CITATION: *Inquest into the death of Albert Robbo* [2005] NTMC 034

TITLE OF COURT: Coroner's Court

JURISDICTION: Darwin

FILE NO(s): D0024/2004

DELIVERED ON: 9 June 2005

DELIVERED AT: Katherine

HEARING DATE(s): 9-10 May 2005

FINDING OF: Greg Cavanagh

CATCHWORDS:

INQUEST – investigation of police conduct – dangerous act by driving – report to Director of Public Prosecutions

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Northern Territory Police:	Mr Tony Young
KRALAS for Family:	Mr Peter O'Brien
AJAC	Mr Chris Howse

Judgment category classification:	B
Judgement ID number:	[2005] NTMC 034
Number of paragraphs:	41
Number of pages:	20

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

No. D0024/2004

In the matter of an Inquest into the death of

ALBERT ROBBO
ON 6 FEBRUARY 2004
AT KATHERINE HOSPITAL

FINDINGS

(Delivered 9 June 2005)

Mr GREG CAVANAGH SM:

1. Albert Robbo ("the deceased") died on 6 February 2003 in Katherine after being run over by a police vehicle. At the time he was run over, at approximately 11.30pm on 5 February 2004, he was apparently asleep under the covered shelter of the Beaurepaires business premises at No. 3 O'Shea Terrace, Katherine. His death clearly fell within the definition of a "reportable death" pursuant to s. 12 of the *Coroners Act* as it was a death which resulted directly or indirectly from an accident or injury.

2. The deceased was not in police custody at the time of his death. At the time that the investigation into the deceased's death commenced, the Deputy Coroner was contacted by the investigating police about this issue. The advice, given in writing to the Commissioner of Police, was that whilst it appeared that the deceased was not a person in custody pursuant to the *Coroners Act*, it was nevertheless requested that the investigation be conducted by a senior investigator to a "similar extent and level" as a death in custody. Given that it was not a death in custody, this Inquest was held at my discretion pursuant to s. 15 (2) of the *Coroner's Act*.

3. The Inquest was held on 9 and 10 May 2005 in Katherine. Ms Roberts appeared as Counsel Assisting the Coroner. Mr Peter O'Brien, of Katherine

Regional Aboriginal Legal Aid Service appeared on behalf of family members of the deceased. Mr Tony Young of Counsel, instructed by Ms Mary Chalmers, appeared on behalf of the Northern Territory Police. Mr Chris Howse of the Aboriginal Justice Advisory Committee also sought my leave to appear and that leave was granted.

4. Section 34(1) of the *Coroner's Act* ("the Act") details the matters that an investigation coroner is required to find during the course of an inquest into a death. The section provides:

> “"(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; or
>
> (b) a disaster shall, if possible, find –
> (i) the cause and origin of the disaster; and
> (ii) the circumstances in which the disaster occurred."

5. Section 34(2) of the Act operates to extend the Coroner's function as follows:

> "(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."

6. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s. 35 of the Act, which provides as follows:

> "(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."

7. Five witnesses were called to give oral evidence at the Inquest. They were Detective Sergeant Lauren Hill, Rachel Morris, Bessie Inverway, Senior Constable Ron Millar and Constable Luke Kingsbury. At the conclusion of the evidence I heard oral submissions from Counsel at the bar table. The investigation brief prepared by Sergeant Hill was tendered. It contains approximately twenty two statements, photographs and other reports.

8. During the Inquest, issues were raised concerning the provision of further evidentiary material and the course that preparation for the Inquest had taken. At the outset I referred all counsel to a memorandum contained in the brief in which Superintendent Matthew Hollamby had recommended “that the Coronial Investigation file be forwarded to the Coroners office via legal services”. This memo was prepared after the police investigator, Sergeant Hill, had forwarded the brief to Superintendent Hollamby, her supervisor, and she had not seen it. I was informed from the bar table by Mr Young, and I entirely accept, that the Coroners brief did not in fact pass through legal services prior to its arriving at the Coroner’s Office.

9. It is for obvious reasons that it would not be appropriate for a brief of evidence prepared on behalf of and for the Coroner, to be forwarded to the Coroner “via” some review by lawyers appointed to act for any person involved in the death. This is particularly the case where those being investigated are police officers themselves. Independence of investigation, and the appearance of that independence, are vitally important to the role of the Coroner as an impartial investigator of all reportable deaths, including and especially those in which police officers were involved. I will return to this issue later in these findings.

CORONERS FORMAL FINDINGS

10. Pursuant to s. 34 of the *Coroners Act* I find, as a result of the evidence adduced at the Inquest the following:

    (a) The identity of the deceased is Albert Robbo, an Aboriginal male who was born at Wave Hill Settlement, Northern Territory on 30 September 1968.

    (b) The time and place of death was 1.09 am on 6 February 2004 at Katherine Hospital.

    (c) The cause of death was multiple injuries resulting from a motor vehicle accident in which the deceased was run over whilst lying on the ground by a Nissan Patrol 4WD Police vehicle driven by Constable Luke Kingsbury.

    (d) Particulars required to register the death are:

        (1) The deceased was a male.

        (2) The deceased was Albert Robbo.

        (3) The deceased was an Australian resident of Aboriginal origin.

        (4) The death was reported to the Coroner.

        (5) The cause of death was multiple injuries.

        (6) The Forensic Pathologist was Doctor Terence Sinton and he viewed the body after death.

        (7) The deceased's father was Robbie Wailbri.

        (8) The deceased's mother was Julie Wailbri.

(9) The deceased resided in the Katherine area (no fixed place of abode).

(10) The deceased had no usual occupation.

(11) The deceased was born on 30 September 1968 and was 35 years old at the time of his death.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH

11. The deceased was born in Wave Hill and during his adulthood lived in various areas including Kalkaringi, Lajamanu, Katherine and Darwin. The deceased, when drunk, had been on occasions taken into protective custody or to the sobering up shelter in Katherine.

12. In Katherine he stayed at the bush camp at Kalano Community, and in Ryan Park. Aboriginal witnesses who gave statements and evidence before me also often slept in Ryan Park and would sometimes spend the day drinking and playing cards in the Ryan Park area. During the day on 5 February 2004 these witnesses do not recall specifically seeing the deceased. Richard Long and Rachel Morris, along with Bessie Inverway, had spent the day playing cards and drinking. At about 9.00pm it started raining. Rachel Morris, Richard Long, Bessie Inverway and Mary Watson moved from the Ryan Park area across the road to the shelter of the covered driveway area of the Beaurepaires business premises at 3 O'Shea Terrace, Katherine. They gave evidence that they regularly sheltered there when it was raining.

13. Similarly, the police witnesses gave evidence that the Beaurepaires business was on their regular patrol on rainy nights. The owner of the premises had complained to the local police of the mess left there, and of having to move people on when he opened the business in the morning. On 18 December 2003, an incident is recorded on "Promis" (the computerised police recording system) in which the owner requested that the police conduct a patrol of the premises after business hours for those reasons. According to

both officers who gave evidence before me, this request for a patrol found its way on to their job sheets, and it was something that they regularly did when it was raining.

14. On the night of 5 February 2004 the deceased arrived at the sheltered area, probably shortly after the other four arrived. Richard Long, in his recorded interview with the police, recalls the deceased asking him for a cigarette. Rachel Morris said that she had gone straight to sleep when she arrived at the covered area because she was drunk. She did not wake up until the police car arrived. The four witnesses had arranged themselves with some bedding up against the wall of the workshop under the covered shelter, furthest from the open area. The deceased placed his mattress under the covered shelter in the middle of the driveway. He was in a position where a motor vehicle would ordinarily drive.

15. On the same evening, Constable Luke Kingsbury was working with Senior Constable Ron Millar in a 4WD Nissan Patrol. Constable Kingsbury was the driver. As part of their general mobile patrol they turned onto O'Shea Terrace and into the Beaurepaires driveway. The vehicle turned into the driveway with the headlights on high beam. As it proceeded towards the covered area the driver and his passenger saw the four people up against the wall on the left side. Constable Kingsbury put his headlights on low beam, and continued through the covered area of the driveway. The vehicle drove over the deceased who was apparently asleep on a mattress. It appears from the post-mortem evidence and the forensic examination of the vehicle that the axle of the right wheel struck his head, and the right rear tyre essentially crushed his chest area. Neither officer had seen the deceased. They felt the bump and turned the vehicle around. When they did they saw the deceased lying next to the mattress.

16. Constable Kingsbury applied first aid to the deceased who was still breathing and Senior Constable Millar called for the ambulance and police

assistance. The deceased was taken to Katherine Hospital by ambulance. He died about one hour later. Investigations which had commenced at the scene halted upon hearing of the deceased's death. CIB investigators Hill and Watkinson were called on duty at about 1.00am. In her statement dated 28 September 2004, and in oral evidence before me, Sergeant Hill detailed the steps she took in the investigation. Consistent with the instruction from the Deputy Coroner, all eye witnesses had their statements electronically recorded as soon as reasonably possible after the incident.

17. On 18 February 2004, Sergeant Hill asked Officers Kingsbury and Millar whether they would participate in a video re-enactment of the incident. At paragraph 20 of her statement she states that essentially she was told that after seeking legal advice the officers declined to do so unless the weather conditions were the same. A similar request on 28 March 2004 was met with a similar response. A "re-enactment" was conducted on Sunday 29 February 2004 but it did not involve any of the witnesses or officers involved with the original incident. Although the video recording of that re-enactment has been tendered in an exhibit in these proceedings, I find that it has little relevance.

18. That there was no re-enactment of this incident performed by the involved officers is unfortunate. In my findings at the Inquest into the death of Eduardo Concepcion [2001] NTMC 25, a police shooting, I made comments about the use of re-enactments as an investigative tool. At paragraph 65, I said:

> "Also, in my experience, it's almost always the case that video re-enactments are carried out in investigations of these kind of deaths, however, in the current case the legal representatives of [the involved officers] determined that they would not be involved in such an exercise. In my view, if an experienced and trained Police investigator believes that re-enactments are necessary, and the Police investigator in this case would not have asked for such re-enactments if he did not think so, then the Police officers ought to have been ordered to do so. Of course, if they wanted to decline on the basis of

> their privilege against self incrimination, then so be it, however I understand that at no time did the officers exercise such privilege."

19. Those comments are apposite here and I repeat them in relation to this investigation. Where any person, including a police officer, has information relating to a death which has been reported to the Coroner, he or she is required to provide that information when asked to do so. Sergeant Hill is a senior officer to each of the police officers involved in this incident. She could have directed them to participate in a re-enactment as she had formed the view that it would be helpful to her investigation. The only basis upon which they could have declined to cooperate would be by invoking their privilege against self incrimination. That privilege applies in the course of a witness giving evidence at a Coronial proceeding by virtue of s. 38 of the *Coroners Act* (NT). Whether by virtue of allowing for the proper operation of that section, or by the operation of a common law privilege, in my view (without deciding the issue finally) that privilege would extend to an interview situation.

20. In any event, they did not seek to invoke the privilege. An assertion that a witness "does not feel comfortable" in answering a question or participating in a re-enactment is insufficient to absolve him or her of a duty and responsibility under the *Coroners Act* to assist in the investigation. Police investigating matters on my behalf ought not be swayed by vague references to "legal advice" and ought direct junior officers to participate in any aspect of the investigation that the investigator reasonably believes necessary to assist him or her in coming to conclusions about the circumstances of the death.

21. I do not criticise Constable Luke Kingsbury himself for declining to take part in the re-enactment. He was a very inexperienced police officer at the time and it appears that he had "legal advice" that he need not do so. He participated in a recorded interview statement, and he freely gave evidence

before me in this Inquest and subjected himself to cross examination in circumstances where he might have sought to claim privilege.

Evidence of Kingsbury

22. I have read the recorded statement of Senior Constable Ron Millar and listened to his oral evidence before me in this Inquest. Senior Constable Millar was the passenger in the vehicle driven by Constable Luke Kingsbury on the night the deceased was killed. After the accident, the officers were not given the opportunity to discuss the events prior to making their statements. Constable Kingsbury went back to the station and was relieved from duty. Senior Constable Millar remained at the scene for some time initially commencing an investigation until he learnt that the deceased had died. In terms of the driving path taken by the vehicle and the events that occurred within the few minutes the police vehicle was in the Beaurepaires driveway and under the covered area, I found the descriptions between the two officers to be consistent.

23. Senior Constable Millar gave a number of suggested explanations for how it was that the accident occurred. They included that the vehicle itself was cumbersome; that the lighting was poor; that Constable Kingsbury was too short to see over the front of the vehicle; that people would not be expected to be sleeping in the area were the deceased was sleeping. Aside from the last point mentioned, Constable Kingsbury did not explain or seek to explain the accident by reference to any of the matters that Senior Constable Millar raises. In determining the facts and the matters that I need to determine, I am much more assisted by the evidence given by the person who was driving the vehicle.

24. At the time of the accident, Constable Kingsbury was a probationary constable who had been stationed at Katherine for about five months. He was patrolling the Beaurepaires Tyres Workshop on the night in question because he had been “tasked” to do so. His understanding of the reason for

that, was that patrolling was required because a complaint had been received about people hanging around the area drinking alcohol and causing a disturbance and creating a mess. He had patrolled the area previously about 4-6 times as driver, but never in the Nissan Patrol four wheel drive vehicle. He describes how he drove through the area this way (transcript page 110):

> "Down First or Second Street, into O'Shea Terrace and where did you turn into Beaurepaires?---Beaurepaires has two exits or two entry points and I entered the first of the entry points as you move along before the Stuart Highway.
>
> Now just describe, Constable Kingsbury, how you controlled and drove the vehicle from the time of turning into the driveway?---I turned left into the first driveway of Beaurepaires, I used my high beam lights to search the area as long as it's safe to do so and that's what I did on this occasion.
>
> How did you do that?---As I was turning left I used the high beam lights to sweep across from right to left to see if anyone was there.
>
> Yes, thank you, continue?---As I was moving - turning into the driveway I saw that there were people underneath the shelter and I dipped my lights so that now I was on normal lights.
>
> All right. So you turned left, you had your high beam on, turned that down, your wipers were on, it was raining what happened then?---I've come into the driveway, I'm driving slowly at a slow walking pace.
>
> And do you know - you say slowly at a walking pace, what gear were you in?---I don't - I didn't deliberately put the gear into drive, what I'm trying to say is, it's a subconscious thing that I did, to go that slow I would have been in first gear and my foot would have had to have been on the clutch.
>
> THE CORONER: Is a manual vehicle?---Yes, it is, sir.\
>
> MR YOUNG: You approached the - I think you were at the point you were describing as that you were about to turn right into the area under the roof, is that right?---That's correct.
>
> Just continue from there please?---I'm turning right now into the area underneath the awning. I'm aware of the people that are on the left-

hand side. My attention's focussed through the windscreen and out the driver's window in the direction I'm travelling underneath the awning.

All right. So as you turned where were you facing?---I could say that the centre of my vision was out through the front of the windscreen and out to the - the driver's side as I'm turning right - the driver's window.\

Right. And what about the people on the left, when did you see them?---Well, I - these were the same people that I'd observed as I turned in, with my high beam, as I've driven up the driveway I can see them through the front of the windscreen, but as I'm turning right we're obviously there to assess if, for example they were drinking alcohol or if they were creating a disturbance. But Senior Constable Millar was on the left-hand side of the car and he was the person that was seeing what they were doing, what they were up to.\

All right. Now as you turned right, what if anything did you see in front of you on the driveway?---I did not see anything.\

THE CORONER: Were your eyes open and were you looking?---Yes, I was, sir.

MR YOUNG: Did you see any obstacles on the driveway?---No, I did not see any obstacles on the driveway.

Did you see the mattress on the driveway?---No, I did not see any mattress on the driveway.

Did you see a sleeping man?---No, I did not see a sleeping man on the driveway.

THE CORONER: Do you need glasses, what's your eyesight like?---To join the job I actually had laser surgery done so I've got perfect 20-20.

MR YOUNG: You turned right, you were travelling at walking speed you think probably in first gear, what happened then?---I've continued to maintain the same speed and then I felt a bump and it - it surprised me.

Where did you feel the bump, do you know?---I felt the bump on the rear right-hand tyre.

What happened then?---I continued to drive forward at the same speed so I could find an area where I could turn around and bring my lights back around to see what - what the bump was.

Was there any conversation between you and Senior Constable Millar after you felt the bump?---Yes, I was and from what I can remember he said something to the effect that you've run over a tyre. As I was turning round he said, maybe you've run over someone.

You turned around, what happened then?---I've brought the car completely around so it's facing in the direction under the awning so that I can use the lights to see what's there.

Yes. What did you see?---There was a mattress on the ground underneath the awning and there was an elderly male with his right shoulder on the side of the

mattress facing towards me. The - the mattress was running lengthways in the direction I was facing.

THE CORONER: So was it horizontal to where the people were sitting or was it - was it vertical to where the people were sitting?---It was vertical to where the people were sitting.

Thank you.

MR YOUNG: All right.

THE CORONER: In the form of a T then?---Yes, sir, that's correct.

MR YOUNG: You saw the man in the lights, what did you do then?---I stopped the car, jumped straight out of the car took my raincoat off and went straight over and started to give him first aid."

25. Constable Kingsbury agreed that he knew that there might be people drinking and congregating under the sheltered area of the driveway. Indeed this was the reason that the patrol was conducted. He agreed that the weather conditions were poor and that the area was dark. He maintained, as did Senior Constable Millar, that he had never seen a person sleeping otherwise than up against the wall of the shed in the position that the four other witnesses were sleeping. I accept this to be the case. However, taking

into account the likelihood of people being drunk, whether one can rely on a hard and fast rule about where people will be sleeping, is problematic.

26. Constable Kingsbury did not assert that the area was poorly lit to the extent that his visibility was unsatisfactory. Nor did he suggest that he was unable to drive the vehicle or see as effectively as a taller person. He essentially said that although he looked, he did not see the deceased on his mattress. (transcript page 139):

> “Is your evidence then that you've driven into what is effectively a blind spot?---I can't say that that's what's occurred. All I can say that is when I drove forward I was trying to see if - while I was driving forward I made sure it was safe to drive forward and I did so from what I could see.
>
> Can I suggest to you that you weren't looking forward when you were driving?---No, that is not correct.
>
> That you weren't looking forward in observation to the front and in the direction of where the car was headed, you were looking to the left observing the people against the wall?---No, that is not correct.
>
> And it was only when you passed those people that your vision changed away from them and towards the direction of the car and as you did that you turned and that's when the back tyre ran over the deceased?---No, that is not correct.
>
> Could you have positioned your car in a way in which you could have viewed the mattress at the scene with the benefit of hindsight?---With the benefit of hindsight, I can't explain why this has happened. So in hindsight, I don't know how I would have positioned the car better.”

27. In final submissions Mr Howse put to me that the weather and the lack of lighting, rather than being a legitimate explanation for what occurred, were in fact reasons why Constable Kingsbury should have exercised additional caution when he drove into the area. Mr O’Brien put his final submission this way (transcript page 161):

> “Whether it could be - whether it was because Kingsbury couldn’t see into the area and simply drove into a blind spot as he'd have you

> believe, or as Senior Constable Millar will have you believe, or whether he was - wasn't paying attention, was looking to the left, because his attention was fixed on the people and the faces of the people to the left-hand side of the motor vehicle and he drove into an area he hadn't observed, or he'd observed and it wasn't to be seen.
>
> My submission on behalf of the family is that it does not matter. On the one hand he was able to and should have in the circumstances used the additional lights fitted to the vehicle, the spotlights or the lights on the top of the vehicle or the high beam to shed light on the dark area, or position the car so that the entire driveway was visible or wound down the window of the driver's side to ensure visibility and we know that he didn't do that. We know that he only used low beam.
>
> On the other hand his attention as a driver to this particular area, ought not to have been diverted from the course that he proposed to take. A driver who does not know or is not looking where he's going in the circumstances of driving into an area where people are known to sleep, is committing a dangerous act and should have foreseen the consequences of such a seriously neglectful act. At least very arguably a serious disregard by the driver in his driving obligations of that vehicle on that occasion, in that place, is what has occurred."

Mr Young, on behalf of Constable Kingsbury submitted that there was no evidence that Constable Kingsbury was looking to the left or anywhere else other than where he said that he was looking.

28. I find Constable Kingsbury to be an honest witness. He was emphatic that he exercised appropriate caution in the circumstances, yet why he did not see the deceased he cannot explain.

29. It may be that his attention was drawn to the people sitting up on the left hand side against the wall. This was where he expected to see people. He gives a reasonably detailed description of what those people looked like, suggesting that he had some time to observe them. The configuration of the driveway, the shape of the vehicle and the lighting conditions may have led to a quite short window of opportunity to observe the deceased in his position in front of the vehicle: it is possible that during this short window of opportunity, Kingsbury's attention was drawn to the left. Alternatively, it

may be that it happened exactly as he now recalls and the combination of circumstances was such that even for looking he could not see the deceased in the position that he was. In these circumstances, perhaps he should have proceeded differently: used the spotlights, or actually stopped the vehicle and checked the area. Thirdly, it is possible, that he had, again through a combination of circumstances, a "blind spot" of which he was not aware and could not have reasonably been expected to be aware.

30. I am bound to consider these questions to some extent, because an issue which was at the forefront of the cross-examination and Counsel's submissions in this Inquest was the question of whether I ought exercise my duty pursuant to s. 35(3) of the *Coroners Act* to report a crime to the Commissioner of Police and the Director of Public Prosecutions. The section provides:

> "(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 (my emphasis)."

31. I heard submissions from Counsel as to how I should apply this test. In my view the threshold which must be crossed in order to enliven my duty is a low one. Certainly my belief must be based on more than a suspicion or speculation. However, it is not as high as a committal test. The use of the words "may have been" in the section, to my mind raises the bar no higher than a reasonable likelihood that a crime has been committed.

32. The crime I am asked to consider is the very broad *Criminal Code* provision creating the offence of what has become known as "dangerous act". Section 154(1) of the *Criminal Code* provides:

> "Any person who does or makes any act or omission that causes serious danger, actual or potential, to the lives, health or safety of the public or to any person (whether or not a member of the public) in circumstances where an ordinary person similarly circumstanced

> would have clearly foreseen such danger and not have done or made that act or omission is guilty of a crime and is liable to imprisonment for 5 years".
>
> The offence is aggravated where the act or omission causes death.

33. The provision is unique to the Territory. In *Baumer v The Queen* [1988] 166 CLR 51, the Full Court of the High Court of Australia commented at paragraph 7:

> "Section 154 of the Code is an unusual section. As Maurice J. observed, it is not specifically aimed at driving. It 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. The offence so created can therefore cover an enormous range of conduct from the comparatively trivial to the most serious."

For these and other reasons, the provision has been widely criticised by commentators. Indeed I understand that the legislature is considering amendments to the *Criminal Code* to remove or amend the section. Nevertheless, it is still as at this stage part of the *Criminal Code* and it is the provision I have been appropriately asked to consider.

34. In addition to considering reporting of this matter to the DPP pursuant to s.35 of the *Coroners Act*, it has been put to me that I should be critical of the decision of investigators not to charge the driver of the vehicle with a criminal offence. In a recent Inquest into the death of Peter Wiryal [2005] NTMC 019, I criticised police for not doing enough to investigate the accident thoroughly and expeditiously. I noted that that failure may have resulted in a person avoiding prosecution for a criminal offence. That type of comment is not called for here. Leaving the issue of the re-enactments aside, Detective Sergeant Hill has done everything necessary in her investigation for me to fulfil my function and to make the findings that I am required to make under the *Coroners Act*.

35. It used to be the case that one of the functions of a Coroner was to commit persons for criminal trial. Progressively, the Coroners Acts across Australia have been amended to remove the committal function in all jurisdictions. It is not the function of a Coroner to determine or appear to determine a question of criminal liability or to apportion guilt or legal blame for a death.[1] Consistently with this general principle, the *Coroners Act* (NT) specifically prohibits me from including in a finding or comment "a statement that person is or may be guilty of an offence". When s. 34(3) is read together with s. 35(3), the provisions together underpin the broader notion that it is not the Coroner's role to apportion criminal liability but rather the role of the DPP to determine whether a prosecution should proceed against a person for a criminal offence in relation to a death.[2] Accordingly, I do not propose to enter into a consideration of whether or not Sergeant Hill's decision not to recommend a prosecution was correct. I am satisfied that her decision was made bona fide and that the investigation was conducted fully and fairly.

36. Part of Mr O'Brien's final submissions on behalf of the family involve a challenge to the independence, integrity and impartiality of the investigation conducted by Sergeant Hill. It was suggested that one aspect of this was that the police officers involved were "no doubt personally known" to her. The suggestion that Sergeant Hill's investigation was affected by her personally knowing the officers she had to investigate, was not put to her in cross examination. As a matter of fairness, I have obtained a further statement from her dated the 18th May 2005 in relation to this suggestion. In that statement she says:

> "On Wednesday the 4th of February 2004 I began duties at Katherine Police Station. I am the gazetted Officer in Charge of the Katherine Investigations Unit (CIB). Due to the fact that I was in this position,

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[1] R v HAM Coroner for Northern Humberside and Scanthorpe; Ex parte Jamieson (1994) 3 WLR 82 at 100.

[2] See Second reading speech, Coroners Bill (Serial 220) Sixth Assembly First Session 23/02/93 Parliamentary Record No:15 Mr Stone (Attorney-General) Page 7898

> is the reason, I believe that I was called on duty to investigate this incident. I had been in Katherine for only two shifts prior to being called out to this incident. Prior to this incident I have never worked with Senior Constable Ron Millar. I knew his name but do not recall ever meeting him. Prior to this incident, I have never worked with Constable Luke Kingsbury. I vaguely recall seeing him about the PFES College during his recruit training stage but do not recall any direct dealings with him. The possible exceptions would be if I delivered training/lectures to his recruit course or participated on PT session with his course."

37. There is no evidence for the suggestion that there was any partiality or lack of integrity in relation to the investigation conducted by Sergeant Hill.

38. I have already made reference to my concerns about the perception of independence and impartiality when police are investigating other police. This tragic event involved the death of a very disadvantaged member of our society, an itinerant Aboriginal man, in circumstances where police could be at fault. It is of the utmost importance that the investigation be perceived by family members of the deceased person and the public at large to be impartial. The principle is reflected in Police General Order D2: "Deaths in Custody and investigation of serious incidents and/or fatal incidents resulting from police contact with the public." Most of that order applies, not only to deaths in custody but deaths which occur in circumstances such as this.

Recommendations

39. Pursuant to s. 35 (3) of the *Coroners Act*, I **report** this matter to the Commissioner of Police and the Director of Public Prosecutions as I believe that a crime pursuant to s.154 of the *Criminal Code* may have been committed in connection with this death. That is to say, in the circumstances of driving into a darkened driveway at night knowing that it likely contained sleeping drunks, it may be that there was insufficient lookout given and/or care taken.

40. I make no other recommendations or comments.

Dated this 9 day of June 2005.

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GREG CAVANAGH
TERRITORY CORONER