

CITATION: *Inquest into the death of Patrick Wayne Bloomfield*
[2021] NTLC 010

TITLE OF COURT: Coroners Court

JURISDICTION: Alice Springs

FILE NO(s): A0032/2019

DELIVERED ON: 1 April 2021

DELIVERED AT: Alice Springs

HEARING DATE(s): 9, 10 March 2021

FINDING OF: Judge Greg Cavanagh

CATCHWORDS: **Remote Aboriginal Community, RBT avoidance, police pursuit, terminated, rolled 5 kilometres later, death in custody, family access to body and scene not facilitated, suspicions of family not allayed**

REPRESENTATION:

Counsel Assisting: Kelvin Currie

Counsel for Police: Trevor Moses

Counsel for family: Daniel Gorry

Judgment category classification: A

Judgement ID number: [2021] NTLC 010

Number of paragraphs: 68

Number of pages: 21

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0032/2019

In the matter of an Inquest into the death of

PATRICK WAYNE BLOOMFIELD

ON: 25 JULY 2019

AT: ATITJERE COMMUNITY (Harts Range)

FINDINGS

Judge Greg Cavanagh

Introduction

1. The deceased, Kumanjayi Bloomfield, was born 18 May 1977 at Santa Teresa in the Northern Territory to Christine Turner and Herbert Bloomfield. He was 42 years of age when he died. He had five children: Simone, Shaun, Jeremy, Shakira and Stefan. They are now adults and he had a number of grandchildren.
2. He was a Director of Huckitta Enterprises Pty Ltd and lived and worked at Huckitta Station, a cattle station part owned by his father. He was known to be reliable and hardworking. He never obtained a driver's licence. He was said to be a future leader of the community working towards taking over the cattle station. The effect of his death on his family and the community is immense.
3. In the days before his death, Kumanjayi Bloomfield and his father, mother and sister had gone to Lake Nash for a funeral. It was held on Saturday 20 July 2019. They then went on to Mount Isa. On Wednesday, 24 July 2019 they travelled from Mount Isa to Ilparla Outstation. They were in a white Subaru Outback Station Wagon owned by Kumanjayi's father.
4. They arrived at Ilparla Outstation in the early hours of Thursday 25 July 2019. His mother and sister stayed there and Kumanjayi Bloomfield, along with his father and another male, Cameron, travelled to Huckitta Station (about 50 kilometres from

Atitjere). They arrived at about 1.00pm. They had some lunch and his father went to sleep.

5. At about 3.00pm Kumanjayi asked for some fuel for the white Subaru. He was thought to be intoxicated and it was only provided on the basis that he did not drive. Cameron drove the vehicle to Atitjere Community. Kumanjayi told family members about the funeral and then said he had to head back to Huckitta Station. He left Cameron in the community and at about 4.40pm drove the white Subaru out along Mica Road toward the Plenty Highway.
6. The Plenty Highway runs from the Queensland Border (Donohue Highway) 498 kilometres to the Stuart Highway, 68 kilometres north of Alice Springs. Apart from the last 100 kilometres before the Stuart Highway it is largely unsealed. From early 2019 there was work being undertaken to lay bitumen on a six kilometre stretch of the Highway running east from Mica Road at Atitjere. An unsealed bypass road had been constructed running parallel to the Highway. The speed limit on the Plenty Highway is 110 kilometres per hour, on the bypass road it was 60 kilometres per hour.



Photo 1: The Community of Atitjere can be seen in the top left hand. Mica Road runs diagonally toward the bottom right hand of the photo. The Plenty Highway is seen running down the right hand side of the photo. The commencement of the bypass can be seen just below the intersection.



Photo 2: Heading east, the new bitumen on the plenty Highway and running parallel to it, the unsealed bypass road.

7. When travelling along Mica Road toward the Plenty Highway there is a cattle grid across the road and then an unsealed road on the right that goes to the power station and does a loop linking back to the intersection of Mica Road and the Plenty Highway (see Photo 1).
8. After the bypass road was formed, vehicles used the road to the power station as a shortcut between Mica Road and the bypass road. There was a well-worn access point between the loop road at the power station and the bypass used by the local community, including the police.

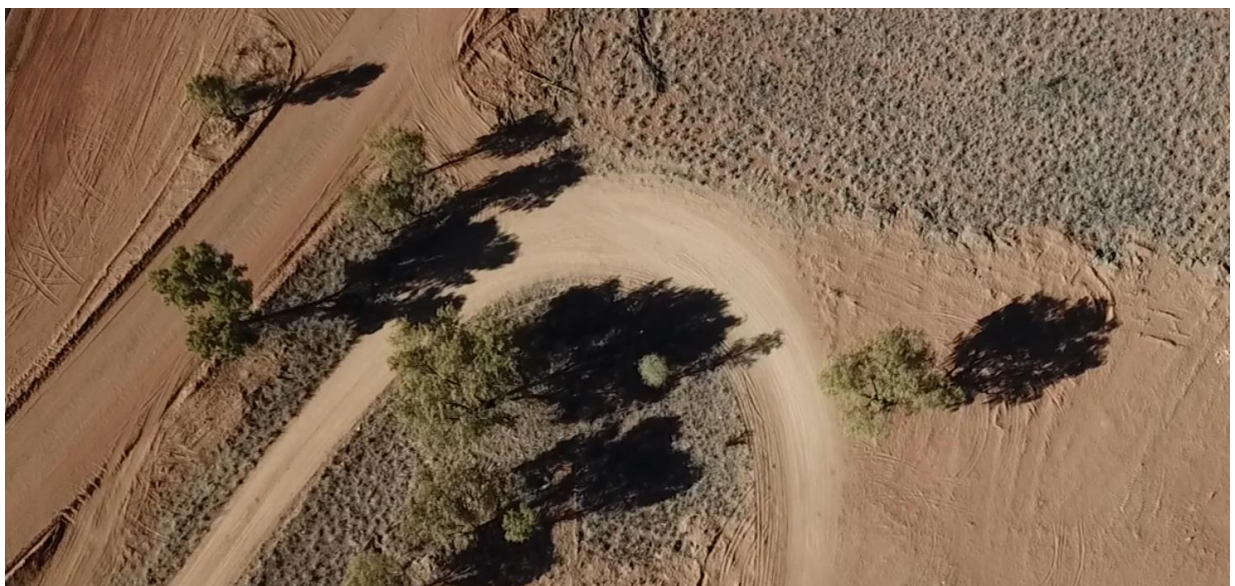


Photo 3: Showing access between the power station loop road and the bypass road.

Circumstances of his death

9. On the afternoon of 25 July 2019 at about 4.20pm the two police officers stationed at Harts Range went out to the intersection of Mica Road and the Plenty Highway and set up a random breath testing (RBT) station. They had the red and blue lights flashing on their Landcruiser vehicle.
10. The RBT station was at “a standard spot” the police used.¹ It was not ideal because of the ability of vehicles heading out of the community to take the road past the power station and onto the bypass, thereby avoiding the station. That situation had only come about in the last number of months after the bypass was constructed.
11. There was not a lot of traffic on the Plenty Highway. The officers waited about 20 minutes before the first vehicle approached. It was tourists from NSW in a white Toyota Landcruiser towing a camper trailer. They were travelling in an easterly direction along the Highway. The police breath-tested the driver and checked the registration. The tourists then continued, travelling along the bypass.
12. A short time later a white Subaru station wagon was seen heading along Mica Road toward the Plenty Highway. It crossed the cattle grid and turned right onto the dirt road going to the power station. It was being driven at an appropriate speed and one of the police officers assumed the driver was attending at the power station where there was maintenance work underway. The other officer suspected the driver was attempting to avoid being breath tested and said, “Do you want to stop it?” As it was passing the power station, both officers ran to the police vehicle. The younger officer got into the driver’s seat and the Remote Sergeant into the passenger seat. By the time they were underway the white Subaru was turning onto the bypass.² The police drove from the bitumen onto the bypass.
13. It was a clear day with little breeze and driving on the unsealed dirt road created a cloud of dust. They could no longer see the Subaru and presumably the driver of the Subaru

¹ Interview Remote Sergeant Q 47

² Transcript p41

could no longer see them. The police turned on the siren and accelerated to 110 kilometres per hour but the cloud of dust made by the Subaru was getting further away.

14. When the police body worn camera is turned on it records sound and vision. It also captures the preceding 30 seconds of vision without sound. About 720 metres from where the police were stationed the body worn (backcapture) shows the Remote Sergeant turn off the siren. Nine seconds later he turned on his body worn video. The time was 4.43pm. He stated that they had discontinued the pursuit of the vehicle. He said he called it off because it was obvious the Subaru was not going to stop and they did not have a resolution strategy. The vision from the body worn video can be compared to the vegetation on the side of the road and indicates that the body worn video was turned on 930 metres after leaving the breath testing station. The video shows the Police vehicle to have slowed to 60 kilometres an hour. There can then be heard the sound of the Remote Sergeant's phone ring tone and he turned off the body worn video and took a phone call. The records of that phone call indicate that it lasted for 5 minutes and 40 seconds.
15. They reached a crest and could see two clouds of dust in the distance. They assumed one of them was the tourist and other, the vehicle they had been pursuing. The tourists were still travelling on the bypass when the white Subaru went past them. The driver said to his wife: "hooly dooly that car is flying". He could not see the make of the vehicle due to the speed and dust.
16. The tourists said the police vehicle did not pass them, nor did they see the police vehicle after leaving the RBT station or hear a siren. When the tourist couple got back onto the Plenty Highway they noticed the wreck on the side of the road but were unaware it was the vehicle that had just passed them. They said they had seen a number of car wrecks along the Highway. When they saw the wreck there were no police in the vicinity.
17. While the senior officer was on the phone, the younger officer continued driving at 60 kilometres per hour until the bypass road terminated at the Plenty Highway. He drove onto the Highway and pulled to the side. When the phone call was finished the officers spoke about whether they should drive to the next community to see if the white Subaru was there or go back to Atitjere to inquire as to who was driving the vehicle.

18. They decided to go on. Before they commenced to move the Remote Sergeant is seen on the body worn video (back capture) to be pointing ahead. He said he saw something on the side of the road he hadn't seen there before. They started to move forward and noticed tyre marks on the road leading to the wreckage. The white Subaru was on its roof in the scrub about 15 metres from the road. They turned on their body worn cameras. The time from terminating the pursuit until they turned the body worn cameras on at the scene of the crash was 8 minutes 38 seconds.
19. They found Kumanjaya Bloomfield lying between the roadway and the wreckage. The vehicle had clearly rolled and he was thought to have been thrown from the vehicle. He was lying on his back, he was not breathing and had no pulse. He had been bleeding from his head and had obviously suffered significant head trauma. Police called the Health Clinic at 4.51pm. The Health staff arrived and pronounced him deceased at 5.02pm.
20. The two officers placed themselves at either end of the scene to protect the tyre marks, the wreckage and the deceased. The officers were about 200 metres apart.



Photo 4: Bypass re-joining Plenty Highway. The Remote Sergeant was stationed at that end of the scene approximate to where the two vehicles are seen.



Photo 5: Looking down the Plenty Highway toward the scene of crash (approximate to white police vehicle parked horizontally and where the other officer stood guard at the scene).

21. Word of the crash got back to the community and two cousin-brothers of Kumanjayi travelled from Atitjere to the scene of the crash. They confirmed his death and took the information back to the community. About an hour later Kumanjayi's father travelling from Huckitta Station came past and stopped. He mentioned that those at the station shouldn't have let his son take the car because he had been drinking. He then went on to Atitjere.
22. General duties officers arrived at 7.30pm to take over guarding the scene. The Major Crash team arrived at 9.00pm and detectives leading the investigation at 11.00pm. His body was picked up by the contractors at 12.07am and transported to the Alice Springs Hospital mortuary.
23. The following day the Major Crash unit marked out the tyre tracks of the Subaru. It is their opinion that the Subaru while travelling from the bypass onto the Plenty Highway at a speed of between 112 and 114 kilometres per hour went into a counter clockwise yaw, overcorrected and went into a clockwise yaw before tripping on the windrow at the side of the road and rolling.



Photo 6: Identification of tyre marks leading to wreckage.

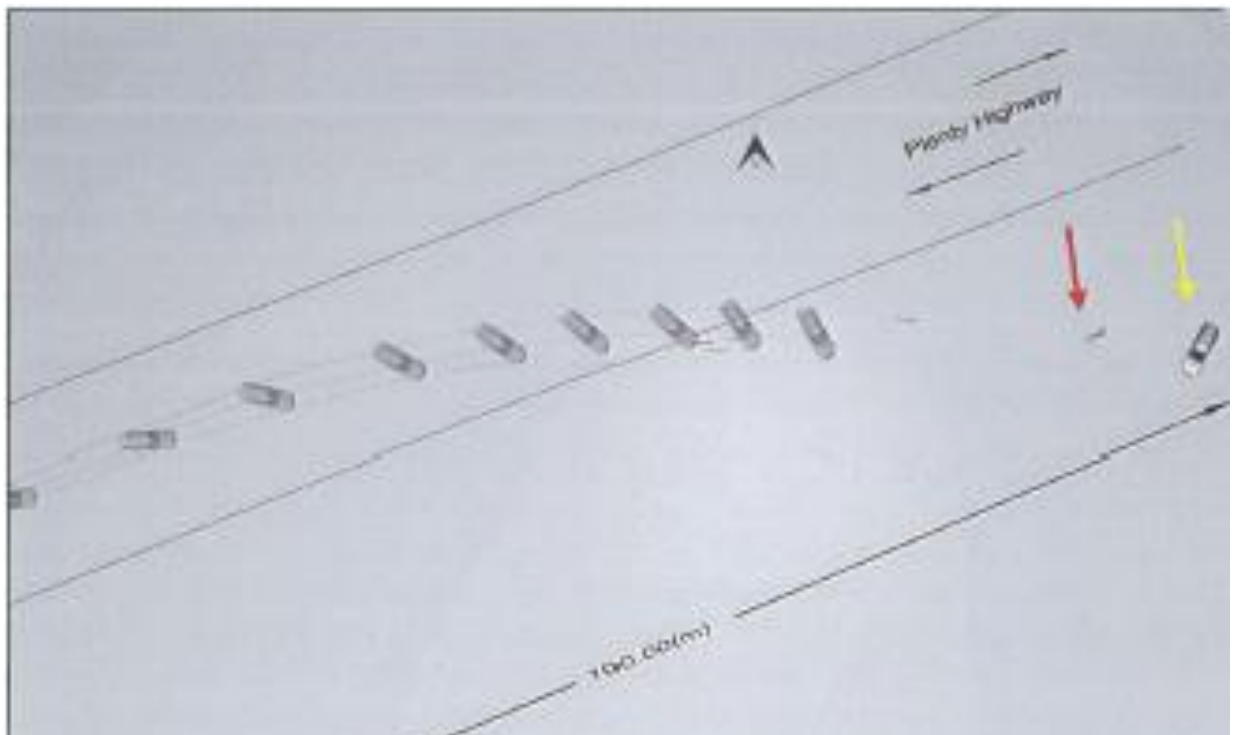


Photo 7: Clockwise yaw leading to rollover and showing position of deceased and the vehicle.

24. An autopsy was performed and the forensic pathologist found that the deceased had, among many other injuries, left side and basal skull fracture. His injuries were not survivable. The forensic pathologist commented:

- Extensive left-sided and basal skull fracture.
- Multiple left-sided rib fractures.
- Left-sided pulmonary contusion and laceration.
- Fracture of the left fifth metacarpal.
- No evidence to suggest that a seatbelt had been worn.
- I am satisfied that death was from blunt force head and chest injuries.
- Unconsciousness is likely to have been immediate and somatic death would have ensued within a matter of minutes.

25. Toxicology indicated that the deceased had a blood alcohol reading of 0.28%.

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

- (i) The identity of the deceased Patrick Wayne Bloomfield, born on 18 May 1977 at Santa Teresa in the Northern Territory.
- (ii) The time of death was about 4.50pm on 25 July 2019. The place of death was the Plenty Highway 6 kilometres east of the intersection with Mica Road.
- (iii) The cause of death was blunt force head and chest injuries caused by a traffic crash where he was the driver.
- (iv) The particulars required to register the death:
 1. The deceased was Patrick Wayne Bloomfield.
 2. The deceased was of Aboriginal descent.
 3. The deceased was a station hand.
 4. The death was reported to the Coroner by police.
 5. Forensic Pathologist, Doctor John Rutherford confirmed the cause of death.

6. The deceased's mother was Christine Turner and his father Herbert Bloomfield.

Issues

Death in Custody

27. The first issue was whether the death of Kumanjayi Bloomfield was a death in custody. The definition of a 'person held in custody' includes a person in the process of being taken into or escaping from the custody or control of a police officer.³ In my opinion Kumanjayi Bloomfield was a person escaping from the control of a police officer. His death is a death in custody.⁴ As such it was mandatory that an inquest was held.⁵ The Police investigation was undertaken on the assumption that his death was a death in custody. It was comprehensive and of high quality.

Police pursuit

28. The family of Kumanjayi were very concerned that it was the actions of police that caused his death. His sister said:

“My family and I are angry about how the Northern Territory Police Force acted on the day that Kumanjayi Bloomfield passed away and on the days since that day... it was dangerous and would have made him drive worse on the road ... the Police did not have to chase Kumanjayi Bloomfield to find out who was in the car. They could have come into community and asked my family who was driving ... I think that if the Police did not chase Kumanjayi Bloomfield on that day then he would still be alive and here with us.”

29. The NTPF Road Policing Strategy 2019 – 2021 at page 4 states:

“The NT continues to struggle to address the most fundamental road safety issues such as drink driving, wearing seatbelts and speeding”.

One of the performance indicators is Random Breath and Drug Testing deployment.⁶ I was told by the Remote Sergeant that there was significant pressure on remote stations to meet the performance indicators. Of the direction to conduct more RBTs he said:

³ *Coroner's Act* section 12

⁴ Both counsel for the family and the Police submitted that to be the case.

⁵ *Coroner's Act* section 15(1)(b)

⁶ Page 14

“It was reiterated at every JMC, reiterated in numerous emails ... RBT numbers are down, they want them higher.”

30. There can be no criticism of the Police for conducting the Random Breath Testing (RBT) station. The issue is, when it appeared to the officers that the Subaru was avoiding the RBT, whether they should have attempted to stop the vehicle or not. The evidence was that at the point the decision was made to stop the Subaru and the officers ran and jumped into their vehicle, the Subaru was being driven in an orderly manner and at an appropriate speed. It was still on the road that went past the power station.
31. Most motorists do stop when a police vehicle with lights and siren indicates they should pull over. Although, with the benefit of hindsight one might regret the decision to give chase, in my opinion it is not appropriate to criticise the police officers for attempting to stop the vehicle. I note also that counsel for the family accepted that it was appropriate to attempt to stop the vehicle. He however submitted it was not appropriate that police pursue.⁷
32. Once onto the bypass the complicating factor became the dust that made visual communication with the vehicle difficult. That was likely, in part, due to the Subaru not keeping to the posted speed limit. There remained the possibility that the driver of the Subaru would hear the police siren and pull over but as the Subaru continued to accelerate it became clear the driver was not going to stop.
33. The *Emergency Vehicle Driving and Pursuit Driving General Order* requires a constant assessment of the risks. The Remote Sergeant clearly undertook a risk assessment and terminated the pursuit. He noted that the Subaru was getting away from them, that there was a tourist vehicle ahead and that they had no resolution strategy even if they could catch up. He said:

“Once I realised he was not going to stop, the decision was made straight then and there. At that point, I had my body worn video camera, I hadn’t turned it on at that point, because I was friggging around with my seatbelt. I turned my body worn video on. Once it started, I looked at my phone for time and date, I’ve given a bit of commentary – introduced myself, time and date, what we were doing and the fact that we had been

⁷ Submissions paragraph 13

trying to apprehend a car headed, was still heading outbound, we were disengaging.”⁸

34. From the body worn video it is calculated that the decision was made to discontinue the attempt 720 metres from the RBT station. At that point the Remote Sergeant can be seen turning off the siren. According to the officers’ evidence, by that time the Subaru was somewhere between 200 – 400 metres in front of them. There would have been a lot of road noise from travelling at speed over the unsealed road. It is unlikely that Kumanjayi heard the siren but if he did he is unlikely to have heard it cease. From the point that police disengaged, Kumanjayi drove another five kilometres and passed the tourists on the bypass before reaching the Plenty Highway.

Pursuit or TRAP

35. Police preferred to characterise the actions of the police as an attempted traffic apprehension (TRAP) rather than a pursuit. For current purposes the distinction is not of importance. That there is some ambiguity might suggest the definition needs tweaking. That appeared to be recognised by Police.⁹ A police vehicle travelling at 110 kilometres per hour in a 60 kilometre an hour zone while chasing a vehicle going even faster would ordinarily be thought to be something more than an attempted traffic apprehension.
36. The ambiguity over what is and isn’t a pursuit under the General Order is due to the requirements of the definition of ‘pursuit’. There are three elements:
- i. The driver indicates by their action or manner of driving that they have no intention of stopping; and
 - ii. The police believe that the driver is aware of the requirement to stop; and
 - iii. There is an active attempt by police with siren and lights to apprehend the vehicle.
37. In contrast, a traffic apprehension does not require assessment of the intent or compliance of the driver, it simply refers to the actions of police in attempting to engage with and stop a vehicle.

⁸ Record of interview page 3

⁹ Statement of Assistant Commissioner Narelle Beer p16

38. In this case, the main issue relates to the second element, whether police believed that the driver was aware of the requirement to stop. Given that the police were at the intersection visible to all cars approaching with red and blue lights flashing, that they jumped into their vehicle and chased believing that the driver was avoiding the RBT and that when they chased, the driver accelerated away from them, there were in my view, reasonable grounds to hold the requisite belief.
39. Whether or not it was a pursuit is important to police because there are significantly more reporting requirements. For instance, there is a requirement to contact the police communications centre or, if remote, the senior member on duty so as to have a ‘pursuit controller’ overseeing the pursuit. That was not undertaken in this case partially because of the limits of communication in remote areas and that the only two police in the area were in the police vehicle. There is nothing in the General Order to disqualify the passenger from being the pursuit controller when also the ‘senior member on duty’, although I doubt that is not the intent of the provisions. There is also a requirement that once a pursuit is terminated the police vehicle must stop.¹⁰ The police vehicle took another 5 kilometres to stop. However, in my opinion, any non-compliance with the Order is unlikely to have contributed to the tragedy.
40. I was urged by counsel for the family to find that police should not have pursued. Although it was said police were entitled to try and stop the vehicle, it was submitted they should not have pursued. Quoted were comments I made in the findings into the death of Annette Kunia in 2003:
- “the starting premises should be that such pursuits ought to be rare, exceptional and to be avoided if at all possible”.
- The issue in that case was police pursuing a vehicle with 10 people in it over 9.2 kilometres until it crashed.
41. Given my view that police were entitled to attempt to stop Kumanjayi Bloomfield, the question is whether they should have disengaged at an earlier time. The police pursued the white Subaru from their position at the RBT station for approximately 30 seconds

¹⁰ Emergency Vehicle Driving and Pursuit Driving General Order para 58(4)

over a distance of 720 metres. The evidence was that when police got to 110 kilometres per hour and the white Subaru was still pulling away from them they disengaged.

42. The Remote Sergeant said that they disengaged once it was realised that Kumanjayi was not going to stop. It was not suggested to him that he should have realised at an earlier time that Kumanjayi was not going to stop. In my view the police disengaged at an appropriate point in time.
43. It should also be noted that after the police disengaged, Kumanjayi drove another five kilometres and likely did not know the police had given up the chase. That was primarily to do with the dust generated by his vehicle. The dust would have been there from the moment he accelerated and as such, whether police stopped at some unspecified earlier point, it is unlikely to have made a difference to the outcome.

Cultural misunderstandings and 'protocol breaches'

44. Family saw Kumanjayi Bloomfield leave the community in the white Subaru. Some heard sirens shortly after and then saw the ambulance leave. They thought something might have happened to Kumanjayi and sent two of his cousin-brothers to find out what had happened. The two men drove down the bypass to the Plenty Highway.
45. At the bypass end of the crash site they came across the Remote Sergeant. He had his body worn in operation. They stopped the vehicle. The officer confirmed it was the white Subaru that had crashed and that the clinic had already been out. They said they had come to find out because he was one of their cousins.
46. The officer said that because they had been doing random breath testing and the deceased had avoided it, the detectives, major crash and the senior sergeant were coming out from Alice Springs. The officer said he didn't want trouble out there and when he was relieved by other police he would talk to the community. The cousin-brothers indicated that the deceased had been drinking and confirmed he was "Patrick from Huckitta". They turned the car around and left.
47. The sister of Kumanjayi said that in their culture it is proper for the cousin-brothers (or brothers and sisters) to see the body of a deceased person first. She was of the

understanding that the Remote Sergeant told the cousin-brothers they had to turn around and go back to Harts Range. That is said to have prevented them from seeing the body.

48. The body worn video of that conversation does not support the version that the cousin-brothers were told to turn around. However, it would be a reasonable assumption on their part that they could not go any further, given that they were met by a police officer guarding the scene. In evidence that officer said that given that there were only two officers and each of them was guarding one end of the scene it would have been difficult to show the cousin-brothers Kumanjayi's body but he recognised that he should have found a way to facilitate that viewing.
49. The family made the assumption that Kumanjayi's body would be taken to the Health Clinic where they would be able to see it before it was taken from the community. However, because as Kumanjayi had died at the scene and no medical intervention was appropriate, he was not taken to the Clinic. He was transported directly from the scene just after midnight to the Alice Springs mortuary by a civil contractor (Central Funerals) at the request of the coroner's constable. The family saw his body at the mortuary a week later but were sad they didn't get a 'last look' in the community, an environment they knew and trusted.
50. Unfortunately that led to suspicions on the part of the family. Those suspicions deepened when the police vehicle was transported out of the community, also late at night. Kumanjayi's sister said:

“We are still wondering why the Police had to get their tow truck out in the middle of the night when their story is that there was no damage done to their car. It costs lots of money to tow cars from Harts Range to Alice Springs, especially in the middle of the night. It made me and my family think there was something wrong with the Police Landcruiser. It made us think that maybe the Police Landcruiser was more involved in Kumanjayi Bloomfield's accident than what Police have told us.”¹¹

51. It was explained by the Major Crash investigator during the inquest that it is normal practice to examine a police vehicle involved in such a situation to rule out any closer involvement and to check the on-board electronics (although in this case the vehicle had

¹¹ Paragraph 28

been driven back to the community by the time it was towed).¹² He was not aware why it was removed late at night.

52. It was also said by family that they were denied the opportunity to have a smoking ceremony for the white Subaru while it was at the police compound. However the evidence is to the effect that the family did undertake a smoking ceremony that was facilitated by the police at short notice.¹³

53. Assistant Commissioner Beer provided evidence of considerable effort by Police to improve the cultural competency of its members. That included:

- i. Induction and training into the environment of each community;
- ii. Formation of a new Community Resilience and Engagement Command; and
- iii. Recruitment of more Aboriginal Liaison Officers by the end of July 2021.

Communication with the family by police

54. The day after the crash, that is, Friday 26 July 2019, the Acting Superintendent and the Detective Sergeant of the Major Crash Unit spoke with family in Atitjere. There however remained significant suspicions. Those were said to be related to the removal of the police vehicle from the community under cover of darkness and the refusal of police to allow the community to talk to the two officers involved. It was said that there were either threats of payback or suspicions there may be payback. There was said to be a threat to drive through the front of the police station.¹⁴

55. In response, the Acting Commander travelled to the community the following day, the Saturday. A meeting was held at the oval. He thought there was some progress. He said he appealed for peace. He then spoke to family separately. He said it was apparent that the community was still unhappy. He recalled their concerns being that they had not had the opportunity to look the police officers in the eye and have their own conversation with the officers about what had happened. Some important family members were not in

¹² Transcript p58

¹³ Transcript p62 and an alternate version was not put to the police witness by counsel for the family.

¹⁴ Transcript p14

the community at that time and the Acting Commander promised to keep returning to the community until the family was satisfied.

56. The Acting Commander returned on the following Tuesday, 30 July 2019. He estimated that there were around 150 to 200 community members present.¹⁵ With him were the two officers involved. However concerns persisted, particularly in relation to the necessity to move the police vehicle at night, not being able to access the crash scene, an inability to view Kumanjayi's body before leaving the community and the belief that it was a corrupt investigation.¹⁶ It was said by family that the Acting Commander told them that Kumanjayi was thrown through the front windscreen during the rollover. That was in conflict with the family's assessment, because the Subaru's windscreen was still relatively intact. During the inquest the Major Crash Unit investigator said that they did not find evidence of which window Kumanjayi was thrown through, but it certainly wasn't the windscreen.

57. The crash scene itself generated suspicions. Kumanjayi's sister said:

“My family and I do not think that the Police told us the full story about how the crash happened. The tyre tracks that my family saw on the Plenty Highway were dug deep into the dirt road. Also, my family only saw two sets of tyre tracks. This made my family feel confused. My family and I have seen lots of tyre tracks for a single car rollover on a dirt road before. Normally there are three or four tyre tracks that skip across the surface.”

58. The family said the community was never told why there were so many police involved in the investigation and that, “it felt like it was my family who was under investigation, not the police”.¹⁷

Length of time before investigation brief provided to Coroner

59. There have been a number of investigations not completed in a timely fashion that caused evident and continued grief to families. Two of the most notable were the investigations into the deaths of Kieffen Raggett and Sasha Green. In this case if the investigation had been completed in a timely fashion there would not have been over 18

¹⁵ Transcript p17

¹⁶ Transcript p18

¹⁷ Narella Bloomfield paragraph 35

months for the suspicions to grow. By the time of the inquest it was obvious that throughout that lengthy period of time the family had not only had their grief extended but had become convinced that the full facts had been kept from them by police.

60. Assistant Commissioner Beer stated:

“So, when a death in custody occurs there is a general order that would say that the findings or the final report needs to be submitted within six months. If it can’t be submitted within six months then there should be a process where it goes before a JMC, a joint management committee, and progresses through to the deputy commissioner of crime ... who would then consider whether an extension would be granted or not. My understanding ... is that there wasn’t a JMC, a joint management committee, and it wasn’t progressed. And I believe that it was at that time where there was some significant movement in the executive. So, that’s a failure of governance within the police hierarchy.”

Comment

61. There is sufficient objective evidence in the form of body worn video and the evidence of the tourists to be satisfied that the circumstances of Kumanjaya’s death were as revealed by the police investigation. I note also that the family were most ably represented at the inquest and their lawyer did not put alternative facts or another scenario to the officers. However, convincing as that evidence may be, it is unlikely to immediately quell the suspicions held by the family for a lengthy period of time. In this case more than 18 months has passed during which the family have been left believing that they have not been told the truth.
62. There is a significant overlap between the expressed cultural breaches of protocol or misunderstandings and the family being given sufficient access to the body, the scene and the vehicles to make their own assessment as to what happened. It is appropriate that family is provided the information and opportunity to make their own assessment. That is particularly important where police are involved in the circumstances of the death.
63. The issue is not new. As submitted by counsel for the family, it formed the basis for recommendations made by the *Royal Commission into Aboriginal Deaths in Custody in*

1991 and has made its way into the Police General Order. The Royal Commission, recommendation 25 states:

“That unless the ... Coroner ... otherwise directs ... in writing ... the family of the deceased or their representative should have a right to view the body, to view the scene of death ... If the Coroner directs otherwise, a copy of the direction should be sent to the family and to the Aboriginal Legal Service.”

64. The commentary in Volume 1 of the Report is in these terms:

4.6.15 Relatives of the deceased should be given the opportunity to see the body of the deceased at a very early stage following the death. In a number of cases investigated by the Commission, the fact that the deceased's body was removed from the place of death for an autopsy prior to the relatives being given an opportunity of viewing it, resulted in concern and suspicions being aroused. In the New South Wales case involving the death of Lloyd Boney the deceased died in a police cell as a result of hanging in Brewarrina in 1987. His body was taken out of town within an hour of being discovered and before any attempt was made to notify any relative. This caused the family a great deal of grief and concern.

4.6.16 Although viewing the body may be very distressing to the family, it should be their choice as to whether or not they wish to see it. Sometimes, family members wish to see the deceased and, in effect, say goodbye. Alternatively, the family may well nominate a representative to view the body on their behalf. In every case it is important that there should be an opportunity to view the body and for the family or their nominated representative to satisfy themselves that there are no suspicious marks or indications of violence. Often, it is better if this occurs prior to autopsy as the conduct of an autopsy may have the effect of accentuating any marks on the body and give rise to unfounded suspicions of foul play.

4.6.17 The major objection to allowing relatives access to the body is, of course, the possible risk of interference and contamination of the body from a forensic science perspective. Some mortuaries have instituted procedures which allow for the viewing of the deceased through a glass partition or with a police officer present. However, a physical barrier or the presence of a police officer at this time may cause the relatives additional pain. Although restrictions may need to be placed on the manner in which the body of the deceased is made available to the view of the family, it is important that the family's right to view the

body should be recognised. Blanket refusals of access are simply not justified.

4.6.18 In many instances families of the deceased and their legal representatives have been denied access to the place where death occurred, especially where the deceased died within a custodial setting. Although the coronial and police investigations need to take precedence to ensure that the scene of death is properly examined, photographed and inspected following the death, refusal by custodial authorities to relatives' requests to see the place where the deceased died generally increase the frustrations, anxieties and suspicions of the family. Relatives of the deceased should be given access to the place of death, although access may have some restrictions placed upon it and may be undertaken in the company of custodial authorities. Once again, openness about such a matter assists in allaying unfounded fears concerning the manner in which the deceased died.

65. The Police General Order '*Deaths in Custody, and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public*', at paragraph 25.12 states:

“Unless the Coroner conducting the inquiry otherwise directs, and providing the viewing does not prejudice the conduct of the investigation, members of the deceased’s family, or a nominated representative thereof, should be permitted to view the body or a scene of death as soon as it is reasonably practicable.”

66. There will undoubtedly be cases where due to the type of investigation such access cannot be facilitated at an early time and that is the reason for the General Order requiring that such cases be referred to the Coroner for a direction. However in other cases, and this case is one of those, it should be possible to involve a nominated member or members of the family in viewing the body, the scene and in this case, the vehicles involved and providing an overview of what police are doing at the scene and in the community.

67. That would provide the family and community with transparency as to what is being undertaken by Police in the aftermath of the death and allow the family to make their own assessment. It must be remembered that a family and community will make their own assessment in any event and it is desirable that such an assessment be made with the benefit of appropriate information.

Recommendation

68. I **recommend** that the Commissioner of Police provide sufficient training and supervision to ensure that families are provided timely viewings and information so as to enable them to make their own assessments of the circumstances and cause of death, particularly when police are involved in those circumstances.

Dated this 1st day of April 2021.

GREG CAVANAGH
TERRITORY CORONER