CITATION: *Inquest into the death of Dale Scott Walkinshaw* [2017] NTLC 026

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0146/2016
DELIVERED ON:	21 November 2017
DELIVERED AT:	Darwin
HEARING DATE(s):	16 – 17 October 2017
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Custody, transporting in caged police vehicle, duty of care, bootlace attached to grill of vehicle cage and then around neck, police inability to see what happening in cage, failure by police to mitigate the risks of the poor vision**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police	Angus Stewart SC

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

No. D0146/2016

In the matter of an Inquest into the death of

DALE SCOTT WALKINSHAW
ON 19 SEPTEMBER 2016
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh:

Introduction

1. Dale Walkinshaw (the deceased) was born 21 July 1993 in Warragul, Victoria to Bronwyn and Geoff Walkinshaw. He had one younger brother.

2. His parents separated when he was very young but they ensured he continued to have a relationship with both of them. His mother brought him to Darwin between 2006 and 2009. During that period he went to Bakewell Primary School.

3. Dale grew into as very fit and popular young man. He played first grade Australian Rules football for Lakes Entrance and Lindenow in Victoria. He also loved to go camping and fishing and shooting. He had a large group of friends to whom he demonstrated a strong sense of loyalty. He didn't like to let anyone down, a trait that contributed to his fateful decision.

4. While in Victoria he commenced an apprenticeship as a builder with Apprenticeships Group Australia. However, that fell through after the first year due to a withdrawal of funding. He became a fencing contractor, however regarded it as an interim occupation. He was looking for other opportunities when one of his friends, Richard, came to the Northern Territory in May 2016.

5. Richard had an older brother who had a building company in the Northern Territory. Dale was able to get a job as a second year building apprentice with that company and followed Richard to Darwin in June 2016. Dale's employer noted that he was a good worker with a strong work ethic.

6. Dale was a gregarious young man and spent a good deal of his evenings socialising with his friends. At 1.45am in the early hours of Friday, 15 July 2016, Dale and Richard were driving home from the pub. Dale was driving Richard's Toyota Hilux vehicle. They were stopped in Gilruth Avenue for a Random Breath Test.

7. Dale was found to be Medium Range concentration of alcohol (0.114). He was given a court attendance notice and appeared in Court on 16 August 2016. He was convicted, fined $900 and his licence was cancelled for 6 months from that date. He didn't tell his employer that his licence was cancelled. He feared his employment would be terminated.

8. On Thursday 15 September 2016 Dale, Richard and another friend went to Monsoons at about 8.00pm. Monsoons is a bar and restaurant in Darwin. Dale met a young woman. It was after 1.00am that Dale asked Richard for the keys to Richard's Toyota Hilux. CCTV vision shows Dale leaving Monsoons with the young woman at 1.15am.

9. Dale drove the Toyota Hilux outbound on the Stuart Highway. Just before the flyover at the Bagot Road intersection, the vehicle mounted the centre medium strip and crashed into a palm tree. The air bags inflated. Dale was not injured. However, the young woman was screaming. She had pain in her back and was passing in and out of consciousness. The time was approximately 1.25am.

10. Dale removed the young woman from the vehicle and carried her to the side of the road behind some vegetation. He tried to keep her awake. He kept

saying “don’t die, don’t die” over and over again and checking the pulse in her neck.

11. At 1.30am Constable 1st Class Waite and Constable Jones (the Constables) were traveling in a Police van on their way to a noise complaint. They observed the crashed vehicle. There was no one in the vehicle and after a short search Dale came from behind the vegetation on the side of the road carrying the young woman in his arms.

12. The ambulance was called at 1.32am. It arrived at the scene five minutes later. Sergeant Turner, who was in the area, stopped to assist. That night he was the Duty Sergeant for Casuarina and was on his way to deliver documents to the Darwin Watch House. Sergeant Sanders also attended. He was the Duty Sergeant on that shift for Darwin.

13. When the ambulance arrived, Dale told the paramedics he was not injured and didn’t want any treatment. The young woman complained that her lumbar spine was hurting and she was finding it hard to breathe. She was put on a spinal board and taken to the Royal Darwin Hospital by ambulance.

14. At 1.40am Dale sent a text to his friend, Richard saying, “I’m so so sorry bro”.

15. Dale did not want to be breath tested but eventually submitted. The test was positive (0.149) and he was arrested for the purposes of undergoing a breath analysis. He remained concerned about the young woman. In evidence, both Constables commented that Dale’s main concern appeared to be the welfare of the young woman.

16. His phone and other items were removed and he was put into the back of the police van (caged vehicle). A conversation took place between Constable Waite and Sergeant Sanders about whether he should be transported to the Hospital or to the Watch House for breath analysis. It was decided to take

Dale to the Watch House. The Police caged vehicle left the scene for the Watch House at 2.11am.

17. The vehicle arrived at 2.18am. Dale was shown to the Breath Analysis room. He sat in the chair looking down. He responded appropriately to questions and showed no outward signs of distress apart from his continuing concern for the young woman. When asked, he blew into the breath analyser. The reading was 0.133.

18. It was the intention of the police to charge Dale and they did not consider that bail was likely to be given. However, the Custody Sergeant, Alan Brown told Constable Waite that Dale would not be accepted at the Watch House until he had been checked by a doctor to ensure he had not suffered any injury in the crash. Dale was shown back to the caged vehicle. The vehicle left for the Royal Darwin Hospital at 2.39am.

19. I mentioned during the course of the evidence that I thought that the Custody Sergeant was correct to require Dale to be seen by a medical person prior to incarceration. I recalled the inquest into the death of another young man (*Adam Chandler* (2010)). On that occasion police took the young man into protective custody after he and his friends were found in the early hours of the morning throwing large pot plants. One was thrown on the young man's abdomen while he was on the ground. Police officers checked him and thought he was fine. He was not. He died the next day from internal injuries well after the time of his release.

20. After getting into the cage Dale sat on the floor with his back to the cabin. He took the bootlace out of his right boot, attached it to the mesh of the cage and then tied it around his neck.

21. The vehicle arrived at Royal Darwin Hospital at 2.55am. Constable Jones opened the cage door. He found Dale sitting bolt upright with his head turned to the side. His tongue was out and his face grey. He knew something

was wrong and presumed he had suffered an injury in the crash. He called to an ambulance officer nearby and with her help removed Dale from the vehicle and commenced cardio pulmonary resuscitation while waiting on assistance from the Emergency Department.

22. It was not until he was on the ground that an ambulance officer noticed the bootlace around his neck. When the caged vehicle was checked the other part of the bootlace was found still attached to the top of the grill.

23. Dale's pulse returned after 6 minutes. However his lactate levels were high and he had severe acidemia (PH6.9). The Intensive Care specialist indicated that was consistent with a long period of oxygen deprivation. He was intubated and ventilated.

24. A CT scan indicated the likelihood of diffuse hypoxic brain injury. His prognosis was very poor. After discussions with his family he was removed from the ventilator at 3.00pm on 19 September 2016. He was pronounced deceased 30 minutes later. He was just 23 years of age.

25. Toxicological testing found that Dale had a blood alcohol level of 0.155 along with ecstasy (MDMA) in his system at the time of his death.

26. The coronial investigation was carried out by Detective Sergeant Matt Allen and I thank him for his careful, thorough and objective investigation.

Issues

27. Dale took his own life while in a vulnerable and distressed state. He was under the influence of alcohol and MDMA. He was clearly worried that he had severely injured or killed the young woman. He may also have thought that he had written off his best friend's Toyota Hilux vehicle, may lose his job and was likely to spend some months in prison. He did not have family or friends with him.

28. The first issue relates to a conversation (the conversation) that was had within his hearing while in the Breath Analysis room. I should however say at this point that there is no criticism that should or could be levelled at Constables Waite and Jones. The CCTV footage from the Watch House and the other evidence demonstrates that they acted appropriately at all times.

29. The second issue is more significant (limited vision into vehicle cages). Dale was in Police custody at the time of his death. He was not exhibiting any signs of distress and there were no indicators that he was considering ending his life. Nevertheless, he was able to end his life with two officers on the other side of the cab window literally within a metre of him. That issue relates to the long standing difficulties police officers have had with the limited vision available into the cage of the vehicle.

The Conversation

30. While Dale was in the Breath Analysis room, Sergeant Turner happened by and had a conversation with Constable Jones within the hearing of Dale. In that conversation Sergeant Turner asked a number of questions and made a number of comments. He commented as to the outcome of a second mid-range PCA: “you get canned for that”. Shortly after that comment Dale asked the officer, “Is she gonna be alright? Is [the young woman] alright”. The officer replied, “I’m not sure, I don’t think her condition has changed but I don’t know.”

31. Sergeant Turner then said: “The difficult part is too that their car’s a write off and won’t get insurance for it”.

32. Two minutes later Dale was in the back of the van being transported to the Royal Darwin Hospital.

33. Given the proximity of that conversation to his actions in taking his own life it is perhaps too easy to draw the conclusion that it may have had an effect on his mental state. It may have, but the overwhelming evidence is that

Dale's continued concern from the time the Police attended the scene of the crash was for the welfare of the young woman.

34. There is no real basis to believe that his concern was heightened by those comments that related not to the young woman but to himself and his friend. Indeed the question he asked after the suggestion that he would probably serve time in prison was not about that, it was about whether the young girl was alright.

35. Be that as it may, it serves as a reminder of the care that should be taken when talking about potential consequences within hearing of those members of our community that find themselves in an isolated and vulnerable position.

Limited Vision into Police Vehicle Cages

36. The visibility from the cabin of police caged vehicles into the caged area is very limited, particularly at night. That was not disputed.

37. I was told that at night time when there is condensation on the rear window it is even more difficult as the light intended to light the cage reflects into the cabin. There was condensation on the rear window that night.

38. Twenty four hours after Dale hung himself in the van. The investigating officer and two other police recreated that journey to better understand the restrictions on visibility. They drew the following conclusions:

- "Vision is severely restricted into the rear of the cage especially at night;
- The position of the LED (outside of the actual cage) distracts the driver;
- The use of the LED improves visibility into the rear of the cage for the passenger however an overhead light within the cage itself would be ideal; and

- The only effective way to adequately check on the prisoner is to stop, alight from the vehicle and physically observe them."

39. As Coroner, I became aware of the limited visibility into the cage area during the inquest into the death of Mr Briscoe in 2012. Mr Briscoe died in the police Watch House after he was taken into protective custody. He had smuggled a bottle of Rum into the caged vehicle and in transit to the Watch House drank a significant amount of it. He walked into the Watch House but soon deteriorated. Police did not understand the change in his demeanour and misinterpreted his behaviour. He was carried to a cell where he died primarily of alcohol toxicity.

40. Mr Briscoe died 4 January 2012. Police obviously recognised the risks of the limited visibility at that time. On 24 January 2013 Superintendent Megan Rowe provided a report that included recommendations for the installation of LED lighting strips to shine into the cage area and video monitoring of the cage area.

41. Five caged vehicles were outfitted with the lighting each with two cameras on the back of the cab that provided a complete view of the inside of the cage. The feeds from those cameras fed to a tablet showing the vision of both cameras on a split screen that was available to the passenger in the cabin.

42. The trial of the cameras was successful. A survey was undertaken to obtain feedback from the police officers using them. One officer stated: "Finally, the NTPFS is catching up on technology. We are responsible for the safekeeping of persons in our vehicle and are now finally getting tools to do so".

43. The Senior Sergeant undertaking the survey made the following comment on 4 June 2013 in his memorandum to the Assistant Commissioner:

> "Whilst the cost to install the CCTV is $823 per vehicle, the reality is that when considering cost versus benefit, the benefit outweighs

the cost. To that end, it is recommended that the CCTV system is rolled out Territory wide …"

44. The cost of fitting out all police caged vehicles was calculated to be $132,000.

45. However, CCTV was not fitted to Police vehicles. The reasons for that are not obvious. At the inquest the Deputy Commissioner told me that the project "dropped off the radar".

46. In the lead up to the inquest, at the request of my Office, police provided critical incident reports relating to injury, death or near misses "at least in part referable to the difficulty of observation into the cage of police vehicles" for the years 2012 to 2017.

47. Many of the critical incidents related to relatively minor injuries to persons held in the cage. Often cuts to the head. Many of those may have been self-inflicted. There were also persons suffering bouts of fitting. Those persons were sometimes found unresponsive with froth around their mouths when opening the cage door on arrival at the Watch House.

48. There were a significant number of incidents where the circumstances bore some direct relevance to the death of Dale Walkinshaw. Not all of them are likely to have been serious attempts at self-harm. However there were others where the only thing that stood between life and death was pure luck. In others it is clear that it was only due to the diligence of the police officers involved that the circumstances were detected before it was too late. The short version of some of those circumstances are set out below:

2012

- January – a male tied the cord from shorts around his neck
- February – the same male tied his t-shirt around neck

- February – a male tied his shoelace around his neck and to the cage door, he was unresponsive when found. The shoelace was removed and he was transported to hospital where regained consciousness.

- May – a female tied her scarf around neck.

- June – a male tied his jumper to the cage and around his neck. He was found seemingly unresponsive. He recovered.

- September - a female tied her underpants around her neck. They were removed with a Hoffman tool. She was semi-conscious and recovered. There were CCTV cameras in the vehicle at that time.

- November – a female tied her dress around her neck.

2013

- April – a male tied his singlet around his neck. Vehicle was not in motion at the time.

- June – a male took his shirt off and set it on fire with a lighter.

- June – a male threaded his belt through the mesh of the cage and then around his neck. He was found unconscious. The belt was cut with a Leatherman tool. CPR was administered and he recovered. Vehicle not in motion at the time.

- September – a female was removed from the cage, seemingly semi-conscious and was found to have her underpants tied tightly around her neck. They were removed with a Hoffman tool and first aid and oxygen administered. She recovered.

- November – a female tried to tie her shirt around her neck. After police removed her shirt she removed her skirt and tried to tie that around her neck.

2014

- April – a female attached her top to the cage and tied it around her neck, then attempted to lie on the floor, she was choking and her breathing laboured when found but she was conscious.

- June – a female while wearing her shirt lit it with a lighter.

2015

- April – a female placed her belt around her neck.

- April – a male tied a phone charger cable to the mesh and then around his neck.
- October – a male cut himself with a Coke can.
- December – a female cut her wrist with a razor.

2016

- January – a female tied her t-shirt around her neck.
- February – a female cut her arms and legs with a razor blade.
- June – a male tried to hang himself with his shorts.
- September – Dale Walkinshaw tied his bootlace to the mesh and then around his neck. He died.

49. Given the relatively frequency of the incidents and near misses one might be forgiven for thinking that the risks due to the poor visibility into caged vehicles would be very high on the police risk register.

50. On 10 and 11 May 2016 I conducted an inquest into the death of a man transported on the floor of the cage to Hospital in a barely conscious state with his head on the floor at the cabin end of the cage (*Inquest into the death of Christopher Murrungun* (2016)). It was not until police opened the cage door that they realised that during the trip Mr Murrungun had vomited. Fortunately, he was still in the recovery position at the time and did not choke or aspirate vomit into his lungs.

51. During the course of that inquest this exchange took place with one of the Senior Constables:

> **Coroner:** I can't see why the police can't spend $400 doing something similar [fixing a camera]. What do you think of that idea?
>
> **Senior Constable**: I'm fully in agreeance with you. I - coming from a different jurisdiction to coming up to here and driving these vans and not being able to see in the back of them, I've never liked them.

> **Coroner:** But if you had a facility - a really cheap facility to press a button and see exactly what's going on in the van, that would fulfil your duty of care, wouldn't it?
>
> **Senior Constable:** I agree."

52. I made the following recommendation:

> "I recommend that Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons."

53. Those findings were published on 2 September 2016. It was just two weeks later that Dale Walkinshaw tied the bootlace around his neck and was not discovered until it was too late.

54. It might be thought that if police had the ability to see what was happening in the cage at that time he would not have been able to end his life so tragically.

55. Two business days before the commencement of this inquest, my office received affidavits from the Deputy Commissioner Katherina Vanderlaan and Assistant Commissioner Michael Murphy. I commented during the inquest on my dissatisfaction at receiving the institutional response so late. It would have been much more helpful if it had been received in the weeks leading up to the inquest.

56. It was detailed that a CCTV trial commenced in August 2017 for police vans. A camera was positioned on the rear window of a vehicle and streamed vision of the caged area. I was told that the trial had been successful and it would be rolled out to the entire fleet within 2 years.

57. I note that the vision from that camera does not include vision immediately above the window and on the floor area below the window. If installed it may not have shown what happened to Dale Walkinshaw or Mr Murrungun. When asked about that the Assistant Commissioner told me that police officers would need to remain vigilant.

58. It is undoubtedly a vast improvement and obviously will greatly benefit the frontline officers attempting to keep those they are transporting safe. However, there are still vulnerabilities in those areas of the cage not able to be viewed through the camera.

59. Neither of the affidavits made the concession that Police had failed to install the CCTV within an appropriate time or that progress over the last year had been slow, or that there was any need to prioritise the CCTV rollout to mitigate the ongoing risk.

60. I was therefore encouraged when the Mr Angus Stewart SC (retained by Police), stated at the commencement of the inquest:

> "Might I just say one thing, your Honour, right at the outset, that I have instructions from the Commissioner of the Northern Territory Police to tell your Honour firstly that the Commissioner accepts that following the recommendations in 2013 with regards to the installation of CCTV in the cages of police vehicles, there should have been a rollout of that and there wasn't.
>
> And, your Honour, the second I'd like to say on behalf of the Commissioner of Police, is that the Northern Territory Police will give whatever priority they can to the rollout of the current installation of CCTV in caged vehicles."

61. In evidence I was told by Assistant Commissioner Murphy that the rollout of the CCTV had been reprioritised and that vehicles in the urban areas would be fitted out within 6 months and the rest of the fleet within 12 months.

System Failure

62. The systems that failed were not the systems for observing the caged area. There weren't any. The systems that failed were:

    i. Analysis of critical incidents. It wasn't until preparation for this inquest that Police apparently recognised the frequency of self-harm attempts in the caged area of police vehicles; and

ii. The risk assessment system. My Office sought from the Commissioner of Police the risk registers from 2012 to 2017 noting the risks to persons in caged vehicles. There were none before 2017.

Comment

63. The Police took action in 2012 and 2013 following the death of Mr Briscoe to explore a solution providing visibility into the caged area of the police vans. They trialled the CCTV solution and recommendations were made for the installation of the cameras. As was conceded during the inquest, the cameras should have been installed at that time, that is, in 2013.

64. Self-harming continued. There were at least 16 occasions when persons in custody apparently attempted to end their lives in the back of caged vehicles by hanging or strangulation alone. In six cases the persons were not detected until they were semi-conscious or unconscious. It wasn't a matter of "if" a person would die in the back of a police van, but "when".

65. Why there was no action on the part of Police became confused toward the end of the inquest. In closing submissions Senior Counsel for the Police seemed to suggest that the inaction was due to monetary considerations:

> "The Commissioner at all times, of course, faces two competing imperatives, one is to fulfil the duty to take reasonable care of those in custody and the other also is to be responsible with regard to properly managing public finances and the processes they have to go through … it's a question of getting those two things right and the Commissioner has accepted that and the balance in this case, looking back, wasn't right …"

66. I find it difficult to accept that the Commissioner would not implement a system costing less than $900 a vehicle to ensure the safety of vulnerable persons taken into custody. I suspect that it was, as the Deputy Commissioner told me in evidence, because it "dropped off the radar". It is

also obvious that it did not need the benefit of hindsight to appreciate what needed to be done and the consequences of it not being done.

67. In my view, it is tragic that it took the death of this young man to focus the minds of senior police.

Formal Findings

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

(i) The identity of the deceased was Dale Walkinshaw born 21 July 1993 at Warragul, Victoria.

(ii) The time of death was 3.30pm on 19 September 2016. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was self-inflicted hanging.

(iv) The particulars required to register the death:

1. The deceased was Dale Scott Walkinshaw.

2. The deceased was of Caucasian descent.

3. The deceased was not employed as a builder at the time of his death.

4. The death was reported to the coroner by Police.

5. The cause of death was confirmed by post mortem examination carried out by Forensic Pathologist, John Rutherford.

6. The deceased's mother was Bronwyn Louise Walkinshaw and his father was Geoffrey Scott Walkinshaw.

Recommendations

69. I **recommend** that the Commissioner of Police review the Police risk registers to ensure they reflect appropriate risks in a form that provides the mitigation treatments for each identified risk;

70. I **recommend** that the Commissioner of Police ensure ongoing analysis of all critical incidents and near misses to ensure that the actual level of risk is appreciated;

71. I **recommend** that the Commissioner of Police ensure the rollout of an appropriate camera system to ensure that front line police officers can observe those in the cage of the caged vehicles at all times.

Dated this 21 day of November 2017.

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JUDGE GREG CAVANAGH
TERRITORY CORONER