CITATION: *Inquest into the death of Anne Chantell Millar* [2005] NTMC 056

TITLE OF COURT: Coroner's Court

JURISDICTION: Coroners

FILE NO(s): D0039/2003

DELIVERED ON: 2 September 2005

DELIVERED AT: Darwin

HEARING DATE(s): 1, 2 February and 11, 14 March 2005

FINDING OF: Greg Cavanagh SM

CATCHWORDS:

INQUEST – Death by foul play, Domestic Violence, police conduct in relation to domestic violence restraining order.

REPRESENTATION:

Counsel:

Assisting: Mr Jon Tippett Q.C

Northern Territory Police: Mr John Lawrence

Aboriginal Justice Advocacy Committee (AJAC): Mr Chris Howse

Judgment category classification: B
Judgement ID number: [2005] NTMC 056
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0039/2003

In the matter of an Inquest into the death of

ANNE CHANTELL MILLAR
ON 28 MARCH 2003
AT DARWIN

FINDINGS

(Delivered 2 September 2005)

Mr GREG CAVANAGH SM:

1. Anne Chantell Millar ("the deceased") died at approximately 3.44am on Friday 28 March 2003 at the place adjacent to the Stuart Highway and near the "Fifteen Mile Camp" just outside Darwin. The deceased was bashed to death by her male partner in circumstances where a domestic violence order ("DVO") was in existence, and which was meant to keep her partner away from her and protect her. Her 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 violence. The investigation into the deceased's death commenced as a murder inquiry and I note that the deceased's partner was eventually convicted of a crime relating to her death.

2. The inquest was held on 1, 2 February 2005 and 11, 14 March 2005 in Darwin. Mr John Tippett Q.C appeared as Counsel Assisting the Coroner and I thank him. Mr John Lawrence of Counsel, appeared on behalf of the Northern Territory police. Mr Chris Howse of the Aboriginal Justice Advocacy Committee also sought my leave to appear and that leave was granted.

3. Section 34(1) of the *Coroner's Act* ("the Act") details the matters that an investigating 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."

4. 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."

5. 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."

6. I heard sworn evidence from eleven witnesses, and in addition, further witness statements and other written material were received with evidence.

CORONERS FORMAL FINDINGS

7. Pursuant to s. 35 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 Anne Chantell Millar (also known as Ann Chantell Millar), an Aboriginal female, who was born at Mt Isa in the state of Queensland on 1 September 1981.

   (b) The time and place of death was approximately 3.44am on 28 March 2003 at a place adjacent to the Stuart Highway and opposite the "Fifteen Mile Camp" outside Darwin in the Northern Territory.

   (c) The cause of death was multiple blunt trauma with a significant contributing factor being acute alcohol toxicity.

   (d) Particulars required to register the death are:

      (i) The deceased was female.

      (ii) The deceased was Anne Chantell Millar (also known as Ann Chantell Millar).

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

      (iv) The death was reported to the Coroner.

      (v) The cause of death was as per paragraph 7 (c) herein.

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

      (vii) The mother of the deceased was Yvonne Weir and the father of the deceased is unknown. Attempts have been made by Coronial Support Officer Alana Carter to recover that information from Queensland and the Northern Territory, but it remains unavailable as all records have been destroyed.

Enquiries of close family members have provided the name of the deceased's mother.

(viii) The deceased resided at Darwin in the Northern Territory.

(ix) The deceased had no usual occupation and was unemployed.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING RECOMMENDATIONS

Events leading up to and immediately after the death.

8. On Friday 28 March 2003, Sergeant Antony Stuart Deutrom was on duty as the Palmerston General Duties Supervisor. His duties included establishing a roadside random breath testing station at about 2.00am that morning. Shortly after setting up the random breath testing station ("RBT") at 2.15am he was contacted by Police Communications and directed to attend an incident at the Palmerston Sports Club. A disturbance or fight had broken out at that establishment and Sergeant Deutrom was required to speak to a number of people before returning to a position on the Stuart Highway near "Fifteen Mile Camp" to continue the operation of the RBT station. Shortly after his return, he was spoken to by Senior Constable Breen who mentioned seeing two Aboriginal people near the Stuart Highway. Sergeant Deutrom asked Senior Constable Breen what the people were doing, to which Breen replied, "they were sitting down". Sergeant Deutrom thought nothing more of the matter. The area where the people had been seen by Senior Constable Breen is adjacent to the "Fifteen Mile Camp" where pedestrian traffic is usually quite heavy. Sergeant Deutrom had frequently seen people in that area at all hours of the night and day. It is an area where he frequently established RBT's.

9. Sergeant Deutrom left the RBT station at 3.31am and began his journey, north bound on the Stuart Highway, back to Palmerston. Approximately 500m from the location of the RBT station he observed two Aboriginal people lying down on the median strip between the outbound and inbound

lanes. He slowed the vehicle and observed that the two people were a man and a woman. He stopped the vehicle and called in his location to police communications. He noticed what appeared to be blood about the female's face. The woman appeared to be trying to sit up. He noticed at that point a swelling to her face and a number of cuts to her forehead. The woman appeared to be semi-conscious. The male, on the other hand, appeared to be sleeping. He had blood on his white sneakers but only the left sneaker remained on his foot. Sergeant Deutrom tried to speak to the woman who was non responsive. He noticed the woman appeared to be having difficulty breathing. Sergeant Deutrom also attempted to speak to the male who, likewise, was non responsive. The woman was Anne Chantell Millar ("the deceased").

10. Sergeant Deutrom requested an ambulance to attend the location. Senior Constable Breen and Constable Manser arrived at the location and placed the female into the recovery position. Breen observed the deceased to move around on the ground a few times and while waiting for the ambulance monitored her breathing. As the ambulance arrived, Senior Constable Breen noticed that the deceased stopped breathing. He requested Constable Manser to check her left wrist for pulse but one could not be found. An ambulance arrived at 3.43am. At that point, Paramedic Ben Minchin observed the deceased lying on the ground motionless on her right side in the lateral position. He examined her and found that she had no obvious signs compatible with life. He also noted that she appeared to have multiple trauma to the head and face and bruising to the back as well as blood pooling in the lower abdominal area. At 3.44am, Paramedic Minchin "called the female deceased".

11. The deceased was just over 21 years of age when she died. She was a mother of two children, Kailing Millar, a daughter, born 11 November 1999 and Akeen Millar, a son, born 30 October 2000. The non-responsive male lying next to her on the median strip in the middle of the Stuart Highway

was Gregwyn Jabaltjari Green. In the 6 months or so prior to the deceased's death, she had been in a relationship with Mr Green. The relationship was pitted with domestic violence and it effectively ended her life.

12. On Friday 3 October 2003, Justice Angel of the Northern Territory Supreme Court sentenced Mr Green to 4 years imprisonment with a non-parole period of 2 years for aggravated dangerous act contrary to section 154(1), (3) and (4) of the Criminal Code. In the course of his sentencing remarks the Judge said:

> "Offences of this nature call for an expression by the Court of a sentence that reflects general deterrence. Time and again this Court has commented about the level of violence by aboriginal men on aboriginal women and it is sufficient simply to refer, yet again, to the comments of the Court in R v Wurramarra (1999) 105 A CRIM R at 512, 520 to 522 where the Court discussed the concerns regarding the issue of violence in aboriginal communities and the need to, so far as can, protect weaker members of such communities, particularly women and children, from excessive violence."

13. Justice Angel observed that Mr Green was a relatively young offender and that his prior criminal history was not particularly bad. The Judge went on to say that the case contained aggravating features and was "yet another all too common example of domestic violence ending in the death of a female at the hands of a male, both drunk." I note in passing, that Mr Green was initially charged with the manslaughter of the deceased but that charge was later amended to a charge of aggravated dangerous act, contrary to section 154(1), (3) and (4) of the Criminal Code for which the maximum penalty is 14 years imprisonment.

14. Tragically, it was not the first time that the couple had come to the attention of the police.

The violent relationship between Gregwyn Green and the deceased.

15. On 20 January 2003, Senior Constable Timothy James Moseley, at that time gazetted to General Duties at the Darwin Police Station, attended an incident

in the Smith Street Mall involving Mr Green and the deceased. He became concerned about the welfare of the deceased. He spoke to the deceased in relation to the incident and concluded that she was scared of Mr Green and very reserved about speaking to the police about Mr Green's treatment of her. At 6.20pm that day, Senior Constable Moseley began taking a typed statement from the deceased regarding an incident that was said to have taken place between the deceased and Mr Green.

16. In her typed statement, which she declared on the same day, the deceased told police that she had met Mr Green in late October 2002. She said they had only been seeing each other for about three weeks when Mr Green began to be aggressive towards her. She told police, "he would get very jealous of me when he thought I might be with another man. When Gregwyn gets jealous he gets very physical and angry. Since this day in October I have tried on many occasions to leave Gregwyn but he won't leave me. At first he would just threaten to hurt me, but he soon started hitting me". According to her statement to police, the beatings began in early November 2002 and became regular. She spoke of being beaten on more than ten occasions. She said the last beating had occurred on Sunday 19 January 2003, when she was punched and kicked not far from the McDonald's store in Smith Street. After that beating, she accompanied Mr Green back to a house at 1 Mile Dam. There, she was again beaten until it seems Mr Green became disinterested and decided to go to sleep. At the conclusion of her interview with Senior Constable Moseley, she said that she was very afraid of Gregwyn and that she did not want him to ever come anywhere near her again. She also said that she did not want to have Gregwyn charged by police for hitting her as she was frightened to go to court and give evidence. Her last request to police was that she "only want(ed) to get that order that stops him from coming anywhere near me.".

17. Senior Constable Moseley elected to act pursuant to the provisions of s. 6 of the *Domestic Violence Act* and arranged for a restraining order to be taken

out against Mr Green. The order was served on Mr Green by Patricia Docker of the Magistrates Court at 10.45am on 22 January 2003. The restraining order served on Mr Green, on that day, contained the following conditions:

(1) must not enter or remain near the premises situated at 10 Cobham Court, Palmerston;

(2) must not assault, cause or threaten to cause personal injury to Anne Chantell Millar;

(3) must not cause or threaten to cause damage to property in the possession of Anne Chantell Millar;

(4) must not act in a provocative or offensive manner towards Anne Chantell Millar;

(5) must not approach or contact directly or indirectly Anne Chantell Millar.

18. The conditions of the restraining order were granted pursuant to s. 6 of the Act by a magistrate and the return date of the process was 22 January 2003. On 22 January 2003, the Magistrates Court made orders by consent in the same terms and it was noted that the PROMIS Alerts System was to be updated accordingly.

19. I understand that the "PROMIS" system is the computerised police information system used to record complaints and other actions. The "IJIS" system is another computerised police information system to record apprehensions/arrests and subsequent actions.

20. The police PROMIS system is designed to enable police officers to place warnings on the system for the information of other police officers in relation to a number of matters including, but not limited to, domestic violence orders. On 3 March 2003, an instruction was issued by the

Assistant Commissioner Services Command to police officers to ensure that when placing warnings on the PROMIS system, the warnings were also placed on the IJIS system. That instruction arose as a result of audits that were conducted by the Northern Territory Police Force on both the PROMIS and IJIS systems, wherein it had become apparent that serious discrepancies in the recording of health and behaviour alerts between both systems had arisen. The instruction noted that numerous examples, including suicide attempts, of one system being updated to the exclusion of the other had been noted. At the time of providing that instruction to all members of the police force, the PROMIS / IJIS administration team had been tasked to continue audits across both systems to detect any discrepancies.

21. As I have already stated, Mr Green entered a plea of guilty to the offence of dangerous act causing death on 3 October 2003. Initially, I was of the view that an inquest was unnecessary, however, the history of contact accompanied by additional features resulted in me choosing to hold an inquest pursuant to my jurisdiction as set out in s. 16 of the *Coroners Act*. That decision was predicated upon the fact that during the investigation of the deceased's death, it came to light that there were a number of apparent failures on behalf of police officers who had had dealings with both the deceased and Mr Green in relation to domestic violence responsibilities. In the period prior to the deceased's death, it appeared that breaches of the domestic violence order by Mr Green had not been prosecuted or adequately investigated by police. On 20 December 2004, I released findings of the inquest into the death of Valerie Wurramara, which involved a graphic case of domestic violence and the inadequate police response to the issue. In the present case, I was concerned to examine the police response in relation to instances of domestic violence that had come to their attention over months prior to the death of the deceased, with a view to assessing whether any failures by police were, or might be considered to be, systemic or occasioned by inadequate operational procedures or an inappropriate

approach by police officers to the circumstances of aboriginal people who become involved in instances of domestic violence.

22. Further to the events surrounding the death of the deceased and the history of domestic violence as set out in the body of these findings, an inquiry was conducted by Commander Field of the Northern Territory Police Professional Responsibility Division into the response by police to breaches of the domestic violence orders pertaining to the deceased. Commander Field's report was delivered on 25 May 2004.

Significant findings at post mortem.

23. The autopsy report of Dr Terence John Sinton, dated 2 June 2003, was tendered during the inquest. The significant findings upon examination of the deceased included:

    (i) Lacerations, abrasions and bruisers variously to the head, neck and face, to the back of the trunk and to both arms and both legs;

    (ii) Extensive and severe subcutaneous haemorrhage to the scalp and to both forearms.

24. In Dr Sinton's opinion, the deceased died of the effects of extensive blunt trauma with acute alcohol toxicity being a significant condition contributing to death but not related to the condition causing death. Those findings came at the tragic conclusion of a series of events that commenced when the restraining order was made by the Court on 22 January 2003. On the evidence before this inquest, that order was breached on 5 occasions (to the knowledge of the police) leading up to the deceased's death from the injuries described at post mortem.

Incidents relating to domestic violence and involving police subsequent to restraining orders made in January 2003.

Breach No 1

25. On 1 February 2003, the deceased rang police at 2.13am with a request that the police come to Palmerston. She told the "Comms" operator that "I've got a restraining order". The transcript of the conversation between the deceased and police indicates that the deceased was rational and capable of giving detailed information which included her name, date of birth, her brother's name and his line of work, the name of the perpetrator Gregwyn Green and the type of restraining order she had namely "domestic violence". She was asked where Mr Green was at the time the conversation was taking place and she replied "he's right beside me". The "Comms" operator, in conclusion, advised the deceased "I'll trace this call and get the police to come down there, okay?" The attending police officers Dobson and Thompson were made aware that there was a current "no contact" domestic violence restraining order ("DVO") in force between the pair. They attended the area where the telephone call had been made but were unable to locate the deceased or Mr Green and no further investigation was carried out.

26. Police conduct in the relation to this incident does not disclose any failures that could be the subject of significant criticism. The police officers conducted extensive patrols of the car park area and the interior of the Coles Palmerston store without success. The deceased did not make further contact with police regarding that occasion. They were not in a position to execute the minimum response as required by police General Order D7 and it was not unreasonable for them to continue with their ordinary duties in the circumstances. However, General Order D7, which governs the nature of the police response to domestic violence, requires that instances of such violence be treated as a "serious crime". It is to be observed that if the

police had so viewed the matter they would have continued to search for the couple until they were found. The evidence in this inquest supports the conclusion that police officers operating in Palmerston at the time were aware of the requirements of D7. In this instance, however, the officers treated the matter somewhat differently to how they might have treated a serious crime. The actions of police suggest that the import of the provisions of General Order D7 was not understood by them.

Breach No 2

27. On 4 February 2003, at 4.57am, George Drummond (the senior next of kin of the deceased and the person who, in company with his wife Elizabeth Drummond, had been caring for the deceased's children for several months) contacted police and advised that both the deceased and Mr Green were at his residence at 10 Cobham Court, Moulden causing a disturbance. First Class Constable Colin Ragg and Constable Tanya Thurlow attended the premises. On this occasion, the officers did not arrest Mr Green for any breach of the DVO as they did not become aware of any current orders until 11 April 2003, when they were advised by the Police Domestic Violence Unit ("DVU") that there was a current order and they were instructed to prosecute Mr Green for the breach.

28. Apparently, neither Ragg nor Thurlow were advised by Communications that a DVO was in force. The deceased was spoken to and stated that she did not wish to be left with Mr Green and she was then taken into protective custody. Police drove to "Fifteen Mile Camp" with the deceased in the vehicle. No-one was home at the house the deceased nominated and she was then taken to the Watch House. During the incident she advised police that she did not wish to stay with her boyfriend. Apparently she did not advise police that a domestic violence order was in place. Police did observe at that time that she was intoxicated, however, she was able to tell police where she wanted to be taken and into whose custody she wished to be

delivered. Her boyfriend, Mr Green, accompanied her in the back of the police van and during the course of her journey, until such time, she insisted that she did not wish to stay with him. It is unclear what happened to Mr Green once police had decided that the deceased should be taken to the Watch House and placed into protective custody.

29. First Class Constable Tanya Thurlow, gave evidence that she had received training in relation to handling situations of domestic violence when at Police College in 2000. She said that she first discovered that Mr Green and the deceased were in a relationship after they had been placed in the back of the police van. She became aware that a DVO was in place restraining Mr Green, only after her partner on the job, First Class Constable Colin Ragg, was asked to attend to the fact that on the face of information received by police, a breach of the DVO had taken place and that an investigation of that breach should be carried out. The fact that the breach had not been picked up by police arose as a result of an audit of the PROMIS system. Constable Ragg gave evidence that he made inquiries in relation to the matter and asked a number of people to make statements, including the deceased. The deceased refused to make any statement in relation to the breach.

30. In case report dated 8 March 2003 – log number 31, PROMIS-608824 Breach of DVO the following information is noted:

> "Task Results:
>
> Finally found Millar and Green. Millar informed me that the order has finally been changed. She also stated that she did not want to make any complaint against Green, and that she had invited him around to the address. I can proceed with a Breach DVO against Green based on Thurlow's and my statements, if you believe this will suffice. Signed Colin"

31. On 11 February 2003, a PROMIS entry to Constable Thurlow from Lauren Hill attached to the DVU notes that the conditions of the DVO were clearly breached by Mr Green. Hill advised Thurlow that she will need to undertake

an investigation into the matter. "Even if Millar is not willing to provide a statement or complaint, then your evidence and that of the complainant will be sufficient for prosecution." "It may also be relevant to canvas Millar into having the DVO varied to a more realistic 'non-violent' order rather than a full non-contact. If this is the case then please incorporate that into the statement. A copy of this statement can then be forwarded to DVU Prosecutor to have the DVO varied. This will assist police in the long run, so where we attend incidents we will not have to deal with a breach unless there has been an act of violence."

32. Constable Thurlow in her statement tendered before the inquest, notes "Constable Ragg and myself were then tasked by Domestic Violence Unit to proceed with a breach of the above restraining order. I then made this statement." Constable Ragg and Thurlow gave evidence that they were aware of the provisions of General Order D7 but they said that their departure from the provisions of that order, namely the failure of the officers to proceed to arrest and charge Mr Green, was a consequence of the "nature of the request" they were given and the steps they were asked to take in the course of investigation (T127.9). If their instructions had been different, Constable Ragg's evidence was that he would have immediately "done a breach of domestic violence order" (T127.10). There does appear to be some degree of confusion in relation to the instructions given to Officers Ragg and Thurlow, as set out in the PROMIS entries under Folio 26, Exhibit 1. The entry for 11 February 2003 ends "DVU will follow up in providing advice to the victim and if we locate her first then we will obtain a statement and forward to the investigating member (Ragg)." In the circumstances, the failure of either Officer Thurlow or Officer Ragg to pursue the investigation to the point of arresting and charging Mr Green in accordance with the "no drop" policy set out in General Order D7, can be explained on the basis of a lack of clear direction given to them by the DVU itself. I accept that

Officers Thurlow and Ragg would have pursued the matter to arrest should they have been given clear direction to do so.

33. I note in relation to Constable Ragg's failure, Commander RW Field in his report dated 25 May 2004 decided that it would be inappropriate to criticise Constable Ragg for any failure to pursue the investigation for the reason that he relied on information from the deceased to the effect that the DVO had been varied and consequently saw no reason to take any further action. In my view, the decision not to properly pursue DVO infringements on the basis of information and direction given by complainants is not a good idea. In many cases, complainants are disadvantaged indigenous women, unsophisticated, "battered and bruised" and still scared of their partners, drunk or with diminished faculties caused by alcoholism. Such persons need to be protected from themselves and no doubt, this is why police General Orders, in this regard, are prescriptive in nature.

34. In conclusion, in my view the police response on that evening of 4 February 2003 left something to be desired. While the officers indicated in evidence that "there was nothing that would indicate to me of a relationship at that point of time (when the parties were placed into the rear of the police vehicle)", the police clearly knew they were in some kind of relationship and inquiries regarding each of the parties should have been made. Constable Ragg gave evidence that "when we got to 15 Mile and she said she didn't want to stay there with her boyfriend. That was probably the only indication I had there was a relationship." (T126.4). Commander Field noted that "Constable Ragg, as a member stationed at Palmerston, would no doubt have been aware of the incidents involving Millar and Green and the general nature of their relationship." Certainly the deceased and Mr Green appear to have been notorious characters in and about the Palmerston area and it is surprising that on 3 February 2003 neither Constable Ragg nor Constable Thurlow had any idea that the two were in a relationship until they had driven to the "Fifteen Mile Camp".

Breach No 3

35. On 5 March 2003 shortly after 11.00pm, Sergeant Glazebrook, the Night Shift Supervisor at the Palmerston Police Station, was waved down in the Palmerston area and advised that an Aboriginal male was assaulting an Aboriginal female in a car park. When he attended, Sergeant Glazebrook found the deceased with obvious signs of injury, a swollen lip, a laceration above her eye and lumps on her forehead and Mr Green in the immediate vicinity acting aggressively towards her. The deceased told Sergeant Glazebrook that "my boyfriend bash me". Sergeant Glazebrook arranged for a General Duties Patrol to attend and then spoke to Mr Green. According to Sergeant Glazebrook, Mr Green was intoxicated and identified himself as "Craig Win". Constable Connor and Constable Currie arrived and Mr Green was taken into protective custody. Sergeant Glazebrook then arranged for an ambulance to attend to check on the deceased's injuries. The ambulance crew elected to convey the deceased to hospital, Constable Connor gave the deceased a card with reference number on it. It would appear that Sergeant Glazebrook and Constables Connor and Currie were not aware of the existence of a DVO in relation to Mr Green. However, it was obvious that the deceased had been the victim of domestic violence and the provisions of police General Order D7 in those circumstances, were required to be followed by Sergeant Glazebrook and the other officers. The order is extensive and deals with minimum responses to a complaint of physical violence, threats of violence, harassment of any person within a domestic/family environment being received by police. The General Order requires such complaint to be treated as a "serious crime" (paragraph 1.5), whether or not the deceased made a complaint of assault. Also as a Supervisor, it was incumbent on Sergeant Glazebrook to comply with the provisions of paragraph 24 of General Order D7 which requires that at the end of a shift, all PROMIS details are complete and applications for restraining orders have been completed where required.

36. The ambulance officers Ingham and Minchin who attended at the request of Sergeant Glazebrook, arriving at the scene at 11.30pm, obtained the following history:

> "Previous Hx of domestic violence by same person".
>
> "21 year old woman patient post assault by ex partner (restraining order against him). Patient punched and kicked repeatedly with closed fist/boots??"

37. It was noted by the inquiry conducted by the Professional Responsibility Division, that it was strange that the ambulance officers apparently did not pass on the information they gleaned from the deceased to police. It would appear also strange, that the deceased did not pass on that information to Sergeant Glazebrook in the period whilst he attended the scene.

38. On the night in question, Mr Green was the subject of an "active" alert on PROMIS showing that he was currently on a DVO in relation to the deceased and that it was a full "non contact" order. An audit of the PROMIS system shows that Gregwyn Green's "person" details were accessed by Frederick William Glazebrook at 0100 hours on 6 March 2003. Even if Sergeant Glazebrook felt nothing could be achieved that night in relation to steps being taken to arrest Mr Green for a breach of the DVO, he had a clear responsibility to ensure that the incident was followed up at the first opportunity. His duty was to investigate and/or prosecute a breach of the order while Mr Green was still in custody. Constables Connor and Currie had taken Mr Green into protective custody due to the extent of his intoxication and because he was in an agitated state. His arrest should have taken place upon his release from custody for intoxication.

39. In his evidence given on the second day of the inquest, Sergeant Glazebrook was blunt and refreshingly frank. He said he was aware of the provisions of General Order D7 and would be astounded if police officers working from the station at the time were unaware of the provisions of that order (T105.9).

He agreed that his failure to arrest and charge Mr Green for a breach of the DVO was a breach of his responsibilities pursuant to General Order D7 and as a supervisor on the evening. Sergeant Glazebrook was dealt with by the Professional Responsibility Division for his failure in his responsibilities as a supervising sergeant regarding his lack of action in relation to the DVO restraining Mr Green. Commander Field referred Sergeant Glazebrook's actions to a further inquiry by the Professional Responsibility Division with a view to taking disciplinary action. During that investigation, Sergeant Glazebrook did not attempt to provide an explanation for his failures and conceded that he had breached various provisions of General Order D7 (T107.9). In the light of Sergeant Glazebrook's concession that he was "doubly as at fault" (T106.2) for failing to ensure that jobs arising from the PROMIS system were properly carried out, this inquest need only acknowledge the honest and forthright manner in which his evidence was given.

Breach No 4

40. On 13 March 2003, police Officers Mirtschin and Thurlow attended a disturbance in Temple Terrace, Palmerston. They found Mr Green being restrained by a security guard from Woolworths and the deceased standing on the footpath about three metres away from Mr Green. At that time, Constable Thurlow "knew that there was a domestic violence order in place for these two and that they should not be together". Constable Thurlow noticed that Mr Green had what looked like a knife wound to his left shoulder which was bleeding slightly. According to Constable Mirtschin, the deceased did not want to make a statement. Sergeant Deutrom, who was also present, informed Mr Green that he was under arrest for breach of a DVO. In the course of Mr Green's arrest, he struggled free and began to run but was ultimately secured by Constable Mirtschin, who tackled him and brought him to the ground. Mr Green was conveyed to the Watch House, where the police officers were advised to take Mr Green to the hospital due

to wounds that were bleeding and cuts to his lip. Constable Thurlow and Constable Mirtschin were advised by hospital staff that Mr Green would need to be admitted for four to five days in order for his condition to be assessed and treated. Consequently, Mr Green was released into the hospital's care. Theoretically, it was open for the police to attend the Royal Darwin Hospital on Mr Green's discharge and re-arrest him, however, that step was considered impracticable by police as often persons like Mr Green discharge themselves from hospital before police can carry out the task of re-arrest. However, if the provisions of General Order D7 are to be adhered to and the matter treated as a serious crime, police should have immediately taken steps to find and arrest Mr Green. Otherwise, only "operational lip service" is paid to D7, and, in my view, that appears to have been the case in this instance.

41. Sergeant Deutrom told the inquest that he concluded that the man and the woman in the disturbance were having a probable domestic argument. Consequently, he conducted a check through police communications to determine whether an order existed. Once he determined that it did, he directed that Mr Green be charged. His approach to the incident on 13 March was in full compliance with General Order D7. His evidence was matter of fact and the conclusions he arrived at, upon an assessment of the situation, were commonsense. In particular, the fact that the situation involved a man and a woman caused him to make enquiries as to whether or not a DVO was in place. As he discovered that a non-contact DVO was outstanding, he proceeded directly to the next step and arrested Mr Green. It is to be regretted that his full compliance with the letter and spirit of General Order D7 was not the subject of follow through.

Breach No 5

42. On 27 March 2003, the deceased and Mr Green had been drinking together. They started drinking at the Palmerston Tavern that morning and were told

to leave the premises by Manager, Peter Kennedy. The deceased was the subject of a trespass notice in respect of the premises. Early in the afternoon, he also told Mr Green to leave the premises. Some time after 4.00pm that day, Mr Kennedy returned to the Palmerston Tavern. As he drove past the beer garden, he saw the deceased outside on the footpath leaning against the wall "screaming and carrying on" and Mr Green over in the car park. He parked his car and walked over to where the deceased was. Someone at that point indicated to him that Mr Green had given the deceased a "flogging in the beer garden". Mr Kennedy said that surprised him because neither should have been in the beer garden anyway. While Mr Kennedy stood near the deceased, Mr Green came running over and "had another go at Chantelle by punching her in the head". Shortly thereafter, a police van arrived manned by Constable Curyer and Probationary Constable Fisher. Mr Kennedy spoke to them upon their arrival and told them that the deceased and Mr Green had been fighting.

43. In his evidence before the inquest, Peter Kennedy said in relation to his conversation with police, "I just told them that Chantelle had been in the hotel and …….and that her and her boyfriend had been having problems in the beer garden." And I don't think there was too much more said to the police ……. both, male and female, and they went off and the ……. male police officer spoke to Greg and the female spoke to Chantelle as I recall". (T136.6). Mr Kennedy said that the deceased often came to the hotel and caused problems with other drinkers. In relation to the assault upon her by Mr Green on that afternoon, Mr Kennedy said "I saw him strike her in the head" (T138.2). He went on to say that he recalled blood on the deceased's face, "she certainly had blood on her" (T138.4). He said he saw blood "on her face" (T138.5). Later he told the inquest that "Greg and Chantelle were both very well known to police, particularly Chantelle" (T140.3). The evidence of Mr Kennedy appeared consistent with that of Constable Curyer. Save for the fact that Constable Curyer did not note injuries to the face of

the deceased. In his statement, sworn 3 June 2003, Constable Curyer said "there was no blood on her face and she did not appear to require any medical attention". Constable Debra Fisher said in her statement that the deceased "pointed to a small mark on her forehead where she said Gregwyn had hit her". In her evidence before the inquest, she said she could "see a red mark" (T59.4) where the deceased alleged she had been hit. It must have been clear to Constable Fisher that the deceased was making an allegation of assault upon her by Mr Green at the Palmerston Tavern.

44. Constable Fisher gave evidence that she did not engage a minimum response as set out in General Order D7 "because we were going down the lines of protective custody. It wasn't – in my mind it wasn't a domestic that we were attending, so no, I can't say that I agree that …" (T50.9). In summary, Constable Fisher said that the situation was not a situation of domestic violence but rather it was a fight in a public place and that it was treated by she and her fellow officer Curyer in that respect. The Constable said that the deceased "wasn't emphasising the assault" (T51.9) and she agreed that there was no allegation by the male at the Palmerston Tavern that he had been assaulted by the deceased (T52.7). She agreed that the incident appeared to be between a man and a woman but distinguished it from a domestic disturbance on the basis that it was "a disturbance at a licensed premises" (T52.9). She gave evidence that it was clear in her mind, as at 27 March 2003, how she should deal with the domestic situation but contended that a domestic situation is "not a licensed premises disturbance" (T64.9). The Constable went on to agree, in cross-examination, that domestic situations can occur in car parks and hotels, including other places such as beaches for example (T64.10 and T65.1). In my view, Constable Fisher's evidence insofar as it attempts to distinguish the situation that presented itself at the Palmerston Tavern from that of a situation of domestic violence that would call her to act appropriately in another way, such as to put in place the minimum response as required by General Order D7, is not

accepted as an adequate or proper explanation. The distinction that Constable Fisher endeavoured to draw in her evidence between a domestic situation and a situation involving a male and a female on a licensed premises is disingenuous. In the course of questioning by the Coroner, Constable Fisher agreed that she was inexperienced and lacking confidence at the time that she dealt with the situation at Palmerston Tavern. She agreed that she was not as competent a police officer as she is now (T66.5). As at 27 March 2003, Constable Fisher was a probationary Constable and she was partnered to Senior Constable Wayne Curyer. She agreed with the suggestion that her failure to take steps personally to ask questions and further assess the situation was due, in part, to her reliance upon her senior partner (T52.7). That is understandable, however, her evidence in which she endeavoured to reconstruct the circumstances of the taking of the deceased into custody on 27 March 2003 so as to divest herself of any responsibility under General Order D7 by distinguishing those circumstances from a domestic situation, does not permit of a similar understanding.

45. Constable Curyer, on the other hand, gave frank evidence that his judgment on the afternoon and evening of 27 March 2003 disclosed significant errors. He told the inquest that "she told me she'd been hit by – I don't know whether she said her boyfriend or Gregwyn or whatever, but she told me that she'd been hit." (T75.10). He said his decision to take her to the sobering up shelter and later to Kulaluk, upon discovering the sobering up shelter was full, was based upon the fact that the hotel management "didn't wish to charge Chantelle with assault and throwing the chair" (T76.6) and as she was "very angry and agitated" (T76.2) and "she was highly intoxicated" (T75.8) to the extent that "she was finding it difficult to even stand up and walk" (T75.9), he made the decision to take her into protective custody pursuant to the provisions of s. 128 of the *Police Administration Act*. Constable Curyer frankly agreed that to treat the situation as a protective custody situation was the wrong thing to do (T84.7). He attributed the

errors of judgment he made on that afternoon and evening to personal circumstances that included the fact that he was suffering from depression and being medicated at the level of 100mg of Zoloft per day under the directions of Dr Wal Tracey, whom he had been seeing over some period of time. His depression had arisen from "some departmental problems I'd had in Port Keats" (T73.7). Those departmental problems had arisen out of the fact that he had been the subject of criminal charges preferred upon him as a result of an incident at Port Keats where he had discharged a firearm in the course of a police pursuit. Prior to that, Constable Curyer had suffered from a marriage breakdown which caused him to be diagnosed with stress and depression. As a result of his illness, he was referred to a psychologist through Police Welfare (T83.9). He told the Court that at that time, he was not handling his living arrangements at home at all well and as a result he was transferred to Port Keats. After the transfer, "I didn't have any more medical assistance". (T83.10). After the departmental problems at Port Keats, he was treated by a Dr Price, then by a psychologist and at the time giving evidence, as has already been noted, by Dr Wal Tracey. Constable Curyer described his problems as at 27 March 2003, as "a mental disability" (T85.1). He said he believed that his senior officers were aware of his circumstances and his condition at the time he was on the road dealing with members of the public on 27 March 2003. He said his belief, to that effect, was based upon the fact that he had continued assistance through Police Welfare and that he had not been at work for a very long period of time (T85.3). He went on to tell the inquest that he had not received any recommendation from the Police Welfare division or from his superiors to the effect that he should not engage in work that would bring him into conflict with other people, particularly members of the public, and more particularly, circumstances in which he was likely to experience stress. (T85.3).

46. Constable Curyer said that the situation that presented itself at the Palmerston Tavern was "clearly a domestic situation" (T86.9). He appreciated that the deceased was making an allegation of assault upon her by Mr Green (T87.7). He agreed with the conclusions arrived at by Commander Field in his report referred to above and dated 25 May 2004. Commander Field arrived at the following conclusions which are supported by the evidence in this case:

> "For his part, Constable Curyer had known Millar for several years and he was also aware that Millar and Green were in a relationship. Even though he knew about the DVO, Curyer decided to take no action against Green for a breach."

47. Commander Field, later in his report, went on to say "it is difficult to criticise Curyer for trying to make more suitable arrangements for Millar's care than simply placing her in the watch house…although Curyer was not motivated by 'domestic violence' consideration, he had achieved an effective separation of the parties and placed Millar in a place of safety at least for the short term". Commander Field, at page 10 of his report, concluded that "certainly, there is no basis to suggest that either member (Ragg or Curyer) acted negligently or deliberately ignored or flouted the provisions of general order D7 in reaching their decision which each believed to be correct." Constable Curyer, himself, did not believe that the steps he took were in any way appropriate. Commander Field does not refer to any concession by Constable Curyer that he engaged in an error of judgment on 27 March 2003. Nor does the report of Commander Field refer to the medical condition of Constable Curyer and the part that condition probably played in the behaviour of the police officer at that relevant time. It is to be observed that in April 2003, Constable Curyer began seeing a psychiatrist (T84.5).

48. The evidence of this inquest, in relation to Constable Curyer and his physical and mental state, does raise the significant question of how his superiors came to permit a person who was obviously severely vulnerable to

stress, to go about general duties policing involving direct contact with the public. After all, such duties would involve the Constable inevitably in stressful situations of urgency, pressure and decision making involving the wellbeing and safety of the public. I note, sadly, that Constable Curyer broke down several times crying in the giving of his evidence before me. I am pleased to note that in response to coronial findings in relation to the death of Scott Williams (reference D0177/04), the Commissioner of Police has informed my office by letter dated 4 August 2005, that a whole new professionally-based welfare service for police members is to be set up in the near future to provide, inter alia, welfare/counselling/other services to those in need.

49. In conclusion, the fact that Constable Curyer was permitted to work on the street in circumstances that would inevitably give rise to a situation of pressure which his medical condition was unlikely to satisfactorily cope with, resulted in an unsatisfactory situation which brought about errors of judgment. Those errors of judgment resulted in a failure of police to arrest Mr Green and place him in custody on 27 March 2003 until he was brought before a Magistrate on a charge that he had breached the provisions of a non-contact DVO. The death of the deceased at 3.44am on Friday 28 March 2003, may well have been a preventable death. It is not to the point that the relationship between the deceased and her boyfriend was one that, if it continued into the future might have resulted in the bashing that brought about the deceased's death. The death of the deceased at the hand of Mr Green was not inevitable. The powers given to police to enforce "non-contact" DVO's are designed to ensure that the person in relation to whom the order is made is protected; and where the order is breached, that protection extends to the removal of the offender so that further violence cannot be perpetrated upon the victim. The argument that police placed the deceased in a safe environment at the Kulaluk Community in circumstances where they believed that Mr Green was at "Fifteen Mile Camp" and

therefore unlikely to, in the short term, come into one another's company is no answer to a failure by police to implement the minimum response required by General Order D7.

The police investigation into the death.

50. The police investigation into the death of the deceased was exhaustive and was conducted by two of the Northern Territory Police Force's senior investigative officers, Detective Sergeant Greg Lade and Senior Constable Wayne Michael Brayshaw. Senior Constable Brayshaw also compiled the brief for the Coroner in the matter. In the course of the investigation, thirty statements were taken from police officers and other investigative personnel, such as forensic biologists and forensic officers. Four statements were taken from medical personnel including attending ambulance officers and the Forensic Pathologist Dr Terry Sinton. Thirteen lay witnesses had statements taken from them as to the events regarding the breaches of the DVO and the death of the deceased. The coronial file comprises of 39 folios of material that cover every aspect of the investigation conducted by police and the Coroner's office. The inquest has had the benefit of a thorough and painstaking investigation in relation to this matter and Constable Brayshaw is to be commended for his exhaustive attention to detail and the compilation of a comprehensive set of materials that has allowed the office of the Coroner to confidently make findings in this matter.

Recommendations.

51. Mr Chris Howse submitted, inter alia, that I make various recommendations concerning legislative changes to the *Police Administrative Act* and the *Public Sector Employment and Management Act*. I decline to do so as I believe that such recommendations are outside the scope of my jurisdictional powers. I make no comment as to the validity or substance of such submissions. Mr Howse also submitted that police "General Order D7 is by and large, honoured in the breach in dealings police have with itinerant

indigenous women". He pointed not only to the evidence in this inquest, but to my findings in the deaths of two indigenous women, viz. Reba Lakuwanga (D0148/2001), findings delivered 26 February 2003 and Valerie Wurramara (D0068/2002), findings delivered on 20 December 2004. In both these inquests, I found it necessary to criticise police in their performance of duty in relation to Aboriginal women and domestic violence general orders. Disturbingly, I find it necessary to criticise police once again in the same way. I do not adopt the broad generalisation made by Mr Howse. However, the evidence in this case reveals that the actions of police were simply not good enough in relation to the enforcement of the DVO supposedly protecting the deceased. I very much put all the weight of my office behind the recommendation contained in paragraph 55 hereof.

52. I recommend that the Commissioner review the circumstances in which Constable Wayne Anthony Curyer was permitted to be a senior uniformed officer on patrol and in contact with members of the public on 27 March 2003, while suffering from a mental illness that required a significant dosage of antidepressant medication and in relation to which he was under the care of both medical and psychiatric specialists and which condition made him vulnerable to the stress that inevitably accompanied his working environment.

53. I recommend that the Commissioner review police procedures including protocols between the Police Welfare Division and senior officers charged with the duty of placing police officers in general duties, to ensure that police officers suffering from mental illness are not subjected to inappropriate levels of pressure or stress so that they might become a danger either to themselves or members of the public.

54. I recommend that the Commissioner review protocols for the release of persons in police custody into the care of hospital staff for treatment where those persons may have committed a breach of a DVO and who are at risk of

discharging themselves from hospital care without advice or notification to police. Early notification to police by medical authorities at RDH, that such a person has apparently discharged themselves from the hospital, might result in an early arrest and the prevention of yet another breach of the DVO.

55. I recommend that the Commissioner reinforce, in everyway possible, the importance of compliance by police with General Orders pertaining to domestic violence, and I note, in this regard, that proactive steps have been taken (vide Exhibits 6 and 8 being affidavit and letter by Assistant Commissioner of Police, Graham Kelly).

Dated this 2nd day of September 2005.

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GREG CAVANAGH
TERRITORY CORONER