CITATION: *Inquest into the death of Dennis Wurramarrba (aka Denis Eston Lee Lalara*)[2015] NTMC 013

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0059/2014
DELIVERED ON:	31 July 2015
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HEARING DATE(s):	26 May 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Motor vehicle accident, drink driver, police pursuit, Death in Custody.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Next of Kin:	Matthew Derrig
Commissioner of Police:	Greg MacDonald

Judgment category classification:	A
Judgement ID number:	[2015] NTMC 013
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0059/2014

In the matter of an Inquest into the death of
DENNIS WURRAMARRBA
(aka DENIS ESTON LEE LALARA)
ON 29 MARCH 2014
AT THE INTENSIVE CARE UNIT
ROYAL DARWIN HOSPITAL

FINDINGS

Introduction

1. This is an inquest into the death of Dennis Wurramarrba ("Mr Wurramarrba"), aka Denis Eston Lee Lalara, who died following his involvement in a single motor vehicle crash that occurred at approximately 1.43am on Thursday 27 March 2014. In accordance with a request from his senior next of kin and out of respect for the family, I will hereafter refer to the deceased as Mr Wurramarrba, with the exception of the formal findings.

2. The motor vehicle crash occurred at the intersection of the Stuart Highway and Amy Johnson Avenue, Darwin. That morning; members of the Northern Territory (NT) Police, namely Constable ("Const.") Chris Harden and Constable ("Const.") Luke Hanson, were travelling north bound on the Stuart Highway near Pinelands. They had been tasked to attend a disturbance at Knuckey Lagoon. Const. Harden was driving and Const. Hanson was in the passenger seat.

3. On their way to that disturbance they observed a vehicle wandering in its lane. A decision was made to conduct a traffic apprehension after the officers formed the opinion the driver may be intoxicated. As a result the

officers activated their emergency lights just prior to the intersection between the Stuart Highway and McMillans Road.

4. At that time, and unknown to the officers, the vehicle was occupied solely by Mr Wurramarrba. Shortly after activating the emergency lights, the officers observed the vehicle reduce its speed and activate the brakes. They formed the opinion the driver was going to pull over to the left hand side of the road and was looking for a safe place to stop. The vehicle slowed and this continued for approximately 200 to 300 metres when suddenly the vehicle drove back on to the road and quickly accelerated away.

5. Due to the actions of the driver, the police activated their sirens in addition to their lights and began to follow the vehicle. They contacted police communications ("COMMS") and advised of what had just occurred. The police subsequently reached a speed of approximately 120 kms./hr and could see Mr Wurramarrba's vehicle continuing to pull away. The officers realised that a major intersection between the Stuart Highway and Berrimah Road was approaching. As a result they made a decision not to continue their pursuit and deactivated the vehicle's emergency lights and sirens, slowing the vehicle to approximately 80 km/hr. Both officers subsequently lost sight of Mr Wurramarrba's vehicle.

6. The next people to see Mr Wurramarrba's vehicle were Senior Constable ("Snr Const.") David Finch and Const. David Mitchell who were in the area on their way to a domestic disturbance in Palmerston. Snr Const. Finch and Const. Mitchell had heard the COMMS exchange with officers Harden and Hanson. Snr Const. Finch was the driver and made a decision to turn off Tiger Brennan Drive onto Amy Johnson Avenue to see whether he could observe the offending vehicle.

7. When officers Finch and Mitchell were approximately 200 to 300 metres from the intersection of the Stuart Highway and Amy Johnson Avenue, Snr Const. Finch saw a vehicle move from his right to left at a "reasonable

pace". He got the attention of Const. Mitchell. Both officers then saw some dust or smoke, and then a large street light crash down and land on the road. They observed more dust or smoke and saw the vehicle leave the road and land in the bushes, coming to rest at the corner opposite the Defence Establishment in Berrimah.

8. Snr Const. Finch and Const. Mitchell attended the crash scene immediately. They called for assistance. The vehicle was significantly damaged and there was a small grass fire burning under and around the vehicle with smoke coming from the engine bay. Mr Wurramarrba was slumped over the steering wheel, bleeding profusely and was unresponsive. Despite attempts by police to remove him, he was trapped inside the vehicle and was obviously in a critical condition. He was eventually rescued from the vehicle by police, paramedics and Northern Territory Fire and Rescue Service ("NTFRS") after hydraulic cutting equipment was used to free him. He was treated at the scene and subsequently at the Royal Darwin Hospital ("RDH") but did not respond to treatment. Brain death testing was subsequently undertaken and Mr Wurramarrba was declared deceased at 10.00am on Friday 28 March 2014. Following the arrival of his family the following day, extubation of Mr Wurramarrba from life support occurred at 1.00pm on Saturday 29 March 2014.

Jurisdiction to hold an Inquest

9. As set out in the Introduction above, shortly before this crash occurred, police had engaged their red and blue flashing beacons together with their siren to indicate for the driver to stop. They commenced to pursue the vehicle. When they reached a speed that they estimated to be approximately 120 kms./hr and noted the upcoming location of the intersection between the Stuart Highway and Berrimah Road, they made a decision to cease their pursuit. As a result, they deactivated their flashing beacons and siren and slowed, but they did not stop. They did however lose sight of Mr

Wurramarrba's vehicle and subsequently came to a stop at the traffic lights at the Berrimah Road intersection.

10. The Coroners Act ("the Act") provides under section 15 that a public inquest must be held where the death was "caused or contributed to by injuries sustained while the deceased was held in custody" (my emphasis added). Section 12 defines "person held in custody" to include a person in the custody or control of the police and extends that definition to include a person "in the process of being taken into" the custody of police. In this particular case the evidence establishes that the police were attempting to apprehend Mr Wurramarrba, as the driver of the vehicle which had failed to stop as directed. I therefore find that this death is a death "in custody". As a result, and pursuant to s.15(1) of the Act, this Inquest is mandatory.

11. In these circumstances it is entirely appropriate that the police investigation carried out on my behalf was conducted as a death in custody investigation and in accordance with NT Police General Order entitled "Deaths in Custody and Investigation of Serious and/or Fatal Incidents resulting from Police contact with the Public".

12. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Matthew Derrig appeared for the next of kin and Mr Greg Macdonald appeared for the Commissioner of Police. A total of five (5) witnesses gave evidence before me, namely Detective Senior Constable ("DSC") Domenic Crea, Luke Hanson (who is no longer a police officer but will be referred to as such for ease of reference in these findings), Judith Lalara (senior next of kin), Const. Chris Harden, and Const. David Mitchell. A brief of evidence containing various statements, together with numerous other reports, police documentation and General Orders were tendered into evidence (exhibit 2). The death was investigated by DSC Domenic Crea to a high standard and I thank him for his assistance.

13. Pursuant to s.34 of the *Act*, I am required to make the following findings if possible:

> "(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*"; and
>
> (v) Any relevant circumstances concerning the death."

14. 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"

15. Additionally, where there has been a death in custody, 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. Must 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 must make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant"

Background of the Deceased

16. Despite the best attempts of DSC Crea during his investigation, only a small amount of information was able to be established as to Mr Wurramarrba's background. Mr Wurramarrba was born at the Royal Darwin Hospital on 8 February 1986 and was therefore 28 years of age at the time of his death. His mother was Elizabeth Dingabelle Lalara who has since passed away. Although not recorded on the birth certificate, his father is Gideon Wurramarrba, who is currently in care at the Juninga Aged Care Centre in Coconut Grove, but was in attendance for the majority of the inquest.

17. Mr Wurramarrba's birth certificate records his name as Denis Eston Lee Lalara. I received into evidence a statement from the deceased's maternal aunt, namely Judith Lalara, who reported that she had taken the deceased into her care when he was about 7 or 8 years of age. Mrs Lalara states that when the deceased was born, his parents were not together. I heard evidence that this was because his father was in prison at the time. As a result, the deceased was given the surname "Lalara" when he was born, but grew up being known as a "Wurramarrba". Mrs Lalara stated that this regularly occurs in her community. I am satisfied that this is the same person.

18. Mr Wurramarrba was brought up by his maternal aunt, Judith Lalara. He attended school at Angurugu Community. He had two younger siblings; a sister namely Kimane Wurramarrba and a brother namely Gideon Stephen

Wurramarrba. Both continue to reside at Angurugu. Mrs Lalara gave evidence and told me that the deceased had two sons, aged 7 and 2 years respectively, who he loved dearly and who miss their father very much. He had a large extended family and they all continue to miss Mr Wurramarrba. I was grateful to hear from Mrs Lalara and thank her for the respect she showed to the coronial process.

19. The deceased had been in trouble with the police and courts since the age of 16 years. These mostly related to domestic violence matters and traffic offences, consisting mainly of driving whilst unlicensed. Mr Wurramarrba had been in a long term relationship with Priscilla Bara who was known as his wife and they had two sons together. Unfortunately most of the domestic violence incidents related to the relationship between the deceased and Priscilla Bara. He was unemployed at the time of his death. It is clear from the evidence of Mrs Lalara that Mr Wurramarrba was greatly loved and is very much missed by his extended family.

The day of the crash

20. I received evidence that on Tuesday 25 March 2014, Priscilla Bara purchased a silver coloured 1998 Honda Accord sedan from Mango Motors located in Winnellie. The vehicle was registered and in a roadworthy condition at the time of its purchase. Although Ms Bara purchased the vehicle, she had never held a driver's licence in the Northern Territory. Mr Wurramarrba on the other hand had previously held a learner's licence, but this had expired on 4 November 2005 and he had not obtained a licence since. His criminal history shows that over the years he had driven a number of times, including on this occasion, without being licensed.

21. During the afternoon of Wednesday 26 March 2014, the deceased and Ms Bara consumed a mixture of Bundaberg Rum, Victoria Bitter beer and cask wine. They were both intoxicated. Later that night, the deceased drove Ms

Bara's car to Kurringal flats in Fannie Bay, where family were drinking alcohol.

22. There was a large group of approximately 10-12 people gathered around drinking at Kurringal flats. It appears that a short time later, Ms Bara and the deceased entered into an argument and as a result, one of the persons in the group called police at approximately 10.30pm. Police were dispatched to attend at the flats, but prior to their arrival, Ms Bara took the keys to the car from the deceased and left the scene. Police subsequently attended but no one in the group nominated the deceased (who was still present) as having caused any trouble. The police were instead advised that the relevant persons had left and after tipping out the alcohol in the area, the police also left.

23. Ms Bara returned shortly thereafter. She got out of the car and spoke with the group. There was no alcohol left; having been tipped out by the police and so a short while later she and the deceased left in the car with the deceased driving. This is the last time the deceased was seen by the group.

24. Ms Bara gave a statement to the police detailing that not long after leaving Kurringal Flats, she and the deceased started to argue again. They were intoxicated and were on their way to Palmerston. It appears that during the course of that argument and whilst the car was still moving, Ms Bara opened her door to get out. As a result the deceased stopped driving and Ms Bara got out and started to walk. This occurred somewhere on the Stuart Highway, but Ms Bara was unable to recall precisely where. Ms Bara recalled that the deceased drove off but returned twice, asking her to get back in the car. Ms Bara refused and told the deceased she did not want to get back in the car because he "drink and drive really - really fast". The deceased then drove away.

25. Ms Bara reported that later, whilst walking, she saw a car driving really fast and a paddy wagon following. Ms Bara stated that the paddy wagon had its

"red and blue lights on", but no siren. When she saw this she thought; "that was maybe Dennis" and so she turned around and began to walk back in the direction she had just come from. After walking for some time, she saw the police blocking the road and went to speak to them. It was then that she realised that Mr Wurramarrba had been in a motor vehicle crash.

Action taken by police

26. According to the evidence of Constables Harden and Hanson; at approximately 1.40am on Thursday 27 March 2014 they were travelling north bound on the Stuart Highway near Pinelands on their way to a disturbance reported at Knuckey Lagoon Indigenous Village, aka Knuckey Town Camp. They were in Palmerston police unit 420, which was a marked Toyota Hilux caged utility bearing NT registration 826 152. Const. Harden was the driver and Const. Hanson was in the passenger seat.

27. Whilst they were driving, both Constables recalled seeing a silver coloured sedan about 200 to 300 metres in front of them, drifting from the far left lane into the middle lane and then back again without indicating. As a result of the actions of the driver, Const. Harden stated that he made a decision to conduct a traffic apprehension ("TRAP") and perform a breath test believing the driver was intoxicated. This was discussed with Const. Hanson, who also agreed. Const. Harden then activated the police vehicle's emergency lights (or red and blue lights) only. He stated that he did not turn on his siren at this stage as his intention was merely to have the vehicle stop and he did not consider the siren necessary at that point. Const. Harden stated that he turned the emergency lights on just prior to McMillans Road where it intersects with the Stuart Highway. Both officers gave evidence that at this stage they could not see how many occupants were in the vehicle or who was driving.

28. Following the activation of the emergency lights, both officers stated that they observed the vehicle's speed reduce and the brake lights were

activated, as if the driver was going to pull over on the left hand roadside verge. The vehicle appeared to slow down to a speed of approximately 20-30 km/h. Each officer gave evidence that they believed at that time that the driver was looking for somewhere safe to stop as there was a slight bend on that intersection. The vehicle drove for approximately 200-300 meters along the roadside verge, when suddenly it drove back onto the road and quickly accelerated away.

29. Const. Hanson gave evidence that when this occurred he accessed the radio and immediately advised police communications ("COMMS"). A copy of the transcript of that call was tendered into evidence and it records that at 1:41:56am Const. Hanson states:

> "VKM this is 420, we've had to trap a vehicle, ah that is now has taken off inbound Stuart Highway ah heading past Knuckeys Camp now."

30. Const. Harden gave evidence that he activated the police sirens and accelerated to approximately 110 km/h. At the same time, Const. Hanson is recorded as relaying this information to COMMS at 1:42:30am:

> "420, 110 kilometres and nil traffic."

31. Both officers stated that the vehicle continued to accelerate and distance was being gained between the vehicles. As a result, Const. Harden increased his speed to 120 km/h to try and apprehend the vehicle. The vehicle continued to accelerate, gaining more distance on the police. Const. Harden stated that being aware that he was approaching a major intersection between the Stuart Highway and Berrimah Road he decided to terminate the pursuit. He gave evidence that he informed Const. Hanson that he was terminating the pursuit and this was corroborated by Const. Hanson.

32. As a result, Const. Harden immediately deactivated the vehicle's emergency lights and sirens and reduced his speed to approximately 80 km/h. He quickly lost sight of the vehicle. At the same time, Const. Hanson contacted

COMMS to advise what was happening and at 1:42:51am, he is recorded as saying the following:

> "420 ah target vehicle is exceeding 140 km/h approaching Berrimah lights. We've switched off the lights and pulling back".

33. A copy of the COMMS audio recording was also tendered into evidence and the sirens can be heard at the start of that transmission and then stop. The pursuit appears on the evidence to have lasted a total of 55 seconds.

34. Whilst the pursuit was ongoing, and in accordance with NT Police General Order 'Emergency Vehicle Driving (EVD) and Pursuit Driving', the COMMS operator, namely Senior Auxiliary Scott Romanes, had informed the Police Communications Sergeant ("Sgt"), namely Sgt Robin Kidney, of the pursuit. As a result, at 1:43:06am Sgt Kidney is recorded as contacting Constables Harden and Hanson by radio and asking what the purpose is of the pursuit. Const. Hanson responded at 1:43:14am as follows:

> "420 yeah the vehicle was seen swerving widely across both lanes, it was just an apprehension"

35. Sgt Kidney is then recorded as asking if the officers are still pursuing, to which Const. Hanson responds at 1:43:28am:

> "Ah no we've switched off lights and ah we're driving down to see if we can locate the direction in which he went".

And further at 1:43:35am:

> "420 further we're stationary at the Berrimah lights".

36. Both officers gave evidence that they had lost sight of the vehicle and did not know which direction it had continued to travel in. It is clear from the evidence tendered before me that what had in fact occurred is that Mr Wurramarrba had continued to travel north along the Stuart Highway and crossed the intersection of Berrimah Road. Although there are fixed speed and red light cameras at this intersection, I received evidence that the

deceased's vehicle was not captured on these recording devices and there are two reasons which could account for this:

a) The deceased travelled through the intersection on a green light at the posted speed limit of 90 km/h or less, which would then not have triggered the speed or red light camera, or

b) The deceased travelled through the intersection at speed and may have breached the red light, however at the relevant time speed detection in some of the lanes was disabled as the road surface was uneven and exposing the loops, therefore offending vehicles were not being detected correctly. It appears that this is the far more likely reason based on the evidence that follows.

37. After passing through the Berrimah Road intersection, Mr Wurramarrba's vehicle was captured on closed circuit television ("CCTV") security footage located at Harvey Norman. I received evidence via a report prepared by Sgt Mark Casey of the Major Crash Investigation Section of various calculations he had made of the timing of this recording and the distance travelled. As a result of those calculations, Sgt Casey estimated the speed being travelled by Mr Wurramarrba's vehicle at that time to be 182 km/h. At that time the vehicle was being driven along the Stuart Highway towards the intersection with Amy Johnson Avenue.

38. I also received statements from two Serco Sodexo security guards working at Defence Establishment in Berrimah, namely Wayne Humphry and Faye Dickens. Both persons were working as security officers at the front gate that morning. Both recalled that just before 1.45am they heard a car driving past. Mr Humphry described it as:

"It sounded like it was going really fast".

and

> "The engine was revving like the car was at top speed. It wasn't the sound of a car accelerating; it was a car at top speed. I don't know what speed it was doing but it just sounded to me like it was speeding".

39. Ms Dickens stated:

> "… I heard a loud engine revving. It sounded to me like someone was coming along the Stuart Highway speeding. It is the kind of noise you hear when a car is going really fast".

40. Both witnesses stated that before hearing the speeding car, they did not hear or see any other cars go past. Very shortly after hearing the speeding car both witnesses stated that they heard loud thuds or thumps and each assumed that the car had crashed. They did not hear the sound of any skidding or braking before the sound of the thuds.

41. At the time that the initial radio transmissions were being made by Constable Hanson to COMMS, Snr Const. David Finch and Const. David Mitchell were travelling south bound on Tiger Brennan Drive on their way to a domestic disturbance reported at Palmerston. They were in Palmerston police unit 418, which was a marked Toyota Hilux caged utility. Snr Const. Finch was the driver and Const. Mitchell was in the passenger seat. Both officers provided statements which were tendered into evidence before me. Const. Mitchell also gave oral evidence.

42. Both officers recalled that they had heard the COMMS exchange with Const. Hanson. Snr Const. Finch set out in his statement that he decided to turn into Amy Johnson Avenue on the "off chance" he could see the offending vehicle and attempt to assist in the identification of the offender. Snr Const. Finch was adamant that he had "no intention" of getting involved in a pursuit with the vehicle and he in fact had a "personal policy" not to pursue due to a "recent incident" that he had been involved in.

43. Snr Const. Finch stated that by the time he turned into Amy Johnson Avenue he was aware that the pursuit had been terminated by Palmerston 420. He

stated that as he reached within 200 to 300 metres of the intersection between the Stuart Highway and Amy Johnson Avenue he saw a vehicle move from his right to left at a "reasonable pace". He then saw "dust or smoke kicking up" and then "a rather large street light start crashing down and land on the road". He saw the vehicle come to rest at the corner opposite the Defence Establishment. When this occurred he told Const. Mitchell to "call it in".

44. The COMMS transcript records that at 1:43:48am a radio call was received from police vehicle 418 where Snr Const. Finch can be heard saying "Call it in". After this is heard, Const. Mitchell is recorded as follows:

> "VKM 418 Amy Johnson and Stuart Highway that vehicle has just ah been involved in a collision of the lights".

45. Consistent with Snr Const. Finch's evidence that he was not intending to involve himself in a pursuit, is the evidence also heard in the COMMS recording where there is initially no sound of any sirens and then a short time later the sirens can be heard to have been activated. This accords with the stated intention of Snr Const. Finch that he was not getting involved in the pursuit.

46. Const. Mitchell was also clear that there were no discussions whatsoever between him and Snr Const. Finch about involving themselves in the pursuit. He recalled hearing the pursuit on the radio but he was in fact carrying out a review of the job that he had Snr Const. Finch had been tasked to attend and was not concentrating on the specifics of the pursuit. So little attention was being given by Const. Mitchell that he had not taken any particular notice that the car had turned on to Amy Johnson Avenue and it was not until he heard Snr Const. Finch say "call it in" that his attention was drawn to the vehicle in question.

47. After reaching the location of the crash, Snr Const. Finch parked the police vehicle and both officers immediately got out. Snr Const. Finch ran to the

driver's side of the crashed vehicle and could see the driver was bleeding profusely. He contacted COMMS via his portable radio and advised them of what he could see and the fact that it appeared that the driver was "unconscious". As a result of that radio call, at 1:44:24am arrangements were made for ambulance and the fire brigade to assist.

48. At 1:44:53am Constables Harden and Hanson are recorded at arriving at the crash site. It is clear from the evidence of all the officers that the scene was chaotic. Mr Wurramarrba was bleeding heavily from his face and was trapped in the vehicle. There was a small fire burning under and near the vehicle which meant that the police officers were unable to remove Mr Wurramarrba from the vehicle as they could not breathe and therefore could not get into the vehicle long enough.

49. Const. Mitchell used a fire extinguisher from their vehicle and extinguished the fire however there was still dust and smoke surrounding the area making it difficult for the officers to breathe. Eventually Snr Const. Finch was able to access the vehicle via the rear passenger side door and Const. Harden opened the front passenger side door. Both officers then stabilised Mr Wurramarrba's head and neck in the hope of maintaining his airway. At 1:49:34am Const. Harden is recorded on the COMMS transcript as confirming that the driver was still "stuck in the car" and that police were "just trying to maintain his air way". It is clear that the officers were doing all that they could to assist.

50. St John Ambulance paramedics and the NT Fire Service are recorded via the COMMS transcript as arriving at the scene at 1:51:19am and 1:53:15am respectively. In order to get Mr Wurramarrba out of the vehicle, the fire officers used hydraulic cutting equipment, freeing him from the vehicle at approximately 2.00am. Mr Wurramarrba was treated at the scene and the ambulance is recorded as departing at 2:13am and arriving at RDH at 2:26am. He was unconscious throughout this entire period.

Events at the hospital

51. I had tendered into evidence a detailed statement of Dr Ruth Hardstaff as to events at the RDH. Dr Hardstaff is a General Surgical Consultant at RDH. She recorded that at the hospital, Mr Wurramarrba did not regain consciousness. He was intubated and scans were conducted showing that he had suffered a contained hepatic contusion (i.e., a lacerated liver which was not bleeding), fractures of the second, third and fourth rib on the right hand side and bilateral (i.e. both sides) chest contusions with the right being worse than the left.

52. In addition he had multiple fractures and intracranial (i.e. within the cranium) injuries, namely:

> "a. Depressed skull fracture;
>
> b. Extensive pneumocephalus (i.e. presence of air within the cranial cavity);
>
> c. A large subdural haematoma (i.e. collection of blood within the brain/cavity space);
>
> d. Widespread multifocal petechial haemorrhage suggestive of diffuse axonal injury. This is a brain injury in which damage in the form of extensive lesions in white matter tracts occurs over a widespread area. It is one of the most common and devastating types of traumatic brain injury;
>
> e. Extensive base of skull fracture;
>
> f. Midline shift of 16mm (which is a shift of the brain past its centre line);
>
> g. Inferior cerebellar tonsils extending to foramen magnum."

53. These were serious and significant injuries. Dr Hardstaff noted that initially the Consultant Surgeon, namely Mr David Read, considered there had been a fatal primary brain injury and that surgery would be futile. Discussions were held with Dr Nick Vrodos, Consultant Neurosurgeon at Flinders

Medical Centre in Adelaide. Dr Vrodos suggested further time be allowed for the fentanyl to wear off and for a brain stem reflex assessment to then be conducted. When this was undertaken, Mr Wurramarrba was found to have a gag reflex. As a result, further discussion was held with neurosurgery and a decision made to proceed to surgery. It was still however considered by all that the outcome was likely to be fatal.

54. Mr Wurramarrba was taken to theatre and a craniectomy was performed together the insertion of an intraventricular catheter. Dr Hardstaff noted that when the surgery was performed the brain was:

> "… noted to be contused, some of it looking necrotic. It was also herniating out of the wound at the end of the operation".

and further:

> "Mr Wurramarrba was taken to intensive care post operatively. He was supported with ventilation, antibiotics and inotropes. He was noted to have bilateral fixed pupils, no corneal reflexes and was producing large quantities of urine.
>
> Formal brain stem reflex tests were done on 28/03/14 which showed no activity. Time of death was recorded at 10.00 hours".

55. It is noted that this was some 8 hours after the motor vehicle crash. His family were contacted and arrived the following morning. They were present when Mr Wurramarrba's life support was turned off at 1.00pm on Saturday 29 March 2014.

Cause of death

56. Dr Terence Sinton performed an autopsy on the deceased on 3 April 2014 and his report was tendered in evidence before me. He described Mr Wurramarrba's significant injuries as:

> "a. Severe internal and external traumatic brain damage;
>
> b. A severely fractured skull;

c. A ruptured liver;

d. Fractured ribs on the right side of the chest."

57. Dr Sinton opined that Mr Wurramarrba died from injuries received in the motor vehicle collision. I agree with this opinion. He also noted within his report that a sample of blood was taken during Mr Wurramarrba's admission to hospital which revealed an alcohol concentration of 0.157%. Over three times the legal limit. Following on from this analysis, Dr Sinton expressed the opinion that Mr Wurramarrba was:

> "… also likely to have been suffering from acute alcohol toxicity at the time of the collision".

58. I will return to this issue of Mr Wurramarrba's blood alcohol level later in these findings; however I accept Dr Sinton's opinion in this regard.

Cause of the crash

Were police in pursuit of the vehicle at the time of the crash?

59. As noted previously, I heard evidence from both Constables Harden and Hanson who commenced the pursuit of the deceased. I accept their evidence that it was initially their intent to perform a traffic apprehension of the deceased when they formed the opinion that he may have been driving whilst intoxicated and that they only had their emergency lights on at that time. I consider their actions at that time to be entirely reasonable and in accordance with the evidence that they were presented with. Mr Wurramarrba's driving was, even in those initial stages, a risk to himself and other road users and the officers were acting in accordance with their powers and duties when they made the decision to apprehend him. Drink drivers are extremely dangerous on our roads and should not be permitted to simply drive off whenever directed by police to pull over.

60. It is also clear that when Mr Wurramarrba failed to pull over and instead quickly accelerated away, that Constables Harden and Hanson made a

decision to conduct a pursuit of him. They were full and frank in this regard at all times. I note that when that decision was made, the police siren on the vehicle was activated in addition to the emergency lights. They also took action to ensure that the fact that they were in pursuit of the vehicle was recorded with COMMS, again in accordance with their duties.

61. I note their evidence that the deceased continued to accelerate and that in turn they accelerated the police vehicle in the hope of apprehending the deceased. When they reached approximately 120km/hr the deceased was continuing to pull away from their vehicle. I accept Const. Harden's evidence that at this point in time he made a decision, as the driver, that it was "futile" to continue the pursuit and this was one of the reasons why he terminated the pursuit. I also accept his evidence that another reason he terminated the pursuit was that he was aware that he was approaching the Stuart Highway and Berrimah Road intersection, and although he could not yet see the intersection, he was concerned that if the lights were red the driver may still travel through at speed and "something happen". I note in particular his oral evidence where he stated that in terms of matters operating on his mind at the time, one was the consideration that (tp.49.1):

> "(You) want everyone to go home to their family"

And this included the deceased.

62. I accept his evidence that the factors that he took into account when deciding to terminate the pursuit were (tp.50.4):

> "The main factors were the manner of driving of the person of the target vehicle and my biggest concern was knowing that he was approaching the Berrimah lights and I wanted to give him ample time to see that we had stopped and to make a, or try and make a proper judgment decision to slow down and go through there safely".

63. I note that when this decision was made to terminate, Const. Harden advised Const. Hanson, who conveyed this information to COMMS via the radio.

This occurred at 1:42:51am, a matter of 55 seconds after the pursuit was commenced. At the same time Const. Harden deactivated the emergency lights and sirens. The sirens are in fact heard to cease during that call to COMMS. Const. Harden also gave evidence, which is supported by the evidence of Const. Hanson, that he slowed the vehicle to approximately 70 to 80 km/hr and lost sight of the driver.

64. In relation to this issue of speed and location of the police vehicle, I note that the report of Sgt Casey also analyses the speed and distance travelled of the police vehicle. As a result of his investigations, Sgt Casey calculates the average speed travelled by the police vehicle during the pursuit to be 110km/hr. This is consistent with the evidence given by the officers involved. Sgt Casey also calculates that the police vehicle was approximately 1.4kms away from the vehicle being driven by the deceased at the time of the crash. Again this is consistent with the evidence given by the officers involved and I accept this evidence.

65. Const. Harden stated that by the time he was reaching the intersection between the Stuart Highway and Berrimah Road, he was travelling at approximately 40-50km/hr. He then physically stopped the vehicle at the intersection. He stated he was attempting to ascertain the direction that the driver had travelled and also to have it recorded that he had stopped in that location. The fact that they were stationery at the lights was also conveyed to COMMS by Const. Hanson at 1:43:35am.

66. Then at 1:43:48am the records show that officers Finch and Mitchell advise COMMS that there has been at crash at the Amy Johnson Avenue intersection. Constables Harden and Hanson then travelled to that location to see if they could assist.

67. Consistent with the evidence of Constables Harden and Hanson that they had terminated the pursuit is the evidence of Mr Humphry and Ms Dickens who

did not hear any sirens, see any emergency lights, or sight another vehicle travelling when they noticed the sound of the speeding vehicle.

68. As a result of the evidence, I find that a pursuit of the deceased in his motor vehicle was commenced by Constables Harden and Hanson. However, a risk assessment was conducted and determined that it was too dangerous to continue to pursue the deceased and a decision was made to terminate approximately 55 seconds later and action taken to terminate that pursuit. Whilst I have found that the officers did commence a pursuit, I find it was terminated appropriately and I do not consider that the actions of the police caused this crash.

Conduct of the driver

69. At the time of the crash, Mr Wurramarrba was unlicensed. In fact, as previously noted, the evidence shows that the only licence he ever held was a Learners licence which expired on 4 November 2005. Mr Wurramarrba also had a criminal history which involved a number of traffic offences. Since the expiry of his licence in 2005, Mr Wurramarrba had in fact appeared in court for driving unlicensed on 6 separate occasions, namely 17 August 2011, 18 October 2011, 9 February 2012, 22 February 2012, 24 February 2012 and 11 June 2012. It is clear that court appearances, fines and potential terms of imprisonment were not stopping this man from driving when he was well aware that he should not have been.

70. Further, as earlier noted, Dr Sinton noted within his autopsy report that a sample of blood was taken during Mr Wurramarrba's admission to hospital. This was in fact ante mortem blood taken from the deceased at 4.50am on 27 March 2014. It was analysed by Forensic Science South Australia and showed the deceased recorded a blood alcohol level of 0.157% at that time. This was over 3 hours after the crash.

71. The RDH medical records show "admission" bloods were taken from Mr Wurramarrba. I note that admission is recorded at approximately 2.27am. These bloods were also analysed and show the deceased recorded a blood alcohol level of 0.182% at that time. A sample of blood was also taken at 9.30am on 27 March 2014. It was analysed by NT Forensics and showed the deceased recorded a blood alcohol level of 0.65% at that time. This was almost 8 hours after the crash.

72. As part of his investigation, DSC Crea requested that NT Forensics conduct a "count back" in order to provide an estimate of the deceased's blood alcohol levels at various times. He stated that utilising the above samples, forensics estimated that at the time of driving and the crash, the deceased had a blood alcohol level of 0.205%, 0.182% and 0.193%. On any one of those estimates it is clear that the deceased had a very high blood alcohol level and he clearly should not have been driving.

73. As noted previously, it was initially the nature of the deceased's driving as he drove in and out of his lane that caught the attention of police. When police activated their emergency lights to conduct a TRAP, the deceased drove his vehicle in such a way as to indicate that he was about to pull over. He then suddenly sped away from the police and drove at high speed down the Stuart Highway. He was unlicensed and he was very heavily intoxicated. Despite police terminating their pursuit, Mr Wurramarrba continued to drive in this same manner. I find that it was Mr Wurramarrba's conduct in driving in the manner that he did that caused the crash, which resulted in his injuries and ultimate death.

Police General Order – Emergency Vehicle Driving (EVD) and Pursuit Driving

74. As set out earlier in these findings, this was a death in custody in accordance with the extended definition of "in custody" to include a person in the process of being taken into the custody of police. In this particular

case the evidence establishes that the police were attempting to apprehend Mr Wurramarrba, as the driver of the vehicle which had failed to stop as directed. I have therefore considered carefully the conduct of the officers involved and whether they had complied with the applicable General Orders for Emergency Vehicle Driving ("EVD") and Pursuit Driving promulgated on 21 November 2013.

75. "Pursuit" is defined at paragraph 14.12 of the "General Order – Emergency Vehicle Driving (EVD) & Pursuit Driving", which provides as follows:

> **"Pursuit** is the attempt to intercept a moving vehicle that has:
>
> 1. Failed to comply with a direction to stop, the vehicle fails to stop as soon as practicable, and it is believed on reasonable grounds the driver of the vehicle is attempting to evade police. The speed of the vehicle is immaterial as the determining factor is the failure to stop when called upon to do so; or
>
> 2. Fled the presence of police at speed in an apparent attempt to avoid apprehension by the police;
>
> but does not include searching for or seeking to identify a vehicle to which 1 or 2 apply where the vehicle is not within view and the speed limit is not exceeded."

76. I find that in terms of these circumstances, Mr Wurramarrba had been directed to stop by Constables Harden and Hanson when they put on their emergency lights. His action in activating the brake, pulling off the road and slowing down are indicative that he understood he was being so directed. Given his subsequent actions, I find that he engaged in deliberate and intentional conduct to deceive police that he was going to stop and then "took off" and reached high speeds in an attempt to evade police. The action of Constables Harden and Hanson to activate their siren in addition to their emergency lights was consistent with their decision to commence a "pursuit" of the deceased's vehicle. Such action fell within the definition of "pursuit" pursuant to the General Order. However it is equally clear that whilst this was a pursuit, it was a momentary one, i.e. 55 seconds.

77. During the course of the inquest, matters were raised on behalf of the next of kin as to various concerns of potential breaches of the General Order as to pursuits. I will address each of these suggested breaches:

a) Paragraph 29 of the General Order

i. This provides that *before* undertaking a pursuit, police are to conduct a risk assessment and notes that safety to members, other road users, the community and occupants of any vehicle is paramount. It also highlights the "overriding consideration for pursuits" as being the danger to the public if the offending vehicle is not apprehended. This is appropriate.

ii. I heard evidence from both Officers Harden and Hanson of the various matters they considered before undertaking their pursuit. I found their evidence to have been credible, believable and not disingenuous at any time. I consider it important to note, just as I did at the completion of the evidence that is easy in the cold light of day in the antiseptic atmosphere of a court room to retrospectively analyse the actions of two policemen at night in their vehicle attempting to apprehend a person who had led them to believe he was a drunk driver, therefore committing an offence and therefore being a danger to other traffic and road users, who has then led them to believe he's going to stop and then taken off like a bat out of hell towards the city. However to then analyse what they did in the next moments in time one has to be careful to understand that the decision making that takes place in those circumstances is not an arena of perfection.

iii. I accept the evidence of both Officers Harden and Hanson. I find that they did in fact conduct a risk assessment. I further find that their risk assessment was a continual process and that within 55 seconds they had formed the opinion that it was no longer

appropriate for the pursuit to continue and it came to an end. I make no criticism of their actions in this regard.

b) Paragraph 30 of the General Order

i. In summary, this provides that all personnel involved in pursuits should undertake an assessment of risk and that it should be continual and "where necessary intervene to positively influence" the incident.

ii. As is set out in the paragraph above, I find that the officers Harden and Hanson did undertake an assessment of risk and that it was continual. In relation to any other members who may have been considered directly involved in the pursuit, e.g. the COMMS officer or pursuit supervisor, given that the pursuit last 55 seconds I consider that their capacity to undertake an assessment and (if they considered necessary) to have intervened was minimal. I also consider it was not necessary; given the prompt decision which was made to terminate the pursuit.

c) Paragraph 36 of the General Order

i. I will set this paragraph out in full, which provides as follows:

> "All instances of pursuit driving places an onerous duty on police that weighs heavily in favour of the need for prudence, restraint and the absolute commitment to the protection of life".

ii. I positively find that this was not breached at any time by either officer Harden or officer Hanson. It is clear that they took the decision to pursue Mr Wurramarrba very seriously and considered it carefully in the context of the short duration for which the pursuit lasted. As I stated to counsel for senior next of kin, if the evidence was that the police had commenced this pursuit due to a failure to indicate, then I would agree that the onerous duty placed

upon them would not have been met. However that was not the case here.

iii. In this matter, police were dealing with a driver showing all the usual indicia of a drunk driver. Deaths from drunk drivers on Territory roads are three times the national average. This is very, very serious and if drivers in the Territory were to learn that they were never going to be pursued by police if they were thought to be intoxicated and refused to comply with a direction to pull over, then their risk to all road users (not just themselves) would increase even more significantly. I find there is no basis for any suggestion that this paragraph was not complied with.

d) Paragraph 47 of the General Order

i. In summary this requires that initial notification to Territory Communications Section (TCS) or other Police Communications is to include a number of identified details "as might be reasonable and possible in the circumstances". Each of the details are then set out.

ii. As already noted, this pursuit lasted 55 seconds. There were a number of communications between Const. Hanson and the COMMS officer. These have already been set out in these findings. There were three in all before the pursuit was terminated. They identified that a pursuit has commenced, the location and direction of travel, their speed, the status of any traffic, and finally further information that identifies an impact on the risk assessment and the fact that the pursuit has been terminated.

iii. In considering the condition precedent of this paragraph, i.e. "as might be reasonable and possible in the circumstances", given this

lasted for 55 seconds; I consider that this paragraph has been complied with and I make no criticism.

e) Paragraph 49 of the General Order

i. Officers Harden and Hanson were in a marked twin cab utility (van). Paragraph 49 of the General Order provides that such vans are not to engage in pursuits without approval from the pursuit controller. I accept that if this paragraph were interpreted strictly, then there was a breach when the pursuit was *commenced*. However I consider that such breach was reasonable given the circumstances that presented the officers at the time and the quick thinking decision making they were required to make.

ii. I also note that communications we occurring with COMMS and also being considered by the pursuit controller. Both the COMMS officer and the pursuit controller and the officer's direct supervisor were all aware that Constables Harden and Hanson were in a marked twin cab utility and no direction was given to immediately terminate. I find that given the pursuit lasted only 55 seconds because Officers Harden and Hanson assessed the risk as too high and terminated the pursuit, that their actions were reasonable. I make no criticism.

f) Paragraph 63(b) of the General Order

i. Paragraph 63 sets out the duties and obligations of members not involved in a pursuit. Importantly it commences with identifying that such members should "abstain from any non-pursuit related or non-urgent police radio communications on the Dispatch Channel".

ii. It appears that the concern raised on behalf of the next of kin is that officers Finch and Mitchell were in the "immediate area" at

the time of the pursuit and "able to assist", yet they did not notify COMMS.

iii. Again, it is important to put these circumstances into context. This pursuit was 55 seconds in length. Officers Finch and Mitchell were on their way to another job when Snr Const. Finch decided to divert onto Amy Johnson Avenue and see if he could see the vehicle to provide details of the registration or number of occupants. He was clear that he was not going to involve himself in the pursuit and that he had heard, by the time he diverted onto Amy Johnson Avenue, that the pursuit had been terminated.

iv. I also find that it was not clear at that time to Snr Const. Finch whether he was even going to see the relevant car. It is questionable therefore whether he was, at that time, in the "immediate area" given he was not sure if the vehicle would be able to seen by him. I therefore do not consider either officer to have breached this paragraph in the circumstances. In fact, as was noted by Mrs Lalara in her evidence, it was somewhat fortunate these officers were there as it enabled them to attempt to provide assistance almost immediately.

78. As I noted during the course of submissions, whilst it may be arguable that counsel for the next of kin raised some borderline technical issues of potential non-compliance with current policy, I find that none of these matters were causal in the death of Mr Wurramarrba. As previously stated, I find that it was not the conduct of the police that caused this crash and Mr Wurramarrba's death. I find that it was Mr Wurramarrba's own conduct in continuing to drive at speed, whilst extremely intoxicated and continuing to attempt to evade police when they would have long disappeared from his rear vision mirror, which brought about his death. I further consider the actions taken by Constables Harden and Hanson to have been appropriate in

the circumstances in which they found themselves at the time and in accordance with the relevant General Order which calls for continuous risk assessments to be conducted, before, during and after the commencement of a pursuit.

Police General Order – Deaths in Custody, and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public

79. During the course of the inquest, counsel for the next of kin also raised concern of a potential breach of the General Order as to the investigation of deaths in custody, being the failure to ensure "immediate segregation" of witnesses "particularly any police members directly involved in the incident".

80. As noted earlier in these findings, it is clear on the evidence that when this crash occurred the immediate aftermath was chaotic to say the least. There was smoke and a small fire. Members could not rescue Mr Wurramarrba from the car. They did all they could to keep him stable until medical personnel and fire services could attend. Thereafter this was a crash scene. It had to be secured so that investigations could be carried out as to its cause. I heard evidence that this was a busy shift and it was difficult to obtain sufficient number of members to secure the scene.

81. Officers Hanson and Harden then had to be decontaminated following the crash. They were then in a room together whilst they prepared, on separate computers, their statutory declarations. It is noteworthy that at this point in time Mr Wurramarrba was still alive.

82. It is regrettable that they were not immediately segregated; however I accept the evidence of DSC Crea that when he became aware that they had not been segregated he made arrangements to ensure they were and to reduce the risk of collusion. I do not criticise the officers involved in this regard however I do remind the Commissioner of Police and all NT police members of the

importance of the terms of this General Order and the importance of its compliance whenever possible. It may be timely for a reminder to be sent to members about these provisions and their importance.

Formal Findings

83. On the basis of the tendered material and oral evidence at this inquest I am able to make the following formal findings in relation to each of the deaths.

i. The identity of the deceased was Dennis Wurramarrba, (aka Denis Eston Lee Lalara) who was born on 8 February 1986, at the Royal Darwin Hospital, Darwin in the Northern Territory of Australia.

ii. The time and place of death was at approximately 10.00am on Saturday 28 March 2014 at the Royal Darwin Hospital, Darwin.

iii. The cause of death was multiple injuries following a motor vehicle crash while concurrently suffering from acute alcohol toxicity.

iv. Particulars required to register the death:

a. The deceased was male;

b. The deceased's name was Dennis Wurramarrba, (aka Denis Eston Lee Lalara);

c. The deceased was of Aboriginal descent;

d. The cause of death was reported to the Coroner;

e. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 3 April 2014;

f. The deceased's mother was Elizabeth Dingabelle Lalara (deceased). His father is Gideon Wurramarrba;

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

Recommendations and Comment

84. I find myself forced once again to make comment on the ongoing community outrage and despair that is caused by the actions of drunken drivers. As I have stated previously, the profound sadness and community outrage caused by drunken drivers is so great and so destructive of community harmony that

measures which may at first seem draconian are now necessary in my view. As in a number of cases it is clear that for Mr Wurramarrba, criminal sanctions of licence disqualification, fines and even possible imprisonment, are not working to deter drunks from driving.

85. Although it is to be noted that the deceased had only one prior conviction for driving under the influence, and on that occasion it was under the influence of a prohibited drug, he did have 6 prior convictions for driving unlicensed before this crash, as well as 2 prior convictions for driving without due care. He had been fined and clearly this had not deterred him at all.

86. In previous inquests I have made a number of recommendations as to changes to be considered to discourage people from evading police, in particular in the *Inquest into the deaths of Clifford Norman and Jennifer Taylor [2013] NTMC 001*. I note as well that I was referred by counsel for the next of kin to previous decisions in NSW and Qld concerning deaths from police pursuits and I have considered those decisions carefully and particularly the question of whether recommendations should be made in relation to certain offences being "non-pursuit" offences.

87. I also received a statutory declaration from Acting Assistant Commissioner of Crime and Specialist Services David Proctor, whose substantive position is Commander of Traffic and Operational Support. He provided evidence as to measures introduced by police since my earlier recommendations, including:

a) automatic number plate recognition cameras and in car data technology into the police vehicle fleet;

b) trialling of "emergent video technology" in police vehicles;

c) trialling of "body worn video camera technology" for police members;

d) continuing investigation of emerging technologies enabling the remote disabling of vehicles;

e) assessment of the potential for tyre deflation devices to be used

f) liaison between police and the Department of Transport in relation to the expansion of seizure and impounding laws;

g) the imposition of tougher penalties for offenders who drive recklessly or dangerously when evading police through amendments to s.174FB of the *Criminal Code* (NT);

h) continued review and updating of the policy and procedures around Emergency Vehicle Driving and pursuits, and update of the relevant General Order, including in December 2014.

88. I am satisfied that the Northern Territory Police are continuing to consider these issues very carefully. I encourage them to continue their regular reviews of such important pieces of police policy and to consider the current Queensland policy of "non-pursuit mattes" and pursuit categories. I do not however consider that this is a matter at the present time which requires recommendations from my Office, given the work already being undertaken and continuing to be undertaken by Northern Territory Police. I therefore do not intend to make any further recommendations at this time and have no formal recommendations to make in relation to this death.

Dated this 31st day of July 2015

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GREG CAVANAGH
TERRITORY CORONER