CITATION: *Inquest into the death of Jason Donald* [2007] NTMC 016

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Katherine
FILE NO(s):	D0012/2006
DELIVERED ON:	16 March 2007
DELIVERED AT:	Darwin
HEARING DATE(s):	4th and 5th December 2006
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Police Pursuit

REPRESENTATION:

Counsel:

Assisting:	Mr Tom Berkley
Family of Deceased:	M/S P. Dwyer

Judgment category classification:	B
Judgement ID number:	[2007] NTMC 016
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0012/2006

In the matter of an Inquest into the death of

JASON DONALD
ON 25th JANUARY 2006
AT ROYAL DARWIN HOSPITAL

FINDINGS

16th March 2006

Mr Greg Cavanagh SM:

1. Jason Donald ("the deceased") was an aboriginal male born on 19 December 1972 at Wave Hill in the Northern Territory, and who died at approximately 0816 hours on the morning of 25 January 2006 in the Intensive Care Unit of the Royal Darwin Hospital ("RDH"). At approximately 0400 hours on 30 December 2005 the deceased was severely injured in a single vehicle accident in which the motor vehicle that he was driving crashed off the side of the Stuart Highway near Katherine in the Northern Territory. At the time of that crash the deceased had a blood alcohol reading of 0.285. The deceased was conveyed to the Katherine District Hospital and, later that day, to the Emergency Department of RDH.

2. A short time before the vehicle crashed off the Stuart Highway, the NT police had been in pursuit of the vehicle driven by the deceased. The police had followed that vehicle from the centre of the Katherine Township in a northerly direction along the Stuart Highway. The police activated the lights and sirens of their vehicle just prior to reaching the intersection of Zimin Drive and the Stuart Highway. The pursuit was terminated after the vehicle being driven by the deceased negotiated a bend adjacent to

Emungalan Road and police lost sight of it. The police continued to search for the deceased, with the view of apprehending him, and eventually discovered the deceased crashed off the side of the Stuart Highway. I am satisfied that the deceased's death falls within the broad definition of a "death in custody" in the *Coroners Act*, and the holding of this inquest is mandatory.

3. Section 26 of the *Coroners 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."

4. Pursuant to section 34 of the *Coroners Act*, I am required to find, if possible:

> "(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."

5. Mr Tom Berkley appeared as counsel assisting me in this inquest. Ms Peggy Dwyer of the North Australian Aboriginal Justice Agency ("NAAJA") was granted leave to appear on behalf of the family of the deceased.

6. Witnesses called to give evidence at the inquest were Senior Constable Karl Day, Ms Noeline Andrews, Ms Samara Andrews, Ms Lorraine Booth, Constable Kenneth Bradshaw, Constable Mathew Parsons, Senior Constable Adrian Marshall, Detective Sergeant Lauren Hill, Senior Sergeant Wayne Jenkinson, Dr Diane Stephens and Dr Terence Sinton. Several other witness statements and interviews were part of the brief of evidence tendered as Exhibit 1. In addition to Exhibit 1, there were another 13 exhibits. Exhibits 2 to 4 were the statements of Noeline Andrews, Samara Andrews and Lorraine Booth respectively all adopted under oath at the inquest.

7. The Northern Territory Urgent Duty Driving and Pursuit Policy dated 20 May 2004 was admitted as Exhibit 5, and video and audio tapes involving a run through of the course of the pursuit and accident scene and reconstructions of the police pursuit were admitted as Exhibit 6.

8. Copies of two media releases seeking witnesses to the pursuit were admitted as exhibit 7. Certificates issued under the *Motor Vehicles Act* relating to vehicle registered number 588 811, driven by the deceased, were admitted as exhibit 8, and documents relating to the vehicle used by the police in the pursuit, being NTG 818 684 were admitted as exhibit 9.

9. Exhibits 10 and 11 comprise audio tapes of police interviews with relatives and acquaintances of the deceased.

10. A post mortem examination of the deceased was conducted by Dr Terrence Sinton on 25 January 2006, and the autopsy report was admitted as exhibit 12.

11. A report from Dr Tim Watkins regarding the care of the deceased by the deceased's relatives during his stay in RDH was admitted as exhibit 13, and the birth certificate of the deceased was admitted as exhibit 14.

12. The evidence contained in the very thorough investigation brief (Exhibit 1) prepared by Detective Senior Constable Karl Day is in itself sufficient for me to reach conclusions on all of the matters I am required to find as part of my formal findings in this matter. The examination and cross examination of witnesses called to give oral evidence was directed toward some particular issues arising from the circumstances of this death, which I discuss in my findings below.

FORMAL FINDINGS

Particulars required to register the death

13. Pursuant to section 34 (1) of the *Coroners Act*, I find:

(a) The identity of the deceased person is Jason Donald an aboriginal male born on 22 September 1972 in Darwin in the Northern Territory;

(b) The time and place of death was 08:16 hours on 25 January 2006 in the Intensive Care Unit of the Royal Darwin Hospital;

(c) The cause of death was multiple injuries sustained when the deceased was involved in a single vehicle roll over crash of the vehicle he was driving;

(d) The additional particulars needed to register the death under the *Births, Deaths and Marriages Registration Act* are:

i) The deceased was a male of Australian aboriginal origin;

ii) The death was reported to the Coroner;

iii) The cause of death was confirmed by a post mortem examination carried out at 1400 hours on 25 January 2006 by Dr Terence Sinton, Forensic Pathologist at Royal Darwin Hospital;

iv) The deceased's father was Mack (Mick) Jundjinging Djangiling;

v) The deceased's mother was Judith Donald;

vi) The usual address of the deceased was Rockhole Community, Katherine;

vii) The deceased was unemployed.

Relevant Circumstances Surrounding the Death

14. During the morning of Thursday 29 December 2005 the deceased travelled from Katherine to Mataranka in a VN Holden Commodore NT registration 588 811 driven by his wife Noeline Andrews. After dropping family members at Mataranka, Andrews drove back to Katherine with the deceased before returning to Rock Hole Community. Throughout the day and evening the deceased consumed alcohol.

15. Later in that evening the deceased was intoxicated and became angry towards his wife and verbally abused her. Noeline Andrews became fearful

for her safety and travelled into Katherine from the Rock Hole Community and telephoned police informing them that the deceased was "humbugging her". Andrews then returned to the Rock Hole Community and went to her sister's house to avoid the deceased. At some after her return, the deceased confronted Andrews and threatened her with physical violence when she refused to give him the keys to the Holden Commodore 588 811. She relented and gave him the keys.

16. Police Constables Bradshaw and Tucker went to Rock Hole Community in response to Andrews' first phone call at about 0030 hours on 30 December 2006, but could not locate Andrews. She again contacted Police at around 0300 hours on the morning of 30 December 2006, after the deceased had driven away from the Rock Hole Community. At between 0300 and 0330 hours that morning Constables Bradshaw and Tucker arrived back at Rock Hole Community where they obtained a handwritten statement of complaint from Noeline Andrews alleging a breach by the deceased of a restraining order (DVO) in favour of Noeline Andrews.

17. Constable Bradshaw radioed to "VKM Katherine" (the police radio channel) a description of the vehicle believed to be driven by the deceased and the allegation of a breach of the restraining order.

18. At about 0345 hours on 30 December 2006, Senior Constable Marshall and Constable Parsons were engaged in a vehicle patrol of Katherine Township in a Toyota Hi-Lux Police vehicle. Senior Constable Marshall was driving. They observed a Holden Commodore sedan matching the description of the white Commodore they were alerted to look out for, travelling north along Katherine Terrace, outbound near the Eugene Betti Bridge. Those officers followed the vehicle north along the Stuart Highway and made a decision to conduct a traffic apprehension at the intersection of Zimin Drive and Stuart Highway. The lighting at that intersection made it suitable for such an apprehension. The grounds for their decision to apprehend the deceased

varied slightly in sworn evidence, but common elements were (1) that the deceased was alleged to have breached a DVO and there was a danger to Noelene Andrews, and (2) he was most likely driving under the influence of alcohol and posed a great risk to the public if he continued to drive. Both Constable Parsons and Senior Constable Marshall noticed that the deceased was driving erratically at various times after he was first located.

19. When the police lights and sirens were activated by Constable Parsons, who was in the front seat passenger in the Police vehicle, the deceased did not stop and continued travelling north along the Stuart Highway through the intersection of Zimin Drive. Constable Parsons radioed "VKM Katherine" informing them that a pursuit had commenced.

20. According to the pursuing Police a white Toyota Landcruiser Ute 4X4 with a bull bar and large HF aerial and another small sedan were parked at the intersection of Zimin Drive and the Stuart Highway at the time that the pursuit commenced. As part of the investigation two media releases (Exhibit 7) were issued locally attempting to identify the persons or vehicles at the intersection, or any witnesses to the pursuit, but with no success.

21. During the pursuit the Police increased their speed to 110km/h and observed the Commodore rapidly pull away from them around the bend just after the Emungalan Road intersection with the Stuart Highway. It was estimated by the driver of the Police vehicle, Senior Constable Marshall, that the deceased was travelling in excess of 130 km/h at this point and that he had increased the gap between himself and the police to about 400 metres. The Police officers terminated the pursuit and turned off their lights and siren. The Police officers then continued travelling north along the Stuart Highway to a point after the Edith Falls turn-off in search of the deceased, before turning around and driving back towards Katherine.

22. On the return journey Senior Constable Marshall observed a vehicle lying on its side in bushland about 1km north of the Stuart Estate turn off. Senior

Constable Marshall and Constable Parsons stopped the police vehicle and soon realized it was the white Commodore which they were looking for, and had earlier attempted to apprehend.

23. Later investigation by the "Major Crash Unit" showed that the vehicle had commenced an anti-clockwise yaw about 150 metres from where it had come to rest. The Commodore sedan had commenced the yaw in the wrong lane for its direction of travel and the vehicle slipped to the left as it negotiated a slight right hand bend. The vehicle then left the Stuart Highway and crashed into the bush.

24. Upon entering the crash site, Constable Parsons located the deceased approximately 20 metres from the vehicle and notified VKM Katherine and requested an ambulance. The deceased was transported to Katherine Hospital and later to Royal Darwin Hospital, where he remained until his death on 25 January 2006.

25. A crime scene was established at the crash site and the NT Police crash investigation unit arrived on 31 December to commence their investigation into the crash.

The Pursuit

26. It became apparent at the inquest that some members of the deceased's family thought that the police had pursued the deceased unnecessarily, and may have even come into contact with the white Commodore sedan that the deceased was driving, causing the deceased to run off the road.

27. Radio transmissions from officers involved in pursuits are monitored so that a senior officer at the monitoring police station can overview the pursuit and, if that officer considers that the risks involved in the pursuit are not justified, that senior officer can order the termination of the pursuit. Normally, a pursuit is recorded at Katherine police station by a portable hand held recorder, of the same type as are issued to general duties police.

These devices are common and inexpensive. The fact that Katherine is not served by some form of automatic recording device like Alice Springs, Tennant Creek and Darwin is inexplicable. The very reason for that recording is to have a real time record of the pursuit that can also, in cases such as the present, allay the fears expressed by family members in this inquest. The installation of a recording system at Katherine Police Station that can record police radio transmissions should be a priority.

28. Detective Senior Constable Day gave evidence that he understood that an attempt was made to record this particular pursuit, but that the recorder was found to be faulty. This is why the Police records of the pursuit start after the pursuit had ceased. Constable Bradshaw gave oral evidence that he could hear the pursuit over the Police radio whilst he was still at the Rock Hole community obtaining statements from witnesses to the alleged breach of the DVO current against the deceased. It was not suggested by counsel that he was in error. He estimated that the pursuit lasted 1-2 minutes. Constable Tucker, who was with Bradshaw at Rockhole community, was not called to give evidence, nor was his presence as a witness requested at the inquest. In his statement contained in Exhibit 1 he says that he heard the pursuit being called and its termination because the vehicle being pursued had sped off.

29. I find that Constable Parsons contacted "VKM Katherine" and informed the operator of the fact that he and Senior Constable Marshall were engaged in a pursuit. I find that both the lights and sirens of the police vehicle were activated on the commencement of the pursuit, and that radio transmissions to VKM Katherine continued during the course of the pursuit.

30. I have considered the evidence of Senior Constable Marshall and Constable Parsons, which I discussed earlier, in light of the Northern Territory Urgent Duty Driving and Pursuit Policy (Exhibit 5). Each decision to engage in a vehicle pursuit involves weighing the factors listed Part 3, Section 11 of that Policy. This is the risk assessment required to be done before undertaking

any pursuit. The risk assessment is not a formal process, and it is often intuitive. It really comes down to comparing the desirability of apprehending a suspected offender against the real and potential risks of harm to the suspected offender, the police and or the community. It is usually a decision taken quickly and without the opportunity of calm reflection.

31. I am satisfied that the pursuing Police officers had assessed the risks of a pursuit in accordance with that Policy, and that the decision to commence a pursuit was reasonable in the circumstances of this case.

32. On viewing of the re-enactment of both Constable Parsons and Senior Constable Marshall (Exhibit 6) it is evident that those officers continually assessed and reassessed the risks of engaging in the pursuit as required by section 14 of the Northern Territory Urgent Duty Driving and Pursuit Policy. Once it became apparent that continuing the pursuit was futile (as the fleeing vehicle was rapidly pulling away from the police vehicle) and the risks posed to the driver of the fleeing vehicle were increasing exponentially with his rapid acceleration, the pursuit was terminated. I find that the pursuing police did not see and were not in contact with the deceased's motor vehicle thereafter.

33. When a Police vehicle is involved in a pursuit, or Urgent Duty Driving, it is to be sent for a physical assessment of any damage to the vehicle in accordance with Police Standing Orders. That was not done in this case, or at least there is no record of it having been done. Senior Constable Karl Day checked the available Police records concerning Police vehicle NTG 818 684 during the Inquest and could not find any evidence that the vehicle was assessed for damage. The vehicles are normally assessed at Master Motors in Katherine, who are the contracted suppliers of automotive services for police vehicles in the Katherine Police District. Documents that Senior Constable Day could obtain relating to police vehicle NTG 818 684

(Exhibit 9) show that vehicle underwent an Urgent Duty Driving Check at Master Motors in Katherine on 28 December 2005, two days prior to the pursuit in this case. No work on that vehicle was apparently required as a result of that check. Senior Sergeant Wayne Jenkinson gave evidence that he expected that another Urgent Duty Driving Check would have been done after the pursuit of 30 December 2005, and was surprised by the lack of documentary evidence to indicate that such a check had been done.

34. Senior Sergeant Jenkinson was the officer in charge of Katherine Police Station on the morning of 30 December 2005. He attended the crash scene at 0507 hours on 30 December 2005 and conducted breath tests on the officers present, being Marshall, Parsons and Tucker. Those breath tests were negative. After securing the crash scene as a crime scene and giving other directions concerning the management of the scene he returned to Katherine Police Station. He gave oral evidence that it was clear in his mind that the officers involved in the pursuit should make statements of their involvement separately, to avoid the appearance of collusion between them. Constable Parsons made a statement of his involvement in the pursuit separately to Senior Constable Marshall, who had gone home shortly after arriving back at Katherine Police Station. Marshall was tired and had a beer when he got home. He rested and returned to the station in the afternoon to complete his statement. Both officers were interviewed separately in relation to their involvement in the pursuit, in accordance with Police Standing Orders.

35. Senior Sergeant Jenkinson was also involved in the video taped re-enactments of the pursuit, which are Exhibit 6 and which were conducted at about 0315 hours on the morning of 31 December 2005. He drove the police vehicle involved in the pursuit (NTG 818 684) for the purposes of those re-enactments. He did not notice any damage to the vehicle on either the 30 or 31 December 2005. He said that there was nothing that he noticed to

indicate to him that the police vehicle NTG 818 684 could have come into contact with the Commodore sedan 588 811 during the pursuit.

36. It is understandable that the failure of the recording equipment meant to record a pursuit, and the failure to have the Police pursuit vehicle assessed for damage after the pursuit, would lead to suspicion in the minds of some members of the deceased's family that the Police have been covering up some impropriety in the course of the pursuit. Those concerns were properly addressed in cross-examination of the Police officers, but it was not put to me that I should find that there was any impropriety in the Police conduct of the pursuit. After hearing the police witnesses I am satisfied that there was no such impropriety, and that the Holden Commodore 588 811 left the Stuart Highway and crashed into the bush due to the manner of driving and intoxication of the deceased. The failure to have the Urgent Duty Driving Check done was probably because the police vehicle was required to be used for the re-enactment of the pursuit on the morning of Saturday 31 December 2005. The next two days were public holidays, when Master Motor may not have been opened, which may have contributed to the required assessment being forgotten.

Medical Treatment of the Deceased

37. After he was discovered the deceased was transferred to Katherine District Hospital and then to RDH in Darwin. The deceased received initial first aid care from Constable Parsons and Senior Constable Marshall. Those officers were concerned for the deceased's condition and made sure that the ambulance responded as quickly as it could on an emergency basis. I am satisfied that all of those involved in the deceased's initial care at the scene, during transportation of the deceased, and at Katherine District Hospital, acted with professionalism and compassion toward the deceased.

38. At RDH the deceased was diagnosed with multiple injuries sustained from the motor vehicle accident including a severe closed head injury, severe

bilateral lung contusions, fractured ribs and a flail chest on the left side, and a complex fracture of his right femur. An initial CT scan demonstrated a subdural bleed and intra-ventricular blood with haemorrhages visible in both hemispheres including the right basal ganglia, the right frontal cortex and inferior to the left basal ganglia close to the sylvian fissure. The scan was consistent with the diagnosis of a severe closed head injury with diffuse axonal injury.

39. Dr Dianne Stephens, the Director of the Intensive Care Unit at RDH, was called to give evidence. She had, on 27 February 2006, provided a detailed report on the injuries sustained by the deceased, his treatment, and the causes of his death at RDH. That report is contained in Exhibit 1. Dr Stephens gave evidence that there was some initial improvement in the deceased's medical condition. By 5 January 2006 he was awake and cooperative enough to have his mechanical ventilation removed. On 11 January 2006 the deceased developed abnormal liver function tests and a raised white cell count. He was diagnosed with alcalculous cholecystitis. As his liver function was improving and the tenderness in his right abdomen had resolved, it was decided to manage the cholecystitis medically, rather than surgically. On 13 January 2006 the deceased was transferred from the High Dependency Unit to the general ward. He remained febrile and continued on antibiotics.

40. On 19 January 2006 the deceased's condition deteriorated, he became confused and lethargic with a temperature of 39.1 ºC. Another CT scan of his abdomen revealed a necrotic left kidney and an abscess associated with his gall bladder extending into the right paracolic gutter. A radiological cholecystostomy failed to drain the abscess and the deceased was admitted to the High Dependency Unit.

41. On 21 January 2006 the deceased was admitted into the operating theatre and a gangrenous gall bladder was removed and large pericholecystic

collection was drained. It was also noted that his neck and scalp wounds, sustained in the crash, had deteriorated and that he had developed necrotizing fasciitis of the back of his head and side of his neck.

42. After the operation the deceased was returned, ventilated, to the Intensive Care Unit for further management. He failed to wake up and a CT scan of his head was done. The CT scan showed a sizeable area of hypodensity involving the right lentiform nucleus and internal capsule consistent with infarction within the distribution of the middle cerebral artery.

43. On 23 January 2006 an urgent CT scan showed a large intracerebral bleed originating from the right internal capsule hypodensity that had been noted on the previous scan. The intracerebral bleed was extensive and his neurological outcome and prognosis was extremely poor. His pupils became fixed and dilated with no gag reflex. Mechanical ventilation was ceased at 08:00 hours and the deceased died at 0815 hours on 25 January 2006.

44. Dr Sinton also gave oral evidence. He had not seen Dr Stephens' report. The evidence of the autopsy findings given by Dr Sinton correlated with the diagnosis of Dr Stephens and her staff. Dr Stephens and Dr Sinton agreed that the cause of death, in lay terms, was extensive bleeding inside the deceased's skull. Both doctors also agreed that the large abdominal abscesses around the gall bladder and left kidney, and the necrotizing fasciitis, had developed naturally from common bacteria that he was too weak too fight because of the multiple injuries he sustained in the vehicle crash. These conditions lead directly to the extensive bleeding inside his skull, which ultimately killed him. The deceased died as a direct result of the multiple injuries he sustained in the motor vehicle crash at Katherine on 30 December 2006.

RECOMMENDATIONS AND COMMENTS

45. I find that the care of the deceased at Royal Darwin Hospital was appropriate and I have no criticism to make. I have also no criticism to make of the police officers involved in the pursuit of the deceased prior to his death and afterwards

46. I recommend that the Katherine Police communications be upgraded to a standard comparable with the larger centres to enable the automated recording of police radio communications.

Dated this 16th day of March 2007.

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GREG CAVANAGH
TERRITORY CORONER