REPORT BY THE NSW STATE CORONER

into deaths in custody/ police operations

2010

(Coroner's Act 2009, Section 23.)

The Honourable Gregory Smith
Attorney General of New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000

31 March 2011

Dear Attorney,

Pursuant to *Section 37(1) of the Coroners Act 2009*, I respectfully submit to you a summary of all *Section 23* deaths reported and inquests held by the State Coroner or a Deputy State Coroner during the year 2010.

Section 23 provides:

> A senior 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
>
> (b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
>
> (c) as a result of, or in the course of, police operations, or
>
> (d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
>
> (i) a detention centre within the meaning of the *Children (Detention Centres) Act 1987*,
>
> (ii) a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*,
>
> (iii) a lock-up, or
>
> (e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

They also 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.

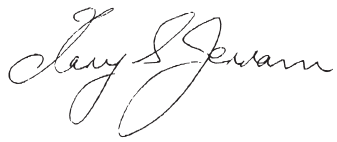
Deaths occasioned during the course of a police pursuit are always of concern and have also been subject to intense media scrutiny in the past, like deaths in the latter categories; these critical incidents are thoroughly investigated by independent police officers from an independent Local Area Command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

In 2010 there were **41** *Section 23* deaths were reported in 2010. **25** matters were completed by way of inquest. In many inquests constructive and far-reaching recommendations were made pursuant to *Section 82*. **62** cases await inquest.

Many of these matters are in the investigative stage or set down for inquest in 2011.

I submit for your consideration the State Coroner's Report, 2010.

Yours faithfully,



Magistrate Mary Jerram
(State Coroner NSW)

STATUTORY APPOINTMENTS

Under the *Coroners Act 2009*, 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 2010

Her Honour 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.

His Honour Magistrate SCOTT MITCHELL

Deputy State Coroner

1972	Admitted as Solicitor of the Supreme Court of NSW
1975	Admitted to the NSW Bar.
1993	Appointed a Magistrate
2001	Appointed a Children's Magistrate
2004	Appointed Acting Senior Children's Magistrate
2005	Appointed Senior Children's Magistrate and Deputy Chief Magistrate
2010	Appointed Deputy State Coroner

His Honour 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.
2003	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

His Honour 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.

His Honour 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

His Honour Magistrate WILLIAM BRYDON

Deputy State Coroner

1977	Office of the Clerk of the Peace
1978	Corporate position with Mining Company
1982	Admitted as Solicitor of the Supreme Court of NSW
1984	Solicitor, Office of the Clerk of the Peace
1985	Admitted as a Solicitor in England and Wales
1990	Solicitor, Crown Prosecution Office, Kent, England
1991	Solicitor, Office of the Director of Public Prosecutions (NSW)
1994	Senior Solicitor, Legal Representation Office
1997	Appointed Acting Magistrate for the State of New South Wales
1998	Appointed Magistrate for the State of New South Wales
2010	Appointed New South Wales Deputy State Coroner

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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 Migration Act 1958 (Cth),

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 23, *Coroners Act* expands 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.

The NSW State Coroner has advised Corrective Services that she considers the death of a person whilst serving an Intensive Community Order to be a death in custody pursuant Section *23 of the Coroners Act 2009*.There have been no deaths reported to the State Coroner of a person who is subject to a sentence of an Intensive Community Order at the time of writing.

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.

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

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

Corrective Services NSW has a policy of releasing prisoners from custody prior to death, in certain circumstances. This generally occurs 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 result in a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of *Section 23*, 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 set out potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in *Section 23* of the Act, as follows:

The circumstances of each death will be considered in determining whether *Section 23* is applicable:

- **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 than fifteen years of operation, most of the scenarios set out above have been the subject of inquests.

It may well be that having considered all of the evidence the death is not finally determined to be a death in custody or in the course of police operations.

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 believe this to be necessary.

It is critical that all aspects of police conduct be reviewed notwithstanding the fact that for a particular case it is 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 former New South Wales Coroner, Mr Kevin Waller.

> *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 also agree 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 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 an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.

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

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

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

As soon as a death in custody/police operation occurs 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 to notify immediately the State Coroner or a Deputy State Coroner, 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, although 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 to promptly 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 for 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 to 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.

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 the inquest.
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 identified and addressed.

In respect of all identified *Section 23* deaths, post mortem experienced forensic pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the coroner

Section 81, *Coroners Act 2009* provides:

(cf *Coroners Act 2009*, s 81)

(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and

(b) the date and place of the person's death, and

(c) in the case of an inquest that is being concluded — the manner and cause of the person's death.

(2) The coroner holding an inquiry concerning a fire or explosion must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict:

(a) as to the date and place of the fire or explosion, and

(b) in the case of an inquiry that is being concluded — as to the circumstances of the fire or explosion.

(3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

Section 78 provides:

(1) This section applies in relation to any of the following inquests or inquiries:

(a) an inquest or inquiry held by a coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:

(i) a person has been charged with an indictable offence, and

(ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned,

(b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the coroner forms the opinion (having regard to all of the evidence given up to that time) that:

(i) the evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and

(ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

(iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(2) If this section applies to an inquest or inquiry as provided by subsection (1) (a), the coroner:

(a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:

(i) in the case of an inquest—the death, the identity of the deceased person and the date and place of death, or

(ii) in the case of an inquiry—the date and place of the fire or explosion, and

(b) after taking that evidence (or if that evidence has been taken), must suspend the inquest or inquiry and, if there is a jury, must discharge the jury.

(3) If this section applies to an inquest or inquiry as provided by subsection

(1) (b), the coroner may:

(a) continue the inquest or inquiry and record under section 81 (1) or (2) the coroner's findings or, if there is a jury, the verdict of the jury, or

(b) suspend the inquest or inquiry and, if there is a jury, discharge the jury.

(4) The coroner is required to forward to the Director of Public Prosecutions:

(a) the depositions taken at an inquest or inquiry to which this section applies, and

(b) in the case of an inquest or inquiry referred to in subsection (1) (b) —a written statement signed by the coroner that specifies the name of the known person and the particulars of the indictable offence concerned.

Role of the Inquest

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.

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 a possible link with the death).

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.

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 82 of the *Coroners Act 2009*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations.

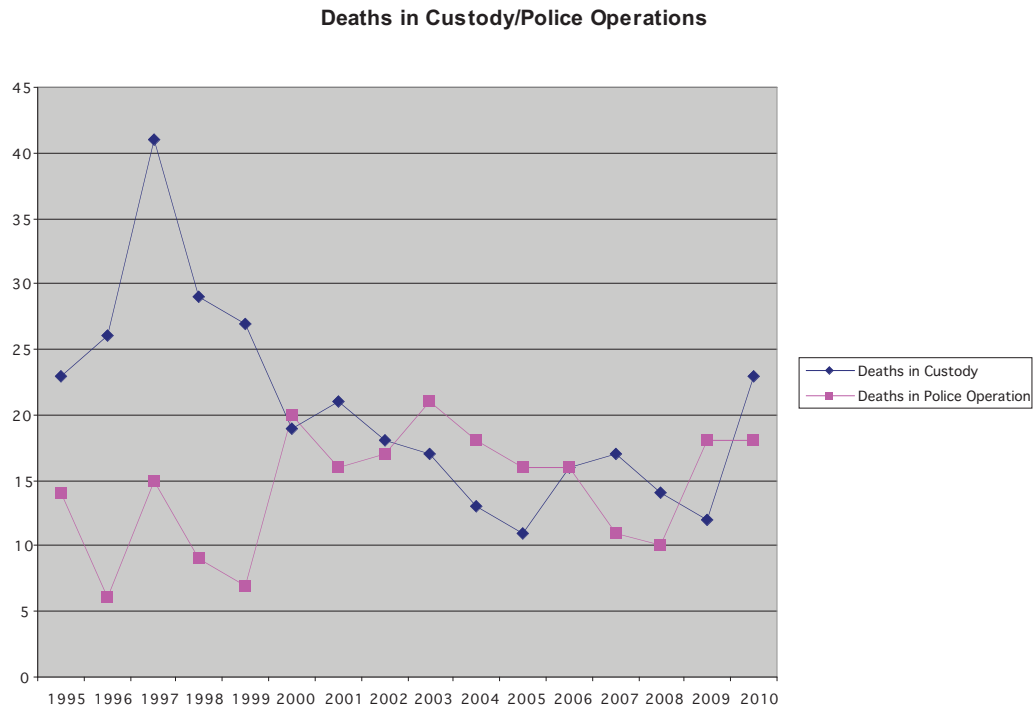
Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

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

OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2010.

Table 1: Deaths in Custody/Police Operations, 1995 - 2010.

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
2010	23	18	41

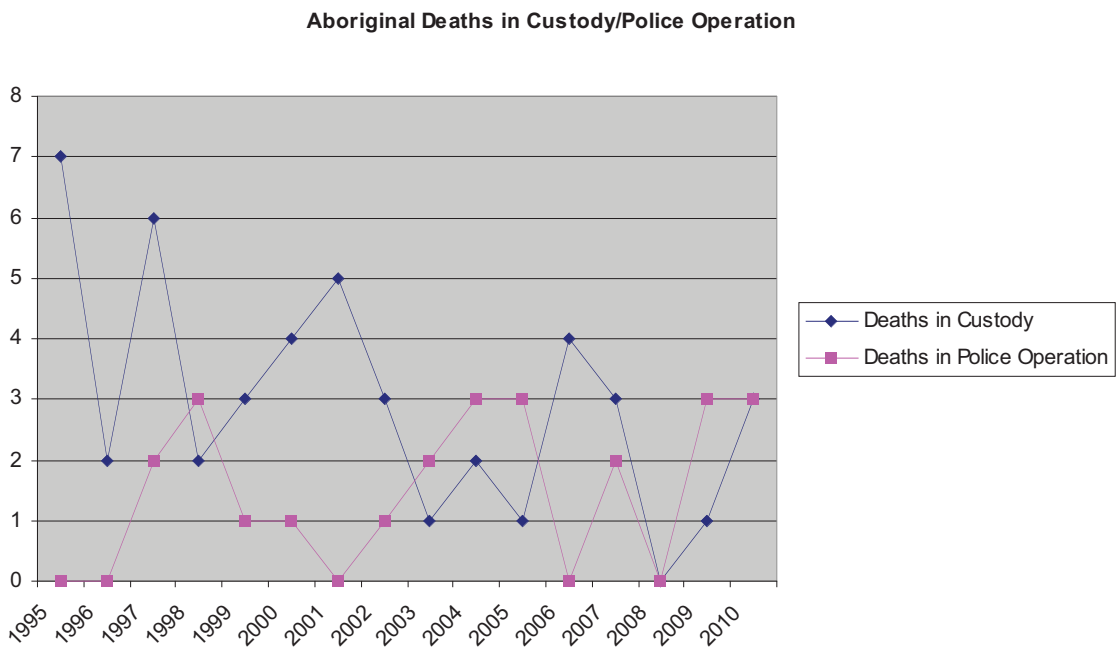


Aboriginal deaths which occurred in 2010

Of the 41 deaths reported during 2010 pursuant *to Section 23, Coroners Act 2009*, there were 6 aboriginal deaths reported.

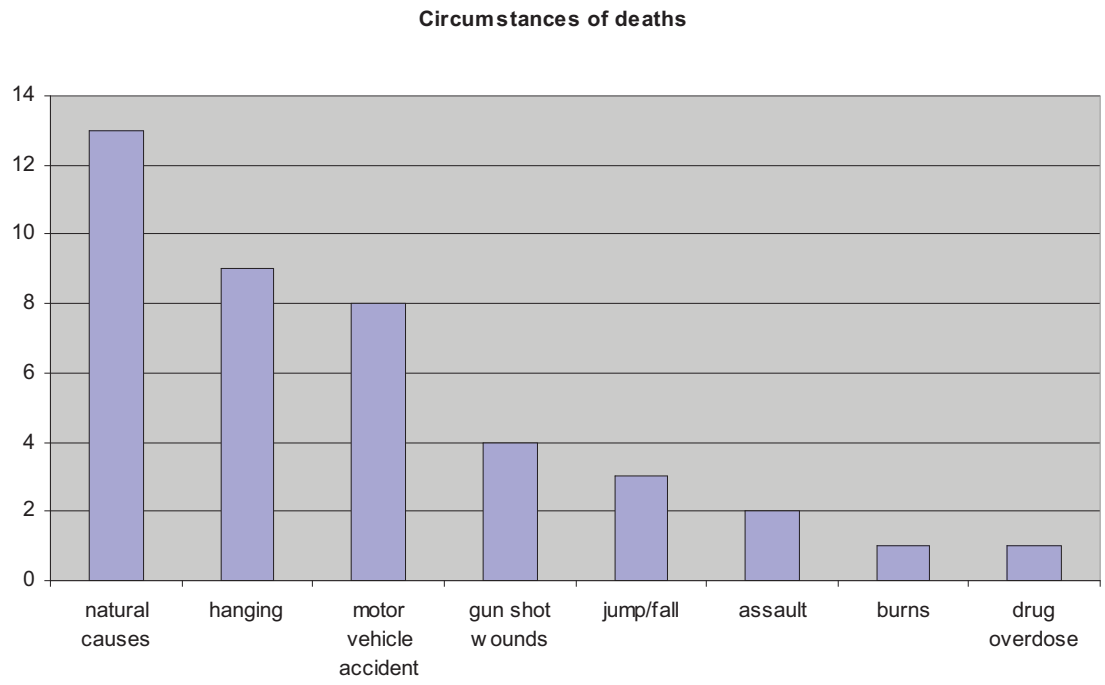
Table 2: Aboriginal deaths in custody/police operations during 1995 to 2010.

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
2010	3	3	6



Circumstances of deaths of persons who died in Custody/Police Operations in 2010:

13	natural causes	**1**	burns
8	motor vehicle accident	**3**	jump/fall
4	gun shot wounds	**2**	assault
9	hanging	**1**	drug overdose



Unavoidable delays in hearing cases

In 2010 the State Coroner and the Deputy State Coroners completed 25 inquests of deaths reportable by *Section 23.*

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times, unavoidable and there are many various 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 comprehensive 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.

SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2010.

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner, Senior Deputy State Coroner and the Deputy State Coroners in **2010.** These findings include a description of the circumstances surrounding the death and any recommendations that were made.

INQUESTS UNDERTAKEN IN 2010

	Case No.	Year	Name	Coroner
1	1740	2009	Gary Kelso	Magistrate MacPherson
2	749	2007	Jason Callaghan	Magistrate Mitchell
3	1020	2007	Name suppressed	Magistrate MacPherson
4	2303	2008	Craig Wade	Magistrate Mitchell
5	63	2008	Christy Moffitt	Magistrate Mitchell
6	418	2008	Name suppressed	Magistrate MacMahon
7	2625	2009	Branko Lazarovski	Magistrate Mitchell
8	1202	2008	Gordon Moran	Magistrate Jerram
9	1435	2008	Paul Hogan	Magistrate Jerram
10	1793	2008	Michael Capel	Magistrate MacMahon
11	1969	2008	Wayne Pearsall	Magistrate Brydon
12	1647	2008	Glen McDonald	Magistrate Mitchell
13	40	2009	Koan Heng	Magistrate Jerram
14	168	2009	Halmarko Quibulue	Magistrate Jerram
15	180	2009	Name suppressed	Magistrate Brydon
16	744	2009	Grant Willcocks	Magistrate Jerram
17	777	2009	Lucas O'Connor	Magistrate Jerram
18	1196	2009	Bradley Clennett	Magistrate Brydon
19	1519	2009	Elijah Holcombe	Magistrate Jerram
20	1961	2009	Robert Dunn	Magistrate Jerram
21	2897	2009	Name suppressed	Magistrate Jerram
22	3043	2009	Robert Bullenden	Magistrate Brydon
23	3744	2009	Skye Sassine	Magistrate MacMahon
24	2493	2009	Jospeh Cho	Magistrate Brydon
25	429	2009	Name suppressd	Magistrate Brydon