CITATION: *Inquest into the death of Sasha Loreen Napaljarri Green* [2018] NTLC 016

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs/Tennant Creek
FILE NO(s):	A0059/2013
DELIVERED ON:	21 June 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	29, 30 November 2017 17, 18, 19 April 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Unlawful killing, inexperienced investigators, inadequate investigation, inadequate supervision by senior police, continued inability by some investigators to adequately assess evidence, continuing destruction by police of vital forensic material**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police:	Stephanie Williams
Counsel for family:	John Lawrence SC

Judgment category classification:	B
Judgement ID number:	[2018] NTLC 016
Number of paragraphs:	146
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IN THE CORONERS COURT
AT ALICE SPRINGS AND
TENNANT CREEK IN THE
NORTHERN TERRITORY OF AUSTRALIA

No. A0059/2013

In the matter of an Inquest into the death of

SASHA LOREEN NAPALJARRI GREEN
ON 22 NOVEMBER 2013
AT LOT 4 CASEY STREET

FINDINGS

Judge Greg Cavanagh

Introduction

1. At the request of the family and for cultural reasons the deceased will be referred to as Kwementyaye or Kwementyaye Green.

2. Kwementyaye was born in Alice Springs Hospital on 10 April 1988 to Louise Rankine and Casper Green both from McLaren Creek Community. She was raised and went to school in Ali Curung. She then went to St John's College in Darwin to complete her schooling.

3. Kwementyaye Green entered into a marriage like relationship when she was a teenager. It was a volatile relationship plagued by alcohol fuelled violence. Both she and her husband spent time in prison due to that violence. On one occasion she stabbed him 17 times in the back, puncturing a lung. From that relationship Kwementyaye gave birth to two children (2003 and 2005).

4. The relationship ended in 2012 and the following year she entered a relationship with Rodney Shannon (Rodney). There is no record of domestic violence between Kwementyaye Green and Rodney. She was twenty-five years of age at the date of her death.

5. On 21 November 2013 Kwementyaye and Rodney were drinking throughout the day. After it got dark they got a lift to Unit 1, 9 Casey Street. It was the

unit of Bernice Shannon. Until a week earlier they had been living at that address but had been asked to move out.

6. At that address was Rodney's older brother Kevin Shannon and his wife, Rachel Camphoo along with Rowena Shannon and Bernice Shannon. Everybody was drinking alcohol. Late in the evening arguments started. It seems that Rodney was arguing with his brother because his brother wouldn't give him cigarettes and was occupying the area he still regarded as his sleeping space. Kwementyaye Green was said to be arguing with Bernice Shannon also about cigarettes and alcohol.

7. At about that time the Police dropped Juliet Shannon at the unit. She had been taken into protective custody at 5.34pm that evening. She was released from protective custody at 11.27pm and driven to the unit because it was raining.

8. Bernice Shannon told Rodney and Kwementyaye Green to leave and rang the Police to have them removed. They left. When the Police arrived, Kevin Shannon and Bernice Shannon told the Police they were last seen heading toward Staunton Street. By that time there was a significant amount of rain falling. The Police looked around the area but couldn't find them. The rain got heavier. It was the first rains of the wet season.

9. Across the road and two houses down Casey Street toward Staunton Street is a vacant block of land that is used as a thoroughfare. There is a track through it leading to a large vacant scrubby area. The vacant block is known as Lot 4 Casey Street.

10. On the far side of the vacant block is a house on Lot 2 Casey Street. It is the last house before Staunton Street. At that house was a disability support worker. His bedroom window facing the rear of the property was open. He was woken in the night. He estimated the time to be between 2.00am and 2.30am, although he didn't look at a watch. He said he was woken by voices

of persons he believed were in the vacant block next door. He thought there were three people and believed them to be stationary in the vacant lot and having a good time.

11. He thought the people were Aboriginal because they were speaking in Language and English. An argument broke out and continued for about an hour before the disability support worker fell asleep once more.

12. The next morning after 6.30am Tanzia Limbari was walking from Kargaru Camp to her mother's house in Bornite Street. There was a lot of water on the ground from the rain overnight. She took the shortcut through the scrubland and the vacant block.

13. Partly on the track and surrounded by a puddle of water she saw two people under an unzipped sleeping bag. The bag covered their bodies and faces. Tanzia said, "Hey come on get up from sleep". One of the people sat up. She recognised him as her cousin, Rodney Shannon. She looked at the other person still lying on the ground and recognised her as her cousin, Kwementyaye Green. Her eyes were closed.

14. Rodney tapped Kwementyaye Green on the shoulder and said "wake up". She did not. Tanzia said "get up sis". She did not wake and Tanzia walked over and tapped her on the side. Kwementyaye Green was stiff. Tanzia knew she was dead and saw blood on the ground.

15. Tanzia got scared and started to walk away. As she was doing so she saw Rodney start to do compressions on Kwementyaye's chest. She then saw Bernice and Juliet Shannon come out of 9 Casey Street. She approached and spoke with them. Juliet went to the vacant lot. She told Rodney to go and get help. She said she would sit down with Kwementyaye for a couple of minutes.

16. Rodney went to the Plummer's house at Lot 8. Rodney knocked on the door. His uncle, Ronald Plummer opened it. Rodney asked that an ambulance be

called. Ronald's daughter called "000" at 6.43am. The operator asked what the emergency was and Ronald's daughter passed the phone to her father. Ronald told the operator "I dunno, I think someone got stabbed or whatever".

17. The Police and Ambulance arrived shortly after. Rodney approached the first police officer. He said that his partner was over in the scrub and she had been stabbed. The officer did not note what he said in her notebook. The other two police officers went over to Kwementyaye's body. They set up a crime scene.

18. Detective Senior Sergeant Bedwell arrived at the scene at about 7.15am. He spoke to the first officer and then went to speak to Rodney Shannon. Rodney said, "I was the one who called the ambulance. I tried to give her first aid. I didn't stab her".

19. Due to the likelihood of more rain Detective Bedwell recorded the scene on video with the intention of removing the body and preserving as much of the evidence as possible.

20. Kwementyaye Green was wearing dark trousers and her cause of death was not initially obvious. Detective Bedwell noticed a small amount of blood staining on grass adjacent to Kwementyaye's left leg. The right leg of her trousers appeared to be wet. At that point it was not clear from where she was bleeding or why she was bleeding.

21. It was not until he undid the waistband of the trousers that he was able to see a "one to two centimetre" stab wound to her upper right thigh. It was the mid outer part of the thigh. He also saw a substantial amount of blood and congealed blood inside her trousers leg. It was obvious that she had bled out from the wound.

22. Detective Bedwell formed the belief that Kwementyaye Green had died as a result of an unlawful act and the fact that the cause of death was not obvious

until the thigh was exposed suggested that the reports to police of her being "stabbed" had significant evidential value. He arrested Rodney Shannon in relation to the death.

23. At about 8.00am a steak knife was found on the ground across the road from Lot 4 on the corner of Casey Street and Martin Court (it could not later be forensically established that was the knife with which she was stabbed).

Major Crime Squad

24. The Major Crime Squad, based in Darwin sent two officers to take over the investigation. The lead investigator had been a Police Officer at that stage for 13 years, firstly in Victoria and since 2008 in the Northern Territory. He had been with the Major Crime Squad from March 2012 and held the designation of "detective" from the end of January 2013.

25. The other detective was a Senior Constable attached to the missing persons unit. It was his first day working with the Major Crime Squad. The two detectives took a charter flight to Tennant Creek. They arrived at 3.00pm that day, 22 November 2013. The lead detective took over the investigation and from 4.00pm to 5.00pm had a briefing with Detective Bedwell and other officers. The lead investigator had concerns as to the validity of the arrest. Some of the reasons for that he expressed as:

    i. The lack of direct evidence linking the defendant to the deceased's death.

    ii. The large unaccounted time frame from when they left the premises at Casey Street until when they were found.

    iii. The cause of death was not known at that point and it wasn't obvious that the deceased had died an unnatural death … self-harm could not be ruled out.

    iv. It was unknown if it was a suspicious death, and even if there was suspicion around the circumstances, it was weak. The autopsy at its earliest wouldn't occur until Sunday 24

November, some three days away and too long to keep the defendant in custody without corroborating evidence.

26. A decision was made to release Rodney Shannon from custody. He was released at 9.04pm that night. After his release he was asked whether he would participate in an interview. He said he would but would need an interpreter. A police vehicle was organised to take him home.

27. While waiting for the vehicle, Rodney said, "last night she stabbed herself". The lead investigator immediately cautioned Rodney that he didn't have to say anything further and whatever he said could be used as evidence in a court. The following conversation then took place:

> "Rodney said, "no worries".
>
> The lead investigator said, "She stabbed herself? Did you see that?"
>
> Rodney replied, "my cousin was very intoxicated, I think that's what she said to me". [1]
>
> The lead Investigator then said, "where was that?"
>
> Rodney said: "inside the house".

28. Rodney was driven home.

The first interview

29. Rodney returned the following day (Saturday, 23 November 2013) for an interview. It commenced at 10.30am and lasted over two hours. An interpreter was present. He said when they got to unit 1, 9 Casey Street, on the evening of 21 November 2013 they were offered beer. He said he declined. He said his brother Kevin and his brother's wife were using their bed and they had an argument. He said that Rowena and Bernice had told them to "fuck off".

[1] In his interview with Police on 27 November 2013 he said the person that told him was his cousin, Rowena Shannon.

30. Rodney then said he went to the toilet and Kwementyaye Green left without him. He caught up to her about 60 metres down the road. He took her back to the premises and told her to sit on the couch while he went to make up a bed for them. On the way to the toilet his brother called out to him that she was leaving again. She walked away with a sleeping bag. He chased after her and kept calling out to her. She took a left turn. She told him "if you love me let's camp outside here where the rain is falling". He begged her to go home. She wouldn't listen. He said:

> "No matter how hard I tried pushing her and telling her to get up, not quite pushing her, just asked politely a couple of times if she wanted to get up and come back with me."

31. He said they had sex. He said she fell asleep and he heard her snoring. He said he then fell asleep. He said he was woken in the morning by Tanzia, his cousin.

32. He said he felt a pulse but it wasn't normal. She had a "small breath" but it wasn't enough. He said she then had no pulse and he commenced CPR. His cousin came and told him to go and get help. At that time he said her pulse and breathing were low and she felt cold. He left and went two doors up and asked his uncle to call the ambulance.

33. When he returned he said her pulse and breathing had "reduced dramatically".

The Autopsy

34. At 1.15pm on 24 November 2013, the lead detective received information after the autopsy. He made notes that included the following:

- "Femoral artery was completely severed
- Minor bruising noted to the temple and elbow
- A mark on her left hand – not an obvious defensive wound

- Knife wound was 55mm deep and 18mm long and 6mm wide
- The knife police had located and suspected of being used to inflict the injury was a possibility
- If the deceased was lying down, five minutes maximum before she would have bled out / lost consciousness. If she was upright and walking, the time could have been reduced
- The pathologist could not say if the wound was due to self-harm or suspicious
- It was unlikely she could have walked from 9 Casey Street to the vacant block with the artery severed.
- The provisional cause of death was provided as acute haemorrhage due to severed artery caused by a stab wound to the thigh"

35. Toxicology (when later returned) indicated that at the time she had 0.159% alcohol in her blood and 0.194% in her urine.

36. On that same day (24 November 2013) the lead investigator noted that the three police from Alice Springs were returning to Alice Springs and he considered the investigation as likely to be protracted. He requested additional resources from the Acting Senior Sergeant of the Major Crime Squad. Four additional police arrived the following day, 25 November 2013 at about 1.00pm.

Second interview

37. On 27 November 2013 commencing at 11.08am and finishing at 1.35pm the lead detective conducted another interview with Rodney Shannon. Rodney told him that he had a conversation with Kevin Shannon and Kevin had asked him whether he (Kevin) had followed them out the yard that night. He said he told Kevin he hadn't.

38. He said he wasn't aware the next morning that Kwementyaye Green had been stabbed. He denied he said to the first Constable on the scene "she's over there in the scrub and she's been stabbed, I didn't stab her". He

recalled being cautioned by the Constable and said it was due to his level of intoxication at that time (0.077%) that he said he would rather speak to a lawyer in response to the caution.

39. He said the only knives he had were in the tucker box at the premises. He said on the morning of Kwementyaye's death, "I thought I was gonna come in and go straight into Alice Springs". He said due to that he gave his step-sister, Juliet the key to the tucker box and said "Juliet hold this key for me".[2]

40. When asked why he thought he was going to get locked up, Rodney said:

> "Oh, for doing first aid on my missus probably … and I put my fingerprint on her and that's why I got scared."

41. Initially he said he didn't recall saying that he was told Kwementyaye Green stabbed herself. When pressed he said of his cousin Rowena:

> "She seen my wife walk in the kitchen, grab a knife, she's telling me and then she done something, I was in the toilet, I didn't know anything, she was arguing them two there, Rowena and her."

42. After completion of that interview the lead detective went to unit 1/9 Casey Street with other police and the two crime scene examiners and with the consent of the occupier searched the unit from 1.55pm until 3.00pm.

Lead Detective returned to Darwin on day 7 of the investigation

43. The next day, Thursday 28 November 2013 the lead detective spoke to his Senior Sergeant and Superintendent (James J O'Brien). He said the investigation was not progressing. It was agreed that he would return to Darwin and leave two members to complete outstanding statements and tasks over the next day or two. He returned to Darwin at 3.20pm that same day.

Nothing much happened

[2] Interview p41

44. On 2 December 2013 the lead detective arranged for a forensic case conference. A further one followed on 4 February 2014. No blood was detected on the knives that were seized. There was no semen detected on the swabs taken from Kwementyaye Green. The forensic evidence did little to advance the case. Nothing else appears to have happened. In August 2015 (i.e. nearly two years later) he returned to Tennant Creek to:

> "follow up on rumours about the defendant and who was responsible for the deceased's death, as well as obtain outstanding statements from witnesses, however was afforded no new information that was able to positively progress the investigation."

Delay

45. On 1 October 2015 the Coroner's Office sought advice from Police as to the status of the investigation file. Police advised it would be submitted before the end of the year.

46. In January 2016 when there was still no investigation file. Further inquiry was made. Police said it would be provided by March 2016. At the end of that time they were asked again. They said another three months and said the same each time thereafter.

47. On 9 March 2017 there was still no investigation file available. On 13 March 2017 my office advised the family and Police that an inquest was to be held in Alice Springs on 29 and 30 November 2017.

48. Part of the investigation brief was received by the Coroner's Office on 11 October 2017. On 6 November 2017 another instalment was received. That was almost four years after the date of death.

Declaration of Major Crime

49. On 17 November 2017, three years, eleven months and 27 days after the death, Northern Territory Police declared that the death of Kwementyaye

Green was a major crime. That declaration is alleged to have provided to the investigation more resources and supervision.

50. The inquest commenced two weeks later on 29 November 2017.

ISSUES

51. During the course of the inquest it became obvious that not only had the investigation taken an inordinate amount of time, but that it was of very poor quality. The issues started with a lack of appreciation of the evidence available from the first hour of police involvement on 22 November 2013.

52. From that first hour there were three critical pieces of evidence. The importance of them was appreciated by Senior Sergeant Bedwell who commenced the investigation. However when the detectives from the Major Crime Unit arrived that afternoon the evidence seems to have been overlooked or undervalued.

The "000" Call

53. At 6.43am on the "000" call the call-taker had been told "I dunno I think someone got stabbed or whatever". That was said by Ronald Plummer the occupier of the house from which the call was made and the uncle of Rodney.

54. Statements were taken that same day from Ronald and his family in the house. It is however apparent that those taking the statements were not seeking evidence as to how it was known that Kwementyaye Green was "stabbed or whatever". That may have been a missed opportunity.

55. That issue was not revisited until three days later on 25 November 2013. On that date Ronald told police, "I was just saying to her that maybe the person got stabbed or something. I don't actually know what happened …"

Statements made to first police responders

56. The first officer on the scene took notes of names and addresses of those at the scene but did not take notes of what was said to her. She signed her statement on 26 November 2013 (4 days later). In it she stated:

> "I spoke to Rodney Shannon who said (his partner was over in the scrub and that she had been stabbed)".

57. Senior Sergeant Bedwell took notes and it is likely that he at least made a statement of his interactions that day. In that statement he recorded the conversation he had with Rodney Shannon prior to arrival of the Ambulance at 7.30am:

> "Rodney: I was the one who called the ambulance. I tried to give her first aid. I didn't stab her".
>
> Bedwell: "Tell me who was here with you last night."
>
> Rodney: "Just me and my wife."
>
> Bedwell: "Tell me how you got to be here."
>
> Rodney: "We were at my brother's house over there (pointed to 1/9 Casey Street). I went there to get cigarettes from my family. I had an argument about cigarettes. He wouldn't give them to me. We also had an argument about sleeping there. We left there and walked there (pointing to the vacant block). She wanted to go to Village Camp, but I wanted to stay at my brother's house. We had an argument about that and decided to camp over there (pointed to vacant lot)."

58. That is not without issues however because the statement was not signed and dated until 16 day April 2014. It is also not entirely consistent with the notes Senior Sergeant Bedwell took at the scene.

59. Those may not have been issues if police attending the scene had been required by the lead investigator to complete their statements that day.

The video showing the stab wound and congealed blood

60. The video of the deceased in situ at the vacant lot was taken at 7.30am. It showed Senior Sergeant Bedwell's examination of the body. It showed that the stab wound was only visible once her track suit pants were lowered. It showed the congealed blood down the inside of her trousers. From a viewing of that video it was obvious that she had bled to death from the stab wound.

Failure to analyse evidence

61. When the lead detective arrived the afternoon of Kwementyaye's death he went to Lot 4. However he did not view the video. He did not obtain signed statements outlining the conversations of the first responding police.

62. The decision to release Rodney Shannon was made without a proper examination of the evidence gathered. The recorded reasons to release Rodney Shannon included the statement: "it wasn't obvious that the deceased had died an unnatural death".

63. The incomplete understanding of the evidence was passed on to his supervisors in Darwin. Without the actual facts any supervision or advice was bound to be inadequate.

64. Section 137 *Police Administration Act* provides powers to hold a person in custody for a reasonable period while investigating. Section 138 provides a number of aspects that, where relevant, should be taken into account when calculating the reasonability of the period over which a person is held in custody. Those include:

> "(c) the time taken to interview available witnesses;
>
> (d) the need of investigators to assess relevant material in preparation for interviewing the person;
>
> (g) the need to visit the place where any offence under investigation is believed to have been committed or any other place reasonably connected with the investigation of any such offence;

(k) the time taken in awaiting the completion of forensic investigations or procedures;"

65. One of the reasons for the section is to allow for the gathering of evidence without the potential for a suspect to interfere with forensic evidence and witnesses.

66. Having made the decision to release Rodney Shannon, the urgency to complete those investigations seems to have evaporated. There was seemingly no consideration that witnesses or forensic evidence might be compromised. Indeed there was no real attempt to undertake the forensic examination of the unit until four days later. By that time it appears clear that the unit had at a minimum been swept and tidied.

67. Similarly, searches for a knife continued the day after Rodney's release and as did the further questioning of all witnesses including those Rodney asked to call an ambulance.

68. It is clear that Rodney went back to Unit 1/9 Casey Street the very night of his release. He said he did so to change his shirt.[3]

Preoccupation with the self-harm hypothesis

69. There was no suggestion that the death of Kwementyaye Green was due to self-harm at the time of the decision to release Rodney. Nevertheless, the lead investigator believed the possibility was significant enough to mention in his reasons for Rodney's release: "Self-harm could not be ruled out". He said in evidence that he was keeping an "open mind".

70. That evening (22 November 2013) just after Rodney's release the first suggestion that it might have been self-harm was made by Rodney. The suggestion had enough detail to investigate such that it could be "ruled out". Rodney said his cousin had given the details and it happened inside the house. However, when a statement was taken on 25 November 2013,

[3] p48 second interview

Rowena was not asked about whether she had said those words to Rodney. It was not until the 30 November 2013, two days after the lead investigator had left Tennant Creek that she was asked about whether she had said Kwementyaye had self-harmed. She denied it.

71. Similarly the inside of the Unit was not forensically examined until 27 November 2013. Why it took so long was never satisfactorily explained. There was no issue with access to the unit. Police had available to them extensive Crime Scene powers under the *Police Administration Act,* or they could have sought a warrant. They could also have asked the occupier for access. In fact in her second statement made on 23 November 2013, the occupier stated at para 41:

> "I am giving the police permission to go into my house at 1/9 Casey Street, because I think Rowena's phone might be inside. The police can also look around the house for anything they might need."

72. On that day two police officers looked through the unit but it was not forensically examined until four days later.

Lethargy at all levels of police

73. The many failures were not recognised by senior police. How that could be so is worrying. In fact the lack of urgency, intent and competence in the first investigation is mirrored in the actions of senior police.

74. I was told that supervision and governance over major crime investigations is provided by the Joint Management Committee (JMC). The Chairperson of that Committee is the Assistant Commissioner for Crime.

75. However that supervision and governance is only available if a Declaration of a Major Crime is made. That is made by the Assistant Commissioner Crime and apparently, only if there is an application.

76. A declaration was not made (until almost 4 years later). That was not the fault of the lead detective. He was advised by his immediate supervisor to

make application for a declaration. He did so and it was passed through his immediate supervisors to the then Superintendent of Crime, James J. O'Brien. It appears that it went no further.

77. On 14 March 2017 parties were advised that an inquest had been set down commencing 29 November 2017. Also in March 2017 police sought "the JMC minutes or any records of the governance". [4] They were unable to be located.

78. In essence, it appears that not only was a declaration not made, it was not realised it had not been made by senior police until March 2017. Upon coming to that realisation it still took another eight months to make the declaration.

The Superintendent

79. My office made a request for a statement from Commander James J. O'Brien in the second part of November 2017. On 14 December 2017 Counsel Assisting advised police in writing that Commander James J. O'Brien would be required to give evidence. A summons for his attendance was issued by my office on 19 December 2017. He was served with that summons on 5 January 2018.

80. Many further conversations were had with the investigators and my office was assured that the statement was being prepared. My office was then informed that Commander James J. O'Brien would not be able to appear because he was to have a medical procedure on or about the date of the inquest. That caused some concern and it was stressed that if that was to be the case the statement would need to be comprehensive.

81. His statement was eventually received at 11.46am on 16 April 2018. That was the day before the inquest recommenced (and while many of those

[4] Transcript 18.04.2018 p122

involved were in transit to Tennant Creek). It was not detailed. It made no mention of the application for a declaration or why it was not advanced.

Supervision

82. The JMC was of course not the only potential source of supervision and governance in relation to the investigation.

83. The lead detective had a sergeant and senior sergeant in the Major Crime Squad that should have been more robust in their supervision of the case. That was readily conceded. I found the sergeant and acting senior sergeant to be impressive witnesses of candour.

84. It is obvious that at the time of this investigation there was quite a deal happening in Major Crime. It was described as "busy". One of the other cases being dealt with was the disappearance of Carlie Sinclair.

Other systems that failed

85. Assistant Commissioner Murphy provided the institutional response in this matter on 16 April 2018 (the day before the resumption of the inquest). In that response it was detailed that there were a number of systems that police have to ensure the timely submission of coronial files.

86. It was explained that there is a report generated by the PROMIS system outlining all outstanding coronial investigations. That report is emailed to all superintendents and commanders on a weekly basis. It was explained there is also a monthly report prepared by the Coronial Investigation Unit that goes to the Commander Crime.

87. It was explained that same report goes to the Police Operations Group chaired by the Deputy Commissioner. It was said:

> "Any issues or potential failure to meet timeframes is discussed at this meeting and direction, assistance and supervision provided to the member for the timely completion of the brief."

88. It was explained that there is also another layer of supervision:

> "A further layer of high level supervision and monitoring of the progress and completion of coronial briefs has been implemented, whereby the Assistant Commissioner of Crime and Commander Crime have overall oversight …"

89. On paper those systems should provide more than an adequate level of governance and supervision. What is abundantly clear is that no system operated to progress this investigation in a timely manner. This investigation was known to those in the positions exercising governance and supervision to the level of Deputy Commissioner. The question is why nothing was done.

90. This is not the first time such issues have arisen.

Inquest into the death of Kieffen Raggett[5]

91. On 8 April 2011 I delivered findings into the death of Kieffen Raggett, an 8 year old Aboriginal boy that went missing in October 2007 in Borroloola. He was found two days later in a dam 500 metres from where he was residing. Police quickly concluded that it was an accidental drowning despite any reasonable analysis of the evidence indicating that was most unlikely.

92. Two years and 11 months later the police had not provided my office with the investigation file and I set it down for inquest. The police then belatedly sought to investigate. It was too late. Memories had dimmed and police had destroyed exhibits (including anal swabs) without ever testing them.

93. At the inquest police identified that there were serious failures in the initial investigation including:

- "Failures concerning security of the crime scene, seizing of exhibits, the thoroughness of the crime scene examination, and forensic testing;

[5] Inquest into the death of Kieffen Owen Jayden Raggett [2011] NTMC 011

- Lack of clarity as to reporting requirements and the line of command;

- An irrational focus on substantiating an accidental cause of death as opposed to an objective assessment of the evidence, most notably in relation to the rocks located in the shorts of the young boy which were not adequately explained by the accidental hypothesis;

- Inadequate briefings to senior officers and, concomitantly, inadequate review by senior officers;

- An "abject failure" to document or record critical decisions;

- An "abject failure" by responsible members to comply with the Police General Order concerning the provision of reports to the Coroner. (As noted earlier but worthy of repetition, **that this coronial file took 3 years to complete is totally unacceptable**); and

- Generally, an across-the-board failure to comply with Northern Territory Police policies."

94. The review recommended that:

- "All Commands report on outstanding coronial files that exceed 6 months during Command Status Reports;

- Monthly meetings between the Commander Crime and Specialist Support and the Deputy Coroner; and

- All members be reminded of their obligations under the *Coroners Act* and *Regulations*."

95. The superintendent who undertook the review and provided evidence to the court was impressive. Amongst other things he stated in his evidence:

> "As a disciplined and professional force the Northern Territory Police Force should have done much better. As a Superintendent I've been authorised to make clear to the family of the young boy and to the Borroloola community that the Northern Territory Police apologise for the mistakes that we made. The community is entitled to expect better from their police force and on this occasion they didn't receive what they should have got. The police force recognises

this and I'd like to apologise to the community, but mainly to the family of this young boy and I'd like to say that we're deeply sorry for what occurred."

96. In the findings I observed:

> "That this death occurred is a tragedy. That the sufferings of the young boy's family have been compounded by police inaction and delay is a matter of deep regret. I hope and trust that lessons have been learned."

97. One year and 7 months after the heartfelt and sincere apology from the superintendent, Kwementyaye Green died.

98. During the inquest, four years and five months later, police conceded:

- More expertise should have been placed on the ground initially;
- The officers should have stayed longer;
- A case theory was arrived at too early in that it was suspected Kwementyaye Green had self-harmed;
- There was information available early in the case that should have been recognised as inconsistent with that theory;
- The suspect should not have been released prior to the completion of the necessary investigations;
- Stronger governance and better communication practices should have taken place;
- The handling of forensic evidence required better management and two items were destroyed (pubic hair and a blood sample of Kwementyaye Green);
- A media broadcast should have been formally created and disseminated;
- The governance and supervision of the investigation and the timely submission of the coronial brief were not satisfactory.

99. At the inquest the Assistant Commissioner said:

> "On behalf of the NT Police, I apologise to the family and friends for the delays in the investigation and prosecution of this matter. As a professional and disciplined service, the NT Police should have done better, and the family and community are entitled to expect better from their police force. I apologise for the mistakes we have made and again we are deeply sorry for your loss."

Inquest into the death of Natalie McCormack[6]

100. On 29 March 2015 Ms McCormack, a 31 year old Aboriginal woman with two young children died in Alice Springs. At the time she was working as a youth carer. She had no history of self-harm. But there was a history of domestic violence with her spouse.

101. She had a stab wound to the front of her right thigh. The police investigators were told by her husband that she stabbed herself. Police adopted that view and failed to investigate the more likely scenario appropriately.

Concerns

102. As was submitted by Counsel for the family, homicide investigations are the very pinnacle of police work. Without doubt there were some difficulties to overcome. There was the distance. Tennant Creek is a long way from the major centres. There was the fact that it had rained heavily overnight and much of the forensic evidence may have been destroyed by the rain and there was the difficulty that most of the key witnesses had been heavily intoxicated.

103. But it is also obvious that inexperienced investigators were sent to manage the investigation. That had also happened in the other investigations mentioned. Sending inexperienced investigators is obviously an issue, especially when they are sent to places some distance from major centres without direct supervision.

[6] Inquest into the deaths of Wendy Murphy and Natalie McCormack [2016] NTLC 024

104. However, that does not account for why the case languished for four years. No reasonable explanation for that has been provided. Senior police were aware the investigation had not progressed.

105. It languished despite regular promptings by my office and regular questions by the family of the deceased. Yet the "totally unacceptable" period of three years it took to receive the file in the Kieffen Raggett case turned into four years in this case and in both it took the setting of a date for inquest to even obtain the investigation file.

106. It should be noted that in both cases the delay meant that later investigations were difficult and not particularly fruitful. No one has been prosecuted in relation to the death of Kieffen Raggett and no one has been prosecuted in relation to the death of Kwementyaye Green.

107. Although not a matter where delay played a significant role the poor initial investigation into the death of Natalie McCormack has resulted in no person being prosecuted in relation to her death.

108. During that same period police have undertaken some difficult and successful investigations. For instance, the investigation into the death of Carlie Sinclair on 18 June 2013 led to the conviction of Danny Deacon for murder on 15 September 2016. The investigation into the death of Wendy Murphy on 20 December 2014 led to the conviction of Stanley Scrutton for murder on 20 June 2016.

109. Mr John Lawrence SC, submitted that the explanation for the poor performance in the investigations into the deaths of Kieffen Raggett, Natalie McCormack and Kwementyaye Green was due to institutionalised racism.

110. He contrasted the performance of the police in this investigation to their performance in the investigation into the death of Carlie Sinclair. Compared to that investigation this investigation looks exceedingly poor. Having said

that, it looks exceedingly poor when compared to the investigation into the death of Wendy Murphy (an Aboriginal woman)[7].

111. Mr Lawrence referred me to the Report of the Stephen Lawrence Inquiry.[8] Twenty five years ago Stephen Lawrence was stabbed on Well Hall Road in London by a group of white youths. The police investigation was poor and resulted in an Inquiry.

112. The Inquiry found there was institutional racism. It was said to be a more subtle concept than overt racism. It was said to influence police service delivery through "a systematic tendency that could unconsciously influence police performance":[9]

> "It can arise from unfamiliarity with the behaviour or cultural traditions of people or families from minority ethnic communities … A colour blind approach fails to take account of the nature and needs of the person or the people involved, and of the special features which such crimes and their investigation possess."[10]

113. The Report noted:

> "The only explanation or excuse offered to us for the failures and mistakes in this case are that they are the result of incompetence and misjudgement … incompetence does not without more, become discrimination …[but] … mere incompetence cannot of itself account for the whole catalogue of failures, mistakes, misjudgements, and lack of direction and control which bedevilled the Stephen Lawrence investigation."

114. Many of the criticisms made of the police in that case could be made in this case. Some of the similarities certainly invite some consideration.

115. One of the aspects of this investigation and that of Natalie McCormack that raises concern is the irrational preoccupation of the police with the

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[7] Inquest into the deaths of Wendy Murphy and Natalie McCormack [2016] NTLC 024
[8] The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny. February 1999.
[9] Paragraph 6.5
[10] Paragraph 6.17 – 6.18

hypothesis of self-harm. That is mirrored in the Kieffen Raggett case by the preoccupation with accidental drowning. Perhaps, it is lazy policing. Just trying to find the easiest way to wind up an investigation. Or perhaps, it is cultural ignorance.

116. In my experience stabbing the femoral artery is well known to Aboriginal people. In an inquest in 2007[11], I was presented with a research paper that was published in the *ANZ Journal of Surgery*. It was titled, *"Epidemic of Stab Injuries: An Alice Springs Dilemma"*.[12]

117. The paper looked at stab injuries treated at the Alice Springs Hospital. There were 1550 stab injuries from 1998 to 2005. The incidence per annum was 390/100,000 said to be the highest incidence of stab injuries in the world.

118. Fifty three percent (820) of the victims were young women. In only 6.8% (56) of those cases were the injuries self-inflicted. That was in contrast to the men (728). In 22.8% (166) of those cases the injuries were said to be self-inflicted.

119. Thirty-eight percent of the self-inflicted injuries were to the thigh. A search of Coronial files was able to detect only one case where a woman had died from a self-inflicted stab wound to the thigh.

120. The point to be made is that from that study and my experience the chances of women stabbing themselves is low. A lot lower than the chance of being stabbed by someone else. On those figures 6.8% versus 93.2%.

121. The attraction to the police of the hypothesis of self-infliction is therefore difficult to understand. In this case and the case of Natalie McCormack there was no history of self-harm, there was no evidence of self-harm from any source other than from a statement of the likely offender. The preoccupation

[11] Inquest into the death of Ricky Ryder [2007] NTMC 084
[12] Authored by Abraham O. Jacob, Fred Boseto and Jacob Ollapallil -Vol 77: 621-625

with the remote possibility appears to have misled the investigators in both cases.

Comment

122. The investigation was undertaken by inexperienced officers in an incompetent fashion. In my view, it was so poor that prosecution would only have been possible if the killer confessed.

123. As has been noted by police in their response to both the death of Kieffen Raggett and Kwementyaye Green, the community and the families of the deceased are entitled to expect better from their police force.

124. Both of those investigations and the investigation into the death of Natalie McCormack were substandard. I note the words from the Report into the death of Stephen Lawrence: *"Nobody has been convicted of this awful crime. That also is an affront both to the Lawrence family and the community at large".*[13]

125. Here police have repeated the affront and compounded the sufferings of the family by inaction and delay once again. The lessons have not been learned.

126. There is a time when apologies are no longer sufficient. The community is not only entitled to expect better investigations, it is entitled to expect that the Police Force will learn from its mistakes.

127. The overall impression is that the detectives were inexperienced, their immediate supervisors were stretched. There was no supervision and governance from superintendent level to the Commissioner of Police despite many systems designed specifically to provide it. Criticising the lower ranks is difficult when the higher ranks were aware of the problems and did nothing.

[13] Paragraph 1.12

128. What is particularly frustrating is that the higher ranks were spoken to specifically about these problems. Not only did that make no difference, their response to the inquest was late and inadequate.

129. The lack of responsiveness is also seen in the problems with the retention of forensic samples. I said during the inquest:

> "I don't want to have another inquest where forensic material of relevance, I find has been destroyed. The whole concept of cold case investigations must be redundant up here if these kind of exhibits are going to be destroyed, and I continue to find them destroyed. I don't understand why there isn't something explicit, in capital letters in the forensic institute or the offices down in the McAulay Centre that says, "Don't do this."
>
> I don't understand why it's happening, madam. And, it continues to happen."

130. Those comments were due to my frustrations over police failure to change their procedures even after assurances to me they would do so. The assurances were provided during the course of the Kieffen Raggett case where the possibility of sexual motive and identity of the potential perpetrator couldn't be confirmed because the forensic exhibits had been destroyed.

131. Then in February 2013 a young singer died on a cruise ship[14]. The forensic pathologist could not determine the cause of death. The coronial findings were provided to the family on 10 June 2014. The police forensic laboratory destroyed the two vials of blood in their possession without reference to my office. The distraught family desperately wish to further forensically investigate the cause of death. However, the destruction of the vital forensic material in combination with what appears to be misadventure in relation to a third vial of blood makes that impossible.

[14] Jaquelyn Ann Kastrinelis

132. As I noted in court, solving cold cases based on DNA is unlikely to happen in the Northern Territory because police continue to destroy forensic exhibits even after they have been asked not to do so. It is outrageous.

133. The retention of such exhibits is extremely important to families and the community at large. Section 5 of the *Police Administration Act* states that one of the core functions of police is *"to prevent, detect, investigate and prosecute offences"*. It is obvious that if the very evidence by which that is to be accomplished is routinely destroyed then at least part of that function cannot be realised.

134. The failure to manage this issue over an extended period by senior police even after it was brought to their attention is concerning. Families have been prevented from finding the closure to which they are entitled. The community has been denied the potential to bring to justice those that have committed these dreadful crimes. Senior Counsel for the family submits that these many failures are due to institutional racism. Perhaps it might be said that submission does not give adequate weight to those good investigations conducted by police (such as the investigation into the death of Wendy Murphy).

135. However, the inexplicable preoccupation of police investigators with theories of self-harm or misadventure is extremely concerning. The case theory continues to be held in spite of the likelihood that it is not self-harm or misadventure and evidence indicating it to be an unlawful killing.

136. There is not sufficient evidence to indicate why such views are formed and then clung to by investigators for far too long, or why senior police do not question or correct those views. There is no doubt that incompetent management of this case from all levels contributed to the very poor outcome.

137. Whether it was due to institutional racism however, is another issue. The report into the death of Stephen Lawrence was not obtained or read until after completion of the evidence and submissions. If it had been read prior to preparation for the inquest, the witnesses called to give evidence may well have included a great many more of the senior police. I am loathe to make a finding of institutional racism until there is an opportunity to specifically examine that issue throughout an inquest and with all levels of the police force.

Vacating suppression orders

138. During the course of the inquest I was told by police that there was a possibility that Rodney Shannon might in the near future be charged over the death of Kwementyaye Green. I made orders suppressing the reporting of evidence heard during the inquest so as to ensure any trial was not prejudiced.

139. However, police have now provided a copy of the letter from the Director of Public Prosecutions indicating that there is insufficient evidence to prosecute (attached).

140. Accordingly, there is now no reason to continue the suppression orders and they are vacated.

Formal Findings

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

(i) The identity of the deceased was Sasha Loreen Napaljarri Green born 10 April 1988 at Alice Springs in the Northern Territory.

(ii) The time of death was before 6.00am on 22 November 2013. The place of death was Lot 4 Casey Street, Tennant Creek in the Northern Territory.

(iii) The cause of death was acute haemorrhage due to a severed femoral artery caused by a stab wound to the thigh.

(iv) The particulars required to register the death:

1. The deceased was Sasha Loreen Napaljarri Green.
2. The deceased was of Aboriginal descent.
3. The deceased was not employed at the time of her death.
4. The death was reported to the Coroner by police.
5. The cause of death was confirmed by Dr Eric Donaldson.
6. The deceased's mother was Louise Rankin and her father, Casper Green.

Recommendations

142. I recommend that the Commissioner of Police do all things necessary to ensure that specimens and exhibits from Coronial investigations are not destroyed without the written consent of a coroner.

143. I recommend that the Commissioner of Police do all things necessary to ensure that specimens and exhibits are not destroyed that relate to sexual offences or other serious offences going to the identity of the alleged offender.

144. I recommend that the Commissioner of Police do all things necessary to ensure that those that investigate major offences have the appropriate skill, experience and resources to undertake the investigations to which they are tasked.

145. I recommend that the Commissioner of Police do all things necessary to ensure that senior police undertake their roles in facilitating, supervising and providing governance in relation to all major investigations.

146. I believe that offences may have been committed in connection with the death of Sasha Green and in accordance with section 35(3) *Coroners Act* I report my belief to the Commissioner of Police and the Director of Public Prosecutions.

Dated this 21 day of June 2018.

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GREG CAVANAGH
TERRITORY CORONER

DIRECTOR
OF PUBLIC
PROSECUTIONS
NORTHERN TERRITORY

Director - WJ Karczewski QC

Our ref: PD180047:SR

1 June 2018

Detective Superintendent Scott Pollock
Superintendent of Crime
Northern Territory Police
Peter McAulay Centre
McMillans Road
Berrimah NT 0828

Attention: Detective Sergeant Matthew Allen

Dear Detective Superintendent Pollock,

RE: Rodney SHANNON – 21806211

I refer to the request for an opinion as to the sufficiency of evidence to prosecute Rodney Shannon for the alleged murder of Sasha Green at Tennant Creek on or about 21 November 2013.

The materials briefed have been carefully considered. The Director is of the view that on the evidence as it presently exists there are no reasonable prospects of a successful prosecution for the offence of murder, nor for any other related offence.

The brief of evidence will be returned in due course.

Yours faithfully

STEPHEN ROBSON
ASSISTANT DIRECTOR SOUTH

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