CITATION: *Inquest into the death of Robert James Hodgkinson* [2000] NTMC 49

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	9918655 111/99
DELIVERED ON:	14 June 2000
DELIVERED AT:	Katherine
HEARING DATE(s):	13 June 2000
JUDGMENT OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Coroners - Coronial Inquest - death in custody - police pursuit – fire extinguishers

REPRESENTATION:

Counsel:

Counsel assisting the Coroner:	Ms Elizabeth Morris
Counsel for Northern Territory Police:	Mr Michael Whelan

Solicitors:

Police:	Mr Greg McDonald

Judgment category classification:	A
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IN THE CORONERS COURT
AT KATHERINE IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 9918655

In the Matter of an Inquest into the death of

ROBERT JAMES HODGKINSON

FINDINGS

THE NATURE AND SCOPE OF THE INQUEST

1. At about 0100hrs on the 15th of August 1999 Robert James Hodgkinson ("the deceased") drove his vehicle onto the incorrect side of Florina Road, Katherine, then drove off the road and collided with a large tree. His vehicle was being followed by police officers at the time with the apparent intention of apprehending the driver. As a result of the collision the vehicle caught on fire, and the deceased was incinerated. The death is properly categorised as a death in custody. The deceased was a "person held in custody" within the definition in s 12(1)(a)(i) and (c) of the *Coroners Act 1993* (NT) ("the Act"), in that he was a person in the process of being taken into or escaping from the custody or control of a member of the Police Force.

2. The death is a "reportable death" which is required to be investigated by the Coroner pursuant to s14 (2) of the Act. Also, as a consequence of the deceased dying in custody, a mandatory public inquest must be held pursuant to s15 (1)(c) of the Act. A further consequence is that the scope of the inquest is governed by the provisions of s 26 and 27 as well as s 34 and

35 of the *Coroners Act.* It is convenient and appropriate to recite these in full.

> "**26. Report on Additional Matters by Coroner**
>
> (1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –
>
> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and
>
> (b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.
>
> (2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.
>
> **27. Coroner to send Report, &c, to Attorney-General**
>
> (1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.
>
> (2) Where the Attorney-General receives under subs (1) a report or recommendation that contains comment relating to –
>
> (a) an Agency, within the meaning of the Public Sector Employment and Management Act, the Attorney-General shall, without delay, give to the Minister a copy of the report or recommendation; or
>
> (b) a Commonwealth department or agency, the Attorney-General shall, without delay, give to the Commonwealth Minister who has the responsibility for the department or agency, a copy of the report or recommendation.
>
> (3) The Attorney-General shall present a copy of each report or recommendation referred to in subs (1) to the Legislative

Assembly within six (6) sitting days of the Assembly after receipt by the Attorney-General of the report or recommendation.

34. Coroners' Findings and Comments

(1) A coroner investigating –

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

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

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

(v) any relevant circumstances concerning the death.

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

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

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

35. Coroners' Reports

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

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

(3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director

of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

3. The public inquest into the death commenced on the 13th of June 2000 at Katherine. The evidence concluded on the same day. Ms Elizabeth Morris appeared as counsel assisting the coroner. Mr Michael Whelan appeared as counsel for the Northern Territory Police. I made an order pursuant to s43 (1) (c) of the Act suppressing publication of the name of the deceased or any details that may identify him. I continue that order.

4. The following witnesses were called and exhibits tendered:

1. John Graham Hodgkinson
2. Dr David Arnold Brummitt
3. Detective Sergeant Kris Evans – OIC Coroner's investigation
4. Senior Constable Virginia Read
5. Constable Angelo Giacinto DeNale
6. Constable Michael Deutrom
7. Peter Bentley, Fire Service Officer
8. Sergeant Kerry Gordon James
9. Senior Constable Kenneth John Flood
10. Matthew Elliot, Chubb Fire, by telephone conference
11. Station Officer Ian McLeod, Fire Safety Unit
12. Peter John Campbell: Manager Fleet Services

Exhibits

1. The Police Investigation File, including all statements

2. Taped records of conversation

3. Three fire extinguishers

4. Internal Police Memorandum

5. Northern Territory Police letter and memo re Fire Extinguishers in Police Vehicles

6. Birth Certificate of the deceased

CORONER'S FORMAL FINDINGS

1. The identity of the deceased was Robert James Hodgkinson, a male Caucasian born on the 2nd of March 1976.

2. The time and place of death was at about 0100hrs on the 15th of August 1999 at Florina Road, Katherine, approximately three kilometres west of the intersection with Zimmin Drive.

3. The cause of death was incineration from a motor vehicle accident in which the deceased was a driver.

4. The particulars required to register the death are:-

    i. The deceased was a male.

    ii. The deceased was of Australian non-Aboriginal origin.

    iii. The cause of death was as per clause (3) above.

    iv. The death was reported to the Coroner.

    v. The death was confirmed by post-mortem examination.

vi. The pathologist (Dr Michael Anthony Zillman) viewed the body after death and carried out the post-mortem examination.

vii. The mother of the deceased was Wendy May Hodgkinson (nee Morrison) and the father was John Graeme Hodgkinson.

viii. The deceased normally resided at 6 Victoria Highway, Katherine in the Northern Territory of Australia.

RELEVANT CIRCUMSTANCES, REPORTS AND COMMENTS

The Deceased

5. The deceased at the time of his death was 23 years old. He was born in Ipswich in Queensland and moved with his family around Queensland, the Northern Territory, New South Wales and Victoria. He received formal schooling to the age of 14 and nine months. He was employed as a mechanic's assistant for three years. After that he had a sporadic employment history. The deceased had left home by 18, but kept in regular contact with his parents.

6. In 1993 the deceased formed a de facto relationship. The deceased was prone to bouts of depression that caused stress on the relationship. In about April of 1997 the deceased attempted to take his own life by hanging, however his partner saved him. The relationship broke up finally in mid 1998. In about August of 1998 the deceased again attempted to take his own life by hanging, but was unsuccessful. After this attempt the deceased received treatment for his depression, and was prescribed Zoloft.

7. The deceased moved to Katherine to live with his parents in June of 1999. His father was and is a Minister of Religion responsible for the Katherine Parish of his Church. The deceased received treatment from Dr Brummitt,

who prescribed a further course of Zoloft. Dr Brummitt arranged appointments with the Katherine Mental Health Service, however the deceased did not keep these appointments. In early August 1999 a friend of the deceased committed suicide, exacerbating the deceased's depression.

The deceased's medical history

8. Evidence was tendered and witnesses called in relation to the deceased's medical history, including history of depression and mental illness. Dr Brummitt, a local Katherine doctor, saw the deceased on two occasions. On the 29th of June 1999 he initially presented with a respiratory infection, but it became obvious that the deceased also suffered from depression. After hearing his medical history, Dr Brummitt prescribed Zoloft at an increased dosage to the previous dose the deceased had used. The deceased also gave the doctor a history of three failed suicide attempts.

9. Dr Brummitt saw the deceased again on the 4th of August 1999. Whilst presenting as depressed, the deceased denied any suicidal thoughts. Dr Brummitt arranged for the deceased to see a worker from the Katherine Mental Health Team. Correspondence received by the doctor indicated that the deceased did not keep that appointment. Dr Brummet in evidence thought that in hindsight he may have been able to do more for the deceased. However I can make no criticism of his treatment or recommendations for the deceased.

Events leading up to the death of the deceased

10. On the night of Saturday the 14th of August 1999 the deceased consumed a bottle of wine with his father. Mr Hodgkinson stated that his son appeared in a good mood. At approximately 10.30pm the deceased telephoned his ex de facto, Ms Joanna Barstow. The conversation ended amicably near midnight, although it would appear that the deceased wanted to keep talking.

At some stage that evening the deceased consumed another bottle of wine by himself.

11. Sometime between midnight and 12.30hrs the deceased must have written a note which he attached to the refrigerator. The note read;

"I love you both very much. Please look after Mong. Im sorry, Rob."

12. At about 12.30am on the 15th of August Mr Hodgkinson was woken by a loud noise. He found that one of the parish vehicles, a Toyota Camry had been driven through the locked gates of the yard. He then notified police that the car had been stolen. At around the same time Senior Constable Read saw a vehicle with panel damage and a possible flat tyre, drive across the bridge in the Darwin direction. It appeared to her that the driver may be intoxicated, and may have been involved in an accident. She gave evidence that the driver seemed to be transfixed, staring straight ahead. She notified the Communications section for a patrol unit to attend and investigate.

13. There were two police units on duty that night. The Supervisor was Senior Constable Flood in a police sedan, and Constable DeNale and Deutrom in a police marked van. Both units overheard the communication and went to the High Level Bridge. They arrived at around the same time, with Flood in front. Senior Constable Read also joined in and bought up the rear. After crossing the bridge they went separate ways in a search for the vehicle, Flood going straight ahead, Read going to the right, and the other vehicle turning left.

14. Constables DeNale and Deutrom caught up with a vehicle, initially not believing it was the vehicle they were searching for. However has they attempted to overtake the vehicle, they realised it was the suspect car, due to the panel damage. They then activated the Police siren and flashing lights and attempted to intercept the vehicle. The driver of this vehicle was the

deceased. The police were not aware at that stage who the driver was, nor that the vehicle had been reported stolen.

15. The deceased continued along Florina Road, however did not increase or decrease speed from an estimated 80/km/hour. The speed limit in that area was 100/km/hour. The police followed at about the same speed with lights and sirens for approximately two kilometres. Without physical warning, the deceased's vehicle then veered off to the right side of the road and collided with a large tree. The police gave evidence of the lack of warning, such as no brake lights or indicators, of the manoeuvre. On all of the evidence I find that the collision was deliberate.

16. Police immediately stopped their own vehicle in order to render assistance. They found the deceased unconscious and firmly trapped in the vehicle. At this time the deceased's car caught fire. Assistance was called for, and the two members attempted to free the deceased and extinguish the fire using the police vehicle fire extinguisher. They were unsuccessful and the fire took hold. The presence of leaking fuel and dry grass, no doubt, made such extinguishment attempts very difficult if not futile. Senior Constable Flood on arriving at the scene also attempted to free the deceased and extinguish the fire, as did Senior Constable Read. All attempts failed. The deceased was incinerated.

17. All four police officers gave evidence before me. They were all affected in some way by the events of that night. In recalling their actions, terms such as "frantic" and "desperate" were used. They used everything possible at their disposal in order to extinguish the flames. This included the use of a bottle of "Coke" sprayed into the dashboard of the car. At one stage they were scrabbling around on their hands and knees gathering handfuls of dirt and sand in order to throw them on the fire. They also tried every option in endeavouring to pull the deceased from the vehicle.

18. The Senior Police officer present eventually had to admit defeat, and ordered the Constables to stand back from the vehicle for their own safety.

19. The fire service arrived shortly afterwards to find that the vehicle was completely engulfed in flames. The fire service extinguished the fire by the use of a hose, and ultimately needed to use hydraulic equipment in order to free the deceased's body.

CORONIAL INVESTIGATION

20. The Coroners Act sets out the need for independent investigations to be carried out under the direction of the Coroner. Detective Sergeant Kris Evans and his officers carried out their investigations in accordance with the requirements of Police General Order D2. That General Order specifically relates to the Investigation and Reporting of Deaths in Custody. Paragraph 3.2 directs that each investigation into the death of a person held in custody be carried out on the presumption that it is a homicide. Paragraph 3.5 provides that the investigation is to be conducted by experienced investigators, and that the officer in charge should be of or above the rank of Superintendent. The member in overall charge of an investigation is to liaise with counsel assisting the Coroner, and carry out the directions given by the Coroner. (Paragraph 3.7)

21. Detective Sergeant Kris Evans gave evidence and through him was tendered the Coronial Brief of evidence. I congratulate Sergeant Evans on a well-prepared and thorough investigation. He concluded that the deceased took his own life. I accept this sad conclusion. The evidence being the note, the manner of the accident, the presence of the vacuum hose, and the deceased's previous depression.

Forensic Examination

22. In pursuance of the investigation a number of forensic examinations were conducted.

23. At the direction of the Coroner, Doctor Michael Zillman conducted a post mortem on the 17th of August 1999. A copy of his report has been tendered in this Inquest. In his opinion the cause of death was incineration from a motor vehicle accident where the deceased was a driver. I accept that opinion.

24. Toxicology results revealed that the deceased had a blood alcohol content of 0.102%. Six percent of haemoglobin in the blood was in the form of carboxyhaemoglobin, which is a non-fatal concentration. No common drugs were detected in the blood of the deceased.

25. Doctor Zillman found that the deceased had head injuries which were "consistent with the effects of blunt trauma sustained at the moment of vehicle impact, and suggest that the deceased was unconscious at the time of the vehicle fire." He further states "The low carboxyhaemoglobin saturation and the absence of soot deposition in the lower airways indicate that death was very rapid".

26. Alan Bond, a transport and Works vehicle inspector examined the vehicle driven by the deceased. His statement has been tendered in this Inquest. Although the vehicle was extensively damaged, Mr Bond could find no evidence of any contributing defect that may have been present in the vehicle prior to the accident.

27. Dr Peter Thatcher and other members of the Police Forensic Section also examined the vehicle. Whilst not definitive, the most logical cause of the fire is that the fuel injection pipes were snapped from the engine on the impact of the vehicle with the tree. This caused a fuel leak, which was ignited by an electrical current.

28. During the examination of the vehicle, the remains of a domestic vacuum cleaner hose were discovered on the passenger side floor of the vehicle. Such a hose was found to be missing from the Hodgkinson family home. No

other logical explanation could be offered for its presence in the vehicle, but that the deceased put it there with the apparent intention of using it to suicide.

Duty of Care

29. The police vehicle followed the deceased's vehicle for about two kilometres, with lights and sirens activated. They intended to apprehend the vehicle. The attempted apprehension of the deceased was not called in to the Communications section as a "pursuit" by either of the two Constables. The pursuit was not of "high speed" and was not increasing in speed. Constable DeNale felt that no one was in immediate danger. The police vehicle was about 50 metres behind that of the deceased.

30. I have been presented with no evidence that the deceased was "forced" off the road by the police vehicle. They were not travelling at high speed, they were indicating through lights and sirens that the deceased should pull over or stop. The movement of the deceased's vehicle off the road was sudden and apparently deliberate. Accident investigation of the scene that night by Sergeant James, a qualified accident investigator, found no reason for the vehicle to swerve, nor any braking or deceleration marks.

31. Constables DeNale and Deutrom were those immediately on the scene at the time of the crash. Their actions can be described as heroic attempts to rescue the deceased, using everything at their disposal. Due to the damage to the vehicle the only door that could be opened was the rear passenger door. Deutrom entered the vehicle through this door in attempt to free the deceased. The vehicle was on fire at this stage. Fire extinguishers retarded the fire at an early stage, but could not put it out. A bottle of soft drink was used, finally the officers, including Flood and Read, resorted to handfuls of dirt in order to try and extinguish the fire.

32. Constable Deutrom was in the cabin of the vehicle trying to release the deceased. The cabin would have been filled with noxious fumes. Constable Deutrom received a number of burns to his arms from the molten plastic whilst inside the vehicle in his valiant attempt to free the deceased. Senior Constable Flood also received minor burns to his hands. Constable DeNale gave evidence of being affected by smoke and fumes.

33. Sadly they were not successful, but it is my view that the members involved showed commendable courage in their attempts to assist the deceased after the accident. Indeed, in my view they put their lives at some risk in attempting to remove the deceased from the crashed and burning vehicle. Mr and Mrs Hodgkinson also wished to publicly express their thanks to the police and fire officers who attempted to assist their son. I allowed them that opportunity at the Inquest.

Police Equipment and Training

34. Evidence was before me that some of the small standard fire extinguishers available in the police vehicles on that night did not function properly. Station Officer McLeod, after hearing the evidence, thought the reason to be a lack of propellant. It is a simple measure to check the gauge on an extinguisher for available propellant. This should have been done on a regular basis. I do not find that this fault contributed to the death.

35. As a result of this death, the Assistant Commissioner, Operations Command issued an internal memorandum very promptly (within a fortnight), dealing with the need to properly maintain fire extinguishers in police vehicles. This memo authorises, amongst other things, extinguishers to be checked, tipped and shaken, every fortnight.

36. More recently on the 8th of June 2000, a new directive was issued authorising maintenance checks at least every month. The text of that

memorandum is to be e-mailed to all police officers and published in the Police Gazette.

37. Mr Matthew Elliot, an employee of Chubb Fire who gave evidence over the telephone, also suggested training in the use of fire extinguishers. He suggested annual refresher courses. Mr McLeod recommended recruit training, but did not see the necessity for annual courses.

38. Mr Elliot also recommended if possible the provision of a larger fire extinguisher. Whilst obviously a large extinguisher would be able to be used for a wider number of fire situations, there are practical problems. I accept the evidence of Mr Peter Campbell that fitting such an object to standard police vehicles would cause difficulty and some danger. Whilst police vehicles are emergency units, they are not fire tenders, nor are police officers, fire officers. They should, however, be familiar with the use of extinguishers, and given basic instruction in their use.

Conclusion and Recommendations

39. After hearing and reading the evidence in this sad case, I am of the opinion that the deceased intended to take his own life, by deliberately steering his vehicle into the tree with which he collided.

40. The actions of the police officers did not contribute to the decision, and did not aid his suicide. I have earlier made acclamation of their efforts to save the deceased. In my view they ought to be commended for their actions.

41. I do recommend that training in an accredited course in fire equipment operation should be carried out as part of police basic training.

42. I also commend the adoption of the Assistant Commissioner's approved memorandum in relation to fire extinguisher maintenance. A copy of that memorandum is attached to these findings at Attachment "A".

Dated this 14th day of June 2000.

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Greg Cavanagh
Territory Coroner

Fire Extinguishers in Police Vehicles

Far the safety of the public and members alike it is necessary to ensure that all Fire Extinguishers in Police Vehicles are maintained in goad working order. It is important that extinguishers are shaken regularly to ensure proper performance.

To achieve this ever fire extinguisher is to be physically checked;

- ❖ Each month when the mileage of that vehicle is obtained for recording.
- ❖ Whenever the vehicle is serviced.
- ❖ Whenever a changeover of a vehicle occurs.
- ❖ After any use of the fire

A check of the pressure gauge is to be male to gee if the fire extinguishers are fully charged. The extinguishers are also to be shaken each time they are checked arid the hold-down brackets an
the vehicles arc to be inspected to ensure serviceability. If a fire extinguisher is not fully charged the unit is unserviceable, immediate steps are to be taken through the Mechanical Workshops or the relevant local contractors to have the extinguisher replace,.

APPROVED

ASSISTANT COMMISSIONER
JUN 2000
OPERATIONS COMMAND