CITATION: *Inquest into the death of Asera aka Ezra Young* [2018] NTLC 009

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0060/2016
DELIVERED ON:	6 April 2018
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HEARING DATE(s):	19, 20 March 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in custody, police entry to private residence, waking an intoxicated and elderly man, absence of police powers, duty of care not fulfilled, not recognised as custody incident, delayed investigation**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police:	Stephanie Williams
Counsel for family:	Peter Bellach

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

No. D0060/2016

In the matter of an Inquest into the death of

ASERA aka EZRA YOUNG
ON 30 MARCH 2016
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Mr Young (the deceased) was born 14 December 1946 in the Kubin Community on Moa Island in the Torres Strait. His parents were Lima Hammond (from Hammond Island) and Krismis Young (from Moa Island).

2. It is thought that Mr Young came to Darwin in the 1960s. After Cyclone Tracy he and his family moved to Milingimbi and then to Galiwinku where he worked in the community. He came to be a well-respected member of the Galiwinku community and a good role model.

3. His wife died in 2013. Thereafter he lived with two of his grandsons in Progress Drive, opposite the Nightcliff shops. He had very few interactions with the Police and his family did not consider him to be a person who drank to excess. It is said that he would regularly look after friends and family if they drank too much.

4. He was 70 years of age.

5. On the morning of 18 March 2016 Mr Young attended a unit in Litchfield Court (about a block away from his residence), with a friend. They stayed

there during the day in the living room socialising with a number of other persons including persons living at that address.

6. The address is part of a significant number of public housing units in Nightcliff, in Darwin.

7. At 5.47pm an anonymous person giving her name as “Peta” and using a phone without a SIM card contacted “000” requesting an ambulance for one of the persons at the premises.

8. When asked why the person needed an ambulance, Peta said the person was from Adelaide and was “drinking broke”. There was a lot of loud talking in the background and the call was abruptly terminated.

9. Due to the talking in the background the call-taker asked the Police to attend also. Police were told that there was no information on the job apart from there was yelling in the background. It was said, “There was something about drinking and too many people from Adelaide that need to go”.

10. The ambulance arrived at 5.53pm. The ambulance officer knocked on the door. A woman answered. The officer thought she was intoxicated. She asked why he was there. The ambulance officer told her someone had called for an ambulance. Someone inside the unit said “this man needs an ambulance”.

11. The Ambulance Officer took a step inside. The unit was dark and there was food and bottles on the floor. He saw at least 10 people he assessed to be heavily intoxicated. He noticed Mr Young lying asleep on the floor.

12. One man pointed to another who was looking around a corner. He said “This man needs an ambulance”. The Ambulance Officer did not feel it safe to go into the unit to get the man and said, “That’s fine get him to come out here”. The officer stepped back outside.

13. The man “shuffled on his backside toward the door” assisted by others. He had a hospital band on his wrist with the name “Kenny” on it. The ambulance officer went to get a stretcher. While getting the stretcher Police Officers arrived.

14. The police spoke to a woman outside the unit. She stated she lived there and wanted the people out of the unit. She said they didn’t belong there. She said she didn’t know them. It transpires that was not in fact the case. Two of the people lived with her in the premises and Mr Young had lived next door to her at one stage and had cultural and family connections to her.

15. The two police officers walked into the unit. As they did so some of those in the unit left via the back door. That left about three to five people in the unit. Three of them appeared to be asleep on the floor. Police asked those that were awake to leave.

16. About that time the police shift supervisor arrived. He walked into the unit and stood at the point the kitchen met the lounge room. One of the officers saw a woman he thought was pretending to sleep trying to hide something under a pillow. He said he didn’t know what she was trying to hide and went and asked her to show it to him. Eventually, after some coaxing she held a three quarter full bottle of rum toward him. He took it and went to the back door to tip it out along with other alcohol he found in the premises. In all he said he tipped out about 10 litres of alcohol.

17. Another police officer went to where Mr Young was sleeping on a mattress on the floor. He spoke to him but Mr Young didn’t wake. He shook his shoulder. Mr Young woke and the officer helped him to a seating position. The officer told him he had to go and assisted him to a standing position. The police officer then went to wake another woman asleep on the floor nearby.

18. Mr Young was unsteady on his feet. He took two or three steps toward the front door. He then appeared to trip and stumble backward over the woman lying on the floor. He fell heavily, hitting his head on the wall.

19. An ambulance officer heard the thud. He said "He's knocked cold, isn't he". A police officer replied "yes". The ambulance officer got Kenny to the Ambulance and went back to attend to Mr Young.

20. He found Mr Young adjacent to the wall with one foot on top of a rug and one underneath it. He formed the opinion that he had tripped on the rug. He was only partially conscious (GCS 9).

21. The ambulance officers took both Mr Young and Kenny to the hospital. By the time they arrived Mr Young's conscious state had improved (GCS 14). He arrived at the Hospital at 6.52pm. On the Ambulance Case Card the ambulance officer wrote: "Pt fell over in house whilst attempting to escape VKM." The ambulance officer had assumed that Mr Young had woken up, seen police and in fright had tried to run away.[1]

22. He was assessed in the Emergency Department at 7.05pm. The admission notes state "was at party that was suddenly broken up by police. Was running away from police then ran into brick wall – head first".

23. By 9.00pm his GCS fell to 11. At 9.20pm he had a CT scan of his brain. He had a fronto-parietal contusion, a left subdural haematoma (8mm) and extradural haematoma (7mm). After advice from specialists at Royal Adelaide Hospital he was placed in the High Dependency Unit for close neurological observations (hourly).

24. By 8.00am the next morning he had regained full consciousness (GCS 15). He remained improved until 11.00am the following day (20 March 2016), when his GCS dropped to 11 and continued to fall. He was taken for a CT

[1] Transcript p 33

scan of his brain at 11.30am. The scan showed an increase of the haemorrhage. He was taken to surgery for a craniectomy to relieve the pressure at 1.00pm and was returned to the Intensive Care Unit (ICU) at 3.40pm.

25. However, his condition remained unstable. His intracranial pressure increased and at 6.00pm he was taken for another CT scan that showed a large left sided haematoma. He was returned to theatre at 7.10pm for extension of the craniectomy. He returned to the ICU at 10.00pm.

26. The next day it was explained to his relatives that he was unlikely to survive. His condition did not improve and another CT scan on 22 March 2016 showed a worsening picture. His sedation was ceased. There was no recovery of brain function in the days that followed.

27. On 25 March 2016 he was extubated and his treatment changed to comfort care only. He died, without regaining consciousness, at 2.46am on 30 March 2016.

28. Toxicology indicated that at the time Mr Young arrived at Hospital his blood alcohol level was 0.288%.

Issues

29. During the course of the inquest I made the following observation:

> "Coming from our background, which is not an Aboriginal background, knowing that our home is our castle and what the common law has said for hundreds of years of how precious that is, that we are safe in there from the state, to be woken up from a drunken state by a uniformed police officer probably with all the accoutrements, is a scary notion that we don't like. You would hope that if they are going to do that, they are empowered to do so."[2]

[2] Transcript p 95

30. What the police officers did on that day is not unusual for them. In this case Mr Young died while in control of the police and as a direct consequence of their attempts to move him on. It provided NT Police an opportunity to examine what powers they utilise in such circumstances and the manner in which those powers are employed.

31. It also gave Police an opportunity to examine what care should be provided to persons asked to move on.

32. The police officers did not give a great deal of thought to the powers they were utilising. I was told the training for what they did was "on-the-job training".[3] But it is clear the actions taken were, nevertheless, what senior police expected of them.

33. My office raised with the investigating police and the police hierarchy the potential issues well before the investigation was completed and at frequent intervals thereafter. However, Police were clearly satisfied that everything had been undertaken appropriately. The institutional response provided by Police almost two years after Mr Young's death stated:

> "In this instance, it appears that the police officer's actions were adequate and in accordance with their obligations and duty of care responsibilities."

Police Powers

34. During the coronial investigation by the investigating detectives, the attending police officers were not asked what powers they were using. The first officer said however, that they met the "lawful occupier" of the unit outside:

> "She … confirmed that she did not know anyone inside her residence. She did not want them there. She said they didn't have permission to drink there. She wanted them all removed. Um – we went inside,

[3] Transcript p 65

basically told everyone to get up. Um – a lot of people were quite heavily intoxicated."

35. The second officer stated that the occupier said:

> "Everyone here is drunk, they don't belong here. I don't want them here anymore. Can you get them out?"

36. He then said:

> " … we entered the unit … there was probably 5 or 6 people in different states of intoxication … people passed out on the floor … we proceeded to ask people to leave … some people were assisted to their feet, others got up of their own accord."

37. The institutional response from police set out a number of powers that were said to be available to police in the circumstances in this case. Those powers were said to be:

a. Section 128 *Police Administration Act* (protective custody)

b. Section 7 *Trespass Act* (direction to leave); and

c. Section 28E *Housing Act* (direction).

Section 128 *Police Administration Act*

38. The section states as follows (the most relevant parts I have highlighted):

> **"128 Circumstances in which a person may be apprehended**
>
> (1) A member may, without warrant, apprehend a person and take the person into custody if the member has reasonable grounds for believing:
>
> (a) the person is intoxicated; and
>
> (b) the person is in a public place or trespassing on private property; and
>
> (c) because of the person's intoxication, the person:

(i) is unable to adequately care for himself or herself and it is not practicable at that time for the person to be cared for by someone else; or

(ii) may cause harm to himself or herself or someone else; or

(iii) may intimidate, alarm or cause substantial annoyance to people; or

(iv) is likely to commit an offence.

(2) For the purposes of carrying out his duties under subsection (1), a member may, without warrant, enter upon private property.

(2A) A member who takes a person into custody under subsection (1), or any other member, must establish the person's identity by taking and recording the person's name and other information relevant to the person's identification, including photographs, fingerprints and other biometric identifiers.

(3) A member of the Police Force who takes a person into custody under subsection (1) may:

(a) search or cause to be searched that person; and

(b) remove or cause to be removed from that person for safe keeping, until the person is released from custody, any money or valuables that are found on or about that person and any item on or about that person that is likely to cause harm to that person or any other person or that could be used by that person or any other person to cause harm to himself or another.

(4) For the purposes of subsection (3), the person of a woman shall not be searched except by a woman.

(5) All money or valuables taken from a person under subsection (3) shall be recorded in a register kept for that purpose and shall be returned to that person on receipt of a signature or other mark made by that person in the register.

(6) A member may use the force that is reasonably necessary to exercise a power under this section."

39. As can be seen at subsection (1)(b), the power is only available if the person is in a public place or trespassing. Mr Young was not in a public place. It is important therefore to determine whether Mr Young was trespassing.

Trespass defined

40. The requirements necessary to constitute a "trespass" are found in the common law. The requirements relevant to these circumstances were put succinctly by Dixon J. in *Cowell v Rosehill Racecourse Co Ltd* [1937] HCA 17 citing *Cornish v. Stubbs* (1870) L.R. 5 C.P. 334:

> "A licensee does not become a trespasser until he has received notice that the licence is countermanded and until a reasonable time has elapsed in which he may withdraw from the land and remove whatever property he has brought in pursuance of the licence ..."

41. In *Wilson v State of New South Wales* [2010] NSWCA 333, the requirement for notice was stated in these terms:

> "Thus, in my opinion, the licensee must first *have notice* that the licence is revoked; and consistently with the general legal position in relation to the giving of notice, that requires a communication to the licensee, which the licensee understands as a revocation of the licence or which a reasonable person in the position of the licensee would understand as a revocation of the licence."

42. Mr Young did not have notice that he was no longer welcome, that his license to be there was countermanded or revoked. He was asleep at the point in time the occupier decided she wanted him to leave. He could not therefore have been trespassing.

43. As such the powers under section 128 *Police Administration Act* were not available to police.

Section 7 *Trespass Act*

44. The *Trespass Act* only provides powers to police where a person is trespassing. It does not provide powers to police to take any action at all when a person is not a trespassing.

45. As noted, Mr Young was not trespassing at any time. Nevertheless police believed they could use section 7.

46. The relevant part of Section 7 of the *Trespass Act* is in the following terms:

> **7. Trespass after direction to leave**
>
> (1) A person who trespasses on any place and, after being directed to leave that place by an occupier or member of the Police Force acting at the request of the occupier, fails or refuses to do so forthwith or returns within 24 hours to that place, commits an offence. (emphasis added)
>
> Maximum penalty: 20 penalty units.

47. It can readily be seen that the direction to leave can only be given to a trespasser. As Mr Young was not trespassing there were no powers in the *Trespass Act* (including section 7) that police had available to them.

Section 28E *Housing Act*

48. The first subsection is in these terms:

> **"28E Power to give direction to person on public housing premises**
>
> (1) This section applies if a public housing safety officer reasonably believes a person on public housing premises has been, is or will be engaging in conduct, or permitting conduct to be engaged in, on public housing premises that constitutes a prescribed offence or antisocial behaviour."

49. Mr Young had not been, was not and was not about to engage in conduct that constituted an offence or antisocial behaviour. That power was not available to police. Police readily conceded that was the case.

Other Powers

50. After it was pointed out that Mr Young was not trespassing, police argued that they were entitled to take the actions they did for other reasons. Those reasons were said to be that their actions were:

    a. Under the authorisation of the lawful occupier.

    b. Pursuant to a duty to Mr Young.

Authorisation of the lawful occupier

51. The evidence was that the lawful occupier had asked police to remove the persons from her unit. That included Mr Young. In effect what police argued was that they were entitled to act on her behalf to provide the notice to Mr Young and the others in the unit that their licence to be there was being revoked and they were required to leave.

52. Acting Assistant Commissioner Fuller said in evidence:

> "I believe we were acting in good faith in assisting the woman, the lawful occupier of the place, to give people the opportunity to leave because she no longer wants them there. And there is no specific power for that … We act on behalf of people all the time for that and particularly frail people who are too scared to ask the person themselves. We do that quite regularly."[4]

53. That evidence reminded me of the inquest into the death of Mr Christopher Murrungun (May 2016). In that case police took Mr Murrungun to hospital in the back of the caged vehicle even though he could not support himself and there was an ambulance at the scene. I was reminded of that inquest

[4] Transcript pp 81, 82

because it appears in both that case and this, police were trying to be, as counsel for the family submitted, "all things to all people".

54. The law envisages that the notice to people that are no longer welcome will be delivered by the occupier. The occupier might authorise someone else to notify the person that permission to remain is withdrawn. However, case law suggests that if police seek to act in such circumstances on behalf of occupiers they may not be acting in the course of their duties.[5]

55. In any event, in this case the officers did not stop at merely advising those in the unit that they were no longer welcome and must leave. They also gave a direction to leave and physically assisted Mr Young to his feet in furtherance of that direction.

56. In effect, if they were operating under the authorisation of the occupier they amalgamated into that authorisation the section 7 *Trespass Act* direction to leave and the section 10 *Trespass Act* power to use force. Section 10 states that if a person after being directed to leave under section 7 does not leave:

> "a member of the Police Force may warn that person of the consequences of not leaving the place *forthwith*".

57. If they fail to leave *forthwith* the police officer may use reasonable force to eject them or arrest them.

58. If police seek to clothe themselves in the authority of the occupier while in full uniform it will of course be difficult for a person in the position of Mr Young to distinguish the owners request for him to leave from a direction from a police officer.

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[5] *R v Roxburgh* (1871) 12 Cox CC 8; *Chen v State of New South Wales* [2014] NSWCA 41. I note in passing that section 27 of the *Criminal Code Act* does not justify the actions of police.

59. It is difficult to know what would have happened if the appropriate steps had been taken by the occupier and police in this case. Perhaps the occupier might have considered that if police were unwilling to intervene, Mr Young could stay and sleep off the intoxication. Or, if woken by the occupier he might have taken more time to wake up and may not have felt rushed to leave.

60. If police understood the limits of their powers and nevertheless decided to be involved in notifying Mr Young he was no longer welcome, they would have understood that he was not required to leave forthwith, that he had a reasonable time to leave the premises. They would have understood that they were not entitled to direct him to leave. They would have understood that they had no reason to immediately get him to his feet and no power to do so.

Duty to Mr Young

61. The other argument that senior police raised was not that they had a power to do what they did but that they had a duty to do it.

62. Acting Assistant Commissioner Fuller put it this way:

> "Well when you are talking about duty of care I think it is reasonable that we do wake that person up to establish, you know, is he a protected person in that location. I get back to the place he is in. It is not a nice place. We've had 24 incidents since 2014 at that very premises. The place is renowned for antisocial and alcohol and drug fuelled violence so I think it was reasonable for us to ask, to establish that person's identity and to make sure he was safe there."[6]

63. He later added:

> "A number of them left of their own accord. We don't know who they were. What orders they were under, whether he was a protected person. We don't know and without establishing his identity we

[6] Transcript p 77

> wouldn't know. I think we were obliged … whether he was wanted, whether he had some illnesses that we should be aware of."[7]

64. I suspect there was a failure to appreciate the difference in what Police ordinarily did when utilising section 128 *Police Administration Act* and what they could do when those powers were unavailable to them.

65. Police need powers to establish the identity of persons anywhere let alone in a private residence. The suggestion that where powers are not available they are duty bound to do what they would ordinarily do anyway is obviously incorrect.

66. As much as police might wish they did have such powers disguised as "duties" it is obvious they do not. The common law duty of care is predicated on there being a foreseeable risk of harm by reason of action or omission. There was no reasonably foreseeable risk of harm to Mr Young by reason of police action or omission prior to police waking him and directing him to leave.

67. It is also noteworthy that the reasons advanced by the three police officers at the scene did not include the claims made by senior police. They presumed him to be intoxicated and asleep. They wished to move him on. They didn't seek to identify him until after he was injured.

Peace Officers

68. There is another potential power, although again not applicable in this situation, the power to intervene where there is a breach of the peace or to prevent an imminent breach of the peace. It provides some indication as to the traditional role of police in these circumstances. It is a common law power and is referred to in section 5 of the *Police Administration Act.*

[7] Transcript p 78

69. In the case of *Innes v Weate* [1984] Tas R 14, Justice Cosgrove discussed "self-help" by occupiers to remove persons on their property and the possibility that in utilising that remedy there might be a breach of the peace. He went on to say:

> "The existence of the remedy of self-help is an indicator of circumstances which could cause a situation where a breach of the peace is imminent. Its existence alone may call for police presence. But police action is not called for or justified until a breach of peace is imminent."[8]

70. There was no breach of the peace or imminent breach of the peace in the circumstances of this case.

Duty of Care

71. Having woken Mr Young and directed him to leave there **was** a reasonably foreseeable risk of harm to him. He was 70 years of age. He was frail. He was intoxicated. His trousers were ill-fitting such that the legs of them were covering his feet. He was in a deep sleep from which it took effort to wake him.

72. Even getting out of the unit posed risk. The unit was dark. There were other people sleeping on the floor. There were rugs and a mattress on the floor. The floor was said to be wet and there were cigarette butts, food, and wine "all over the floor".[9]

73. The officer woke him by shaking his shoulder, sat him up, directed him to leave and then stood him to his feet. The officer then left him and went to wake a woman on the same mattress.

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[8] Page 22
[9] Transcript p 36

74. The officer readily conceded that on reflection he should have taken more time to assess Mr Young and provided greater assistance to him in navigating the unit.

75. Acting Assistant Commissioner Fuller appeared to concede in the witness box that police had not fulfilled their duty of care to Mr Young. It was the first time that any concession had been made by senior police on that issue. He said:

> "Given the circumstances, the only issue that I have is that the officer could have spent more time assessing Mr Young and he admits that … obviously from what I heard yesterday the surroundings were not that great and the lighting was pretty poor, there were trip hazards around. They could have spent more time ensuring that he left the premises safely".[10]

Destroying the Alcohol

76. The police tipped out about 10 litres of alcohol, including a bottle of rum. The premises was not a restricted premises pursuant to section 101E *Liquor Act*. It was lawful to have and drink alcohol on the premises. The common areas of the units were restricted and so drinking alcohol outside in the common areas was not permitted.

77. If premises are restricted a sign is put at the front indicating them to be restricted. There was no sign at the front of the premises. However, one of the officers told me he thought the premises were restricted premises.

78. He said that a sign on the common property was pointed out to him by the occupier. He said he didn't read the sign and mistook it as referring to the unit. He said, it was due to that mistake, he seized and tipped out the alcohol. He accepted he had no lawful power to do so.

[10] Transcript p 85

Custody Incident

79. The police officers did not understand that when Mr Young suffered injury while in their control it constituted a custody incident. They did not submit a Custody Incident or Illness Report. The shift sergeant said it was his responsibility to do so and he didn't recognise it as a custody incident.

80. That had significant consequences. The only information as to what had happened was in the report of the ambulance officers. That was repeated in the medical notes. In both it was stated that Mr Young was injured while fleeing police. That was the version that family were told and it caused significant suspicion. The police officer at the hospital could find no record of the incident. That compounded the family's suspicion.

81. It also meant that the investigative response by police was delayed. By the time it commenced many of the people present during the incident were unwilling to provide statements to the investigating detectives.

82. The failure to recognise the injury as a custody incident is likely to stem from a lack of understanding as to the definition of "person in custody". In the *Coroners Act* that includes:

> "a person in the custody **or control** of a police officer".

83. Similarly, after Mr Young's death there was some resistance by senior police to categorise it as a "death in custody". It is likely that was due to the same lack of understanding.

Formal Findings

84. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased is Asera aka Ezra Young, born on 14 December 1946 on Moa Island, Torres Strait, Queensland.

(ii) The time of death was 2.46am on 30 March 2016. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was blunt force head injury (operated).

(iv) The particulars required to register the death:

1. The deceased was Asera aka Ezra Young.

2. The deceased was a Torres Strait Islander.

3. The deceased was a pensioner at the time of his death.

4. The death was reported to the Coroner by Royal Darwin Hospital Staff.

5. The cause of death was confirmed by Dr John Rutherford.

6. The deceased's mother was Lima Hammond and his father was Krismis Young.

85. Section 26(1)(a) of the *Coroner's Act* requires that I must investigate and report on the care, supervision and treatment of the deceased while he was under the control of police.

86. The time that Mr Young was in the control of police was very short. It extended from the time he was being woken until the paramedics took control of his care. In my view the care, supervision and treatment of Mr Young while in the control of police was inadequate.

87. Section 34(2) of the *Coroners Act* operates to extend my function as follows:

> "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."

Comment

88. The circumstances of this death and the response from senior police indicate either a significant misunderstanding of the law or a careless disregard for it.

89. Mr Young died on 30 March 2016. His death was first listed for inquest in September 2017 and later in November 2017. At the request of family that was then further adjourned to March 2018. Yet at the commencement of the inquest senior police were still of the view that police had acted appropriately and fulfilled their duty of care to Mr Young.

90. I got the impression that police thought that I was being somewhat pedantic or overly "technical" in my interpretation of their powers. The officer in charge of the investigation was asked:

> "Q. If Mr Young wasn't trespassing how could section 7 be utilised?"
>
> A. Well I guess if you look at a purely technical point of law then maybe section 7 wouldn't have been in effect as of then."

91. I observed at that point:

> "Uniformed police officers, the enforcement arm of the state, when dealing with citizens, have to keep themselves within the law, even if the law is technical. Do you understand that?"

92. In all the circumstances of this case the death of Mr Young may well have been a preventable death. Yet almost two years after his death Police remained satisfied that nothing was amiss. They showed little willingness to critically analyse the circumstances surrounding Mr Young's death.

93. It was not until the end of the inquest that Police made the following concessions through their counsel:

> "I have instructions that NT Police will take the lessons learned, particularly in respect of there being no specific power … and

> immediately roll out information and training to their officers, their members, to deal with this kind of scenario in the Territory."

94. Moving people on is something undertaken each and every day by Northern Territory Police. One of the attending officers said they did 20 "social order" jobs a day. Moving people out of private residences is also something that often happens. The attending sergeant said they would do two or three "jobs like that" a shift.

95. I understand that sometimes occupiers either due to fear or for cultural or family reasons are not willing to ask people to leave their premises. Police in the Northern Territory appear to have readily entered that space and are ready and willing to revoke peoples' permission to be there, ask them to leave and follow it up with force if necessary.

96. Police believed that section 128 of the *Police Administration Act* and section 7 of the *Trespass Act* gave them the power to do that. As indicated above, they do not where persons are not trespassing. If police take that role they may be found to be acting outside the course of their duties. That has a number of potential consequences that police would generally seek to avoid.

97. If police genuinely believe it necessary for them to continue to ask people to leave private premises (when not trespassing) then they might seek to persuade the legislature, to provide to them that power through for instance, amendment of the *Housing Act*.

98. Otherwise and until such legislative change might occur (if that course is successfully pursued) senior police should give consideration to providing guidance to frontline police for dealing with similar situations such that their powers are not exceeded. One solution might be following the suggestion implicit in the words of Justice Cosgrove, noted above: maintaining a police presence while people are asked to leave by the occupier.

Recommendations

99. I **recommend** that the Commissioner of Police provide instruction and training to the police in relation to the limits of their powers under the *Police Administration Act* and the *Trespass Act* and the appropriate procedure to follow in similar circumstances.

100. I **recommend** that the Commissioner of Police provide instruction and training to police in relation to their duty of care to persons being "moved on".

101. I **recommend** that the Commissioner of Police provide instruction and training to police so it is understood that persons **in the control** of police are categorised as being in police custody for the purposes of Police Custody Incident and Illness Reports and the reporting of deaths to the Coroner.

Dated this 6th day of April 2018.

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GREG CAVANAGH
TERRITORY CORONER