CITATION: *Inquest into the death of Matthew Leonard Rosewarne* [2018] NTLC 024

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0093/2016
DELIVERED ON:	10 October 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	18, 19 September 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Police investigation, gunshot death, shot in back of neck, safety catch on, investigated as suicide, role of investigative bias**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police	Angus Stewart SC

Judgment category classification:	B
Judgement ID number:	[2018] NTLC 024
Number of paragraphs:	107
Number of pages:	25

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

No. D0093/2016

In the matter of an Inquest into the death of

MATTHEW LEONARD ROSEWARNE

ON 28 OR 29 MAY 2016
AT 2 PUMPA COURT FARRAR

FINDINGS

Judge Greg Cavanagh

Introduction

1. Matthew Leonard Rosewarne (the deceased) was born 19 March 1971 in Mannum, South Australia to Pauline and Stephen Rosewarne. He grew up and went to school in Adelaide. His father took him and his brothers out hunting and fishing. He was athletic and remembered by his father as a "mad-keen" hunter and fisherman. He was said to be a "bit of a lad" who loved a drink.

2. He left school at 15 years of age and went to work at the Gepps Cross Abattoirs with his father. He worked at the abattoirs for 10 years before getting a job on the production line at General Motors Holden at Elizabeth. He was a tall (190.5cm), powerful man and was said to be a hard worker.

3. In the year 2000 he entered a relationship with Ms Christine Staines. A year later they left South Australia and moved to Darwin. He obtained work at Woolworths as a night-fill manager and then as a storeman at the Coolalinga store. They lived in the caravan park at Coolalinga.

4. In 2005 Mr Rosewarne and Ms Staines moved to Gove for work. She had obtained a position as the Produce Manager at Woolworths. While in Gove

Mr Rosewarne initially worked for Woolworths as a warehouse manager before getting a position with Perkins Shipping.

5. They returned to Darwin two years later when Ms Staines' contract ended. Mr Rosewarne continued to work for Perkins Shipping. In 2015 he accepted a management position running the Toll Inpex site for Toll Energy.

6. Mr Rosewarne's main hobbies revolved around guns. Ms Staines said, "guns were his life". He was a member of the Darwin Pistol Club. He reloaded his own ammunition and was licensed to possess firearms. He had a gun safe in his shed that contained four handguns and four rifles. He went shooting every Thursday evening and Saturday morning. He also hunted wild pigs, often at Gunn Point (about an hour's drive).

7. For many years Mr Rosewarne had struggled with drinking and smoking. He started drinking at the age of 14 years. From time to time he tried to give up both. There were at least two occasions while reducing his consumption of alcohol that he had seizures associated with withdrawal.

8. On 3 February 2011 Mr Rosewarne was admitted to Royal Darwin Hospital and over the next four days completed a hospital withdrawal. He was discharged on 7 February 2011.

9. On 3 April 2012 at 11.45am Ms Staines took him to the Emergency Department of Royal Darwin Hospital. She said that she had brought him in to detoxify. She said he had been binge drinking for three to four weeks. She said he had a history of alcohol related seizures. She said he was feeling suicidal and that he would leave if not seen in 20 minutes.

10. When Mr Rosewarne was seen by the doctor at 2.55pm he said he had been drinking to excess since February. He said he had decided to stop on that day. He denied having abnormal thoughts or suicidal ideation. He was told he couldn't be admitted and an appointment was made for 9.00am the following day with Alcohol and Other Drugs for a full assessment. At that

appointment he was told he would need to wait another 7 days for an appointment. A note states: "client and partner upset at having to wait so long to commence withdrawal".[1]

11. Toward the latter part of 2015 Mr Rosewarne had been trying to reduce his alcohol consumption. That was in part due to Ms Staines giving him an ultimatum that it was either the alcohol or the family. However, by the end of 2015 things were not going well with the relationship and in February 2016 Ms Staines moved out with their son. Mr Rosewarne stayed in the house.

12. The breakdown of the relationship had a substantial effect on Mr Rosewarne. He once more began to drink to excess. There began a dispute over contact with his son. Mr Rosewarne went to see a lawyer. The dispute over contact had not been resolved at the date of his death.[2]

13. Mr Rosewarne didn't attend work in the week beginning 16 May 2016 because he considered that he would not pass the breathalyser testing.[3] He sent a text to his boss (one of his best friends) saying he would come to work the next day. He didn't. On Thursday, 19 May 2016 his boss went to check on him. He got to the premises at about 11.00am. Mr Rosewarne appeared to be home but did not answer the door. After an hour his boss requested that Police undertake a welfare check.

14. When Police arrived Mr Rosewarne opened the door. He agreed to go with the officers to the Hospital for a mental health evaluation. He asked to speak to his boss. He said "It's all fucked. It's all falling down".

15. On arrival at the Hospital at 1.50pm his blood alcohol level (BAL) was 0.251%. He told the clinician that he had low mood for approximately 6

[1] CCIS 04/04/2012
[2] Transcript pp 40, 41
[3] Clinical Assessment 26 May 2016

months due to stressors such as selling the house, the relationship breakdown and work. He said it had been worse in the past week. He denied suicidal ideation, thoughts of self-harm or harm to others. The clinician noted that the trigger appeared to be his wife leaving him and not letting him see their 8 year old son.

16. After he "sobered up" (0.138% BAL) he was assessed by the Mental Health Team. He was noted to be well dressed, talking normally and was insightful to his situation. He said he dealt with the stress by consuming a carton of beer and a bottle of vodka each day.

17. He said he had overcommitted financially when purchasing the house 2 years ago. He said he had reached "rock bottom" and understood that he needed to stop drinking as it was making things worse. He said he would like to stop drinking altogether. He said he had managed to do so in the past. He said he needed to get financial advice and was willing to step down as a manager at work to relieve the stress. He said he lived alone and had firearms at home but had no intention of using them.

18. He was given four diazepam tablets for the tremors while withdrawing from alcohol. Mental Health were of the opinion that he was fit to continue to hold his firearms licence. The Police were told that to remove his firearms would place him under further psychiatric strain as he was such an active member of the gun club and he needed structures and groups to help facilitate his recovery. He was discharged and taken to his residence by his boss.

19. The next day (Friday 20 May) Ms Staines with their son, took dinner over to Mr Rosewarne's residence. They had a family dinner.

20. On 24 May 2016 (Tuesday) Mr Rosewarne was due to go to Alcohol and Other Drugs but they were too busy. Ms Staines invited him to come and stay at her place to detoxify. He stayed on the 25th (Wednesday).

21. On the 26th he was told that the Hospital would not have a bed for him for another two weeks (for his detoxification). In the meantime he was prescribed Naltrexone. He stayed at Ms Staines' residence on the 26th (Thursday).

22. On the 27th (Friday) he was advised that he could enter a detoxification program conducted by DAAS at Stringybark Centre. He arrived there at about 12.40pm. His blood alcohol level at that time was 0.082%. From 3.00pm until 5.00pm he was assessed by the psychiatrist. He was told he should stay for 7 days and that a letter would be sent to the Motor Vehicle Registry to revoke his licence until he had been abstinent for 1 month. All seemed good until he was shown the accommodation. As soon as he saw it he said, "I'm out of here. No way I'm staying here".[4] He signed a "Refusal of Treatment" form and left at 6.37pm. He sent a text to Ms Staines saying he didn't feel safe because the doors had no locks.

23. On Saturday morning (28th) Ms Staines dropped his mattress and pillow back to him at his residence at about 10.30am. She told me that she was upset that he hadn't stayed at the Centre to detoxify. She said to Mr Rosewarne, "I can't help you, we need to get you help".

24. He loaded his quad onto the trailer and went hunting at Gunn Point. While there, he was drinking and was noted by others to be intoxicated. When he returned home he unloaded the quad and drove out again with the trailer still attached to his vehicle. It is uncertain where he went. He returned at 6.55pm.

25. In preparing to back the trailer into his driveway he utilised the driveway of his neighbour across the road. However, instead of selecting "reverse" he selected a forward gear and his vehicle rammed a small hatch in the driveway pushing it through the neighbour's garage door. He got out of his

[4] CCIS notes 27/05/2016

vehicle without applying the brakes. It rolled back. The door knocked him to the ground before scraping down the side of another vehicle.

26. Given the mayhem he had caused, Mr Rosewarne seemed relatively calm. He went across the road to his residence to get a cigarette. The Police and ambulance arrived at about 7.00pm. He was taken to the hospital by ambulance 13 minutes later. He told the ambulance officers he knew he would be uninsured for the damage because he was drunk.

27. He arrived at the Hospital at 7.40pm. His blood was taken. It returned a blood alcohol reading of 0.125%. He said he did not want to be reviewed by a doctor. He discharged himself and caught a taxi, arriving home prior to 9.30pm.

28. Just prior to 9.00pm Ms Staines was alerted to the damage done to the neighbour's property. She had been having a few drinks at home and so with others got a lift to his premises. She got there just after 9.30pm. She spoke to the neighbours for 5 – 10 minutes. They told her Mr Rosewarne was inside the house. She said she was going to go in and take his alcohol.

29. She went to the front door. She banged on it. There was no answer. She called out, "you can't hide, I'm coming in". She used her keys to open the door and went in. She was heard to say, "What the fuck!"

30. Ms Staines said that Mr Rosewarne walked in from the patio area. She said he looked at her blankly, "he just seemed - like, he was physically there but he wasn't there".[5] She said he sat on the couch with his back to her. The only thing he said was "don't take my alcohol". She said she saw alcohol, prescription medication and two pistols on the kitchen bench.

31. She said there was a beer carton on the bench. She took a few of the beers out to leave them for him. She put a three-quarters full bottle of vodka in the

[5] Transcript p 22

carton along with the two pistols and a magazine (for one of the pistols) and left with the carton.

32. She said she wanted to go to the Police Station to give them the guns. She was driven to the Police Station in Palmerston. It was closed. She went home and called the police at 10.08pm. She told the call-taker she had done something really stupid and taken two guns because she was afraid for Mr Rosewarne's welfare. She thought the guns were a Glock and a Colt. She said she didn't know how to handle them and didn't know if they were loaded. She said she just took them in a rage. She said she didn't think Mr Rosewarne knew what was going on.

33. At 10.14pm Ms Staines' mobile phone received a text from the mobile phone of Mr Rosewarne, saying, "Yup toot every time". That was the last text message sent from that phone.

34. Police members attended at Ms Staines residence at 10.30pm along with Territory Response Group (TRG) members. They ascertained that the guns were a Glock .40 and a Smith and Wesson .357. The Glock had one round in the chamber but the magazine was empty. The other magazine was full of ammunition. The Smith and Wesson had a full barrel (7 rounds). The handguns were unloaded and removed by Police.

35. Ms Staines told the TRG members that Mr Rosewarne had years ago been depressed and she had concerns about self-harm. She said she was also concerned that he would come to her house in an agitated state due to her taking his firearms. She said he had recently padlocked her dog to the fence which caused her to have the dog put down. She said Mr Rosewarne was "anti-police". She told me that what she meant to convey to Police was that they should expect a confrontation with Mr Rosewarne.[6] She told them the

[6] Transcript p 31

combination to the gun safe and gave them a set of keys to the house. She understood that they would seize his remaining firearms.

36. However, the Senior Sergeant on duty that night did not believe there was sufficient risk to Ms Staines or any other person to send in Police to seize the firearms at night time. He suspected that the guns were out for cleaning after Mr Rosewarne returned from pig hunting that day. The other guns he surmised were probably locked in the safe and all of the lights were out at the residence suggesting Mr Rosewarne was asleep. He thought it better for the day shift to reconsider the matter.

37. The day shift did not reconsider. That it seems was partially due to their information and storage system, PROMIS being "down". The Officer that had attended that evening had every intention of following up himself. However early in his shift he was diverted to a fatal motor vehicle accident that took his attention for the rest of the shift. Ms Staines said she did not check on Mr Rosewarne or make contact with the Police that day (the Sunday).

38. On Monday 30 May 2016, Ms Staines said she drove by his house at about 7.45am. She said the gate to the carport was open. She thought that most unlike him. She said that she rang Police on 131444 and asked the call-taker "for a welfare check, or at least check if police knew if he was in hospital or locked up". She said the woman call-taker was rude to her.

39. Police were unable to find any record of receiving that phone call. During evidence Ms Staines offered that the call log on her phone may still have that call. However, it did not. She said she must have deleted it. Other calls on that day had not been deleted.

40. In any event, at about 2.00pm that same day Ms Staines rang Police seeking a welfare check. She said she had not heard from Mr Rosewarne since she saw him on the Saturday night. She said she was worried because he didn't

have alcohol or medication and was a high risk of seizure. She said she didn't know whether he had been locked up by Police or was in the house but she needed to know for her own sake and also so she knew whether to feed the dog.

41. Police attended to conduct a welfare check at about 2.25pm. They found Mr Rosewarne lying on his back in the shed next to a weight lifting bench. He was obviously deceased and decomposition was underway. The Police declared a crime scene at 2.30pm.

The Forensic Examination

42. The Crime Scene Examiner from the Forensic Science Branch of Police arrived at about 2.55pm. He spoke to the police that had set up the crime scene and was told of the recent police involvements with Mr Rosewarne. He then looked around the shed until the Firearm and Toolmark Examiner, also from the Forensic Science Branch, arrived at 3.12pm.

43. When they entered the shed they observed a Gold Cup Trophy Colt .45 calibre semi-automatic handgun on the concrete floor not far inside the door. About three metres to the right of the door they observed a bullet and the bullet casing on the concrete in close proximity to each other.

44. In front of them in the centre of the shed was a weightlifting bench and on the other side of it, running almost parallel to it, was the deceased. Next to him was a large plastic container filled with camping gear on its side. There was blood around the back of his head. There was also blood that had run from his nose and mouth.

45. The metal ceiling and walls of the shed were examined. No evidence of bullet impact was found. Between the weight lifting bench and the Colt .45 was what appeared to be a bullet strike to the concrete. It was not considered relevant.

46. On inspection of the deceased they observed a gunshot wound just under the front of the deceased's jaw. When they turned him over they observed another wound at the back of his neck at the position of the 4th cervical vertebrae.

47. On inspecting the Colt .45 it was observed that the safety catch was in the "on" position. It had scuffing marks on that side including on the safety catch itself, apparently from the concrete floor.

48. There was a gun safe at one end of the shed. The door to it was locked. On the other side of the weight bench was a blue bag that Mr Rosewarne used to transport his equipment to the gun club. It was zipped closed.

49. Within an hour the forensic examiners had determined that it was a suicide. The only departure from the classic scene was that the safety catch was in the "on" position. It was hypothesised that the catch must have slid on when the gun hit the ground. So confident in their hypothesis were the examiners that they did not fingerprint or swab the scene. They did not test for blood splatter. They did not look for ammunition for the Colt .45. They did not look in the gun safe. They did not look in the bag. They did not swab or fingerprint the beer bottle in the shed. They did not enquire after or test the two handguns removed from the house two days before.

50. In the house were quite a few beer bottles. Some of them were empty and two of them had three or four centimetres of beer still in them. None of the bottles were seized. None were swabbed. None were fingerprinted.

51. There were two mobile phones, an iPad, an iPod and a laptop computer on the kitchen bench along with some prescription medication and 9 millimetre ammunition. The mobile phones and the prescription medication was taken by the coroner's constable. The remaining items were left at the scene.

52. Two days later, on 1 June 2016, the Forensic Pathologist examined the body. He noted that the bullet appeared to have entered the back of the neck and

exited under the chin. That afternoon he conducted a CT scan. That showed that indeed the bullet had entered the back of the neck.

53. On 3 June 2016, the forensic examiners returned to the scene. They believed that they now understood the relevance of the bullet strike in the concrete. It was hypothesised that the deceased had shot himself in the back of the neck with the hand gun inverted. The bullet had then struck the concrete. The inversion of the gun was also consistent with the position of the casing as the casings are invariably ejected from that hand gun to the right. They were at the scene for about 40 minutes. They only examined the bullet strike to the concrete. They did not test for blood or bodily fluid around the bullet strike or conduct any other examination.

54. The forensic examiners concluded that the new information that the bullet entered the back of the neck strengthened their belief that the death was self-inflicted because it explained the bullet strike on the concrete. They undertook lead testing of the strike to ensure it was from a bullet.

55. The investigators seized the electrical items on the kitchen bench on that occasion but did not seize any of the beer bottles or ammunition in the kitchen or the shed for further testing.

56. Later testing showed the bullet found nearby was fired from the Colt .45. Gunshot residue was found on the palms and the back of the hands of the deceased. Swabs of the grip pads on the handle of the hand gun and the trigger ridges matched the DNA profile of Mr Rosewarne. Swabs of the safety catch, the bullet lip and groove and the outside surface of the magazine did not extract sufficient DNA for identification. Swabs of the remaining three rounds in the Colt .45 provided a mixed DNA profile, some of the DNA components matched those of Mr Rosewarne. The remaining components were insufficient for identification purposes. The ridges of the slide of the Colt .45 were swabbed and provided DNA from Mr Rosewarne and at least one other person. However there was insufficient DNA to

identify the other person or persons. Mr Rosewarne's fingerprints were found on the slide of the Colt.45. No other fingerprints were found on the gun.

57. Despite the confidence exhibited in the suicide hypothesis, the Firearm and Toolmark Examiner in his statement dated 20 July 2016 wrote:

> "Although suicide is one possible explanation for the death of the deceased, I cannot exclude the involvement of another person at the scene either during or sometime after the event."

58. In evidence at the inquest he said that the safety catch sliding to the "on" position when falling to the ground was "improbable". But he said that improbability must be assessed with the other evidence collected from the scene. The other evidence he pointed to was the positioning of the body and casing. It seems that he believed those aspects to be consistent with the hypothesis of suicide, particularly the casing as being ejected from the right of the handgun.

59. However, there was nothing about the positioning of the body or the casing that was inconsistent with the involvement of a third party. It takes very little imagination to think of reasons for the positioning of the casing if there was a third party involved. It is obvious that there was insufficient forensic testing undertaken at the scene to exclude the involvement of another person.

60. There was no testing for the approximate body position needed to allow for the bullet strike. In his statement of 20 July 2016 the Firearm and Toolmark Examiner noted the following:

> "The bullet impact mark on the concrete floor is generally round in shape which indicates that the exiting bullet has struck at an almost perpendicular angle."

61. In evidence he said that might be an angle of 70% or 80%. There is obviously a position where the bullet could have gone through the neck and

left the strike mark on the concrete. However the difficulty was that there was no evidence as to what that position was likely to be. That is of obvious importance given that Mr Rosewarne's body was found over the other side of the weight lifting bench suggesting that he had fallen backwards after he was shot.[7]

The Investigation

62. After the forensic examination of the scene the investigator obtained the records of Mr Rosewarne's visits to the Hospital and statements from his friends, family, ex-partner, work colleagues, neighbours, those who saw him at Gunn Point on the 28th and police and ambulance members who had involvement with Mr Rosewarne or the scene of his death.

63. My Office raised with Police on a number of occasions that given the safety catch was on and Mr Rosewarne was shot through the back of the neck there were issues with the level of assurance that the gunshot wound was self-inflicted. However those communications seemed only to strengthen police steadfastness that the death was due to suicide.

64. On 20 November 2017 Police submitted their investigative brief. The conclusion was in these terms:

> "Upon review of the forensic evidence at the scene and the surrounding circumstances, the investigating officer believes the cause of death was suicide, and there is no further evidence to suggest the involvement of any other party in the deceased's death."

65. There was attached to the file a memo from the Detective Senior Sergeant. It stated:

[7] Understanding was not assisted because the only demonstration as to how it might happen had the demonstrator's chin resting on his chest. A bullet exiting under the jaw in those circumstances would leave some mark on the chest. There was none. There was an illustration contained in the Police evidence but the gun was positioned at the base of the skull and probable trajectory was rather different than in this case.

> "After considering all the available evidence, the only logical hypothesis is that the death was a suicide … I concur with the comments and conclusions of the investigator, in that the death is attributable to a self–inflicted single gunshot to the base of the skull with no information or evidence to suggest third party involvement."

66. There was attached to the file another memo from the Acting Superintendent. It stated:

> "Rosewarne shot himself in the back of his head using a firearm he owned … There is nothing to suggest that any other party was involved in Rosewarne's death."[8]

67. Given that the Firearm and Toolmark Examiner could not exclude the possibility of third party involvement and that the balance of the investigation did not seek to exclude third party involvement those conclusions seemed to lack a sound basis.

The Expert

68. On receipt of that investigation I instructed my Office to obtain an expert review of the file. Forensic Consultant, Dr Mark Reynolds APM was provided the brief for that purpose. He had reservations about the investigation and the conclusions drawn and made recommendations for further investigation.

69. In particular he stated:

> "… a review of the literature related to suicidal gunshot wounds to the head and more specifically to wounds located in the back of the neck (as opposed to back of head) finds only one study specifically documenting back of neck entry wound locations. It found just 3 of 1006 suicidal gunshot wounds to that area of the body. What the literature more commonly stresses is that where bullet entry wounds are located in highly unusual or biomechanically difficult areas of

[8] It is worth noting that neither the Senior Sergeant nor the Acting Superintendent appreciated that the bullet did not enter the back of the head or at the base of the skull. It entered his neck in the position of the 4th cervical vertebrae (about halfway down his neck).

> the body the investigative assumption should always be that the injury was not self-inflicted."[9]

70. Dr Reynolds highlighted the role of investigative bias (contextual bias, expectation bias and confirmation bias) in the forensic decision making throughout the investigation. He footnoted the biases in these terms:

> **Contextual bias**: Experts are made vulnerable to making erroneous decisions by extraneous information and influences. Objectivity is hampered as the extraneous information and influences can cause experts to subconsciously develop expectations about the outcome of the examination. These extraneous influences and pressures bias the expert and are difficult to overcome due to the natural human tendency to see what is expected. Thompson, W.C. (1995) *Subjective Interpretation, Laboratory Error and the Value of Forensic DNA Evidence: Three Case Studies*, 96 *Genetica* 153.
>
> **Expectation Bias**: The tendency to observe, believe and record information that agrees with the person's expectations for the outcome and to disbelieve, discard or downgrade any other information that appears to conflict with those expectations. Kerstholt, J et al (2010) *Does Suggestive Information Cause a Confirmation Bias in Bullet Comparisons*. *Forens Sci. Int* 138(2): p 78-90.
>
> **Confirmation bias**: When examiners give extra weight to or intentionally seek evidence that will endorse their expectations and beliefs while unintentionally ignoring evidence that could negate their belief. Byrd, J, S (2006) *Confirmation Bias, Ethics and Mistakes in Forensics*. *Criminal Justice Periodicals* 56(4): pp 511 – 513.

71. Dr Reynolds also spoke of a tendency labelled, "Anchoring" or "focalism": A tendency to rely too heavily or "anchor" on the first piece of information received.

[9] Case Review 1.13

72. The review by Dr Reynolds provided a number of recommendations as to how to advance the investigation. Dr Reynolds' report was received on 19 February 2018. It was provided to the Commissioner of Police that same day.

Further Investigation

73. Police also obtained a review of the file by one of their most experienced officers, Detective Superintendent Scott Pollock. He made recommendations as to further investigations also.

74. A further Police brief was provided to my Office on 12 July 2018. As part of that the Director of the Forensic Science Branch provided a statement. He wrote:

> "It is my view the second visit on 3 June 206 to the crime scene should have reconsidered potential evidence further than examining the concrete floor for an apparent bullet strike. The revisit was prompted by the information regarding the chin being an exit rather than an entry wound which not only raised questions due to its unusual positioning but should have led to a reassessment of evidence. It should have been viewed as an opportunity to investigate the potential of another person(s) being involved. The opened beer bottles in the garage and kitchen should have been seized for DNA and fingerprints."

75. The covering memo from the Commander Crime stated in part:

> "Based on the available evidence, suicide from a self-administered gunshot to the back of the neck is plausible and a possible cause of death. The involvement however of an unidentified third party in the death cannot be discounted."

The Inquest

76. The Forensic Examiner indicated it was his belief that it was a suicide. It seems that because of that there was very little examination of the scene so as to attempt to exclude any involvement of another person. However he said:

> "…perhaps it would have been prudent to swab the alcohol bottles because I think that now, with hindsight, even though I came to the opinion that it was most probably a self-inflicted wound, there is always - always the possibility that new information may arise which may point to a second person … if I had had the information that I - that I have now, in this - in this environment, I probably would do things a lot different."[10]

77. The Firearm and Toolmaker Examiner said he should have documented more, taken more photographs and taken "a lot more measurements in regards to the bullet impact mark on the ground and its relation to everything else in regards to where he was located".[11]

78. He agreed that with the benefit of hindsight they could have undertaken fluid and blood spatter testing but indicated that it wasn't his role to do so.

79. He said he would normally examine the gun safe and ammunition but didn't do so because he couldn't get access. He didn't know that Police were given the access code two nights before. He also had no knowledge of the guns taken from the house two nights previously. He said he didn't examine the house because he wasn't asked to do so.[12]

80. He agreed that there was no evidence from which it was able to be concluded that the gun found at the scene was the gun that was used to inflict the fatal wound to Mr Rosewarne.[13]

THE ISSUES

Not removing the firearms

81. On Saturday, 28 May 2016 the Watch Commander made the decision that the TRG not go into Mr Rosewarne's premises to seize the remaining six

[10] Transcript pp 55, 59
[11] Transcript p 69
[12] Transcript p 69, 70
[13] Transcript p 70

firearms. The Watch Commander believed there to be a reasonable explanation for the two guns that had been seized. He thought the guns may have been on the kitchen bench for cleaning after the hunting trip that day.

82. Police were also positioned outside the residence to ensure Mr Rosewarne did not pose a danger to Ms Staines. There had been no threats of self-harm made by Mr Rosewarne and so it was assessed that the risks to himself and others were lower than the risks of sending police into the residence at night to forcibly remove the firearms.

83. With the benefit of hindsight there is a tendency to assume that should there have been a different decision things might have turned out differently. However even with the benefit of hindsight, it is not clear that the decision can be criticised. If the TRG had gone into the premises it would have been in the early hours of Sunday morning. It is unclear whether they would have found Mr Rosewarne already deceased, or whether there would have been a confrontation. The plan of letting Mr Rosewarne sleep after the evenings' events and not putting his officer's and Mr Rosewarne at further risk is difficult to criticise even at this point in time.

84. Police in reviewing those events thought that the decision should have been to at least knock on the door. That is of course a matter for them. The more important issue, however, is why there was no reconsideration about taking the firearms the following day. There should have been. That is what the Watch Commander intended. It is obvious that the systems for handover of the work between shifts did not function as intended.

85. Having said that, the primary system that failed was the Police records management system (PROMIS). It crashed on 27 May 2016 and was not restored until 1 June 2016. That was a particular catastrophic event rather than a systemic failing.

86. The father of Mr Rosewarne was upset that his son's firearms were not taken after he was taken to hospital. He said:

> "I would like to ask the Coroner why Matthew still had his guns after he was taken to the hospital. I felt that if he did not have his guns, he might not have taken his own life. I understand that if he did want to do this he could have found another way, but I felt if he did not have easy access to the gun, he might have had more time to decide not to do this. I honestly believe he would be regretting what he did."

87. There were two occasions he was at the Hospital. The first on the 19th May 2016. On that occasion the mental health assessment cautioned against it. On the second occasion he was taken for blood and a check-up after being involved in the accident on the 28th May 2016.

88. Taking his firearms at either point may have had an impact. However, in my opinion there is no reasonable basis to criticise Police for not removing the firearms at either point in time.

Managing Investigative Bias

89. Investigative bias has been an issue in a number of inquests including the recent inquest into the death of Sasha Green.[14] In this death, despite there being at least two "red flags" (the safety catch being on and the bullet entering the back of his neck), Police explained them away. They seemed committed to the hypothesis that the death was self-inflicted and did not seek to exclude third party involvement during the forensic stages of the investigation. Thereafter the case continued to be investigated as a suicide rather than a potential homicide. Police concede that was not appropriate.

POLICE RESPONSE TO ISSUES

90. In effect Police provided two formal responses. Both were provided under the hand of Acting Assistant Commissioner, Travis Wurst. The first was

[14] *Inquest into the death of Sasha Loreen Napaljarri Green [2018] NTLC 016*

with the additional brief of evidence on 12 July 2018. The second was on 12 September 2018, just prior to the inquest. Neither of the responses was defensive. In fact, in the first of the responses it was noted that for two of the individual police officers there was defensiveness in their statements. It was said:

> "This highlights a challenge for police around accepting criticism and using that criticism to improve practices, enhance capacity and build resilience."

91. Both responses indicated Police were making significant efforts to ensure the mistakes of the past were not repeated. They included the following information:

a. In August 2018 Police commissioned an external review of the Forensic Science Branch in partial response to the Sasha Green recommendations. The review will expressly include consideration of levels of skill, experience, training, expertise and supervision. The final report is anticipated in late 2018.

b. Steps are being taken to eliminate the impact of bias on investigations and on the mindset of executive management. It was stated:

> "Further, understanding of the impact of such bias is not isolated to investigators or Detectives but can impact any and all elements of operations conducted by the NT Police if not understood and acknowledged as a risk that is managed appropriately. For this reason, the Acting Deputy Commissioner Operations directed Training Authorisation commence to develop a specific and dedicated training package for the NT Police so as to highlight this issue and minimise its impact on current and future investigations, operational decision making and senior executive understanding of these issues. Attached at Annexure B is a draft copy of this training request that is approved and awaiting finalisation of the training program … The impact of investigative bias (which encapsulates all types of bias's) has also been included in the Crime Command Risk register so as to ensure this risk is not ignored but remains as part of

> our ongoing efforts to deliver a professional and high standard investigative service to the NT community."

92. The response went on to detail further reforms and then stated that the *Instruction relating to Coronial Investigations and Inquests* has been updated to specifically highlight the necessary caution when investigating gunshot wounds. The revised Instruction is in the following form:

> **Death involving the use of a Firearm**
>
> 68. Care must be taken when investigating a death which appears to result from the use of a firearm. Assumptions leading to the determination that any wound was self-administered (suicide) are dangerous and every effort must be made to ensure there has been no third party involvement in any such death.

93. The Institutional Response went on to say:

> "In the case of this death investigation under the new policy, once the evidence regarding the point of entry of the gunshot wounds and the fact the safety on the firearm located within the crime scene was engaged, sufficient concern regarding the cause of death and potential for third party involvement would have initiated a declaration and the instigation of Joint Management Committee so as to provide a greater level of consistent senior executive oversight across such an investigation."

94. I commend Police on their thorough and objective analysis of the facts in this case and their positive response. As I stated during the course of the inquest, this is the best response by Police I have received for a number of years. There was a thorough identification of the issues and a demonstrated willingness to learn and improve.

Formal findings

95. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

> (i) The identity of the deceased is Matthew Leonard Rosewarne, born on 19 March 1971 in Mannum, South Australia.

(ii) The time of death was on 28 or 29 May 2016. The place of death was 2 Pumpa Court, Farrar in the Northern Territory.

(iii) The cause of death was gunshot wound to the neck.

(iv) The particulars required to register the death:

1. The deceased was Matthew Leonard Rosewarne.
2. The deceased was of Caucasian heritage.
3. The deceased was a Site Manager working for Toll Energy Logistics Pty Ltd at the time of his death.
4. The death was reported to the Coroner by Police.
5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.
6. The deceased's mother was Pauline Rosewarne (nee Wilson) and his father was Stephen James Rosewarne.

Comment

96. This death should have been investigated as a potential homicide. It was not. The forensic team made a determination that it was a suicide within the first hour and did not seek to exclude the involvement of another person.

97. At this stage and without the ability to undertake the investigations omitted at the time by the forensic team an investigation to exclude the involvement of another person is more difficult.

98. Police have however accepted the shortcomings of the investigation and taken significant steps to correct those failings. They are commended for their efforts.

99. There was one last submission by Senior Counsel for the Commissioner of Police. Counsel Assisting had submitted that because the investigation did not exclude third party involvement, the red flags remained and I would need to return an open finding.

100. Senior Counsel's submissions on behalf of the Commissioner of Police in response to that submission included the following:

> So there are some shortcomings in the investigation which can never be recovered and DNA or fingerprints on the beer bottles is one and is the most obvious one. There may be others which are really much further removed from any likelihood of having anything to say about the matter … But we're a lot further down the track so, whilst accepting there are weaknesses in the investigation and whilst accepting that some of those weaknesses even mean that some evidence is now lost, one remains in the situation or one has now reached the situation where, on the evidence, it's **overwhelmingly probable**,[15] and certainly would reach the level of your Honour being comfortably satisfied, that this death was self-inflicted.
>
> There's no positive evidence of any third party involvement, none whatsoever. There's nothing in the evidence inconsistent with suicide. There are two improbabilities, yet they both remain plausible or can be plausibly or are plausibly explained. One is the safety catch and that's plausibly explained by the ease with which it's switched on and the damage to the firearm. Then the other one is the bullet to the back of the neck, which is unusual but not unheard of, and is also similarly plausible.
>
> [If an open finding were made] it would be left in circumstances of very unfortunate and, I would submit, unfair uncertainty for the family who would not be able to reach closure. There would remain this slightly floated between the lines, insinuation of possible involvement, whereas my submission is there's just simply no evidence to support that.

101. The issue however, is that it is unknown whether the paucity of the evidence relating to the involvement of another person is because police didn't look for it or it wasn't there.

102. If the only evidence is of suicide because that is all the police investigated, that evidence is somewhat less than compelling. To suggest the evidence

[15] My emphasis

makes suicide “probable” is an interesting proposition, particularly when two aspects have been conceded to be “improbable” in circumstances of a suicide.

103. But even if one could say that the evidence taken as a whole could lead to a conclusion that suicide was “probable”, that is not the level of confidence required to make a finding that the death of Mr Rosewarne was self-inflicted. Putting it into a sentence illustrates the vagueness sought to be conveyed by use of the term. If it was said, “He probably killed himself”, that is hardly the level of assurance associated with findings of fact.

104. The term “overwhelming probable” used by Senior Counsel does not add a great deal. Levels of probability remain levels associated with vagueness. If it was said, “He overwhelmingly probably killed himself” I suspect that most would not understand that to be an appropriate level of assurance.

105. I do agree with Senior Counsel for the Commissioner of Police on one aspect: That leaves the unfortunate circumstance where family may not be able to reach closure. As I indicated during the inquest, that is a significant issue. However, it is not one I can cure by a simple finding. The forensic examiner cannot exclude the involvement of another person, nor can the Firearms and Tool Mark Examiner, nor can the Commander Crime. The involvement of another person remains a real possibility. One that was ignored. I am now asked to similarly ignore it. I cannot.

106. It is plain that Mr Rosewarne died from a gunshot wound to the neck. However the circumstances of how that occurred remain open.

Recommendations

107. I have every confidence the NT Police will undertake the review and training outlined in the Institutional Response and accordingly make no formal recommendations.

Dated this 10th day of October 2018.

_____

GREG CAVANAGH
TERRITORY CORONER