CITATION: *Inquest into the death of Gottlieb Rubuntja* [2010] NTMC 048

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0012/2009
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HEARING DATE(s):	18 - 21 May 2010
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in Custody, use of Taser devices, apprehension of mentally ill persons, apprehension of physically ill persons.

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Senior Next of Kin:	Ted Sinoch
Commissioner of Police:	Kelvin Currie

Judgment category classification:	A
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0012/2009

In the matter of an Inquest into the death of
GOTTLIEB RUBUNTJA
ON 16 APRIL 2009
AT ALICE SPRINGS HOSPITAL,
ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Mr Gottlieb Rubuntja was born on 1 April 1970 at Hermannsburg in the Northern Territory. He died on 16 April 2009 at the Alice Springs Hospital. In these findings I will refer to Mr Rubuntja as "the deceased". I do so in accordance with the request of the family and because I am aware that in Aboriginal culture it is traditional not to mention the name of the deceased during the period of mourning, which can be for a considerable period of time. His cause of death was found, following an autopsy, to be coronary atherosclerosis, which is a disease of the coronary arteries where a fatty material builds up, hardens and then blocks the artery.

2. At the time of his death, police were in the process of taking the deceased into their custody or control. According to the evidence, this was as a result of strange behaviour that had been exhibited by the deceased throughout that day and into the evening. Police formed the opinion that they were required, pursuant to s32A of the *Mental Health and Related Services Act,* to take the deceased into their custody or control and deliver him to the Alice Springs Hospital for the purposes of a mental health assessment.

3. As a result, the death of the deceased was reportable to me pursuant to s12 of the *Coroners Act* ("the Act"). The deceased was determined to be a person held in custody pursuant to the definition contained in s12 of the Act,

which includes a person in the process of being taken into the custody or control of a member of the Northern Territory police. As a result, and pursuant to s15(1) of the Act, this Inquest is mandatory.

Jurisdiction and Findings

4. Section 26 of the Act provides as follows:

"(1) Where a Coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the Coroner –

a. Shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

b. May investigate and report on the matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A Coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant"

5. Pursuant to s34 of the Act, I am required to make the following findings:

"(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) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*.

6. I note that section 34(2) of the Act also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 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.
>
> (3) A Coroner shall report to the Commissioner of police and 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"

7. Counsel assisting me at this Inquest was Ms Jodi Truman. Mr Kelvin Currie was granted leave to appear on behalf of the Commissioner of Police. Mr Ted Sinoch, instructed by Central Australian Aboriginal Legal Aid Service ("CAALAS") appeared on behalf of the deceased's family. I thank each Counsel for their extremely helpful assistance in this matter. I also note that a large number of family members attended each and every day of the Inquest and I thank them for the respect they showed in what were clearly still very difficult circumstances.

The Conduct of the Inquest

8. A total of 17 witnesses gave evidence at the Inquest. Those persons were:

   a. Detective Senior Sergeant Peter Malley, the Officer in Charge of the Coronial Investigation.

   b. Mrs Audrey Rubuntja, the mother of the deceased.

   c. Mr Anthony Crowe, a Teacher at the Bradshaw Terrace Primary School.

   d. Constable Aaron Watts.

   e. Sergeant Sirri Tennosaar.

   f. Senior Constable Jennifer Hamilton.

   g. Ms Melissa Rubuntja, family member of the deceased.

   h. Mr Billy Ngalkin, family member of the deceased.

   i. Mr Paul Korner, resident of Bromley Street.

   j. Mr Peter Cairns, resident of Chalmers Street.

   k. Dr Terrence Sinton, Forensic Pathologist.

   l. Mr Angus Thornten, School Bus Driver for Bradshaw Primary School.

   m. Constable Joshua McDonald.

   n. Constable Brodie Anderson.

   o. Constable Marc Watson.

   p. Constable Martin Frost.

q. Sergeant Gregory Hansen.

9. A brief of evidence containing 25 civilian statutory declarations and 29 statutory declarations from police officers, together with numerous other reports, photographs, police documentation and medical records for the deceased, was tendered at the Inquest ("exhibit 1"). The death was investigated by Detective Senior Sergeant Peter Malley, who prepared a thorough investigation brief to a very high standard. Public confidence in Coronial Investigations demands that when police (who act on behalf of the Coroner) investigate deaths that involve police, they do so to the highest standard. Detective Senior Sergeant Peter Malley has done this and I thank him for his investigation.

Formal Findings

10. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings in relation to this death:

i. The identity of the deceased person was Gottlieb Rubuntja born 1 April 1970 at Hermannsburg in the Northern Territory of Australia.

ii. The time and place of death was 11.46pm on 16 April 2009 at the Alice Springs Hospital.

iii. The cause of death was coronary atherosclerosis.

iv. Particulars required to register the death:

a. The deceased was a male.

b. The deceased's name was Gottlieb Rubuntja.

c. The deceased was of Aboriginal descent.

d. The death was reported to the Coroner.

e. A post mortem examination was carried out by Dr Terrence Sinton who confirmed the cause of death.

f. The deceased's mother was Audrey Rubuntja nee Swift and his father was Lloyd Rubuntja (now deceased).

g. The deceased usually lived at Hermannsburg in the Northern Territory of Australia.

h. The deceased was unemployed at the time of his death.

Personal History

11. The deceased was 39 years of age when he died. He grew up in Hermannsburg and regularly visited the community of Alice Springs. He had no prior history of criminal offending and according to the material before me was regularly employed in community development type work and also in the oil and gas industries. The deceased had 4 sisters and was also the father of 4 children, namely Rikeisha, Sheila, Lloyd and Corey. As a teenager the deceased played football and was held in good regard as to his skills.

12. The deceased had some medical history of possible seizures and mental health issues in 1997. It appears from the medical records tendered in evidence before me that the deceased was under treatment for some form of medical condition in 1997, but there were no significant concerns held for his welfare. In addition, although the deceased had been reported as suffering from seizures in the past he did not keep an appointment for an assessment at the Alice Springs Hospital and this condition was therefore never confirmed.

13. By virtue of the number of family members who attended the Inquest each day and had travelled some distance in order to do so, it is clear to me that

the deceased was a very much respected and loved man who has been missed deeply since his death.

Circumstances Surrounding the Death

14. A few days prior to 16 April 2009 the deceased had travelled to Alice Springs to visit his mother. I heard evidence that this was not an unusual occurrence and that the deceased would regularly visit with his mother in Alice Springs. I heard that around the same time the deceased's son, Lloyd, had been admitted to the Alice Springs Hospital and that this admission may have been causing the deceased some concern. The deceased's mother, Mrs Audrey Rubuntja, gave evidence before me that on Wednesday 15 April 2009 she noted that the deceased began to behave strangely. In the evening Mrs Rubuntja reported that the deceased told her that a man on the television was talking to him. Mrs Rubuntja gave evidence that from about that time she became concerned for the deceased.

15. As previously outlined, there is some evidence to indicate that the deceased may have been suffering, or suffered in the past, issues associated with his mental health. Unfortunately files relevant to the deceased's previous treatment with Mental Health Services have been found to be "lost" by those relevant medical facilities. There is no such history detailed in the hospital files themselves. In addition it appears that although the deceased may have suffered mental health difficulties, his health was sufficiently well that it enabled him to lead a relatively normal life with there being no record of any previous involvement with police, which can so often occur when a person is mentally unwell. It does appear however that in the days leading up to his death the deceased was exhibiting symptoms that were noticed, and described, by his family as strange and that it was this very behaviour that brought him to the attention of the police.

16. This strange behaviour escalated on Thursday 16 April 2009, when the deceased attended at the Bradshaw Primary School and made attempts to see

one of his daughters, namely Sheila. I had tendered in evidence before me a number of statements from various persons who saw the deceased at the school on that day. All persons described the behaviour of the deceased as strange and of concern. It appears that the deceased stated he wanted to provide a drink to his daughter. This was something that the deceased had never previously done and, of itself, was behaviour easily described as unusual. Mrs Audrey Rubuntja was concerned enough about the behaviour of her son to have in fact followed him to the Bradshaw Primary School.

17. The deceased was seen to wander the classrooms and into groups of children in an attempt to try and find his daughter. Mr Anthony Crowe gave evidence before me as to the behaviour of the deceased on the school premises and of being asked to leave. Mr Crowe described the deceased's behaviour as "quite agitated"; in the sense that the deceased was not holding a conversation, but was simply adamant that he wanted to come onto the school to give his daughter a drink.

18. Because of the deceased's behaviour, Mr Crowe gave evidence that he made a decision that he required assistance to remove the deceased from the premises. It was at this time that the deceased followed Mr Crowe into the school building. When the deceased was confronted by Mr Crowe and another male teacher and told to leave, he did so. During this period of time the deceased's mother, Mrs Audrey Rubuntja, spoke with Mr Crowe and requested that he call police and an ambulance to provide her with assistance.

19. Mr Angus Thornton also gave evidence before me as to the deceased's behaviour when he entered the school bus and attempted to give a drink to the children on the bus. Mr Thornton stated that he initially thought the children knew the deceased, but quickly realised this was not the case. As a result he requested that the deceased leave the bus so that he could take the

children home. Mr Thornton also described the deceased behaviour as unusual, however eventually the deceased left the bus without any trouble.

20. According to the evidence, after attending at the school, the deceased then returned to his mother's address at 29 Chalmers Street. He was in the company of his mother. Included in exhibit 1 was a copy of the police Computer Assisted Dispatch ("CAD") records, which show that a telephone call was received by police communications at approximately 2.17pm. This call requested police attend at 29 Chalmers Street in relation to a suspicious person who had been attempting to give a drink to children at the school. The records show that at 2.31pm Constables Aaron Watts and Damien Mullen were dispatched in vehicle 453 to that address.

21. The CAD records show police arrived thereafter at approximately 2.36pm. Constable Watts gave evidence that at the time of their arrival they saw Mrs Rubuntja outside raking leaves. Both he and Constable Mullen spoke with Mrs Rubuntja and she advised that she wanted the police to take the deceased to hospital because she was worried about him. Constable Watts gave evidence that shortly thereafter he and his partner spoke with the deceased and made various observations.

22. Constable Watts gave evidence that at the time he spoke to the deceased, the deceased did not appear to be acting in an aggressive manner, no offences had been committed, he was interacting with police appropriately, was coherent, appeared to understand them and answered all their questions. Constable Watts stated he had no concerns for the deceased at that time. As a result Constable Watts gave evidence that despite the request of Mrs Rubuntja, he did not consider that he could take the deceased to the hospital against his will.

23. Constable Watts gave evidence that as a result of his observations he made contact with his Shift Sergeant, namely Sirri Tennosaar. Sergeant Tennosaar gave evidence that the officers communicated with her and told

her of their observations. Because of the concerns raised by the mother Sergeant Tennosaar recommended that the officers conduct a mental health check. Sergeant Tennosaar then made arrangements to attend upon the scene herself.

24. Constable Watts gave evidence that he made contact with police in communications and requested a mental health check be conducted. Senior Constable Jennifer Hamilton received that request and gave evidence that she made contact directly with the Alice Springs Hospital and requested that they conduct a mental health check as to all records concerning the deceased. Senior Constable Hamilton gave evidence that she was informed by the hospital that the Critical Assessment Team (CAT) held no records for the deceased, including Ward 1 (or mental health) records. I note the CAD records show that this information was received at approximately 3pm and thereafter provided by Senior Constable Hamilton to Constables Watts and Mullen.

25. The CAD log also records that at 3.07pm Sergeant Sirri Tennosaar arrived at 29 Chalmers Street. Sergeant Tennosaar gave evidence that upon her arrival she spoke with the deceased's mother who advised her that the deceased had not been behaving normally and, although she was not fearful of the deceased, she was concerned that his behaviour was unusual and she wanted him to go to the hospital. Sergeant Tennosaar stated that she then attempted to speak with the deceased, who by that stage had locked himself inside the house. Sergeant Tennosaar noted however that the deceased had given his mother the keys to the house and therefore access could easily be gained.

26. Sergeant Tennosaar stated that eventually she was able to persuade the deceased to allow her into the house and she spoke with the deceased and persuaded him to come outside. Whilst outside, Sergeant Tennosaar stated that she spoke to the deceased and he appeared to understand her and answered all her questions. She indicated that he was coherent and made

clear that he did not wish to go to the hospital, stating on one occasion to his mother "Clean your ears out, I don't need to go".

27. Sergeant Tennosaar stated that as a result of the conversation she had, and heard, with the deceased, she formed the opinion that the deceased appeared to understand that people were trying to help him but that he did not consider he needed it. As a result Sergeant Tennosaar stated that in her opinion there was no basis to take the deceased into police custody for mental assessment involuntarily. Sergeant Tennosaar stated that when she explained this to the deceased's mother, she asked Mrs Rubuntja what she wanted to have happen and Mrs Rubuntja stated she would prefer that the deceased not stay at the residence. Sergeant Tennosaar conveyed this message to the deceased, who agreed to leave of his own accord. Sergeant Tennosaar stated that she watched the deceased go to a nearby park and play some football. Sergeant Tennosaar spoke with the deceased's mother and confirmed there was nothing else the police needed to do and then left. The CAD records show that police finally left 29 Chalmers Street at approximately 3.37pm.

28. Unfortunately it appears quite clear that over the next few hours the deceased's behaviour escalated and his condition deteriorated. The CAD records show that at approximately 10.15pm, Mrs Rubuntja again telephoned the police and sought their assistance. Tendered in evidence before me is a transcript of the call made by Mrs Rubuntja to the police (folio D of exhibit 1). In that call Mrs Rubuntja is recorded as stating, inter alia, the following:

> "My son is getting mad"
>
> "He's getting horrors"
>
> "We are frightened of him"
>
> "He might hit us"
>
> "I'm frightened of him because he might hit me"

> "He didn't threaten me but I was just worrying about him because he might do something to himself"
>
> "I want somebody to come and pick him up and take him to hospital"
>
> "I can't stay in that house because I am frightened"
>
> "Can someone come and pick him up and take him to hospital so he can go to sleep"

29. It is clear from the contents of that 000 call that Mrs Rubuntja was frightened of her son and his behaviour. It is also clear however that the details provided to the police of precisely what was going on at the house were very confusing.

30. In addition to the evidence contained in the transcript of the call to Communications I also received evidence from Ms Melissa Rubuntja and Mr Billy Ngalkin. Both witnesses were present at 29 Chalmers Street and witnessed the deceased's behaviour prior to, and post, the arrival of the police. Both witnesses gave audio-recorded statements to the Police within a few short hours after the events on 17 April 2009. Melissa Rubuntja gave evidence substantially in accordance with that contained in her statement to the police. She stated that she was scared of the deceased and that he had not been listening to anyone at the house. She stated that she thought the deceased might hurt himself, but that she did not approach him directly because she was afraid he might hit her.

31. Mr Ngalkin on the other hand gave evidence that differed from the statement that he provided to the police. I note that Mr Ngalkin stated that he wished to give his evidence before me with the assistance of an interpreter in the Western Arranda language. In accordance with this request, he was permitted to do so. Mr Ngalkin gave evidence before me that there were some things that he wished to tell me that were not contained in his statement because he had not been afforded an interpreter by police.

32. Mr Ngalkin stated that the deceased had been behaving strangely and appeared to be having "dry horrors". Mr Ngalkin explained the deceased was walking around, singing and looking up into the sky and talking to himself. Mr Ngalkin stated that he did in fact attempt to make physical contact with the deceased to stop him from behaving so strangely and that when he did this the deceased physically pushed and elbowed him away. Mr Ngalkin stated that when the police arrived he saw the deceased go out immediately towards them, jump the short fence and begin saying that he was the one police were looking for and giving them his name. This evidence was substantially similar to that set out in his statement.

33. Mr Ngalkin then gave evidence to suggest that as soon as the deceased went out, the police pulled out their Tasers and used them on the deceased. Mr Ngalkin gave evidence to indicate that nothing appeared to have been said by police prior to the use of the Taser and that he (Mr Ngalkin) attempted on several occasions to intervene and try and assist the police to calm the deceased down, but the police basically ignored him and told him to get back. This evidence was very different to that contained in Mr Ngalkin's statement.

34. Whilst I agree that it is disappointing that an interpreter was not made available to Mr Ngalkin prior to him giving his statement to the police, I have no evidence before me to indicate that Mr Ngalkin in fact requested the assistance of an interpreter. I have also read the recorded statement given by Mr Naglkin, and on a number of occasions Mr Ngalkin gives spontaneous answers to police questions and provides some significant details therein. I therefore do not accept that Mr Ngalkin did not understand the questions that were being asked of him by the police at that time, and I therefore do not accept the evidence given by Mr Ngalkin in the witness box where it differs from the evidence he gave to the police when providing them with his statement in the early hours of the morning of 17 April 2009.

35. In particular, I note that Mr Ngalkin stated to the police in his recorded statement that he did not see what happened when the police got to 29 Chalmers Street (p.20.5). Mr Ngalkin also stated that it was only after he went around the corner to see the deceased, that he saw the police holding the deceased on the arms, with the deceased lying on the ground (p.22). Mr Ngalkin goes on to say that he did not see anything more after that time, because he then became "frightened" (p.23). I also note that Mr Ngalkin's statement to the police is far more consistent with the statements given by other family members in the hours immediately following the incident, in particular Ms Melissa Rubuntja and Mr Ngalkin's own wife, namely Nancy Inkamala. I therefore prefer the evidence he gave in his statement where it differs from that given before me.

Involvement of the Northern Territory Police

36. I heard evidence that as a result of the call from Mrs Rubuntja, the police "job" was designated as a "disturbance". As a result, police were eventually dispatched to the job at 11.04pm. Detective Senior Sergeant Malley gave evidence before me that this almost 50 minute delay was not unusual given the categorisation of the job as a disturbance and the amount of work that was also being undertaken by the police at the same time. I accept this evidence and make no criticism of police in terms of the time it took to attend at the address.

37. According to the evidence, Constables Marc Watson and Martin Frost were the officers to be dispatched in vehicle 453 to 29 Chalmers Street. They arrived at the residence at approximately 11.06pm. Both Constables Watson and Frost gave evidence before me, provided audio-recorded statements to the police and agreed to undertake a re-enactment for the purposes of the coronial investigation.

38. I received evidence that at the time of departing from the station, Constable Frost was armed with an electro-muscular control device or what is

colloquially known as a Taser (I also note that the Taser is a reference to the brand name). I received evidence that the Taser is a device whereby 2 barbs (or probes) are fired by compressed air at an offender. Attached to the barbs are very light wires which conduct electricity at a very high voltage, but low current, thereby administering a severe and instantly disabling shock to the subject. In order to be effective the barbs must connect with the target in order for the energy to be transferred between the two barbs, completing the electrical circuit and delivering pulses to temporarily incapacitate the target. For energy to be transferred from the Taser via the barb, contact must be made with the target by both barbs to complete the circuit. If either barb does not make good contact with the target then the Taser's energy will arc in front of the device with no energy being transferred and the target will not likely receive any of the Taser energy and therefore not be incapacitated.

Constable Marc Watson

39. Constable Watson gave evidence that upon his arrival at 29 Chalmers Street he saw a large group of people at the location. Constable Watson was driving. He parked the police vehicle across the road from 29 Chalmers Street with the driver's side closest to that address. Constable Watson stated that shortly after arrival he noticed the deceased coming towards the police vehicle quite quickly. By this stage the deceased was already on the road. As a result of the behaviour of the deceased, Constable Watson stated that instead of getting out of the vehicle he in fact closed his door again, and began telling the deceased to stop and asked what was going on. Constable Watson stated that he was trying to communicate verbally with the deceased but at that stage the deceased was already waving his arms around and he considered his behaviour to be "very irrational, quite extreme", behaving in what he described was an agitated manner.

40. Constable Watson gave evidence that he saw the deceased go towards the back of the caged police vehicle. Constable Watson stated that at that stage

he considered that the deceased "should be detained for a mental health assessment under s32A of the Mental Health and Related Services Act". Constable Watson stated the reason for this was because of the deceased's irrational and extreme behaviour. Throughout this period Watson stated that the deceased continued to act in an agitated fashion; waving his arms around, and yelling and speaking in a manner that Watson could not understand. Watson stated that around this time a lady at the scene said words to the effect that the deceased was "mad" and that the police needed to "lock him up". Watson stated that the deceased was behaving very irrationally and that he was "trying to talk to him, talk him down" but that "it didn't seem he was listening to us". Watson stated that he considered there was a need to actually detain the man for the purposes of a mental health assessment. He did not consider it was applicable to call a mental health practitioner to the scene. Watson stated he did not consider it practical "with the time" and he also considered "the situation was too extreme".

41. Watson stated in his statement and re-enactment that at some stage the deceased threw an item at the police and it went past them and underneath the police vehicle. Once that item was thrown, the deceased then ran towards the front of 29 Chalmers Street and continued to wave his arms around and yell. Watson stated that during this time his partner, Constable Frost, was closer to the deceased and began attempting to get the deceased's attention. Watson recalled Frost speaking with the deceased and telling the deceased to get down on the ground. Watson stated that he was also pleading with the deceased at the same time to settle down.

42. Watson stated that both he and Frost began yelling at the deceased to get down on the ground, but the deceased appeared not to be listening and continued to yell and scream. Watson stated in evidence that the next thing that occurred is that the deceased made his way towards his partner, Frost, and appeared to strike Frost "in the face". Watson stated that on the angle

that he was on, it appeared that Frost was struck. Watson stated that he then saw Frost "back-up" and retreat "several steps" from the deceased. Watson stated that at this point he had "made an attempt to move in with the intention of taking the male down in the form of a tackle". Watson stated he then noticed that Frost had his Taser drawn and was aiming it at the deceased and telling the deceased to "get down on the ground". Watson stated that when he saw the Taser he immediately stopped and did not continue with his intended tackle. He stated this was in accordance with his training.

43. Watson stated that despite the Taser being de-holstered and aimed at the deceased, the deceased once again approached Frost. Watson saw Frost discharge the Taser and saw the barbs hit the deceased to the chest and torso area. When this occurred, Watson stated that the deceased immediately fell to the ground and appeared to be effected by the Taser for the mandatory 5-second discharge period. Whilst the charge was occurring, Watson stated that he moved in and attempted to take control of the deceased, but was unable to do so. Watson stated that as soon as the Taser charge ended the deceased immediately "started waving his arms around and his feet around". As a result Watson stepped back.

44. Watson stated that he then heard Frost deploy the Taser for a second time whilst the barbs of the Taser were still in position. Watson stated that the Taser appeared to have an effect upon the deceased but on this occasion, whilst the charge was occurring, the deceased had rolled towards the fence and his arms were "clamped tight across his belly", therefore preventing Watson from being able to effect a hold upon the deceased. Watson gave evidence that when the 5 second charge had ended the deceased "got straight back onto his feet" and then "ran to the back of the police vehicle". During the course of doing so the deceased appeared to dislodge one of the barbs from the Taser. As outlined previously, once one of the barbs is removed or

dislodged, this basically renders the Taser ineffective as only a very small and localised charge can then occur via the barb still in situ.

45. Watson stated that he turned towards the deceased and continued to yell for the deceased to “Get down”. He stated that the deceased was not responding to police and continued to wave his arms around and yell. In his recorded statement and re-enactment, Watson stated that at this point the deceased began coming towards him continuing to yell. As a result Watson took out his Oleoresin Capsicum (or OC) Spray. Watson stated that the deceased continued to come towards him; waving his arms and yelling. Watson then discharged his OC Spray into the face of the deceased. Watson admitted, quite frankly, that he discharged whatever was left in his can and that it appeared to land directly “around the forehead and face area” of the deceased. Despite this large hit, the OC Spray appeared to have no effect whatsoever upon the deceased.

46. After using the spray, Watson stated that the deceased then ran off down Chalmers Street towards Bromley Street. Watson stated that he recalled hearing the sound of the Taser “clicking” on Chalmers Street after the deceased ran, however he saw no effect upon the deceased. Watson stated that he and Frost followed the deceased and that he did not see anyone between he, his partner and the deceased. Watson accepted there could have been other persons in the vicinity, and he recalled persons following him and his partner down the road, however he did not see anyone between the police and the deceased. Watson stated that as he and Frost followed the deceased they continued yelling at the deceased to stop and were “trying to reason with the male but it was not working”.

47. Watson stated that shortly after turning onto Bromley Street the deceased did in fact stop. Both Frost and Watson continued to yell at the deceased to calm down and get down on the ground. Watson stated that the deceased did not appear to respond to this at all and continued to yell and wave his arms

around. Watson maintained that throughout this period he was never able to understand anything that was said by the deceased. Watson stated that at this point in time he and Frost were “continually trying to verbally reason” with the deceased and to “communicate with him” and then the deceased “came towards us”. Watson stated that he saw Frost take out his OC Spray and deploy the spray into the face of the deceased. Watson stated this second hit also appeared to have no effect upon the deceased and instead he saw the deceased run towards Bradshaw Terrace.

48. After a short distance the deceased stopped near a tree and he saw Frost attempt to grab the deceased, but it did not work. Watson stated that the deceased then came back out towards him on the road. As a result, Watson stated that he made a decision to try and bring the deceased down to the ground and he tackled him. Watson stated that during this period he could hear the sound of the Taser “clicking” and he looked down and saw that the Taser “wasn’t making contact with the male” and he could see the Taser was “pointing in a different direction from where everyone was”.

49. Watson stated that he and Frost placed the deceased into a 3-point hold which meant one of their knees was on the scapula and shoulder area and the other knee was behind the deceased’s elbow, with the other hand locking the wrists into a wrist lock. Watson stated that throughout this entire episode, ie. from the moment of taking the deceased to the ground, the deceased continued to struggle and was “obviously trying to fight to get up”. Watson stated that he and Frost attempted to put handcuffs upon the deceased, but the deceased resisted throughout. Watson described the deceased as “a very, very strong man with big forearms” which made it “extremely hard to put cuffs on”, particularly with the deceased struggling. Watson recalled that during this period, a security guard from “Talice Security” arrived upon the scene.

50. Watson gave evidence that on a number of occasions during the incident he attempted to contact police communications but his radio was "trunking". I will return to this aspect of the evidence later.

51. Watson stated that he and Frost struggled to place the handcuffs upon the deceased. During the course of the handcuffing, Watson reported that the deceased grabbed hold of one of his hands and that he tried to prise open the deceased's grip but was unable to do so. As a result he used two "palm strikes" to the deceased's hand to get him to release. Once the cuffs were placed upon the deceased, Watson recalled the security officer was asked to give assistance so that Frost could go and get the police vehicle. At that point in time the security officer took hold of the deceased, whilst Frost ran off towards the police vehicle still located on Chalmers Street.

52. Watson stated that the deceased continued to struggle and then started "to bang his head on the ground on the road". As a result Watson placed his hand on the deceased's head and held his head to the ground to "stop him from banging his head", and to prevent any further injury to the deceased.

53. A short time later, Watson stated that he noted the deceased's "strength diminished". As a result he made a decision to place the deceased onto his side and then into a seated position. When he did this, Watson stated that he noticed that the deceased was making a "wheezing noise in his breathing". Watson stated "as soon as he started wheezing I put the male in the recovery position because obviously I knew something wasn't right with his breathing. Watson then gave the following evidence at transcript page 111:

> "MS TRUMAN:And what happened next?
>
> WATSON: I had him in the recovery position and then the wheezing stopped, then I definitely knew something was wrong with him so that's when we've rolled him on to his back and I told Frosty to get the handcuffs off the male. I ran to the passenger side of the police vehicle and got the mouth-to-mouth mask, ran back and then started CPR."

54. Watson stated that around the same time that he commenced CPR he noted that a second police vehicle had arrived occupied by Constables Brodie Anderson and Joshua McDonald. Watson stated that both officers provided assistance and CPR was continued until St John Ambulance arrived and took over.

<u>Constable Martin Frost</u>

55. Constable Martin Frost also gave evidence before me, he had only been a police officer for six months. Frost was the passenger in the police vehicle on this night. He stated that upon his arrival he too noticed a group of people standing on the road. He understood that the police had been called to attend "an outstanding disturbance", but very little other information had been provided. Shortly after his arrival, Frost stated that he quickly ascertained that it was the deceased who appeared to be the centre of attention and was causing some grief to other persons in the street. Frost, like Watson, also recalled a person stating shortly after their arrival that the deceased had "gone mad".

56. Frost stated that upon their arrival the deceased was "waving his arms in the air and shouting something. It was not understandable. It didn't sound like Aboriginal language, it didn't sound like English. It was gobbledygook". Frost stated that his partner initially attempted to converse with the deceased and then it appeared to him that none of those communications were "being acknowledged by the deceased" and were "not making any effect on him whatsoever". Frost stated that he heard his partner asking people in the area what was going on and what was happening and that very soon after he heard him say words to the effect of "whoa, mate, get back, step back, what's going on, are you alright?"

57. Frost stated that upon determining that the communication was not working, and because the deceased was "acting in such an agitated erratic manner" he decided that it would be "best at this stage to get the deceased to comply by

lying himself down on the ground". As a result Frost started yelling at the deceased to "get down on the ground". Frost stated that at that time he had "formed the belief he (the deceased) was having some sort of psychiatric episode and that the main goal was to detain him and take him to the hospital for the safety of everybody in the area".

58. At this point in time Frost also recalled the deceased throwing an item at the police and it landing under their vehicle. Shortly after this, the deceased came towards him with his fists clenched and attempted to make contact with Frost's face and head. Frost stated that he shut his eyes and pulled his head in and he felt contact around the back of his head and neck. Frost stated that he received scratches to his neck on both sides and to his chin. Frost stated that he stepped away from the deceased and then drew his Taser and stated words to the effect of "if you don't comply I will Taser you" and for the deceased to get down on the ground. Frost stated that at this point in time the deceased came at him again and Frost once again pulled back. Frost stated that the deceased then moved towards the curbside closer to 29 Chalmers Street and continued to behave in an "erratic, agitated, aggressive manner". Frost stated that he focused the Taser upon the deceased and placed the red dot "which is the aiming device for painting the person with the Taser", at which point the deceased came towards him again. As a result Frost said "Taser, Taser, Taser" and deployed the Taser at the deceased.

59. Frost, like Watson, stated that the Taser probes appeared to hit the deceased in the chest and torso area. The Taser discharged the 5-second current into the body of the deceased. Frost gave evidence that this appeared to have a physical effect upon the deceased and the deceased fell to the ground with his arms across his chest. Frost stated that he saw his partner step in and attempt to take hold of the deceased, but was unable to do so. Frost stated that as soon as the 5-second charge was over, the deceased began to kick and hit out towards Watson. Frost stated that when this occurred he discharged a further 5-second current from the Taser. Again this appeared to have a

physical effect upon the deceased, however on this occasion the deceased "rolled over" and faced towards the fence preventing Watson from taking a hold.

60. Frost also stated that as soon as the second discharge was at an end the deceased immediately got to his feet. It also appeared to Frost that the deceased had dislodged one of the probes of the Taser. Frost stated that he in fact discharged the Taser again on possibly 2 further occasions but they appeared to have no effect whatsoever upon the deceased, further reinforcing his belief that one of the probes was no longer making contact with the deceased, thereby rendering the Taser ineffective.

61. Frost stated that he saw the deceased go to the rear of the police vehicle and heard his partner "again continually verbalise with him, trying to communicate, with absolutely no effect whatsoever". Frost described the deceased as "still very aggressive and still yelling non-understandable words". Frost stated that he heard his partner warn the deceased to place himself on the ground and he then saw the deceased come towards Watson who then used his OC Spray. Frost stated this appeared to have no effect upon the deceased. After this occurred the deceased then ran down Chalmers Street towards Bromley Street. Frost stated that he and Watson gave chase and during the course of that chase he removed the cartridge from the Taser and threw it under a nearby vehicle "so that no one could touch it", thus preserving the cartridge for further examination. This was also in accordance with his training.

62. Frost, like Watson, also gave evidence that at no stage did he see anyone between he, his partner and the deceased, as they chased the deceased down the road. Frost gave evidence that shortly after going around the corner, heading towards Bradshaw Drive, the deceased stopped and came towards Frost. Frost stated that he heard his partner yell at him to use his OC Spray and he did so. Frost stated in his statement that he used a "not

inconsiderable" amount of the spray upon the deceased, but again it had no effect.

63. Frost stated that at this stage the deceased came towards him and was waving his arms around and yelling. Frost stepped aside and saw the deceased go towards his partner. Frost saw Watson take hold of the man and attempt to take him down to the ground. Frost stated he then approached the deceased with the intention of utilising his Taser to "drive stun" the deceased. Frost explained that "drive stun" is a reference to placing the actual Taser physically upon the body of the deceased, without utilising the cartridge and the probes.

64. Frost stated that when he did this, the deceased grabbed hold of his hand that had the Taser in it. A struggle ensued, and he could hear the Taser "crackling". He did not believe that the Taser made any physical contact with the deceased and he saw no effect. Eventually Frost was able to regain control of the Taser and returned the Taser to its holster. Frost stated that he and Watson then put the deceased into a 3-point hold and assisted his partner in placing handcuffs upon the deceased. Throughout this time Frost stated that the deceased continued to struggle and fight with the officers and he yelled at the deceased on a number of occasions to "stop resisting", but this had no effect. Frost stated that he recalled the deceased yelling words, but he was not able to understand them.

65. Frost also recalled the security officer attending at the scene and the deceased banging his head on the ground. Frost stated that upon the security officer giving assistance, he ran to get the police vehicle to bring it to the scene. Frost stated that when he left, the deceased was still struggling and resisting. When at the vehicle, Frost called police communications. The CAD log records Frost making contact at 23:12:55 and informing communications that the deceased had been Tasered and sprayed with OC Spray.

66. Frost gave evidence that when he returned to the scene, he got out of the vehicle and could see Watson appearing to attempt to find a pulse on the deceased. Frost stated Watson then told him that they need to take the handcuffs off and Frost took them off and then they lay the deceased into the recovery position. Watson then told Frost to call for an ambulance and Frost did so. This is recorded in the CAD log at 23:14:46. Frost stated Watson took the mask from the police vehicle and commenced CPR. Shortly thereafter Frost noted that Constables Anderson and McDonald had arrived and assisted with administering CPR.

Other Witnesses

67. In addition to the two relevant officers, I also received evidence from two persons who resided in the general area. Paul Korner gave evidence before me that he resided on Bromley Street. On this particular evening Mr Korner went out of his house to have a cigarette and heard a man yelling. Mr Korner then went to his front gate area and saw a man running down the street with two police officers following and yelling "stop". Mr Korner stated that he saw the police catch up to the man near the corner of Chalmers and Bromley Streets and tried to restrain the man. He indicated that he saw a struggle take place and believed he saw the man take a swing at one of the officers.

68. It was at this point in time that Mr Korner stated he believed that the police used a Taser on the man because of the noise that he heard at that time. Shortly thereafter Mr Korner stated that he saw the man fall to the ground and the police restrain him by putting handcuffs on. Mr Korner stated he saw the man then get up and run away from the police towards Bradshaw Drive but then turn around and come back at the officers. At this point in time Mr Korner stated that he saw one of the officers grab the man in an arm lock and take him down onto the ground. Thereafter he saw a car arrive and then he stopped looking.

69. Mr Peter Cairns also gave evidence. He resided in Chalmers Street almost directly across the road from number 29. Mr Cairns stated that he had heard noise coming from 29 Chalmers Street all evening and had taken particular note of it because he was having a BBQ and it was causing him some annoyance. Mr Cairns stated that sometime after 11pm he decided to go outside to speak to the neighbours about the noise. Mr Cairns stated when he went outside that he saw the police were already in attendance.

70. Mr Cairns stated that when he first went outside there was already a struggle going on between the police and the deceased. He believed he saw one of the police throw some punches at the deceased that landed in the shoulder area. He stated the deceased appeared aggressive and was throwing his arms around. Mr Cairns agreed however that he had told police in his statutory declaration that there was only "grabbing" that occurred and he stated that his memory was better at the time of speaking to the police, than at the time of giving his evidence before me. Mr Cairns stated that he could not recall hearing the deceased say anything, but he heard mumbling or low voices coming from the police.

71. Mr Cairns then gave evidence that he saw the Taser used twice upon the deceased and that the police appeared to re-load the Taser, as he recalled seeing a cartridge fall on the ground. Mr Cairns describes the deceased as getting hit with the Taser and going down onto the ground, but then getting up again. After the second hit from the Taser, Mr Cairns described seeing the deceased and police head up towards the intersection of Bromley and Chalmers Street. In evidence in chief, when asked why he believed the Taser had been used on a second occasion, Mr Cairns stated it was because he saw the police re-loading the Taser, but he did not recall anything happen with the man when he thought the Taser had been used on the second occasion.

72. Mr Cairns made clear that the aggressive behaviour of the deceased appeared to him to continue throughout. Mr Cairns gave evidence that after he saw the deceased and police run towards Bromley Street he went inside to tell his partner what was happening. By the time he came outside he saw a police officer running down Chalmers Street to the paddy wagon.

73. Both Constables Brodie Anderson and Joshua McDonald gave evidence before me. They accorded substantially with the description of events given by Constables Frost and Watson as to what they did upon their arrival. Both officers confirmed that the reason they attended at this incident was because they had been made aware of the job when commencing their duties. They each stated that as a result they made a decision to attend to see if Frost and Watson required any assistance because the "job" had very little detail.

74. During the course of driving to the area both officers stated that they could hear some chatter on the radio, but it was difficult to establish precisely what was occurring because of "trunking". Detective Senior Constable Malley gave evidence that trunking is a phenomenon whereby a number of persons are attempting to communicate on the radio at precisely the same time and they effectively prevent messages from getting through. This means that the person utilising the radio hears a "brr" type sound, like an engaged signal, indicating that the message has not been successful. Detective Senior Sergeant Malley gave evidence that this has been a problem in Alice Springs for some time due to the increase in workload over the radio but that the system is being upgraded in August 2010 to deal with this issue.

75. As a result of their difficulties in establishing what was occurring, Constable Anderson and McDonald stated that they drove to the address. Very shortly prior to their arrival they heard that the deceased was no longer breathing and upon their arrival they immediately assisted in the

administration of CPR. Both officers confirmed that this continued until St John Ambulance took over.

Cause of Death

76. Dr Terence Sinton gave evidence before me and provided a report. Dr Sinton is the Director of the Forensic Pathology Unit at the Royal Darwin Hospital. He conducted the autopsy upon the body of the deceased at 5.30pm on 17 April 2009. Dr Sinton noted in his report that the condition leading directly to the death of the deceased was coronary atherosclerosis. Dr Sinton described this as material that "looks like porridge", and is "grey fatty material" that deposits and hardens in the arteries and eventually blocks the arteries.

77. Dr Sinton stated that such a condition leads to a "very significant risk of sudden and unexpected damage to the heart with death frequently following". Dr Sinton stated that the coronary arteries servicing the heart are comparatively small, being maybe between 4 to 6mms in diameter. When the atherosclerosis forms within that artery it restricts or blocks blood flow to the heart.

78. In terms of the deceased, Dr Sinton noted in his report that there was narrowing in the coronary arteries, which was estimated at 70% in the worst effected vessel, and 40% in other effected areas. Dr Sinton stated that such restriction means that death "commonly occurs when, as a result of some particular event, there is an extra requirement for the heart to beat faster. And if those blood vessels are damaged and restrict blood flow, that extra blood flow can't get through at times of stress and crisis" when needed the most.

79. Dr Sinton had identified before him a number of stressors or circumstances that appeared to have occurred in relation to the deceased. Those stressors or circumstances are the following:

a. The deceased's continued arguments throughout the day with his mother about going to the hospital.

b. The deceased's argument with the police about going to the hospital.

c. The deceased's scuffle with the police.

d. The placement of the deceased on the ground.

e. Being successfully Tasered 2, or possibly 3, times.

f. Being sprayed with not inconsiderable amounts of OC Spray on two separate occasions.

g. The deceased continuing to argue with police.

h. Running around.

i. Falling down.

80. Dr Sinton was asked whether out of each of those stressors or circumstances he could pick any particular stressor that might have caused the deceased's heart attack. Dr Sinton stated that they were all "combinations of a great deal of stress" and that "they would all contribute". Dr Sinton stated that in his opinion it was:

> "more likely a combination. I have to say I don't believe it's my opinion that the Tasering of itself was the cause of death. I don't believe that. I believe it hurts quite severely and that would contribute to the stress that this man was likely suffering. But I could not, I would have to be very careful of my wording but I don't believe I could isolate that as a particular event in this circumstance".

81. In relation to coronary atherosclerosis, Dr Sinton gave evidence that it was a common condition in both Caucasian and Aboriginal males of the age of the deceased, namely 39 years of age. Dr Sinton also stated it was an "extremely common occurrence" that individuals may have no idea that they

suffer from the condition and therefore death is usually extremely unexpected.

82. In terms of this death, Dr Sinton gave evidence that paradoxically with heart attacks or heart failures, an individual needs to survive a heart attack for a sufficient length of time in order for the development of the necessary pathological signs that indicate that a heart attack has in fact occurred. Because the deceased did not survive, there were no pathological signs found, however it was clear on the evidence that it was Dr Sinton's strong opinion that this was what had in fact occurred.

83. Dr Sinton gave evidence during cross examination conducted on behalf of the family that in terms of the use of the Taser, its usage on a man with significant coronary heart disease may or may not cause heart failure and that in this particular case he could not say whether it did or did not, however it was his opinion that the Taser did not cause the death by itself. Dr Sinton made clear that he considered the Taser may have contributed to the death but at the relevant time the deceased was under great stress for various reasons, and he maintained that Tasering a man with significant coronary heart disease may or may not by itself cause heart failure.

84. When specifically asked by Counsel for the family what the deceased's prognosis would have been, given the heart condition that he discovered, Dr Sinton stated that in his opinion "generally it would have been poor, to say the best for it". Dr Sinton was then asked by Counsel for the family for a time frame on the deceased's life expectancy to which he stated "I have to say if I did so I would really be guessing but this man having such severe disease throughout his arteries at his age, one would have to say that there was a high likelihood of further significant damage if not death in the next few years".

85. Dr Sinton went on to say that he considered that the behaviour exhibited by the deceased, which was described variously as agitated, disorientated and

difficult to understand, may in fact have been indicators that the deceased was at the time suffering a heart attack. Dr Sinton stated such behaviour was a relatively common occurrence because with the actual loss of blood supply to the brain as well as the heart the individual can "become hypoxic and react in very bizarre ways". Unfortunately because the deceased did not survive there were no pathological signs of a heart attack and therefore Dr Sinton could not prove this theory absolutely.

86. Dr Sinton also gave evidence that he had considered the possibility of positional asphyxia having occurred in relation to this death, particularly given the placement of the deceased on the ground by police. Dr Sinton gave evidence that when making his assessment as to whether positional asphyxia had occurred the "classic signs that occur....are little pin-like pink spots that you see classically in the whites of the eyes or on the pink bits inside the mouth. Sometimes you will see it under fingernails and these are called petechial haemorrhages". Dr Sinton stated that he did not find any sign of such petechial haemorrhages and therefore the absence of such signs did not support a finding of positional asphyxia.

Comments on Police Conduct

87. At the commencement of this Inquest, Counsel Assisting raised with me 7 matters for consideration in terms of this death. Those matters were as follows:

    1. The lawfulness of the decision by police to take the deceased into their custody or control.

    2. Whether the use of the Taser and/or the OC Spray by police was reasonable and/or necessary in the circumstances.

    3. Whether the restraints used by police were reasonable and/or necessary.

4. Whether when employing those techniques, specifically the Taser, OC Spray and restraints, Constables Watson and Frost were complying with the Northern Territory Police Force procedures and training.

5. Whether the Northern Territory Police Force procedures and training should be modified in any way in light of the events flowing from this death.

6. Whether the actions by the police in utilising the Taser, OC Spray or restraints caused or contributed to the death of the deceased.

7. A consideration of the appropriateness and sufficiency of the training of police with respect to their obligations and responsibilities, particularly concerning mentally ill people in their care, custody or control.

Decision to apprehend the Deceased

88. I find that the decision made by Constables Watson and Frost to attempt to take the deceased into their custody or control for the purpose of taking him to the Alice Springs Hospital for a mental health assessment was reasonable in all of the circumstances. It is clear from the evidence that when police first had contact with the deceased he was behaving in a very strange and agitated manner, if not overtly aggressive. It is also clear that the situation was changing very quickly and required police to make decisions on a split second basis. Neither Constables Watson nor Frost had the luxury to examine over hours or days (such as in this inquest) what option to take in relation to the deceased. I therefore find that their decision, based on the information they had to hand, to take the deceased into their custody for a mental health assessment was reasonable.

89. I note that a precondition for the exercise of the power of apprehension under s32A of the *Mental Health and Related Services Act* is that a police officer believes on reasonable grounds that the deceased was about to

commit suicide or harm himself or another. Both officers gave evidence that they believed that the deceased may require treatment or care and that they were concerned that if he was not taken for such treatment or care then the deceased may harm himself or another. It is clear that the mother of the deceased also held these concerns when she rang the police at approximately 10.15pm seeking their assistance. The civilian witnesses also described being in fear of the deceased, and particularly that he may hurt them. I therefore consider that the police decision in this regard was reasonable and the precondition was met.

90. In addition, s32A requires that it is not practicable to seek the assistance of a psychiatrist, medical practitioner or mental health practitioner at the scene. Given the state of such services in Alice Springs and the quickly changing circumstances at the scene, I do not consider it unreasonable that the police considered it was not practicable to seek such assistance "at the scene". I note that Constable Watson in particular stated that he did not consider it practicable to call someone to the scene because he considered the circumstances to be "too extreme" situation and he therefore considered others were also at risk.

<u>The Decision to use Force and the reasonableness of the force used</u>

91. In relation to decisions to use force, I heard and received important evidence from Sergeant Gregory Hansen. Sergeant Hansen gave evidence in relation to the guiding principles behind the "Northern Territory Operation Safety and Tactics Training" ("NTOSTT") provided to Northern Territory police, in addition to an analysis of the Taser that was utilised on this occasion. I heard evidence that the guiding principles behind the NTOSTT (which reflect International policing standards and principles regarding the use of force) are to promote the avoidance of force where possible and to use the minimum use of force where it is unavoidable.

92. I had tendered in evidence before me (as part of exhibit 2) a copy of the "Northern Territory Police Special General Order" entitled "Operational Safety, Training and Procedures Manual" as at 4 October 2007. It is clear from perusal of that manual that it is the policy of the Northern Territory Police Force that each situation where police are involved "must be carefully assessed so that only the minimum level of force will be applied to resolve each situation safely and effectively" (see clause 2.3) and that members should "use the minimum amount of force necessary to control the subject and effect arrest and apprehension" (see clause 6.2). It is noted within the policy that "a violent confrontation is to be avoided wherever practicable" and that "the use of force is to be avoided wherever practicable" (see clause 6.3).

93. Sergeant Hansen gave evidence before me that these principles are provided to all recruits at the time of their training and also during re-qualification training which is now held ever year.

94. In addition to the Manual, a copy of the "Electro-Muscular Control Device (ECD) – Good Practice Guide" ("ECD Guide") as at 25 February 2008 was also tendered into evidence as part of exhibit 2. Sergeant Hansen gave evidence that this guide stood separate from the Manual, but was to be read in conjunction with the provisions of the Manual. Sergeant Hansen gave evidence that the reason for the separation of the 2008 ECD Guide from the Manual was because the use of Tasers was intended to be reviewed over a period of time following its initial introduction.

95. The 2008 Guide sets out, at p.3, the manner in which an ECD (otherwise known as a Taser) can be used to achieve subject control by police. Those are as follows:

- Drawing the ECD from the holster and warning that it may be used.

- Activating the laser on the ECD as a further warning – sometimes referred to as "laser painting".

- Arcing the contacts on the body of the ECD (with no cartridge or only a fired cartridge attached) as a further warning.

- Direct contact to a part of the subject's body without discharging the barbs to achieve a localised effect (ie. a drive stun).

- Firing the barbs into the subject's body or clothing.

96. In relation to these possible usages, I note that Constable Frost gave evidence that he did refer to the Taser when he initially de-holstered the device and warned it may be used. Frost also stated that he painted the laser onto the deceased's body as a further warning, but that neither of these attempts worked to encourage the deceased to calm down.

97. At page 6 of the 2008 Guide it sets out when an ECD should **not** be used. There are 11 circumstances identified, however the 2008 Guide makes clear that there is no absolute prohibition. In addition at page 5 of the 2008 Guide it sets out the justifications for use by an officer of the Taser as follows:

- "Defend themselves, or others, if they fear physical injury to themselves or others, and they cannot reasonably protect themselves, or others, less forcefully; or

- Arrest an offender if they believe on reasonable grounds that the offender poses a threat of physical injury and the arrest cannot be effected less forcefully; or

- Resolve an incident where a person is acting in a manner likely to physically injure themselves and the incident cannot be resolved less forcefully; or

- Deter attacking animals”

98. I pause to note here that it was the general thrust of the evidence of Constable Frost that the basis for his decision to utilise the Taser was an attempt:

    a. To defend himself and his partner from fear of physical injury and he did not believe he could reasonably protect himself or others less forcefully; or

    b. To bring the deceased into police custody as he considered the deceased posed a threat of physical injury and he could not effect the custody of the deceased less forcefully; or

    c. To resolve the incident with the deceased who was at that time acting in a manner that Frost considered was likely to result in an injury to the deceased and the incident could not be resolved less forcefully.

99. I also note that Constable Watson gave evidence that had he been the one in possession of the Taser on this day, he too would have made a decision to utilise the Taser at the time it was used by Frost. Watson stated this was because he considered it necessary for safety and to avoid the deceased repeating his aggressive behaviour and avoid the situation escalating.

100. Also tendered into evidence as part of exhibit 1 was an “Occupational Safety Tactics and Training Analysis” of the force utilised by police in the apprehension of the deceased. That review was conducted by Sergeant Steve Nalder and dated 26 July 2009. It formed folio number 63 of exhibit 1. During the course of his evidence Sergeant Hansen was referred to the report and confirmed that he had read and reviewed the report himself. Sergeant Hansen stated that he agreed with the contents of the report and the conclusions reached in relation to the use of force.

101. In terms of the number of times that the Taser was discharged on this occasion, I note that the evidence shows that the Taser was discharged on 8 occasions over a period of 2 minutes and 14 seconds. Sergeant Hansen gave evidence that in all his years of experience and training with the Taser he did not believe there was any way that an individual could "fight against it". Sergeant Hansen stated, "I've seen very big men not being able to fight against it. It locks up the muscles, that is it overloads the brain's ability to tell the muscles what to do. It causes like a static inside the nervous system and it just locks you up" (p.160). Sergeant Hansen stated that he had seen the Taser used "at least into the hundreds" of times and in all those times "if the barbs are in the person I've always seen them go down, I've never seen them be able to get up" (p.160).

102. In these circumstances, Sergeant Hansen stated that given there was no reaction by the deceased to the Taser, and given that there was a noise that was heard by a number of witnesses, he was of the opinion that the probes were not connected at the relevant time and although there were 8 discharges, only 2 appear to have been successful. I accept this evidence.

Compliance with NT Police Procedure and Training

103. Sergeant Hansen stated that it was his opinion that Constables Frost and Watson had acted in accordance with the police policy and training that was in place as at the date of this incident. I note that I challenged Sergeant Hansen in relation to this opinion. I indicated during the course of Sergeant Hansen's evidence that I had certainly apprehended that Tasers, upon their introduction, were to be limited in their utilisation to life threatening situations. I indicated to Sergeant Hansen that I certainly had been left with the impression that Tasers were only to be used in life threatening situations where a weapon, threats to kill or attempts to kill had arisen, and/or that a high level of aggression had been utilised before the Taser was to be used.

104. Sergeant Hansen indicated that it was certainly the intention of the Northern Territory police that Tasers were only to be used in those situations where there was a "high level of aggression". Sergeant Hansen stated that as a result of the review by police into the usage of Tasers it had been "recommended that we tighten the policy and make it so it is at a high level, at a greater risk to life, that the Taser is used". Sergeant Hansen stated that he was unsure whether, when the policy came out initially, that this "higher level" had been made clear. Sergeant Hansen stated that, as a result, the 2008 ECD Guide had been reviewed and amended, but not yet disseminated.

105. I note that a copy of the draft of the proposed amended ECD Guide ("2010 Guide") was tendered in evidence before me as exhibit 11. Sergeant Hansen highlighted that one of the important changes proposed in the 2010 Guide was that justification for the use of the ECD now provided (at p.18) that "the use of an ECD should be reserved to those situations where no other less forceful option would bring about a safe resolution", and "should be reserved for those situations where there is a real and imminent risk of serious harm either to a member of the public, a member of the police force or (in the case of self harm) the person on whom the ECD will be used".

106. Sergeant Hansen stated that another important proposed change in the 2010 Guide was the clear provision at p.19 that an ECD "should not be used as a compliance measure". It is clear from the evidence that this had not previously been set out in the 2008 Guide. Sergeant Hansen stated it was hoped that having this particularly stipulated would mean there was no room for confusion. I note that Sergeant Hansen was quite frank in his evidence that it was certainly not the intention of the Northern Territory Police Force that the ECD would become a compliance tool or be used "as an equivalent of a cattle prod".

107. I heard evidence that previously the justification for use under the 2008 Guide was that "the ECD should be reserved for those situations where there

is a real and imminent risk of violence" (see p.5). The test is now proposed to be increased to a "real and imminent risk of serious harm" (see p.18). Sergeant Hansen stated quite openly and honestly in his evidence that, although pursuant to the provisions of the old policy, the use of the ECD on this occasion fitted within the training which was then being provided to police, he did not consider that such action would fit under the new policy and he would not expect police officers to use an ECD in a situation like the one which confronted police on this occasion, in future. I AGREE.

108. In relation to the use of force, and particularly the Taser on this occasion, I note that both Constables Frost and Watson agreed that there were other tactical options available to them that they could call upon in terms of the range of force to be utilised when dealing with the deceased. Both Constables Watson and Frost agreed that those options were as follows:

a. Negotiation/Communication.

b. Empty hand tactics.

c. Tactical disengagement.

d. Cordon and containment.

e. OC Spray.

f. Baton.

g. Firearm.

109. I note that these options form part of the Tactical Options Model set out in the Operational Safety Training and Procedures Manual. Sergeant Hansen gave evidence that the Northern Territory Police Force had adopted this model since approximately 1997 as a result of recommendations by the Australasian Centre for Police in Research ("ACPR"). Prior to 1997 Sergeant Hansen stated that police had utilised a use of force continuum

whereby police took incremental steps increasing their level of force when faced with a particular situation, ie. if communication failed then empty-handed tactics would be considered, if that failed then the officers would gradually continue through the options increasing the level of seriousness incrementally.

110. Sergeant Hansen gave evidence that it was recognised by ACPR that the difficulty with the use of force continuum is that it meant that police came under the misapprehension that they needed to continue increasing the level of force used in any given situation and had to escalate their response, rather than being able to de-escalate in any given situation. Sergeant Hansen stated that the training methodology used by NT Police now requires officers to think about all options as existing on the same plain, or field, and determine whether to escalate or de-escalate depending on the circumstances they were facing at the time.

111. In relation to the decisions made by Constables Watson and Frost, both officers gave explanations before me as to why they did not consider certain methods appropriate for the situation they were confronted with at the time of dealing with the deceased. I pause to note here that each officer appeared sincere and truthful when they gave their evidence. Both also conceded that there were other possible options available and that, with the benefit of hindsight, perhaps other methods could have been utilised, however at the relevant time they considered the actions they were taking to be an appropriate response to the situation they considered they were facing.

112. Constable Watson in particular noted that he did not consider tactical disengagement to be appropriate in the circumstances of this event as he was concerned about the “extreme nature” of the situation police were facing, “and the speed that it happened”. Constable Watson conceded that tactical disengagement was certainly an “alternative option”, but he stated quite honestly and frankly “I don’t know whether it would’ve been better”.

113. Counsel for the family asked Constable Watson whether he had utilised other Aboriginal persons present at the scene to assist in attempting to try and calm the deceased. Constable Watson stated that he did not do this, however he stated that "due to the manner in which things were unfolding I didn't think it was applicable to utilise anyone". I note that there was also absolutely no evidence before me that any person at the scene offered to help, or to try and provide assistance to the police at any time. In addition, I consider that the evidence makes clear that even if such assistance had been offered it would have been extremely unlikely to be successful given that all civilians witnesses had previously stated that they had been trying to communicate with the deceased prior to the arrival of police, but had been unsuccessful.

114. Constable Frost stated that in terms of the other options available to police at the relevant time, he considered that communication with the deceased had been attempted, but had been unsuccessful as such attempts were not being acknowledged by the deceased and appeared to have no effect "whatsoever". He accepted that attempts at communication had been for a relatively short period of time, however he also noted that circumstances were changing very quickly, and as a result of the deceased's "aggressive actions" he considered, at the relevant time, that further communication "was not going to be effective".

115. Constable Frost also stated that he believed that he and Watson had tried to cordon and contain the deceased when they had positioned the deceased over near the fence of 29 Chalmers Street. Constable Frost stated that he considered this was unsuccessful by virtue of the fact that the deceased had then come at him and attempted to grab him around the head and shoulders. Constable Frost also stated that he considered that there was no opportunity of tactical disengagement, or to call for back up, due to the quickly changing set of circumstances in terms of the deceased's behaviour. As a result

Constable Frost stated that he considered that there were no other options to de-escalate the situation other than to utilise the Taser.

116. In relation to the use of the Taser, I also note that both officers gave evidence before me that they had each been shocked by the Taser during their training. Sergeant Hansen gave evidence that when Tasers were initially introduced, each and every officer who was provided with a Taser was required to receive a discharge from the Taser as part of their training. Sergeant Hansen gave evidence that this has now changed and police officers are no longer Tasered. Both Constables Watson and Frost stated that it was as a result of having experienced the discharge from a Taser that they were aware of just how painful, or uncomfortable, it felt. I formed the opinion from the evidence given by the officers, and the manner in which it was given, that both Constables did not wish to inflict the pain caused by the discharge of a Taser upon any person, unless they considered it absolutely necessary.

117. Constable Watson gave evidence that he had never used a Taser in the 4 years that he had been a police officer. Constable Frost stated that he had never used a Taser prior to this incident and had not used a Taser since. It is clear from the evidence that both police officers consider that the Taser is a tool to be utilised only in the most serious of circumstances. I accept, given what they have experienced on this occasion, that neither officer would be likely to utilise the Taser again, except in the most serious of circumstances and certainly only in accordance with the proposed new policy of requiring a real and imminent risk of serious harm.

118. In hindsight, and in circumstances where the deceased was not armed nor making any threats to kill or cause serious harm, in my view the use of the Taser was premature and inappropriate. However, given the speed and confusion of the event, and agitation and non-compliance of the deceased, I do not wish to criticize the inexperienced and junior police officer himself

(ie: Constable Frost). In my view, better training of officers such as Constable Frost in just when to use the Taser is necessary.

Whether Police Procedures and Training should be modified

119. Sergeant Hansen gave evidence that police believe there needs to be an increase in the terms of the level of risk that must be reached prior to police discharging a Taser, and I agree. In my view, the community as a whole would expect that police would not utilise the Taser except in the most serious of circumstances and as a method of last resort, ie. prior to the utilisation of lethal force via a firearm. It is important that police understand this and that it is conveyed to each and every officer during the course of their training, and subsequent re-training.

120. I note that as part of the submissions delivered on behalf of the family their Counsel, namely Mr Sinoch, submitted that the "inescapable logic of the evidence before the court" was such that there was an "unacceptable risk of death" and, as such, the use of Tasers in the Northern Territory should be discontinued. I do not accept this submission and I do not agree that this is the only conclusion that can be reached upon the evidence. Indeed, in my view, the use of Tasers is preferable (despite any inherent risks) to the use of deadly force with high powered guns and revolvers. In this regard, I refer to the findings in the death of *Eduardo Concepcion* [2001] NTMC 25 handed down in Darwin on the 25 January 2001.

121. I note that during the course of his evidence Counsel for the family asked Sergeant Hansen whether there should be a restriction on the issue of Tasers in relation to junior members of the force. I note that in response to this question, Sergeant Hansen stated that he did not consider the logic of restricting the use of Tasers could be upheld, particularly in light of the circumstance that junior officers, immediately upon completion of their initial training and whilst still on probation, were given a firearm to use. Sergeant Hansen stated that he did not consider the argument made "a lot of

sense" that junior members could be provided with a firearm for which they could use lethal force, but not a Taser. I accept this evidence.

122. I do however consider that it should be made clear to all police officers, and in no uncertain terms, that Tasers or ECD devices should **only** be deployed in cases where there is a real and imminent risk of serious harm and that all other less forceful methods have been considered and discounted.

Whether methods used caused or contributed to death

123. Given the autopsy findings by Dr Sinton it is clear that the health of the deceased was extremely poor. He was suffering from coronary atherosclerosis and as indicated by Dr Sinton this condition leads to a very significant risk of sudden and unexpected death. Although I have no doubt that the deceased's interaction with police would have been extremely stressful, I am simply unable to discount the possibility as raised in the evidence of Dr Sinton that the deceased may have already been undergoing a heart attack at the time the police were called to the scene. This would perhaps explain the behaviour of the deceased.

124. In my view, on the evidence the actions of the police in relation to the deceased may have contributed to his death BUT they may not have.

Further Comment

125. In addition, I note that during the course of his submissions, Counsel for the family requested that as part of my findings I make a reference to the Office of the Director of Public Prosecutions (DPP) in relation to the allegation that Constable Watson punched the deceased during the course of their interaction. In this regard I note that Mr Billy Ngalkin and Mr Peter Cairns gave evidence that they had seen an officer punch the deceased. In relation to the evidence of Mr Ngalkin, I repeat that I have significant difficulties with the evidence given by him in the witness box, particularly where it conflicts with the material contained in his audio recorded statement given

only hours after the incident. I note in particular that Mr Ngalkin made no mention whatsoever in his recorded statement of having seen any punches thrown.

126. In relation to Mr Cairns, I also note that he too indicated that from the angle that he was on he "supposed" that some punches were thrown. Mr Cairns was quick to subsequently admit however that his memory of events was far better when he gave his audio recorded statement to the police, than at the time of giving his evidence from the witness box. Again Mr Cairns made no mention in his statement of having seen such an assault.

127. In this regard I note that Constable Watson made clear that he had entered into a struggle with the deceased and I consider it is therefore quite possible that during the course of this struggle it would have appeared on certain angles that punches were thrown. Both Constables Frost and Watson were very clear in their evidence however that at no time did they punch the deceased and at no time did they see their partner punch or hit the deceased. I accept their evidence. In these circumstances I do not consider it appropriate for there to be a reference made to the DPP and I decline to do so.

128. Given the circumstances that occurred immediately prior to this death, I consider it appropriate to make brief comment in relation to the investigation of this death. It is clear to me that the investigation by Detective Senior Sergeant Peter Malley was exhaustive and detailed. It is also important to highlight that during the course of this investigation arrangements were made for the immediate segregation of the police members involved in the incident. This is in accordance with clause 3.3 of the Deaths in Custody General Order (General Order D2), which requires that the first senior members reporting to the scene shall ensure that communications between such witnesses is prevented, and arrangements made for their immediate segregation.

129. I note that clause 6.1.2 of General Order D2 also requires that where a police member is involved in a serious or fatal incident, arrangements should be made for such members to be interviewed before the completion of their shift. Although this did not occur here, I note that attempts were in fact made in this regard and that each officer indicated that they wished to obtain legal advice. An opportunity was given to those officers to do so and the very next day they participated in interviews. I do not consider that there was an unacceptable delay and I am satisfied that it was reasonable and appropriate that these officers obtained legal advice.

130. I do not consider that the time taken by the officers to seek such advice was used in any way to undermine the apparent purpose of the requirement in clause 6.1.2 to ensure that the most contemporaneous statement possible is obtained. As I set out in my findings in the *Inquest into the death of Robert Plasto-Lehner and David Gurralpa aka Moscow* [2009] NTMC 014, if it is not possible to interview a member before the end of their shift because they seek to obtain legal advice, then that member should be interviewed as soon as reasonably possible, preferably by the following day. I consider that this occurred in these circumstances.

131. I also note that during the course of my findings into the *Inquest into the death of Robert Plasto-Lehner and David Gurralpa aka Moscow*, I made recommendations pursuant to my powers under s34(2) of the *Coroners Act.* In particular, those recommendations related to amendment of the NT Police Custody Manual concerning the requirement that members take any apparently mentally ill or disturbed person apprehended under the *Mental Health and Related Services Act* by the most direct practical route, and as quickly as possible, to a hospital or doctor for the purposes of assessment. I received evidence during the course of that Inquest contained in the statutory declaration of Acting Commissioner Mark Payne (exhibit 4) that those amendments are under way, and are still in a negotiation phase between police and the Department of Health and Families. I encourage

both organisations to attend to those recommendations as quickly as possible.

RECOMMENDATIONS

132. Finally, I am encouraged by the fact that the Commissioner of Police, via the evidence of Sergeant Gregory Hansen, is continuously reviewing the use of Tasers to ensure that there is no abuse of this device. I recommend that police training in relation to the use of Tasers be such that police understand quite clearly that Tasers should not be used simply as a compliance tool and their use should only be considered in the most serious of circumstances.

133. I recommend the Commissioner to continue with his review of the use of Tasers and I consider the amendments proposed as set out in the evidence given by Sergeant Hansen to be appropriate. In particular, I note that Sergeant Hansen accepted that a further amendment that should be considered to the Good Practice Guide is an inclusion in relation to "target areas", which would include provision that the recommended point of aim be to the back when practical and that where such shots are not practical the point of aim should be to the lower centre of mass for front shots. I would encourage the Commissioner of police to consider such an amendment be included in any amendments proposed by police to their ECD Good Practice Guide in future.

Dated this 11th day of August 2010 ________________________

GREG CAVANAGH
TERRITORY CORONER