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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Territory Coroner's Findings and recommendation regarding the death of Mr Patrick Wayne Bloomfield (also known as Kumanjayi Bloomfield)

Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendation of Local Court Judge, Greg Cavanagh, the Territory Coroner, dated 1 April 2021, regarding the death of Mr Patrick Wayne Bloomfield (also known as Kumanjayi Bloomfield) (the Deceased) (refer Attachment A).

This Report includes the response to the recommendation from Mr Jamie Chalker APM, the Commissioner of Police (the Commissioner) (refer Attachment B).

The Deceased, a 42 year old man of Aboriginal descent, died at about 4.50 pm on 25 July 2019, on the Plenty Highway six kilometres east of its intersection with Mica Road in Atitjere, Harts Range in the Northern Territory.

The cause of death was blunt force head and chest injuries sustained in a traffic crash where the Deceased was the driver. The Deceased was not wearing a seat belt and was ejected out of a motor vehicle after it lost control and rolled. The forensic pathologist found that the injuries were not survivable, and commented that unconsciousness would likely have been immediate and that somatic death would have ensued within a matter of minutes.

The crash took place after a police pursuit of the Deceased's vehicle which was suspected as avoiding a police random breath testing station. The pursuit took place for a short while by two police officers in a police vehicle with siren on. It was discontinued when it became obvious to the two police officers that the Deceased was driving his vehicle at high speeds on unsealed roads, was not going to stop and they did not have a resolution strategy. The police officers later noticed the crashed vehicle of the Deceased on the side of the road.

The toxicology report found the Deceased to have been intoxicated with a blood alcohol intoxication reading of 0.28 per cent.

The family of the Deceased were very concerned that it was the actions of the police chasing the Deceased that caused the death.

Recommendation of the Coroner

The circumstances of the Deceased's death required it to be investigated as a death in custody. While the Coroner was satisfied that the police investigation was 'comprehensive and of high quality', and was not critical of police actions prior to the traffic crash, the Coroner was somewhat critical of how Police managed relatives at the crash site shortly after the crash, in particular cultural misunderstandings and protocol breaches surrounding the death of a community member. To that end, the Coroner made the following recommendation:

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

Response to Coroner's recommendation

A copy of the Coronial Findings was provided to the Commissioner of Police, on 13 May 2021, in accordance with section 46A(1) of the Act.

A written response was received from the Commissioner dated 30 July 2021, as required by section 46B(1) of the Act, advising that the NT Police Force (the NTPF) accepted the recommendation of the Coroner and were taking the following action:

a) 'Crime Command are currently in the process of revising all General Orders and Instructions, which relate to the recording, reporting and investigation of deaths and other serious incidents.

   The revision includes the combining and contemporising of:

   - General Order – Coronial Investigations;
   - General Order – Death and Serious Injury arising from Police contact with the Public; and
   - General Order – Major Crime, Major Investigations and Critical Incident Response.'

b) 'Once the new General Order is complete, the NTPF will ensure that it is widely promulgated to all members involved in the management and investigation of these incidents. All Investigator and Detective training material will be updated, and in-service training will be provided as part of the regular Command Training cycle.

   It is the intention of the NTPF that all members who may be involved in death in custody investigations, not just investigating members, have an awareness and understanding of the General Order. This will ensure that appropriate family liaison and supervision of the entire response is in accordance with both the recommendation and the new instructions within the General Order.'

c) 'Progress made on all active recommendations (made by the Coroner to the Agency) will be included as part of the Agency's' [*sic*] report to the NT Coroner which occurs every six months.'

I am satisfied that the Commissioner of Police has considered the recommendation of the Coroner and is taking necessary steps with respect to the recommendation.

DATE: - 2 SEP 2021

Selena Uibo

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