IN THE CORONERS COURT
OF THE NORTHERN TERRITORY

INQUEST INTO THE DEATHS OF

DAVID GURRALPA

ROBERT PLASTO-LEHNER

SUBMISSIONS BY THE AUSTRALIAN HUMAN RIGHTS COMMISSION

1 Introduction

1. The Northern Territory Coroner has conducted concurrent inquests into the death of Mr David Gurralpa on 1 January 2008 and the death of Mr Robert Plasto-Lehner on 28 December 2007. Mr Gurralpa was in custody at the time of his death and Mr Plasto-Lehner's death was caused or contributed to by injuries sustained while being held in custody.

2. These submissions by the Australian Human Rights Commission focus on the human rights issues surrounding the deaths of Mr Gurralpa and Mr Plasto-Lehner.

3. These human rights issues are relevant to the matters on which the Coroner shall report under s 26(1) of the *Coroners Act 1993* (NT), as they relate to the care, supervision and treatment of the deceased persons while being held in custody. The human rights issues are also relevant to the recommendations that the Coroner may make under s 26(2) of the *Coroners Act*, as they relate to ways to prevent deaths from happening in similar circumstances in the future.

4. The Commission recognises at the outset that decisions made by police in the field about the use of force can be very difficult ones. They are often made quickly, at times of high stress and require police to balance the protection of the community, themselves and the individual. The purpose of these submissions is to assist the Coroner to identify where mistakes may have been made, and where police training may have been inadequate, and to suggest practical reforms to police training and policies that could prevent future deaths and enhance the administration of justice.

5. The Commission's submissions are organised as follows:

- **Part 2: The death of Mr Gurralpa**

  Part 2.1: Police use of the prone restraint: the dangers and risk factors.

  Part 2.2: The obligations imposed by the right to life (article 6 of the ICCPR), including that by arresting and detaining individuals police take responsibility to care for their life.

  The Commission submits that:

- the Northern Territory police members failed to properly care for Mr Gurralpa's life during his detention (**Part 2.3**);

- the Northern Territory police members must be trained in the dangers of the prone restraint and the risk factors that make certain persons more susceptible to death by positional asphyxia (**Part 2.4**); and

- the Northern Territory police members must be trained to monitor the health of persons where practicable during the restraint, as well as immediately after the prone restraint (**Part 2.5**).

- **Part 3: The death of Mr Plasto-Lehner**

  Part 3.1 The human rights instruments and principles relevant to the treatment of Mr Plasto-Lehner.

  Part 3.2 The prone restraint of Mr Plasto-Lehner at Royal Darwin Hospital.

  Part 3.3 Transporting Mr Plasto-Lehner to Royal Darwin Hospital.

  Part 3.4 The police investigation into the serious injury and death of Mr Plasto-Lehner.

  The Commission submits that:

  - the decision to use force and the degree of force used against Mr Plasto-Lehner was not necessary or proportionate;

  - the decision to use force and the degree of force used was inconsistent with Mr Plasto-Lehner's right to humane treatment as a detained person and as an involuntary patient suffering mental disturbance;

  - the Northern Territory police members failed to properly care for Mr Plasto-Lehner's life during detention;

  - being transported to Royal Darwin Hospital via Darwin Police Station was inconsistent with his right as a detained person to be treated humanely and may have exacerbated his suffering;

  - Northern Territory police members must be trained to ensure they have the necessary skills and confidence to appropriately deal with mentally ill persons; and

  - the police investigation into the serious injury and death of Mr Plasto-Lehner was inconsistent with the obligation to provide an effective remedy in respect of Mr Plasto-Lehner's right to life, as the police investigation failed to comply with the requirements of Part 10 of the Custody Manual – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting From Police Contact with the Public.

- **Schedule One: Recommendations the Coroner may make under s 26(2) of the *Coroners Act***

  Schedule one sets out detailed, practical recommendations that the Coroner may make relevant to the prevention of future deaths in similar circumstances and the administration of justice. These recommendations can be summarised as follows:

  1. The Northern Territory Police should ensure that all members are trained and re-trained using reality based techniques to ensure an understanding of positional asphyxia.

  2. The Northern Territory Police training on the risk factors associated with positional asphyxia should be extended.

  3. The Northern Territory Police should ensure that all members are trained and re-trained to monitor the health of persons where practicable during the use of the prone restraint, as well as immediately after the use of the prone restraint.

  4. The Northern Territory Police should ensure that all members are trained and re-trained in strategies to deal with mentally ill persons both in custody and generally in the course of their duties.

  5. The Northern Territory Police should amend the General Order on Transport of Persons in Custody, and Part 6 of the Custody Manual – Mentally Ill Persons to include step-by-step instructions for police members on exercising the power of immediate apprehension for the purposes of a mental health assessment.

  6. The Northern Territory Police should amend Part 10 of the Northern Territory Policy Custody Manual – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public.

2 The death of Mr Gurralpa

6. The Commission submits that the events leading to the death of Mr Gurralpa can be summarised as follows.

7. There were some inconsistencies in the accounts given by witnesses at the inquest in relation to certain aspects of these events. There are a number of possible reasons for this including the length of time that has passed since the events, and the impact of stress, trauma and other highly emotional experiences on perception and memory.[1] Witness statements were taken by the police shortly following the incident; the accounts provided in these statements have been preferred to the extent of any inconsistency.

8. Mr Gurralpa was a 39 year-old Aboriginal man. He was present at a New Year's Day celebration at 18 Waterhouse Crescent on 1 January 2008. At 4.46pm, Jessica Wilson made a 000 call from 18 Waterhouse Crescent to the police stating that 'lots of people are fighting and they are all intoxicated', 'they are throwing saucepans at each other'.[2]

9. At 4.51pm, Constable Brendan Berlin and Constable Marcus Lees arrived at 18 Waterhouse Crescent.[3] They were the first attending police members. Constables Berlin and Lees were not dispatched to the job, but they heard the call on the radio and 'decided to attend as well to lend some assistance'.[4]

10. On arrival, Constable Berlin spoke to Peggy Rankin and she informed him that she was the lawful occupier of the property and there were two people there she wanted removed. Constable Berlin says that Peggy Rankin informed him that they had been causing trouble, drinking and that someone had hit her over the head with a saucepan. That person was Mr Gurralpa.[5]

11. Constable Berlin asked Mr Gurralpa to leave. Mr Gurralpa agreed and began to walk towards the front of the property with Constable Lees.[6]

12. By this time, two more police members had arrived, Constable Neil James and Constable Devrim Kanyilmaz. The members logged their arrival at 4.57pm.[7] They were also not dispatched to the job, but they heard the call on the radio and decided to drive by to see if everything was okay.[8]

13. For reasons that remain unknown, but probably because of something said by Peggy Rankin, as Mr Gurralpa was walking toward the front of the property he

---

[1] Exhibit 24 – A.Artwohl, '*Perceptual and Memory Distortion During Officer-Involved Shootings'.*
[2] Exhibit 22 - Statement of Gerald Brendon Oliver dated 26 February, Annexure 1, p 1. Evidence of Jessica Wilson on 26 February 2009, p 77 of the transcript.
[3] Unit 036: Exhibit 22 - Statement of Gerald Brendon Oliver dated 26 February, Annexure 1, p 1.
[4] Statement of Brendan Berlin dated 1 January 2008, p 2 at Folio C of the Police Brief.
[5] Evidence of Brendan Berlin on 2 March 2009, p 270 of the transcript. Evidence of Peggy Rankin on 27 February 2009, p 171 of the transcript. Exhibit 15 – Notebook of Brendan Berlin pp 26-29. See also, Evidence of Marcus Lees on 2 March 2009, p 327 of the transcript.
[6] Evidence of Brendan Berlin on 2 March 2009, p 271 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 328 of the transcript.
[7] Exhibit 22 - Statement of Gerald Brendon Oliver dated 26 February, Annexure 1, p 1.
[8] Evidence of Neil James on 27 February 2009, p 204 of the transcript.

turned and lunged aggressively towards Peggy Rankin.[9] The members believed Mr Gurralpa was going to strike or attack Peggy Rankin.[10] Constable Berlin stepped between Mr Gurralpa and Peggy Rankin and grabbed Mr Gurralpa by the arm. Constable Lees grabbed him by the other arm. Mr Gurralpa began struggling. Constables Berlin, Lees and Kanyilmaz attempted unsuccessfully to restrain him against the side of a car. The members lost their hold a few times because he was resisting, he was sweaty and because they didn't have a good grip. The members and Mr Gurralpa fell to the ground, at which time the three members commenced 'ground stabilisation'.[11]

14. Constable Berlin was on the right side of Mr Gurralpa, Lees was on his left and Kanyilmaz was at his feet. Mr Gurralpa continued struggling. Constables Berlin and Lees each pulled one of Mr Gurralpa's arms out from underneath him and placed their knee on his scapula and applied pressure whilst Mr Gurralpa was face down. This is called the three point hold.[12] Constable Kanyilmaz attempted to control Mr Gurralpa's legs, by placing them in a leg lock. The leg lock failed and Constable Kanyilmaz instead placed his knee on Mr Gurralpa's left leg and held his right leg down with his hands.[13] Constables Lees and Kanyilmaz told Mr Gurralpa to 'settle down' and 'stop resisting'.[14]

15. The members were asked whether they considered they had any other options once they fell to the ground, including stepping back and attempting to deescalate the situation. All members said they did not.[15] Mr Gurralpa was initially compliant, and then the intensity of his struggle dramatically escalated. The intensity of the struggle was variously described by members as between seven and nine out of ten.[16] The members considered Mr Gurralpa to be a danger to themselves and others, including Peggy Rankin.

16. During the struggle, Constable James stood between Mr Gurralpa and the crowd. He had a can of OC Spray in his hand and was telling the crowd to 'stay back, stay back'. Constable James observed Lees lose his grip and he thought Mr Gurralpa was going to get up. Constable James lifted Mr Gurralpa's head and

---

[9] Evidence of Brendan Berlin on 2 March 2009, p 272 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 328 of the transcript. Statement of Simeon Moscoa, dated 15 January 2008, pp 16, 18, Folio B of Police Brief. Statement of Jessica Wilson, dated 15 January 2008, pp 6, 11-12, Folio B of Police Brief. Statement of Genevieve Smith dated 2 January 2008, p 9, Folio B of Police Brief.

[10] Evidence of Brendan Berlin on 2 March 2009, p 288 of the transcript. Evidence of Neil James on 27 February 2009, p 205 of the transcript.

[11] Evidence of Brendan Berlin on 2 March 2009, p 274-5 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 324 of the transcript. Evidence of Devrim Kanyilmaz on 3 March 2009, p 393-4 of the transcript.

[12] Evidence of Marcus Lees on 2 March 2009, p 335-7 of the transcript. Evidence of Brendan Berlin on 2 March 2009, p 278 of the transcript.

[13] Evidence of Devrim Kanyilmaz on 3 March 2009, p 394 of the transcript.

[14] Evidence of Marcus Lees on 2 March 2009, p 337 of the transcript. Evidence of Devrim Kanyilmaz on 3 March 2009, p 394 of the transcript.

[15] Evidence of Brendan Berlin on 2 March 2009, p 287-9 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 356 of the transcript. Evidence of Devrim Kanyilmaz on 3 March 2009, p 401-2 of the transcript. See also evidence of Neil James on 2 March 2009, p 229 of the transcript.

[16] Constable Berlin described the struggle as nine out of ten, Constable Lees as seven out of ten, Constable Kanyilmaz described the struggle as 'very high up on the scale': Evidence of Brendan Berlin on 2 March 2009, p 277 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 339 of the transcript. Evidence of Devrim Kanyilmaz on 3 March 2009, p 395 of the transcript.

sprayed him with OC Spray for one or two seconds.[17] The can was inverted at the time it was sprayed.[18] None of the other members were affected by the OC Spray, and it didn't affect the intensity of Mr Gurralpa's struggle.[19] Constable Lees was the only member involved in the ground stabilisation who knew it had been sprayed. He could smell it and taste it, but it didn't affect him.[20] Sergeant Hansen gave evidence that members are trained to hold the can vertically when spraying. He conducted tests on the impact of spraying when the can is inverted. He found that you release only the small amount of material in the tube, and then all of the nitrogen gas. The can is then useless.[21] It would appear that the use of OC Spray did not contribute to the cause of death.

17. Constable James returned to monitor the crowd. The crowd were calling out warnings to the members including 'he has asthma', 'he is a sick man'. Constables Lees, James and Kennedy heard these warnings.[22]

18. Three more police members arrived whilst Mr Gurralpa was being restrained, Senior Constable David Wilson, Constable Melissa Kennedy and Constable Ben Parfitt. Constables Wilson and Parfitt assisted with crowd control[23] and Constable Kennedy was asked to get out her handcuffs. She did so and attempted to place them on Mr Gurralpa. It was difficult as his wrists were large. Another member assisted and Mr Gurralpa was handcuffed.[24] Mr Gurralpa was then lifted up and carried to the police van.

19. All members reported that Mr Gurralpa stopped struggling once handcuffed. Constable Lees observed that Mr Gurralpa's body went limp and he appeared to be unconscious at this time. Constable Lees didn't mention this to anyone. He got up and turned to monitor the crowd. He stated in evidence that he didn't turn his mind to the health of Mr Gurralpa. He was more concerned by the crowd who were 'yelling and screaming at me'.[25]

20. Constable Kennedy observed that Mr Gurralpa showed no signs of life as he was being carried to the police van. She said he appeared rigid, his eyes were closed and he wasn't saying anything. She expressed her concerns and said the other members took note.[26] Constables Berlin, Parfitt and Kanyilmaz did not observe Mr Gurralpa to be unconscious until he was in the police van.

21. Once in the police van, the members checked Mr Gurralpa's vital signs, his handcuffs were removed and resuscitation commenced. Mr Gurralpa's heart had

---

[17] Evidence of Neil James on 27 February 2009, p 206-7 of the transcript.
[18] Evidence of Neil James on 2 March 2009, p 235 of the transcript.
[19] Evidence of Neil James on 27 February 2009, p 209 of the transcript.
[20] Evidence of Marcus Lees on 2 March 2009, p 338 of the transcript.
[21] Evidence of Sergeant Hansen on 10 March 2009, p 940 of the transcript.
[22] Evidence of Neil James on 27 February 2009, p 207 of the transcript. Evidence of Marcus Lees on 2 March 2009, p 339 of the transcript. Evidence of Melissa Kennedy on 3 March 2009, p 371 of the transcript.
[23] Evidence of David Wilson on 3 March 2009, p 445-7 of the transcript. Evidence of Ben Parfitt on 3 March 2009, p 421 of the transcript.
[24] Evidence of Melissa Kennedy on 3 March 2009, p 369-70 of the transcript.
[25] Evidence of Marcus Lees on 2 March 2009, p 342-3 and 346 of the transcript.
[26] Evidence of Melissa Kennedy on 3 March 2009, p 373 of the transcript.

stopped at this time. At 5.01pm an ambulance was called.[27] The ambulance arrived at 5.14pm.[28] Mr Gurralpa was not revived in the ambulance, nor was he revived on arrival at Royal Darwin Hospital.

22. Post mortem and autopsy examination revealed that Mr Gurralpa was an obese man with significant (80%) coronary artery narrowing. Toxicology showed a blood alcohol level of 0.035. Dr Botterill expressed the cause of death as:[29]

> 1a Coronary Artery Atheroma
>
> 2 Restraint asphyxia; obesity; hypertensive heart disease; hepatic steatosis; alcohol intoxication

And Dr Botterill stated:

> My rational [sic] is that although each of these conditions may have resulted in a cardiac arrest, the underlying long standing coronary artery disease represented the most significant and thus likely cause of death… Nevertheless, one cannot ignore the temporal association with the restraint event, and it is difficult to completely exclude the potential contributions that the remaining conditions could have added to the risk of cardiac arrest from coronary artery disease.

23. Dr Botterill stated in evidence that he considered the restraint event to be a material contributing factor to Mr Gurralpa's death.[30]

2.1 Police use of the prone restraint: the dangers and risk factors

24. Three police members held Mr Gurralpa in the prone restraint with pressure on his upper torso, handcuffing and leg restraint. Four members were involved in the restraint at the time of the handcuffing. The members say they did not deliberately force Mr Gurralpa to the ground; they fell to the ground during the struggle and then employed ground stabilisation techniques. The techniques the police employed, including the three point hold and the attempted leg lock, were in accordance with the techniques taught in training. Mr Gurralpa was struggling in the prone restraint for about one to two minutes.[31]

25. Research has found that deaths from positional asphyxia can occur where an individual was held down or placed in the prone position and restricted in their movement – either because their hands were handcuffed behind them or because someone was on top of them, placing pressure on their back.[32]

26. A number of factors may increase the risk of death from positional asphyxia, including:

---

[27] Exhibit 22 - Statement of Gerald Brendon Oliver dated 26 February, Annexure 1, p 1.
[28] Statement of Nicole Bouma dated 10 January 2008, p 5, Folio B of Police Brief.
[29] Exhibit 6 – Report of Dr Botterill dated 11 February 2009.
[30] Evidence of Dr Botterill on 5 March 2009, p 661 of the transcript.
[31] This estimate is taken from the times the members logged their arrival and the time the ambulance was called: Exhibit 22 - Statement of Gerald Brendon Oliver dated 26 February, Annexure 1, p 1.
[32] A.Leigh, G.Johnson, A.Ingram, *Deaths in Police Custody: Learning the Lessons,* Police Research Series Paper 26, United Kingdom, 1998, p 48.

- **Obesity, particularly 'big bellies'**: excessive body weight makes chest wall movement more difficult while prone and excessive abdominal fat limits diaphragmatic motion.[33]

- **Pre-existing heart disease**.[34]

- **Significant physical exertion before and/or during restraint**: the risk is compounded when an individual is involved in a violent struggle with a police member(s).[35] Police members involved in the restraint often describe the persons as unusually strong and persistent in their struggle:

  > The victims are generally described as being unusually aggressive. They do not respond appropriately to reasoning or commands and exhibit unusual strength.[36]

  Increased oxygen demand from physical activity could increase susceptibility to asphyxiation during restraint with pressure on the chest.[37]

- **Acute psychosis and agitation, potentially stimulant drug induced.**[38]

27. The Commission submits that an additional risk group not identified in the literature should be middle-aged Aboriginal men. This is because of the known health factors for that group, including a higher incidence of heart disease, respiratory disease and diabetes.[39] The Commission notes the evidence of Dr Botterill:[40]

> Is there a health profile that puts them [middle-aged Aboriginal men] at risk in terms of positional asphyxia? Certainly, I think obesity, previous lung disease associated with smoking, of those two factors alone and with those the increased risk of diabetes and heart disease all increase the potential risk compared to the general public.

28. Relevantly for present purposes, case studies conducted of sudden death by positional asphyxia have found that it is not necessary for a person to be held in the prone restraint for a long period of time for death to occur. The case studies have indicated that sudden death has occurred after an individual has been held in the prone restraint for two minutes.[41]

---

[33] R.L.O'Halloran and J.G.Frank, 'Asphyxial Death During Prone Restraint Revisited: A Report of 21 Cases', (2000) 21(1) *The American Journal of Forensic Medicine and Pathology* 39, at Additional Documents Folio in Police Brief, Document 2, p 19. See also, evidence of Dr Botterill on 5 March 2009, p 654 of the transcript.
[34] R.L.O'Halloran and J.G.Frank, op cit, p 19.
[35] US Department of Justice, 'Positional Asphyxia – Sudden Death', National Law Enforcement Technology Centre, June 1995, p 2.
[36] D.Robison, 'Sudden In-Custody Death Syndrome', (2005) 27 *Topics in Emergency Medicine* 36, 36.
[37] R.L.O'Halloran and J.G.Frank, op cit, p 19.
[38] R.L.O'Halloran and J.G.Frank, op cit, p 1.
[39] Human Rights and Equal Opportunity Commission, *Social Justice Report 2005,* Chapter 2; B. Pink and P.Allbon, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples,* 2008, p 103 (see also Chapters 7 and 8 generally).
[40] Evidence of Dr Botterill on 5 March 2009, p 669 of the transcript.
[41] R.L.O'Halloran and J.G.Frank, op cit, p 14.

29. Moreover, case studies have indicated that despite prompt and extensive resuscitation attempts by police members and attending paramedics, in the majority of cases the individual was not able to be revived.[42]

2.2 The obligations imposed by the right to life

30. Article 6 of the *International Covenant on Civil and Political Rights* (ICCPR) provides, relevantly, that 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'.

31. It is well accepted that article 6 of the ICCPR requires the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction.[43] The Human Rights Committee has stated:[44]

> The right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures.

32. In particular, States have a positive duty to protect the life of people in custody. The Human Rights Committee has stated [emphasis added]:[45]

> The Committee affirms that it is incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection.
>
> …**the essential fact remains that the State party by arresting and detaining individuals takes the responsibility to care for their life**.

33. For the reasons set out below, the Commission submits that the Northern Territory police failed to properly care for Mr Gurralpa's life during his detention.

34. Further, the Commission submits that in order to comply with the obligation to take appropriate steps to safeguard the lives of those within its jurisdiction, the Northern Territory police must train recruits and members:

- in the dangers of the use of the prone restraint and the risk factors that make certain persons more susceptible to death from positional asphyxia; and
- to monitor the health of persons where practicable during the restraint, as well as immediately after the use of the prone restraint.

35. These are matters that properly fall within the scope of the present inquest as they are matters related to the care, supervision and treatment of the deceased

---

[42] R.L.O'Halloran and J.G.Frank, op cit, p 14.
[43] *Osman v United Kingdom* (1998) 29 European Human Rights Reporter 2452 at [115]; *Keenan v United Kingdom* [2001] ECHR 242 (3 April 2001), within the meaning of the equivalent provision in the *Convention for the Protection of Human Rights and Fundamental Freedoms*.
[44] Human Rights Committee, General Comment No.6: The right to life (Art 6): 30/04/82, CCPR General Comment No.6 at [5].
[45] *Lantsov v Russian Federation,* Human Rights Committee, Communication No. 763/1997: CCPR/C/74/D/763/1997 at [9.2].

while being held in custody and relate to ways to prevent deaths from happening in similar circumstances in the future.

2.3 Police failure to care for Mr Gurralpa's health and life

36. It is an essential component of the right to life that police, by arresting and detaining individuals, take responsibility to care for their life.

37. The Commission submits that the Northern Territory police failed to properly care for Mr Gurralpa's life during his detention in the following respects:

- the police members failed to heed warnings from Mr Gurralpa's family in relation to his health; and
- the police members failed to take immediate steps to provide Mr Gurralpa with medical assistance once it was observed he was unconscious.

38. Whilst Mr Gurralpa was being held in the prone restraint, his family members were calling out warnings to the police including 'he has asthma', 'he is a sick man'. These warnings were heard by Constables Lees, James and Kennedy, as well as by a man in a neighbouring property.[46] These warnings were not heeded and police members continued with the restraint. There are a number of possible reasons for this including:

- the members were focused on the intensity of their struggle and their aim, which was to restrain Mr Gurralpa;[47] and
- the members were not aware that asthma and pre-existing medical conditions were risk factors that make persons more susceptible to death by positional asphyxia.

39. In the Commission's submission this demonstrates that attention must be paid in training to the dangers of the prone restraint and the associated risk factors. Moreover, in situations where the use of the prone restraint cannot be avoided, members must be trained to be mindful of the risks and alert to any signs or symptoms of positional asphyxia.[48]

40. Additionally, the police members failed to take immediate steps to provide medical assistance to Mr Gurralpa once it was observed that he was unconscious. A member gave evidence that he noticed Mr Gurralpa's body went limp and he appeared unconscious immediately after he was handcuffed. He did not mention this to anyone, and instead stood up to monitor the crowd. When asked 'Did you even turn your mind to his health?' He replied 'No'.[49] The member stated in evidence that he fell down in his training in this respect.[50]

---

[46] Statement of Russell Nichols dated 7 January 2008, pp 2, 3, at Folio B of the Police Brief.
[47] See, for example, evidence of Brendan Berlin on 2 March 2009, p 288-9 of the transcript.
[48] Exhibit 17 (Confidential) - Northern Territory Police Operational Safety and Tactics Training Unit, Defensive Tactics Manual, 2006, p 24.
[49] Evidence of Marcus Lees on 2 March 2009, p 343 of the transcript.
[50] Evidence of Marcus Lees on 2 March 2009, p 346 of the transcript.

41. Whilst there was no evidence that the actions of this member contributed to Mr Gurralpa's death, the failure to provide immediate medical assistance is of serious concern. In the Commission's submission, it demonstrates that attention must be paid in training to the requirement that members monitor the condition of a person both during and immediately after the prone restraint, in conjunction with raising members' awareness of the dangers of the prone restraint.

2.4 Police training in the dangers of the prone restraint and the risk factors

42. The Commission submits that Northern Territory police members must be properly trained in the dangers of the use of the prone restraint and the risk factors that make certain persons more susceptible to death from positional asphyxia.

43. The Northern Territory Police Operational Safety and Tactics Training Unit have developed the Defensive Tactics Manual 2006.[51] The Defensive Tactics Manual is provided to Defensive Tactics instructors for training purposes. It is not available to recruits, police members or the public.

44. The Defensive Tactics Manual deals with the correlation between restraint positions and sudden deaths due to positional asphyxia. The Manual identifies each of the risk factors for positional asphyxia outlined above, and includes the following additional risk factors:[52]

> **Pre-existing physical conditions -** …asthma
>
> **Multiple Police -** … where several police are involved the pressure and restriction to the person's respiration is increased…
>
> **OC Spray –** Members should bear in mind the effects of Oleoresin Capsicum Spray on a person's respiratory system. This may increase the risk of a person succumbing to PAD [positional asphyxia death].

45. The Manual describes the typical combination of behaviour by the person and responding police members that may lead to a positional asphyxia death. This is referred to as the downward spiral. The Manual states 'recognition of this pattern may enable police to alter the method in which they attempt to resolve the situation and avert a tragic outcome':[53]

> **Stage 1 – Development of the incident**
>
> The individual exhibits irrational, violent behaviour with aggressive and/or paranoid features, resulting in hypoactivity and extreme physical exertion.
>
> **Stage 2 – Intervention**

[51] Exhibit 17 (Confidential) - Northern Territory Police Operational Safety and Tactics Training Unit, Defensive Tactics Manual, 2006.
[52] Exhibit 17 (Confidential) – op cit, p 22.
[53] Exhibit 17 (Confidential) – op cit, p 23.

> …a struggle ensues…The individual may be out-numbered and will probably be placed in a prone restraint, often with one or more persons sitting on his or her chest. Regardless of the mental state of the person this level of restraint is likely to cause restricted breathing and discomfort. Facing suffocation and pain the person may fight even harder in an attempt to get relief. If the person continues to struggle the interveners will apply more force.
>
> **Stage 3 – Exhaustion**
>
> In panic, madness or desperation the individual persists in forceful attempts to breathe and escape restraint. Interveners see this as a continued threat of harm to themselves and others. Interveners will perceive it to be necessary to apply even more force to restrain the person... While in a prone position the individual will continue to expend what energy they have left, just trying to breathe. Rapidly, the individual becomes lethally exhausted.

46. The Manual goes on to outline the signs and symptoms of which members should be aware, and take immediate action to remedy. These include gasping sounds, cyanosis, panic/prolonged resistance and sudden tranquillity.[54]

47. Finally, the Manual details the following prevention strategies to reduce the likelihood of positional asphyxia death occurring:[55]

> **Identify persons at risk**
>
> **Avoid prone restraint unless absolutely necessary**
>
> **Identify danger signs of asphyxia**
>
> **Constantly monitor the person**
>
> **Seek medical attention**

48. As part of recruit training, a one day Defensive Tactics theory package is presented to recruits. This includes, amongst other things, a 'powerpoint' presentation on positional asphyxia. The text of the positional asphyxia powerpoint presentation is taken from the Defensive Tactics Manual.[56]

49. Members are also required to attend requalification training each year. This consists of two eight hour days, incorporating both practical and theoretical components. The theoretical component includes, amongst other things, positional asphyxia. Stephen Nalder, a Defence Tactics instructor, gave the following evidence:[57]

> When covering positional asphyxia I work from the manual and discuss the topic with participants as we go. In order to make members more aware of the risks involved in restraint tactics I have started to use these two unfortunate deaths as case histories in recruit training and will ensure that all instructors are aware of the issues raised in this inquiry. I have not used these cases for

[54] Exhibit 17 (Confidential) – op cit, p 24.
[55] Exhibit 17 (Confidential) – op cit, p 25.
[56] Exhibit 18 in the Plasto-Lehner inquest: Statement of Stephen Nalder dated 3 March 2009, [4].
[57] Exhibit 18 in the Plasto-Lehner inquest: Statement of Stephen Nalder dated 3 March 2009, [7].

> requalification training yet, because I do not want to compromise the coronial process…

50. Despite the information contained in the Defence Tactics Manual that is provided to instructors, and the training and requalification sessions for recruits and police members, the members involved in the incident with Mr Gurralpa recalled very little as to the dangers of positional asphyxia and the associated risk factors. The members appeared to recall what little information they had retained from recruit training, rather than requalification training.

51. All of the members were aware in very general terms of the phenomenon of positional asphyxia. However, very few of the members were aware of the risk factors that may make certain persons more susceptible to death from positional asphyxia. Obesity was the risk factor most commonly recalled. However, of interest was the evidence given by Constable Kanyilmaz:[58]

> Given the training that you had about overweight people, did you – were you alert to the risk in relation to the deceased when he was brought to the ground? – No, I didn't classify him as obese. I didn't think he was obese, so I wasn't – didn't really come to mind what you're asking, no.

52. This evidence demonstrates that obesity is a risk factor that may be difficult to judge. In the Commission's submission, it would be helpful to acknowledge this difficulty in training and inform members that having a 'big belly', whether or not the person appears otherwise overweight, is a risk factor.

53. Moreover, most of the members were not aware of other risk factors relevant to Mr Gurralpa's death including physical exertion during restraint and a pre-existing medical condition such as asthma or heart disease.[59]

54. None of the members recalled being trained in the downward spiral, which is the typical combination of behaviour by the person and responding police members that may lead to a positional asphyxia death. Relevantly, none of the members considered that Mr Gurralpa's attempts to break free were because he was having difficulty breathing rather than because he was trying to continue resisting the police.[60] The Commission submits that this is likely to be what was happening with Mr Gurralpa, but the police failed to realise it.

55. Finally, and perhaps most importantly, none of the members were aware of the prevention strategies to reduce the likelihood of positional asphyxia death, including identifying persons at risk and avoiding the prone restraint unless absolutely necessary. Such awareness may have allowed the downward spiral to be averted at stage 2 (intervention).

---

[58] Evidence of Devrim Kanyilmaz on 3 March 2009, p 411 of the transcript;
[59] Evidence of Neil James on 2 March 2009, p 230 of the transcript; Evidence of Brendan Berlin on 2 March 2009, p 289 of the transcript; Evidence of Marcus Lees on 2 March 2009, pp 346, 354-5 of the transcript; Evidence of Melissa Kennedy on 3 March 2009, p 376 of the transcript.
[60] Evidence of Neil James on 2 March 2009, p 228 of the transcript; Evidence of Melissa Kennedy on 3 March 2009, p 377 of the transcript; Evidence of Devrim Kanyilmaz on 3 March 2009, pp 404, 409 of the transcript; Evidence of David Wilson on 3 March 2009, p 456 of the transcript.

56. In the Commission's submission, the evidence of the police members demonstrates that there is a significant gap between the information contained in the Defensive Tactics Manual that is available to the Defensive Tactics instructors and the information that operational members recall in the performance of their duties. This issue must be addressed by the Northern Territory police by improved training of recruits and retraining of members.

57. Mr Hansen, the Sergeant attached to the Northern Territory Police Operational Safety and Tactics Training Unit accepted that Northern Territory police training in positional asphyxia required improvement. Sergeant Hansen listened to the evidence of the members during the coronial inquiries and said that hearing the evidence assisted his understanding of the areas that required improvement in the training of police members and recruits.[61] These included:[62]

- the methods of teaching the dangers of positional asphyxia (noting that reality based training was the most effective way of communicating);[63]
- teaching on at risk population groups, including adding additional risk groups such as middle aged Aboriginal men;
- seeking medical advice on how to teach about pre-existing health issues;
- elaboration of teaching on the downward spiral; and
- elaboration of teaching on prevention strategies to reduce the likelihood of death by positional asphyxia.

58. Sergeant Hansen also identified an overarching issue that may be affecting the quality of member requalification training. That is, there is no quality assurance program in relation to the requalification or 'in service' trainers and accordingly it is difficult to control what they teach. The in service trainers are different to the recruit trainers who are permanently attached to the Police Training College. The in service trainers are provided with a package of information from which they teach, but it is not possible to ensure they appreciate the seriousness of certain issues and include it in their training. Sergeant Hansen agreed that this was an issue that should be addressed.[64]

2.5 Police training in monitoring the health of persons during and immediately after the use of the prone restraint

59. The Commission submits that in order to comply with the obligation to take appropriate steps to safeguard the lives of those within its jurisdiction, Northern Territory police members must be trained to monitor the health of persons where practicable during the restraint, as well as immediately after the use of the prone restraint.

---

[61] Evidence of Sergeant Hansen on 10 March 2009, p 940-1 of the transcript.
[62] Exhibit 19 in the Plasto-Lehner inquest: Document prepared by Sergeant Hansen, undated.
[63] Evidence of Sergeant Hansen on 10 March 2009, p 941 of the transcript.
[64] Evidence of Sergeant Hansen on 10 March 2009, p 939 of the transcript.

60. At present, the Defensive Tactics Manual provides only that police members are to monitor the condition of the person immediately after restraint. There is no requirement that members monitor the person **during** the restraint process.

61. The reason it is crucial to monitor the person during the restraint process is because research into positional asphyxia suggests that loss of consciousness/death can occur extremely rapidly. Moreover, in most cases despite prompt and extensive resuscitation attempts by police members and attending paramedics the person was not able to be revived.

62. Evidence was heard at the inquest that it may not be practical to monitor a person's health during the course of a violent confrontation, especially in circumstances where there are only two members present.[65] The Commission acknowledges this practicality. However, in the case of Mr Gurralpa there were seven police members present; four restraining Mr Gurralpa and three monitoring the crowd. The Commission put to Sergeant Hansen that in a case such as Mr Gurralpa's where seven members were present, one of the members could have been responsible for monitoring Mr Gurralpa's condition during the restraint if so trained. Sergeant Hansen responded 'that's certainly something that I think we should look at, yes'.[66]

63. The Commission submits that the Northern Territory police should be trained to monitor the health of persons where practicable during the restraint, as well as immediately after the use of the prone restraint. The monitoring process could include watching for the signs and symptoms of positional asphyxia. These include listening to what the person may be saying, gurgling/gasping sounds, cyanosis, panic/prolonged resistance and sudden tranquillity.[67]

2.6 Recommendations the Coroner may make under s 26(2) of the Coroners Act

64. The recommendations which the Commission submits the Coroner should make in respect of the prevention of future deaths in similar circumstances are set out below at Schedule One.

[65] Evidence of Sergeant Hansen on 10 March 2009, p 959 of the transcript.
[66] Evidence of Sergeant Hansen on 10 March 2009, p 959-60 of the transcript.
[67] Exhibit 17 (Confidential) – op cit, p 24.

3 The death of Mr Plasto-Lehner

65. The Commission submits that the events leading to the death of Mr Plasto-Lehner can be summarised as follows.

66. Mr Plasto-Lehner was a 57 year-old man. He travelled to Darwin from Alice Springs on 19 December 2007 to spend Christmas with his sister's family.

67. Mr Plasto-Lehner's sister, Mrs Dorothy Coleman, gave evidence that Mr Plasto-Lehner was in a very poor state of mental health when he arrived in Darwin. Although the Coleman family made several appointments on Mr Plasto-Lehner's behalf for him to see a doctor between 19 December and 22 December, Mr Plasto-Lehner was too afraid and confused to do so, refusing to attend each appointment.[68]

68. Mr Plasto-Lehner was also a heavy smoker and overweight. He weighed 126 kilograms, had a large abdomen, and suffered from a chronic obstructive airways disease, bronchiectasis.

69. On Saturday 22 December 2007, Mr Plasto-Lehner left his room at the Mirambeena Hotel in central Darwin without telling his family where he was going. At 12:54pm, Louise Brennan of The Cavanagh Hotel in Darwin, rang the police to inform them that a male patron was behaving irrationally and was attempting to give away money to staff ($100) together with his ATM card. Ms Brennan noted that the man appeared unwell and was sweating profusely.

70. Aboriginal Community Police Officer (ACPO) Jon Morrison and ACPO Vanessa Martin attended The Cavanagh Hotel and Mr Plasto-Lehner was identified as the person of interest, on the basis of the ATM card the staff were holding behind the bar on his behalf.

71. ACPO Jon Morrison and ACPO Martin located Mr Plasto-Lehner nearby on Knuckey Street at approximately 3pm. Mr Plasto-Lehner was sweating and shaking and speaking in an incoherent manner.[69] ACPO Jon Morrison determined that Mr Plasto-Lehner needed urgent medical assistance due to his mental health state, and tried to convince Mr Plasto-Lehner to get into the back of the police caged vehicle, explaining to him that they wanted to take him to Royal Darwin Hospital. Mr Plasto-Lehner walked to the back of the vehicle with the two police members. ACPO Morrison said that when they reached the door of the cage, Mr Plasto-Lehner paused and said 'just, just let me have a few minutes' and sat on the back of the van.[70] ACPO Jon Morrison states that Mr Plasto-Lehner started speaking to himself again and then, suddenly, stood up, ran towards a tree on the footpath and bearhugged it, putting his whole body up against it. ACPO Jon Morrison said that he realised then that Mr Plasto-Lehner was strong and radioed for backup assistance.[71]

---

[68] Evidence of Dorothy Coleman on 10 March 2009, p 885 of the transcript. See also statement of Dorothy Coleman dated 3 January 2008, p 7, Folio 3 of the Police Brief.
[69] Statement of Jon Morrison dated 28 December 2007, pp 3-4, Folio 1 of the Police Brief.
[70] Statement of Jon Morrison dated 28 December 2007, p 5, Folio 1 of the Police Brief.
[71] Statement of Jon Morrison dated 28 December 2007, p 5, Folio 1 of the Police Brief.

72. Constables Adrian Kidney and Linda Sayers arrived to assist a short time later, approximately five to ten minutes. Constable Kidney approached Mr Plasto-Lehner while he was hugging the tree and had a conversation with him for about twenty minutes. Constable Kidney established a rapport with Mr Plasto-Lehner through being able to talk about AFL players that Mr Plasto-Lehner had mentioned. Constable Kidney said that Mr Plasto-Lehner would go very quiet and almost cry, saying 'I'm sorry, sorry to waste your time'.[72] Constable Kidney said that Mr Plasto-Lehner agreed to go to the hospital in the police vehicle with him, saying 'I'll go with you but I'm not gonna go with him' pointing to ACPO Jon Morrison.[73] Constable Kidney said that as they approached the police vehicle, Mr Plasto-Lehner said 'I'm not getting in the back cage, can I get in the backseat',[74] and that Constable Kidney explained to him that it was not appropriate. At this point, Constable Kidney said that Mr Plasto-Lehner took off his shirt and ran back to the tree and started hugging it again.[75]

73. In the time that Constable Kidney was speaking with Mr Plasto-Lehner, three more police members arrived to assist, Acting Sergeant Bradley Fox, ACPO Eric Morrison and Constable Walter Todd. Acting Sergeant Fox was the Darwin Station Shift Supervisor for the evening shift on that day. Constable Kidney had received a call from his supervisor on his radio asking if everything was alright, and Constable Kidney had requested some extra male police members to help him put Mr Plasto-Lehner in the cage of the vehicle.[76]

74. Constable Kidney approached Mr Plasto-Lehner again and convinced him to walk back towards the police vehicle. When Mr Plasto-Lehner was walking towards the police vehicle ACPO Jon Morrison and ACPO Eric Morrison each took one of Mr Plasto-Lehner's arms and guided him into the back cage of Constable Kidney and Constable Sayer's police vehicle.

75. Acting Sergeant Fox told Constable Kidney to drive Mr Plasto-Lehner to Central Darwin Police Station for a changeover of staff before Mr Plasto-Lehner was taken to Royal Darwin Hospital. Mr Plasto-Lehner was kept in the locked caged section of the police vehicle outside the Darwin Police Station on Mitchell Street while the staff changeover occurred. On the best evidence, this changeover took 15-16 minutes.[77]

76. ACPO Eric Morrison and ACPO Nicolette Krepapas took over the police caged vehicle and drove Mr Plasto-Lehner to Royal Darwin Hospital. Acting Sergeant Fox and Constable Jackson followed behind in the shift supervisor's vehicle.

77. On the way to the hospital, Mr Plasto-Lehner was observed to be quite anxious and distressed, constantly shifting seats.[78]

---

[72] Evidence of Adrian Kidney on 4 March 2009, p 475 of the transcript.
[73] Statement of Adrian Kidney dated 28 December 2007, p 7, Folio 1 of the Police Brief.
[74] Statement of Adrian Kidney dated 28 December 2007, p 7, Folio 1 of the Police Brief.
[75] Evidence of Adrian Kidney on 4 March 2009, p 476 of the transcript.
[76] Evidence of Adrian Kidney on 4 March 2009, p 476 of the transcript.
[77] Evidence of Bradley Fox on Monday 9 March 2009, p 808 of the transcript.
[78] Evidence of Eric Morrison on 5 March 2009, p 617 of the transcript.

78. ACPO Morrison and ACPO Krepapas parked the police vehicle in the reserved police parking spot near the ambulance bay at Royal Darwin Hospital and walked Mr Plasto-Lehner through to the Emergency Department, accompanied by Acting Sergeant Fox and Constable Jackson.

79. At 3:54pm the triage nurse, Theresa de Groot, assessed Mr Plasto-Lehner as Category 2, which meant that he was a high risk patient and should be attended to by a doctor within ten minutes.[79] Mr Plasto-Lehner was placed in the Oleander Room to wait for further medical attention. The door to the Oleander Room was kept open, with ACPO Eric Morrison and ACPO Krepapas sitting outside, and Acting Sergeant Fox and Constable Jackson also sitting nearby.

80. There was another patient waiting for psychiatric assessment at this time, Ross Lenard. He was moved to the room opposite the Oleander Room when Mr Plasto-Lehner arrived. It was agreed that the two police members who were waiting with Mr Lenard could leave, and the two hospital guards, Mr Randall Edwards and Mr Francis Kondambu, would stay with Mr Lenard and the four police officers who arrived with Mr Plasto-Lehner would stay with him. Mr Edwards, however, developed a rapport with Mr Plasto-Lehner and Mr Edwards assisted with encouraging Mr Plasto-Lehner to return to the Oleander Room on the numerous times when he wanted to leave the room.

81. At 4:18pm, the Registrar for the Emergency Department, Dr Elinor Cromarty, assessed Mr Plasto-Lehner. At 4:30pm Dr Cromarty signed a notice, pursuant to s 34 of the *Mental Health and Related Services Act* (NT) which meant that Mr Plasto-Lehner became an involuntary patient of Royal Darwin Hospital.[80] Mr Plasto-Lehner continued to wait in the Oleander Room to see the Psychiatric Registrar, Dr Belinda Bautista.

82. At some point when Mr Plasto-Lehner was in the Oleander Room he was given a cup of water, as well as two sandwiches which he ate. Also during that time he came out of the room several times to sit on the seats in the hallway outside the Oleander Room. Randall Edwards and some of the police members directed him back into the Oleander Room each time.

83. At 4:55pm, Dr Cromarty gave Mr Plasto-Lehner 5mg of Olanzapine, an anti-psychotic medication.

84. At 5:17pm, Dr Cromarty took blood samples from Mr Plasto-Lehner for the purpose of ruling out organic causes of his psychotic behaviour.

85. At approximately 5:43pm, Mr Plasto-Lehner requested to go to the bathroom, and he was escorted by hospital security guard Mr Edwards and ACPO Eric Morrison to the bathroom in the fast-track area of the Accident & Emergency Department. Mr Edwards says that Mr Plasto-Lehner 'sort of jacked up and refused to go in', saying that he was locked up once and that he can't go in there.[81] Mr Edwards says that Mr Plasto-Lehner's voice began to rise and he

---

[79] Evidence of Theresa De Groot on 4 March 2009, p 528 of the transcript.
[80] Evidence of Elinor Cromarty on 6 March 2009, p 776 of the transcript.
[81] Statement of Randall Edwards dated 8 January 2008, p 31, Folio 2 of the Police Brief.

began to become agitated. After a few minutes, Mr Edwards and ACPO Eric Morrison walked Mr Plasto-Lehner back towards the Oleander Room. Mr Plasto-Lehner walked past the door of the Oleander Room and stood in the door frame of the two double doors which are the fire doors of the Accident & Emergency Department, looking outside through the ambulance bay doors. Mr Edwards says that he tried two or three times to get him back into the Oleander Room, gesturing him towards the door. Mr Edwards also says that Acting Sergeant Fox asked Mr Plasto-Lehner to go back into the Oleander Room. Mr Edwards says that Mr Plasto-Lehner started to raise his voice again and say that he wanted to go outside for some fresh air and to have a smoke. Mr Edwards notes that he had earlier told Mr Plasto-Lehner that he would take him outside for a cigarette if the doctors agreed, but that he would need to wait to see the doctors first.[82]

86. Mr Edwards states that Mr Plasto-Lehner 'was sort of raising his arms'.[83] Nurse Rebecca Weir also gave evidence that Mr Plasto-Lehner throwing up his arms could be described as 'windmill' arms,[84] something which is typical of psychiatric patients.[85]

87. Mr Edwards states that Mr Plasto-Lehner pushed past Acting Sergeant Fox, taking a few steps into the foyer of the ambulance bay area, ignoring Acting Sergeant Fox's instructions for him to return to the Oleander Room. Constable Jackson and ACPO Krepapas were standing in front of him, between him and the glass sliding doors of the ambulance bay.[86]

88. Acting Sergeant Fox states that a few moments earlier he had read an A4 sized piece of paper, like a hospital directive, stating that patients were not to be allowed outside into the ambulance bay to have a cigarette, because there was a risk that the person might go over the ledge at the end of the ambulance ramp.[87]

89. When Mr Plasto-Lehner took a few steps into the foyer of the ambulance bay area, Acting Sergeant Fox grabbed Mr Plasto-Lehner by one arm and ACPO Eric Morrison took his other arm and Acting Sergeant Fox took Mr Plasto-Lehner down to the ground into a prone restraint position in the ambulance bay foyer.[88] This happened in the course of a few seconds.

90. Once on the ground, Mr Plasto-Lehner struggled as he was held face down and weight was applied down on his body. Acting Sergeant Fox and ACPO Eric Morrison were assisted in restraining Mr Plasto-Lehner by Constable Jackson, ACPO Krepapas, Mr Edwards, and Patient Care Assistant (PCA)

---

[82] Statement of Randall Edwards dated 8 January 2008, p 17, Folio 2 of the Police Brief.
[83] Statement of Randall Edwards dated 8 January 2008, p 18, Folio 2 of the Police Brief.
[84] Evidence of Rebecca Weir on 6 March, p 720 of the transcript.
[85] In a similar coronial inquest, the Victorian Coroner accepted evidence that a mentally ill person throwing his arms up in the air did not pose a threat to anyone and that the police should have stepped back and considered other options, rather than trying to apprehend him. See State Coroner of Victoria, Inquest of Gregory David Couper, 7 June 2002, p 28.
[86] Evidence of Angela Jackson on 4 March 2009, p 548 of the transcript; Statement of Nicolette Krepapas dated 28 December 2007, p 5, Folio 1 of the Police Brief.
[87] Evidence of Bradley Fox on 9 March 2009, p 822 of the transcript.
[88] Evidence of Bradley Fox on 9 March 2009, p 820 of the transcript.

Peter Toogood. Mr Plasto-Lehner was restrained on the ground for approximately two minutes.[89]

91. During this time, Acting Sergeant Fox and ACPO Eric Morrison applied significant weight to Mr Plasto-Lehner's upper torso, trying to effect a '3 point hold'. Acting Sergeant Fox says that he was using all his physical strength and weight, trying to shift it onto Mr Plasto-Lehner's torso to prevent Mr Plasto-Lehner from pushing away from the ground,[90] and that his right knee was on Mr Plasto-Lehner's left scapula. Acting Sergeant Fox says he also held Mr Plasto-Lehner's head down with his left knee.[91] Acting Sergeant Fox said that he did this to prevent any fluids or blood being spat at him and to contain his head.[92]

92. ACPO Eric Morrison states that he had his knee on Mr Plasto-Lehner's right scapula and held him in that position.[93]

93. ACPO Krepapas was holding Mr Plasto-Lehner's left arm, trying to pull it out from underneath him and sweep it round to his back so that he could be handcuffed.[94] Constable Jackson took hold of Mr Plasto-Lehner's right arm and was struggling to get the handcuff on, as his wrists were large.[95]

94. Also at this time, Mr Edwards held Mr Plasto-Lehner's feet down, struggling to stop him moving.[96] PCA Toogood applied his body weight to hold his legs down.[97] It may be that the security guard Francis Kondambu was also restraining Mr Plasto-Lehner's legs.[98]

95. Dr Cromarty states that she heard commotion from where she was on the 'flight deck' and came down to see what was happening. She saw Mr Plasto-Lehner restrained face down on the floor with several police members lying across him and others restraining his arms and legs. Dr Cromarty says that when she arrived, the police members were struggling to get handcuffs on Mr Plasto-Lehner, and she asked if the handcuffs were really necessary.[99] She felt she had a good rapport with Mr Plasto-Lehner and she thought she might be able to help calm him down so that the police would release him from the restraint.

---

[89] Philip Strickland SC on Tuesday 10 March 2009, p 962 of the transcript.
[90] Statement of Bradley Fox dated 28 December 2007, p 5, Folio 1 of the Police Brief.
[91] Evidence of Bradley Fox on 9 March 2009, p 827 of the transcript.
[92] Evidence of Bradley Fox on 9 March 2009, p 828 of the transcript.
[93] Evidence of Eric Morrison on 6 March 2009, p 674 of the transcript.
[94] Evidence of Nicolette Krepapas on 4 March 2009, pp 513 – 515 of the transcript.
[95] Evidence of Nicolette Krepapas on 4 March 2009, p 516 of the transcript. Evidence of Angela Jackson on 4 March 2009, p 550 of the transcript.
[96] Evidence of Randall Edwards on 6 March 2009, pp 737 – 738 of the transcript.
[97] Statement of Randall Edwards dated 8 January 2008, p 7, Folio 2 of the Police Brief.
[98] The following four eyewitnesses say that they saw both of the security guards restraining Mr Plasto-Lehner: Evidence of Lai Heng Foong on 5 March 2009, p 625 of the transcript; Statement of Elinor Cromarty dated 9 January 2008, p 8, Folio 2 of the Police Brief; Evidence of Theresa De Groot on 4 March 2009, p 532 of the transcript; and Evidence of Carissa Oh on 4 March 2009, p 556 of the transcript.
[99] Statement of Elinor Cromarty dated 9 January 2008, p 8, Folio 2 of the Police Brief.

96. Dr Cromarty says that as she tried to approach Mr Plasto-Lehner, one of the police members put his knee on Mr Plasto-Lehner's head and Mr Plasto-Lehner's head smacked into the floor.[100] At this point, Dr Cromarty was concerned as Mr Plasto-Lehner appeared to struggle less and his face was becoming quite red. Dr Cromarty states that

> I asked the policeman – um – I asked if they could just please ease up a little bit and was told – um – that they had to do this for their own safety and – and I should back off and I – he put his hand in towards my face to tell me to back off, which I did because someone put their hand in my face.[101]

97. Dr Cromarty noticed some of her colleagues standing nearby, Dr Lai Heng Foong, Dr Oh and Natasha Roberts. Dr Foong also asked Acting Sergeant Fox to release Mr Plasto-Lehner, so that they could talk to him.[102] Dr Cromarty and Dr Foong knelt at Mr Plasto-Lehner's head, trying to talk to him. Dr Cromarty said 'just try and – try and just really relax Robert, and then we'll – we'll get these guys off – off you…'.[103] Dr Cromarty says that Mr Plasto-Lehner really did seem to try to lift his head to us, and as he did so, she and Dr Foong could see that there was blood on the floor and a laceration on or near his eyebrow.[104] Dr Cromarty and Dr Foong observed that Mr Plasto-Lehner was starting to go blue in the face, and Dr Foong said 'just let go of him, he's getting blue'.[105] Dr Foong says that nothing happened when she said this, and that she had to say it again, 'get off him, he's going blue' before anyone responded.[106]

98. When the police members and hospital staff holding Mr Plasto-Lehner released him from the prone restraint hold and turned him over, he wasn't breathing and he was still very blue.[107]

99. Constable Jackson removed the handcuffs from Mr Plasto-Lehner and he was taken into the resuscitation room by Dr Foong and Dr Oh. Mr Plasto-Lehner was asystolic, that is no heart beat and no electric output from his heart.[108] PCA Hodge commenced CPR on Mr Plasto-Lehner.[109] Dr Oh intubated Mr Plasto-Lehner and he was administered adrenalin.[110] Mr Plasto-Lehner was moved shortly thereafter to the Intensive Care Unit.[111]

100. The blood and fluids on the ground where Mr Plasto-Lehner had been restrained were temporarily covered up with a wheelchair and then were cleaned up by hospital staff.

---

[100] Evidence of Elinor Cromarty on 6 March 2009, p 778 of the transcript; Evidence of Carissa Oh on 4 March 2009, p 556 of the transcript; Evidence of Theresa De Groot on 4 March 2009, p 534 of the transcript.
[101] Statement of Elinor Cromarty dated 9 January 2008, p 9, Folio 2 of the Police Brief.
[102] Statement of Lai Heng Foong dated 8 January 2008, p 3, Folio 2 of the Police Brief.
[103] Statement of Elinor Cromarty dated 9 January 2008, p 9, Folio 2 of the Police Brief.
[104] Statement of Elinor Cromarty dated 9 January 2008, p 9, Folio 2 of the Police Brief.
[105] Statement of Lai Heng Foong dated 8 January 2008, p 3, Folio 2 of the Police Brief.
[106] Evidence of Lai Heng Foong on 5 March 2009, p 630 of the transcript.
[107] Statement of Elinor Cromarty dated 9 January 2008, p 10, Folio 2 of the Police Brief.
[108] Statement of Lai Heng Foong dated 8 January 2008, p 4, Folio 2 of the Police Brief.
[109] Statement of Chris Hodge dated 11 January 2008, p 6, Folio 2 of the Police Brief.
[110] Statement of Carissa Oh dated 9 January 2008, p 4; Folio 2 of the Police Brief.
[111] Statement of Lai Heng Foong dated 8 January 2008, p 16, Folio 2 of the Police Brief.

101. Mr Plasto-Lehner was later transferred into the Intensive Care Unit. He did not recover consciousness and died in the Intensive Care Unit on 28 December 2007. Dr Sinton prepared the post mortem report and expressed his opinion that the cause of death was acute bronchopneumonia, compounded by concurrent acute cerebral hypoxia, acute renal failure secondary to rhabdomyolysis and chronic cardiomyopathy.

102. Dr Botterill, a forensic pathologist, was requested by the Northern Territory Deputy Coroner to provide a review of the post mortem report, the circumstances of this death and the issue of restraint-associated deaths. Dr Botterill stated that he would have expressed the cause of death as:[112]

> 1a Combined effects of restraint asphyxia, obesity-associated heart disease and chronic airways disease
>
> 2 Bipolar depressive disorder.

And Dr Botterill stated:

> My rationale is that it is most likely that ALL of conditions (restraint per se, asphyxia associated with restraint, cardiac function compromise associated with heart enlargement most probably due to obesity, heart muscle scarring most probably due to obesity associated heart enlargement, obesity per se, chronic airways disease) have contributed to the circumstances, additively increasing the chance of a cardiac arrest, and that ANY of these conditions alone could also have resulted in that cardiac arrest.

3.1 Human rights instruments and principles relevant to the treatment of Mr Plasto-Lehner

103. The following human rights instruments and principles are relevant to the treatment of Mr Plasto-Lehner.

(a) Rights to humane treatment

104. Article 7 of the ICCPR provides that 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'.[113] The aim of article 7 is to protect the dignity and the physical and mental integrity of the individual.[114]

105. The prohibition in article 7 is complemented in the ICCPR by the positive requirements of article 10. Article 10(1) provides that 'all persons deprived of their liberty shall be treated with humanity and with respect for the inherent

---

[112] Exhibit 5 – Report of Dr Botterill dated 10 February 2009, p 6.
[113] See also Principle 7 of the *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*: 'No person under any form of detention or imprisonment shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
[114] Human Rights Committee, General Comment No. 20: Replaces general comment 7 concerning prohibition of torture and cruel treatment or punishment (Art 7): 10/03/92, CCPR General Comment No. 20 at [2] and [5].

dignity of the human person'.[115] Article 10(1) of the ICCPR imposes this positive obligation on States because individuals who are deprived of their liberty are particularly vulnerable. Respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons.[116]

106. The assessment of whether the treatment of a person is inconsistent with article 7 or 10 depends on all the circumstances of the case, such as the duration and manner of the treatment, its physical or mental effects as well as the sex, age and state of health of the victim. Accordingly, the assessment of whether the treatment is inconsistent with article 7 or 10 of the ICCPR is in part a subjective evaluation. Factors such as the victim's age and mental health will aggravate the effect of certain treatment so as to bring that treatment within article 7 or 10.[117]

(b) Right to life

107. Article 6(1) of the ICCPR states that 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'. It is an essential component of the right to life that police, by arresting and detaining individuals, take responsibility to care for their life.

108. Where the actions of the state, including the actions of the police, may have contributed to a person's death, state parties have a positive obligation to investigate the circumstances surrounding that death to determine whether it was an arbitrary deprivation of life, and to provide redress where a breach of the right to life has occurred.

109. This obligation to investigate is a positive obligation arising from the right to life in article 6 of the ICCPR. Article 2(3) of the ICCPR also requires state parties to ensure that any persons whose rights have been violated shall have an effective remedy in respect of the violation of that right.

(c) Breaches of human rights

110. For the reasons set out below, the Commission submits that the treatment of Mr Plasto-Lehner by the Northern Territory police was inconsistent with both article 10(1) of the ICCPR and the prohibition on inhuman and degrading treatment in article 7 of the ICCPR in the following respects:

---

[115] See also Principle 1 of the *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*: 'All persons under any form of detention or imprisonment shall be treated in a humane manner and with respect for the inherent dignity of the human person.' And, Principle 1(2) of the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*: 'All persons with a mental illness…shall be treated with humanity and respect for the inherent dignity of the human person'.

[116] Human Rights Committee, General Comment No.21: Replaces general comment 9 concerning humane treatment of persons deprived of liberty (Art 10): 10/04/92, CCPR General Comment No.21 at [3]-[4].

[117] *Vuolanne v Finland,* Communication No. 265/1987: CCPR/C/35/D/265/1987 at [9.2]; *Brough v Australia,* Communication No. 1184/2003: CCPR/C/86/D/1184/2003 at [9.4]. See also *Keenan v United Kingdom* [2001] ECHR 242 (3 April 2001), with respect to the meaning of the equivalent provision in the *Convention for the Protection of Human Rights and Fundamental Freedoms*.

- the use of the prone restraint; and
- the failure to convey Mr Plasto-Lehner directly to hospital, including his detention alone in a police vehicle for about 15 minutes.

111. The Commission also submits that the Northern Territory police failed to properly care for Mr Gurralpa's health and life during his detention.

112. Finally, the Commission submits that the failure to properly investigate Mr Plasto-Lehner's serious injury, and ultimate death, was inconsistent with the obligation to provide an effective remedy imposed by articles 2(3) and 6 of the ICCPR.

3.2 The prone restraint of Mr Plasto-Lehner at Royal Darwin Hospital

113. In the Commission's submission, there are three issues of concern in respect of the use of force to restrain Mr Plasto-Lehner at Royal Darwin Hospital:

- the decision to use force;
- the degree of force used; and
- the police failure to monitor Mr Plasto-Lehner while he was restrained.

114. While some hospital staff were involved in the restraint of Mr Plasto-Lehner, the Commission considers that the police remained in control of the restraint of Mr Plasto-Lehner at all times. Accordingly, the Commission restricts its observations in respect of the use of force to the police members involved.

(a) The decision to use force

115. The Commission submits that the decision to use force on Mr Plasto-Lehner was not necessary in the circumstances.

116. When Mr Plasto-Lehner did not go back into the Oleander Room as he was being directed and walked a few steps towards the ambulance bay foyer, Acting Sergeant Fox decided to employ ground stabilisation techniques.

117. In deciding how to respond to Mr Plasto-Lehner's failure to comply with his directions, Acting Sergeant Fox was required to assess whether the use of force was necessary in the circumstances. Section 27 of the *Criminal Code* (NT) states that the use of force, not being such force likely to cause death or serious harm, will not be justified if 'unnecessary force' is used.

118. These statutory requirements are re-stated, in part, in the Defensive Tactics Manual which states:[118]

---

[118] Exhibit 17 (Confidential) - Northern Territory Police Operational Safety and Tactics Training Unit, Defensive Tactics Manual 2006, cl 1.1.4, p 9.

> The basis of this legislation requires that force used must be proportionate to the objective and it must be necessary…
>
> It is important that members have a full knowledge of the Statutory Authority that allows members of the Police to use force during the performance of their duties.

119. Relevantly, the Defensive Tactics Manual states that a 'Safety First' philosophy underpins the operating methods of police members. This philosophy promotes the avoidance of force where possible and the minimum use of force where it is unavoidable.[119]

120. In assessing the range of options which were open to Acting Sergeant Fox and whether the use of force was necessary, it is relevant that there were a number of police members present to assist and contain the situation, as well as two security guards. In particular, ACPO Krepapas and Constable Jackson were situated between Mr Plasto-Lehner and the glass sliding doors to the ambulance bay. The Commission submits that other options were reasonably available to the police members:

- trying to block Mr Plasto-Lehner's access to the green button that activated the sliding doors or the sliding doors themselves;
- seeking to persuade Mr Plasto-Lehner that he could go out another door for fresh air and a cigarette and offer to take him there; or
- otherwise temporarily distracting him, using strategies for dealing with mentally ill persons.

121. In the Commission's submission, it was not necessary for Acting Sergeant Fox to use force in the circumstances. There were a range of options available to him that did not require the use of force, and a significant number of police members present to assist. Nor, as will be set out below, was the degree of force deployed proportionate to the circumstances.

122. The Commission submits that the decision to use force on Mr Plasto-Lehner demonstrates that greater training is needed for Northern Territory police members in dealing with mentally ill persons. Recommendations for training are outlined below at paragraphs 140 - 142.

(b) The degree of force used in restraining Mr Plasto-Lehner

123. The Commission submits that the degree of force used by the police members was not proportionate to the circumstances.

124. As set out above, when Mr Plasto-Lehner failed to comply with his directions, Acting Sergeant Fox employed ground stabilisation techniques, and in particular the prone restraint accompanied by the three point hold. He also

---

[119] Exhibit 17 (Confidential) - Northern Territory Police Operational Safety and Tactics Training Unit, Defensive Tactics Manual, 2006, cl 1.1.4, p 9.

used his knee to restrain Mr Plasto-Lehner's head. Three other police members assisted with the prone restraint of Mr Plasto-Lehner.

125. Mr Plasto-Lehner was a mentally ill person. He was distressed and anxious. He had been scheduled under the *Mental Health and Related Services Act* (NT) and was an involuntary patient of the hospital.

126. Mr Plasto-Lehner had not committed or attempted to commit any offence. Aside from his failure to comply with Acting Sergeant Fox's instructions for him to return to the Oleander Room, Mr Plasto-Lehner had been compliant with directions from the police members, security guards and the hospital staff.

127. Mr Plasto-Lehner presented with a number of risk factors that made him more susceptible to death by positional asphyxia, including:

- obesity, particularly a 'big belly';
- pre-existing heart disease;
- significant physical exertion during restraint; and
- acute psychosis and agitation.

128. Other visible factors which were relevant include the age of Mr Plasto-Lehner, and that he was a heavy smoker. In addition, the number of police members involved in the prone restraint of Mr Plasto-Lehner increased the intensity of the restraint, and it may be that the knee holding Mr Plasto-Lehner's head to the ground also increased the risk of positional asphyxia. As described by Dr Foong:

> ...he must have been full weight because this guy couldn't turn his ...head at all, and that's when he started bleeding, and that's when I got a bit worried, and said, you know, like – and I could see that he was struggling initially, not struggling any more and then he went from a pink colour to blue.[120]

129. In the Commission's submission the degree of force used by police members on Mr Plasto-Lehner was not a necessary and proportionate response to the situation. The police members failed to take account of the fact that Mr Plasto-Lehner was mentally ill, in a distressed and anxious state, and by and large had been compliant with police directions. Moreover, the decision to put Mr Plasto-Lehner in a prone restraint position, such that he was restrained by several people while being handcuffed, failed to properly take into account the risk factors of positional asphyxia relevant to Mr Plasto-Lehner.

130. Additionally, Acting Sergeant Fox used his knee to restrain Mr Plasto-Lehner's head in a manner inconsistent with any techniques taught to Northern Territory police members.[121]

---

[120] Statement of Lai Heng Foong dated 8 January 2008, pp 9-10, Folio 2 of the Police Brief.
[121] Evidence of Gregory Hansen on 10 March 2009, pp 945 – 946 of the transcript.

131. In the Commission's submission, the force used on Mr Plasto-Lehner was excessive and was inconsistent with both the right of a detained person to be treated humanely in article 10(1) of the ICCPR and the prohibition on inhuman and degrading treatment in article 7 of the ICCPR. Moreover, the fact that Mr Plasto-Lehner was suffering an acute psychotic episode is likely to have aggravated the effect of the treatment. That is, it is likely that the degree of force used would have caused Mr Plasto-Lehner a very high level of distress and fear.

(c) The police failure to monitor Mr Plasto-Lehner while he was restrained

132. It is an essential part of the right to life that the State, by detaining individuals, takes responsibility to care for their life.

133. These obligations are implemented, in part, in the Northern Territory Police Custody Manual, in Part One – Care and Safety of Persons in Custody (Care and Safety General Order) and in the Defensive Tactics Manual.

134. The Care and Safety General Order requires police members to act with an active concern for the safety and welfare of detainees.[122] The Defensive Tactics Manual requires police members to monitor the condition of a person immediately after restraint in order to minimise a risk of positional asphyxia.

135. As noted above at paragraphs 59 - 63, the Commission considers that the obligation to monitor a person immediately after use of the prone restraint is not sufficient to prevent a loss of life.

136. When Mr Plasto-Lehner was being restrained there were clear signs that his situation was worsening, but he was not released from the prone restraint position in time to prevent his death. Mr Plasto-Lehner struggled for a prolonged period; his face went a dark red colour; and then his face went blue. The police members did not monitor his condition directly and failed to heed a number of warning calls from the doctors present and calls for them to 'get off'.

137. A number of police members say that the failure to heed warnings was because they did not hear them as a result of being so focused on restraining Mr Plasto-Lehner. For example, ACPO Krepapas says that 'I didn't hear anything they were saying, but I know that they were saying something'.[123] Research has demonstrated that police members acting in a high stress situation have reduced sensory perception, such as 'tunnel vision' and diminished hearing.[124] This has implications for the training of police members in how to respond in high-stress situations, and the importance of having one police member designated to monitor the health and condition of the restrained person where there are multiple police members present. In respect of the training of police members, it has been suggested that in a high-stress situation, police members will revert to an experiential-thinking mode, which is

---

[122] Northern Territory Police Custody Manual Part One - Care and Safety of Persons in Custody, cl 23.1.
[123] Statement of Nicolette Krepapas dated 28 December 2007, p 6, Folio 1 of the Police Brief.
[124] Exhibit 24 - A Artwohl, '*Perceptual and Memory Distortion During Officer-Involved Shootings*'.

thinking based on past experiences produced without conscious thought.[125] Accordingly, it is recommended that police members are not only trained in the skills to respond to warning signs of positional asphyxia but that these skills are tested through repetition *under stress* so that the trained response will take precedent over any previously learned or experienced behaviour.[126]

138. The Commission submits that the Northern Territory police failed to properly care for Mr Plasto-Lehner's life during his detention for the following reason:

- the police members failed to respond sufficiently quickly to the directions of the doctors present that Mr Plasto-Lehner needed to be released immediately from the restraint position.

139. The Commission submits that if the police members had been trained to monitor the condition and health of a person during restraint, and to be alert to the warning signs of the downward spiral of positional asphyxia, it is possible that Mr Plasto-Lehner's death may have been avoided.

(d) Training of Northern Territory police members in dealing with mentally ill persons

140. The Commission submits that the use of force on Mr Plasto-Lehner discloses a significant shortcoming in police training for dealing with persons with a mental illness. While police members receive some training relevant to when they should exercise their powers of detention under the *Mental Health and Related Services Act* (NT), it appears that members receive very little or no training in how best to manage people with mental illness and the sorts of issues that may arise when taking them into custody. In particular, for police involved in conveying people for assessment at Royal Darwin Hospital, there is apparently no training about when it is appropriate for police to seek to restrain a patient and when this role is more appropriate for hospital staff.

141. Ms Bronwyn Hendry, Director of Mental Health, Department of Health and Families, gave evidence that her Department provided an hour and a half training to all new police recruits on recognising the signs and symptoms of mental illness, and that she was aware that they also received some legal training on the *Mental Health and Related Services Act* (NT), but that was the extent of the training that police members received regarding mental illness, to her knowledge.[127] In Ms Hendry's view, the training of police in this regard was inadequate for them to develop the skills and confidence to deal effectively with mentally ill persons.[128] Ms Bronwyn Hendry explained the impact of this:

> Well, I think when people don't have sufficient knowledge and feel they have skills and are confident, then they are fearful of people with mental illness and fearful of the unpredictability of their behaviour. And I think that applies to the public or everyone, not just police officers. And I think when you respond from a position of

[125] Exhibit 24 - A Artwohl, '*Perceptual and Memory Distortion During Officer-Involved Shootings*', p 4.
[126] Exhibit 24 - A Artwohl, '*Perceptual and Memory Distortion During Officer-Involved Shootings*', p 4.
[127] Evidence of Bronwyn Hendry on Friday 6 March 2009, p 759 of the transcript.
[128] Evidence of Bronwyn Hendry on Friday 6 March 2009, p 760 of the transcript.

> fear, then you respond in a much different way than if you are comfortable in that situation and you feel you can manage that.
>
> THE CORONER: You're more likely to be unsubtle in your reactions, aren't you?
>
> BRONWYN MARY HENDRY: Yes.[129]

142. The Commission submits that Northern Territory police members should be comprehensively trained in how to deal appropriately with people with mental illness and practical guidelines should be developed. Such training should include an outline of the standards and principles that apply to mentally ill persons receiving medical attention, so that police members are aware that the use of force should be treated as a matter of last resort when a person is apprehended for the purposes of mental health assessment and treatment. The Commission submits that police members should be made aware of the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*[130] (the 'Mental Illness Principles') as a reference point. The relevant principles include:

- Principle 8(2): every patient is to be protected from harm, including unjustified medication abuse by other patients, staff or others or other acts causing mental distress or physical discomfort;
- Principle 9(1): every patient shall have the right to be treated in the least restrictive environment…; and
- Principle 11: physical restraint … of a patient shall be employed … only when it is the only means available to prevent immediate or imminent harm to the patient or others.

3.3 Transporting Mr Plasto-Lehner to Royal Darwin Hospital

143. The Commission submits that Mr Plasto-Lehner's conveyance to Royal Darwin Hospital via Darwin Police Station was inconsistent with the right of a detained person to be treated humanely in article 10(1) of the ICCPR.

144. The Commission is also concerned that Mr Plasto-Lehner was transported in a police caged vehicle to Royal Darwin Hospital. The Commission submits that being held in a locked caged vehicle can be a punitive and degrading experience for a person who is being transported for an urgent mental health assessment.

145. It is Northern Territory police policy that:

> A person apparently suffering from mental illness should normally not be conveyed in a police vehicle, particularly a caged vehicle. Where immediate apprehension is effected this may be unavoidable and, wherever practicable,

[129] Evidence of Bronwyn Hendry on Friday 6 March 2009, p 760 of the transcript.
[130] General Assembly Resolution 46/119 of 17 December 1991.

> mental health or other medical professionals should be requested to transport mentally ill persons.[131]

146. One of the reasons why a police caged vehicle is inappropriate for transporting people suffering from mental illness is outlined in clause 24.4 of the Northern Territory Police General Order on the Transport of Persons in Custody, which states that:

> Members need to be aware of the hazards involved in transporting a person in custody in the caged section of a police vehicle. These areas, by necessity, do not have:
>
> ….
>
> 24.4 any means of communication.

147. Where a person is suffering from mental illness it is critically important that the person is continually monitored. In the case of Mr Plasto-Lehner, being able to speak to someone and be reassured by that person helped to alleviate his state of anxiety and confusion.

148. Persons detained by police for the purpose of a mental health assessment should be treated with humanity and dignity. When a person who is suffering from mental illness is detained and transported in a locked cage in a police vehicle, this can be a punitive and degrading experience to a vulnerable person and should be a measure of last resort.

149. In the present case, the Commission submits that the use of a police caged vehicle was not a last resort. It was open to the police to request an ambulance to take Mr Plasto-Lehner to the hospital. It was also open to the police to convey Mr Plasto-Lehner in a marked or unmarked police sedan, without detaining him in a locked cage in a public space.

150. It is also noted that no request was made by the police for assistance from Mental Health Services. If this request had been made, it may have been possible that Mr Plasto-Lehner could have been accompanied by a mental health professional.

151. Additionally, and most importantly, the Commission submits that the decision to convey Mr Plasto-Lehner to Royal Darwin Hospital via Darwin Police Station was 'unacceptable'.[132] The effect of this decision was to significantly increase the time that Mr Plasto-Lehner spent in the locked caged section of the police vehicle, an experience which appears to have contributed to his increasing distress and anxiety.

152. The Commission further submits that the overall circumstances of Mr Plasto-Lehner's transport to Royal Darwin Hospital constituted a breach of his right as a detained person to be treated with humanity and with respect for his

---

[131] Northern Territory Police Custody Manual Part Six - Mentally Ill Persons, cl 9.1. See also *Memorandum of Understanding in Respect of Cooperative Arrangements in Mental Health Response Situations*, June 2002, cl 5.7.1.
[132] Philip Strickland SC on Tuesday 10 March 2009, p 966 of the transcript.

inherent dignity. This human right is outlined in article 10(1) of the ICCPR and the Mental Illness Principles specifically recognise the application of the right to people with mental illness:

> All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect of the inherent dignity of the human person.[133]

153. The Commission submits that, as discussed above at paragraph 106, for a person with a mental illness to be treated with humanity and with respect for his or her inherent dignity, the vulnerability and particular needs of that person must be taken into account.

154. The Commission notes that when asked about the Memorandum of Understanding or what training they had had in respect of communicating and negotiating with mentally ill persons, many of the police members involved in the apprehension and conveyance of Mr Plasto-Lehner state that they had not received training on these matters.[134]

155. The Commission also submits that there is insufficient written procedural guidance provided to police members on the transport of persons suffering mental illness, particularly those who are being transported solely for mental assessment. For example, Part 6 of the Northern Territory Police Custody Manual, which is dedicated to interactions between police members and mentally ill persons, could provide much clearer and concise guidance which explains, step-by-step, the considerations to be taken into account when exercising the power to immediately apprehend a person for the purposes of a mental health assessment, including:

- assessing whether each of the requirements of s 32A of the *Mental Health Act* have been met;
- explaining communication strategies for dealing appropriately with a person suffering mental disturbance;
- calling Mental Health Services to see whether they could provide a field assessment at short notice or provide any assistance;
- locating the nearest place of assessment for a person suffering mental disturbance;
- identifying what would be the appropriate form of transport to take the person there, including whether an ambulance could be requested, or whether Mental Health Services could transport the person;

---

[133] *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, article 1(2).

[134] Evidence of Adrian Kidney on 4 March 2009, p 485 of the transcript; Evidence of Linda Sayers on 4 March 2009, pp 496 - 497 of the transcript; Statement of Vanessa Martin dated 29 December 2007, p 5, Folio 1 of the Police Brief; Evidence of Nicolette Krepapas on 4 March 2003, p 521 of the transcript; Evidence of Eric Morrison 6 March 2009, p 684 of the transcript.

- ensuring that the person is promptly taken to the most appropriate place of assessment by the most direct route;

- outlining members' responsibilities in respect of contacting the place of treatment to advise they are bringing a person in, and what their symptoms are;

- directing members to ensure that the appropriate forms are filled out and provided to the place of treatment; and

- providing guidance on when it is appropriate for police members to remain at the place of treatment and when they should leave.

156. The Commission recommends that Part 6 of the Northern Territory Police Custody Manual should be revised accordingly. In addition, the General Order on Transport should be similarly revised.

157. The Commission is also concerned that ACPO police members in particular may not receive essential training in respect of dealing with mentally ill persons and their obligations in respect of mentally ill persons. With respect to Mr Plasto-Lehner, ACPO Jon Morrison radioed twice for police backup within a period of approximately 20 minutes. In this time, ACPO Jon Morrison could have also requested an ambulance to attend Knuckey Street, which the Commission suggests would have been the most appropriate course of action.

158. The Commission recommends that there be greater training on the terms of the Memorandum of Understanding for all police members as well as more in-depth training on dealing with mentally ill persons in the course of their duties.

3.4 The police investigation into the serious injury and death of Mr Plasto-Lehner

159. The Commission submits that the failure to comply with a number of the requirements of Part 10 of the Custody Manual – Deaths in Custody and Investigation of Serious And/Or Fatal Incidents Resulting From Police Contact with the Public (Deaths in Custody General Order) was inconsistent with the State's obligation to provide an effective remedy in respect of Mr Plasto-Lehner's right to life, as required by articles 2(3) and 6 of the ICCPR.

160. The Commission is concerned that there was a failure to comply with a number of the requirements of Part 10 of the Custody Manual – Deaths in Custody and Investigation of Serious And/Or Fatal Incidents Resulting From Police Contact with the Public (Deaths in Custody General Order).

161. The Deaths in Custody General Order requires that there be a police investigation into a serious or fatal incident resulting from police contact with the public. The Commission is concerned that a police investigation was not fully undertaken until Mr Plasto-Lehner's death on 28 December 2007. This is despite the fact that a serious incident resulting from police contact with the public had occurred on 22 December 2007, namely that Mr Plasto-Lehner's heart had stopped as a result of being held in a prone restraint position and handcuffed, with the weight of several persons on top of him.

162. The Commission submits that this was in breach of the Deaths in Custody General Order and this breach compromised the investigation which was initiated after Mr Plasto-Lehner's death. As discussed below, it appears that there was a failure to segregate the police members who were involved in the serious incident which led to the death of Mr Plasto-Lehner, there was a failure to prevent communication between these police witnesses, and there was a failure to establish a crime scene and preserve the evidence.

163. As noted in the Deaths in Custody General Order, where serious injury or the death of an individual occurs as a result of police contact with the public, this can undermine the reputation of, and public confidence in, the police force.[135] It is essential that the police investigation into the serious injury or death is impartial, thorough and completed in an objective and timely manner.[136] Where this does not occur, it is a breach of the Deaths in Custody General Order. It also breaches the obligation to provide an 'effective remedy' in respect of an individual's human rights, in this case the right to life.[137]

(a) Obligations of the senior police member arising upon the report of an incident

164. Clause 3.3 of the Deaths in Custody General Order states that:

> Where the death or serious incident was, or appears to have been, as a result of police contact with the public, the first senior member responding to the scene shall immediately advise the Duty Superintendent or where appropriate the Divisional Superintendent. The senior member will ensure that the scene is secured and only essential personnel involved in the preservation of life are allowed access. The senior member will also ensure that all witnesses to the incident are identified, that communication between such witnesses is prevented and arrangements are made for their immediate segregation, particularly any Police members directly involved in the incident.

165. 'Senior member' is not defined in the Deaths in Custody General Order. It appears that Detective Sergeant Derek Maurice was that senior police member in the present case. Detective Sergeant Maurice was called to attend Royal Darwin Hospital on 22 December 2007. Detective Sergeant Maurice's notes from his notebook indicate that he arrived at Royal Darwin Hospital at 6:50pm. Detective Sergeant Maurice states that by the time he arrived, the blood and bodily fluids had been cleaned up. He says he spoke with Kim Lavender and Doctor Surr at 7:30pm, and conducted the four interviews of the police members back at Darwin Police Station at the end of their shift.

166. In the Commission's view, on 22 December 2007 Detective Sergeant Maurice failed to (i) prevent communication between the witnesses; and (ii) to immediately segregate the witnesses, particularly those police members directly involved in the incident, as required by cl 3.3 of the Deaths in Custody General Order.

---

[135] Northern Territory Police Custody Manual Part 10– Deaths in Custody and Investigation of Serious And/Or Fatal Incidents Resulting From Police Contact with the Public, cl 1.3.
[136] Northern Territory Police Custody Manual Part 10– Deaths in Custody and Investigation of Serious And/Or Fatal Incidents Resulting From Police Contact with the Public cls 1.4 and 4.1.
[137] Article 6(1) of the ICCPR.

(b) Police member responsibilities under the Deaths in Custody General Order

167. Where a police member is involved in a serious or fatal incident, their obligations include being interviewed before the completion of their shift (cl 6.1.2). The Commission is concerned that there was only technical compliance with this obligation. Each of the officers declined to participate in the interview prior to the completion of their shift on the ground that they wished to seek legal advice. Clause 6.1.3 of Part 6 notes that police members are to be given the opportunity to seek legal advice. While this is appropriate, it should not be applied in such a way as to undermine the apparent purpose of the requirement in cl 6.1.2: namely, to ensure that the most contemporaneous statement possible is obtained.

168. In the present matter, statements were not ultimately taken until 28 December 2007. This is an unacceptable delay. The Commission notes that in the Gurralpa matter, Constables Lees and Berlin confirm that they received advice from Vince Kelly of the Northern Territory Police Association over the phone prior providing a statement on the day of the incident.[138] The Commission submits that the General Order should be amended to reflect that where advice is sought by a member who wishes to receive advice and it is not possible to do so before the end of the member's shift, the member should be interviewed as soon as reasonably possible.

4 Recommendations

169. The recommendations which the Commission submits that the Coroner should make in respect of the prevention of future deaths in similar circumstances and the administration of justice are set out below at Schedule One.

[138] Evidence of Marcus Lees on 2 March 2009, p 344 of the transcript; Evidence of Brendan Berlin on 2 March 2009, p 307 of the transcript.

SCHEDULE ONE: RECOMMENDATIONS

The Commission submits that the Coroner should make the following recommendations with respect to the prevention of future deaths in similar circumstances and the administration of justice.

Prone restraint and positional asphyxia

1. The Northern Territory Police should ensure that all members are trained and re-trained using reality based techniques to ensure an understanding of positional asphyxia which should include:

    a. the correlation between restraint positions and positional asphyxia;

    b. the risk factors;

    c. the signs and symptoms of positional asphyxia; and

    d. the prevention strategies to reduce the likelihood of positional asphyxia death, including identifying persons at risk and avoiding the prone restraint unless absolutely necessary.

2. The Northern Territory Police training on the risk factors associated with positional asphyxia be extended to include:

    a. middle-aged Aboriginal men as a risk group; and

    b. the use of the term ‘big bellies’ as a risk factor, in recognition that obesity may be a factor that is difficult to judge.

3. The Northern Territory Police should ensure that all members are trained and re-trained to monitor the health of persons where practicable during the use of the prone restraint, as well as immediately after the use of the prone restraint.

Treatment of mentally ill persons in custody

4. The Northern Territory Police should ensure that all members are trained and re-trained in strategies to deal with mentally ill persons both in custody and generally in the course of their duties. This could include retaining a mental health expert to provide training to police members on matters such as:

    a. communication strategies with mentally ill persons, including how to establish a rapport and calm down a distressed person;

    b. control tactics, including using distraction as a means of de-escalating an aggressive situation, verbal forms of restraint, containment strategies; and

    c. identifying symptoms and understanding changes in behaviour of mentally ill persons to be able to respond appropriately.

    The training should ensure that all members develop and retain the skills and confidence to treat mentally ill persons appropriately and with respect.

5. The Northern Territory Police should amend the General Order on Transport of Persons in Custody, and Part 6 of the Custody Manual – Mentally Ill Persons to include step-by-step instructions for police members on exercising the power of immediate apprehension for the purposes of a mental health assessment, including:

    a. assessing whether each of the requirements of s 32A of the Mental Health Act have been met;

    b. communication strategies for dealing appropriately with a person suffering mental disturbance;

    c. calling Mental Health Services to see whether they could provide a field assessment at short notice or provide any assistance;

    d. locating the nearest place of treatment for a person suffering mental disturbance;

    e. identifying the appropriate form of transport, including whether an ambulance could be requested, or whether Mental Health Services could provide transport;

    f. ensuring that the person is promptly taken to the most appropriate place of assessment by the most direct route;

    g. outlining members' responsibilities to contact the place of treatment to advise they are bringing a person in, and what their symptoms are;

    h. directing members to ensure that the appropriate forms are filled out and provided to the place of treatment; and

    i. providing guidance on when it is appropriate for police members to remain at the place of treatment and when they should leave.

Police investigations of serious or fatal incidents resulting from police contact with the public

6. The Northern Territory Police should make the following amendments to Part 10 of the Northern Territory Policy Custody Manual – Deaths in Custody and Investigation of Serious and/or Fatal Incidents Resulting from Police Contact with the Public:

    a. Part 6 of the Order be amended to ensure that police members' responsibilities arise in respect of all incidents defined by the Order, not just in respect of fatal incidents.

    b. Clause 6.1.2 of the Order be amended to reflect that where legal advice is sought by a member and it is not possible to obtain that advice before the end of the member's shift, the member should be interviewed as soon as reasonably practicable thereafter.