the sound that made?---The caged doors are very loud when they close. It's metal on metal, there's no rubber or anything like that, so it's pretty loud.

Why did someone close the door, do you know?---Well, because at that time we believed that there was still possibly someone who was – well, the Deceased was possibly going to struggle and that's what I was told to do, just close the door.

You closed the door did you?---I don't know if it was me or someone else, I can't remember who closed the door. But I know that I opened it almost straight away.

And why did you open it almost straight away?---Because I could see that he'd slipped over.

So slipped over?---He was sat with his hands cuffed behind him and his back was on the seat and he's obviously slipped over to the left hand side and laying on his side on his shoulder.

And you saw that happen?---I did.

And you opened the door then?---Yeah."

35. Parfitt saw the Deceased sitting on the bench in the police cage and slip over straight away. Parfitt opened the door immediately, checked for the Deceased's pulse on his neck but could not find it. The Deceased's handcuffs were removed and resuscitation was commenced. The Deceased's heart had stopped.

36. James entered the vehicle and checked the Deceased's pulse in his carotid artery and found he had a pulse. James called an ambulance, records show the call was made at 5:01 pm. That call was played during the inquest. James told the 000 operator that the Deceased has "still got vitals." After that call, James continually checked the Deceased's pulse and was not getting any pulse at all. Other police members then checked the Deceased's pulse and could not find one. Police officers attempted to call for an ambulance several times. The ambulance arrived at 5.14pm. It appears that

the delay was caused because it was assumed that there was already an ambulance at the premises, in fact, the ambulance that had been at the premises when Constables Berlin and Lees arrived had already left.

37. Monitoring and resuscitation by ambulance officers commenced at 5.15pm. The ambulance left the premises at 5.22pm and headed directly to Royal Darwin hospital. The Deceased's heart beat, breathing and pulse were regularly monitored by ambulance officers in the ambulance. The cardiac monitor showed that the Deceased had no heart beat. The Deceased exhibited no signs of life whilst in the ambulance.

38. The Deceased arrived at the Emergency Department of Royal Darwin hospital at 5.37pm. He was not able to be revived in the ambulance, nor was he revived at the Royal Darwin Hospital. Kanyilmaz went to the Royal Darwin Hospital and spoke to Dr Didier Palmer, who told him at 5.52pm that the Deceased was dead.

39. The struggle involving the Deceased and the police commenced very shortly after 4.57pm when Kanyilmaz and James arrived. It must have concluded before the ambulance was called at 5.01pm. In my opinion, considering those outer time limits and all the evidence from the eyewitnesses, it is probable that the duration of the struggle whilst the Deceased was on the ground in the prone position was between one and two minutes.

CAUSE OF DEATH

40. In August 2002 at Ramingining health clinic, the Deceased was diagnosed as suffering from hypertension, obesity and high cholesterol. He smoked about 20 cigarettes a day and drank kava. In February 2004, he again attended that clinic and provided blood for screening. He had high Albumin levels consistent with kidney disease. Throughout 2004 and 2005, he did not comply with various medical recommendations concerning medication he should take to deal with those medical conditions. The Deceased's health

condition as at 1 January 2008 was very serious. Tragically, this profile represents a fairly typical profile for a significant proportion of Aboriginal men in the NT community.

41. The Deceased also had a past history of hepatitis B infection and Syphilis. His wife Rhonda Malibirr said he had problems with his kidneys and had asthma but he never mentioned the latter condition to her or to the doctors. She knew he had problems with shortness of breath. She said that the Deceased was given medication for his health conditions but often did not take that medication. There was no evidence in the Hospital or medical records, or from the autopsy that the Deceased suffered from asthma. However, there is considerable evidence from members of the Deceased's family, including his wife, that he was chronically short of breath, probably due to his general ill health and the fact that he smoked approximately twenty cigarettes per day. Dr Paul Botterill, a highly experienced Forensic Pathologist, examined the autopsy report of Dr Sinton (the forensic pathologist who conducted the autopsy), the Deceased's medical files and a number of witness statements. Dr Botterill concluded that the Deceased's underlying long standing coronary artery disease represented the most significant and most likely cause of death. Dr Botterill also listed other factors which contributed to the Deceased's death; the restraint by the Police and asphyxia associated with that, the Deceased's obesity, the enlargement of his heart, his high blood pressure in the past, the fact that he had significant fatty liver and the fact that he was intoxicated with alcohol at the time. He said that the "restraining event" was probably a material contributing factor to the Deceased's death. Dr Botterill concluded that the severity of the Deceased's heart disease was such that the Deceased was at "extreme risk of sudden cardiac event". Accordingly, Dr Botterill's opinion was that confronting agitative events such as the struggle and the restraint and the stress of the complex situation could be enough to trigger a cardiac event. Dr Botterill also observed that people in restraint situations struggle

because they themselves perceive they are having difficulty breathing. Having reviewed the material he thought this probably occurred in the Deceased's case.

42. Dr Terence Sinton, the Director of RDH Forensic Pathology Unit, carried out an autopsy at 9am on 3 January 2008. His significant findings were:

> "(a) Superficial abrasions to the left shoulder, right arm, both legs, and the back of the trunk;
>
> (b) Clinically severe coronary artery disease. The coronary arteries were blocked up to 80% in the worst affected areas;
>
> (c) Extensive damage to the heart as a consequence of at least one previous heart attack;
>
> (d) Abnormal enlargement of the heart, probably a consequence of (c) above;
>
> (e) Fluid accumulation in the lungs, consistent with acute heart failure;
>
> (f) Severe fatty damage to the liver, likely as a consequence of chronic alcohol toxicity."

43. Samples of blood taken on his admission to Hospital indicated an alcohol concentration of 0.035%. Dr Sinton concluded

> "given the history and autopsy findings, he died as a result of long standing coronary artery and heart disease.
>
> 1(a) Condition leading directly to death
>
> 1(b) Coronary Atherosclerosis (clinically severe coronary artery disease).
>
> 2 Other significant conditions contributing to death but not related to the condition causing death: myocardial infarction (heart attack).
>
> Hepatosteatsis."

44. I cannot be satisfied that the Deceased died from suffocation or asphyxia as a result of any direct interference with the Deceased's respiration. I do accept that as a result of the intense restraint and struggle, the Deceased had difficulty breathing, and that this difficulty was accentuated because he had longstanding breathing difficulties (as described by his family) and a large belly which restricted the movement of his diaphragm when he was in the prone restraint position, which in turn affected the amount of air getting into his lungs. This difficulty in breathing may have been one of the factors that led to the cardiac event.

45. I find that the Deceased died from a long standing coronary artery disease and that the immediate cause of his death was a sudden heart attack. The struggle between the Deceased and the police both whilst standing up and particularly whilst the police were restraining the Deceased on the ground during the struggle was a material contributing factor to his death.

COMMENTS ON POLICE CONDUCT

46. The action the police took in restraining the Deceased from attacking Ms Rankine, whilst she was holding her baby, was rapid and appropriate. I accept that once the Deceased was restrained, he became highly aggressive.

47. The police acted properly and in accordance with their training in seeking to force the Deceased's hands behind his back whilst up against the vehicle in the driveway. They did not try to force the Deceased to the ground. In the midst of the intense struggle, they fell to the ground. The police then acted appropriately and in accordance with police training in trying to restrain the Deceased with the three point hold and the leg lock. They had no real alternative to restrain him in the way they did. They properly feared that if they let the Deceased go whilst he was on the ground, he could have presented as a continuing danger to Ms Rankine or other persons present. I accept the evidence from Kanyilmaz that the "incident went from nothing to 100 miles an hour very quickly."

48. The police did not punch the Deceased, stomp or stand on him. There was no gratuitous violence or use of force. I do not accept the evidence of some witnesses that the police dragged the Deceased some distance from the bitumen to the grass. The Aboriginal witnesses described the restraint as involving considerable violence or force by the police. The significant level of force used by police during the restraint was proportionate to the intensity of the struggle by the Deceased.

49. It is highly probable that the Deceased experienced difficulty breathing at some point whilst he was being restrained. I accept that if the Deceased did say he was having difficulty breathing, the police did not hear it. It did not occur to the police that the Deceased's struggle could be related to any difficulty he had in breathing.

50. The one matter that gives rise to some concern is the slowness of the police to realise that once they had applied the handcuffs, and the Deceased stopped struggling, the Deceased was himself in grave risk of death or serious illness. Both police and Aboriginal witnesses noticed that the Deceased had stopped moving altogether whilst he was on the ground. Lees noticed that he had gone limp and unconscious, but he did not turn his mind to the Deceased's health. He gave the following evidence (p.342),

> MR STRICKLAND: "Was another feature of your conclusion that he appeared to be unconscious was that his body went limp?---Yes. Well, Yeah.
>
> Did you immediately say to anybody that he appeared to your observation to be unconscious?---No.
>
> Why not?---Because I, as soon as the handcuffs went off him, went on him I got off him. Because he was restrained and I turned towards the crowd.
>
> But if you observed at that particular point in time that he appeared to be unconscious?---Mm.

Why wouldn't you tell any other police officer that fact?---I had no, I have no answer for you.

THE CORONER: Do you agree that when someone is unconscious, they're not well, I mean there's something wrong with them?---Yes, your Worship.

Next question, please.

MR STRICKLAND: Did you at any stage say to anybody that his handcuffs should be taken off?---No.

And at (p.346)

"Didn't you receive any training that if you noticed something was wrong, like he appeared to be unconscious, you should immediately notify someone or do something about it? Wasn't that - - -?---Yes.

- - -an essential part of the retraining?---Yes.

In hindsight do you think you fell down in not following that part of the training?

---Yes.

And can you explain why?---Because I'd observed the gentleman to, you know, when he stopped resisting and went limp and he appeared to go unconscious I got off him an did nothing about it.

I accept that and I accept your candour in saying that, but do you have an explanation to the court as to why that part of your training you did not appear to comply with?---I was more, to be honest, I was more worried with the other people who were yelling and screaming at me."

51. Kennedy had warned her police colleagues that something was wrong with the Deceased when they were carrying or dragging the Deceased towards the van. Berlin knew that something was wrong with the Deceased. Neither Kennedy, nor Berlin nor any other officer knew that the Deceased was moments away from death. They did not even know he was critically ill. However, the fact remains that the Deceased was placed in the back of a caged police van with his handcuffs still on behind his back and the doors of that van were then closed even though the Deceased had exhibited signs of

serious ill health after a violent struggle. The back of the police van was smeared with the Deceased's blood.

52. The police failed to give the Deceased urgent medical attention as soon as it was observed that the Deceased had gone limp. This highlights a serious deficiency in police training which requires urgent attention.

53. As soon as a person in police custody who has been involved in a violent struggle exhibits any warning signs of ill health (such as going limp, becoming rigid or completely still), the police cannot assume that this change of behaviour represents a sudden desire to co-operate with police or that it is a result of intoxication. Applying their Safety First principles, police must be trained and informed of those warning signs and what medical attention must be provided before an ambulance or trained medical help can be obtained.

54. However, there is no evidence that this failure by police contributed to the Deceased's death. The Deceased had suffered a major cardiac event whilst on the ground and there is no evidence to indicate that even the most urgent medical assistance could have saved him.

55. I also accept that as soon as the police saw the Deceased had slumped in the back of the police van, they immediately opened the caged door and did everything they could to revive him and save his life.

THE POLICE INVESTIGATION INTO THE DEATH OF MR GURRALPA

56. The investigation by Donna Cayley was a thorough, detailed and transparent examination of the circumstances of Mr Gurralpa's death.

RELEVANT CIRCUMSTANCES LEADING TO DEATH OF ROBERT PLASTO-LEHNER

57. The Deceased was fifty seven years old at the time of his death. He spent his childhood in mining communities and moved to the Northern Territory in

1966. He began a cadetship with the ABC in Darwin. He had an accomplished career in radio, television and as a film producer. The Deceased suffered from long term bipolar depressive illness. The Deceased was also a heavy smoker and over- weight. He weighed 126kgs. He suffered from chronic obstructive airway disease (Bronchiectasis).

58. The Deceased had two children, Georgina and Jacqueline from his first marriage to Kathy Howard and had two children, Rune and Tyge from his second marriage to Josephine Richardson.

59. The Deceased was in close contact with his sister, Dorothy Coleman and her family who lived in Darwin. On 19 December 2007, the Deceased travelled from Alice Springs to spend Christmas with Dorothy and her family. He was collected at the airport by his nephew, Justin Coleman, who checked the Deceased in at the Mirambeenba Resort. During the time he was in Darwin, Dorothy and Justin made several appointments for the Deceased to see a doctor because Dorothy could see that the Deceased's mental illness was the worst she had ever seen. It was obvious to her that the Deceased was not taking Lithium and Stelazine, the medication he had been prescribed to combat his illness.

60. On 22 December 2007 the Deceased left his room at the Mirambeena hotel without telling his family. At 1.01pm on that day, Louise Brennan from the Cavenagh hotel in Cavenagh Street called 000 to report that she had witnessed a man – the Deceased – whom she described to the 000 operator as "completely delusional". He was ranting and raving, giving away $100 bills, talking irrationally, shaking and sweating profusely. She said that one of her customers had dealt with people like this before and he "thinks he might be a suicide case because he's giving stuff away."

61. At 2.35pm, unit 443 with Senior ACPO John Morrison (7217) and ACPO Vanessa Martin (7193) was dispatched to attend to a "mentally ill person" at Cavenagh Street .They went to the Cavenagh Hotel and spoke with Louise

Brennan. At 2.59pm, both officers reported to the Communications Centre that they had seen and spoken to the Deceased at Knuckey St and they called for backup. Morrison stated that the Deceased was shaking and sweating and speaking incoherently. Morrison believed that the Deceased needed urgent medical assistance due to his mental state. He tried to convince the Deceased to get into the back of the police caged vehicle. The Deceased walked back to the police van, but before he got into the van, he said he wanted to have a few minutes and he ran towards a tree and bear hugged it with his full body weight. The Deceased said to Morrison, "I trust you guys.....because you saved my life". He then said that he trusted Morison because he trusted 'brown people'.

62. At 3.03pm, Constables Adrian Kidney and Linda Sayers arrived from Darwin police station to assist. When they arrived at Knuckey Street, they saw the Deceased hugging a tree and being spoken to by ACPO John Morrison. Kidney observed the Deceased behaving irrationally and showing abnormal behaviour. He said he made the decision to convey him to Royal Darwin Hospital for a mental assessment due to his behaviour. Kidney established a rapport with the Deceased. They shared a common interest in Australian Football. Kidney spoke to the Deceased for 20 minutes seeking to persuade him to enter the police van. Significantly, Kidney had been a prison officer for 10 years before he joined the police force and, in that job, he had dealt with mentally ill people nearly every day, and had developed fairly good communication skills in dealing with persons with mental illness.

63. The Deceased approached Kidney's police van, but said he did not want to go in the caged area. He wanted to go into the back seat. However, Kidney told the Deceased that he could not go in the back seat. He told the inquest that he thought it was risky to have him in the back of the police van due to his behaviour. The Deceased then took off his shirt and ran back to the tree and started hugging it again.

64. At 3.11pm, Kidney received a call from his supervisor, Sergeant Campbell over the radio. He told Campbell that he was at Knuckey Street with a large male who needed to be conveyed to Royal Darwin Hospital for a mental assessment, and that he needed a couple of extra police to help him into the cage. After that call, Kidney persisted with the Deceased. Constable Sayers heard Kidney say to the Deceased, "look mate. We'd like to take you to the hospital and get you like mentally checked out". The Deceased said, "Yeah, I want to go. I want to go". Kidney coaxed the Deceased back into the vehicle with the help of ACPO John and ACPO Eric Morrison. Sayers observed that the Deceased was compliant; he resisted at no time, but he did things at his own pace. Sayers said that he "looked as strong as an ox, a big boy, but he seemed to be a gentle sort of guy." She said at no time did she fear for her safety or feel threatened by him.

65. Kidney understood that he was apprehending the Deceased under section 163 of the *Mental Health and Related Services Act*. Section 163 (which was repealed and substituted by section 32A on 17 May 2007) provides that a Police Officer may apprehend a person and take a person to a medical practitioner, an authorised psychiatric practitioner or designated mental health practitioner for an assessment under section 33 if the Police Officer believes, on reasonable grounds, that:

    (a) The person may be mentally ill or mentally disturbed;

    (b) The person has within the immediately preceding forty eight hours, attempted to commit suicide or to harm himself or herself or another person, or who is about to attempt to commit suicide or to harm himself or herself or another person; and

    (c) It is necessary to immediately apprehend the person; or it is not practicable to seek the assistance of a medical practitioner etc.

66. Kidney believed he had the power to apprehend the Deceased without warrant under section 163 because he believed that he was displaying signs of mental illness. He was not aware of the other preconditions in section

163. Kidney's evidence was that he did not think the Deceased was going to kill or harm himself or harm anyone else. However, Acting Sergeant Fox gave evidence that Kidney had told him certain things that led him to believe that the Deceased might harm himself.

67. Very shortly after 3.11pm, Acting Sgt Fox and ACPO Eric Morrison were in attendance at Knuckey Street. Fox did not speak to the Deceased. He saw the Deceased in the caged vehicle and described him as "seeming to be very disturbed at being apprehended and in police care at the time". Fox saw the Deceased continually swapping seats in the caged vehicle.

68. Fox gave evidence that he was aware at the time of his powers to apprehend the Deceased, and remembered this from his recruit training. He said that based upon what Kidney told him, he believed on reasonable grounds that the Deceased was mentally ill or mentally disturbed. Fox also said that he had reason to believe that it was necessary to immediately apprehend the Deceased because of his condition.

69. Fox told Kidney to drive the Deceased to Central Darwin police station for a changeover of staff before the Deceased was taken to Royal Darwin Hospital. The police officers involved in the change-over estimated that it took 4-6 minutes. However, that estimation was incorrect. The communication records and the records of police swipe-cards, which record the times when police officers access the police station, established that the Deceased remained alone in the stationary vehicle for about 16 minutes – from 3.21pm to 3.37pm whilst Sgt Fox attended to other duties and arranged for 2 other police officers – ACPO Krepapas and ACPO Eric Morrison - to take him to Royal Darwin Hospital.

70. At 3.55pm, the police arrived with the Deceased at Royal Darwin Hospital. A hospital orderly pressed the green button which allowed them entrance via the ambulance bay doors. The ambulance bay doors do not open

automatically, rather someone has to press the green button from inside the Emergency Department to exit from the ambulance bay doors.

71. At 4.03pm, the Deceased was seen by the triage nurse, Ms De Groot. His condition was categorised by De Groot as a Triage Category 2 on the basis of his "severe agitation". Under the triage scale, he should have been assessed within 10 minutes. The Deceased was placed in the Oleander Room, the psychiatric room of the Emergency Department, to wait for further medical attention. The Oleander room is used to assess patients waiting for a mental assessment. The door to the Oleander Room was kept open, with ACPO Eric Morrison and ACPO Krepapas sitting outside, and Acting Sergeant Fox and Constable Jackson also sitting nearby.

72. There was another patient waiting for psychiatric assessment at this time, a Mr L. He was moved to the room opposite the Oleander Room when Mr Plasto-Lehner arrived. It was agreed that the two police members (Constable Sayers and Mullins) who were waiting with Mr L could leave, and the two hospital guards, Mr Randall Edwards and Mr Francis Kondambu, would stay with Mr L and the four police officers who arrived with Mr Plasto-Lehner would stay with him.

73. At 4.18pm, the Deceased was assessed by Dr Cromarty in the Oleander room. The hospital notes detail her examination and the bizarre and irrational statements made by the Deceased during that examination. The notes record he was "pleasant and cooperative." He was sweaty. She recorded "no insight into current state but does say he will do whatever I think he needs to get better". Those notes are consistent with the evidence that until immediately before the use of force incident, he was co-operative and not aggressive to anyone.

74. At 4.30pm, at the conclusion of her examination, Dr Cromarty sectioned the Deceased under section 34 (1) of the *Act*, the effect of which was that a recommendation had been made that the Deceased be psychiatrically

examined. That section 34 notice authorised the Deceased to be held at the Royal Darwin Hospital until either he was taken to Cowdy Ward or he was assessed by the psychiatric registrar and released. He was no longer in the custody of the police, but was an involuntary patient in the care and control of the hospital.

75. Section 34(3) of the *Act* authorises the practitioner, an ambulance officer or anyone else specified in the recommendation to do one of a number of things including (a) to control the person and bring the person to an approved treatment facility for assessment and (b) if the person cannot be brought immediately to an approved treatment facility – to hold the person at hospital until it becomes practicable to do so. Section 34(4) provides that the recommendation may authorise a police officer to exercise, or to assist someone else in exercising, the powers under subsection (3)(a) if the practitioner considers there is no other alternative in the circumstances. Significantly, the power under s 34(4) does not extend to a police officer exercising a power under s 34(3)(b) to hold the person at hospital until it becomes practicable to bring him to an approved treatment facility. Section 34(8) provides that the practitioner, ambulance officer or anyone specified in the recommendation may use reasonable force and assistance.

76. The section 34 certificate signed by Dr Cromarty did not specify anyone as being authorised to do any of the things specified in s 34(3). Accordingly, the police had no power under the Act to force the Deceased to remain at the hospital or to restrain him from leaving the hospital if he chose to do so.

77. Dr Cromarty told Nurse Rebecca Weir that the Deceased was "acutely psychotic and he needed psych reg [psychiatric registrar] assessment". Dr Cromarty said she spoke to a police officer (Fox) shortly after 4.30pm and told him that she had sectioned the Deceased. She also told him that she was concerned that the Deceased was psychotic. The NT police have submitted that Dr Cromarty may not have sectioned the Deceased at 4.30pm. However

her evidence that she sectioned him at 4.30pm was unchallenged during the hearing, as was her evidence that she told Fox that she had sectioned him at that time and he would be awaiting psychiatric assessment. Dr Cromarty told Fox that the deceased would probably have to go to Cowdy Ward but only after he had been assessed by "the psych registrar". Fox told her that the police had been tasked to guard another person, at the Emergency Department and he would wait around. This was Mr L. Fox said he was not aware that the Deceased was sectioned. I accept that Fox believed that the Deceased was still in police custody. He had never been trained or informed about what his powers were in relation to a person who had been apprehended under s 163 after that person had been brought to RDH, or about the very limited powers the police had under section 34 of the *Mental Health and Related Services Act*.

78. Dr Cromarty said that she asked the psychiatric registrar, Dr Belinda Bautista, if she could see the Deceased. Dr Cromarty said that she saw Dr Bautista arrive in the Emergency Department to see somebody else (Mr L.) and Dr Bautista told Dr Cromarty she would see the Deceased next because he sounded like a priority.

79. Dr Bautista gave evidence that it was not until shortly before 5.45pm that she received a call on her mobile phone from Dr Cromarty about the need to assess the Deceased. She then immediately had a conversation about the Deceased with Dr Cromarty at the flight deck and could see the Deceased from there. She had no knowledge of the Deceased until that call. She said that she was intending to assess the Deceased within a few minutes of the use of force incident.

80. In any event, the Deceased continued to wait in the Oleander Room to see the Psychiatric Registrar. At some point he was given a cup of water and two sandwiches which he ate. The Deceased often talked to himself. The people who heard him speak could not make sense of what the Deceased was

saying. He was highly agitated. He was standing up, sitting down and walking in and out of the Oleander room. He sat on the seats in the hallway outside the Oleander Room. The Deceased was informed that he could not stay in that narrow hallway where staff and patients were walking up and down. Randall Edwards and, occasionally, some of the police officers directed him back into the Oleander Room each time. Edwards, whom the Deceased gravitated towards, said that he believed he had struck up a rapport with the Deceased through a common interest in Australian Football. He also smiled a lot at the Deceased and used passive gestures towards him. Edwards said that seemed to work and the Deceased complied with Edwards' requests to return to the Oleander room. The Deceased, who was a chain smoker, repeatedly asked the other security guard, Frances Kondambu, for a smoke. Edwards said that he had told the Deceased that he would take him outside for a cigarette if the doctors agreed, but that he would need to wait to see the doctors first. The longer the Deceased was waiting at the hospital, the more agitated he became.

81. At about 4.55pm, Dr Cromarty gave the Deceased 5 mg of Olanzpeine (anti-psychotic medication). At about 5.18pm, Dr Cromarty took some blood samples from the Deceased in order to conduct tests for the purposes of ruling out the organic causes of psychotic behaviour. Dr Cromarty said that the Deceased was always very cooperative with her.

82. CCTV footage played at the inquest showed that at about 5.43pm, the Deceased requested to go to the bathroom, and he was escorted by Edwards and ACPO Eric Morrison to the toilet which was in the fast track area of the Emergency Department. The security camera only captured the movements of the Deceased in the corridor of the emergency department. There was no security camera in the ambulance bay foyer.

83. Edwards told the investigating police that he opened the toilet door, but the Deceased did not want to go into the toilet. The CCTV footage shows the

Deceased sitting down and Edwards speaking to the Deceased. Edwards stated to investigating police:

> "[the Deceased] sort of jacked up and then did not want to go in saying that he was locked up once and he can't go in there and he refused to go into the toilet".

84. After a few minutes, the Deceased abruptly got up from his seat, brushed past Edwards, almost knocking him off his feet and started walking down the hallway towards the foyer area of Emergency Department. Edwards noticed that the Deceased's face and mannerisms changed at that point.

85. The Deceased walked past the door of the Oleander Room and stopped near the door frame of the two double doors which are the fire doors of the Emergency Department, looking outside through the ambulance bay doors. Mr Edwards, who had positioned himself in front of the Oleander room, tried two or three times to get the Deceased back into the Oleander Room, gesturing him towards the door. Acting Sergeant Fox also asked the Deceased to go back into the Oleander Room. Edwards told the investigating police that the Deceased

> "raised his arms. He said he wanted to go outside for some fresh air and to have a smoke, and he's sort of pushed past the police officers and gone towards the ambulance ramp doors"

86. Dr Cromarty, who was further up the hallway, heard the Deceased say something about wanting to go for a cigarette and the police tell him to wait to see the doctor. Rebecca Weir heard the Deceased say at this point in time on two occasions: "I want to go and get some air". Frances Kondambu heard the Deceased say at least twice: "I want to have fresh air." These witnesses all heard the Deceased saying those words loudly and clearly and more than once. All of the witnesses were in a position to hear what they say they heard. They were reliable witnesses. They were further away from the Deceased than the police witnesses, and yet none of the four police officers

say they heard anything like this being said by the Deceased. Jackson heard the Deceased continually say: "I want to go outside. I want to go outside."

87. Edwards was trying to coax the Deceased back into the Oleander room saying: "Come on mate, come on, come on back in". Rebecca Weir thought that Edwards was doing quite well and that it looked like the Deceased was going to go back into the Oleander room because he paused and made a step back as if he was about to return to the Oleander room. She then heard Fox, with a bit more of an abrupt tone saying to the Deceased: "Get back in the room" and saw him gesture towards the Oleander room with his arm. Each of the police present heard Fox say to the Deceased something along the lines of: "You're not free to go just yet. You're going to have to wait a little bit longer".

88. The Deceased ignored Fox's verbal instructions and his gestures and continued to walk into the foyer towards the glass sliding doors, which had a sign stating: "NO PUBLIC EXIT. AMBULANCE AND EMERGENCY STAFF **ONLY**". The sliding glass doors could only be opened from the inside by pushing a green emergency button located to the left of the sliding doors.

89. Fox was between the Deceased and the glass doors and Morrison was just to the right of the Deceased. Fox then took hold of the Deceased's left arm. The Deceased tried to shake off Fox's grip on his left arm and began waving his right arm up and down. Morrison then grabbed his right arm. Rebecca Weir described the Deceased wheeling around his arms like a windmill.

90. Fox forced the Deceased down to the ground into a prone restraint position in the ambulance bay foyer. This happened in the course of a few seconds. Fox gave the following evidence of what happened (p.818):

> "Okay. What happened then?---Then I could see that the Deceased wasn't listening or you know complying with the directions of the security guard so I intervened. I jumped, I ran out sort of into the

> opening of the, well, from that corridor of the Oleander Room to the opening where the ambulance door is and I gestured to the Deceased to go back that way as in towards the room or the confined area and placed my hand not on him but to the rear of him just to you know contain him, he kept on moving.
>
> Yes?---And that's where I initiated a, the takedown."

91. Fox also said that before he initiated the 'takedown', he directed the Deceased to head back into the Oleander room, be seated and wait for the doctors. Very shortly, six or seven men including all four police officers became involved in the restraint of the Deceased.

92. Whilst on the ground, Fox and ACPO Eric Morrison applied significant weight to the Deceased's upper torso. At one point, Fox was using his pectoral area to lie forward on the Deceased's left shoulder. At some stage, Fox's right knee was also used to push down the Deceased's left scapula trying to effect a '3 point hold'. The Deceased was resisting and pushing up with his right hand. Acting Sergeant Fox says that he was using all his physical strength and weight. He described the intensity of the struggle as a ten out of ten. He said it was possibly the hardest apprehension in that manner he had ever undertaken. ACPO Morrison was putting his left knee on the Deceased's right pectoral. Fox also held the Deceased's head down with his left knee. He says he did this to prevent any of the Deceased's fluids or blood being spat at him and to contain his head.

93. ACPO Eric Morrison states that he had his knee on the Deceased's right scapula and held him in that position. He heard Fox telling the Deceased to stop resisting. Morrison helped Jackson handcuff the Deceased's right wrist.

94. ACPO Krepapas was holding the Deceased's left arm, trying to pull it out from underneath him and sweep it round to his back so that he could be handcuffed. Krepapas said that it took about 20-30 seconds to get the

Deceased's wrist around to Jackson, and another 5-6 seconds to actually apply the handcuffs.

95. Constable Jackson took hold of the Deceased's right arm and was struggling to get the handcuff on because he was resisting and his wrists were large. She told the Deceased to relax and bring his arm around his back. She said it took 10 to 20 seconds to apply the handcuff on his right wrist.

96. Randall Edwards held the Deceased's feet down, struggling to stop him moving. Edwards described the Deceased yelling and struggling whilst he was in the restraint position. A Patient Care Assistant applied his body weight to hold his legs down.

97. Patient Care Assistant Chris Hodge was not involved in the restraint. He heard a commotion in the ambulance bay and rushed in there and observed two police officers on the Deceased. He then went to close the five sets of doors in case the situation escalated. That took Hodge about 1 ½ to 2 minutes. When Hodge returned to the scene, he saw the Deceased still belly down on the ground yelling. He heard the Deceased yell that he was having difficulty breathing and had chest pain.

98. A number of doctors and nurses heard or saw a commotion and rushed to the foyer area. Nurse Rebecca Weir saw the police attempt to restrain the Deceased and immediately informed Dr Cromarty that "your patient is becoming violent and you need to come down here and sort this out". She asked Dr Cromarty if she wanted midazolam. She went up to the flight deck of the ward, unlocked the cupboard and got midazolam out. She said that task took about 50 seconds. When she returned to the ambulance bay area, the Deceased was still prone on the ground, but his handcuffs were on behind his back.

99. Dr Cromarty states that she heard commotion from where she was on the 'flight deck' and came down to see what was happening. She saw the

Deceased restrained face down on the floor with several police members lying across him and others restraining his arms and legs. Dr Cromarty told the investigating police on 15 January 2008 that when she arrived, the police members were struggling to get handcuffs on the Deceased, and she asked if the handcuffs were really necessary. She felt she had a good rapport with the Deceased and she thought she might be able to help calm him down so that the police would release him from the restraint. Dr Cromarty says that as she tried to approach the Deceased, Fox put his knee on the Deceased's head, and she heard the head smack onto the floor. She and Dr Lai Heng Foong leant down and clustered around the Deceased's head and told the Deceased to relax, and that she would try to get the police off him. Dr Cromarty was concerned as the Deceased appeared to struggle less and his face was becoming quite red. Dr Cromarty told the investigating police:

> "I asked the policeman[Fox] – um – I asked if they could just please ease up a little bit and was told – um – that they had to do this for their own safety and – and I should back off and I – he put his hand in towards my face to tell me to back off, which I did because someone put their hand in my face"

100. Dr Carissa Oh, Dr Lai Foong and Theresa De Groot corroborated Dr Cromarty's version of Fox saying words to that effect. Patient Care Assistant, Chris Hodge heard Fox say that they were trying to protect the staff.

101. Dr Lai Heng Foong, the lead registrar in charge of the shift, who had seven years training in clinical medicine, heard screaming from the flight deck and came running to the ambulance bay. Dr Foong shouted at the police in a very loud voice to back off a bit and "ease off the pressure", "let us talk to him". She remembers very clearly seeing Fox place what appeared to be his whole weight on the Deceased's head so his face was completely crushed into the floor. Dr Foong saw the Deceased trying to move his body and lift his head, she believed, in order to breathe and talk. She observed that Fox's knee was on top of his head whilst the Deceased was turning red and later blue. She

observed blood come from a cut above his eyebrow and from the Deceased's nose whilst he was on the ground. Her evidence on this point was (p.628)

> "And do you remember now seeing blood come from the Deceased's nose while he was on the ground?---I'll never forget it, yes, I do.
>
> And why will you never forget it?---Because this is a patient that was scheduled and supposed to be protected by the hospital and he was being restrained with excessive force, compromising his ability to breathe and, despite my pleas, there was no easing of the pressure put on his face."

102. Dr Clarissa Oh said that she saw Fox apply a knee to the Deceased's head when it was about 15 cm above the ground. Dr Oh saw that when Fox put his knee on the Deceased's head, it hit the ground, and she heard a significant thud.

103. Both Dr Oh and Dr Cromarty observed that the Deceased lifted his head up, and saw some blood from a laceration from his eyebrow. Medical notes written at 8pm that night record: "[Deceased] placed in prone position with knee restraining head". Dr Oh told the investigating police that she believed that the way he was restrained caused him to stop breathing.

104. Therese De Groot said she saw a police officer (Fox) with his knee on the Deceased's head and heard a thump at least once.

105. Nurse Natasha Roberts heard the Deceased say quite loudly words to the effect of: "Can I get up? Sorry, let me get up".

106. Dr Cromarty, Dr Foong and Dr Oh all saw the Deceased begin to turn blue, and that shortly after that he stopped struggling. Dr Cromarty and Dr Foong shouted at the police that he was turning blue and that they had to get off him. Dr Foong said nothing happened and she again had to say: "Guys let go of him. He's getting blue".

107. Constable Jackson and ACPO Krepapas heard the medical staff say that the Deceased's face was turning blue. Jackson heard those words when she was

clicking on the second handcuff, and she said that she would take his handcuffs off. Jackson then noticed that the Deceased relaxed. When the Deceased was rolled over, she saw that his face had turned blue and she thought he had passed out. Randall Edwards and Frances Kondambu, both of whom were involved in the restraint of the Deceased, heard the doctors saying that the Deceased's lips were turning blue. Kondambu's evidence was that Jackson then asked the doctors: "Should I remove the handcuff?" and the medical staff told her to remove the handcuffs. Kondambu helped Jackson remove the handcuffs. After the handcuffs were removed, Kondambu saw the Deceased's body shake and then go quiet.

108. Fox said that the Deceased was restrained on the ground for about thirty to forty seconds. He did not hear any nurses or doctors say 'he's going blue'. He said that once the handcuff was applied, the struggle ended, and he got off the Deceased. He said "we realised he had changed a different colour in the facial region" and he was then turned over to his side. ACPO Morrison said he did not hear the medical staff say anything until we went to take the restraints off and then he heard someone say: "Take the restraints off". He says he did not even see the medical staff until the Deceased was turned onto his side. Both Fox and ACPO Morrison denied that the medical staff shouted warnings had anything to do with the police getting off the Deceased or putting the Deceased into a recovery position.

109. Based upon the times shown on CCTV footage from two cameras and on time estimates of the civilian witnesses, in particular, Chris Hodge who shut the five doors and Nurse Rebecca Weir, the restraint on the ground probably took place over one to two minutes. It had certainly concluded by 5.49pm, some three minutes after the Deceased had left the toilet area.

110. As soon as the police and security guard got off the Deceased and removed his handcuffs, they turned him over into a recovery position. Dr Foong said that the Deceased did not look like he was breathing because his chest was

not moving. He was still very blue. Dr Foong told someone to get oxygen and a bed to take him to the resuscitation room.

111. The Deceased was taken into the resuscitation room by Dr Foong and Dr Oh. The Deceased was asystolic (no heart beat) and there was no electric output from his heart. Hodge commenced CPR on the Deceased. Dr Oh intubated the Deceased and he was administered adrenalin. He was moved shortly thereafter to the Intensive Care Unit[1]. The blood and fluids on the ground where the Deceased had been restrained were temporarily covered up with a wheelchair and then were cleaned up by hospital staff.

112. The Deceased was later transferred into the Intensive Care Unit. He never recovered consciousness and died in the Intensive Care Unit on 28 December 2007.

CAUSE OF DEATH

113. Dr Paul Goldrick, who was the staff specialist in the Intensive Care Unit at Royal Darwin Hospital treated the Deceased on 27 and 28 December 2007. He noted the observations of the Senior Emergency Department Specialist who orchestrated the resuscitation of the Deceased that his pharynx (the back of the mouth) was full of vomit at the time he went to insert a formal airway. The clinical significance of that was that vomit carries germs and that this can lead to ongoing infection and abscesses and pus in the lungs. He noted that the most significant problem faced by the Deceased during his course in Intensive Care was respiratory failure and ongoing infection of the lungs. His opinion was that (p.594) that

> "the vomit and the consequent aspiration pneumonia/respiratory failure/sepsis lead to precipitous decline and resulted eventually in his death".

114. Dr Sinton, in his post mortem report expressed the opinion that the cause of the Deceased's death was acute bronchopneumonia, compounded by concurrent acute cerebral hypoxia, acute renal failure and chronic cardiomyopathy.

115. Dr Botterill gave evidence that Dr Sinton's opinion concentrated on the end point of death, which was the severe infections caused to the lungs as a result of the Deceased being on a ventilator machine, and the pneumonia and acute renal failure which related to the melting down of the muscle. All these conditions were caused by the triggering events of 22 December 2007.

116. Dr Botterill's evidence concentrated on the triggering events of 22 December. Dr Botterill found the Deceased had suffered significant brain damage (acute cerebral hypoxia) which in turn had most probably been caused by a cardiac event or cardiac arrest which occurred at the time of the restraint event.

117. Dr Botterill's opinion was that there were two possibilities as to why the Deceased suffered a cardiac event:

> "He was asphyxiated which caused his heart to stop; or
>
> His heart could have stopped because of the strain of the restraining event and because he had an unhealthy heart. That itself could have caused him to stop breathing."

118. Accordingly he expressed the cause of death as follows:

> "1a Combined effects of restraint asphyxia, obesity-associated heart disease and chronic airways disease
>
> 2 Bipolar depressive disorder."

119. Dr Botterill stated:

> "My rationale is that it is most likely that ALL of conditions (restraint per se, asphyxia associated with restraint, cardiac function compromise associated with heart enlargement most probably due to

obesity, heart muscle scarring most probably due to obesity associated heart enlargement, obesity per se, chronic airways disease) have contributed to the circumstances, additively increasing the chance of a cardiac arrest, and that ANY of these conditions alone could also have resulted in that cardiac arrest."

COMMENTS ON POLICE CONDUCT

120. In my view the conduct of the police in this matter involved a litany of serious errors and misjudgements that led to the tragic and unnecessary death of the Deceased.

121. The Police Custody Manual and the Police General Order relating to Transport of Persons in Custody require a police officer apprehending a person apparently suffering from a mental illness to notify a hospital Emergency Department that they are attending with the person. This was not done. It was practicable to do so and it should have been done. It may have sped up the process of the Deceased being examined when he arrived. Fox described this omission as an oversight, which I accept.

122. More seriously, the Deceased was not taken directly to Royal Darwin hospital. Instead, he was taken to the police station where he was kept in the back of a caged vehicle for 16 minutes. That conduct is unacceptable. The Deceased was not a prisoner. He was not a suspect. He was not, as Fox described the Deceased during his interviews to investigating police a "person of interest". He was a person who was a potential patient. The only power the police had under section 163 was to apprehend him and take him to a medical practitioner or an authorised psychiatrist for the purposes of an assessment under s 33. A precondition for the exercise of that power is that a police officer believed on reasonable grounds that the Deceased was about to commit suicide or harm himself or another. The police observed that the Deceased was agitated when in the caged vehicle constantly changing seats. The Deceased did not want to be in the back of that vehicle. It was basic common sense in those circumstances to take the Deceased directly to Royal

Darwin Hospital. The police officers could easily have changed shift at the hospital or have continued on the shift and claimed overtime. The decision to keep the Deceased alone in the back of the caged vehicle at the police station undoubtedly added to the Deceased's agitation. Fox accepted that this was an oversight.

123. The *Mental Health and Related Services Act* required a member of the police force to give written details to the medical practitioner as per Form section 163A, which details police observations and the condition of the person apprehended. Fox did not fill out such a form and was unaware of its existence.

124. After the Deceased was sectioned by Dr Cromarty at 4.30pm, the police had no legal power at all to detain the Deceased at the hospital or to prevent him from leaving the hospital. The section 34 recommendation did not specify that any person could exercise the powers contained in section 34(3). The only people who had such a power were Dr Cromarty or any ambulance officer. Further, there is no common law power that the police can call in aid of. The common law does not even impose a positive duty upon police to take affirmative action to prevent a person such as the Deceased from committing suicide (*Stuart v Kirkland-Veenestra [2009]* HCA 15 at [99],[127]). I accept that neither Fox nor any other police officer was aware that they had no power to detain or control the Deceased at the hospital.

125. The Custody Manual, the Police General Order and the Memorandum of Understanding in respect of Cooperative Arrangements in Mental Health Response Situations (an agreement between the Commissioner of Police and the Department of Health and Families) contain no clear guidance to operational police about either the handover of persons apprehended under section 163 from the police to medical practitioners or the powers of police after such a handover. Unless the section 34 recommendation contains a

clear statement that police do have authority to exercise the powers under the *Act*, there is no effective role the police can play after the handover.

THE DECISION TO USE FORCE

126. The guiding principles behind the NT Operational Safety Principles (which reflect international standards and principles on the use of force) promote the avoidance of force where possible and the minimum use of force where it is unavoidable. Members should only resort to the use of force when strictly necessary and to the extent required to control the particular situation. Violent confrontation is to be avoided whenever practicable. Those principles are supposedly drummed into all recruits at their recruitment training and during their re-qualification training which is now held every year. The Defensive Tactics Manual, which is used by trainers to train recruits emphasises the importance of communication skills prior to the application of any level of force.

127. In my view the decision to use force against the Deceased was not necessary and the police did not apply the minimum use of force. The relevant decision to use force involved forcing the Deceased to the ground ('ground stabilisation' or 'take-down') and applying a three point hold on the Deceased whilst he was in a prone position on his stomach. The decision was taken by Fox and other police officers assisted him in executing that decision.

128. The police began their dealings with the Deceased at about 3.00pm on 22 December. From 3pm to about 5.46pm, the Deceased had been co-operative with the police and with all medical staff. He had not been in any way aggressive and he had not said or done anything which indicated that he intended to harm himself or anyone else. However, his agitation increased as he continued to wait at the hospital. At 5.46pm the Deceased got up from sitting on a bench outside the toilet, he brushed past Randall Edwards who noticed his face and demeanour change.

129. I accept that the Deceased said on more than one occasion in a loud voice that he wanted to go outside to get some fresh air or he wanted to have a smoke. This is in accordance with his persistent requests to Kondambu that he wished to have a smoke; and with Edwards' promise that he would take the Deceased outside for a smoke. It is also consistent with the evidence of his sister Dorothy Coleman (p.885-886)

> "And from time to time did you hear him say things about he won't be get - did he have an obsession with air, getting fresh air?---He always had to have fresh air, he always opened every window and he always had to be outside and have fresh air. He was always - since he was a child. He had a lung condition, as you've stated, so he has trouble getting air and he likes to be out in the fresh air."

130. All four police officers were in close proximity to the Deceased at that time he said those words. I do not accept that not a single police officer heard the Deceased say those words or words to that effect. It is telling that none of the police asked the Deceased why he wanted to go outside. That is either because the Deceased had told them why he wanted to go outside or it did not occur to the police to engage in any dialogue with him.

131. There is no cogent evidence that the Deceased was intending to flee or escape or attempt to hurt himself. However, given the Deceased's evident psychotic state, his irrational statements to himself and others and his extreme agitation, I accept that Fox was not and could not be sure what the Deceased's actual intentions were if he had gone outside. I accept that there is a reasonable possibility that Fox believed that the Deceased might come to some harm if he went outside. Fox said that he had read the notice on the glass sliding doors prohibiting people from leaving via those doors. He also said he was thinking of another incident where a similar matter had occurred near Parliament House.

132. Significantly, Randall Edwards told investigating police that he was concerned for the Deceased's safety if he left the ambulance bay because

> "we've had patients run out there and jump over the ambulance ramp which is about 20 foot high so they actually stop. I was initially at first thought when the restraint started [he was] heading towards that way. I was a bit worried about that at the start."

133. However, I do not accept that Fox believed that the Deceased was intending to kill himself if he went outside. Further, I do not accept the evidence of Morrison, Krepapas or Jackson that they each shared Fox's fear at the time of the restraint incident that the Deceased might jump over the ramp. No mention of this fear was made by any of the police officers before or at the time of the restraint. Unfortunately, there was plenty of opportunity for the police between the time of the incident and their initial interviews with investigating police to talk about the details of the incident, and they admitted that they did so.

134. Morrison's evidence (p.646-647) at the inquest was that he did not want the Deceased to go outside because "there was a ramp out the back" and he feared that the Deceased was going to jump over it. However, later in his evidence when he was asked (p.681)

> "When you were restraining him what did you think the reason was you were restraining him for?" He replied: "I didn't think about the reason.....I was acting on Acting Sergeant Fox's movements. He grabbed first....I was helping my partner out. That's what you do".

135. Morrison let the cat out of the bag when the interviewing police asked him: "What was your fear if he'd gone outside the hospital area and into the ramp area?" He replied:

> "Because it's a large drop and it's not very far from where that door closes to where the ramp ends to the drop. <u>That was our fear</u>, that he'd run towards the ramp area"

136. Morrison denied that before his interview on 23 December he had spoken to the other police about this fear. When asked why he used the words "our fear", his evidence at the inquest (p.680) was that "I just suspected that it might have been their fear as well."

137. Jackson's evidence at the inquest was that immediately before the restraint, she thought that because he was mentally unstable, he might have jumped off the ramp. However, she ultimately admitted (p.610) that the thought that the Deceased might jump off the ramp "cropped up in [her] mind after the event as a possible reason to restrain him".

138. I do not believe that either Morrison or Krepapas or Jackson restrained the Deceased because of any unstated shared fear that the Deceased might jump off the ramp. When they saw Fox begin to restrain the Deceased and the Deceased began to resist, their training clicked in and they came to Fox's assistance. They would have done better to honestly admit that at the inquest rather than fashion an excuse about a fear that the Deceased would jump over the ramp.

139. The critical issue is whether there were other reasonable options open to Fox other than forcing the Deceased onto the ground and restraining the Deceased in the prone position. Fox's evidence is that even with the benefit of hindsight, he would have done nothing differently. Morrison gave the same evidence. Fox said that he had no other choice but to force the Deceased onto the ground. He said the negotiation and communication with the Deceased had 'broken down'. He said that because of the size of the Deceased, he did not think he could contain him or push him back or pull him back into the Oleander room.

140. Given the importance of this issue, I extract the key evidence Fox gave at the inquest about his perceptions of the options available to him. (p.822-826):

> "Did it ever occur to you to say to the Deceased you can't go out that way but we'll take you out the front of the ED?---For the purposes of what?
>
> Just listen to that, did it ever occur to you to say something like that to him?

---He was leaving, he wasn't going outside for any purpose other than to leave.

How do you know sir what purpose he was going outside for if you didn't ask him?

---Well, I was of the belief, I formed the belief that he was trying to leave and get away.

But what was the basis of that belief?---That he wasn't listening, he didn't, he's getting agitated, he, the amount of pacing back and forward within the Oleander Room and that corridor and then he just up and wanted to go.

But it's true to say isn't it, you had no idea why he wanted to go outside?

---That's correct.

Right. He could have been going outside for fresh air?---Possibly.

He could have been going outside because he wanted a smoke?---Yeah, possible.

Didn't you think you should ask him before forcing him onto the ground?

---Well, the negotiation and communications had broken down and I was left with the you know, the option of cordoning him and containing him to that location.

But the negotiations and communications had lasted what, a couple of seconds?

---He was, he had momentum, he was actually going that way.

You haven't answered my question. The negotiations, I'm just reading, going back to your words, negotiations and communications, what they'd gone for a couple of seconds?---That's correct.

Do you think that's a long period for negotiations and communications?---Not at all.

Right. Did you ever warn him that you were going to use force before you did?

---There was no opportunity.

Did you answer that question no?---No, I didn't have the opportunity, yeah.

And, no, you didn't?---No, I didn't.

When you said you didn't have the opportunity, that's because you perceived at the time that it was essential to you to force him onto the ground to prevent him from leaving, is that right?---Yes.

You saw nothing, you saw no other option?---Not at the time.

When you say 'not at the time' - - -.---What I said, what I mean to say is I saw no other option other than containing him to that location for his safety.

With the benefit of hindsight, do you think there were other options available to you?

---Well, I utilised negotiation and communication which had failed so that way it comes to you know condone and containment and that's an empty hands tactics and that's the next use of force option. He wasn't aware, he wasn't concerned about our presence or, he just kept on pushing past.

But do you think you had exhausted the negotiations and communications option?

---At the time yes.

THE CORONER: What about in retrospect?---It's very hard to you know look back and, it's a split second decision.

That may be right, but what about in retrospect?---Whether I'd exhausted my negotiation?

Yes?---Well, I had, Yeah, I believe I had exhausted it because all the conversation I had leading up to that he became less respondent to our questions and he was making no sense so the verbal communication had broken down.

Well, ask the question again then about retrospect.

MR STRICKLAND: In retrospect, do you think you had exhausted the negotiations, communications option?---Yes."

.....

“Do you really say that the use of force in those circumstances, forcing him to the ground and restraining him on the ground, was unavoidable?---There was no other option.

Do you agree, in retrospect, that your intervention, in fact, escalated the situation not diffused it?---No.

Okay. When what you have described is that you forced him to the ground after he continued to walk and ignore your instructions, correct?---That’s correct.

You haven’t described any action of him to be violent towards you, correct?

---That’s correct.

All you’ve described is non-compliance with a direction?---Yes.

Didn’t you think that rather than force him to the ground, you could have pushed him back towards the Oleander Room?---I don’t think I could push that man. He was a very large gentlemen.

But there were six of you there, sir?---Yeah, I was the first person to put hands on the person and Morrison.

Yes. And the two of you together couldn’t have ushered him back to the Oleander Room?---We had a split second choice of and I initiated the takedown to place the gentleman on the ground for his safety and that was, Yeah, Morrison followed.

You see but are you saying that you forced him on the ground for his own safety?

---That’s correct, to prevent him from fleeing, for leaving the premises, escaping lawful custody.

You had no idea whether he was going to escape lawful custody or not did you?

---He was leaving lawful confinement.

But you didn’t know whether he wanted to go outside and just stand outside for some fresh air or for a smoke or not, did you?---No, I don’t.

You made an assumption that he was wanting to flee lawful custody, didn't you?---I conducted a risk assessment and I took appropriate action.

You had no idea based upon what he had said to you or did that his intention was to flee lawful custody did you?---Can you say that again please?

Okay, I'll put it another way. There was absolutely nothing from what the Deceased said or did that could make you draw a reasonable conclusion that his intention was to flee lawful custody. Do you agree with that or not?---No, I don't.

Well, what was it that he did or said that made you believe his intention was to flee lawful custody?---The, the direction he was exiting via.

Yes?---And the fact that he didn't adhere to our commands, our verbal commands and his momentum, the sheer momentum of the gentleman.

But all that suggests is that he wanted to go outside. That's all that suggests. He may have wanted to go outside just to get some fresh air or a smoke, even though he wasn't allowed in that area. Do you understand?---I understand what you're saying but - - -

That must be so, mustn't it?---That's that was he was intending to do?

No, that could have been his intention for all you knew?---Possibly.

Right. But you jumped to the conclusion that he was trying to flee lawful custody?

--- Well, given the, the notice that I read moments earlier and I'd also formed in my mind the potential threat in the ambulance bay of the gentleman, whether, he never said anything that he wanted to hurt himself or jump off anything like outside there, but the means to do something like that or cause harm were there. Also that ramp, ambulance officers drive up there at a rate of knots when they're coming into that area."

AT p.843

MR STRICKLAND: "Did you ever at the time of this incident you said that he you had two seconds of communication and negotiation,

did you think at all, 'Look, I wonder if there is a way of distracting this bloke?' Distracting him away from his intended purpose of going outside the sliding doors?---Not at the time."

At p.856

THE CORONER: "Well, you decided to use force because he won't do what he's told, right?---Yes.

And he's walking away from you?---Yes.

Tell me does that automatically lead to ground stabilisation the next instant?---In that instance, it did, yes.

So like outside Discovery at 3 o'clock in the morning, he's tipsy and you decide he's been disorderly and he goes – and you go to arrest him and goes to walk away from you, are you going to ground stabilise him or are you just going to grab him with another officer by either arm and march him to the – tell me what you do then?---I can't, it's all determined upon each incident if it's case by case, I guess.

So is there (inaudible) no incidents – incidences where you have to stop and contain someone like that that you would not ground stabilise?---In some circumstances you wouldn't or you don't or it's not necessary, but in this circumstance it was necessary.

Why?---I don't believe I was able to physically hold him in an upright position and I don't think Morrison would have been either, you know, larger blokes with this – this fellow was quite large."

At p.862

MR STRICKLAND: "But what I'm – what I'm getting at is before you actually decide to put him on the ground why not try to push him back?---I don't think I was – I would have been able to.

You didn't try?---I didn't want to fail either.

But - - -?---I had – I had a duty of care to contain him to that area.

But if you had tried and succeeded then there's no need to force him on the ground, isn't that right?---That would be correct.

> Right. But you didn't – you didn't even try to do that?---Because I established in my mind that I wouldn't be able to do that. That's why I've gone – you work out certain options. All these things are occurring in split second like [click fingers] and you've got to make a decision and the decision was to ground stabilise and place him on the ground.
>
> THE CORONER: Okay, that's maybe, not maybe, is very understandable?---Yeah.
>
> But we get back in retrospect today, do you think you made the right decision to put him on the ground?---Yes, I do.
>
> MR STRICKLAND: Do you think you made the right decision to put him on the ground before attempting to push him back, pull him back, block him?---Well, considering how hard it was to get him to the ground to start with I don't think I would have been able to push him back. I don't think I – my capability, and I don't know if Morrison was in the position to do the same thing."

141. I do not accept that Fox had no other options other than to restrain the Deceased in the prone position. There were other options and they should have been obvious at the time. They were certainly obvious in retrospect. Neither Fox nor any other officer asked the Deceased the basic question: "why do you want to go outside?" Neither Fox nor any other police officer suggested to the Deceased that he could go outside for a short time, but not out the back door because it was dangerous. Fox gave the Deceased directions, which he ignored. But he did not seek to question him, persuade him, distract him or negotiate with him in any meaningful sense. Kidney and Randall Edwards, who had developed a rapport with the Deceased, had managed to persuade the Deceased to do things he did not initially want to do.

142. Even if those discussions had failed, there were other options open. Fox could have tried to block the Deceased from getting to the green button which was necessary to open the door. He could have attempted to push or pull the Deceased back to the Oleander room. He knew that other police were in the vicinity. He could have called for the assistance of the other

police. The decision to use force increased the Deceased's agitation and escalated the situation rather than defused it.

143. I also find that if force was required to be used against the Deceased, the force actually used on the Deceased was unnecessary and excessive. It was not necessary to force the Deceased onto the ground and apply the restraint holds on him. Fox and the other police officers and security guards (there were 6 in total) could have forcibly pushed or pulled the Deceased into the Oleander room. It was not necessary for Fox to apply his knee to the Deceased's head. I accept the evidence of the civilian witnesses that Fox applied his knee to the Deceased's head when it was lifted about 15 cm above the ground causing the Deceased's head to hit the floor. Fox's conduct was not in accordance with the training provided by the NT police.

144. I find that a number of medical staff were shouting at the police to get off the Deceased or to ease off the restraints and warned them he was turning blue. Fox should have immediately heeded the warnings of the trained medical practitioners. He should not have told Dr Cromarty to back off. Fox should have recognised that he was in a hospital and that medical practitioners not police had the primary duty and the skills to care for their patients, whether the patients are voluntary or involuntary. Any danger to the safety of the police and the medical staff was caused primarily not by the Deceased's conduct, but by the precipitous and unnecessary action of the police to force the Deceased to the ground and restrain him.

145. If I am to accept the evidence of the police officers that they could not hear any or all of the repeated and shouted warnings of the medical practitioners and nurses, and they could not hear the Deceased's words, and that they could not see or properly understand the signs of his distress whilst on the ground, and did not notice that he was turning red and then blue until it was too late, that can only be explained by the significantly reduced sensory perceptions experienced by police in high stress situations. Those matters

can only highlight the dangers of the restraint techniques they applied, and reinforce why those techniques should only be used as an absolutely last resort.

146. In making the decision to use force, the police members failed to take into account that the Deceased was mentally ill, that he was in a distressed condition and was in an agitated and anxious state after an unnecessarily prolonged wait at the hospital. Further, the decision by police to restrain the Deceased whilst prone on his belly whilst a number of police (including two large strong police) by putting weight on both of the Deceased's scapula, as well as on his head, waist and legs failed to take into account that this would probably have caused a man of that size to have difficulty in breathing.

147. The police were not to know that the Deceased had another risk factor, which was a pre-existing heart disease.

148. In making these findings, I fully acknowledge that the police involved in the use of force incident had to make split second decisions in difficult circumstances. They did not have the luxury, as the lawyers and myself have, to deliberate for hours or days over what option to take. I also accept that the situation they faced clearly caused them a high level of stress, which affected their ability to make rational and calm decisions.

149. In determining both the reliability and truthfulness of the evidence of the police and civilian witnesses, I have taken into account that the memory of people who have participated and even those who have observed rapid and highly stressful incidents are flawed. Research tendered at the Inquest establishes that police who are involved in an arrest experience "tunnel vision" - a loss of peripheral vision and heightened visual clarity within a narrow field of vision. They become visibly oblivious to surroundings and events and actions that they would ordinarily see. Involvement in highly stressful events can also affect the ability of participants to hear sounds that they would ordinarily hear (that is it can cause auditory exclusion).

150. Finally, I accept that the decision to use force was not made for any malicious reason. The police honestly believed that what they were doing was necessary.

151. Jackson and Krepapas candidly acknowledged that in retrospect they would have acted differently. Morrison and Fox did not.

152. I commend Constable Kidney for his patience and skill in dealing with the Deceased before he arrived at the hospital.

INVESTIGATION INTO DEATH OF MR PLASTO-LEHNER

153. The investigation by Detective Senior Sgt Pollock was an exhaustive, detailed and completely transparent examination of the circumstances of Mr Plasto-Lehner's death.

154. The one problem that arose in the investigation (which was not the fault of Detective Pollock) was that arrangements were not made for the immediate segregation of the Police members involved in the incident.

155. Clause 3.3 of the Deaths in Custody General Order (General Order D2) states that:

> "Where the death or serious incident was, or appears to have been, as a result of police contact with the public, the first senior member responding to the scene shall .....ensure that all witnesses to the incident are identified, that communication between such witnesses is prevented and arrangements are made for their immediate segregation, particularly any Police members directly involved in the incident."

156. 'Senior member' is not defined in the Deaths in Custody General Order. It appears that Detective Sergeant Derek Maurice was the senior police member in the present case. Detective Sergeant Maurice was called to attend Royal Darwin Hospital on 22 December 2007. Detective Sergeant Maurice's notes from his notebook indicate that he arrived at Royal Darwin Hospital at 6:50pm. Detective Sergeant Maurice states that by the time he arrived, the

blood and bodily fluids had been cleaned up. He says he spoke with Kim Lavender and Doctor Surr at 7:30pm, and conducted the four interviews of the police members back at Darwin Police Station at the end of their shift.

157. Where a police member is involved in a serious or fatal incident, their obligations under clause 6.1.2 of General Order D2 include being interviewed before the completion of their shift. There was only technical compliance with this obligation because although each of the officers was interviewed, they declined to participate in the interview prior to the completion of their shift on the ground that they wished to seek legal advice. Statements were not ultimately taken until 28 December 2007. This is an unacceptable delay. I am left with the strong impression that on certain points, the police members' discussions with one another concerning the details of the incidents contaminated parts of their statements to investigating police and parts of their evidence before the Inquest.

158. Clause 6.1.3 of the General Order provides that police members are to be given the opportunity to seek legal advice. That clause should not be applied in such a way as to undermine the apparent purpose of the requirement in clause 6.1.2, which is to ensure that the most contemporaneous statement possible is obtained.

159. The Police Commissioner should give consideration to amending the General Order to reflect that where legal advice is sought by a member and it is not possible to do so before the end of the member's shift, the member should be interviewed as soon as reasonably possible, preferably by the following day.

HANDOVER OF PERSONS FROM POLICE TO DOCTORS

160. This inquest has revealed significant problems relating to the transfer of responsibility of patients between police and medical practitioners. It is not clear what powers the police have after they bring a patient to hospital who

is then involuntarily admitted. There is also no mechanism for a formal transfer of responsibility once a patient has been sectioned. The problem has practical implications for the care of patients. It also exposes operational police to potentially serious criminal and civil liability.

161. Dr Didier Palmer, the director of Emergency Medicine at the Royal Darwin Hospital gave compelling evidence [at 754] that on the issue of transfer of responsibility of patients, "error occurs..right through medical practice."

162. He recommended an agreement be reached between Police and the Royal Darwin Hospital to resolve the ambiguity as to who has responsibility to do what when a patient is transferred from police custody to the custody of the hospital.

163. If the Commissioner and the Department of Health and Families or any relevant health service or hospital determines that there should be any role for the police in caring for a patient after a section 34 recommendation has been made in respect of the patient, it is essential that section 34 be amended to provide a clear statement about the powers and responsibilities of the police after such a recommendation has been made. That is necessary for the orderly and proper care of patients and for the protection of police. If, as was the present case, the police have no power conferred by section 34 of the Act to exercise control over a patient , any act or omission by the police in relation to that person (whether or not done in good faith) will not attract the immunity from suit conferred under s 164 of the Act.

REPORT UNDER s 35(3) OF THE CORONERS ACT

164. Pursuant to section 35(3) of the *Coroners Act* NT, I report to the Commissioner of Police and the Director of Public Prosecutions that on 22 December 2007 at Royal Darwin hospital a crime under section 188(2) of the *Criminal Code* may have been committed against Mr Robert Plasto

Lehner whereby he was assaulted and suffered harm and was unable because of his situation to defend himself or retaliate.

POLICE TRAINING

165. Bearing in mind the common and overlapping issues, it is convenient to deal with police training as it pertains to the investigation of both deaths. In relation to the training on the dangers of the prone restraint, I found the submissions from the Human Rights and Equal Opportunities Commission on this aspect of the inquest particularly helpful.

TRAINING ON THE DANGERS OF THE PRONE RESTRAINT AND RISK FACTORS

166. The Inquest has highlighted the need for all Northern Territory police members to be properly trained in the dangers of the use of the prone restraint and the risk factors that make certain persons more susceptible to death from positional asphyxia.

167. The Northern Territory Police Operational Safety and Tactics Training Unit have developed the Defensive Tactics Manual 2006. The Defensive Tactics Manual is provided to Defensive Tactics instructors for training purposes. It is not available to recruits, police members or the public.

168. The Defensive Tactics Manual deals with the correlation between restraint positions and sudden deaths due to positional asphyxia. The Manual identifies each of the risk factors for positional asphyxia outlined above, and includes the following additional risk factors:

Obesity- particularly a large bulbous abdomen or beer belly

Psychosis

Pre-existing physical conditions – heart disease, asthma, bronchitis, chronic pulmonary disease

Respiratory Muscle Fatigue – This may follow violent muscular activity (such as fighting or running away), and results in hypoxia (a deficiency of oxygen reaching the tissues).

Multiple Police - … where several police are involved the pressure and restriction to the person's respiration is increased…

OC Spray – Members should bear in mind the effects of Oleoresin Capsicum Spray on a person's respiratory system. This may increase the risk of a person succumbing to PAD [positional asphyxia death].

169. The Manual describes the process described above as insidious, because a person might not exhibit any clear symptoms before they simply stop breathing. Generally, it takes several minutes for significant hypoxia to occur, but it can happen more quickly if the subject has been violently active and is already out of breath.

170. This description is particularly apt in the case of both the Deceased, who were struggling violently and then all of sudden stopped moving. If the police had been properly trained or had properly heeded the training they had been given, this would have been a clear warning sign that something was gravely wrong. However, such warning signs, particularly in the case of Mr Gurralpa, were ignored.

171. The Manual describes the typical combination of behaviour by the person and responding police members that may lead to a positional asphyxia death. This is referred to as the downward spiral. The Manual states 'recognition of this pattern may enable police to alter the method in which they attempt to resolve the situation and avert a tragic outcome':

> "STAGE 1- DEVELOPMENT OF THE INCIDENT
>
> The individual exhibits irrational, violent behaviour with aggressive and/or paranoid features, resulting in hyperactivity and extreme physical exertion.

STAGE 2 – INTERVENTION

…a struggle ensues…The individual may be out-numbered and will probably be placed in a prone restraint, often with one or more persons sitting on his or her chest. Regardless of the mental state of the person this level of restraint is likely to cause restricted breathing and discomfort. Facing suffocation and pain the person may fight even harder in an attempt to get relief. If the person continues to struggle the interveners will apply more force.

STAGE 3 - EXHAUSTION

In panic, madness or desperation the individual persists in forceful attempts to breathe and escape restraint. Interveners see this as a continued threat of harm to themselves and others. Interveners will perceive it to be necessary to apply even more force to restrain the person... While in a prone position the individual will continue to expend what energy they have left, just trying to breathe. Rapidly, the individual becomes lethally exhausted."

172. The Manual goes on to outline the signs and symptoms of which members should be aware, and take immediate action to remedy. These include gasping sounds, cyanosis, panic/prolonged resistance and sudden tranquillity.

173. Finally, the Manual details the following prevention strategies to reduce the likelihood of positional asphyxia death occurring:

"Identify persons at risk

Avoid prone restraint unless absolutely necessary

Identify danger signs of asphyxia

Constantly monitor the person

Seek medical attention"

174. Despite the information contained in the Defence Tactics Manual that is provided to instructors, and the training and requalification sessions for recruits and police members, the members involved in the incidents involving both Deceased recalled very little as to the dangers of positional

asphyxia and the associated risk factors. The members appeared to recall what little information they had retained from recruit training, rather than requalification training.

175. All of the members were aware in very general terms of the phenomenon of positional asphyxia. However, very few of the members were aware of the risk factors that may make certain persons more susceptible to death from positional asphyxia. Obesity was the risk factor most commonly recalled. However, of interest was the evidence given by Constable Kanyilmaz:

> "Given the training that you had about overweight people, did you – were you alert to the risk in relation to the Deceased when he was brought to the ground? –
>
> No, I didn't classify him as obese. I didn't think he was obese, so I wasn't – didn't really come to mind what you're asking, no."

176. This evidence demonstrates that obesity is a risk factor that may be difficult to judge. It would be helpful to acknowledge this difficulty in training and informing members that having a 'big belly', whether or not the person appears otherwise overweight, is a risk factor.

177. Most of the police were not aware of other risk factors relevant to either of the Deceased's death including physical exertion during restraint and a pre-existing medical condition such as asthma or heart disease.

178. None of the members recalled being trained in the downward spiral, which is the typical combination of behaviour by the person and responding police members that may lead to a positional asphyxia death.

179. None of the members considered that the struggle involving both Deceased whilst prone on the ground could have been because they were having difficulty breathing rather than because they were trying to continue resisting the police.

180. Finally, none of the members were aware of the prevention strategies to reduce the likelihood of positional asphyxia death, including identifying persons at risk and avoiding the prone restraint unless absolutely necessary.

181. There is a significant gap between the information contained in the Defensive Tactics Manual that is available to the Defensive Tactics instructors and the information that operational members recall in the performance of their duties. This issue must be addressed by the Northern Territory police by improved training of recruits and retraining of members.

182. Mr Hansen, the Sergeant attached to the Northern Territory Police Operational Safety and Tactics Training Unit accepted that Northern Territory police training in positional asphyxia required improvement. Sergeant Hansen listened to the evidence of the members during the coronial inquiries and said that hearing the evidence assisted his understanding of the areas that required improvement in the training of police members and recruits. These included:

> "the methods of teaching the dangers of positional asphyxia (noting that reality based training was the most effective way of communicating);
>
> teaching concerning at risk population groups, including adding additional risk groups such as middle aged Aboriginal men;
>
> seeking medical advice on how to teach about pre-existing health issues;
>
> elaboration of teaching on the downward spiral; and
>
> elaboration of teaching on prevention strategies to reduce the likelihood of death by positional asphyxia."

183. The Northern Territory police should be trained to monitor the health of persons where practicable during the restraint, as well as immediately after the use of the prone restraint. The monitoring process could include watching for the signs and symptoms of positional asphyxia. These include

listening to what the person may be saying, gurgling/gasping sounds, cyanosis, panic/prolonged resistance and sudden tranquillity.

184. The research into positional asphyxia tendered at the inquest (part of which is reflected in the Defensive Tactics Manual) establishes that loss of consciousness/death can occur extremely rapidly. In most cases despite prompt and extensive resuscitation attempts by police members and attending paramedics the person was not able to be revived.

185. In many cases, it may not be practical to monitor a person's health during the course of a violent confrontation, especially in circumstances where there are only two members present. However, in both cases, there were sufficient police members or security guards present for one of the police officers to be allocated the task of monitoring the person being restrained.

186. Sergeant Hansen identified an overarching issue that may be affecting the quality of member requalification training. There is no quality assurance program in relation to the requalification of 'in-service' trainers and accordingly it is difficult to control what they teach. The in-service trainers are different to the recruit trainers who are permanently attached to the Police Training College. The in service trainers are provided with a package of information from which they teach, but it is not possible to ensure they appreciate the seriousness of certain issues and include it in their training.

187. Stephen Nalder, the officer in charge of the Operational Safety and Tactics Training Unit gave evidence that he had started to use these two deaths as case histories in recruit training and he undertook to ensure that all instructors became aware of the issues raised in this inquest.

TRAINING ON DEALING WITH A MENTALLY ILL PATIENT

188. The training received by operational police about dealing with the mentally ill was clearly inadequate. Sergeant Hansen, who has had extensive experience over many years in training Northern Territory police,

acknowledged that the NT police were not given any specific training on negotiation or 'tactical disengagement' or communications with mentally ill people. His experience was that without specific training, the conduct of the mentally ill could be misinterpreted by police.

189. Bronwyn Hendry, the Director of Mental Health in the NT, gave evidence of the training received by NT police and security guards in relation to mentally ill people. She regarded that training as inadequate. She said (p.759-760)

> "And you regard the training they do receive, that is the training police receive on dealing with mentally ill patients is inadequate, is that correct?---I think it's inadequate for them to develop the skills and the confidence to deal effectively with mentally ill people, yes.
>
> And can you elaborate on that answer? Why do you regard it as inadequate?---Well, I think when people don't have sufficient knowledge and feel they have skills and are confident, then they are fearful of people with mental illness and fearful of the unpredictability of their behaviour. And I think that applies to the public or everyone, not just police officers. And I think when you respond from a position of fear, then you respond in a much different way than if you are comfortable in that situation and you feel you can manage that.
>
> THE CORONER: You're more likely to be unsubtle in your reactions, aren't you?
>
> .....
>
> ---Yes.
>
> I know that the training that mental health staff receive, for instance, is very focused on de-escalation and offensive tactics and restraint is a very last resort and there's a lot of attention paid to how restrain safely.
>
> .....
>
> what I'd really like to see is police trained in other forms of response and also better understanding about mental illness and how people with a mental illness may behave. And not just people with a mental illness, but people who may be confused and delirious to a trauma or

due to an organic illness. I think there needs to be training around responding to those types of presentations."

CORONER'S FORMAL FINDINGS INTO DEATH OF DAVID GURRALPA

190. Pursuant to section 34 of the *Act*, I find as a result of evidence adduced at the Inquest as follows:

(i) The identity of the Deceased person was David Gurralpa born 18 January 1969 at Ngangalala (Rings) Outstation.

(ii) The place of death was at Royal Darwin Hospital.

(iii) The date of death was 1 January 2008 and the time of death was between 5.00pm and 5.52pm.

(iv) The cause of death was a sudden heart attack.

(v) Particulars required to register the death:

1. The Deceased was a male.
2. The Deceased's name was David Gurralpa.
3. The Deceased was of Aboriginal Australian origin.
4. The cause of death was reported to the Coroner.
5. The cause of death was a sudden heart attack.
6. The pathologist was Dr Terry Sinton.
7. The Deceased's mother was Marawur Bangadijan Ganalbingu and his father was Manbarara Gamarang Jinang.
8. The Deceased was unemployed at the time of death.
9. The Deceased was born on 18 January 1969.

CORONER'S FORMAL FINDINGS INTO DEATH OF ROBERT PLASTO-LEHNER

191. Pursuant to section 34 of the *Act*, I find as a result of evidence adduced at the Inquest as follows:

(i) The identity of the Deceased person was Robert William Plasto-Lehner born 4 November 1950 at Geraldton, Western Australia.

(ii) The place of death was at Royal Darwin Hospital.

(iii) The date of death was 28 December 2007 at 8.17am.

(iv) The cause of death was the combined effects of restraint asphyxia, obesity associated heart disease and chronic airways disease

(v) Particulars required to register the death:

1. The Deceased was a male.

2. The Deceased's name was Robert Plasto-Lehner.

2. The Deceased was of Australian origin.

4. The cause of death was reported to the Coroner.

5. The cause of death was the combined effects of restraint asphyxia, obesity associated heart disease and chronic airways disease

6. The pathologist was Dr Terry Sinton.

7. The Deceased's mother was Dorothy Louise Lehner and his father Joseph William Plasto.

8. The Deceased was self employed at the time of death.

9. The Deceased was born on 4 November 1950.

RECOMMENDATIONS

192. I make the following recommendations pursuant to my powers under s 34(2) of the *Coroners Act.*

193. The NT Police Custody Manual be amended to provide that members must take any apparently mentally ill or disturbed person apprehended under s 163 of the *Mental Health and Related Services Act* by the most direct practical route and as quickly as possible to a hospital or doctor for the purposes of an assessment.

194. The NT Police Custody Manual, the Police General Orders and the Memorandum of Understanding dated June 2002 offer no clear guidance to operational police in relation to the handover of patients by police to hospital. They should be revised accordingly.

195. That Northern Territory Police ensure operational police are trained and retrained using reality based training techniques to a sufficient degree to ensure a proper understanding of the dangers of sudden cardiac arrest and positional restraint asphyxia in relation to:

> "to the use of the prone restraint;
>
> risk factors; warning signs of a rapid onset of serious injury or death which can potentially occur in connection with certain restraint positions when subjects are in the prone position;
>
> prevention strategies;
>
> the monitoring of a subject person's health if practical during and certainly immediately after the subjects are in the restraint positions. For example, taking pulse rates, listen to breathing, being aware of signs, symptoms and statements about breathing difficulties or heart problems or general distress."

196. The Northern Territory Police should ensure that all members are trained and re-trained in strategies to deal with mentally ill persons both in custody and generally in the course of their duties in relation to:

"communication strategies with mentally ill persons, including how to establish a rapport and calm down a distressed person;

control tactics, including using distraction as a means of de-escalating an aggressive situation, verbal forms of restraint, containment strategies; and

identifying symptoms and understanding changes in behaviour of mentally ill persons to be able to respond appropriately."

197. The Northern Territory Police should amend the General Order on Transport of Persons in Custody, and Part 6 of the Custody Manual – Mentally Ill Persons to include step-by-step instructions for police members on exercising the power of immediate apprehension for the purposes of a mental health assessment, including:

"assessing whether each of the requirements of s 32A of the Mental Health Act have been met;

communication strategies for dealing appropriately with a person suffering mental disturbance;

calling Mental Health Services to see whether they could provide a field assessment at short notice or provide any assistance;

locating the nearest place of treatment for a person suffering mental disturbance;

identifying the appropriate form of transport, including whether an ambulance could be requested, or whether Mental Health Services could provide transport;

ensuring that the person is promptly taken to the most appropriate place of assessment by the most direct route;

outlining members' responsibilities to contact the place of treatment to advise they are bringing a person in, and what their symptoms are;

directing members to ensure that the appropriate forms are filled out and provided to the place of treatment; and

providing guidance on when it is appropriate for police members to remain at the place of treatment and when they should leave."

198. The Northern Territory Police should amend clause 6.1.2 of the Police Custody Manual – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public so that Clause reflect that where legal advice is sought by a member and it is not possible to obtain that advice before the end of the member's shift, the member should be interviewed as soon as reasonably practicable thereafter.

199. That the legislature consider amending section 34 of the *Mental Health and Related Services Act* to clarify police powers and responsibilities after a section 34 recommendation has been made.

Dated this 10th day of June 2009

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GREG CAVANAGH

TERRITORY CORONER