CITATION: *Inquest into the death of Cedric Trigger* [2010] NTMC 036

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0002/2009
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HEARING DATE(s):	9, 10, 11 and 12 March 2010
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Death in custody, Role of watch house keeper, watch house procedures, risk assessment of intoxicated prisoners

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Commissioner of Police	Mr John Stirk
Family of deceased	Mr Ted Sinoch (CAALAS)

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

No. A0002/2009

In the matter of an Inquest into the death of

CEDRIC TRIGGER
ON 10 JANUARY 2009
AT ALICE SPRINGS POLICE STATION

FINDINGS

19 May 2010

Mr Greg Cavanagh:

INTRODUCTION

1. Mr Cedric Trigger was arrested by Northern Territory police members some time after midnight on Friday 9 January 2009 and conveyed to the Alice Springs Watch house. Less than two hours later, he was found not breathing on the floor of a police cell within the Alice Springs watch house, and formally pronounced deceased at Alice Springs Hospital at 3:40am after all appropriate resuscitation efforts had proved unsuccessful. A post mortem examination found the cause of death to be a subdural haemorrhage resulting from a blunt head trauma. At the inquest, the circumstances leading to the deceased's death were examined in detail.

2. My jurisdiction to investigate this death and to hold a public inquest arises from ss 12, 14 and 15 of the *Coroners Act*. Because the deceased was in custody at the time of his death, this inquest is mandatory pursuant to section 15 of the *Coroners Act*.

3. His death was investigated on my behalf by Detective Sergeant Isobel Cummins along with other members of the Major Crime Unit based in Darwin. That investigation was carried out in accordance with Police

General Order D2. The investigation was of a high standard. A detailed and complete investigation brief was submitted to my office within four months of the death. I make particular comment about this given my criticisms about unwarranted delays and/or substandard investigation files in other matters. I am pleased to say that the opposite occurred in this case.

4. Counsel assisting me at the inquest was Ms Helen Roberts. Mr Trigger's mother and other family members attended the inquest and their interests were represented by Mr Ted Sinoch of the Central Australian Aboriginal Legal Aid Service. The Commissioner of Police and the police witnesses were represented by Mr John Stirk, on instructions from the Solicitor for the Northern Territory.

5. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(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.

6. Section 26 of the Act provides:

> "(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."

FORMAL FINDINGS

7. In order to make the findings required by s 34 (1) and consider the matters I must consider under s 26, I had tendered in evidence before me the following material: the birth certificate of the deceased (Exhibit 1), an investigation brief of multiple folders containing witness statements, reports, policies and other documents as well as some additional witness statements tendered separately (Exhibits 2, 4-6); a disc containing footage from the Alice Springs watch house, and two discs containing "re enactment" interview of witnesses (Exhibit 3). I heard oral evidence from Detective Sergeant Isobel Cummins, Tom Miles, Steve Thompson, Constable Corey Brown, Constable Jason Mather, Constable Benjamin Streeter, Sergeant Dave Chalker, Constable Ricardo Da Silva, Constable Christopher Thurgood, Aboriginal Community Police Officer Annie Curtis, Senior Constable Tanya Mace, Dr Nigel Buxton, Dr Marguerite Harding, Commander Anne-Marie Murphy.

8. Pursuant to section 34 of the *Coroners Act* I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased person is Cedric Trigger.

(ii) The time and place of death was approximately 3:00am in the Alice Springs police station.

(iii) The cause of death was a subdural haemorrhage resulting from a blunt head trauma. .

(iv) Particulars required to register the death:

1. The deceased was born on 17 May 1976 at Alice Springs hospital.

2. The deceased was of Aboriginal descent.

3. The death was reported to the Coroner.

4. A post mortem examination was carried out by Dr Terrence Sinton.

5. The deceased's mother was Judy Ukambari and his father was Derek Wantentang Trigger.

6. The deceased usually lived at Mutitjulu.

7. The deceased was unemployed.

CIRCUMSTANCES CONCERNING THE DEATH

Background

9. The deceased was born on 17 May 1976 at Alice Springs hospital. He was from Mutitjulu community. His mother, Judy Trigger, attended the inquest and her interests were represented by Mr Sinoch of the Central Australian Aboriginal Legal Aid Service. I thank him for his assistance to the deceased's family and to the court.

10. The deceased had a criminal history which included alcohol related offences and assaults upon his wife Janet Miller with whom he had two children. A domestic violence order against him had expired on 30 October 2008. As a result of a further alleged assault upon his wife in November 2008, the deceased was wanted for questioning by police and had not been located by

them prior to 9 January 2009. As at 9 January 2009 there was also a "bench warrant" appearing on the police system, for the deceased's arrest in relation to a drink driving charge.

11. In the days leading to this incident, the deceased's wife and children had been staying at Stuart Lodge, a short term accommodation facility within Alice Springs town. The premises are locked at night and a security guard is employed overnight to ensure that only residents are allowed to enter. On the evening of 7 January 2009 a security guard contacted police to report that the deceased was intoxicated, and had been throwing rocks or bricks at the property when he was refused entry. Police attended but were unable to locate him at that time.

Events at Stuart Lodge

12. On 9 January 2009, the deceased, Ms Miller, and a number of other people had spent the afternoon drinking on the lawns of the Royal Flying Doctor Service across the road from the Stuart Lodge. At about 10pm Ms Miller returned to the Lodge. Despite speaking with a number of witnesses, investigators were unable to ascertain what the deceased did for the next few hours. Detective Cummins therefore cannot positively exclude the possibility that he suffered some relevant injury during that time.

13. Tom Miles was the security guard on duty overnight at Stuart Lodge, commencing his shift late on 9 January 2009. At about 12:45am on 10 January 2009 he noticed a man (who was the deceased) near the fenceline within the property. He approached him, told him that he had to leave and started walking him towards the exit gate. On the way they passed Steve Thompson who was sitting on a bench having a coffee. Mr Thompson was a temporary resident of Stuart Lodge. He had finished a shift as a security guard elsewhere and was still wearing his uniform. He recognised the deceased and said to Tom Miles something to the effect that the man was "trespassed" from the Lodge for causing trouble a few nights earlier. Mr

Miles understood this as a reference to the events of 7 January and recalled a report he had read about this. He said to the deceased that he was going to call the police. Upon hearing this information, the deceased, who had been cooperative to this point, became agitated and ran towards the locked fence. As Mr Miles spoke on the telephone, Mr Thompson saw the deceased climb up and over the locked gate, in a single fast motion which Mr Thompson described as a 'duck dive', headfirst on to the other side.

14. Mr Miles handed Mr Thompson the gate keys and he unlocked the gate, expecting to see the deceased on the other side, injured. It was very dark, and he didn't see anyone. After a brief moment he felt the deceased tackle him from the side and put him through the fence. Mr Thompson said "from there it started into a wrestle" during which he tried to restrain the deceased by getting him into an arm lock (T 66). The deceased continued to struggle but ultimately Mr Thompson restrained him.

15. At 12:54am on 10 January 2009, the police system records a '000' call indicating that 'security at Stuart Lodge is holding a male who has gone through the fence; require police urgently as they are having trouble holding male who is violent'. This followed a similar call a few minutes earlier to the (non-urgent) police assistance line.

16. Both Miles and Thompson were cross-examined as to their interaction with the deceased, and denied inflicting any blows directly on the deceased during the 'struggle' or 'scuffle' on the ground. When the police arrived they saw the two restraining a large Aboriginal man on the ground, adjacent to the damaged fence panels. Thompson told the police that the deceased "took [him] through the fence and [is] solid and strong" (T 73). He did not go into any further detail because he was not interested in getting involved with making statements and becoming involved in any further matters on his own time (T 74). The arresting police had learned that the deceased "had a warrant" and therefore they had grounds for an arrest independent of the

details of the present incident. They did not seek any further information other than the brief description given. Neither Miles nor Thompson told the police that the deceased had apparently fallen headfirst over a fence which was over 2 metres high.

The arrest and transfer to the watch house

17. On that particular night shift there were three 'car crews' on the road. The shift supervisor was Acting Sergeant (senior constable) Tanya Mace. The Watch Commander on the night shift was Peter Winton, who was in fact a senior constable 'acting up' as a senior sergeant (he had completed his sergeant's exams but did not hold the rank of sergeant). Staffing the watch house was Aboriginal Community Police Officer Curtis, and Probationary Constable Thurgood. Probationary Constable Da Silva was dispatching crews to 'jobs' from communications. The Officer in charge of Alice Springs police station (although not working that night) was Senior Sergeant David Chalker. . It would be fair to say that the shift comprised junior to very junior members. I was given to understand that this was not out of the ordinary in Alice Springs, even for a Friday night.

18. The police who arrested the deceased were Constable Corey Brown, who had at that time about 2 years experience in Alice Springs general duties, and Probationary Constable Jason Mather, who had about 6 months experience in Alice Springs general duties (although he had prior experience as a prison officer). It was an effort to handcuff the deceased and place him into the van. He was continuing to struggle and kick out at the officers, and shout, although they could not understand what he was saying. Once they had the deceased in the back of the van they drove directly to Alice Springs police station, a journey of less than five minutes, and parked in the outside entrance to the watch house. That area, as well as the inside of the watch house, is recorded by closed circuit television cameras. They are designed to record audio visually, however, the sound quality was too poor to decipher.

(I heard evidence that the system is to be upgraded to a digital system by May 2010)

19. In their interviews, Constables Brown and Mather described the presentation of the deceased once they arrived at the watch house and opened the back of the vehicle as "refusing to bear his own weight" (T 95) and "slumping to the ground" (T 117). What I saw on the recording was the deceased falling from the tailgate of the police vehicle on to the concrete, and lying there for a few minutes seemingly making a few unsuccessful attempts to sit up. The officers were not assisting him at this time. They then dragged the deceased, face down, still handcuffed, for several metres to the holding cell. Those few minutes captured on the video demonstrated treatment of the deceased – or any person taken into the custody of the police- which was undignified and inappropriate. Neither of the officers had seen the video until the inquest proceedings commenced, and to their credit, both officers were uncomfortable when they saw it. Commander Murphy said it should not have happened (T 201), and I agree.

20. Once the deceased was in the cell, Constable Brown attempted to place him on his side. While he was in the process of doing this, Acting Sergeant Mace ran into the cell and told the two officers to "go go go" to attend an urgent call for assistance from Constable Streeter who was involved in a foot pursuit in a town camp. They immediately left. As they did so, the deceased, still handcuffed, rolled on to his front.

21. Acting Sergeant Tanya Mace was the shift supervisor for the evening. She was in fact in the watch house, dealing with a drink driver, when Brown and Mather arrived with the deceased. She directed Probationary Constable Thurgood to go and assist them to bring the deceased in. She knew that he could not stand up and had to be dragged into the cell but said that this was a "regular occurrence" (T 191). When she ordered the arresting members to leave immediately, her priority was the member requiring back up at a camp,

and that "the male in the watch house could be observed by two watch house staff and I was quite happy with that arrangement" (T 191).

22. Constable Brown also said that he had dragged a person or seen a person dragged into a cell on a number of other occasions, on the basis that if "someone doesn't cooperate with you, you're going to have to get them into the cells one way or another" (T 100). He believed that the deceased was "just an intoxicated uncooperative person". It did not occur to him, nor his partner, Constable Mather, that there could be an explanation for the deceased's non-responsive presentation other than extreme intoxication. Neither did his change of demeanour during the five minute journey (from actively resisting to relatively non-responsive) strike them as unusual.

23. However, the more experienced police members who gave evidence said that they would have held concerns. Senior Constable Winton, for example, said when asked about assessing apparently intoxicated prisoners for risk, "obviously if they're unable to be woken or roused in any way then that would send alarm bells for me" (T 59) and that if he was unable to conduct a risk assessment at all due to the person's state, he would not accept them into the watch house, but have them taken to hospital (T 58).

24. It may be the case that from time to time an uncooperative drunk person needs to be manoeuvred into a cell in a way which is less than dignified. This is a reality. However, in circumstances where a person is so unresponsive that extreme measures such as dragging an inert body are resorted to, this should alert police to the risk inherent in that presentation. Police cannot afford to assume, as they did in this case, that a person who cannot move himself is necessarily only drunk. A person in the deceased's condition should not have been in the watch house, much less left in a holding cell with no risk assessment carried out, for over one hour while the arresting members attended to other matters as occurred in this case.

25. Constables Brown and Mather proceeded quickly from the station to the town camp as directed. By the time they arrived at the town camp, the situation had been resolved such that their assistance was no longer required. They started to return to the station, indicating over the radio that they were returning to "process" their arrest. The communications operator, Probationary Constable Da Silva, directed them to attend two further jobs. The first was a report of a potentially seriously injured woman (which turned out to be less serious than first reported). As they again started to return to the station, Da Silva directed them to go to a pub in town to assist security with an intoxicated person who was refusing to leave. This took them some time. Brown and Mather took the view that it was not their role to "argue with comms" but that they were to attend jobs as directed. Watch Commander Winton said he was not aware at the time that they had left a prisoner in the watch house. A/Sgt Mace said that she heard the radio transmissions diverting them, but did not intervene because she was satisfied that the deceased was being 'watched' by the two police officers who were working in the watch house. She had no information about the deceased's risk status (nor did she seek it), and on that basis she decided it was more important that Brown and Mather attended the other incidents (T 193).

26. Less than two minutes after Brown and Mather left, Probationary Constable Thurgood removed the deceased's handcuffs. He asked his colleague ACPO Curtis if she knew who the prisoner was, but she did not. He conducted and documented regular cell checks (ascertaining that the deceased was breathing). During this time, the deceased remained in the same position he had been left in the cell, face down, albeit making small movements up until shortly before the return of the arresting officers.

The Watch house Keeper

27. The Alice Springs Police Station Watch house Standard Operating Procedures, which form part of the Custody Manual, provide, inter alia (my emphasis):

> "The Watch Commander is in charge of the watch house at all times. He/she is responsible and accountable for the management of the watch house and the safe custody and care of all persons. The Watch House Keeper has immediate responsibility for the watch house and the events occurring in its precincts ...
>
> If the Watch Commander is not physically present in the watch house the watch house keeper acts with the authority of the Watch Commander. On each shift a member has been designated as a watch house keeper. That is to say that the watch house keeper has the authority to accept or reject a person in custody, disposition of prisoners, management of the admittance of prisoners, judgment in regard to "AT RISK" prisoners and the provision of medical treatment if and when required."

28. On the night when the deceased was brought in, P/Constable Thurgood was working in the watch house on an overtime shift, with ACPO Annie Curtis. He had worked with her before and knew she had more experience than he did working in the watch house. He assumed that she was the watch house keeper. ACPO Curtis said that on the night itself she was not aware of which of them was the watch house keeper. A/Sgt Mace, who had made the arrangements for P/Constable Thurgood to do his overtime shift in the watch house, said that it was her understanding that the "duties [of watch house keeper] were shared between the members" (T 186).

29. Watch Commander Winton had about 12 years experience in the NT police, including 5 years general duties in Alice Springs between 1995 and 2000. He was familiar with the NT wide Custody Manual but had not read the Alice Springs Watch house Standard Operating Procedures. He understood and accepted that as the watch commander, he was the person accountable in terms of the duty of care for prisoners. He also understood the primary duty of the watch house keeper, to be, to "say who comes and goes – who's accepted in the watch house, who's not". As to the question of who was the watch house keeper on the night in question, he frankly conceded that he did not made a specific allocation (T 55).

30. As a result of the evidence I heard at this inquest, I find that this was not an unusual situation. All of the junior police members were asked about whether they had filled the role of watch house keeper at any of the times they had worked in the watch house in Alice Springs. The witnesses told me, variously, that: he "believed [I] was classed as the watch house keeper" (T 97); "thought [the role] was taken on by the senior partner; didn't know there was a set person on each shift" (T 111), as the senior person "I guess I would have" been the watch house keeper (T 137); thought she was "probably" the watch house keeper (T 154); that based on their respective rankings, he "believed" he would have been (T 165); "I may have on a couple of occasions, I can't definitely state whether I was or not" (T 172). Most of the answers were based on a (post facto) analysis of which of the two members working in the watch house was the more senior or experienced member.

31. I find that the practice of the watch commander or shift supervisor specifically allocating a watch house keeper, as required by the Alice Springs Watch house Standard Operating Procedures, was not a practice which was being observed in Alice Springs on 9 January 2009 and the months and possibly years leading up to that date, and after that date, until recently.

32. The consequences of the failure to observe that important requirement led to a lack of leadership in the watch house on the night that the deceased was brought there. Neither of the two members working in the watch house took it upon themselves to question – or raise with their superiors - the condition or health of the deceased, the reason he was in the watch house, nor the absence of the arresting members for what turned out to be a significant period of time. I do not intend these comments to be critical of the two members working in the watch house, both of whom impressed me as conscientious officers who were carrying out their duties as best they understood them on the night in question.

33. P/Constable Thurgood impressed me with his good sense and maturity, despite his lack of police experience. Although his supervisor, A/Sergeant Mace, on a number of occasions both in her interview and her evidence referred to the deceased as a "PC" (protective custody, ie a drunk), Thurgood noted immediately that he must have been arrested due to the fact that he was handcuffed. He removed the deceased's handcuffs a few minutes after the arresting officers had left. He was anxious about the fact that he had no information whatsoever about the person in the cell, and by the lengthy absence of the arresting officers but was unsure about what steps he could take to remedy the situation. He said that by the time of the inquest, having 14 months more experience than he had at the time of the incident, he could think of other things he could have done, for example, using the radio to query either the arresting members or the watch commander about the situation (T 181) and I have no doubt that he would now take those steps.

Cause of Death

34. Once Constables Brown and Mather returned to the station, they spent some time completing the paperwork, recording brief details, before Mather went to the holding cell to start the process of moving the deceased into another cell. He found that he was not breathing. The alarm was raised and CPR commenced. Resuscitation efforts were taken over by ambulance officers when they arrived and continued until arrival at Alice Springs Hospital. The evidence establishes that the deceased had passed away while still in the holding cell.

35. A post mortem examination was carried out by Dr Sinton who found that the cause of death was a traumatic subdural haemorrhage. Dr Sinton was not available to give evidence at the inquest but I heard from Dr Nigel Buxton, forensic pathologist, who reviewed Dr Sinton's report and assisted with an explanation of the findings. He explained that the deterioration from the point at which the head injury occurs commonly takes a few hours as the

pressure from the bleed builds up in the brain. Many of the symptoms of the haemorrhage, including slurred speech, aggression, unconsciousness and snoring, can all be similar to signs of drunkenness. Dr Buxton said (T 129):

> "I have certainly seen cases where people have received a blunt head injury, it hasn't been appreciated, and they die either in the hospital or at home …and at autopsy they have been shown to have a massive traumatic subdural or extradural haemorrhage. This gentleman fits that category very well."

36. The inquest also received evidence from Dr Harding, specialist neurosurgeon presently employed at Royal Adelaide hospital. She had reviewed Detective Cummins' report to the Coroner (summarising all of the evidence) and the post mortem report. In her opinion, it was certainly possible that a fall such as that described by Miles and Thompson could have caused the injury which was observed at autopsy.

37. There was no witness to the deceased's actual fall (both Miles and Thompson being on the other side of the fence when it happened). Further, there is no reliable evidence about the events of the late evening of 9 January shortly before the deceased was seen at Stuart Lodge. Despite this, the medical evidence assists me to make a finding that it is probable that the deceased sustained his fatal head injury when he climbed over the locked gate to exit Stuart Lodge and fell to the ground. The symptoms of a head injury causing bleeding to the brain could be easily mistaken for signs of significant intoxication, particularly by lay people including police officers. The haematoma (bruising) and oedema (swelling) to the brain were not observable externally. Additionally, and importantly in this case, the witnesses Miles and Thompson did not tell the attending officers Brown and Mather of the deceased's "duck dive" over the 2 metre fence.

38. Both Dr Buxton and Dr Harding gave evidence that specialist medical intervention – neurosurgery – would have been required within 1-2 hours after the injury was sustained for the deceased to have any chance of

survival. Even with such intervention, he may have suffered irreversible brain damage such that he would have died anyway, or survived with severe disabilities. Specialist neurosurgery is not available at Alice Springs hospital. Even if the police had taken the deceased straight to Alice Springs hospital emergency department, and it had been reported or recognised that he had suffered a head injury, in all probability he would still have died. Police actions or inactions did not cause, or hasten, the deceased's death.

39. Having said that, it remains the case that the deceased should not have died face down in a police cell in circumstances where no risk assessment had been carried out to assess his health or well being, and no considered decision had been made by any officer as to whether it was appropriate for him to be brought into, or remain in, the watch house in the non responsive state he was in.

40. Approximately ten years ago I held inquests into the deaths of two men in Alice Springs watch house: *Gardner* (1997) and *Ross* (1998). It was as a result of those matters that the Alice Springs Watch house Standard Operating Procedures were amended to define and emphasise the role of the watch house keeper as quoted above. The circumstances of those deaths highlighted the onerous responsibilities of police concerning the many hundreds of people taken into "protective custody" each year. I commented then about the unexciting yet unrelenting task which falls to junior police to 'pick up drunks' and take them into their custody in large numbers every day and every night of the year in Alice Springs. That situation has not changed.

41. It has been appropriately recognised by Commander Murphy (who took on the role of Commander in Alice Springs in October 2009, after this incident) that the importance of this task and the duty of care it entails must be recognised and emphasised. I agree with the submissions of Mr Sinoch on behalf of the family that it must be so recognised, not just by senior and

supervising police officers, but also by the junior and inexperienced police members who are regularly carrying out the task.

42. Commander Murphy gave evidence that once she reviewed the details of this particular matter, she immediately realised that the role of watch house keeper was not being appropriately formalised in Alice Springs. She has implemented changes to ensure that on each shift there is now a designated watch house keeper. With regard to the specifics of this case, Commander Murphy said that it was a 'rare occurrence' that a person needs to be dragged into a cell and that if a person is in such a state, he should be taken to hospital. Further, she confirmed that the period of time the deceased was in the holding cell without a risk assessment was too long. The absence of a watch house keeper contributed to this occurring in the way that I have already discussed.

43. There was evidence of some inconsistencies between the Custody Manual and the Alice Springs Watch house Standard Operating Procedures, as well as a lack of clarity in the latter document which has not been updated for some time. I am pleased to hear that it is intended that the Standard Operating Procedures will be amended into a clear and concise document which simply forms a short supplement to the Custody Manual, emphasising matters which are of particular relevance to the Alice Springs watch house, rather than a lengthy restatement of principles and policy.

44. Commander Murphy said (T 202):

> "Since I've read this file I've had a few conversations with some of my management team about the way the watch house has been functioning or not functioning in accordance with the custody manual, particularly in terms of the watch house keeper, and the assessment of people that come in to make sure that they really clearly understand that we do not want people at risk in the watch house unless we absolutely have to. I intend to meet with all the watch commanders in their next forthcoming meeting that they have prior to their rosters coming out, to reinforce these assessments and their responsibility in terms of the watch house. And its up to them to

reinforce that with their various members on their patrols: their supervisors and their patrols which includes their watch house staff."

45. But for Commander Murphy's evidence, I would have made recommendations pursuant to section 26 of the Coroners Act centred around watch house procedures. However, it is not necessary to do so when I am confident that measures have already been put in place to address these matters.

Dated this 19th day of May 2010.

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GREG CAVANAGH
TERRITORY CORONER