**CITATION:** ***Inquest into the death of Reba Lakuwanga*** **[2002] NTMC 007**

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| TITLE OF COURT: | CORONERS COURT |
| JURISDICTION: | Coronial |
| FILE NO(s): | D0148/2001 |
| DELIVERED ON: | 26 February 2003 |
| DELIVERED AT: | Darwin |
| HEARING DATE(s): | 17,18,19,20 September, 21 October, 11, 14, 21 November 2002 |
| JUDGMENT OF: | Mr Greg Cavanagh SM |

**CATCHWORDS:**

Coroners Inquest, Death in Custody, detention for purposes of protective custody, belief in the commission of crime, duty of care.

**REPRESENTATION:**

*Counsel:*

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| Counsel Assisting the Coroner: | Ms Elizabeth Morris |
| Counsel for the Northern Territory Police: | Mr David Lisson |
| Counsel for the Family: | Ms Julie Condon |
| Counsel for the Aboriginal Justice Advocacy Committee: | Mr Chris Howse |
| Counsel for Mr Goldstein and Mr Cook | Mr Eric Hutton |

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| Judgement category classification: | A |
| Judgment ID number: | [2003] NTMC 007 |
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| Number of pages | 34 |

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0148/2001

In the matter of an Inquest into the death of

**REBA LAKUWANGA**
**AT 44 BROLGA STREET, WULAGI**
**ON 3 OCTOBER 2001**

**FINDINGS**

(Delivered 26 February 2003)

MR GREG CAVANAGH:

## NATURE AND SCOPE OF THE INQUEST

1. The deceased died on 3 October 2001, after being fatally assaulted by John Joseph Collins. The death is a "reportable death" which is required to be investigated by the Coroner pursuant to s14 (2) of the *Coroners Act* ("the Act"). As a consequence of the deceased being held in police custody immediately prior to her death, a public inquest was held pursuant to s15 (1)(c) of the Act. The definition of "custody" in the Act is expansive and the scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of the *Coroners Act.* It is convenient and appropriate to recite these provisions 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.

**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."

2. The Coronial investigation concluded with a Public Inquest before me, commencing on the 17 of September 2002. Evidence was heard through to the 20 of September 2002, with the inquiry being adjourned until the 21 of October 2002 for presentation of written submissions. The Inquest was further adjourned and finally concluded on the 21 November 2002 in order for the father of a daughter of the deceased to make submissions.

3. Counsel assisting me was Deputy Coroner Elizabeth Morris. Leave was granted to Mr David Lisson to appear for the Police Commissioner, Ms Julie Condon to appear for the family of the deceased, Mr Chris Howse to appear for the Aboriginal Justice Advocacy Committee, and Mr Eric Hutton to appear for Mr Goldstein and Mr Cook. Ms Camilla Hughes sought and was granted leave to monitor proceedings and make written submissions on behalf of the Top End Women's Legal Service. I received several written closing submissions from Counsel and others. I have read and considered all of them.

4. I granted an application for suppression of the publication of the deceased's name for cultural reasons. I also suppressed the publication of the name of a serving prisoner in Berrimah Gaol who gave evidence before me.

5. The Inquest heard from eleven witnesses. They were:

   i. Detective Greg Lade
   ii. Dean Goldstein
   iii. Steven Cook
   iv. Constable Bernard Marsh
   v. Auxiliary Julianne Hurley
   vi. Acting Sgt Sally Zylstra
   vii. Carlie Rostron
   viii. John Joseph Collins
   ix. Maria Tutt
   x. Dianne Maison
   xi. Professor Anthony Ansford
   xii. Assistant Commissioner Smith

6. In addition to this evidence, a full brief of evidence was tendered by Detective Sergeant Lade. This evidence included statements from various witnesses and numerous other records of the Police investigation.

7. Exhibited at the Inquest were the following items:

   i) Investigation brief
   ii) Set of Photographs
   iii) Audio Tape (police communications)
   iv) Report of Commander Fields
   v) Domestic Violence Training Manuals (2)

vi) Statement of Terese Meyer

vii) Identification records of deceased (5 pages)

viii) Transcript and audio tape (2) from police communications

ix) Set of 5 Colour photocopies

x) Statutory declaration of Michael Moss

xi) Statutory declaration of V.L. Balchin

xii) Statement of M.A.R MacPherson

xiii) Statement and annexures of Assistant Commissioner Smith

(xiv) Statement of Sergeant Greg Lade and email of Carmen Eckhoff

**S34 Particulars**

8. To allow this death to be registered under the *Births, Deaths and Marriages Registration Act* the evidence shows that the following particulars can be provided to the Registrar:

(a) The Identity of the deceased Person

The deceased is Reba Lakuwanga, sometimes spelt Lakruyana, a female Aboriginal Australian who was born on 3 December 1959 at Darwin, Northern Territory.

(b) The Time and Place of Death

The deceased died at 44 Brolga Street, Wulagi some time between 1509 hrs and 1518hrs on 3 October 2001 aged 41 years.

(c) The Cause of Death

The cause of death was an intra abdominal haemorrhage caused by a ruptured spleen. The death was due to violence.

(d) The particulars required to register the death

1. The deceased was a female.

2. The deceased was of Australian Aboriginal origin.

3. The cause of death was an intra abdominal haemorrhage caused by a ruptured spleen.

4. The cause of death was confirmed by a post-mortem examination.

5. Death was from violence.

6. The pathologist viewed the body after death.

7. The pathologist was Professor Anthony Joseph Ansford, Locum Forensic Pathologist of Royal Darwin Hospital.

8. The father of the deceased was George Irindili.

9. The mother of the deceased was Maudie Nan-Mang-Gark.

10. The deceased resided in the Maningrida area or in the Leanyer long grass area of Darwin.

11. The deceased was unemployed.

**REPORTABLE DEATH AND DEATH IN CUSTODY**

9. It is a reportable death because immediately before death, the deceased was in custody, and because an "accident or injury" caused the death (*Coroner's Act*, s.12). The word "immediately" in the *Coroner's Act* is not defined. To determine whether or not someone was in custody immediately before death is something that depends of the circumstances of each case. Factors taken into account include time, geographic location, actions, intervening actions, and other factors peculiar to each incident. In view of the purposes of the legislation, I should not give a restrictive or narrow definition to "immediately".

10. In this case the deceased was clearly taken into custody by Police Officers Goldstein and Cook on the 3rd October 2001. Their evidence indicated an intention to take the deceased into protective custody under s.128 of the *Police Administration Act*, and an actual taking into custody, with the deceased being placed either inside the van (according to some witnesses) or put up against and leaning on the back tail gate area of the van, according to the Officers. The deceased was then released, but was found dying by other attending police officers some 16 minutes later. Whilst there may have been intervening action by Mr Collins, this death falls clearly into the category of death in custody.

**CORONIAL INVESTIGATION**

11. The death was investigated by the NT Police, appropriately, as a death in custody pursuant to General Orders.

12. The *Coroners Act* requires an independent investigation in these circumstances at the direction of the Coroner. Detective Sergeant Greg Lade and officers under his direction carried out an investigation according to the requirements of Police General Orders D2. That general order specifically relates to the Investigation and Reporting of Deaths in Custody. Detective Sergeant Lade stated in evidence (Transcript P12):

> "*The Coroner: Did you start off also investigating this as a murder investigation?---That's correct.*
>
> *Not just because of the standing orders that require any death in custody to be investigated with that resourcing but also it appeared to be an unlawful death?---That's correct, sir.*
>
> *Yes, so you can up it to a criminal investigation it's side by side as a coronial investigation?---That's correct, sir.*
>
> *The coronial investigation, I take it, you realised contained wider issues rather than just who killed who?---That's correct, sir, yes."*

13. Detective Sergeant Lade's report and investigation was thorough and insightful, and he is to be commended for its preparation. He was criticised by Mr Howse at one stage for not recommending the prosecution of police officers Goldstein and Cook; he stated that in his view there was insufficient evidence for any criminal charges to be laid against them. Detective Lade may be right, he may be wrong, however, I note that the brief of evidence compiled by him in relation to the death was forwarded to the Director of Public Prosecutions and did not result in anyone except Mr John Collins being prosecuted on indictment.

14. Mr Howse spent some time in his written submissions criticising the internal police review and report of the matter by Commander Fields of the Police Professional Responsibility Division of the Northern Territory Police. I make no findings in relation to his report; comments by me on the internal review are beyond the scope of this Inquest.

15. Mr John Collins was presented in the Supreme Court and pleaded guilty to causing the death. The facts agreed before the Judge were as follows (Transcript P15-18):

> "*As of Wednesday 3 October 2001, John Joseph Collins and the deceased had been in a close relationship for about a month. On the morning of 3 October 2001, the accused and the deceased went to a house at 44 Brolga Street Wulagi. A woman called Carlie Rostron lived there, and on that day Carlie's niece, Jessie Rostron; her sister, Mary Rostron; and her stepdaughter Lee Rostron, were also at the house.*
>
> *The deceased went to the house to see Carlie Rostron. Throughout the morning and early afternoon everyone except for Lee Rostron, began drinking wine from casks and became heavily intoxicated. The accused and the deceased started arguing. The accused assaulted the deceased at different stages of the day. The assaults included incidents where the accused pulled the deceased's hair, hit her in the neck and chin with his fist, dragged her by the neck across floor and hit her twice with his fist to her chest. At some stage the defendant kicked the deceased.*

*At about 2.05pm, Carlie Rostron called the police using a telephone line inside the house. She reported that the accused and the deceased were fighting, arguing with each other, and that they were damaging her house.*

*At about this time the accused and the deceased walked outside of the residence and the accused took off all the deceased clothes except for a pair of knickers. The two walked across the road and the deceased went to the front yard of the house opposite, being number 43. She knocked loudly on the security screen of the front door.*

*The owner of the house, Maria Tutt opened the front door and saw the deceased lying in the carport area of the house. Ms Tutt responded by ringing the police straight away. She rang them at about 2.30. The accused then approached the deceased, lifted her off the ground and dropped her back onto it with force.*

*At about 2.34pm, two police officers arrived in a police van responding to the earlier telephone call from Carlie Rostron. They observed the deceased and the accused outside 43 Brolga Street. The deceased was still only wearing a pair of knickers at this stage. She was sitting on the ground.*

*One of the police noticed a graze to the deceased's left elbow. The police decided to take the deceased into protective custody due to her level of intoxication. The accused put a shirt onto the deceased from a bag which was on the ground near-by, then assisted the police, placed the deceased into the rear of the police van.*

*The police then heard over their police radio that a man had been observed outside a take-away food shop in the city, sitting in a car with a bottle of whisky between his legs, and a shotgun by his side. The police decided to leave Brolga Street and attend the incident in the city. The deceased was assisted out of the back of the police van by the accused. The police left Brolga Street at about 2.41pm.*

*The accused then carried the deceased into the residence at 44 Brolga Street where he placed her into a shower. At about this time he kicked her hard somewhere to her back or chest. The deceased crawled out of the shower.*

*At about 2.57pm, a different pair of police officers arrived at 44 Brolga Street. The accused came to the door of the house. He stated to the police that he had been fighting with the deceased. The police entered the house and saw the deceased lying naked on the floor in the doorway of her bedroom. The deceased was still alive at this*

*point, but unconscious. The police went back to the lounge room whilst Lee Rostron dressed the deceased.*

*The police then carried the deceased to the lounge room noticing she was very cold to the touch and very pale. They noticed that she had a 3 centimeter open cut on her jaw and a small cut to her left eyebrow. They found her laboring for breath and with a weak pulse.*

*At about 3.08pm, the police requested an ambulance attend. One arrived about 10 minutes later. Very shortly after the ambulance officers arrived they observed the deceased stopped breathing. They checked for a pulse but could not find one. They began heart and lung resuscitation. The deceased was transported to Royal Darwin Hospital by ambulance arriving at about 3.43pm. She was pronounced dead shortly after arriving.*

*The accused was arrested at the residence at 44 Brolga Street and transported to the Peter McAulay Centre where he was detained pursuant to section 137 of Police Administration Act. The following morning, Thursday 4 October 2001, the accused took part in an electronically recorded interview with the police officers. He stated that he had little recollection of what had occurred the previous day due to his consumption of alcohol.*

*During the afternoon of Thursday 4 October, a qualified forensic pathologist carried out an autopsy upon the body of the deceased. He determined that the cause of death was a massive intra-abdominal haemorrhage as a result of a ruptured spleen, associated with four fractured ribs in the area of the spleen. These injuries were consistent with one forceful or several less forceful blows to the left lower rib cage area, most likely with unclad feet. It was also consistent with extremely heavy punches to the same area.*

*The accused delivered the injuries that caused the death of the deceased. Internal examination revealed a large laceration to the superior surface of the spleen, there was cirrhosis of her liver which had rendered the spleen more susceptible to injury. There was minor narrowing to the coronary arteries which may have contributed to the death by making the deceased more susceptible to the effects of blood loss. The pathologist found the deceased would not have died immediately after the inflicted injury to the spleen, but may have survived for up to an hour or more.*

*The injury would have been survivable with prompt medical and surgical intervention. The pathologist also noted the following signs of recent injury:*

*(1) A small laceration about 7 millimeters long at the outer corner of the left eyebrow. (2) A slightly gaping laceration, 30 x 0.5 millimeters under the right side of the point of the chin. (3) A small crusted abrasion about 5 millimeters across on the right forehead. (4) A possible abrasion 20 millimeters across just above the natal cleft on the back of the body. (5) Some abrasions on the back of the right elbow.*

*Also found where two discrete areas of haemorrhage in the subcutaneous tissues of the scalp, the first about 30 millimeters above her right eye, and about 30 millimeters across. The second was about 60 millimeters above her right eye, being a regular bruising about 30 millimeters across.*

*Another haemorrhage was found in the soft tissues near the left angle of the jaw, the deceased blood contained 0.253 per cent alcohol."*

**THE DECEASED**

16. The deceased was born at Darwin in the Northern Territory on 3 December 1959. The Aboriginal population records held by the Registrar of Birth, Deaths and Marriages confirm this date.

17. The deceased was married on more than one occasion and had four children. One of the deceased's children, Anthea, and her father, a former partner of the deceased, attended the Inquest. Other family members were represented by Ms Condon. At the time of her death the deceased was living in the long grass around the Leanyer area of Darwin. She had formed a recent relationship of about a month's duration with John Joseph Collins.

**EVENTS AT 44 BROLGA STREET, WULAGI**

18. There was little evidence as to the movements of the deceased prior to the 3rd of October 2001. It appears from the evidence of the residents of 44 Brolga Street, and from Mr Collins that the deceased arrived at that address sometime that morning. Mr Collins, at least, had been drinking heavily for some three days. The Deceased and Mr Collins were in a relationship. At

some time that morning, a neighbour, Ms Tutt saw the deceased and Mr Collins outside her house. At 1407hrs witness Carlie Rostron, who gave evidence, phoned Police and told the operator that "John" and "Reba" were fighting at her house; they were drunk; they were husband and wife and they were damaging her property.

19. The Communications operator, Auxiliary Hurley entered the above details into the Police "ICAD" system giving the call a job description of "disturbance – domestic". Subsequently the job transferred from the "ICAD" system into the Police "Promis" system with a job number of 395388.

20. Subsequent to that call, Ms Tutt also rang the police. She was informed that the police would check with her upon attending. This message was not passed on to either of the attending sets of Officers.

21. At 1429hrs, Unit 413 (a police wagon with a caged compartment at the rear) containing members Goldstein and Cook was dispatched to attend 44 Brolga Street, Wulagi. At 1434hrs, Unit 413 arrived in Brolga Street where they found the deceased and John Collins in the street roughly opposite 44 Brolga Street. The Deceased was seated on the ground and wearing only a pair of panties. The Officers formed an opinion that the deceased was intoxicated to such an extent that she was in need of care and, therefore, she was arrested pursuant to provisions of Section 128 of the *Police Administration Act* for her protective custody. It was the intention of members to convey her to the Sobering Up Shelter. In my view it is important to note that the police officers made their decision regarding the need for her to be taken into protective custody in the presence of Collins, and indeed proceeded to take her to the open entrance of the paddy wagon in his presence.

22. In forming this intention neither Officer spoke to anyone apart from Mr Collins. They did see another person sitting in the yard of 44 Brolga Street. They did not ask or question the deceased about what had happened.

23. The deceased was assisted to the rear of the Police vehicle by Collins. She, at the very least sat in the doorway area of the cage. Evidence as to how the deceased was treated was given at the Inquest by Ms Maison, and also in a tendered statement by Reginald Petherick,

24. At this time, Goldstein and Cook became aware of an urgent job in Darwin City (the "Uncle Sams" job) and advised Communications that they would attend, despite not completing the job at hand, and without reference to any supervisor or being specifically requested to attend.

25. Goldstein and Cook then, it appears formed the opinion that the deceased did not in fact need their care and could be adequately cared for by Collins and released her into his care. Neither member confirmed with the deceased whether she was happy with this arrangement, they relied instead on her failing to protest the arrangement despite her being in Goldstein's words "incoherent".

26. Unit 413 then left the area of Brolga Street. The police officers say they did not see how the deceased was taken from the back of the van area, or what happened to her after they got back in the police vehicle. They did not look in the rear view mirror, or indeed pay any attention to the deceased or Mr Collins once the van door was shut.

27. Evidence available suggests that Collins then carried the deceased roughly over his shoulder and into the house situated at 44 Brolga Street. Several witnesses were worried about the manner in which Mr Collins carried the deceased – her head was towards the ground and it looked as if she might be dropped in this position.

28. Mrs Dianne Maison of 35 Brolga Street, Wulagi gave evidence at the Inquest; she is a preschool assistant by occupation and is married to a Northern Territory Police Officer. Mrs Maison is a mature lady and I found her evidence to be frank, credible and reliable. Mrs Maison gave evidence

inconsistent with that of officers Goldstein and Cook. She gave graphic evidence of seeing the deceased in the back of the van with Collins standing at the rear. She saw this man take the deceased from out of the van. The physical manner in which this removal occurred caused her alarm and she demonstrated quite a muscular action by Collins in "reefing" (the witness's word) from the van. The body of the deceased at this stage was described by her as (transcript p261):

> *"Ms Morris: And did the person inside the van appear to be protesting or you couldn't see?---I – by looking at the body – the body motion, it was a very – it was very floppy and like a rag-doll type thing, if you can - - -"*

29. Mrs Maison went on to describe how Collins then put the deceased over his shoulder, and in a position wherein the deceased was being held by her thighs. Mrs Maison stated that she thought that Collins was going to drop the deceased on her head at this point.

30. Counsel for Goldstein and Cook cross-examined Mrs Maison with a view to diminishing her reliability, however, in my view he did not succeed. I accept the evidence of Mrs Maison.

31. Witnesses spoken to by Detective Lade from that address state that Collins had assaulted the deceased both prior to the arrival of Goldstein and Cook and after they had left. Indeed, the Police Communications dispatch to them indicated violence.

32. At 1451hrs Unit 410, containing two different police officers, viz Constables Marsh and Wilson, was dispatched by Communications to attend 44 Brolga Street. It appears that this occurred as Unit 413 had not "cleared" or finalised the job on their departure. This meant that the task went into a "pending" list on the police communications system.

33. Unit 410 arrived at 44 Brolga Street at 1457hrs and subsequently located the deceased inside the house. She was found on the floor near the bathroom

doorway. Members readily identified that the deceased was in need of urgent medical assistance and at 1509hrs requested an ambulance attend their location. The members noted that the deceased seemed to be having trouble breathing and again requested the urgent attendance of an ambulance. At 1518hrs, the ambulance arrived and commenced CPR treatment. The evidence shows that the deceased died at 44 Brolga Street however CPR efforts continued until her arrival at the Royal Darwin Hospital where she was pronounced deceased.

34. I find from the evidence, both tendered and given by Constable Marsh, that Officers Marsh and Wilson acted promptly, appropriately and with consideration. They made every effort to save the life of the deceased and are to be commended.

35. John Joseph Collins was arrested at 44 Brolga Street for assault and conveyed to the Berrimah Watchhouse where he was lodged in the cells and detained under the provisions of 137 of the *Police Administration Act*. Due to his state of apparent intoxication, he was not interviewed until the following morning. The following morning in a formal electronically recorded record of interview, Collins stated that due to his level of intoxication the previous day, he had no recollection of what had occurred at 44 Brolga Street. He did however claim some recall of when Police attended, of Police locking the deceased up and of Police letting the deceased go shortly after. He claimed no recall of having assaulted the deceased that day. Mr Collins has subsequently pleaded guilty to dangerous act causing death (ie the death of the deceased), and has been sentenced by the Supreme Court of the Northern Territory.

36. Despite the evidence of Goldstein and Cook, I do find that Mr Collins was in fact seriously intoxicated on the 3 of October at the time those Officers attended 44 Brolga Street. The level of intoxication was remarked upon just a short time later (16 minutes later) by Officers Marsh and Wilson.

Detective Lade also made observations as to Mr Collins level of intoxication. (transcript p14):

> *"He was drunk, he was affected by alcohol to such an extent I couldn't speak to him in my capacity as an investigator, going to caution him and interview him about a criminal matter."*

37. Ms Carlie Rostron gave evidence at the Inquest; this was the lady who made the first call to police concerning the deceased. She stated that Collins had been drinking just like everyone else at the home including the deceased. She went on to say in relation to the violence inflicted on the deceased by Collins (transcript p114):

> *"MS MORRIS: Did he hurt her after the police came the first time?---He hurted her first before the police came and I rang them.*
>
> *THE CORONER: And what about afterwards, did he hurt her again?---Yes. But I can't remember. My sister knows – but she was doing the same, she trying to stop it."*

38. It is to be noted that officers Goldstein and Cook could easily have gone over to the house to discover this information.

39. As to the level of intoxication of Collins, police officer Marsh who attended the home shortly after Goldstein and Cook left told me in evidence (transcript p119):

> *"The issue I want to take you to is the man who was there, Mr Collins. Do you believed when you first arrived that he was under the influence of alcohol?---Yeah, we were first confronted by two females and then John Collins came to the door. He obviously walked to the door and he was standing but his speech was slurred and we could smell alcohol on him very – very – about a metre away there was definitely an odour – but again all these people seemed intoxicated. He was talking and he was slurring his words and he was unsteady on his feet.*
>
> *THE CORONER: In your brief career with the police force you would have come in contact and picked up and arrested and or taken into custody lots and lots of drunk people, is that right?---That's correct, sir.*

*In your opinion, was he affected by liquor?---Yes, sir.*

*Thank you.*

*MS MORRIS: Was he affected to such an extent that you would consider or did consider whether or not you should take him into protective custody?---We were – that was our first consideration, we were going to place him into protective custody due to his level of intoxication."*

40. On all of the evidence I simply do not accept the assertions of Goldstein and Cook that Collins did not appear very intoxicated, at best they were indifferent to his level of intoxication and at worst they were aware and did not care less.

41. Mr Collins gave evidence before me at the Inquest. He was a reluctant witness, and I made an order suppressing publication of his evidence, given that he was a serving prisoner and I wanted to encourage such persons to cooperate with Coronial Inquests. He told me in evidence (transcript p206):

*"MS MORRIS: Did they ask you to do anything?---When they wanted me to – when they wanted to take that girl, take her, they told me, they like forced me to put her in the back.*

*How did they do that, did they - - -?---You have – that's your – like your woman – you – that's – the younger fellow was alright, the one on the left-hand side he was not too bad, he could see she was crook. He said, 'Look she looks like she needs to go to hospital instead of going to the sobering-up shelter' – no – and that's what he sort of – she looked crook but the other bloke reckoned, 'We'll put her in the back first', and what's going on – and I think that young – that other copper, on that side, right-hand side, he went to go in there to have a yarn to them mob. I don't know if he made all the way or not, but he came back. He was the – sort of – the cheeky one.*

*And so he went away for a short period?---Yeah.*

*The other one?---Yeah.*

*And was the back of the cage door open, or shut, when he went away, can you remember?---(Inaudible).*

*THE CORONER: So they asked you to take her over to the van, did they?---She was taken – when they pulled up where we was, was right there behind the van, it was right there.*

*MS MORRIS: Can you remember which one opened the door of the van, the cage door for the back?---No.*

*THE CORONER: Did it – you referred to the cheeky one, did the cheeky one appear to be the boss of the two of them?---Yeah like – well, I had a feeling that the bloke on the left he was a rookie, like he only been in there for a little a while. This other bloke he sort of may be letting that rookie be in charge but he's still doing the standing over tactics – stand over man like he the boss sort of - - -*

And (transcript p207 - p208)

*"THE CORONER: Was it all the way in?---No, none of her body was hanging out.*

*MS MORRIS: Then what happened?---They closed that door. I thought they were going to take her then, it would be alright. Now this is a bit see, when he went over to the house – I don't know if he went over after they put her in the back or before they put her in the back, but at whatever stage then, when they had that closed thing – that thing closed and they closed it, that's when I heard that – he get that call then for Uncle Sam's, and I heard it because – I remember hearing that radio and he looked at me and I looked at him and I could listen, and they saying bloke having like a gun, a shotgun, and I – and I listen and he's going, oh, that's – he didn't want anything to do with us and this – and he's looking at the other young bloke, but the young bloke was alright, it's the other bloke that was no good and then they saying oh, this more – this is more – like he come across to me – trying to be like Dirty Harry. He didn't want anything to do with us, he said, 'You get her out of the car, we got, we got much more priority' – I'm sure I said like, 'You've got to take one of us', 'No, she'll be right'. The young bloke was alright, it was that other copper, now that was no good. He – but he should of took one of us. No this is more, this is priority, this is - this is – we – like he couldn't waste the time with the paperwork. The other young copper said, 'She looks sick, she needs to go either the hospital or take her' – he said that, because I remember – he said, 'No, this is priority, you take – well you get her out – no, you get her out of the car, this is your woman'.*

*And what did you do?---I had to, like they're forcing me. I didn't want to – I should of – I wished I ducked in the back of the thing and locked it and make em take us, we would have been right then."*

42. When considering his evidence, it is to be remembered that he has already been dealt with by way of a plea of guilty in relation to the death, that there was no consideration of him giving evidence upon his sentencing and that apart from a natural inclination to diminish his own role, there would be little for him to gain by his evidence. However, he is a criminal, an admitted killer and it may be that he was anxious to have others share the blame. Certainly he said (transcript p214):

> *"And do you remember telling Detective Sergeant Lade that you couldn't remember anything about this?---Yeah, well, it's all come and goes.*
>
> *So as at 4 October you couldn't remember but almost a year later you have some sort of vivid memory of it?---I didn't even have time to think about these things first, firstly sitting in prison, eh.*
>
> *Well, if can't remember things the day after the event, how can you have a better memory of it afterwards?---Well, you got time to sit down and recall and think to yourself what all this – what's happened."*

43. Standing by itself I could not use his evidence to draw any confident conclusions.

## CARE, SUPERVISION AND TREATMENT IN CUSTODY

44. I am required in an investigation into a death in custody, to report on the care, supervision and treatment of a person in custody (*Coroner's Act* s.26). In doing so in this case it is necessary to examine the actions of Goldstein and Cook. Were their actions appropriate? In my view the evidence reveals that they were not, indeed, their actions fell far short of an expected response by Northern Territory Police to an incident such as this.

45. General Order D7 – Domestic Violence of the Police General Orders outlines the "minimum response" for members attending a domestic violence incident. A copy of this general order formed part of the Investigation Brief (Folio 6).

46. Members Goldstein and Cook were interviewed by both Detective Lade and Officers from the Professional Responsibility Division. Transcripts of those interviews were tendered. They also gave evidence and were cross-examined by Counsel. By their own admissions, very little conversation occurred between them and others in Brolga Street. They made no inquiry with the complainant or others at 44 Brolga Street. They both claim that the job was given as a "disturbance – general" which carries a lower level of response. As could be heard from the communications tape, this is incorrect and the job was given as a "disturbance – domestic".

47. It is difficult to explain why they both were under this misapprehension. Whilst "blackspots" regarding transmissions of communications were mentioned, if some or the entire message was not understood, a repeat would have or should have been called for. Regardless of the job description it would appear that the members fell short on taking the appropriate action once they arrived at the scene. There was sufficient evidence available that even if they attended as a "general disturbance" they should have become aware on arrival that they were actually attending a domestic violence incident.

48. They both claimed that Collins was not overly intoxicated and seemed to be very helpful in assisting with the deceased to the rear of the van. They both believed that they could release the deceased into his care in accordance with Section 131 of the *Police Administration Act*. As Detective Lade says in his covering report:

> *"A simple inquiry with the complainant at 44 Brolga Street would have revealed how unwise their course of action would be."*

49. Had they also made inquiries with Ms Tutt, who had seen the deceased being "bounced" by Mr Collins, they should have formed serious misgivings as to the safety of the deceased at that address. Neither member conducted any investigation to establish the true position of the situation before them.

50. Constable Goldstein had been in the Northern Territory Police force some three years prior to the death. He was the Senior Officer that day, indeed, Constable Cook stated to me (transcript p125):

> *"And as the junior member in that team with Mr Goldstein, did you understand that it was he who made decisions in relation to what you did and where you did it?---Yes.*
>
> *Or a decision to arrest someone or not arrest somebody?---Yeah, it was definitely under Dean's guidance."*

51. Goldstein on the very morning of the death had handed in his resignation from the Northern Territory Police Force; he left two weeks later to join the Queensland Police Force. Apparently six months later he ceased with the Queensland Police Force. Goldstein stated as follows (after receiving the open communication about trouble at Uncle Sam's) (transcript p38 – p39):

> *"Prior to receiving that call, is it correct that you felt the deceased needed to be taken into protective custody for her own protection?---Because she was intoxicated in a public place, yeah.*
>
> *Post receiving that call, what had changed that you felt you could leave the deceased with Mr Collins?---Just his conduct during the time that we were there, he was helpful, as I said he appeared sober to us.*
>
> *THE CORONER: What changed between the moment that she's sitting on the back of the iron cage and you're about to slip her in further, to when you released her to Collins, but before I ask – how many seconds are we talking about between those two moments?---Maybe for the call to come over, probably 30 seconds to a minute.*
>
> *Is it the only thing that changed was this call, isn't that the situation?---Yes, sir.*

*MS MORRIS: So Mr Collins demeanour hadn't changed while you were there?---None at all.*

*THE CORONER: You weren't asked specifically to go to Uncle Sam's, were you?---Not when the call first came over, no, sir."*

And (transcript p59 - p60):

*"If it was good enough to release this lady into the care of Collins after you got the radio call about Uncle Sam's, then I suggest it was good enough to release this lady into Mr Collins' care before the time of that call, do you agree with that?---Yes.*

*So why didn't you?---Again we hadn't got that far with - - -*

*Wait there, you got as far as putting her in the van?---But as we've said we didn't get to have an in depth conversation about the situation finding out exactly what had gone wrong.*

*But you didn't afterwards either, did you?---After what, sir?*

*After the radio message about Uncle Sam's?---No.*

*Well, I ask you once again, if it was good enough to release that lady to Mr Collins after you got the Uncle Sam's call, then you've agreed it was good enough to release her to Mr Collins before the Uncle Sam's call?---Yes.*

*Why didn't you?---Because what we would have done was had conversations with them both and found out what had happened, there are jobs that we go to where there may be arguing prior to us getting there, but upon police arrival we can diffuse the situation, and both parties or all parties are all happy to go on without any further police intervention.*

*But none of that happened, did it?---No, it didn't.*

*Either before or after the Uncle Sam's call?---No, sir."*

52. Constable Goldstein's evidence, in my view, was characterised by the use of selective memory, and by the ready use of answers such as "don't remember" or "did not hear" when pressured about embarrassing matters concerning his conduct. His explanation as quoted above I found to be simply disingenuous.

53. Constable Stephen Cook joined the Northern Territory Police Force on 29 January 2001, he graduated after 6 months training in July of that year. He resigned from the Northern Territory Police Force on 18 December 2001. He appeared (coincidentally) to have also not heard key communications, not remembered key points of relevance and also thought Collins was not unduly intoxicated as did Goldstein. He was not prepared to disagree with Mrs Maison's evidence as to how the deceased had been "reefed" out of the van; he told me he and Goldstein were either not concentrating or not looking. He told me, and I quote (transcript p135):

> *"Why did you feel that you could leave the deceased with Mr Collins?---Just from what I observed – what I had observed from the time we got there to the time we left he was acting in her best interests, he was helping her – he was helping her walk. He was communicating with her to some degree and he had a bag full of clothes for her, he was trying to help her get dressed, he appeared to be acting in her best interests.*
>
> *THE CORONER: But even despite that you weren't prepared to leave her with him, were you, you were going to take her away?---Of leaving and going to take her away, yes.*
>
> *Yes. And the only thing that changed your mind was this radio call?---Yes, you're probably right there."*

And (transcript p152):

> *"Well, okay, put it this way, a quick decision to leave and your decisions in respect of her were hasty and not appropriate?---They were inappropriate based on the whole of the information, I agree with that.*
>
> *Well, I think it's going to go further than that. They're going to say what you knew then you should have at least asked a few more questions before you left?---I can't disagree that a few more questions would have helped."*

And (transcript p154):

> "*Now you – let's just take a step back here, assume this, the deceased gets into the wagon and assume also that the way in which she was removed was by Collins forcefully dragging her out, ripping*

*her over his shoulder and reefing her out in such a manner that he looked like he might drop her, it would in fact be outrageous to leave her in his custody, if that had happened, wouldn't it?---I can see what you're saying, I don't disagree.*

*Well, it would be- you agree that it would be outrageous if that happened to have left her in Collins custody?---As I just said I don't disagree with you.*

*Now you've heard that there's a member of the public who says that's precisely what – how Collins removed this woman from the vehicle. So that's totally at odds with what you say in your evidence today in chief, isn't it?---I wouldn't say totally at odds because there's only certain aspects of what I've seen to what this witness has seen.*

And (as to coincidences in terms of mistakes and memories with Goldstein) he stated (transcript p181):

*"What are those alternatives?---Well, we were both in a very similar situation, part of a – attending the same job. It is likely that Dean is telling his side of the story. I'm telling my side of the story. Its fair to say that we'd tell very similar stories in the same situation. I'm not denying that, yes, mistakes were made, but in regards to say the hearing of the radio then, you know, its fair to say that mistakes were made, it's not a – necessarily a coincidence and it's not necessarily fabricated.*

*All right?---You see, there's alternatives.*

*I see, yes. Just one more thing. In the course of that interview with counsel, is it – did it happen that both you and Goldstein – telling your stories and saying 'Well look, this must have been the way it happened', in other words, reconstructing the events?---Like I've said a bit earlier, I can't remember specific conversation. I know we had a conversation with counsel, the three of us were there, but what the actual conversation was is not in my memory.*

*So you don't deny – well, you don't rule out as a possibility, that you may have both reconstructed the events and made a decision about what must have happened, effectively joined up?---Again, I do see your point of view, and what your saying is a possibility, something – if you were to make some assumptions, you'd say it's a possibility."*

54. The only factor which changed their decision to take the deceased into protective custody was the radio call regarding the "Uncle Sam's job". The demeanour of Mr Collins had not altered. They could not have formed the opinion that to leave the deceased with Mr Collins was the appropriate option, in my view and at best they simply did not think about it at all, but merely 'offloaded' the deceased in order to attend the other task.

55. There is no doubt that the deceased had been apprehended in accordance with Division 4 – Apprehension without Arrest, of the *Police Administration Act*. It therefore follows that the deceased was in the custody and care of both members. The Northern Territory Police Custody Manual as one would expect, details among other things, a duty of care of persons in custody together with member's responsibilities. It is clear that both Officers failed to comply with the requirements of this Manual although they claimed that they transferred that care issue to Mr Collins.

56. The evidence given by both former officers was extensive. However neither was prepared to acknowledge that they saw anything at the time of their attendance, which caused them concern regarding the deceased's welfare. It is difficult to see how this corresponds with the evidence of other witnesses, such as Ms Maison. I agree with Counsel Assisting's submission that Mr Goldstein and Mr Cook treated the deceased in a perfunctory and cavalier way, and have sought to downplay in their evidence her condition, which should have led them to have real concerns about her continued welfare.

57. Officer Goldstein in his first interview with Detective Sergeant Lade, revealingly in my view, described the deceased as "just a drunk Aboriginal female". He was asked about this description at the Inquest (transcript p50):

> "*Right, I'll remind you what the answer was, this is at page 13, sir, of the first interview – Mr Lade said:*

> *Okay, you know hindsight's a wonderful thing, do you think you would have done it any other – any different way now knowing what you know?*
>
> *And you've replied:*
>
> > *No, because what we were presented with as I said, was what we believed was just a drunk Aboriginal female, we had someone sober to leave her in the custody of and we had a more urgent job to go to.*
>
> *Now just in relation to your comment being 'just a drunk Aboriginal female', well you're nodding your head there, do you accept you said that?---I accept that I said it, but the 'just' was not to devalue her in any way whatsoever. The just was that it was just a drunken person"*

58. Sadly, in the case of Officer Goldstein, I find that his lack of attention to the needs and care of the deceased came about from an attitude based on his own perception that the deceased was "just a drunk Aboriginal female". On all the evidence presented at the Inquest (including his own), I reject his endeavour to explain away his comments. I find (to use his own words) that he did indeed by his actions and attitude "devalue her" as a person.

## THE COMMUNICATIONS AND TASK ASSIGNMENT SYSTEM AS IT WORKED ON THAT DAY

59. Auxiliary Julianne Hurley and Acting Sergeant Sally Zylstra gave evidence in relation to the Communications system of the NT Police. Hurley was the dispatch operator and Zylstra the Communications Supervisor on the day in question. Of concern is the 23 minute time lapse between the call coming in and the dispatch of a unit to the job.

60. Records perused by Commander Fields indicate that the shift was not a particularly busy one. The investigation of Commander Fields discovered that there was a unit available earlier than Goldstein and Cook's unit, unit 409. Hurley could not recall why she did not use that unit. In her words it (transcript p229):

*"should have been blatantly clear to use 409 but why I didn't I do not know, cannot remember."*

61. It is also of concern that the message was not passed on to members that Ms Tutt would be spoken to by police.

62. Both Hurley and Zylstra were frank in their evidence that they do not know why the call for assistance was in pending for such a period of time, and why they did not institute normal procedures, such as a general call, prior to sending Goldstein and Cook. Hurley gave evidence that a priority one job pending for even 10 minutes was rare and would cause concern.

63. Officer Hurley frankly agreed that mistakes were made in relation to the dispatch; she stated in evidence (transcript p239):

*"The Coroner: You've been frank enough today, haven't you, to admit in this open court, you didn't have a real good day, that day, did you, in terms of 44 Brolga?---No."*

and

*"Do you consider yourself to be a professional?---Yes, I do.*

*Have you learned something from this incident?---Yes."*

64. Auxiliary Hurley admitted to leaving her screen for a break without logging off her user identification. She had in fact been working since 7.00am that morning, with only a 15 minute break for lunch. There were new staff on that day, and Hurley was one of the experienced operators. These factors may have contributed to her inattention, despite the acceptance of a 12 hour shift system as a preferred system of work.

65. Acting Sergeant Zylstra was also frank in acknowledging the same mistakes and simply could not ascribe any reason for same.

66. Simply put a response should have occurred that saw the arrival of police help to 44 Brolga earlier than the 29 minutes from call to arrival. If earlier

response had have happened then maybe consequences would have been different.

67. Commander Fields (of the Professional Responsibility Division of the Northern Territory Police) completed a report into the performance of Hurley and Zylstra and apparently they will be counselled and otherwise dealt with internally over their performance. In my view in the giving of their evidence before me, they were frank, credible and reliable witnesses obviously contrite for the mistakes made by Police Communications in relation to the calls concerning the deceased. In my view, there was nothing to suggest that indifference or undue negligence was the reason for their mistakes (in contrast to the behaviour of other police officers that same day).

**CAUSE OF DEATH**

68. On 4 October 2001, an autopsy was carried out by Professor Anthony Ansford. His findings were that the deceased died of an intra abdominal haemorrhage given rise to by a ruptured spleen. His report was tendered as part of Exhibit 1 (folio 30).

69. There is no doubt that the injuries leading to death were caused by John Joseph Collins, and that he was responsible for her death.

70. It is possible that the fatal injuries were caused prior to the phone call to police from Ms Rostron, or prior to the arrival of Goldstein and Cook, or after they left, and prior to the arrival of Constables Marsh and Wilson. Evidence was called from the Forensic Pathologist. In his opinion (transcript p218 – p219):

> *"the minimum and maximum are a bit rubbery, they're not meant to be absolutely set in concrete but I would have thought 15 to 20 minutes might be a minimum time and one to two hours or possibly even a bit longer could be a maximum time. We have to take into account, also, in these situations...any pre-existing conditions and*

*also the degree of damage to the spleen, because if there is a lot of damage to the spleen then blood loss will be more rapid and if the pre-existing condition which potentates bleeding, then the blood loss will be more rapid. In this particular lady, she had quite a bad injury to the spleen and she also had cirrhosis of the liver consistent with long term alcohol abuse and that can be associated with increased tendency to bleed, the cirrhosis of the liver, and she also had a high blood alcohol reading, and people with a high blood alcohol bleed more readily than people who don't…So she had pre-existing factors which might have accelerated the rate at which she would have bled from that quite bad injury to her spleen."*

71. I can not give an exact time for the striking of the fatal blow. It is difficult to imagine that the deceased was able to move uncomplaining, as described by Goldstein and Cook, with four broken ribs. It is probable, from all the evidence, including that of the residents of 44 Brolga Street, that the fatal injury occurred after the deceased was left with Mr Collins. It is possible however, for it to have occurred prior to Goldstein and Cook's arrival.

**REPORT TO THE COMMISSIONER OF POLICE AND THE DIRECTOR OF PUBLIC PROSECUTION ("DPP")**

72. If I believe that a crime may have been committed in connection with this death I must report to the Commissioner of Police and the Director of Public Prosecutions. (*Coroners Act* s.35(3)). I must not include in a finding a statement that a person is or may be guilty of an offence. (*Coroner's Act* s.34(3))

73. John Joseph Collins, of course, has already been dealt with by the justice system. Is there evidence that another crime may have been committed?

74. Section 154 of the *Criminal Code* deals with the issue of criminal negligence. This section "casts a wide net, so as to cover all acts or omissions endangering the life, health or safety of any member of the public where the risk ought to have been clearly foreseen and the act or omission avoided." (Baumer v The Queen (1988) 166 CLR 51 at 55). Section 154 imposes a general liability when the omission to act seriously endangers

others. "This widens s154 considerably beyond the limited circumstances in which omissions have been recognised as attracting criminal liability…"(Blokland: Criminal Law Journal Vol 19, p74 at 79).

75. My belief, must be reasonable in the circumstances of the case. In my view, having regard to all of the evidence, I am firmly of the belief that risk to the deceased ought to have been clearly foreseen.

76. Accordingly, I refer the matter of the death back to the Police Commissioner and the DPP for their attention as I believe crime(s) as defined by Section 154 of the *Criminal Code* were committed in connection with the death. That is to say, further crimes in addition than that committed by John Joseph Collins.

77. I note that section 35(3) of the *Coroners Act* mandates me to make a report to the Police Commissioner and the DPP once I form a belief as to a crime being committed in connection with the death ie. once a belief is formed I have no option but to make a report.

78. In making this report pursuant to Section 35(3) of the *Coroners Act* I expressly reject the following submissions of Mr Lisson and find them misconceived that:

a) I must be satisfied beyond reasonable doubt of the commission of a crime before I make my report of my belief as to the commission of such crime.

b) I should not make any such report despite a belief as to the commission of crime because it "would serve no useful purpose", it would be "tantamount to an insult to (the DPP's) professional competence", and the same in relation to the Commissioner of Police.

c) I should not make any such report because it "would give the appearance of an endorsement to a prosecution".

79. Furthermore, I do accept Mr Hutton's submission that "I only have to believe that a crime may have been committed, such belief must be reasonable". However, I expressly reject and find misconceived his submission that any report pursuant to Section 35(3) "must necessarily be a private function of the Coroner and not a determination that is recorded in his official findings". This submission does not accord with the public nature of my function at Inquest, and would have me sending private missives behind people's back to police and prosecutorial authority.

## CONCLUSIONS AND RECOMMENDATIONS

80. I summarise my findings;

a) concerned residents of a home in Wulagi telephone police to ask for help in relation to fighting at their home between a couple viz. the deceased and her boyfriend "(the job)".

b) Despite the "job" being logged by the police communications staff as a "Domestic – code one" with all the serious attention that such disturbances are supposed to receive (in terms of police priority, standing orders and policy), and despite various communication devices and other procedures eg. 5 minutes overdue alarms), a police unit is not dispatched for 23 minutes to the home.

c) The police unit is dispatched with information alerting officers Goldstein and Cook to the fact that the job is a domestic disturbance with some violence, and arrives some 29 minutes after the telephone call.

d) Prior to police arrival, a neighbour is concerned enough to telephone police with worries about the deceased (who apparently has collapsed

in the carport of her house, and a half caste man has come in and lifted her up and then threw her or bounced her on the ground). Police communications advise that police are on their way. The neighbour's worries and information are not passed onto Goldstein and Cook

e) The police officers in the unit discover an Aboriginal lady (the deceased) adjacent to the home sitting in the street, naked except for panties, with a male companion standing next to her. One of the police officers notices a minor injury on her. There is evidence of blood on the footpath in the immediate area. The police officers assumed (correctly) that the companion is her boyfriend (transcript p37).

f) The police officers decide to arrest the lady and place her in protective custody having decided she was severely intoxicated – they take steps to place her in the back of their paddy-wagon with the help of her male companion. I find that she was placed entirely inside the wagon. The male companion assisted and also obtained some clothing for her.

g) The male companion was also severely intoxicated at this time.

h) The police officers suddenly change their mind about detaining the deceased. They make no enquiry with the deceased about the matter, they make no enquiry with neighbours or other witnesses about the deceased; they make no enquiry with those at the given address about the deceased.

i) In deciding to leave without the deceased they do not "log off" from the job as required, and they do not advise their supervisor.

j) They direct the deceased's boyfriend to take the deceased from the van. They allow him to grab her and "reef" her out of the van

roughly and in a manner detrimental to her safety; he throws the severely intoxicated deceased over his shoulders with her head pointing to the roadway and he staggers off with her. The police van hurries away.

k) The boyfriend had been bashing the deceased prior to the arrival of the police and continued on with bashing her after the police left. This violence inflicted on the deceased by the boyfriend, prior to the police arrival, would have been easily discovered upon enquiry by them.

l) A quarter of an hour later another police vehicle arrives (because the "job" had not been "logged off" as finished) and discovers the deceased in the house dying from the violence inflicted on her.

81. In my view prior to the arrival of police officers Marsh and Wilson, the performance of the Northern Territory Police Force in relation to the deceased's welfare on the day of her death was abysmal. It is to be noted that the Police Commissioner's office would not appear to disagree given the unqualified apology to the family and friends of the deceased proffered in evidence by Assistant Commissioner Smith (transcript p300).

82. Assistant Commisioner Smith told me (transcript p.282 / 283):

> "Now what is the police policy in respect of domestic violence in the Northern Territory? --- The policy is that they're a priority 1 task, we treat them with the highest degree of seriousness because quite often they can be life threatening. There's extensive training from the very induction of people into the organisation with respect to how you deal with domestic violence matters and as far as I'm concerned, they're the highest priority for me to deal with as the assistant commissioner of operations command because they have the most significant impact on people in the Northern Territory, of anything."

The difficulty facing the police force, highlighted by this case, is endeavouring to have such high level dictates enforced on the streets in day to day policing. Neither officer recalled much of their cross-cultural training, yet it appears from the evidence to have been extensive. Neither

Officer commenced any of the standard procedures for dealing with domestic violence situations, even when faced with sufficient evidence to suggest that this was indeed such a situation.

83. I recommend that the Northern Territory Police confirm the role of the shift supervisor, in authorisation of members to break from one job to attend another prior to completion.

84. Despite the evidence showing that initial police training in relation to domestic violence and cross-cultural issues is extensive and not tokenistic, I recommend the Northern Territory Police continue to confirm through training and ongoing refresher courses, the necessity of making appropriate and sensitive inquiries when attending a domestic incident.

85. I further recommend that an examination be made of the shift lengths and breaks for Communications staff, with a view to fatigue management.

86. Commander Fields in his report concludes that:

> *"Problems raised in the report do not arise from a failure of the system, lack of training, inadequate procedures, insufficient resources or the like. They occurred because members did not do the jobs they were trained for." (Report:p16)*

I agree with Ms Morris's submissions that members not doing the jobs they were trained for is a failure of the system. A system that failed the deceased on the 3 of October 2001. That is to say, a system is only as good as the people who operate it.

Dated this 24th day of February 2003.

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GREG CAVANAGH
TERRITORY CORONER