Report by the

NSW State Coroner

into deaths in
custody/police operations.

2009

(Coroner's Act 1980, Section 13A.)

NSW Office of the State Coroner

Department of Justice and Attorney General

ISSN No: 1323-6423

The Honourable John Hatzistergos
Attorney General of New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000

31 March 2010

Dear Attorney,

Pursuant to *Section 12A(4), Coroners Act 1980,* I respectfully submit to you a summary of all *Section 13A* deaths reported and inquests held by the State Coroner or a Deputy State Coroner during 2009.

Section 13A provides:

(1) ***A coroner who is the State Coroner or a Deputy State Coroner has jurisdiction*** *to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died or that there is reasonable cause to suspect that the person has died:*

(a) While in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody, or

(b) as a result of or in the course of police operations, or

(c) while in, or temporarily absent from, a detention centre within the meaning of the Children (Detention Centres Act 1987, a correctional centre within the meaning of the Crimes (Administration of Sentences) Act 1999 or a lock-up, and of which the person was an inmate, or

(d) while proceeding to an institution referred to in paragraph ©, for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care or custody.

(2) If jurisdiction to hold an inquest arises under both this section and section 13, ***an inquest is not to be held except by the State Coroner or a Deputy State Coroner.***

They include deaths of persons in the custody of the NSW Police, Department of Corrective Services, the Department of Juvenile Justice and the Federal Department of Immigration. Persons on home detention and on day leave from prison or a juvenile justice institution are subject to the same legislation.

Deaths during the course of a 'Police Operation' can include shootings *by* police officers, shootings *of* police officers, suicide and other unnatural deaths.

Deaths occasioned during the course of a police pursuit are always of concern and have also been subject to intense media scrutiny in the last 6 months, like deaths in the latter categories; these critical incidents are thoroughly investigated by independent police officers from an independent Local Area Command.

30 *Section 13A* deaths were reported in 2009, a moderate increase from the previous year.

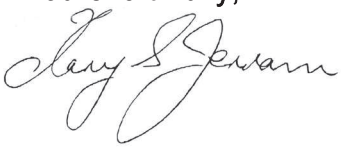
23 matters were completed by way of inquest. In many inquests constructive and far-reaching recommendations were made pursuant to *Section 22A, Coroners Act 1980*.

45 cases await inquest. Many of these matters are in the investigative stage or set down for inquest in 2010.

The Deputy State Coroners and I have put considerable effort into reducing the delay in finalising Section 13A deaths as any recommendation that may flow from an inquest could save further lives in the future.

I submit for your consideration the State Coroner's Report, 2009.

Yours faithfully,



Magistrate Mary Jerram
(State Coroner NSW)

STATUTORY APPOINTMENTS

Under the 1993 amendments to the *Coroners Act 1980*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests, the subject of this report, were conducted before the following Coroners:

NSW State and Deputy Coroners 2009

From left**: Deputy State Coroner's MacMahon & Dillon, State Coroner Jerram, Deputy State Coroner's Milovanovich & MacPherson.**

MAGISTRATE MARY JERRAM

New South Wales State Coroner

1983	Admitted as a Solicitor of the Supreme Court of NSW.
1983	Industrial Legal Officer Independent Teachers Union.
1987	Solicitor and Solicitor Advocate for Legal Aid Commission.
1994	Appointed as a Magistrate for the State of NSW
1995	Children's Court Magistrate.
1996-98	Magistrate Goulburn.
2000	Appointed Deputy Chief Magistrate.
2007	Appointed NSW State Coroner.

MAGISTRATE CARL MILOVANOVICH

Deputy State Coroner (Retired 31 December 2009)

1968 Department of the Attorney General. (Petty Sessions Branch).

1976 Appointed a Coroner for the State of New South Wales.

1984 Admitted as a Solicitor of the Supreme Court of NSW

1990 Appointed a Magistrate for the State of New South under the Local Courts Act 1982.

2002 Appointed as NSW Deputy State Coroner.

MAGISTRATE MALCOLM MACPHERSON

Deputy State Coroner

1965 Department of the Attorney General (Petty Sessions Branch).

1972 Appointed a Coroner for the State of New South Wales.

1986 Bachelor of Legal Studies Macquarie University.

1987 Admitted as a Solicitor of the Supreme Court of NSW.

1991 Appointed as a Magistrate for the state of New South Wales.

2006 Appointed as New South Wales Deputy State Coroner.

MAGISTRATE PAUL MACMAHON

Deputy State Coroner

1973	Admitted as a Solicitor of the Supreme Court of New South Wales and Barrister and Solicitor of the Supreme Court of the Australian Capital Territory and the High Court of Australia.
1973-79	Solicitor employed in Government and Corporate organisations.
1979-2003	Solicitor in private practice.
1993	Accredited as Specialist in Criminal Law, Law Society of NSW.
2002	Appointed a Magistrate under the Local Court Act, 1982.
2003	Appointed Industrial Magistrate under the Industrial Relations Act, 1996.
2007	Appointed NSW Deputy State Coroner

MAGISTRATE HUGH DILLON

Deputy State Coroner

1983	Admitted as Solicitor.
1984-5	Worked as Legal Projects Officer, NSW Council of Social Service.
1986-96	Worked as Lawyer in government practice, principally with NSW Ombudsman's Office and Commonwealth Director of Public Prosecutions.
1996	Appointed a Magistrate of the NSW Local Court.
2007	Appointed Visiting Fellow, Faculty of Law, UNSW. Also appointed a part-time President of Chief of Defence Force Commissions of Inquiry (Defence Force inquests).
2008	Appointed NSW Deputy State Coroner.

Contents

Introduction by the New South Wales State Coroner

Overview of deaths in custody/police operations reported to the New South Wales State Coroner in 2009

Summaries of individual cases completed in 2009

Appendices

Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to the Royal Commission into Aboriginal Deaths in Custody recommendations, that a definition of a death in custody should, at the least, include[1]:

1 the death wherever occurring of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the (Commonwealth) Migration Act, 1958.

2 the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;

3 the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

4 the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Section 13A, *Coroners Act* expands on this definition to include circumstances where the death occurred:

1. while temporarily absent from a detention centre, a prison or a lock-up; as well as,

2. while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in custody or during the course of police operations.

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[1] *Recommendation 41, Aboriginal Deaths in Custody*: *Responses by Government to the Royal Commission 1992 pp 135-9*

This is a matter for determination by the Coroner after all the evidence and submissions, from those granted leave to appear, and has been presented at the inquest hearing.

The Department of Corrective Services has a policy of releasing prisoners from custody prior to death, in certain circumstances. This has generally occurred where such prisoners are hospitalised and will remain hospitalised for the rest of their lives. Whilst that is not a matter of criticism it does indicate a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of *Section 13A*, such prisoners are simply not "in custody" at the time of death.

Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

What is a death as a result of or in the course of a police operation?

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in *Section 13A* of the Act.

The circumstances of each death will be considered in reaching a decision whether *Section 13A* is applicable but potential scenarios set out in the Circular were:

- **any police operation calculated to apprehend a person(s);**
- **a police siege or a police shooting**
- **a high speed police motor vehicle pursuit**
- **an operation to contain or restrain persons**
- **an evacuation;**
- **a traffic control/enforcement;**
- **a road block**
- **execution of a writ/service of process**
- **any other circumstance considered applicable by the State Coroner or a Deputy State Coroner**

After more ten years of operation, most of the scenarios set out above have been the subject of inquests.

The Deputy State Coroners and I have tended to interpret the subsection broadly.

We have done this so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believed this to be necessary.

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Service and the public generally have the opportunity to become aware, as far as possible, of the circumstances surrounding the death.

In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police was found not to warrant criticism by the Coroners.

We will continue to remind both the Police Service and the public of the high standard of investigation expected in all coronial cases.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

I agree with the answer given to that question by Mr Kevin Waller a former New South Wales State Coroner.

> *The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated*[2].

I agree also with Mr Waller that:

> *In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's*

[2] *Kevin Waller AM., Coronial Law and Practice in New South Wales, Third Edition, Butterworth's, page 28*

pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined[3]*,*

Coronial investigations into deaths in custody are a monitoring tool of standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.

New South Wales coronial protocol for deaths in custody/police operations

Immediately a death in custody/police operation occurs anywhere in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required immediately to notify the State Coroner or a Deputy, who are on call twenty-four hours a day, seven days a week.

The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, though another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

The DOI is also required promptly to notify the Commander of the State Coronial Investigation Unit, a specialised team of police officers under the umbrella of the Homicide Unit who are responsible to the State Coroner for the performance of their duties.

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions that experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist attend the scene of the death. The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified the Aboriginal Legal Service is contacted.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the coronial medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practicable, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. He or she will continue to liaise with the Coroner and with the police investigators during the course of the investigation.

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[3] *Kevin Waller AM., Waller Report (1993) into Suicide and other Self-harm in Correctional Centres, page 2.*

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local coroner in the particular district, and the local coronial medical officer to attend the scene.

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operation are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the police

When informed of a death involving the NSW Police, as in the case of a death in *police* custody or a death in the course of police operations, the State Coroner or the Deputy State Coroners may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death. This course of action is considered necessary to ensure that justice is done and seen to be done.

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner. Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

In respect of all identified *Section 13A* deaths, post mortem experienced forensic pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the coroner

Section 22, *Coroners Act 1980* provides:

(1) The Coroner holding an inquest concerning the death or suspected death of a person shall at its conclusion. record in writing his or her findings. As to whether the person died, and if so:

(a) the person's identity,
(b) the date and place of the person's death, and
(c) except in the case of an inquest continued or terminated under section 19, the manner and cause of the person's death.

In general terms *Section 19* provides:

1. if it appears to the Coroner that a person has been charged with an indictable offence or the coroner forms the opinion that evidence given in an inquest is capable of satisfying a jury that a person has committed an indictable offence and that there is a reasonable prospect of a jury convicting the person of the offence; and

2. the indictable offence is one in which the question whether the known person caused the death is in issue the Coroner must suspend the inquest.

    1. The inquest is suspended after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner, specifying the name of the known person and particulars of the offence.

    2. An inquest is an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

    3. Deaths in custody are personal tragedies and have attracted much public attention in recent years. A Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards to a possible link with the death).

    4. The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or in physical surroundings, which may reduce the risk of suicide in the future. Similarly in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures.

    5. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, as far as possible, that remedial action is taken.

Recommendations

The common law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to *Section 22A* of the *Coroners Act 1980*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations *(S.22A(2))*.

Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroners require, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly.

Contacts with outside agencies

During 2009 the State Coroner's office maintained effective contact with the following agencies:

- New South Wales Department of Forensic Medicine (Department of Health);
- Division of Analytical Laboratories at Lidcombe (Department of Health);
- Aboriginal Prisoners and Family Support Committee (New South Wales Department of Justice and Attorney General);
- Aboriginal Deaths in Custody Watch Committee;
- Indigenous Social Justice Association;
- Aboriginal Corporation Legal Service;
- Aboriginal and Torres Strait Islander Commission;
- Australian Institute of Criminology in Canberra;
- Office of the State Commander New South Wales Police Service;
- Department of Corrective Services;
- Corrections Health.
- Emergency Management Australia.
- NSW Crown Solicitors Office

Close links were also maintained with Senior Coroners in all other states and territories.

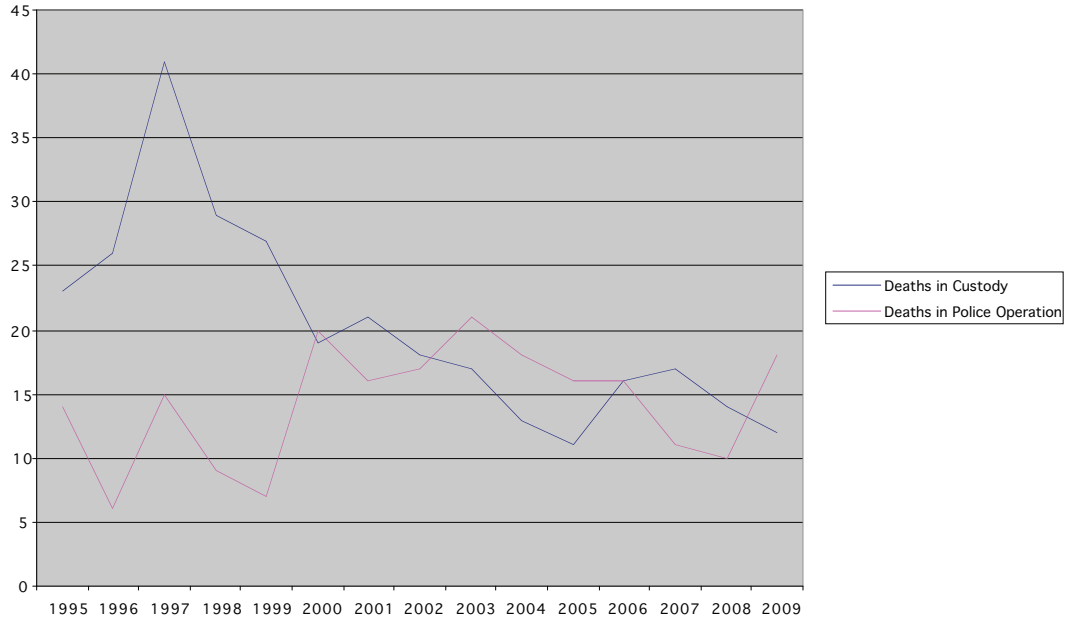
OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2009.

Table 1: Deaths in Custody/Police Operations, which occurred in 2009.

These were cases of deaths in custody and cases of death as a result of or in the course of police operations reported to the State Coroner in 2009.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30

Deaths in Custody/Police Operations



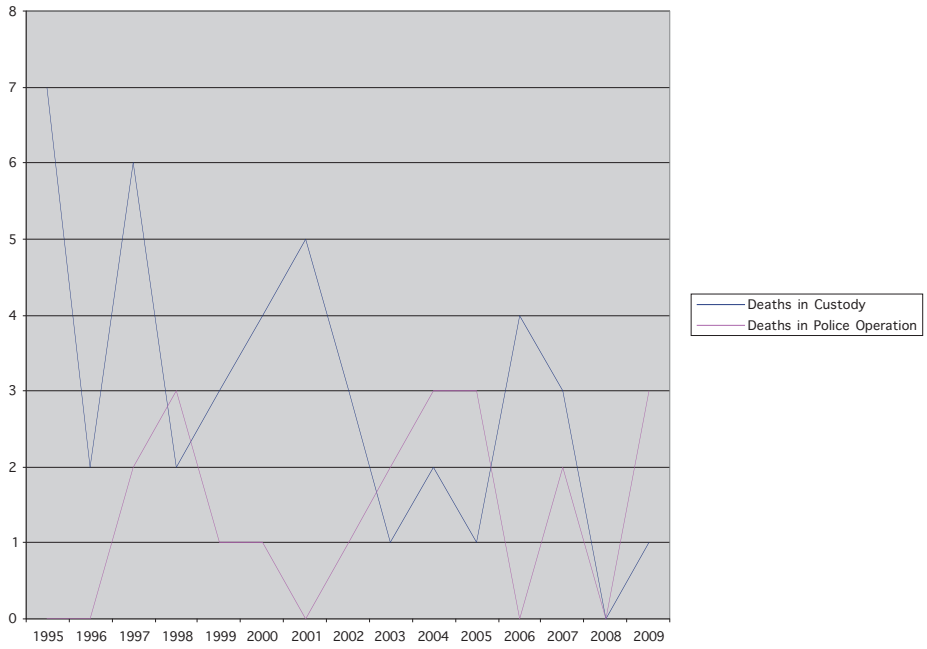
Aboriginal deaths which occurred in 2009

Of the 30 deaths reported during 2009 pursuant *to Section 13A, Coroners Act 1980*, there were **4** aboriginal deaths reported up from **0** in 2008.

Table 2: Aboriginal deaths in custody/police operations during 1995 to 2009.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4

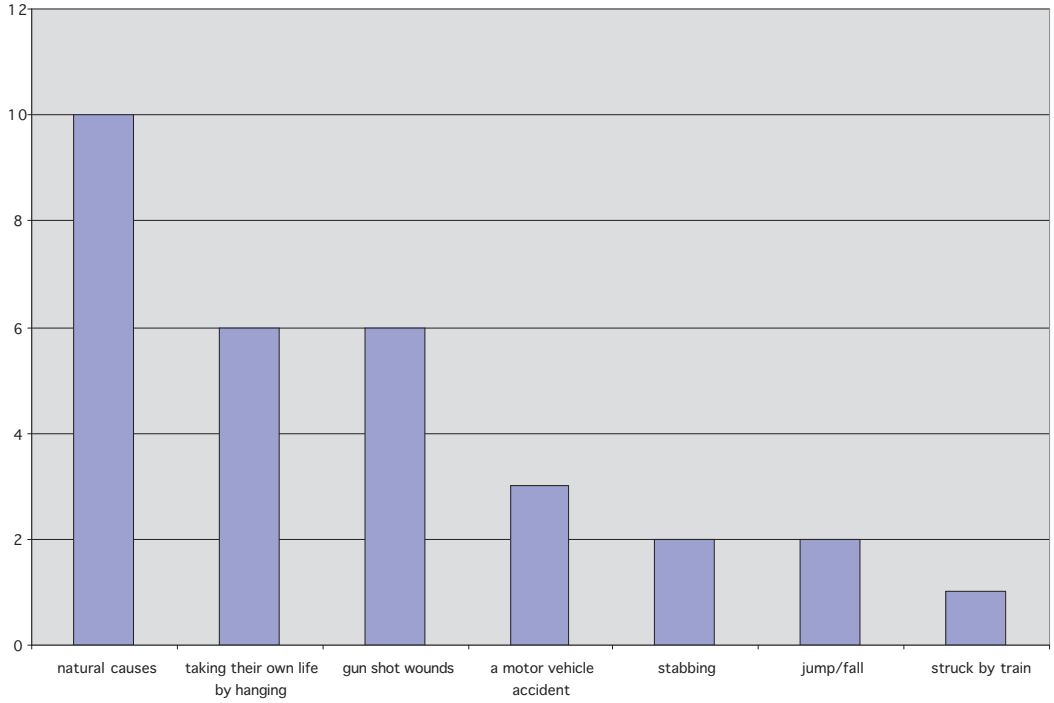
Aboriginal Deaths in Custody/Police Operation



Circumstances of deaths of persons who died in Custody/Police Operations in 2009:

6 by hanging
3 by a motor vehicle accident
6 by gun shot wounds
1 by struck by train
2 by stabbing
10 by natural causes
2 by jump/fall

Circumstances of deaths



Unavoidable delays in hearing cases

In 2009 the State Coroner and the Deputy State Coroners completed 22 inquests of deaths reportable by Section 13A.

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases at times is unavoidable. There are many different reasons for delay.

The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as complete as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.

It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.

The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.