CITATION:	*Inquest into the death of Carlene Anne Marie Coombe* [2005] NTMC 042.
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0126/2004
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HEARING DATE(s):	21, 22, 23 February, 17 March 2005
FINDING OF:	Ms Jenny Blokland SM

CATCHWORDS:

UNEXPECTED DEATH – UNCERTAIN AND SUSPICIOS CIRCUMSTANCES CONCERNING DEATH – OPEN FINDING

REPRESENTATION:

Counsel:

Assisting:	Mr Jon Tippett QC
Family:	Mr Peter Tiffin - NAALAS

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0126/2004

In the matter of an Inquest into the death of

CARLENE ANNE MARIE COOMBE

ON 26 JULY 2004
AT 2 / 1 MUSGRAVE CRESCENT,
COCONUT GROVE

FINDINGS

(Delivered 19 July 2005)

Jenny Blokland SM

Introduction

1. Carlene Anne Marie Coombe ("the deceased") died at approximately 2.00am on Monday 26 July 2004. A public inquest into the death of the deceased was held at Darwin on 21, 22 and 23 February and 17 March 2005. At the hearing leave was granted to Mr Tiffin from the North Australian Aboriginal Legal Aid Service to appear on behalf of the family.

2. The inquest heard sworn evidence from 12 witnesses including Detective Acting Sergeant Travis Wurst of the Major Crimes Unit Darwin, 10 lay witnesses and the forensic pathologist Dr Terrence Sinton. Other witness statements were admitted into evidence as part of the Coronial File (Exhibit 1) in these proceedings. Fifty nine documents comprising primarily witness statements have been compiled in the course of an exhaustive investigation conducted by the Major Crime Unit Darwin into the death of the deceased.

3. Section 34 (1) of the *Coroners Act* sets out the matters that the Coroner is required to find during the course of an inquest. That section provides:

"(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) cause of death;

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

(v) any relevant circumstances concerning the death;"

Coroner's formal findings

4. The formal findings I make in this matter are as follows:

(a) The identity of the deceased is Carlene Anne Marie Coombe, a woman of Aboriginal descent of 14 Mayhew Crescent, Jingili, NT, born on 26 March 1961 at Todd Morton Station, South Australia.

(b) The time and place of death was approximately 2.00am on Monday 26 July 2004 at Coconut Grove, Darwin in the Northern Territory of Australia.

(c) The cause of death was a stab wound to the chest with other significant contributing factors being aspiration and acute alcohol toxicity.

(d) The particulars required to register the death are:

(i) The deceased was a female.

(ii) The deceased was an Aboriginal Australian.

(iii) A post mortem was carried out and the cause of death was as stated in (c) above.

(iv) The pathologist viewing the body after death was Dr Terrence John Sinton, Director, Forensic Pathology Unit, Royal Darwin Hospital, who carried out the post mortem examination.

(v) The mother of the deceased was Lorna Coombe and the father of the deceased was Robert Coombe (both deceased).

(vi) The deceased resided at Darwin in the Northern Territory.

(vii) The deceased was unemployed.

Events leading up to and immediately after the death

5. At 2.01am on 26 July 2004, Constables Christopher Butt and Brett Wilson were tasked by police communications to attend at Unit 1/2 Musgrave Crescent, Coconut Grove, where a stabbing incident had been reported. The police communications centre transcript discloses that the person reporting the incident gave his name as "Reggie Richards". Mr Richards told the communications operator "a lady stabbed herself. Quick, quick, quick, quick." "She's dying, mate." "She's just about dead." "She stabbed herself, mate. Fucking just get here." Later in the course of continued conversation with the communications operator Mr Richards said "she stabbed herself with a bloody carving knife"; "And I grabbed it off her and I got blood all over me." When he was asked to describe the position on the body where the stabbing had taken place Mr Richards said "in the heart". Mr Richards went on to tell the operator that he had taken the knife from the deceased and it would appear at the time he made the call he believed the deceased was still conscious. An extract of the transcript of that conversation reads as follows:

COMMS OP : Reggie, I've got an ambulance on the way, all right?

CALLER: OK

COMMS OP: Now listen to me. I need some more information off you, OK?

CALLER: OK

COMMS OP: All right.

CALLER: She stabbed herself with a bloody carving knife.

COMMS OP: With a carving knife eh?

CALLER: Yep. And I grabbed it off her and I got blood all over me.

COMMS OP: OK. OK Reggie..

CALLER: I'm trying to put my finger in there, is that good?

COMMS OP: Reggie, see if you can get a towel or something and –

Whereabouts has she stabbed herself?

CALLER: In the heart.

COMMS OP: She stabbed herself in the heart.

CALLER: Yeah, near there.

COMMS OP: eh?

CALLER: Near there.

COMMS OP: All right mate. Is she still awake?

CALLER: Yep.

6. At 2.05 am Acting Sergeant Brian Bryce and general duties constables arrived at the designated address. As they were getting out of the police vehicle, Constable Wilson heard a male's voice call out "over here fellas". The voice drew Constable Wilson's attention to an area outside 1/2 Musgrave Crescent where a man was leaning over a woman of Aboriginal descent who was lying on the ground. The woman was on her back, face up, with her feet pointing towards the door of unit 2/1 Musgrave Crescent. Constable Wilson later came to know the woman as Carlene Anne Marie Coombe.

7. The deceased was wearing blue denim shorts, a multicoloured top and a brown handbag was slung over her shoulder. There was blood on the front of her shorts in a pattern that might indicate that it had come to be there while she had been standing upright. The male's name is Reginald John Richards. Mr Richards is a Caucasian male born on 31 January 1966. At the time Mr Richards was a solidly built man of 110kgs who was wearing a pair of blue shorts. He was not wearing any clothing on his upper body. When the police arrived he was performing emergency resuscitation. He was also in a highly agitated state yelling to police "help her fellas". He told police "she has been stabbed".

8. Acting Sergeant Bryce attended to the deceased. He checked her for vital signs and applied a face mask to carry out resuscitation. Constable Wilson contacted police communications to obtain an arrival time of the St Johns Ambulance. St Johns arrived at the scene about a minute or so after the police. By that time Acting Sergeant Bryce had begun to perform EAR (Emergency Air Resuscitation) and CPR (Cardio Pulmonary Resuscitation) on the deceased. Mr Richards was standing by. Police noted he seemed very stressed about the incident. His behaviour and close presence caused Acting Sergeant Bryce to ask Constable Butt to take Mr Richards away from the area, obtain his details and gather any information he could on what had happened. As Mr Richards and Constable Butt began to walk

from the area, Richards said to police "bring her back fellas or I'm in the shit".

9. Paramedic Andrew Wheeler and his partner Tracey Zimmerman arrived at the scene approximately a minute after the police general duties unit. Paramedic Wheeler attended to Ms Coombe and confirmed that she was not breathing, had no pulse, and her pupils were not responding. He instructed a police officer, whom he believed was a Senior Constable, to commence CPR and he commenced EAR. He directed paramedic Zimmermann to call for back up and retrieve other necessary equipment from the ambulance. Ms Coombe exhibited no response to stimuli and she appeared pale. Wheeler noticed that there was an incised wound below the left sternal notch which appeared to him to be consistent with a stab wound. He noticed that there was no blood or air coming from the wound itself. Paramedic Zimmermann returned to the scene with equipment including a defibrillator. The defibrillator was connected to the deceased and subsequently informed the ambulance officers that the heart rhythm was "non shockable" and the rhythm on the screen indicated that the heart was asystole, which means that the heart had completely stopped. Paramedic Wheeler then attempted to incubate the deceased on two separate occasions but was unsuccessful on both. Paramedic Zimmerman attempted to insert an intravenous needle into both the left and right cube fossa (crook of the elbow) of Ms Coombe but she did not get any "flash back", indicating the procedure was unsuccessful.

10. At that time another ambulance arrived carrying officers Ben Palzon and Jenny Kirby. Paramedic Wheeler instructed one of those officers to obtain a laryngeal mask which was inserted into the deceased's airway. Officer Palzon then checked and confirmed that the mask was successfully inserted. At that time the deceased did not react to painful stimuli nor were then any audible respirations, no palpable pulse, and her pupils remained non-reactive. It was then determined that there were no signs

compatible with life and all resuscitation was ceased. The ambulance officers removed the equipment and returned it to the vehicles.

11. Paramedic Wheeler returned to the scene and asked one of the police officer's present the name of the deceased. He was directed into a room in the unit close by to where the deceased was lying. There he saw a police officer standing with the male with red hair and dark shorts who he had seen earlier. The man appeared to Wheeler to be upset and asked Wheeler how it was all going, to which Wheeler replied "we have done all we can". The man began to say various things including that he was going to be the subject of payback by the family of the deceased. He also told Wheeler that he had seen the deceased breathing when he first found her but that the breathing had stopped very shortly thereafter. Paramedic Wheeler left the unit and walked back to where the body was lying. He was present when Acting Sergeant Bryce rolled the deceased over slightly and pulled a knife from under her right hand shoulder blade. The knife was a filleting knife, the blade around 20cm in length with a blue plastic handle. The knife was placed beside the body. According to Acting Sergeant Bryce the knife did not appear to have much blood on it. Acting Sergeant Bryce was wearing gloves when he removed the knife from the location where he found it and placed it on the ground near the left side of the deceased. Photographs were later taken of the deceased that showed the knife where Acting Sergeant Bryce had placed it after removing it from the position where he originally found it. There are no photographs of the knife in the position where Sergeant Bryce initially found it.

12. As stated earlier, Mr Richards had been moved from the scene into his unit (number 2) where he had been asked to sit down in a chair near the back door. Mr Richards was heavily intoxicated and objected to being restricted in movement. He also had quite a large amount of blood on his body. Constable Christopher Lyndon advised Mr Richards that he was under arrest. Mr Richards became very angry and verbally abused police. Mr

Richards was held in police custody inside the unit until members of the CIB arrived at which point he was delivered into their custody.

The evidence of Reginald John Richards

13. On the afternoon of the first day of the inquiry, Mr Richards began giving evidence. Mr Richards had been advised that he could seek the advice of a legal practitioner regarding his obligations pursuant to the summons requiring him to attend this inquiry. Detective Sergeant Wurst had earlier told the inquiry that he had made Mr Richards aware of his right to seek legal advice on numerous occasions and had "reiterated that to him every time I have spoken with him" (T20). Mr Richards had been carefully and thoroughly interrogated by investigating police at the Darwin City Police Station on Monday 26 July 2004 between 6.09pm and 8.55pm. He was taken into police custody at 4.29am due to the state of his intoxication. At the time that took place Mr Richards protested, "I did the right thing and youse locked me up". At 4.14 in the afternoon of Monday 26 July, Mr Richards was placed under arrest in relation to the death of the deceased and he was advised that he would be spoken to and that he was entitled to have a person present during his interview.

14. Earlier that morning at approximately 10.30am, Mr Richards had been taken to the Royal Darwin Hospital outpatients' reception to receive a dose of methadone as at that time he was on a methadone program.

15. At 6.09pm on Monday 26 July 2004 a record of conversation was commenced which concluded at 8.55pm on the same evening. The record of conversation was tendered as part of Exhibit 1, (the coronial brief at the inquiry), and discloses detailed questioning that comprises 103 pages of transcript. Throughout the questioning Mr Richards appeared cooperative with police; he consistently asserted his innocence.

16. Mr Richards agreed to give evidence to the inquiry. I note his cooperation meant that it was unnecessary to consider in detail the possible issue of a certificate pursuant to *s 38 Coroner's Act* compelling him to answer in exchange for an undertaking not to use his evidence in any other proceedings. At the outset he expressed certain anxieties about the presence of a particular member of the public while he was giving evidence. In order that he felt free to give his evidence and it appeared in the interests of justice to do so, that person was excluded pursuant to *s 42 Coroner's Act.* (T 33-35)

17. In the main, Mr Richards was cooperative, although from time to time he took issue with the nature and extent of the questioning that he was being exposed to. He complained also that it appeared to him he was in the position of a suspect. That view of his position showed his insight into the seriousness of the subject of the inquiry. His evidence was however occasioned by lapses of memory which are understandable, given the extent of his intoxication as observed by police at the relevant time as well as his consumption of various medications. Just prior to giving evidence he had taken 80mls of methadone and 1 ¼ 30mg tablets of Cerapax. It was clear during the course of the giving of his evidence that Mr Richards was affected by the medication he was taking. His responses to questions were at times slow and confused. At times his answers were non-responsive. Both counsel assisting this inquiry and counsel for the family have submitted that given his medical circumstances at the time he gave evidence to the inquiry, and his severe condition of insobriety on the morning of the deceased's death, it is difficult, if not impossible, to place any reliance upon any aspect of his evidence that is not confirmed by an entirely independent and preferably objective source. I agree with those submissions.

18. Mr Richards faced a lengthy, probing and detailed examination and cross-examination that failed to disclose any substantial departure in his

evidence from the account he gave of the circumstances leading up to the death of the deceased in his record of interview to police. Counsel for the family has also submitted that the time lines Mr Richards has given in evidence must be in error. Counsel for the family acknowledges that he could have been doing the best that he can but overall it is unsatisfactory. To a large degree I accept that submission. It is all part and parcel of his inherent unreliability. Counsel for the family also submitted that Mr Richard's assertion that towards the end of the evening the deceased was throwing things is not supported by the independent evidence available such as the photographs. Counsel has also submitted that only the key card was found in the unit. There did not appear to be anything out of the ordinary. Once again, I agree with that observation but it doesn't lead me to be able to find firmly one-way or the other.

19. Mr Richards came to the inquiry with a written set of notes that were subsequently photocopied and provided to me. Mr Richards was anxious to keep to his notes and when he was asked to rely entirely upon his memory, he became agitated and suspicious. At the conclusion of his evidence his position remained that he had not seen the deceased with a knife prior to hearing a muffled cry from outside his unit as he sat behind a closed wooden door. He first saw the knife when he went to investigate what the cry was all about and found the deceased on the ground shortly before she staggered to her feet with a wound to her chest that was bleeding. He tried to staunch the flow of blood as the deceased collapsed to the ground and later attempted to administer resuscitation before calling emergency services. While it is understandable for observers to be suspicious of Mr Richards, his evidence did not inculpate him in the death of the deceased.

20. In short, Mr Richards describes the deceased on the evening in question as drunk and states she used a boning knife owned by him to injure herself immediately after she left his unit. In response to a direct allegation that he picked up the knife and stabbed the deceased, Mr Richards replied

"yeah, well you can think what you like because I didn't do it. Why would I stab a girl that I love deeply in my heart. Even though we've had arguments and that, I would never do that to that lady. For starters in my criminal history I don't use weapons, never had, always used my fists. I'd never do that, not even think of using it" (T95.5). Although Mr Richards staunchly defended his position the inquiry cannot be satisfied that it adequately or accurately describes the events that took place immediately prior to the deceased's death. On the other hand, even if Mr Richards were to have inculpated himself in some way, the circumstances surrounding the giving of his evidence, the ingestion of medication in particular, and his severe lapses in memory, (probably as a result of intoxication at the time and since the events in question), would inevitably lead to a conclusion that such inculpatory material was unreliable and could not safely be acted upon by the inquiry. I agree with counsel assisting this inquiry that analysis of Mr Richard's evidence becomes a self defeating exercise.

Movements of the deceased prior to her death

21. During the afternoon of 24 July 2004 the deceased went to the residence of Mr David Ian Sephton at 3/7 Nation Crescent, Coconut Grove:(Statement of David Sephton dated 28 July 2004 and T 112- 117). She remained at the residence until midnight that day. They watched television. A friend of Mr Sephton's, Sam, was present at the house. He had slept in the lounge room on Mr Sephton's swag after they returned home in the early hours of Saturday morning: (Statement of David Sephton at 2). The three remained at the premises until about 9.00pm when Mr Sephton went to the Beachfront Hotel and purchased a carton of midstrength beer. They began drinking the beer at the Nation Crescent unit until about 11.00pm when Sam called a cab and went home. Stewart, Mr Sephton's flat mate, and the deceased remained at the premises. The deceased left telling Mr Sephton that she was going to catch the bus and that is why she left the unit before 12 midnight (because the buses only run every hour).

22. Mr Sephton described her as happy. She talked to the people at the unit about programs on television and her family. She told Mr Sephton that her two girls had been to the show on Friday. Mr Sephton told the inquiry she has never tried to harm herself as far as he was aware and never talked to him about trying to harm herself. Mr Sephton did not see the deceased again after her departure from his unit shortly before midnight. It is not known where the deceased spent that night. She apparently told Mr Sephton that she was going to her daughter Starsha's residence in Karama. Mr Sephton believes she left his residence on foot. However according to Starsha Shields, the deceased did not stay at her residence that night.

23. The evidence in these proceedings indicates that at about 2.00pm on the afternoon of Sunday 25 July 2004, the deceased went to Unit 1, Block 3, Runge Street, Coconut Grove, to visit Sonia Smith and Patricia Stewart. She remained at that unit drinking alcohol and a having a "party" with Smith and Stewart and other occupants of the flat. While she was there she told Sonia Smith that she intended to go around to "Reg's place" to get her paints. Ms Smith told police "that the deceased had been talking about doing that all through the day". Miss Smith recalls that by the time the deceased left the unit she was "pretty happy and full of energy". She had consumed some beer but Ms Smith does not recall her smoking any cannabis while she was there. As far as Smith was concerned, "she was really happy that day, she did not have any reason to be angry that day. That's why she wanted to shout the grog that day, she was happy". Sonia Smith was aware that the deceased had suffered depression but she did not think that depression was a factor in her behaviour on that day: (Statement of Sonia Anne Smith, 28 July 2004; T 143-148).

24. Patricia Stewart was ill on the Sunday that the deceased dropped by and did not spend a lot of time with the women while they were drinking and enjoying themselves, however she reported to police that when she went out to where they were, the deceased appeared to her to be happy and

joyful and wasn't "down about anything" (T 151). According to Patricia Stewart, the deceased was drunk at the unit but she had seen her in worse states of intoxication (T 149-153).

25. At about 10.30pm that evening the deceased mentioned to Sonia Smith that she was going to walk to Reginald Richards premises at unit 2/1 Musgrove Crescent, Coconut Grove (a distance of about 100m from the Runge Street unit), to collect some of the painting materials that she had spoken about earlier in the evening which she had left at the unit after she had moved out.

26. It would appear that from about 11.00pm, the deceased went to Mr Richards' residence and continued to drink with him until about 2.00am the following morning when she died.

27. As is mentioned above, Mr Richards was extensively interviewed by police. Each interview was conducted by Detective Acting Sergeant Travis Wurst. Mr Richards described in those interviews the events that took place in his unit between 11.00pm and 2.00am. He said that the deceased had asked him for some "smoko" (cannabis) but the suppliers of the substance were not home; he said that he and the deceased began dancing to some music, the atmosphere was light and happy but it soon deteriorated. The deterioration began with allegations by the deceased that Mr Richards had told people about town that she had AIDS, and that she had given him Gonorrheae. They continued drinking. They then began to discuss their relationship. The deceased was drinking Moselle and Port and he told the police the deceased started to get really "snappy".

28. Mr Richards told police "I did not know she was that bad on Moselle but she is pretty nasty I mean nasty, nasty. And she just started losing it, like and I told her. And she said something like "fuck this, I'm gunna end me, I'm gunna end it all"." "It was some – said like that, you know. And next minute she slammed the door and I heard a bit of a cry. Went out there and

she was lying on the ground." "I said to her "what did you do to yourself" and she – could just see it, blood was pissing out of her all over her shirt and I was trying to tell the fella upstairs to ring an ambulance because she obviously injured herself. And – I don't – I don't know his name but he couldn't savvy what I was saying, like he couldn't understand, you know. And I told him "She needs an ambulance". And Carlene said to me "That's it. It's over" Yeah, then I seen the blue knife laying down next to her and I told the old – the old fella, like "Get down here" and I think I went upstairs and rang the ambulance. Or I might've rang on my mobile. Carlene did get back up and then she fell down again. At that stage I was trying to put my finger in there and she's going "No leave it, that's it". Then she fell down again. And I started giving her mouth-to mouth and trying to put my – not trying – but I put my hands over the blood that was pissing out – pumping out I should say." (Transcript, Record of Conversation, 26 July 2004 17-18).

29. Although I have made comment on the unreliability of Mr Richard's recollections it is important to record that this was essentially his version of the events that he gave to police concerning what took place at his unit between 11.00pm and 2.00am.

30. During the interview Mr Richards denied touching the knife at all on the morning prior to the death of the deceased. He said that he could have used the knife the day before for cutting up some rump steak that he purchased at the butchers in Parap. He drew a diagram of the house during the interview and it is clear that the kitchen area where he says the knife was, had to be passed by the deceased as she left the house before going outside where, according to Mr Richards, she must have stabbed herself. Mr Richards denied consistently throughout the police interview process that he had any responsibility for the incident in which the deceased was stabbed. Apart from some of his behaviour (described above) when he was

first arrested, which can largely be attributed to his severe intoxication, Mr Richards cooperated with police throughout.

31. Mr Richards does however remain a suspect for stabbing the deceased causing her death. The suspicion is not easily displaced. The basis for the suspicion that continues to be held by police includes Mr Richards' violent history. He has previously been convicted of manslaughter in South Australia in 1982 as well as other assaults in both SA and NT. The manslaughter conviction in South Australia needs to be seen in the context that he was a minor at the time and sentenced under the *Children's Protection and Young Offenders Act, 1979 (SA)*. The sentencing remarks of His Honour Justice White on 16 April 1982 indicate the incident involved a group and involved Mr Richards who "hounded, worried, stuck and kicked a security guard." Mr Richards was described as intoxicated; there was also a reference to the victim having a pre-disposition to fatal consequences after such treatment. Mr Richards was sentenced to 18 months imprisonment to be served in a Youth Training Centre. I mention this as it does coincide with Mr Richard's assertion that he does not have a history of using weapons.

32. His recent violent history includes a conviction on 29 August 2003 of aggravated assault against a female. At the time of that offence Mr Richards was before the court in relation to another count of aggravated assault not involving an assault against a female.

33. A number of witness interviewed by police in the course of the investigation described a belief that Mr Richards was assaulting the deceased regularly during the course of their relationship. There appears to be little evidence to support those assertions and what is available is too scant to make any specific findings.

34. On 7 July 2004 there was a domestic incident reported to police as having occurred between Mr Richards and the deceased: (see PROMIS 1097999).

That record indicates "No Offences Detected" and the information recorded by investigating officers states: "attended 2/1 Musgrave and spoke to Reggie Richards and Cara Coombe. Both are intox. and maybe under the influence of other substance. Both have started a verbal and then a physical argument while in this state. …Coombe was abusive, antagonistic and not at all interested in allowing members to sort anything out. She does not live in the house full time so it was decided in the interests of safety to all to PC her - she would provide no other location to take her. She claims to have been hit in the head and he claims she tried to stab him but neither wants to make a complaint at this time. Coombes had no visible injuries other than an old cut to the eyebrow, so she was conveyed after dv options were explained. He says she can come back tomorrow. DV options explained to very uncooperative Coombe at the watchouse."

35. The attending forensic pathologist Dr Terrence John Sinton provided an opinion to police to the effect that the nature of the stab wound was such that it may either been self-inflicted or inflicted by another. The pathologist had also noted bruising over part of the deceased body that may have been associated with the stabbing but which also could have been caused in the natural course of life.

36. An examination of aspects of the deceased's life indicates she had complex problems at the time of her death that would have been exasperated by her substance abuse problems, in particular alcoholism. Those problems and the effect they may have had upon the deceased immediately prior to her death are consistent with the account given by Mr Richards regarding self-harm.

37. No charges have been laid in relation to the death of the deceased. At the conclusion of the police investigation there was no direct evidence forensic or otherwise connecting Mr Richards with an unlawful killing of the deceased.

Issues Relevant to the Deceased's Mental State Prior to her Death

38. On 7 November 2002, orders were made in the *Family Matter Court* declaring both the deceased's youngest daughters in need of care. An application was made by Maxine Coombe and her daughter Cora Lynch that they be the primary carers for the children Pamela and Hayley Dodd. The application resulted in an assessment by Family and Community Services that recommended that the carer application be granted on 30 December 2002. Since that time the Danila Dilba Health and Social Wellbeing Centre's records show that the deceased attended a number of counselling sessions during which she indicated a resolve to regain stability in her life and recover the care of her children.

39. The Danila Dilba Health Services medical records show she visited that organisation for treatment in April and June of 2004. On 16 April 2004 the progress notes indicate that she was suffering from a worsening depression, and sought medication to "stop stressing". The notes indicate a continuing battle with alcohol. On 10 June 2004 the records show that she was seeing counsellors in relation to stress for issues that included court cases relating to assaults, and the fact that her children had been removed from her care. On that occasion she wanted Valium, but the general practitioner attending her refused to prescribe it on the grounds that she exhibited depressant activity, that she was vulnerable to the addictive nature of the medication and at the time she sought the prescription, she was not withdrawing from alcohol.

40. Because of some resistance to the idea of her young daughters going into the care of Maxine Coombe and her daughter Carol, it was Starsha Shields who ultimately took on the responsibility of looking after the children.

41. Many members of the deceased's immediate family were interviewed by the police. They reject the ideas that the deceased may have taken her own life because her death came at a time when she was trying to pull her life

together so that she could recover care of the children. However the emergency department records of the Royal Darwin Hospital indicate that she continued to struggle with alcoholism. On 23 July 2004, she attended the hospital at 1.12am with a history of having collapsed earlier in the day, falling onto the left side of her head. She had been drinking heavily and alleged that she had been assaulted with a hit by a fist to the right side of her face. She was examined and found to have a laceration at the left parietal head. The laceration was 2cm in length and described as superficial. It was not bleeding at the time that it was seen by medical personnel. It was treated by being "glued". After other observations the deceased was discharged home. At the time of the incident it appears that the deceased had been drinking heavily.

42. The precise nature and extent of the deceased's mental state is not clear. The original medical records have been exhibited in the inquiry. The records indicate that the deceased suffered symptoms of depression over a significant period of time and she had been prescribed an antidepressant by her general practitioner. Detective Sergeant Wurst told the inquiry that the Danila Dilba Social Wellbeing file intimated, or gave the indication, that the deceased had suicidal ideations at some point prior to her death. Sergeant Wurst stated "from reviewing all the material not only the Danila Dilba file, it appeared that she (the deceased) had had some issues with substance abuse prior to her death for which she was seeking counselling. She also has – it is stated in this file – she had some suicidal ideations for which she was seeking counselling. She had an issue with the fact that one of her – one or both of her children weren't living with her at a particular point in time, and she was trying to seek help through her counselling and with the assistance of FACS that she would get her children back to live with her. I believe at some time just after she passed away – she was actually receiving some money from a victim of crime incident she was

involved in prior, and she had made mention of that in some of the reports and also to some of the witnesses that I had spoken to. So to make a determination on what her actual state of mind was at the time, it's hard to say, there were a number of things that were impacting upon her life at that particular point in time". (T18.9 to 19.3).

43. The evidence of witnesses such as Sonia Anne Smith and Patricia Lee Stewart to the effect that the deceased exhibited an outwardly happy demeanour on the Sunday evening prior to her leaving their company to go and pick up some personal items from Reginald Richards cannot be regarded as determinative of her mental state shortly before her death.

44. Forensic pathologist Dr Terrence Sinton told the inquiry that "I tend to take the view from my own clinical experience that trying to rationalise with people who appear to be patently irrational at the time is very difficult. You can't apply the same rules. That's my observation, that trying to apply rules to people who for whatever reason break the rules, doesn't make sense, and so there is no logic. There are no rules. You can't tell what's necessarily going in that short period of time". (T138.6 to T138.7). Dr Sinton went on to say that he had experienced cases where a person's mood can change quickly from one of joy or happiness inexplicably to a mood where the person has been capable of carrying out a self-inflicted injury that has given rise to death (T139). The fact that a person is in a "happy mood" at a time prior to death does not lead to the logical conclusion that the person had not developed a changed mood in the context of which a self-inflicted injury came about. I accept his evidence and the observations of Counsel Assisting that outward appearances can be deceptive and life events may trigger mental processes that fuelled by alcohol, and in this case possibly cannabis, can lead to an emotionally depressive response which ends in self-inflicted injury.

45. The evidence in this inquiry does not permit me to make a finding that the deceased suffered from a particular mental state of such detriment to her that she was vulnerable to self harm. Equally, it is clear that the deceased's circumstances were such that she had many problems associated with her personal life that led her to suffer from the depression for which she had been medicated. The deceased heavily abused alcohol and engaged in the ingestion of other drugs including cannabis or THC which was found in her body as evidenced by the toxicology report. Those factors combined with the knowledge that persons who suffer confused or emotional mental crisis in the context of substance abuse may engage in behaviour that is unexpected and uncharacteristic, and which may be contrary to outward signs of emotional stability even hours prior to the event, means self harm cannot be ruled out.

46. Counsel assisting this inquiry suggested that although it is matter of speculation a possibility does emerge from the evidence that the deceased intended to harm herself only superficially, perhaps to draw attention to her emotional plight at the time, or alternatively, to punish herself for her own perceived shortcomings, but that in the confusion of a mind addled by alcohol and affected by drugs, she made a mistake and injured herself to a far greater extent than that which she may have intended. I agree with that possible conclusion. I agree also that we may never know. It is impossible on the evidence before this inquiry to unravel the thought processes of a person who had fought at times bravely and with determination against substance abuse, but who had on so many occasions also failed to succeed.

Forensic pathology

47. Dr Terrence Sinton, Director Forensic Pathology Unit, Royal Darwin Hospital preformed an autopsy on the body of the deceased on 26 July 2004 at 10.30am. He found that the cause of death was a stab wound to the chest and that contributing factors to death included aspiration of stomach

contents into the deceased's lungs and the acute alcohol toxicity to the deceased. In the course of the autopsy samples of blood and urine were taken for toxicological analysis. That analysis was conducted by Mr Chris Kostakis, forensic scientist with the Department of Administrative and Information Services Forensic Science Centre, Adelaide, SA. That report found that the deceased's blood contained an alcohol content 0.313%. Traces of tetrahydrocannabinol were also detected in the blood. The level of THC found in the deceased blood were such that cannabis use may have occurred several days before hand.

48. Dr Terrence Sinton is a highly qualified forensic pathologist whose opinions can be confidently relied upon. However as this inquiry focused on the issue of whether the deceased may have fallen victim to foul play, the Coroner's Office, upon advice, secured the services of forensic pathologist Dr Byron Collins to provide a second opinion.

49. Dr Byron Collins in his report dated 21 February 2005, concluded that "on the information presently available for assessment and it is acknowledged that it is incomplete, it is my considered opinion that the deceased's fatal stab wound is consistent with self-infliction, although it would have to be conceded it could not be entirely excluded that it was inflicted by another individual". Dr Terence Sinton considered the contents of Dr Byron Collins report and agreed in large part with its conclusions. The report was tendered as exhibit 5 in the inquiry with reservations as identified by Dr Sinton (T139 and T140). Dr Sinton referred to the following statement by Dr Collin's that: "These findings are therefore somewhat against the injury being sustained during a violent struggle if such is alleged to have occurred". Dr Sinton said he thought this statement was "somewhat strong, a partisan approach to an opinion without a basis". Dr Sinton said his own view was formed on the basis that a violent struggle may not produce evidence of that fact and it depends on one's interpretation of violent.

50. In short the thorough examination of the circumstances of this death by two eminent forensic pathologists does not allow the inquiry to conclude that there is forensic material that supports a finding that excludes the presence of foul play, but rather the pathologists are of the opinion that the wound is consistent with self-inflicted injury. Consequently, without any other objective factors, either in the evidence of other witnesses or other forensic material that has not been the subject of examination by the forensic pathologists, this inquiry is not in a position to determine with the necessary confidence that the injury was self-inflicted as distinct from being the product of foul play.

The police investigation

51. The police investigation appears to have been entirely thorough with a particularly concerted effort having been made to determine whether Mr Richards' assertion that the deceased took her own life was a legitimate explanation having regard to her history and the circumstances immediately leading up to her death. All relevant lay witnesses were interviewed and extensive statements were taken from each. In all, 43 witnesses were interviewed and a detailed statement was taken from each. Mr Richards was interviewed for an excess of two and a half hours by experienced senior police officers. The forensic investigation appears to have been detailed and exacting. The investigation has not been able to refute the account given by Mr Richards to police nor has the extensive investigation disclosed evidence that might be persuasive of either the position that the deceased took her own life or that she was subject to foul play and died as a consequence.

52. The police investigation examined and analysed the occasions upon which the deceased came into contact with health care officials including counsellors, doctors and other health personnel, insofar as there were reports made or notes taken by such personnel in the course of their

dealings with the deceased. Part of those records suggested the deceased was a person with a profile of depression; that she struggled with alcohol and other substances; that the negative impact of this resulted in her being unable to have her children returned into her care. There is also evidence that at times she had regained some stability in her life.

53. Detective Acting Sergeant Travis Wurst and the other officers involved in this investigation have literally exhausted all channels of inquiry and have been unable to decisively account for the deceased's death on the material that they have gathered together.

54. During the course of Detective Sergeant Travis Wurst's evidence, it came to the attention of the inquiry that the blue handled boning knife had not been the subject of forensic investigation. Detective Wurst explained that lack of investigation by saying that "the knife was sodden with blood, the handle was sodden with blood and so was the blade". (T29.9), consequently, it was concluded that fingerprints of any value to the inquiry would not be found on the knife. It was also concluded that as Mr Richards had frankly accepted ownership of the knife and that he used it in his daily activities in the kitchen, the knife would not yield positive forensic material of value to the investigation. I asked Detective Wurst whether an investigation of the knife might indicate that the deceased had touched it by revealing her fingerprints upon an examination of it. Detective Wurst was asked to submit the knife to forensic examination during the course of the inquiry. That examination revealed no further information. The Coroner's Office has since received a Forensic Services – Fingerprint Report from Sergeant Goodger that after examination of the knife, no marks were located. There is some conflicting evidence concerning the observations about the amount of blood on the knife. I accept these are subjective observations and depend very much on a person's experience in dealing with this type of subject matter. On balance, I would have liked the assurance of having the knife examined earlier but I

accept, that such an examination may not, at the end of the day have assisted with the ultimate finding. Had the deceased's fingerprints been on the knife, it would then have to be examined whether she had had contact previously with the knife. I more than satisfied with the police investigation and thank them for their assistance.

Concluding remarks

55. The focus of this inquiry has been on whether the deceased died by her own hand, either intentionally or accidentally, in the course of conduct that has been described, or whether she died at the hand of another person, in this instance, Mr Reginald Richards. The purpose of a coronial inquiry is to make every endeavour to obtain evidence which will allow the inquiry to arrive at a positive finding in relation to the manner of death. Unfortunately, in this inquiry, I find that the evidence is insufficient to determine the manner of death and that an open finding is the only reasonable recourse having regard to the state of the evidence before the inquiry. The evidence does not permit me to find that the death was the result of a self-inflicted injury by the deceased or the result of the intervention by another party immediately prior to or at the time of death.

56. It is often said that an open finding is not satisfactory to anyone for the reason that both relatives and family of the deceased, as well as the statutory duty accompanying coronial office, seeks wherever possible to solve the puzzle of a death in order that there is finality and that there is a satisfactory degree of understanding as to how the investigated death came about. However, in this case the evidence is, in part, of uncertain character or unreliable and in some instances insufficient, such that it is not merely appropriate but that it is my duty to return an open finding. Both counsel assisting and counsel for the family agree that is the appropriate finding.

57. This is not an appropriate case to make recommendations concerning the practices of government in any particular area, however it is important that

the community have regard to the often fatal consequences for persons caught up in the mix of alcoholism, mental illness, the use of legal and illegal drugs and domestic violence. All of these have been features of the evidence in this inquiry. The consequences in this case, not only for the deceased, but also for her family and friends have been devastating. Although the deceased was a complex individual, it is clear from the evidence she also brought joy to her family and friends. Many members of the deceased's family, including some of her children, her sisters and her former partner have attended the inquiry. I was told that some have travelled significant distances to attend. Clearly the deceased was loved and respected by those close to her and the tragedy of her passing is deeply felt. I feel great sympathy for them as the anniversary of her death approaches.

58. In relation to persons who may seek to publish or comment on these findings, I draw their attention to *s 33 Community Welfare Act* so that no material discloses the proceedings of the *Family Matters Court* referred to above unless permitted by law.

Dated this19th day of July 2005.

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JENNY BLOKLAND SM
CORONER